Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Seamless Care Models Group

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Baltimore, MD 21244

Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model

Second Amended and Restated Participation Agreement

(2023 Starters)

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SECOND AMENDED & RESTATED PARTICIPATION AGREEMENT

This amended and restated participation agreement is between the CENTERS FOR MEDICARE & MEDICAID SERVICES ("**CMS**") and

____,
an Accountable Care Organization ("**ACO**").

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 ACO is an entity composed of health care providers operating under a common legal structure, which accepts financial accountability for the overall quality and cost of medical care furnished to Medicare fee-for-service ("**FFS**") Beneficiaries aligned to the entity.

CMS is implementing the ACO Realizing Equity, Access, and Community Health (REACH) Model ("**Model**") under section 1115A of the Social Security Act ("**Act**"), which authorizes CMS, through its Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program expenditures while maintaining or improving the quality of beneficiaries' care. This Model was known as the Global and Professional Direct Contracting (GPDC) Model for the first two Performance Years of the Model Performance Period. However, on February 24, 2022, the Center for Medicare and Medicaid Innovation announced that it was redesigning the Model and renaming it the ACO REACH Model. The first Performance Year of the redesigned Model began on January 1, 2023.

The Model seeks to reduce Medicare FFS expenditures while improving the quality of care and health outcomes for Medicare FFS Beneficiaries through financial incentives, emphasis on beneficiary choice, strong monitoring to ensure that Beneficiaries maintain access to care, and an emphasis on care delivery for Beneficiaries with complex, chronic, and serious illness.

The ACO has selected to participate in one of two Risk-Sharing Options offered under the Model: (1) a higher-risk option, under which the ACO assumes 100 percent risk for savings or losses and can select either Total Care Capitation Payment or Primary Care Capitation Payment as its Capitation Payment Mechanism ("**Global**"); or (2) a lower-risk option under which the ACO assumes 50 percent risk for savings or losses and must select Primary Care Capitation Payment as its Capitation Payment Mechanism ("**Professional**").

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

On December 29, 2022, the parties executed a participation agreement governing their rights and obligations under the Model Performance Period and any remaining duration of the Agreement Term ("**Agreement**"). On December 21, 2023, the parties executed the First Amended and Restated Participation Agreement ("**First Amended and Restated Participation Agreement**").

The parties now desire to amend and restate the Agreement in its entirety, together with all Amendments to:

- Update Appendix B in its entirety beginning for Performance Year 2025, including but not limited to incorporation of the SAHS billing policy, risk adjustment changes, and removal of the demographic adjuster;

- Update quality measures provisions to expand CMS' ability to update measure specifications during a Performance Year;

- Update the Reports section to include the provision of Beneficiary Level data for quality measures;

- Update the definition of Provisional Settlement to include the demand of Other Monies Owed starting within Performance Year 2025 Settlement;

- Update Appendix R with model overlap information between REACH and other CMMI models;

- Update the definitions section to reference certain categories of services and payments under the Guiding an Improved Dementia Experience (GUIDE) model;

- Update Beneficiary Representation in the ACO's Governing Body to allow an exception in case of extreme circumstances for High Needs Population ACOs;

- Update the Certified Electronic Health Record Technology (CEHRT) regulation reference to reflect changes for Performance Year 2025;

- Update the language of Appendix H to disallow ACOs from holding multiple financial guarantees to cover the requirements of a single Performance Year;

- Update the notification requirements in Section 15.04 for overpayment and fraud.

The parties therefore agree as follows:

ARTICLE I Agreement Term

Section 1.01 Effective Date

The Agreement became effective when it was signed by the last party to sign it (as indicated by the date associated with that party's signature) (the "**Effective Date**").

Section 1.02 Agreement Term

The term of the Agreement (the "**Agreement Term**") began on the Effective Date and expires two years after the last day of the Agreement Performance Period, defined in Section 1.03, unless the Agreement is sooner terminated by CMS in accordance with Article XVII, in which case the Agreement Term ends on the effective date of such termination.

Section 1.03. Agreement Performance Period

The performance period of this Agreement ("**Agreement Performance Period**") begins on January 1, 2025 (the "**Start Date**") and ends at 11:59 PM ET on December 31, 2026, unless the Agreement Performance Period or the Agreement is sooner terminated by either party in accordance with Article XVII, in which case the Agreement Performance Period ends on the Day specified by CMS in writing.

ARTICLE II Definitions

The parties agree that the following definitions apply for purposes of the Model Performance Period:

"**ACO Activities**" means activities related to promoting accountability for the quality, cost, and overall care for a population of REACH Beneficiaries, including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; or carrying out any other obligation or duty of the ACO under the Agreement. Examples of these activities include, but are not limited to, providing direct patient care in a manner that reduces costs and improves quality; promoting evidence-based medicine and patient engagement; reporting on quality and cost measures under the Agreement; coordinating care, such as through the use of telehealth, remote patient monitoring, and other enabling technologies; establishing and improving clinical and administrative systems for the ACO; meeting the quality performance standards of the Agreement; evaluating health needs; communicating clinical knowledge and evidence-based medicine; and developing standards for Beneficiary access and communication, including Beneficiary access to medical records.

"**ACO Professional**" means a Participant Provider who is any one of the following:

A. A physician (as defined in section 1861(r) of the Act); or

B. One of the following non-physician practitioners:

  1. Physician assistant who satisfies the qualifications set forth at 42 CFR § 410.74(a)(2)(i)-(ii);
  2. Nurse practitioner who satisfies the qualifications set forth at 42 CFR § 410.75(b);
  3. Clinical nurse specialist who satisfies the qualifications set forth at 42 CFR § 410.76(b);
  4. Certified registered nurse anesthetist (as defined at 42 CFR § 410.69(b));

5. Certified nurse midwife who satisfies the qualifications set forth at 42 CFR § 410.77(a);
6. Clinical psychologist (as defined at 42 CFR § 410.71(d));
7. Clinical social worker (as defined at 42 CFR § 410.73(a)); or
8. Registered dietician or nutritional professional (as defined at 42 CFR § 410.314).

"**Alignment Methodology**" means the methodology selected by the ACO as described in Section 8.01 that determines the frequency with which REACH Beneficiaries are aligned to the ACO. The two Alignment Methodologies include Prospective Alignment and Prospective Plus Alignment.

"**APO**" stands for "**Advanced Payment Option**" and means a supplemental payment mechanism available for selection by the ACO for a Performance Year as described in Section 8.01 if the ACO also has selected PCC Payment for that Performance Year. If the ACO selects the APO, CMS will make a prospective monthly APO payment to the ACO for APO Eligible Services furnished to REACH Beneficiaries by those Participant Providers and Preferred Providers participating in the APO. The amount of the monthly APO payment is calculated in accordance with Appendix F of the Agreement.

"**APO Eligible Services**" means all Covered Services that are not PCC Eligible Services.

"**APO Fee Reduction**" means a full or partial reduction in Medicare FFS payments to those Participant Providers and Preferred Providers who have agreed to receive such reduced payment for APO Eligible Services furnished to REACH Beneficiaries to account for the monthly APO payments made by CMS to the ACO.

"**At-Risk Beneficiary**" means a Beneficiary who—

A. Has a high risk score on the CMS-Hierarchical Condition Category (HCC) risk adjustment model;
B. Is considered high cost due to having two or more hospitalizations or emergency room visits each year;
C. Is dually eligible for Medicare and Medicaid;
D. Has a high utilization pattern;
E. Has one or more chronic conditions;
F. Has had a recent diagnosis that is expected to result in increased cost;
G. Is entitled to Medicaid because of disability;
H. Is diagnosed with a mental health or substance use disorder; or
I. Meets such other criteria as specified in writing by CMS.

"**Beneficiary**" means an individual who is enrolled in Medicare.

"**Beneficiary Engagement Incentives**" means the following incentives the ACO may choose to make available to REACH Beneficiaries through Participant Providers and Preferred Providers in order to support high-value services and allow the ACO to more effectively manage the care of REACH Beneficiaries: the Part B Cost-Sharing Support Beneficiary Engagement Incentive and the Chronic Disease Management Reward Beneficiary Engagement Incentive.

“**Benefit Enhancements**” means the following enhanced benefits the ACO may choose to make available to REACH Beneficiaries through Participant Providers and Preferred Providers in order to support high-value services and allow the ACO to more effectively manage the care of REACH Beneficiaries: the 3-Day SNF Rule Waiver Benefit Enhancement, the Telehealth Benefit Enhancement, the Post-Discharge Home Visits Benefit Enhancement, the Care Management Home Visits Benefit Enhancement, the Home Health Homebound Waiver Benefit Enhancement, the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement, and the Nurse Practitioner and Physician Assistant Services Benefit Enhancement. The ACO may select one or more Benefit Enhancements for each Performance Year as described in Section 8.01.

“**Capitation Payment Mechanism**” means a payment mechanism available for selection by the ACO for each Performance Year of the Agreement Performance Period as described in Section 8.01, under which CMS will make periodic payments to the ACO during the Performance Year. The Capitation Payment Mechanisms available for selection include PCC Payment and TCC Payment.

“**CCN**” means a CMS Certification Number.

“**Claims-Based Alignment**” means an analysis of certain Primary Care Qualified Evaluation & Management (PQEM) Services furnished by ACO Professionals, Federally Qualified Health Centers, Rural Health Centers, and Method II Critical Access Hospitals to Beneficiaries and used to align Beneficiaries to the ACO.

“**Covered Services**” means the scope of health care benefits described in sections 1812 and 1832 of the Act for which payment is available under Part A or Part B of Title XVIII of the Act.

“**Days**” means calendar Days unless otherwise specified.

“Enhanced PCC” stands for **“Enhanced Primary Care Capitation”** and means a component of the PCC Payment that is calculated in accordance with the requirements of Appendix E using the maximum Enhanced PCC Percentage selected by the ACO for a Performance Year as described in Section 8.01. CMS will use the Enhanced PCC amount, in addition to the Base PCC amount, as defined in Appendix E of the Agreement, in calculating the amount of the prospective monthly PCC Payments made to the ACO in accordance with Section 12.02.C and Appendix E of the Agreement. CMS will recoup the Enhanced PCC amount from the ACO in accordance with Section 12.02.C.3 and Appendix E of the Agreement.

“**Enhanced PCC Percentage**” means the percentage that will be multiplied by the Performance Year Benchmark to determine the Enhanced PCC amount except as otherwise specified in the Agreement. The Enhanced PCC Percentage is calculated in accordance with Section V of Appendix E.

“Final Financial Settlement” means the process during which CMS compares the ACO’s final Performance Year Benchmark against the ACO’s Performance Year expenditures for REACH Beneficiaries to determine the amount of Shared Savings or Shared Losses in accordance with Section 12.04 and Appendix B of the Agreement, calculates the amount of Other Monies Owed, and calculates the net amount owed by either CMS or the ACO for the Performance Year.

“Financial Guarantee Participation Commitment Mechanism” means a type of Participation Commitment Mechanism under which the ACO must either increase the amount of the financial guarantee required under Section 12.05 by an amount specified by CMS and calculated in accordance with Section II.B of Appendix H of the Agreement or obtain a separate financial

guarantee in this amount that complies with the terms of Section 12.03 and Appendix H of the Agreement.

"Health Equity Activities" has the meaning given in Section 5.10.D.

"Health Equity Plan" has the meaning given in Section 5.10.A.

"High Needs Population ACO" means a REACH ACO that focuses on Beneficiaries with complex, high needs, including dually eligible individuals, and is approved by CMS to participate in the Model as a High Needs Population ACO prior to the Effective Date, and has not subsequently been approved by CMS to participate in the Model as a New Entrant ACO or a Standard ACO pursuant to Article VIII. A High Needs Population ACO qualifies for the alternative Beneficiary alignment minimums specified in Section 5.03.C and qualifies for the methodology for calculating the Performance Year Benchmark described in Section III of Appendix B of the Agreement.

"Implementation Period" means a period of Model implementation. The Model has three Implementation Periods; the first occurred between October 1, 2020 and March 31, 2021; the second occurred between August 1, 2021, and December 31, 2021; and the third occurred between August 1, 2022 and December 31, 2022.

"**GUIDE Overlap Services**" means the services listed in Appendix F, Table 4 to the Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement that, when provided to a GUIDE Beneficiary (as the term is defined in the GUIDE Model Participation Agreement): (1) a GUIDE Model Participant (as the term is defined in the GUIDE Model Participation Agreement) receives a Dementia Care Management Payment (DCMP); and (2) a GUIDE Practitioner (as the term is defined in the GUIDE Model Participation Agreement) may not bill under the Medicare Physician Fee Schedule Services.

"GUIDE Payments" means the payments made pursuant to the GUIDE Model Participation Agreement, including GUIDE Dementia Care Management Payments (DCMP), payments for GUIDE Respite Services, and GUIDE Infrastructure Payments.

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

"**Marketing Activities**" means the distribution of Marketing Materials and other activities, including Voluntary Alignment Activities, conducted by or on behalf of the ACO or its Participant Providers or Preferred Providers, when used to educate, notify, or contact Beneficiaries regarding the ACO's participation in the Model.

"**Marketing Events**" means Marketing Activities that are events designed to educate Beneficiaries about the ACO's participation in the Model.

"**Marketing Materials**" means general audience materials such as brochures, advertisements, outreach events, letters to Beneficiaries, webpages published on a website, mailings, social media, or other materials sent by or on behalf of the ACO or its Participant Providers or Preferred Providers, when used to educate, notify, or contact Beneficiaries regarding the ACO's

participation in the Model. Marketing Materials do not include communications that do not directly or indirectly reference the Model (for example, information about care coordination generally would not be considered Marketing Materials); materials that cover Beneficiary-specific billing and claims issues; educational information on specific medical conditions; referrals for health care items and services; and any other materials that are excepted from the definition of "marketing" under the HIPAA Privacy Rule (45 CFR Part 160 & Part 164, subparts A & E).

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

"**Model Performance Period**" means, regardless of the duration of the Agreement Performance Period, the period that began on April 1, 2021, and ends on December 31, 2026, unless CMS modifies or terminates the Model. The Model Performance Period consists of the following six Performance Years:

1. Performance Year 1 (Performance Year 2021): April 1, 2021 – December 31, 2021
2. Performance Year 2 (Performance Year 2022): January 1, 2022 – December 31, 2022
3. Performance Year 3 (Performance Year 2023): January 1, 2023 – December 31, 2023
4. Performance Year 4 (Performance Year 2024): January 1, 2024 – December 31, 2024
5. Performance Year 5 (Performance Year 2025): January 1, 2025 – December 31, 2025
6. Performance Year 6 (Performance Year 2026): January 1, 2026 – December 31, 2026

"**MVA**" stands for "**Medicare.gov Voluntary Alignment**" and means the process by which a Beneficiary may voluntarily align with the ACO by designating a Participant Provider as the Beneficiary's primary clinician on MyMedicare.gov, Medicare.gov, or any successor site. CMS uses the Beneficiary's MVA in performing Beneficiary alignment as described in Section 5.01 and Appendix A.

"**New Entrant ACO**" means a REACH ACO that is approved by CMS to participate in the Model as a New Entrant ACO prior to the Start Date or that has subsequently been approved by CMS to participate in the Model as a New Entrant ACO pursuant to Article VIII, unless the ACO has since accepted an offer pursuant to Section 5.03.B to participate in the Model as a Standard ACO. A New Entrant ACO qualifies for the alternative Beneficiary alignment minimums specified in Section 5.03.B and qualifies for the Performance Year Benchmark methodology specified in Section II of Appendix B.

"**NPI**" means a national provider identifier.

"**Originally Aligned Beneficiary**" means a Beneficiary who is aligned to the ACO on the first Day of the relevant Performance Year using the methodology set forth in Appendix A, and for whom CMS has not since made a determination that the Beneficiary did not satisfy the eligibility criteria for alignment in Section IV of Appendix A on the first Day of the Performance Year.

"**Other Monies Owed**" means a monetary amount owed by either party to the Agreement that is neither Shared Savings nor Shared Losses. Other Monies Owed shall be calculated in accordance with Appendix B, Appendix E, Appendix F, Appendix G, Appendix H, Appendix I, Appendix J, Appendix L, Appendix M, Appendix N, Appendix O, and Appendix T of the Agreement and included in the settlement reports issued by CMS pursuant to Section 12.04 and Appendix B of the Agreement.

“**Participant Provider**” means an individual or entity that satisfies the requirements of Section 4.01.A.

“**Participant Provider List**” means the list that identifies each Participant Provider that is approved by CMS for participation in the Model for a Performance Year that is established in accordance with Section 4.02 and updated from time to time in accordance with Sections 4.03 and 4.04.

“Participation Commitment Mechanism” means a mechanism that incentivizes the ACO to participate in the Model for at least two Performance Years. The two alternative Participation Commitment Mechanisms are the Financial Guarantee Participation Commitment Mechanism and the Retention Withhold Participation Commitment Mechanism.

“Performance Year” or “PY” means the 12-month period beginning on January 1 of each year during the Model Performance Period, except in the case of Performance Year 2021, which began on April 1, 2021, and ended on December 31, 2021.

“**Performance Year Benchmark**” means the target expenditure amount to which Medicare Part A and Part B expenditures for items and services furnished to REACH Beneficiaries during a Performance Year are compared in order to calculate Shared Losses or Shared Savings, as determined by CMS in accordance with Appendix B of the Agreement.

“**Preferred Provider**” means an individual or entity that satisfies the requirements of Section 4.01.B.

“**Preferred Provider List**” means the list that identifies each Preferred Provider that is approved by CMS for participation in the Model for a Performance Year that is established in accordance with Section 4.02 and updated from time to time in accordance with Sections 4.03 and 4.04.

“PCC Payment” stands for “**Primary Care Capitation Payment**” and means a Capitation Payment Mechanism available for selection by the ACO for a Performance Year as described in Section 8.01. If the ACO selects PCC Payment, the ACO may also select its maximum Enhanced PCC Percentage as described in Section 8.01 and may select to participate in the APO as described in Section 8.01. If the ACO selects PCC Payment, CMS will make a prospective monthly payment to the ACO for PCC Eligible Services furnished to REACH Beneficiaries by those Participant Providers and Preferred Providers participating in PCC Payment. The amount of the PCC Payment is calculated in accordance with Appendix E of the Agreement.

“**PCC Eligible Services**” means (1) for services billed on professional claim formats, Primary Care Services billed by Primary Care Specialists, as such terms are defined in Appendix A of the Agreement, and (2) for services billed on an institutional claim format, all Covered Services billed by Federally Qualified Health Centers (FQHCs, Type of Bill = 77x) and Rural Health Clinics (RHCs, Type of Bill = 71x).

“**PCC Fee Reduction**” means a full or partial reduction in Medicare FFS payments to those Participant Providers and Preferred Providers participating in PCC Payment for PCC Eligible Services furnished to REACH Beneficiaries to account for the monthly payments made by CMS to the ACO under PCC Payment.

“Primary Care Qualified Evaluation & Management (PQEM) Service” means either a Primary Care Service furnished by a Primary Care Specialist or a Selected Non-Primary Care Specialist, as such terms are defined in Appendix A of the Agreement, or any service furnished

by a Federally Qualified Health Center (FQHC) (Type of Bill = 77x) or a Rural Health Clinic (RHC) (Type of Bill = 71x).

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

"**Prohibited Participant**" means an individual or entity that is: (1) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier, (2) an ambulance supplier, (3) a drug or device manufacturer, or (4) excluded or otherwise prohibited from participation in Medicare or Medicaid.

"**Prospective Alignment**" refers to the Alignment Methodology in which Beneficiaries are aligned to the ACO only prospectively prior to the start of the Performance Year based on both Claims-Based Alignment and Voluntary Alignment.

"**Prospective Plus Alignment**" refers to the Alignment Methodology in which Beneficiaries are aligned to the ACO prospectively prior to the start of a Performance Year, based on both Claims-Based Alignment and Voluntary Alignment, and aligned prospectively prior to the start of the second through fourth calendar quarters of a Performance Year, to align additional Beneficiaries based only on Voluntary Alignment.

"**Provisional Financial Settlement**" means the process during which CMS compares the ACO's provisional Performance Year Benchmark to the ACO's provisional Performance Year expenditures to determine the amount of provisional Shared Savings or Shared Losses in accordance with Section 12.04 and Appendix B, calculates the provisional amount of Other Monies Owed, and calculates the provisional net amount owed by either CMS or the ACO for the Performance Year. Provisional Financial Settlement is available for selection by the ACO for Performance Year 2023 and each subsequent Performance Year as described in Section 8.01. Provisional Financial Settlement will be followed by Final Financial Settlement.

"**REACH ACO**" means an entity composed of health care providers operating under a common legal structure that has agreed to participate in the Model and to accept financial accountability for the overall quality and cost of medical care furnished to the Beneficiaries aligned to the entity under the Model.

"**REACH Beneficiary**" means a Beneficiary who is aligned to the ACO using the methodology set forth in Appendix A of the Agreement and who has not subsequently been excluded from the aligned population of the ACO.

"Retention Withhold Participation Commitment Mechanism" means a type of Participation Commitment Mechanism under which CMS will withhold the Retention Withhold (as described in Appendix B) from the Performance Year Benchmark for the ACO's first Performance Year pursuant to the methodology specified in Appendix B. The ACO will earn back the Retention Withhold Amount (as described in Section V.D.1 of Appendix B) during Final Financial Settlement for the ACO's first Performance Year in accordance with the methodology described in Appendix B only if the ACO does not provide written notice of termination of the Agreement

Performance Period pursuant to Section 17.03 on or before the Termination Without Liability Date of the ACO's second Performance Year.

"**Risk Sharing Option**" means either Professional or Global.

"**Rural Area"** means an area in which at least 40 percent of Federal Information Processing Standard (FIPS) codes occur within either a non-metropolitan county, a census tract inside a metropolitan county with Rural-Urban Commuting Area (RUCA) codes 4-10, or a census tract with RUCA codes 2 or 3 that is at least 400 square miles in area with a population density of no more than 35 people per square mile.

"**Shared Losses**" means the monetary amount owed to CMS by the ACO due to expenditures for Medicare Part A and Part B items and services furnished to REACH Beneficiaries during a Performance Year in excess of the Performance Year Benchmark. The amount of Shared Losses is determined by CMS in accordance with Appendix B and the Risk Sharing Option and Capitation Payment Mechanism selected by the ACO.

"**Shared Savings**" means the monetary amount owed to the ACO by CMS due to expenditures for Medicare Part A and Part B items and services furnished to REACH Beneficiaries during a Performance Year that are lower than the Performance Year Benchmark. The amount of Shared Savings is determined by CMS in accordance with Appendix B and the Risk Sharing Option and Capitation Payment Mechanism selected by the ACO.

"Standard ACO" means a REACH ACO that is not a High Needs Population ACO or a New Entrant ACO.

"**Stop-Loss Arrangement**" means a risk mitigation option that may be selected by the ACO for each Performance Year as described in Section 8.01. The Stop-Loss Arrangement is designed to reduce the financial uncertainty associated with infrequent but high-cost expenditures for REACH Beneficiaries. ACOs that elect the Stop-Loss Arrangement will be assessed a Stop-Loss Charge and may accrue a Stop-Loss Payout based on the amount of Part A and Part B expenditures for individual REACH Beneficiaries above specified thresholds described in Appendix B.

"**SVA**" stands for "**Signed Attestation-based Voluntary Alignment**" and means the process by which a Beneficiary may voluntarily align with the ACO by using a Voluntary Alignment Form to designate a Participant Provider as their main doctor, main provider, and/or the main place they receive care. CMS uses the Beneficiary's Voluntary Alignment Form in performing Beneficiary alignment as described in Sections 5.01 and 5.02, Appendix A, and Appendix C.

"**Termination Without Liability Date**" means the date by which the ACO must provide written notice of termination of the Agreement Performance Period to avoid liability for Shared Losses for the Performance Year. The Termination Without Liability Date for a Performance Year is the later of either: a) February 28 of the Performance Year or b) 30 Days after CMS distributes the Performance Year Benchmark Report for the Performance Year to the ACO. The Termination Without Liability Date will be no later than August 31 of a Performance Year. There is no Termination Without Liability Date for the ACO's first Performance Year.

"**TIN**" means a federal taxpayer identification number.

"TCC Payment" stands for "**Total Care Capitation Payment**" and means a Capitation Payment Mechanism available for selection by the ACO for a Performance Year as described in Section 8.01 if the ACO is participating in Global. If the ACO selects TCC Payment, CMS will

make a prospective monthly payment to the ACO for all Covered Services furnished to REACH Beneficiaries by all Participant Providers included on the Participant Provider List at the start of a Performance Year and those Preferred Providers that have opted to participate in TCC Payment. The amount of the monthly TCC Payment is calculated in accordance with Appendix G of the Agreement.

"**TCC Fee Reduction**" means a full or partial reduction in Medicare FFS payments to all Participant Providers and those Preferred Providers who have agreed to receive such reduced payments for Covered Services furnished to REACH Beneficiaries to account for the monthly payments made by CMS to the ACO under TCC Payment.

"**Underserved Communities**" means populations sharing a particular characteristic as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

"**Voluntary Alignment**" refers to both SVA and MVA.

"**Voluntary Alignment Activities**" means any Marketing Activities or other activities conducted by or on behalf of the ACO or its Participant Providers or Preferred Providers, when used for purposes of educating, notifying, or contacting Beneficiaries regarding Voluntary Alignment.

"**Voluntary Alignment Form**" has the meaning set forth in Appendix C.

ARTICLE III ACO Composition

Section 3.01 ACO Legal Entity

A. The ACO shall be a legal entity that is identified by a TIN formed under applicable state, federal, or tribal law and is authorized to undertake the activities required under the Agreement in each state in which it operates, including the following activities:

1. Receiving and distributing Shared Savings;
2. Repaying Shared Losses or Other Monies Owed to CMS;
3. Establishing, reporting, and ensuring Participant Provider compliance with health care quality criteria, including quality performance standards; and
4. Fulfilling ACO Activities identified in the Agreement.

B. If the ACO was formed by two or more Participant Providers who are listed as billing under two or more TINs on the Participant Provider List, the ACO shall be a legal entity separate from the legal entity of any of its Participant Providers or Preferred Providers.

C. If all of the Participant Providers who are listed on the Participant Provider List bill under a single TIN, the ACO's legal entity and governing body may be the same as that of the Participant Provider if the ACO satisfies the requirements of Section 3.02.

D. The ACO is not required to be a Medicare-enrolled provider or supplier.

Section 3.02 ACO Governance

A. General

1. The ACO shall maintain an identifiable governing body with sole and exclusive authority to execute the functions of the ACO and make final decisions on behalf of the ACO. The ACO shall have a governing body that satisfies the following criteria:

   a. The governing body has responsibility for oversight and strategic direction of the ACO and is responsible for holding ACO management accountable for the ACO's activities;

   b. The governing body is separate and unique to the ACO, except as permitted under Section 3.01.C;

   c. The governing body has a transparent governing process;

   d. When acting as a member of the governing body of the ACO, each governing body member has a fiduciary duty to the ACO, including the duty of loyalty, and shall act consistent with that fiduciary duty; and

   e. The governing body shall receive regular reports from the designated compliance official of the ACO who satisfies the requirements of Section 15.01.

2. The ACO shall provide each member of the governing body with a copy of the Agreement and any amendments hereto.

3. If CMS determines that the composition of the ACO's governing body, executive leadership, or parent organization compromises the ACO's ability to participate in the Model or to comply with the terms of the Agreement, CMS may take one or more of the remedial actions specified in Section 17.01.

4. The ACO shall ensure that its governing body implements a process for documenting governing body composition, meetings and decisions, and shall retain such documentation in accordance with Section 16.02.

B. Composition and Control of the Governing Body

1. The ACO governing body shall include at least one Beneficiary served by the ACO ("**Beneficiary Representative**") who:

   a. Does not have a conflict of interest with the ACO;

   b. Has no immediate family member with a conflict of interest with the ACO;

   c. Is not a Participant Provider or Preferred Provider;

   d. Does not have a direct or indirect financial relationship with the ACO, a Participant Provider, or a Preferred Provider, except that such person may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO; and

e. Has voting rights on the ACO's governing body.

2. The ACO governing body shall include at least one person with training or professional experience in advocating for the rights of consumers ("**Consumer Advocate**"), who is not the same person as the Beneficiary Representative and who:

   a. Does not have a conflict of interest with the ACO;

   b. Has no immediate family member with a conflict of interest with the ACO;

   c. Is not a Participant Provider or Preferred Provider;

   d. Does not have a direct or indirect financial relationship with the ACO, a Participant Provider, or a Preferred Provider, except that such person may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO; and

   e. Has voting rights on the ACO's governing body.

3. The ACO governing body shall not include a Prohibited Participant, or an owner, employee or agent of a Prohibited Participant.

4. If Beneficiary and/or Consumer Advocate representation on the ACO governing body is prohibited by state law or if a High Needs Population ACO experiences an extreme hardship in finding a beneficiary representative to serve on the board, the ACO shall notify CMS and request CMS approval of an alternative mechanism to ensure that its policies and procedures reflect consumer and patient perspectives. CMS shall use reasonable efforts to approve or deny the request within 30 Days.

5. The governing body members may serve in similar or complementary roles or positions for Participant Providers or Preferred Providers, subject to Section 3.02.C.

6. At least 75 percent control of the ACO's governing body must be held by:

   a. Individual Participant Providers; or

   b Designated representatives of a Participant Provider that is an entity.

   For purposes of this requirement, a designated representative must be an individual employed by or under contract with the Participant Provider entity that designates the representative. The Beneficiary Representative and Consumer Advocate required under this Section 3.02 will be included in both the numerator and the denominator when calculating the percent control. The ACO may seek an exception from the 75 percent control requirement by submitting a proposal to CMS describing the current composition of the ACO's governing body and how the ACO will involve Participant Providers in innovative ways in ACO governance. Any exception to the 75 percent control requirement will be at the sole discretion of CMS.

C. Conflict of Interest. The ACO shall have a conflict of interest policy that applies to members of the governing body and satisfies the following criteria:

1. Requires each member of the governing body to disclose relevant financial interests;

2. Provides a procedure to determine whether a conflict of interest exists and sets forth a process to address any conflicts that arise; and

3. Addresses remedial actions for members of the governing body that fail to comply with the policy.

Section 3.03 ACO Leadership and Management

A. The ACO's operations shall be managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.

B. Clinical management and oversight shall be managed by a senior-level medical director who is:

1. A Participant Provider;

2. Physically present on a regular basis at any clinic, office, or other location participating in the ACO; and

3. A board-certified physician and licensed in a state in which the ACO operates.

C. If the ACO is a High Needs Population ACO, the ACO may not be owned by an individual or entity that also owns another REACH ACO that is a Standard ACO or New Entrant ACO that is participating in the Model and that operates in the same ACO Service Area, as defined in Section 5.04.H.

D. If the ACO is a Standard ACO or a New Entrant ACO, the ACO may not be owned by an individual or entity that also owns another REACH ACO that is High Needs Population ACO that is participating in the Model and that operates in the same ACO Service Area, as defined in Section 5.04.H.

E. A REACH ACO is considered to be owned by an individual or entity if the individual or entity:

1. Has a direct or indirect ownership interest equal to 5 percent or more in the subject entity;

2. Has a combination of direct and indirect ownership interests equal to 5 percent or more in the subject entity; or

3. Has an ownership interest equal to 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a subject entity if that interest equals at least 5 percent of the value of the property or assets of the subject entity.

Section 3.04 ACO Financial Arrangements

A. The ACO shall not condition a Participant Provider's or Preferred Provider's participation in the Model, directly or indirectly, on referrals of items or services provided to Beneficiaries who are not aligned to the ACO.

B. The ACO shall not require, and shall ensure that its Participant Providers and Preferred Providers do not require, that REACH Beneficiaries be referred only to Participant Providers or Preferred Providers or to any other provider or supplier. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a REACH Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the REACH Beneficiary's best medical interests in the judgment of the referring party.

C. The ACO shall not condition the eligibility of an individual or entity to be a Participant Provider or Preferred Provider on the individual's or entity's offer or payment of cash or other remuneration to the ACO or any other individual or entity.

D. The ACO shall ensure that no party to an ACO financial arrangement gives or receives remuneration in return for, or to induce or reward, any Federal health care program referrals or business generated outside of the Model, and the compensation does not induce either party or other providers or suppliers to furnish medically unnecessary items or services, or to reduce or limit Medically Necessary items or services to any Beneficiary.

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

F. The ACO shall notify CMS within 15 Days after becoming aware that the ACO, a Participant Provider, or a Preferred Provider is under investigation or has been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges). If the ACO, a Participant Provider, or a Preferred Provider is under investigation or has been sanctioned but not excluded from Medicare program participation, CMS may take any of the actions set forth in Section 17.01.

G. By the applicable date specified in Section 3.04.H, except as specified in Sections 3.04.G.17 and 3.04.G.18, the ACO shall have an arrangement with each of the individuals and entities that are approved by CMS to be Participant Providers or Preferred Providers that complies with the criteria described in paragraphs (1) through (16) of this Section 3.04.G:

1. The arrangement is in writing and the only parties to the arrangement are the ACO and the Participant Provider or Preferred Provider.

2. The arrangement requires the Participant Provider or Preferred Provider to agree to participate in the Model during the Agreement Performance Period, to engage in ACO Activities, to comply with the applicable terms of the Model as set forth in the Agreement, and to comply with all applicable laws and regulations (including, but not limited to, those specified at Section 15.04). The ACO shall provide each Participant Provider and Preferred Provider with a copy of the Agreement and any amendments hereto.

3. The arrangement expressly sets forth the Participant Provider's or Preferred Provider's obligation to comply with the applicable terms of the Agreement, including any provisions regarding the following: participant exclusivity; quality measure reporting and continuous care improvement objectives; Voluntary Alignment Activities; Marketing Activities; Beneficiary freedom of choice; Benefit Enhancements and Beneficiary Engagement Incentives; participation in evaluation, shared learning, monitoring, and oversight activities; the ACO compliance plan; and audit and record retention requirements.

4. The arrangement requires the Participant Provider or Preferred Provider to update its Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the Participant Provider or Preferred Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.

5. The arrangement requires the Participant Provider or Preferred Provider to notify the ACO of any changes to its Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the Participant Provider or Preferred Provider their right to Medicare payment) within 30 Days after the change.

6. If the ACO has selected TCC Payment as its Capitation Payment Mechanism, the arrangement requires a Participant Provider included on the Participant Provider List at the start of a Performance Year to participate in the ACO's selected Capitation Payment Mechanism in order to participate as a Participant Provider for the Performance Year, and requires a Preferred Provider included on the Preferred Provider List at the start of a Performance Year to make a selection whether to participate in the ACO's selected Capitation Payment Mechanism for a Performance Year in advance of the Performance Year.

7. If the ACO has selected TCC Payment as its Capitation Payment Mechanism, the arrangement prohibits a Participant Provider that is added to the Participant Provider List during a Performance Year or a Preferred Provider that is added to the Preferred Provider List during a Performance Year from participating in the ACO's selected Capitation Payment Mechanism for the Performance Year in which the Participant Provider or Preferred Provider is so added.

8. If the ACO has selected PCC Payment as its Capitation Payment Mechanism, the arrangement requires a Participant Provider included on

the Participant Provider List at the start of a Performance Year to participate in the ACO's selected Capitation Payment Mechanism in order to participate as a Participant Provider for the Performance Year, and requires a Preferred Provider included on the Preferred Provider List at the start of a Performance Year to make a selection whether to participate in the ACO's selected Capitation Payment Mechanism for a Performance Year in advance of the Performance Year.

9. If the ACO has selected PCC Payment as its Capitation Payment Mechanism, the arrangement prohibits a Participant Provider that is added to the Participant Provider List during a Performance Year or a Preferred Provider that is added to the Preferred Provider List during a Performance Year from participating in the ACO's selected Capitation Payment Mechanism for the Performance Year in which the Participant Provider or Preferred Provider is so added.

10. For each Performance Year that the ACO selects to participate in the APO, the arrangement requires a Participant Provider included on the Participant Provider List at the start of the Performance Year or a Preferred Provider included on the Preferred Provider List at the start of the Performance Year to select whether to participate in the APO in advance of the Performance Year.

11. For each Performance Year that the ACO selects to participate in the APO, the arrangement prohibits a Participant Provider that is added to the Participant Provider List during the Performance Year or a Preferred Provider that is added to the Preferred Provider List during a Performance Year from participating in the APO for the Performance Year in which the Participant Provider or the Preferred Provider is so added.

12. The arrangement requires the Participant Provider or Preferred Provider to notify the ACO within seven Days of becoming aware that it is under investigation or has been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).

13. The arrangement permits the ACO to take remedial action against the Participant Provider or Preferred Provider (including the imposition of a corrective action plan, denial of any payments, and termination of the ACO's arrangement with the Participant Provider or Preferred Provider) to address noncompliance with the terms of the Agreement or program integrity issues identified by CMS.

14. The arrangement is for a term of at least one Performance Year, but permits early termination if CMS requires the ACO to remove the Participant Provider or Preferred Provider pursuant to Section 17.01.C.

15. The arrangement requires the Participant Provider or Preferred Provider to complete a close-out process upon termination or expiration of the arrangement that requires the Participant Provider or Preferred Provider to

furnish all data required by the ACO to participate in the Model and any data required by CMS to monitor or evaluate the Model.

16. If the arrangement involves the provision of electronic health records software to one or more Participant Providers or Preferred Providers, such software shall be interoperable (as defined in 42 CFR § 411.351) or satisfy 42 CFR § 411.357(w)(2) (related to interoperability) at the time it is provided to the recipient.

17. The ACO need not have an arrangement that complies with the requirements of Section 3.04.G.1 through Section 3.04.G.16 with an individual approved by CMS to be a Participant Provider ("**Individual Participant Provider**") if all of the following requirements are met:

    a. By the applicable date specified in Section 3.04.H, the ACO has an arrangement with an entity approved by CMS to be a Participant Provider ("**Participant Provider Contracting Entity**");

    b. The arrangement between the ACO and the Participant Provider Contracting Entity satisfies all of the requirements of Sections 3.04.G.1 through 3.04.G.16, identifies the Individual Participant Provider, and documents the Individual Participant Provider's agreement to comply with the applicable terms of the arrangement between the ACO and the Participant Provider Contracting Entity;

    c. The Individual Participant Provider is employed by, or under contract with, the Participant Provider Contracting Entity and has reassigned his or her Medicare billing rights to the Participant Provider Contracting Entity;

    d. The Participant Provider Contracting Entity and the Individual Participant Provider enter into an arrangement that binds the Individual Participant Provider to the applicable terms of the arrangement between the ACO and the Participant Provider Contracting Entity; and

    e. The arrangement between the ACO and the Participant Provider Contracting Entity requires the Participant Provider Contracting Entity to make available a copy of this Agreement and any amendments hereto to the Individual Participant Provider.

18. The ACO need not have an arrangement that complies with the requirements of Section 3.04.G.1 through Section 3.04.G.16 with an individual approved by CMS to be a Preferred Provider ("**Individual Preferred Provider**") if all of the following requirements are met:

    a. By the applicable date specified in Section 3.04.H, the ACO has an arrangement with an entity approved by CMS to be a Preferred Provider ("**Preferred Provider Contracting Entity**");

b. The arrangement between the ACO and the Preferred Provider Contracting Entity satisfies all of the requirements of Sections 3.04.G.1 through 3.04.G.16, identifies the Individual Preferred Provider, and documents the Individual Preferred Provider's agreement to comply with the applicable terms of the arrangement between the ACO and the Preferred Provider Contracting Entity;

c. The Individual Preferred Provider is employed by, or under contract with, the Preferred Provider Contracting Entity and has reassigned his or her Medicare billing rights to the Preferred Provider Contracting Entity;

d. The Preferred Provider Contracting Entity and the Individual Preferred Provider enter into an arrangement that binds the Individual Preferred Provider to the applicable terms of the arrangement between the ACO and the Preferred Provider Contracting Entity; and

e. The arrangement between the ACO and the Preferred Provider Contracting Entity requires the Preferred Provider Contracting Entity to make available a copy of this Agreement and any amendments hereto to the Individual Preferred Provider.

H. The ACO shall have fully executed written arrangements in place that meet the requirements set forth in Section 3.04.G by the following dates:

1. By the Start Date, in the case of arrangements with individuals and entities that were approved by CMS before the Start Date to be Participant Providers and Preferred Providers.

2. By a date specified by CMS, in the case of arrangements with individuals and entities approved by CMS to be Participant Providers and Preferred Providers effective on the first day of the ACO's second Performance Year, and each subsequent Performance Year.

3. For arrangements with individuals or entities approved by CMS to be Participant Providers or Preferred Providers effective on a day other than the first day of a Performance Year, by the date the ACO requests the addition of the individual or entity to the Participant Provider List or Preferred Provider List pursuant to Section 4.03.A.

I. The ACO shall maintain, in accordance with Section 16.02, records of all remuneration paid or received pursuant to the arrangements described in Section 3.04.G, except that in the case of any arrangements between a Participant Provider Contracting Entity and an Individual Participant Provider and any arrangements between a Preferred Provider Contracting Entity and an Individual Preferred Provider, the ACO shall require the Participant Provider Contracting Entity or Preferred Provider Contracting Entity, as applicable, to maintain, in accordance with Section 16.02, records of all remuneration paid or received pursuant to such arrangements.

J. CMS provides no opinion on the legality of any contractual or financial arrangement that the ACO, a Participant Provider, or a Preferred Provider has

proposed, implemented, or documented. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules, or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules, and regulations.

K. The ACO shall ensure that any Participant Provider or Preferred Provider that has been terminated pursuant to Sections 4.01.F or 17.01, or has been removed from the Participant Provider List or Preferred Provider List pursuant to Section 4.03.B, as applicable, does not engage in any ACO Activities, Marketing Activities, Voluntary Alignment Activities, Benefit Enhancements, or Beneficiary Engagement Incentives after the effective date of such termination.

L. The ACO may distribute Shared Savings to any individual or entity that was a Participant Provider or Preferred Provider during the Performance Year for which the Shared Savings were earned, so long as the individual or entity had not been terminated pursuant to Sections 4.01.F or 17.01 during that Performance Year.

M. Availability of Safe Harbor Protection for ACO Financial Arrangements

1. CMS has determined that the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR § 1001.952(ii)(1)) is available to protect ACO financial arrangements reasonably related to the provision of ACO Activities, provided that such arrangements comply with:

a. Section 3.04.A–E; Section 3.04.I; and, in the case of an arrangement between a Participant Provider Contracting Entity and an Individual Participant Provider or an arrangement between a Preferred Provider Contracting Entity and an Individual Preferred Provider, the requirement that the Participant Provider Contracting Entity or Preferred Provider Contracting Entity, as applicable, maintains, in accordance with Section 16.02, records of all remuneration paid or received pursuant to such arrangements;

b. All safe harbor requirements set forth in 42 CFR §1001.952(ii)(1); and

c. Section III.C of Appendices E, F, and G, as applied to PCC Payment Arrangements, APO Payment Arrangements, and TCC Payment Arrangements, respectively.

2. For purposes of this Section 3.04.M, an ACO financial arrangement is an arrangement between or among the ACO, one or more Participant Providers, one or more Preferred Providers, or a combination thereof. ACO financial arrangements include, but are not limited to, PCC Payment Arrangements, APO Payment Arrangements, and TCC Payment Arrangements, as described in Appendices E, F, and G, respectively, of the Agreement.

ARTICLE IV Participant Providers and Preferred Providers

Section 4.01 General

A. The ACO shall contract with one or more Participant Providers. The ACO shall ensure that each Participant Provider:

1. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);
2. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
3. Is not a Preferred Provider;
4. Is not a Prohibited Participant;
5. Has agreed to participate in the Model pursuant to a written arrangement meeting the requirements of Section 3.04; and
6. Is identified on the Participant Provider List in accordance with this Article IV.

B. The ACO may contract with one or more Preferred Providers. The ACO shall ensure that each Preferred Provider:

1. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);
2. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
3. Is not a Participant Provider;
4. Is not a Prohibited Participant;
5. Has agreed to participate in the Model pursuant to a written arrangement meeting the requirements of Section 3.04; and
6. Is identified on the Preferred Provider List in accordance with this Article IV.

C. Participant Providers and Preferred Providers will be included on the Participant Provider List or Preferred Provider List only upon the prior written approval of CMS.

D. CMS shall maintain the Participant Provider List and Preferred Provider List in a manner that permits the ACO to review the lists.

E. The ACO shall maintain current and historical Participant Provider Lists and Preferred Provider Lists in accordance with Section 16.02.

F. CMS may periodically monitor the program integrity history of the ACO's Participant Providers and Preferred Providers. CMS may remove an individual or entity from the Participant Provider List or Preferred Provider List or subject the ACO to additional monitoring pursuant to Section 17.01, on the basis of the

results of a Program Integrity Screening or information obtained regarding an individual's or entity's history of program integrity issues, including but not limited to a Participant Provider's or Preferred Provider's licensure status and ongoing investigations by law enforcement, program integrity, or state licensure bodies. CMS shall notify the ACO if CMS chooses to remove an individual or entity from the Participant Provider List or Preferred Provider List, and such notice shall specify the effective date of removal.

Section 4.02 Participant Provider List and Preferred Provider List for the ACO's first Performance Year

A. The parties acknowledge that the ACO submitted to CMS a proposed list of Participant Providers ("**Proposed Participant Provider List**") that:

1. Identified each individual or entity by name, TIN, and individual NPI, organizational NPI, CCN (if applicable), and Legacy TIN or CCN (if applicable);
2. Specified the Benefit Enhancements and Beneficiary Engagement Incentives, if any, in which each individual or entity has agreed to participate;
3. If the ACO selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year as described in Section 8.01, identified the applicable PCC Fee Reduction for each individual or entity;
4. If the ACO selected to participate in the APO for the ACO's first Performance Year as described in Section 8.01, identified each individual or entity that agreed to participate in the APO with the ACO, as well as the applicable APO Fee Reduction for each such individual or entity.

The parties further acknowledge that the ACO certified that the Proposed Participant Provider List is a true, accurate, and complete list of individuals and entities that have agreed to be Participant Providers, subject to CMS approval, at the start of the ACO's first Performance Year.

B. The parties acknowledge that the ACO submitted to CMS a proposed list of Preferred Providers ("**Proposed Preferred Provider List**") that:

1. Identified each individual or entity by name, TIN, and individual NPI, organizational NPI, or CCN (if applicable), and Legacy TIN or CCN (if applicable);
2. Specified the Benefit Enhancements and Beneficiary Engagement Incentives, if any, in which each individual or entity agreed to participate;
3. If the ACO selected TCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year as described in Section 8.01, identified each individual or entity that agreed to participate in TCC Payment with the ACO, as well as the applicable TCC Fee Reduction for such individual or entity;
4. If the ACO selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year as described in Section 8.01,

identified each individual or entity that agreed to participate in PCC Payment with the ACO, as well as the applicable PCC Fee Reduction for each such individual or entity;

5. If the ACO selected to participate in the APO for the ACO's first Performance Year as described in Section 8.01, identified each individual or entity that agreed to participate in the APO with the ACO, as well as the applicable APO Fee Reduction for each such individual or entity.

The parties further acknowledge that the ACO certified that the Proposed Preferred Provider List is a true, accurate, and complete list of individuals and entities that have agreed to be Preferred Providers, subject to CMS approval, at the start of the ACO's first Performance Year.

C. The ACO states that it furnished written notification to each individual or entity the ACO included on the Proposed Participant Provider List, and that such notice:

1. Stated the individual or entity and the TIN through which it bills Medicare will be identified on the Proposed Participant Provider List;

2. Stated that participation in the Model may preclude the individual or entity from participating in the Medicare Shared Savings Program, another REACH ACO in the Model, the Vermont Medicare ACO Initiative, the Kidney Care Choices Model, any other Medicare initiative that involves shared savings, the Primary Care First Model, the Maryland Total Cost of Care Model, and the Independence at Home Demonstration.

3. If the ACO selected to participate in TCC Payment for the ACO's first Performance Year as described in Section 8.01, stated that the individual's or entity's agreement to participate in TCC Payment and receive the TCC Fee Reduction, as described in Section 12.02.E, must apply for the full Performance Year and must be renewed annually prior to the start of each Performance Year in order for the individual or entity to participate as a Participant Provider for that Performance Year.

4. [Reserved]

5. If the ACO selected to participate in PCC Payment for the ACO's first Performance Year as described in Section 8.01, stated that the individual's or entity's agreement to participate in PCC Payment, as described in Section 12.02.E, must apply for the full Performance Year and must be renewed annually prior to the start of each Performance Year in order for the individual or entity to participate as a Participant Provider for that Performance Year, and that the individual or entity must select a PCC Fee Reduction for that Performance Year from within a range specified by CMS.

6. If the ACO selected to participate in the APO as described in Section 8.01, stated that individual's or entity's agreement to participate in the APO, as described in Section 12.02.E, must apply for the full Performance Year and must be renewed annually prior to the start of each Performance Year in order for the individual or entity to participate in the APO for that Performance Year, and that the individual or entity must select an APO

Fee Reduction for that Performance Year from within a range specified by CMS.

D. The ACO states that it furnished written notification to each individual or entity the ACO included on the Proposed Preferred Provider List, and that such notice:

1. Stated that the individual or entity and the TIN through which it bills Medicare will be identified on the Proposed Preferred Provider List.

2. Stated that participation in the Model may preclude the individual or entity from participating in the Maryland Total Cost of Care Model.

3. Stated that the individual or entity may agree, as described in Section 12.02.E, to participate in the Capitation Payment Mechanism selected by the ACO as described in Section 8.01, that the individual's or entity's agreement to participate in the Capitation Payment Mechanism must apply for the full Performance Year and must be renewed annually prior to the start of each Performance Year in order for the individual or entity to participate in the Capitation Payment Mechanism for that Performance Year, and that the individual or entity must select a TCC Fee Reduction or PCC Fee Reduction, as applicable, for that Performance Year from within a range specified by CMS.

4. If the ACO selected to participate in the APO as described in Section 8.01, stated that the individual or entity may agree to participate in the APO, as described in Section 12.02.E, that the individual's or entity's agreement to participate in the APO must apply for the full Performance Year and must be renewed annually prior to the start of each Performance Year in order for the individual or entity to participate in the APO for that Performance Year, and that the individual or entity must select an APO Fee Reduction for that Performance Year from within a range specified by CMS.

E. CMS states that it conducted a Program Integrity Screening with respect to each individual and entity identified on the Proposed Participant Provider List and Proposed Preferred Provider List and reserved the right to reject any individual or entity on the Proposed Participant Provider List or Proposed Preferred Provider List on the basis of the results of this Program Integrity Screening, history of program integrity issues, or:

1. For any individual or entity on the Proposed Participant Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraphs (1) through (4) of Section 4.01.A; or

2. For any individual or entity on the Proposed Preferred Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraphs (1) through (4) of Section 4.01.B.

F. CMS states that it provided the ACO with a list of individuals and entities that CMS tentatively approved to be Participant Providers and Preferred Providers effective on the Start Date.

G. The ACO states that it had the opportunity to add individuals and entities to its Proposed Participant Provider List and its Proposed Preferred Provider List. CMS

states that it conducted a Program Integrity Screening for each individual or entity the ACO proposed to add to its Proposed Participant Provider List and Proposed Preferred Provider List and reserved the right to reject any individual or entity proposed for inclusion on the basis of the criteria described in Section 4.02.E.

H. CMS states that it provided the ACO with revised lists of the individuals and entities CMS had tentatively approved to be Participant Providers and Preferred Providers at the start of the ACO's first Performance Year, to include any individuals and entities added by the ACO as described in Section 4.02.G that CMS did not reject on the basis of the criteria described in Section 4.02.E.

I. The ACO states that, after a review of the lists of tentatively approved Participant Providers and Preferred Providers, the ACO made any necessary corrections--including the removal of any individuals or entities that did not agree to participate in the Model pursuant to a written arrangement that met the requirements specified in Section 3.04.G, that fail to satisfy the requirements of Section 4.01.A(1)-(4) or Section 4.01.B(1)-(4), as applicable, or that were otherwise ineligible to participate in the Model as a Participant Provider or Preferred Provider--and confirmed the accuracy of the revised lists. The ACO states that it removed from its Proposed Participant Provider List any Participant Provider who did not agree to participate in the ACO's selected Capitation Payment Mechanism as described in Section 12.02.E. The ACO states that it certified that the Proposed Participant Provider List, as revised, is a true, accurate, and complete list of individuals and entities that agreed to be Participant Providers at the start of the ACO's first Performance Year, and that the Proposed Preferred Provider List, as revised, is a true, accurate, and complete list of the individuals and entities that agreed to be Preferred Providers at the start of the ACO's first Performance Year. The parties acknowledge that no additions to the Proposed Participant Provider List or to the Proposed Preferred Provider List were permitted at this time.

J. CMS states that it removed the following from the Proposed Participant Provider List and the Proposed Preferred Provider List: (1) any individuals or entities listed on the Proposed Participant Provider List that bill under a TIN participating in the Medicare Shared Savings Program or any other Medicare initiative that involves shared savings and identifies participants by an entire TIN; (2) any individuals or entities listed on the Proposed Participant Provider List identified by a TIN/NPI combination participating in the Kidney Care Choices Model, the Vermont Medicare ACO Initiative, another REACH ACO in the Model, or any other Medicare initiative that involves shared savings and identifies participants by a TIN/NPI combination, except as otherwise specified by CMS; (3) any individuals or entities identified by a TIN/NPI combination participating in the Maryland Total Cost of Care Model; and (4) any individuals or entities listed on the Proposed Participant Provider List identified by a TIN/NPI combination participating in the Primary Care First Model or the Independence at Home Demonstration.

K. CMS states that it provided the ACO with a final Participant Provider List and a final Preferred Provider List, identifying all individuals and entities that CMS has approved to be Participant Providers and Preferred Providers (including, as

applicable, information regarding participation in a Capitation Payment Mechanism, the amount of the TCC Fee Reduction or PCC Fee Reduction agreed to by the individual or entity, participation in the APO, the amount of the APO Fee Reduction, Benefit Enhancements, and Beneficiary Engagement Incentives) effective at the start of the ACO's first Performance Year.

L. CMS states that it used the final Participant Provider List described in Section 4.02.K to run Claims-Based Alignment for the ACO's first Performance Year. Any individual or entity that is removed from or added to the Participant Provider List after CMS provides the ACO with such final Participant Provider List will not affect Claims-Based Alignment for the ACO's first Performance Year.

M. The ACO shall update the Participant Provider List and Preferred Provider List in accordance with Section 4.03 for updates that occur during the Performance Year and in accordance with Section 4.04 for updates made in advance of a subsequent Performance Year.

Section 4.03 Updating Lists during a Performance Year

A. Additions to the Participant Provider List or Preferred Provider List
If the ACO wishes to add an individual or entity to the Participant Provider List or Preferred Provider List, effective on a date other than the first day of a Performance Year ("**During a Performance Year**"), it shall submit a request to add the individual or entity to CMS in a form and manner specified by CMS and in accordance with the notification schedule provided by CMS ("**List Addition and Removal Schedule**"). The ACO shall not add an individual or entity to the Participant Provider List or Preferred Provider List during a Performance Year without prior written approval from CMS. CMS may accept additions during a Performance Year only under the following circumstances:

1. The request is submitted to CMS at least 30 Days before the first day of the month in which the addition would take effect, or such other period of time as specified by CMS in writing.

2. In the case of a proposal to add a physician or non-physician practitioner to the Participant Provider List, the ACO submits a certification to CMS in a form and manner specified by CMS as to one of the following:

   a. That the individual (1) currently bills for items and services he or she furnishes to Beneficiaries under a Medicare billing number assigned to the TIN of an entity that is currently a Participant Provider, and (2) did not bill for such items and services under the TIN of the same Participant Provider at the time the ACO submitted updates to its Proposed Participant Provider List described in Section 4.02.G or submitted its most recent Proposed Revised Participant Provider List pursuant to Section 4.04.A, whichever is applicable to the Performance Year in which the addition would take effect;

   b. That the individual (1) currently bills for items and services he or she furnishes to Beneficiaries under a billing number assigned to a TIN that is now under the control of the ACO or an entity that is

currently a Participant Provider as a result of a merger or acquisition by the ACO or Participant Provider, and (2) the individual's billing number was not assigned to a TIN that was under the control of the ACO or Participant Provider at the time the ACO submitted updates to its Proposed Participant Provider List described in Section 4.02.G or submitted its most recent Proposed Revised Participant Provider List pursuant to Section 4.04.A, whichever is applicable to the Performance Year in which the addition would take effect;

c. That the ACO included the individual on the most recent Proposed Participant Provider List described in Section 4.02.G or the most recent Proposed Revised Participant Provider List described in Section 4.04.A.1, whichever is applicable to the Performance Year in which the addition would take effect, that CMS removed the individual from the Proposed Participant Provider List on the basis of overlapping participation with another model or other Medicare initiative pursuant to Section 4.02.J or Section 4.04.B.6, as applicable, and that the individual is no longer participating in the model or other Medicare initiative described in Section 4.02.J or Section 4.04.B.6, as applicable; or

d. That the ACO included the individual identified on the most recent Proposed Participant Provider List described in Section 4.02.G or the most recent Proposed Revised Participant Provider List described in Section 4.04.A.1, as is applicable to the Performance Year in which the addition would take effect, that CMS removed the individual from the Proposed Participant Provider List for not being enrolled in Medicare, and that the individual is now enrolled in Medicare.

3. In the case of a proposal to add a physician or non-physician practitioner to the Participant Provider List under the circumstances described in Section 4.03.A.2(b), the ACO shall provide CMS with documentation of the relevant merger or acquisition, upon request. CMS reserves the right to reject the addition of the physician or non-physician practitioner to the Participant Provider List if CMS determines that the ACO purposefully delayed adding the individual to the Participant Provider List in an effort to alter the population of Beneficiaries aligned to the ACO for the Performance Year via Claims-Based Alignment.

4. By requesting to add an individual or entity to the Participant Provider List or the Preferred Provider List, the ACO certifies that it:

a. Has a fully executed written arrangement with the individual or entity it wishes to add to the Participant Provider List or the Preferred Provider List that meets the requirements of Section 3.04.G.1 through Section 3.04.G.16, or has a fully executed written arrangement with a Participant Provider Contracting Entity on behalf of the individual it wishes to add to the Participant Provider List that satisfies the requirements of Section 3.04.G.17, or has a

fully executed written arrangement with a Preferred Provider Contracting Entity on behalf of the individual it wishes to add to the Preferred Provider List that satisfies the requirements of Section 3.04.G.18, as applicable;

b. Has furnished a written notice to each proposed Participant Provider and Preferred Provider that is a physician or non-physician practitioner and to the executive of the TIN through which such individual bills Medicare indicating that the ACO has proposed to add such individual to the Participant Provider List or Preferred Provider List, as applicable; and

c. In the case of a request to add an individual or entity to the Participant Provider List or the Preferred Provider List, that the ACO has furnished a written notice to the executive of each TIN through which such individual or entity bills Medicare indicating that the ACO has proposed to add such individual or entity to the Participant Provider List or Preferred Provider List, as applicable, identifying by name and NPI each individual or entity who is identified on the request for addition as billing through the TIN.

5. CMS may reject a request to add an individual or entity to the Participant Provider List if the individual or entity fails to satisfy the requirements of paragraphs (1) through (5) of Section 4.01.A, on the basis of information obtained from a Program Integrity Screening or history of program integrity issues, or as authorized under Section 4.03.A.9. If CMS approves the request, the individual or entity will be added to the Participant Provider List effective on the first day of the following month, or at such other time specified by CMS.

6. CMS may reject a request to add an individual or entity to the Preferred Provider List if the individual or entity fails to satisfy the requirements of paragraphs (1) through (5) of Section 4.01.B, on the basis of information obtained through a Program Integrity Screening or history of program integrity issues, or as authorized under Section 4.03.A.9. If CMS approves the request, the individual or entity will be added to the Preferred Provider List effective on the first day of the following month, or at such other time specified by CMS.

7. Any individual or entity added to the Participant Provider List pursuant to this Section 4.03.A will not affect Claims-Based Alignment for the Performance Year in which the Participant Provider is added.

8. Any individual or entity added to the Participant Provider List or Preferred Provider List pursuant to this Section 4.03.A will not be able to participate in the ACO's selected Capitation Payment Mechanism or, if applicable, the APO for the Performance Year in which the individual or entity is added. Any individual or entity added to the Participant Provider List or Preferred Provider List pursuant to this Section 4.03.A may participate in any Benefit Enhancements and Beneficiary Engagement Incentives for which the ACO has a CMS-approved Implementation Plan, as required by

Section 10.01.B, as long as the ACO specifies the Benefit Enhancements and Beneficiary Engagement Incentives in which the individual or entity will participate on the Participant Provider List or Preferred Provider List.

9. CMS will reject a request to add the following to the Participant Provider List and the Preferred Provider List: (1) any individuals or entities listed on the Participant Provider List that bill under a TIN participating in the Medicare Shared Savings Program or any other Medicare initiative that involves shared savings and identifies participants by an entire TIN; (2) any individuals or entities listed on the Participant Provider List identified by a TIN/NPI combination participating in the Kidney Care Choices Model, the Vermont Medicare ACO Initiative, another REACH ACO in the Model, or any other Medicare initiative that involves shared savings and identifies participants by a TIN/NPI combination, except as otherwise specified by CMS; (3) any individuals or entities identified by a TIN/NPI combination participating in the Maryland Total Cost of Care Model; and (4) any individuals or entities listed on the Participant Provider List identified by a TIN/NPI combination participating in the Primary Care First Model or the Independence at Home Demonstration.

B. Removals from the Participant Provider List or Preferred Provider List

1. General. In a form and manner specified by CMS, except as otherwise specified in Section 4.03.B.2, the ACO shall provide advance notice to CMS in accordance with the List Addition and Removal Schedule before an individual or entity ceases to be a Participant Provider or Preferred Provider. The notice must include the date on which the individual or entity will cease to be a Participant Provider or Preferred Provider and the basis for removal (i.e., the requirements of Section 4.01.A or Section 4.01.B, as applicable, that the individual or entity no longer satisfies).

a. The removal of the individual or entity from the Participant Provider List or Preferred Provider List will be effective on the date the individual or entity ceases to meet the requirements of Section 4.01.A(1)-(5) or Section 4.01.B(1)-(5), as applicable, except as specified in Section 4.03.B.1(b).

b. For purposes of furnishing Benefit Enhancements and participating in the ACO's selected Capitation Payment Mechanism, the removal of an individual or entity from the Participant Provider List or Preferred Provider List will be effective on the last day of the month the individual or entity ceases to meet the requirements of Section 4.01.A(1)-(5) or Section 4.01.B(1)-(5), as applicable.

2. Loss of Eligibility for Medicare Payment. If an individual or entity on the Participant Provider List or Preferred Provider List becomes ineligible to receive payment from Medicare, the ACO shall notify CMS, in a form and manner specified by CMS, within 15 Days of receiving notice of such ineligibility. The removal of the individual or entity from the Participant Provider List or Preferred Provider List pursuant to this Section 4.03.B.2

will be effective as of the date the individual or entity lost eligibility to receive payment from Medicare.

C. Updating Enrollment Information.

1. The ACO shall ensure that Participant Providers and Preferred Providers report to CMS, consistent with 42 CFR § 424.516, all changes to enrollment information, including changes to reassignment of the right to receive Medicare payment.

2. The ACO shall update the Participant Provider List and Preferred Provider List to reflect the relevant changes in Medicare enrollment information for individuals and entities identified on such lists.

3. In the event the ACO is unable to update the Participant Provider List or Preferred Provider List as required by Section 4.03.C.2, such as during certain reorganizations of a Participant Provider or Preferred Provider in which Medicare enrollment is delayed, CMS may update the Participant Provider List or Preferred Provider List, as necessary, if CMS determines the update is necessary to protect the integrity of the Model's financial calculations with respect to the ACO.

D. Updating Benefit Enhancement Selections. In a form and manner and by the date(s) specified by CMS, the ACO may update its Participant Provider List and Preferred Provider List to identify each individual and entity who has agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement and the Nurse Practitioner and Physician Assistant Services Benefit Enhancement for Performance Year 2023 and each subsequent Performance Year.

Section 4.04 Annual Updates to the Participant Provider List and Preferred Provider List

A. Proposed Revised Participant Provider List and Proposed Revised Preferred Provider List

1. Prior to the end of each Performance Year, unless otherwise instructed by CMS, the ACO shall submit to CMS by a date and in a form and manner specified by CMS, proposed additions, removals, or other revisions to the current Participant Provider List and the current Preferred Provider List to take effect on the first day of the subsequent Performance Year, such that the lists, as revised, identify each individual or entity that the ACO expects to participate in the Model as a Participant Provider or Preferred Provider effective at the start of the next Performance Year ("**Proposed Revised Participant Provider List**" and "**Proposed Revised Preferred Provider List,**" respectively).

2. In a form and manner and by one or more dates specified by CMS, the ACO shall identify the following with respect to each individual and entity identified on the Proposed Revised Participant Provider List and the Proposed Revised Preferred Provider List:

a. Name, TIN, and individual NPI, organizational NPI, CCN (if applicable), and Legacy TIN or CCN (if applicable).

b. Any Benefit Enhancements and Beneficiary Engagement Incentives in which each individual or entity has agreed to participate.

c. If the ACO selected PCC Payment as its Capitation Payment Mechanism:

i. The applicable PCC Fee Reduction for each individual or entity on the Proposed Revised Participant Provider List; and

ii. The individuals and entities on the Proposed Revised Preferred Provider List who have agreed to participate in PCC Payment with the ACO, as well as the applicable PCC Fee Reduction for each such individual or entity.

d. If the ACO selected to participate in the APO, any individuals or entities who have agreed to participate in the APO with the ACO, as well as the applicable APO Fee Reduction for each such individual and entity.

e. If the ACO selected TCC Payment as its Capitation Payment Mechanism, the individuals and entities on the Proposed Revised Preferred Provider List who have agreed to participate in TCC Payment with the ACO, as well as the applicable TCC Fee Reduction for each individual or entity on the Proposed Revised Preferred Provider List.

3. The ACO shall provide notices to those individuals and entities identified on the Proposed Revised Participant Provider List and the Proposed Revised Preferred Provider List, and to the executive of any TIN through which such individuals or entities bill Medicare, in accordance with Section 4.05.

B. Review, Certification, and Finalization of the Participant Provider List and Preferred Provider List

1. CMS shall conduct a Program Integrity Screening for each individual and entity on the Proposed Revised Participant Provider List and the Proposed Revised Preferred Provider List.

2. CMS may reject any individual or entity on a Proposed Revised Participant Provider List or a Proposed Revised Preferred Provider List on the basis of the results of the Program Integrity Screening, history of program integrity issues, or:

a. For any individual or entity on a Proposed Revised Participant Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraphs (1) through (4) of Section 4.01.A; or

b. For any individual or entity on a Proposed Revised Preferred Provider List, if CMS determines that the individual or entity does

not satisfy the criteria in paragraphs (1) through (4) of Section 4.01.B.

3. CMS will provide the ACO with a list of individuals and entities tentatively approved to be Participant Providers and Preferred Providers at the start of the subsequent Performance Year.

4. In a form and manner and by a date specified by CMS, the ACO shall after a review of the lists of tentatively approved Participant Providers and Preferred Providers, confirm the accuracy of the revised Proposed Revised Participant Provider List and the revised Proposed Revised Preferred Provider List with any necessary corrections, including the removal of any individuals and entities that:

   a. Have not agreed to participate in the Model during the subsequent Performance Year pursuant to a written arrangement meeting the requirements of Section 3.04.G;

   b. Fail to meet the requirements of paragraphs (1) through (4) of Section 4.01.A or Section 4.01.B, as applicable

   c. Are otherwise ineligible to participate in the Model as a Participant Provider or Preferred Provider, as applicable; or

   d. Are identified as a Participant Provider and have not agreed to participate in the ACO's selected Capitation Payment Mechanism with the ACO in accordance with Section 12.02.E.

   No additions to the Proposed Revised Participant Provider List or the Proposed Revised Preferred Provider List are permitted at this time.

5. In a form and manner and by one or more dates specified by CMS, the ACO shall certify:

   a. That the revised Proposed Revised Participant Provider List and the revised Proposed Revised Preferred Provider List are each a true, accurate, and complete list of individuals and entities that have agreed to be Participant Providers or Preferred Providers, as applicable, subject to CMS approval, during the subsequent Performance Year;

   b. That each individual and entity on the revised Proposed Revised Participant Provider List and the revised Proposed Revised Preferred Provider List meets the requirements of paragraphs (1) through (4) of Section 4.01.A or Section 4.01.B, as applicable;

   c. That, for every individual and entity included on the revised Proposed Revised Participant Provider List and the revised Proposed Revised Preferred Provider List, the ACO has either:

      i. Entered into a fully executed written arrangement with the individual or entity meeting the requirements of Sections 3.04.G.1 through 3.04.G.16; or

ii. Entered into a fully executed written arrangement with a Participant Provider Contracting Entity or Preferred Provider Contracting Entity that satisfies the requirements of Section 3.04.G.17 or Section 3.04.G.18, as applicable;

d. That each individual and entity listed on the revised Proposed Revised Participant Provider List and the revised Proposed Revised Preferred Provider List as participating in the ACO's selected Capitation Payment Mechanism and, if selected by the ACO, the APO, has agreed to participate in the Capitation Payment Mechanism and, if applicable, the APO for the full Performance Year; and

e. That the revised Proposed Revised Participant Provider List and the revised Proposed Revised Preferred Provider List include true, accurate, and complete information regarding the following: participation in the ACO's selected Capitation Payment Mechanism, the amount of the PCC Fee Reduction or TCC Fee Reduction, participation in the APO, the amount of the APO Fee Reduction, Benefit Enhancements, and Beneficiary Engagement Incentives, as applicable, effective at the start of the subsequent Performance Year.

6. CMS may reject any individual or entity on the revised Proposed Revised Participant Provider List or revised Proposed Revised Preferred Provider List on the basis of the results of a Program Integrity Screening, history of program integrity issues, or consistent with the requirements of Section 4.06 and Appendix R of the Agreement if CMS determines that: (1) the individual or entity listed on the Proposed Revised Participant Provider List bills under a TIN participating in the Medicare Shared Savings Program or any other Medicare initiative that involves shared savings and identifies participants by an entire TIN; (2) the individual or entity listed on the Proposed Revised Participant Provider List is identified by a TIN/NPI combination participating in the Vermont Medicare ACO Initiative, Kidney Care Choices Model, another REACH ACO in the Model, or any other Medicare initiative that involves shared savings and identifies participants by a TIN/NPI combination, except as otherwise specified by CMS; (3) the individual or entity is identified by a TIN/NPI combination participating in the Maryland Total Cost of Care Model; or (4) the individual or entity listed on the Proposed Revised Participant Provider List is identified by a TIN/NPI combination participating in the Primary Care First Model or the Independence at Home Demonstration.

7. CMS will provide a final Participant Provider List and final Preferred Provider List identifying all individuals and entities that CMS has approved to be Participant Providers and Preferred Providers (including, as applicable, information regarding participation in the ACO's selected Capitation Payment Mechanism, the amount of the PCC Fee Reduction or TCC Fee Reduction, participation in the APO, the amount of the APO Fee Reduction, Benefit Enhancements, and Beneficiary Engagement

Incentives, as applicable) effective at the start of the next Performance Year. CMS will use the final Participant Provider List to run Claims-Based Alignment for the Performance Year in which the final Participant Provider List will take effect. Any individual or entity that is removed from or added to the Participant Provider List after CMS provides the ACO with the final Participant Provider List will not affect Claims-Based Alignment for the Performance Year in which the final Participant Provider List will take effect.

Section 4.05 ACO Notices to Proposed Participant Providers, Proposed Preferred Providers, and TINs

A. ACO Notice to Proposed Participant Providers. By a date specified by CMS, the ACO shall furnish written notification to each individual or entity the ACO wishes to include on the Proposed Revised Participant Provider List. Such notice shall:

1. State that the individual or entity and the TIN through which it bills Medicare will be identified on the Proposed Revised Participant Provider List.

2. State that participation in the Model may preclude the individual or entity from participating in the Medicare Shared Savings Program, another REACH ACO in the Model, the Vermont Medicare ACO Initiative, the Kidney Care Choices Model, any other Medicare initiative that involves shared savings (except as otherwise specified by CMS), the Primary Care First Model, the Maryland Total Cost of Care Model, and the Independence at Home Demonstration.

3. If the ACO has selected to participate in TCC Payment for the Performance Year as described in Section 8.01, state that the individual or entity must agree to participate in TCC Payment in accordance with the requirements of Section 12.02.E for the full Performance Year in order for the individual or entity to participate as a Participant Provider for that Performance Year, and that the individual's or entity's agreement to participate in TCC Payment must be renewed annually prior to the start of the next Performance Year in order for the individual or entity to participate as a Participant Provider for that Performance Year.

4. If the ACO has selected to participate in PCC Payment as described in Section 8.01, state that the individual or entity must agree to participate in PCC Payment in accordance with the requirements of Section 12.02.E for the full Performance Year and select its PCC Fee Reduction Percentage in accordance with Section 12.02.E prior to the start of the Performance Year in order for the individual or entity to participate as a Participant Provider for that Performance Year, and that the individual's or entity's agreement to participate in PCC Payment must be renewed annually prior to the start of the next Performance Year in order for the individual or entity to participate as a Participant Provider for that Performance Year.

5. If the ACO has selected to participate in the APO as described in Section 8.01, state that the individual or entity may agree to participate in the APO in accordance with the requirements of Section 12.02.E, in which case the individual or entity must select its APO Fee Reduction percentage in accordance with Section 12.02.E prior to the start of the Performance Year, and that the individual's or entity's agreement to participate in the APO must apply for the full Performance Year and must be renewed annually prior to the start of the next Performance Year in order for the individual or entity to participate in the APO for that Performance Year.

B. ACO Notice to Proposed Preferred Providers. By a date specified by CMS, the ACO shall furnish written notification to each individual or entity the ACO wishes to include on the Proposed Revised Preferred Provider List. Such notice shall:

1. State that the individual or entity and the TIN through which it bills Medicare will be identified on the Proposed Revised Preferred Provider List.

2. State that the individual or entity may agree to participate in the Capitation Payment Mechanism selected by the ACO in accordance with Section 12.02.E, in which case the individual or entity must select its PCC Fee Reduction or TCC Fee Reduction, as applicable, in accordance with the requirements of Section 12.02.E prior to the start of the Performance Year, and that the individual's or entity's agreement to participate in the Capitation Payment Mechanism must apply for the full Performance Year and must be renewed annually prior to the start of the next Performance Year in order for the individual or entity to participate in the Capitation Payment Mechanism for that Performance Year.

3. If the ACO has selected to participate in the APO as described in Section 8.01, state that the individual or entity may agree in accordance with the requirements of Section 12.02.E to participate in the APO, in which case the individual or entity must select its APO Fee Reduction in accordance with the requirements of Section 12.02.E prior to the start of the Performance Year, and that the individual's or entity's agreement to participate in the APO must apply for the full Performance Year and must be renewed annually prior to the start of the next Performance Year in order for the individual or entity to participate in the APO for that Performance Year.

4. State that a Preferred Provider's participation in the ACO may preclude the individual or entity from participating in the Maryland Total Cost of Care Model.

C. ACO Notice to TINs. By a date specified by CMS, the ACO shall furnish written notification to the executive of any TIN through which an individual or entity on the Proposed Revised Participant Provider List or Proposed Revised Preferred Provider List bills Medicare. Such notification must:

1. Include a list identifying by name and NPI each individual or entity that will be identified on the ACO's Proposed Revised Participant Provider

List or Proposed Revised Preferred Provider List as billing through the entity's TIN; and

2. Inform the executive of the TIN that a Participant Provider's participation in the ACO may preclude the entire TIN from participating in the Medicare Shared Savings Program and any other Medicare initiative that involves shared savings and identifies participants by an entire TIN.

3. Inform the executive of the TIN that a Participant Provider's participation in the ACO may preclude the TIN/NPI combination associated with that individual or entity from participating in the Kidney Care Choices Model, Vermont Medicare ACO Initiative, another REACH ACO in the Model, any other Medicare initiative that involves shared savings and identifies participants by a TIN/NPI combination (except as otherwise specified by CMS), the Maryland Total Cost of Care Model, Primary Care First Model, and the Independence at Home Demonstration.

4. Inform the executive of the TIN that a Preferred Provider's participation in the ACO may preclude the TIN/NPI combination associated with that individual or entity from participating in the Maryland Total Cost of Care Model.

Section 4.06 Non-Duplication and Exclusivity of Participation

A. The ACO may not participate in any other Medicare shared savings initiatives, except as otherwise specified by CMS, as described in Appendix R.

B. CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and in the implementing regulations at 42 CFR § 425.114(a) and (b) regarding participation in a model tested under section 1115A of the Act that involves shared savings as they apply to Preferred Providers, subject to the conditions and requirements set forth in Appendix R.

C. The ACO shall require its Participant Providers and Preferred Providers to comply with Appendix R. The ACO shall not include on its Participant Provider List or its Preferred Provider List any Participant Provider or Preferred Provider that does not comply with the participation overlap provisions set forth in Appendix R.

ARTICLE V Beneficiary Alignment, Beneficiary Engagement, and Beneficiary Protections

Section 5.01 Beneficiary Alignment

A. CMS shall, according to the methodology set forth in Appendix A and the precedence rules described in Section 5.01.C, use both Voluntary Alignment and Claims-Based Alignment to align Beneficiaries to the ACO for each Performance Year.

B. CMS will align Beneficiaries to the ACO prospectively, prior to the start of each Performance Year, except as described in Section IV.C of Appendix A. If the ACO selects Prospective Plus Alignment as the ACO's Alignment Methodology for a Performance Year as described in Section 8.01, CMS will also align Beneficiaries to the ACO using Voluntary Alignment prior to the start of the

second through fourth calendar quarters of the Performance Year as described in Section 5.02.B using MVA and, if the ACO selects to participate in SVA for the Performance Year as described in Section 8.01 and submits an SVA List for the relevant quarter as described in Appendix C, using SVA.

C. Precedence Rules

1. CMS shall establish precedence rules to govern the order in which Beneficiary alignment is conducted across Claims-Based Alignment, SVA, and MVA under the Model. CMS will not align a Beneficiary to the ACO for the Performance Year if the Beneficiary is aligned, assigned, or attributed to an entity participating in another shared savings initiative, or an entity in another model currently tested under the authority of section 1115A of the Act for which beneficiary overlap with the Model is prohibited for the Performance Year, except as otherwise specified by CMS.

2. Under the precedence rules described in this Section 5.01.C, the most recent Valid Designation (as described in Section 5.02.A) of a Participant Provider as a Beneficiary's primary clinician, main doctor, main provider, and/or the main place they receive care (whether through MVA or SVA) will take precedence over any prior designations and over any invalid designations, and Voluntary Alignment will take precedence over Claims-Based Alignment. In addition, a Beneficiary who has designated a provider or supplier that is not a Participant Provider as her or his primary clinician through Voluntary Alignment will not be voluntarily aligned to the ACO if the designation is the most recent Valid Designation made by the Beneficiary.

3. The parties acknowledge that CMS notified the ACO of the precedence rules that apply to Beneficiary alignment in advance of the ACO's first Performance Year. CMS will notify the ACO of any changes to the precedence rules that will apply to Beneficiary alignment for each subsequent Performance Year prior to the start of that Performance Year.

Section 5.02 Voluntary Alignment

A. Valid Designation. A designation of a Participant Provider as a Beneficiary's primary clinician, main doctor, main provider, and/or the main place they receive care (whether through MVA or SVA) is valid for a Performance Year, if either: (1) the designation was made no earlier than two years before the start of that Performance Year; or (2) the Participant Provider designated by the Beneficiary has submitted a claim for a PQEM Service furnished to the Beneficiary during the period that began 25 months before the start of that Performance Year and ends 1 month before the start of that Performance Year (**"Valid Designation"**).

B. Prospective Plus Alignment. If the ACO has selected Prospective Plus Alignment as the ACO's Alignment Methodology for a Performance Year as described in Section 8.01:

1. CMS will align a Beneficiary to the ACO via Voluntary Alignment prior to the start of the second through fourth calendar quarters of the Performance Year, to take effect on a date specified by CMS, if

   a. The Beneficiary has completed a Valid Designation through MVA by a date specified by CMS, or the ACO has submitted to CMS a Valid Designation made by the Beneficiary through SVA by a date and in a manner determined by CMS;

   b. The Beneficiary is not aligned, assigned, or attributed to another REACH ACO (except as otherwise specified by CMS), an entity participating in another shared savings initiative, or an entity in another model currently tested under the authority of section 1115A of the Act for which beneficiary overlap with the Model is prohibited for the Performance Year; and

   c. The Beneficiary is otherwise eligible for alignment to the ACO.

2. CMS will use Prospective Plus Alignment to calculate quarterly updates to the ACO's Performance Year Benchmark and to determine the amount of the PCC Payment, TCC Payment, or APO payment the ACO will receive from CMS for each month of the applicable calendar quarter.

C. Influencing or Attempting to Influence the Beneficiary

1. The ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to not, directly or indirectly, commit any act or omission, nor adopt any policy, that coerces or otherwise influences a Beneficiary's decision to complete or not complete a Voluntary Alignment Form or a MyMedicare.gov, Medicare.gov, or any successor site designation, including but not limited to the following:

   a. Completing a Voluntary Alignment Form on behalf of the Beneficiary;

   b. Designating a primary clinician on MyMedicare.gov, Medicare.gov, or any successor site on behalf of the Beneficiary;

   c. Including the Voluntary Alignment Form and instructions with any other materials or forms, including but not limited to materials requiring the signature of the Beneficiary; and

   d. Withholding or threatening to withhold medical services or limiting or threatening to limit access to care.

2. The ACO may instruct its Participant Providers and Preferred Providers to answer questions from Beneficiaries regarding Voluntary Alignment, but must prohibit Participant Providers and Preferred Providers from completing a Voluntary Alignment Form or designating a clinician on MyMedicare.gov, Medicare.gov, or any successor site on behalf of the Beneficiary.

3. The ACO shall require its Participant Providers and Preferred Providers to instruct Beneficiaries to call the ACO for questions about how to make changes to a Voluntary Alignment Form or how to designate a primary clinician on MyMedicare.gov, Medicare.gov, or any successor site.

4. CMS will provide the ACO with information on how a Beneficiary may designate a clinician on MyMedicare.gov, Medicare.gov, or any successor site as his or her primary clinician for purposes of MVA. If the ACO, a Participant Provider, or a Preferred Provider chooses to share this information with Beneficiaries, the sharing of this information would be considered a Voluntary Alignment Activity subject to the requirements of Section 5.04.

5. Failure to comply with the requirements of this Article V and, if the ACO has selected to participate in SVA, the requirements of Appendix C of the Agreement, may result in retroactive reversal of any alignment of Beneficiaries to the ACO that occurred solely pursuant to Voluntary Alignment, to include via Prospective Plus Alignment.

D. SVA. Appendix C shall apply to the Agreement if the ACO selects to participate in SVA during the Performance Year as described in Section 8.01.

Section 5.03 Alignment Minimum

A. If the ACO is a Standard ACO, the ACO shall maintain an aligned population of at least 5,000 REACH Beneficiaries each Performance Year. If the ACO is a Standard ACO, the ACO shall maintain at least 3,000 Beneficiaries that would have been aligned to the ACO via Claims-Based Alignment for Base Year One, Base Year Two, or Base Year Three (as defined in Appendix A) for Performance Year 2023 and each subsequent Performance Year.

B. If the ACO is a New Entrant ACO, the ACO shall maintain an aligned population of REACH Beneficiaries consistent with the following:

1. [Reserved]

2. For Performance Year 2023, at least 2,000 REACH Beneficiaries;

3. For Performance Year 2024, at least 3,000 REACH Beneficiaries;

4. For Performance Year 2025, at least 4,000 REACH Beneficiaries; and at least 3,000 of these REACH Beneficiaries must be aligned to the ACO via Claims-Based Alignment; and

5. For Performance Year 2026, at least 5,000 REACH Beneficiaries; and at least 3,000 of these REACH Beneficiaries must be aligned to the ACO via Claims-Based Alignment.

For Performance Years 2023, 2024, 2025, and 2026, if more than 3,000 Beneficiaries are aligned to the ACO via Claims-Based Alignment for Base Year One, Base Year Two, or Base Year Three (as defined in Appendix A), CMS will offer the ACO the opportunity to participate in the Model as a Standard ACO starting in the Performance Year in which the 3,000 threshold is exceeded. If the ACO accepts such offer, the ACO will be subject to the alignment minimum

described in Section 5.03.A and the Performance Year Benchmark methodology for Standard ACOs described in Section I of Appendix B for each subsequent Performance Year.

C. If the ACO is a High Needs Population ACO, the ACO shall maintain an aligned population of REACH Beneficiaries consistent with the following:

1. [Reserved]

2. For Performance Year 2023, at least 500 REACH Beneficiaries;

3. For Performance Year 2024, at least 750 REACH Beneficiaries;

4. For Performance Year 2025, at least 1,000 REACH Beneficiaries; and

5. For Performance Year 2026, at least 1,250 REACH Beneficiaries.

For Performance Years 2023, 2024, 2025, and 2026, if more than 3,000 Beneficiaries are aligned to the ACO via Claims-Based Alignment for Base Year One, Base Year Two, or Base Year Three (as defined in Appendix A) CMS will calculate the Performance Year Benchmark based in part on the Performance Year Benchmark methodology for Beneficiaries aligned via Claims-Based Alignment to Standard ACOs, as described in Section III.D of Appendix B, starting in the Performance Year in which the 3,000 threshold is exceeded.

D. Termination & Remedial Action for Failure to Maintain

1. For Performance Year 2025 and each subsequent Performance Year, if the ACO's aligned population falls below the applicable minimum when alignment is first performed for a Performance Year, CMS may take remedial action or may terminate the Agreement or Agreement Performance Period pursuant to Article XVII.

2. For Performance Year 2025 and each subsequent Performance Year, except as provided in Section 5.03.E, if the ACO's aligned population falls below the applicable minimum when alignment is first performed for a Performance Year, CMS shall terminate the Agreement or Agreement Performance Period pursuant to Article XVII.

E. For Performance Year 2024 and each subsequent Performance Year, if the ACO's aligned population is less than the applicable minimum, but equal to 90 percent or more of the applicable minimum when alignment is first performed for the Performance Year, CMS will waive the applicable minimum for the remainder of the Performance Year. CMS will waive the applicable minimum under this paragraph once during the Model Performance Period.

Section 5.04 Marketing Activities and Marketing Materials

A. The ACO shall conduct, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, to conduct Marketing Activities, including Voluntary Alignment Activities, only in accordance with this Article V and, if the ACO has selected to participate in SVA, Appendix C of the Agreement.

B. The ACO shall submit to CMS, in a form and manner and by a date specified by CMS, a plan for implementing the Marketing Activities described in the Agreement ("**Marketing Plan**"). CMS shall use reasonable efforts to approve or reject a Marketing Plan by the Start Date.

C. If CMS determines that the ACO's proposed Marketing Plan does not satisfy the applicable requirements of the Agreement, including the Appendices hereto, or is likely to result in program integrity concerns, CMS may reject (or require the amendment of) the ACO's Marketing Plan at any time, including after the Start Date. If CMS rejects the ACO's Marketing Plan, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, not to, conduct Marketing Activities. If CMS determines that any amendments to the ACO's Marketing Plan described in Section 5.04.E do not satisfy the applicable requirements of the Agreement, including the Appendices hereto, or is likely to result in program integrity concerns, CMS may reject the amendment at any time. If CMS rejects any amendment described in Section 5.04.E, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, not to, implement any material changes to the ACO's Marketing Plan described in the amendment that has been rejected in writing by CMS. The ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, not to, conduct Marketing Activities outside the scope of the Marketing Plan including, if applicable, any material changes to the ACO's Marketing Plan described in a CMS-approved amendment.

D. Unless the ACO participated in the Model during the Implementation Period, the ACO shall not conduct, and shall prohibit its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, from conducting Marketing Activities before the Start Date, or such other date specified by CMS.

E. If the ACO wishes to make any material changes to the ACO's Marketing Plan, the ACO shall submit to CMS, in a form and manner specified by CMS, an amendment to the Marketing Plan describing the material changes the ACO proposes to make to the ACO's Marketing Plan. An amendment to the ACO's Marketing Plan shall be deemed approved 10 business days after submission, unless rejected in writing by CMS.

F. In conducting Marketing Activities, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, not to, discriminate or selectively target Beneficiaries based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, geographic location, or income. In conducting Marketing Activities, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities

performing functions or services related to ACO Activities or Marketing Activities, not to, conduct communication or Marketing Activities targeted to Beneficiaries enrolled in Medicare Advantage or any other Medicare managed care plan. Additionally, in conducting Marketing Activities, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, not to, conduct communication or activities related to Medicare Advantage or any other Medicare managed care plan targeted to REACH Beneficiaries.

G. The ACO shall not and shall require Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, not to, conduct Marketing Activities outside the ACO Service Area, as defined in Section 5.04.H.

H. <u>ACO Service Area</u>

1. Except as described in Section 5.04.H.4, the ACO Service Area consists of the Core Service Area described in Section 5.04.H.2 and the Extended Service Area described in Section 5.04.H.3.

2. The Core Service Area includes the counties in which the ACO's Participant Providers have physical office locations. In advance of each Performance Year, by a time and in a form and manner specified by CMS, the ACO shall submit to CMS a list of the counties in which the ACO's Participant Providers have physical office locations. CMS will use this information for purposes of defining the ACO's Core Service Area for the Performance Year.

3. The Extended Service Area includes all counties adjacent to the Core Service Area. CMS will identify the counties adjacent to the counties in the ACO's Core Service Area for purposes of defining the ACO's Extended Service Area.

4. If CMS determines that the ACO's clinical care model does not rely on physical practice locations, such as if the ACO is located in a Rural Area or is a High-Needs Population ACO, and the ACO proposed an alternative service area definition which CMS approved, the ACO's ACO Service Area shall be the alternative service area so approved by CMS.

5. CMS may offer the ACO one or more opportunities to add counties to the ACO's Core Service Area during a given Performance Year to account for the addition of new physical office locations for either newly added Participant Providers or existing Participant Providers during the Performance Year. Any such additions must be submitted in a form and manner and by a deadline specified by CMS. If the ACO adds any counties to the ACO's Core Service Area, the change to the Core Service Area and any changes to the Extended Service Area and the ACO's Service Area that result from such change shall be effective on the date specified in writing by CMS.

I. To ensure that Beneficiaries are not misinformed or misled about the Model, CMS may develop and provide to the ACO template language for certain Marketing Materials. The ACO shall use any template language for Marketing Materials provided by CMS.

J. Marketing Materials and Marketing Activities Review

1. The ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities not to, use Marketing Materials or engage in Marketing Activities until such Marketing Materials and Marketing Activities are reviewed and approved by CMS, or deemed approved in accordance with Section 5.04.J.2.

2. Marketing Materials and Marketing Activities are deemed approved ten (10) business days following their submission to CMS if:

   i. The ACO certifies compliance with all applicable requirements under this Section 5.04 and, if the ACO has selected to participate in SVA, Appendix C of the Agreement; and

   ii. CMS does not disapprove the Marketing Materials or Marketing Activities.

3. If the ACO has falsely certified compliance with any applicable requirements under this Section 5.04, and if the ACO has selected to participate in SVA, Appendix C of the Agreement, CMS may retroactively reverse alignment of Beneficiaries to the ACO that occurred solely pursuant to Voluntary Alignment, including Beneficiaries aligned during the Performance Year via Prospective Plus Alignment.

4. CMS may review the Marketing Materials and Marketing Activities and issue written notice of disapproval of Marketing Materials and Marketing Activities at any time, including after the expiration of the initial ten (10) business day review period.

5. The ACO shall promptly discontinue, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to promptly discontinue, use of any Marketing Materials and Marketing Activities disapproved by CMS.

6. Any material changes to CMS-approved Marketing Materials and Marketing Activities must be submitted to CMS and approved by CMS, or deemed approved in accordance with Section 5.04.J.2, before use.

7. The ACO shall retain copies of all written and electronic Marketing Materials and appropriate records for all Marketing Activities in a manner consistent with Section 16.02.

K. In using Marketing Materials and conducting Marketing Activities, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities not to do any of the following:

1. Engage in activities that could mislead or confuse a Beneficiary regarding the Model, another model currently tested or under development by CMS under the authority of section 1115A of the Act, the Medicare Shared Savings Program, Medicare benefits, or the ACO; or

2. Claim the ACO is recommended or otherwise endorsed by CMS or that CMS recommends that the Beneficiary select a Participant Provider as his or her main doctor, main provider, and/or the main place the Beneficiary receives care; or

3. Expressly state or imply that selecting a Participant Provider as the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care removes a Beneficiary's freedom to choose to obtain health services from providers and suppliers who are not Participant Providers or Preferred Providers.

L. The ACO must translate Marketing Materials into any non-English language that is the primary language of at least 5 percent of REACH Beneficiaries.

M. Unsolicited Contacts

1. Except as otherwise specified in the Agreement, the ACO may use and may permit its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to conduct Marketing Activities through unsolicited direct contact with Beneficiaries using conventional mail and other print media or email, provided that Beneficiaries are given an opportunity to opt-out of subsequent unsolicited contacts.

2. The ACO is prohibited and shall prohibit its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities from using Marketing Materials and conducting Marketing Activities through the use of door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence, approaching Beneficiaries in common areas, such as parking lots, hallways, lobbies, sidewalks, or using telephonic solicitation, including text messages and leaving voicemail messages. This restriction does not apply to solicitation in common areas of a health care setting, which is subject to the limitations of paragraphs (3) through (5) of this Section 5.04.M and, if the ACO has selected to participate in SVA, Appendix C of the Agreement.

3. The ACO may conduct and may permit Participant Providers, Preferred Providers, and other individuals and entities performing ACO Activities or Marketing Activities on behalf of the ACO to conduct Marketing Activities in common areas of a health care setting. Common areas of a health care setting include, but are not limited to, common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms.

4. Except as provided in paragraph (5) of this Section 5.04.M, the ACO is prohibited and shall prohibit its Participant Providers, Preferred Providers,

and other individuals and entities performing ACO Activities or Marketing Activities on behalf of the ACO from conducting Marketing Activities in restricted areas of a health care setting. Restricted areas of a health care setting include, but are not limited to, exam rooms, hospital patient rooms, treatment areas (where patients interact with a health care provider and his/her clinical team and receive treatment, including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).

5. The ACO may distribute and display Marketing Materials in all areas of the health care setting, including both common areas and restricted areas, except as otherwise specified in the Agreement.

N. Marketing Events

1. The ACO shall ensure that:

a. Marketing Events do not involve health screenings or any other activity that is used, or could be perceived as being used, to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services for the purpose of trying to affect the population of Beneficiaries aligned to the ACO for a subsequent Performance Year or, if the ACO has selected Prospective Plus Alignment as described in Section 8.01, a subsequent quarter of the current Performance Year.

b. Marketing Events do not require attendees to provide their contact information as a prerequisite for attending the Marketing Event and that any sign-in sheets used for purposes of the Marketing Event are clearly labeled as optional.

c. Beneficiary contact information provided at a Marketing Event is used only for the purpose for which it was solicited. For example, Beneficiary contact information provided for a raffle or other drawing is used only for purposes of such raffle or drawing.

d. Any Marketing Activities conducted and Marketing Materials distributed as part of the Marketing Event comply with the applicable requirements of this Section 5.04 and Section 5.08.

2. In conducting Marketing Events, the ACO may engage in activities including, but not limited to:

a. Hosting the Marketing Event in a public venue;

b. Answering Beneficiary-initiated questions regarding the ACO's participation in the Model; or

c. Distributing the ACO's, a Participant Provider's, or a Preferred Provider's business cards and contact information to Beneficiaries.

Section 5.05 Beneficiary Notifications

A. In a form and manner and by one or more dates specified by CMS, the ACO shall provide written notice to all Beneficiaries who have been aligned to the ACO

beginning January 1 of the Performance Year and remain aligned as of April 30 of the Performance Year.

B. For purposes of the Beneficiary notification required under Section 5.05.A, the ACO shall use a template letter provided by CMS, in which CMS will designate letter content that the ACO shall not change, as well as places in which the ACO may insert its own original content.

C. In accordance with Section 5.04.J, the ACO shall submit the final Beneficiary notification letter, including any original content inserted by the ACO, for CMS approval prior to sending such letter to Beneficiaries. The final Beneficiary notification letter will be deemed approved as described in Section 5.04.J.2, unless CMS provides a written notice of disapproval.

D. CMS may issue written notice of disapproval of the final Beneficiary notification letter at any time, including after the Beneficiary notification letter is deemed approved as described in Section 5.04.J.2.

E. Notwithstanding Section 5.05.A, in a form and manner and by one or more dates specified by CMS, the ACO shall provide written notice to all Beneficiaries who have been aligned to the ACO after April 30 of the Performance Year.

Section 5.06 Availability of Services

A. The ACO shall require its Participant Providers and Preferred Providers to make Medically Necessary Covered Services available to Beneficiaries in accordance with applicable laws, regulations and guidance. Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR Part 405, Subpart I.

B. The ACO shall not, and shall require its Participant Providers and Preferred Providers to not, take any action to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services for the purpose of trying to affect the population of Beneficiaries aligned to the ACO for a subsequent Performance Year.

Section 5.07 Beneficiary Freedom of Choice

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

B. Notwithstanding the requirements of Section 5.07.A, the ACO may communicate to Beneficiaries the benefits of receiving care with the ACO. All such communications shall be deemed Marketing Materials or Marketing Activities. To ensure that Beneficiaries are not misinformed or misled about the Model, CMS may provide the ACO with scripts, talking points or other materials explaining these benefits.

Section 5.08 Prohibition on Beneficiary Inducements

A. Except as otherwise permitted by applicable law and Sections 5.08.C, 5.08.D, and 5.08.E, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions and services related to ACO Activities to not, provide gifts or other remuneration to Beneficiaries to induce them to receive items or services from the ACO, Participant Providers, or Preferred Providers, or to induce them to continue to receive items or services from the ACO, Participant Providers, or Preferred Providers.

B. <u>Availability of Safe Harbor Protection for Beneficiary Incentives</u>

CMS has determined that the Federal anti-kickback statute safe harbor for CMS-sponsored Model Patient Incentives (42 CFR § 1001.952(ii)(2)) is available to protect remuneration furnished by a REACH ACO, Participant Provider, or Preferred Provider to a Beneficiary that meets all safe harbor requirements set forth in 42 CFR § 1001.952(ii)(2) and the requirements of:

1. Section 5.08.C.1, as applied to certain in-kind remuneration;
2. Section 5.08.D of the Agreement and Sections III and IV.B of Appendix P, as applied to the Part B Cost-Sharing Support Beneficiary Engagement Incentive;
3. Section 5.08.D of the Agreement and Section IV of Appendix Q, as applied to the Chronic Disease Management Reward Beneficiary Engagement Incentive; or
4. Section 5.08.E of the Agreement, as applied to a Beneficiary Refund made by the ACO pursuant to Section IV.B.4 of Appendix T regarding the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.

C. <u>Exception for Certain In-Kind Remuneration</u>

1. Consistent with the provisions of Sections 5.08.A and 5.08.B, and subject to compliance with all other applicable laws and regulations, beginning on the Start Date, the ACO may provide and may permit its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to provide certain in-kind items or services to Beneficiaries in conjunction with any ACO Activities if the following conditions are satisfied:

    a. The in-kind items or services are preventive care items and services or will advance one or more of the following clinical goals for the Beneficiary: adherence to a treatment regime, adherence to

a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition.

b. The in-kind item or service has a reasonable connection to the Beneficiary's health care.

c. The in-kind item or service is not a Medicare-covered item or service for the Beneficiary on the date the in-kind item or service is furnished to that Beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a Benefit Enhancement is considered a Medicare-covered item or service, regardless of whether the ACO has selected to participate in such Benefit Enhancement for the Performance Year as described in Section 8.01.

d. The in-kind item or service is not furnished in whole or in part to reward the Beneficiary for designating, or agreeing to designate, a Participant Provider as his or her primary clinician, main doctor, main provider, or the main place where the Beneficiary receives care through Voluntary Alignment.

e. The in-kind item or service is furnished to a Beneficiary directly by the ACO, a Participant Provider, or a Preferred Provider.

2. For each in-kind item or service provided under this Section 5.08.C, the ACO shall maintain and make available to the government upon request, and shall require its Participant Providers and Preferred Providers to maintain and make available to the government upon request, all materials and records sufficient to establish whether such in-kind item or service was furnished in a manner that meets the conditions of this Section 5.08.C. Such materials and records must be maintained in accordance with Section 16.02 and include, without limitation, documentation of the following:

a. The nature of the in-kind item or service;

b. The identity of each Beneficiary that received the in-kind item or service;

c. The identity of the individual or entity that furnished the in-kind item or service; and

d. The date the in-kind item or service was furnished.

D. Exception for Beneficiary Engagement Incentives

Consistent with the provisions of Section 5.08.A and Section 5.08.B, and subject to compliance with Appendices P and Q of the Agreement and all other applicable laws and regulations, beginning on the Start Date, the ACO may provide, and may permit its Participant Providers and Preferred Providers to provide, the Part B Cost-Sharing Support Beneficiary Engagement Incentive and the Chronic Disease Management Reward Beneficiary Engagement Incentive to certain REACH Beneficiaries.

E. Exception for the Nurse Practitioner and Physician Assistant Services Benefit Enhancement

Consistent with the provisions of Section 5.08.A and Section 5.08.B, and subject to compliance with Section IV.B.4 of Appendix T of the Agreement, the ACO may provide a Beneficiary Refund for certain services furnished pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.

Section 5.09 HIPAA Requirements

A. The ACO acknowledges that it is a covered entity or a business associate, as those terms are defined in 45 CFR § 160.103, of Participant Providers or Preferred Providers who are covered entities.

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

C. The ACO shall maintain the privacy and security of all Model-related information that identifies individual Beneficiaries in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of PHI by covered entities and business associates, as well as other applicable federal and state laws and regulations.

Section 5.10 Health Equity Plan

A. For Performance Year 2023, the ACO shall submit to CMS, in a form and manner and by the date(s) specified by CMS, a plan ("**Health Equity Plan**") that:

1. Identifies one or more health disparities experienced by one or more Underserved Communities within its population of REACH Beneficiaries that the ACO will aim to reduce ("**Target Health Disparities**") and the data sources used to inform the identification of Target Health Disparities;
2. Describes the initiative(s) the ACO will create and implement to reduce Target Health Disparities ("**Health Equity Plan Intervention(s)**");
3. Describes the resources needed to implement the Health Equity Plan Interventions and identifies any gaps in the ACO's current resources and the additional resources that will be needed ("**Resource Gap Analysis**");
4. Provides a timeline for the implementation of the Health Equity Plan Intervention(s) ("**Health Equity Project Plan**");
5. Identifies one or more quantitative metrics that the ACO will use to measure the reductions in Target Health Disparities arising from the Health Equity Plan Interventions ("**Health Equity Plan Performance Measure(s)**"); and
6. Identifies targeted outcomes relative to the Health Equity Plan Performance Measures ("**Health Equity Goals**") for Performance Year 2023 and all subsequent Performance Years, and describes how the ACO will use these Health Equity Goals to monitor and evaluate progress in reducing Target Health Disparities.

B. CMS shall use reasonable efforts to approve or reject the Health Equity Plan and any Material Health Equity Plan Amendment (as defined below) within 60 business days.

C. Consistent with Section 5.04.J, the ACO must submit all Marketing Materials that will be used to educate, notify, or contact REACH Beneficiaries regarding the ACO's Health Equity Plan to CMS for review prior to use. The ACO may submit examples of such Marketing Materials with its Health Equity Plan.

D. The ACO shall engage in activities related to the execution of the ACO's Health Equity Plan approved by CMS under Section 5.10.B, including implementing Health Equity Plan Interventions and monitoring and evaluating progress in reducing Target Health Disparities (**"Health Equity Activities"**). If CMS approves the ACO's Health Equity Plan, the ACO shall and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to Health Equity Activities to conduct Health Equity Activities consistent with the approved Health Equity Plan, including, if applicable, any Material Health Equity Plan Amendment that has been approved by CMS under Section 5.10.G.

E. The ACO shall ensure that Health Equity Activities do not discriminate against any Beneficiary on the basis of race, ethnicity, national origin, religion, or gender. The ACO may identify Beneficiaries for Health Equity Plan Interventions based on other factors, including medical history, health status, health needs, income, or geographic location, so long as the ACO, its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to Health Equity Activities comply with all applicable Federal anti-discrimination laws and regulations.

F. If CMS determines that the ACO's Health Equity Plan does not satisfy the applicable requirements of the Agreement, is inconsistent with the applicable CMS Health Equity Plan guidance, does not provide sufficient evidence or documentation to demonstrate that the Health Equity Plan is likely to accomplish the ACO's intended Health Equity Goals, or is likely to result in program integrity concerns, or negatively impact Beneficiaries' access to quality care, CMS may reject the Health Equity Plan or require amendment of the Health Equity Plan at any time, including after its initial submission and approval. If CMS rejects the ACO's Health Equity Plan, in whole or in part, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Health Equity Activities to not, conduct Health Equity Activities identified in the Health Equity Plan that have been rejected by CMS.

G. If the ACO wishes to make changes to any of the following components of its Health Equity Plan, it must submit to CMS an amendment to the Health Equity Plan in a form and manner and by the date(s) specified by CMS ("**Material Health Equity Plan Amendment**"):

   1. The Health Equity Goals;

   2. The Target Health Disparities, including the one or more Underserved Communities within the population of REACH Beneficiaries affected by

the Target Health Disparities and the data sources used to inform the identification of Target Health Disparities;

3. The Health Equity Plan Intervention(s); or

4. The Health Equity Plan Performance Measures.

If CMS determines that the Material Health Equity Plan Amendment does not satisfy the applicable requirements of the Agreement, is inconsistent with the applicable CMS Health Equity Plan guidance, does not provide sufficient evidence or documentation to demonstrate that the Health Equity Plan, as amended, is likely to accomplish the ACO's intended Health Equity Goals, or is likely to result in program integrity concerns, or negatively impact Beneficiaries' access to quality care, CMS may reject it at any time. If CMS rejects a Material Health Equity Plan Amendment, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to Health Equity Activities to not, implement any change to the ACO's Health Equity Plan described in the Material Health Equity Plan Amendment that has been rejected by CMS.

H. For Performance Year 2024 and each subsequent Performance Year, in a form and manner and by the date(s) specified by CMS, the ACO shall submit to CMS an update on its progress in implementing its Health Equity Plan ("**Health Equity Plan Progress Update**"). The Health Equity Plan Progress Update must include:

1. Updated outcomes data for the Health Equity Plan Performance Measure(s);

2. Updates to the Resource Gap Analysis; and

3. Updates to the Health Equity Project Plan.

If CMS determines that an update to the Health Equity Project Plan does not satisfy the applicable requirements of the Agreement, is inconsistent with the applicable CMS Health Equity Plan guidance, does not provide sufficient evidence or documentation to demonstrate that the Health Equity Plan is likely to accomplish the ACO's intended Health Equity Goals, or is likely to result in program integrity concerns, or negatively impact Beneficiaries' access to quality care, or does not address the ACO's Health Equity Plan Interventions, CMS may take one or more of the remedial actions specified in Section 17.01.

I. CMS may require the ACO to report data on its implementation of the Health Equity Plan pursuant to 42 CFR § 403.1110(b) for the purpose of monitoring and evaluating the Model. Such data shall be reported in a form and in a manner and by a date specified by CMS.

ARTICLE VI Data Sharing and Reports

Section 6.01 General

A. Subject to the limitations discussed in the Agreement, and in accordance with applicable law, including HIPAA and the regulations in 42 CFR Part 2 regarding confidentiality of substance use disorder ("**SUD**") patient records, during the Agreement Performance Period CMS will offer the ACO an opportunity to

request certain Beneficiary-identifiable data and reports using a data request form (the "**HIPAA-Covered Data Disclosure Request Form**") which CMS will provide and maintain. In advance of each Performance Year, CMS will also provide the ACO with an overview of the reporting and data sharing available to the ACO for the Performance Year ("**Reporting and Data Sharing Overview**"). The Beneficiary-identifiable data available for request are described in Section 6.02 of the Agreement and in the Reporting and Data Sharing Overview for the relevant Performance Year.

B. The claims data described in Section 6.02.C.2 will omit individually identifiable data for Beneficiaries who have opted out of data sharing with the ACO, as described in Section 6.04, including Beneficiaries administratively opted out of all claims data-sharing pursuant to Section 6.04.E. The data and reports provided to the ACO will also omit individually identifiable SUD data for any Beneficiaries who have not opted into SUD data sharing, as described in Section 6.05.

Section 6.02 Provision of Certain Claims Data and Beneficiary Reports

A. CMS believes that the health care operations work of the ACO (that is acting on its own behalf as a HIPAA covered entity (CE) or that is a business associate (BA) acting on behalf of its Participant Providers or Preferred Providers that are HIPAA CEs) would benefit from the receipt of certain beneficiary-identifiable data on REACH Beneficiaries and Beneficiaries who have been excluded from alignment to the ACO, including Originally Aligned Beneficiaries. CMS will therefore offer to the ACO an opportunity to request specific Beneficiary-identifiable data by completing the HIPAA-Covered Data Disclosure Request Form. This data set will not include SUD data; however, CMS will notify the ACO in writing if CMS subsequently elects to offer the ACO an opportunity to request Beneficiary-identifiable SUD data by completing the HIPAA-Covered Data Disclosure Request Form. All requests for Beneficiary-identifiable claims data will be granted or denied at CMS' sole discretion based on CMS's available resources and technological capabilities, the limitations in the Agreement, and applicable law.

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

C. The Beneficiary-identifiable data available for request by completing the HIPAA-Covered Data Disclosure Request Form includes the data and reports described in this Section 6.02.C. The aggregated data described in paragraphs (4) through (6) of this Section 6.02.C will incorporate de-identified data regarding Beneficiaries who have opted out of data sharing or who have received treatment for SUD services. While aggregated, the data described in paragraphs (4) through (6) may be identifiable due to cells that represent fewer than 11 Beneficiaries; when this is the case, the data are subject to all requirements under the Agreement and applicable law.

1. ***Beneficiary Alignment Data***. This data will include, for the relevant Performance Year:

(i) A Beneficiary alignment report, shared monthly, that includes a list of REACH Beneficiaries and Beneficiaries who have been removed from alignment to the ACO, including Originally Aligned Beneficiaries, as well as the following information for each such Beneficiary: the Alignment Year the Beneficiary became an Alignment-Eligible Beneficiary (as such terms are defined in Appendix A of the Agreement); the effective date of the Beneficiary's alignment to the ACO; the effective date of the Beneficiary's removal from alignment to the ACO and the reason for such removal (if applicable); the demographic characteristics specified in the Reporting and Data Sharing Overview; if the ACO is a High Needs Population ACO, which of the High Needs eligibility criteria the Beneficiary has met; whether the Beneficiary has Medicare Part D prescription coverage; and the REACH Beneficiary's data sharing preferences made pursuant to Section 6.04 and Section 6.05.B, including whether the REACH Beneficiary is administratively opted out of all claims data-sharing pursuant to Section 6.04.E.

(ii) A provider alignment report, shared annually if the ACO elects Prospective Alignment or quarterly if the ACO elects Prospective Plus Alignment, that connects each REACH Beneficiary to the Participant Provider(s) that contributed to that Beneficiary's alignment to the ACO through either Claims-Based Alignment or Voluntary Alignment.

(iii) A SVA response file, shared quarterly, that includes the results of a REACH Beneficiary's selection of a Participant Provider as his or her main source of care via SVA, if applicable.

2. ***Claims Data***. This data will include:

(i) Three years of historical Parts A, B, and D claims data files specified in the Reporting and Data Sharing Overview from the 36 months immediately preceding the effective date of the Beneficiary's alignment to the ACO;

(ii) Monthly Parts A, B, and D claims data files specified in the Reporting and Data Sharing Overview for REACH Beneficiaries;

(iii) Monthly Parts A, B, and D claims data files specified in the Reporting and Data Sharing Overview for Originally Aligned Beneficiaries for claims with a date of service prior to the date the Beneficiary was removed from alignment to the ACO;

(iv) Weekly claims data files specified in the Reporting and Data Sharing Overview regarding those claims subject to the TCC Fee Reduction (if the ACO has selected TCC Payment as its Capitation Payment Mechanism) or the PCC Fee Reduction (if the ACO has

selected PCC Payment as its Capitation Payment Mechanism) and, if the ACO has selected to participate in the APO, the APO Fee Reduction;

(v) For Performance Year 2024 and each subsequent Performance Year, monthly Bundled Payments for Care Improvement (BPCI) Clinical Episode data files specified in the Reporting and Data Sharing Overview for REACH Beneficiaries; and

(vi) For Performance Year 2024 and each subsequent Performance Year, monthly Bundled Payments for Care Improvement (BPCI) Clinical Episode data files specified in the Reporting and Data Sharing Overview for Originally Aligned Beneficiaries for claims with a date of service prior to the date the Beneficiary was removed from alignment to the ACO; and

(vii) For Performance Year 2024 and each subsequent Performance Year, on at least an annual basis, as specified in the Reporting and Data Sharing Overview, data that contain hospital-specific prospective target prices for each clinical episode category.

3. ***Risk Adjustment Data***. This data will be shared quarterly and will include, for the relevant Performance Year:

(i) The risk scores established in accordance with Appendix B and the demographic information specified in the Reporting and Data Sharing Overview for REACH Beneficiaries; and

(ii) The risk scores established in accordance with Appendix B and the demographic information specified in the Reporting and Data Sharing Overview for Originally Aligned Beneficiaries for the period prior to the date the Beneficiary was removed from alignment to the ACO.

4. ***Aggregated Payment Data***. CMS will provide data to the ACO detailing the ACO's preliminary, interim, and final payment calculations and amounts throughout the Performance Year. In addition, this data will include aggregated monthly, quarterly, and year-to-date information regarding all incurred expenditures for all Covered Services rendered to REACH Beneficiaries and for all Covered Services rendered to Originally Aligned Beneficiaries with a date of service prior to the date the Beneficiary was removed from alignment to the ACO.

5. ***Aggregated Benchmark Data***. For the relevant Performance Year, CMS will provide preliminary, interim, provisional (if the ACO selected Provisional Financial Settlement), and final data to the ACO detailing the ACO's Performance Year Benchmark throughout the Performance Year, as detailed in Sections 11.01.B, 11.01.C, and 12.04.A.2, if applicable, and 12.04.A.3, respectively.

6. ***Quality Performance Scoring Data***. On a quarterly basis, CMS will provide:

(i) For Performance Years prior to Performance Year 2025, on a quarterly basis, data regarding the ACO's performance for a prior quarter of the Agreement Performance Period on quality measures described in Article IX, Appendix D, and the Reporting and Data Sharing Overview for the 12-month period that ends on the last day of the relevant quarter.

(ii) For Performance Year 2025 and each subsequent Performance Year:

a. Data regarding the ACO's performance for the Agreement Performance Period on quality measures described in Article IX, Appendix D, and the Reporting and Data Sharing Overview for the 12-month period that ends on the last day of the relevant quarter.

b. Information regarding which REACH Beneficiaries contributed eligibility towards the calculation of the Health Equity Data Reporting Adjustment.

c. Beneficiary-level performance data on quality measures described in Article IX, Appendix D and the Reporting and Data Sharing Overview for the 12-month period that ends on the last day of the relevant quarter.

7. ***Aggregated Clinical Episode Bundles.*** Beginning Performance Year 2024, and for the relevant performance year, CMS will provide:

(i) Quarterly data on the ACO's Clinical Episodes, as described in the Reporting and Data Sharing Overview; and

(ii) On at least an annual basis, as specified in the Reporting and Data Sharing Overview, data that contain hospital-specific prospective target prices for each clinical episode category.

D. The parties mutually agree that, except for data covered by Section 6.02.M below, CMS retains all ownership rights to the data sources specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form, and the ACO does not obtain any right, title, or interest in any of the data furnished by CMS.

E. The ACO represents, and in furnishing the data sources specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form CMS relies upon such representation, that such data sources will be used during the Agreement Performance Period and at such other times during the Agreement Term as may be specified in writing by CMS solely for care management, care coordination, and quality improvement activities for REACH Beneficiaries, population-based activities relating to improving health or reducing health care costs, and such other purposes described in the Agreement. The ACO agrees that it will disclose, use and reuse the data only as specified in the Agreement or as CMS shall authorize in writing or as otherwise required by law, and not for any other purpose, including but not limited to conducting communications or activities related to Medicare Advantage or any other Medicare managed care

plan. The ACO further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by the Agreement.

F. Information derived from the CMS data specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form may be shared and used within the legal confines of the ACO and its Participant Providers and Preferred Providers in a manner consistent with Section 6.02.G to enable the ACO to improve care integration and be a patient-centered organization.

G. The ACO 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 provider incentive design and implementation, but shall not disseminate (unless required by law) any individually identifiable original or derived information from the data specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form to anyone who is not a HIPAA CE, a HIPAA BA, an individual practitioner in a treatment relationship with the subject Beneficiary(ies), or that practitioner's business associates. When using or disclosing PHI or personally identifiable information (**"PII"**), obtained from data specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form, the ACO must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. The ACO 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 HIPAA-Covered Data Disclosure Request Form.

Subject to the limits specified above and elsewhere in the Agreement and applicable law, the ACO may link individually identifiable data specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form (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 ACO and its Participant Providers or Preferred Providers. The ACO 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 CFR 164.514(b).

H. The ACO 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 (https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A130/a130revised.pdf as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf); and, NIST Special Publication 800-53 "Recommended Security

Controls for Federal Information Systems" (http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf).

The ACO acknowledges that the use of unsecured telecommunications, including the internet, to transmit directly or indirectly individually identifiable information from the files specified in Section 6.02 and requested via the HIPAA-Covered Data Disclosure Request Form or any such derivative data files is strictly prohibited. Further, the ACO agrees that the data specified in Section 6.02.C and requested via the HIPAA-Covered Data Disclosure Request Form 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 HIPAA-Covered Data Disclosure Request Form other than as provided in the Agreement without written approval from CMS, unless such movement, transmission or disclosure is required by law.

I. The ACO 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 HIPAA-Covered Data Disclosure Request Form, for the purpose of inspecting to confirm compliance with the terms of the Agreement.

J. The ACO agrees that any use of CMS data in the creation of any document concerning the purposes specified in this section and the HIPAA-Covered Data Disclosure Request Form must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer Beneficiaries may be displayed. Also, no 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.

K. The ACO shall report within one hour any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2580 or by email notification at cms_it_service_desk@cms.hhs.gov. For Performance Year 2024 and each subsequent Performance Year, the ACO shall also send email notification of the data incident to the ACO REACH Model at ACOREACH@cms.hhs.gov. Furthermore, the ACO shall cooperate fully in any federal incident security process that results from such improper use or disclosure.

L. The parties mutually agree that the individual named in the HIPAA-Covered Data Disclosure Request Form as the ACO's data custodian is designated as custodian of the CMS data files on behalf of the ACO and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, and for the establishment and maintenance of security arrangements as specified in the Agreement to prevent unauthorized use or disclosure. Furthermore, such custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in the Agreement as a condition of receiving such data. In the event the data custodian named in the

HIPAA-Covered Data Disclosure Request Form is unable to perform these functions for any reason, and the ACO has named an alternate data custodian in the HIPAA-Covered Data Disclosure Request Form, the parties mutually agree that the individual named in the HIPAA-Covered Data Disclosure Request Form as alternate data custodian is designated as custodian of the CMS data files on behalf of the ACO and will be responsible for performing these functions. The ACO shall ensure that any individual named in the HIPAA-Covered Data Disclosure Request Form as data custodian or alternate data custodian is either an employee of the ACO or an employee of a BA of the ACO that requires access to the requested data for the purposes for which the data is requested. The ACO shall notify CMS within 15 Days of any change of data custodian or alternate data custodian. 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.

M. The data sources disclosed to the ACO pursuant to the HIPAA-Covered Data Disclosure Request Form may be retained by the ACO until 30 Days after the completion of Final Financial Settlement for the final Performance Year of the Agreement Performance Period, except as CMS shall authorize in writing or as otherwise required by law. The ACO 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 ACO is a HIPAA CE, and the data has been incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom the ACO provides such data in the course of carrying out the Model may also retain such data if the recipient entity is a HIPAA CE or BA and the data is incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. The ACO 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 Final Financial Settlement for the final Performance Year of the Agreement Performance Period, except as CMS shall authorize in writing or as otherwise required by law. CMS may require the ACO 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 ACO shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph. These retention provisions survive the expiration or termination of the Agreement.

Section 6.03 De-Identified Reports

A. CMS may provide reports to the ACO, which will be de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b).

B. Aggregated Alignment Data. CMS provides periodic estimates of the aggregate number of Originally Aligned Beneficiaries, REACH Beneficiaries, or Alignment-Eligible Beneficiaries (as defined in Appendix A of the Agreement) that meet the criteria in Section 5.02.B.1(b) to assist the ACO in planning related

to the requirements described in Section 5.03. Beneficiaries who have opted out of data sharing or who have received treatment for SUD services may be included in the estimates of the aggregate number of Alignment-Eligible Beneficiaries. This aggregate information will not include individually-identifiable health information.

Section 6.04 Beneficiary Rights to Opt Out of Data Sharing

A. The ACO shall provide 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 via 1-800-MEDICARE. Such communications shall note that, even if a Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for care coordination and quality improvement activities for REACH Beneficiaries, and population-based activities relating to improving health or reducing health care costs.

B. The ACO shall allow Beneficiaries to reverse a data sharing preference at any time by calling 1-800-MEDICARE.

C. CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in this Model or who have previously declined data sharing under the Medicare Shared Savings Program, the Pioneer ACO Model, or the Next Generation ACO Model.

D. The ACO may affirmatively contact a REACH Beneficiary who has elected to decline claims data sharing no more than one time during a Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Beneficiaries outside of a clinical setting.

E. In the event that an ACO Professional is terminated from the ACO for any reason, if that departing ACO Professional is the sole ACO Professional in the ACO to have submitted claims for a particular Beneficiary during the 12-month period prior to the effective date of the termination, CMS will administratively opt the Beneficiary out of all claims data-sharing under Section 6.02.C.2 within 30 Days of the effective date of the termination, unless the Beneficiary has selected another ACO Professional as his or her main doctor, main provider, and/or main place they receive care (whether through MVA or SVA) or has become the patient of another Participant Provider or Preferred Provider.

F. Notwithstanding the foregoing, if CMS elects to offer SUD data sharing as described in Section 6.02.A, the ACO shall receive claims data regarding SUD treatment only if the Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved SUD opt in form pursuant to Section 6.05.

Section 6.05 Beneficiary Substance Use Disorder Data Opt-In

A. Upon notification from CMS that CMS will offer the ACO an opportunity to request Beneficiary-identifiable SUD data as described in Section 6.02.A, the ACO may inform each REACH Beneficiary, in compliance with applicable law:

1. That he or she may elect to allow the ACO to receive Beneficiary-identifiable data regarding his or her utilization of SUD services;

2. Of the mechanism by which the Beneficiary can make this election; and

3. That 1-800-MEDICARE will answer any questions regarding sharing of data regarding utilization of SUD services.

B. A Beneficiary may opt in to SUD data sharing only by submitting a CMS-approved SUD opt in form to the ACO. The ACO shall promptly send the SUD opt in form to CMS.

ARTICLE VII Use of Certified EHR Technology

As of the Start Date, the ACO and its Participant Providers shall use Certified Electronic Health Record Technology ("**CEHRT**"), as such term is defined under 42 CFR § 414.1305, in a manner sufficient to meet the applicable requirements of 42 CFR § 414.1415(a)(1), including any amendments thereto.

ARTICLE VIII ACO Selections and Approval

Section 8.01 ACO Selections

A. The parties acknowledge that the ACO was required to submit its selections for the following in advance of the Effective Date by a date and in a form and manner specified by CMS:

1. The ACO's Risk Sharing Option (Professional or Global) for the ACO's first Performance Year subject to the requirements of Section 8.01.D;

2. The ACO's selected Capitation Payment Mechanism for the ACO's first Performance Year;

3. The ACO's selection whether to participate in the APO for the ACO's first Performance Year, if the ACO selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year;

4. The maximum Enhanced PCC Percentage for the ACO's first Performance Year within the range specified in Appendix E, if the ACO selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year;

5. The Benefit Enhancements or Beneficiary Engagement Incentives, if any, that the ACO selected to offer with its Participant Providers and Preferred Providers during the ACO's first Performance Year;

6. The ACO's selected Alignment Methodology (Prospective Alignment or Prospective Plus Alignment) for the ACO's first Performance Year;

7. The ACO's decision with respect to participation in SVA for the ACO's first Performance Year. The ACO's decision with respect to participation in SVA for the ACO's first Performance Year refers to the ACO's decision to participate in Voluntary Alignment Activities specific to SVA in accordance with Appendix C during the ACO's first Performance Year for purposes of: (1) aligning Beneficiaries to the ACO for the ACO's

second Performance Year; and (2) aligning Beneficiaries to the ACO for the second, third, and fourth calendar quarters of the ACO's first Performance Year, provided that the ACO has selected Prospective Plus Alignment for the ACO's first Performance Year and submits an SVA List (as described in Appendix C) to CMS in advance of the relevant calendar quarter; and

8. The ACO's decision whether to participate in Provisional Financial Settlement for the ACO's first Performance Year.

B. In a form and manner and by the date(s) specified by CMS, the ACO shall submit to CMS:

1. Its selection whether to participate in a Stop-Loss Arrangement for the ACO's first Performance Year; and

2. An update to the maximum Enhanced PCC Percentage for the ACO's first Performance Year within the range specified in Appendix E, if the ACO selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year and wants to adjust the maximum Enhanced PCC Percentage the ACO previously selected for its first Performance Year as described in Section 8.01.A.4.

3. Its selection, if any, to participate in the 3-Day SNF Rule Waiver Benefit Enhancement and the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.

C. In a form and manner and by one or more dates specified by CMS, the ACO shall submit to CMS its selections for the following for the ACO's second Performance Year and each subsequent Performance Year:

1. The ACO's decision whether to participate in Provisional Financial Settlement for the Performance Year;

2. The ACO's selected Capitation Payment Mechanism for the Performance Year;

3. The ACO's selection whether to participate in the APO for the Performance Year, if the ACO selected PCC Payment as its Capitation Payment Mechanism for the Performance Year;

4. The maximum Enhanced PCC Percentage for the Performance Year within the range specified in Appendix E, if the ACO selected PCC Payment as its Capitation Payment Mechanism for the Performance Year;

5. The ACO's decision whether to participate in the Stop-Loss Arrangement for the Performance Year;

6. The Benefit Enhancements or Beneficiary Engagement Incentives, if any, that the ACO selects to offer with its Participant Providers and Preferred Providers during the Performance Year;

7. The ACO's selected Alignment Methodology (Prospective Alignment or Prospective Plus Alignment) for the Performance Year; and

8. The ACO's decision with respect to participation in SVA for the Performance Year. The ACO's decision to participate in SVA for a Performance Year refers to the ACO's decision to participate in Voluntary Alignment Activities specific to SVA in accordance with Appendix C during the Performance Year for purposes of: (1) aligning Beneficiaries to the ACO for the following Performance Year, and (2) aligning Beneficiaries to the ACO for the second, third, and fourth calendar quarters of the Performance Year, provided that the ACO has selected Prospective Plus Alignment for the Performance Year and submits an SVA List (as described in Appendix C) to CMS in advance of the relevant calendar quarter.

D. If the ACO selected Professional as its Risk Sharing Option for the ACO's first Performance Year as described in Section 8.01.A, the ACO may select to change its Risk Sharing Option to Global for the ACO's second Performance Year or any subsequent Performance Year pursuant to this Section 8.01.D. Such selection must be submitted to CMS in a form and manner and by a date specified by CMS. If the ACO selected Professional as its Risk Sharing Option for the ACO's first Performance Year as described in Section 8.01.A and has not since selected to change its Risk Sharing Option to Global pursuant to this Section 8.01.D, the ACO's selection of Professional as its Risk Sharing Option will remain in effect. If the ACO selected Global as its Risk Sharing Option for the ACO's first Performance Year as described in Section 8.01.A, the ACO's selection of Global as its Risk Sharing Option will remain in effect for the duration of the Agreement Performance Period.

E. Regardless of whether the ACO selects to provide the Telehealth Benefit Enhancement for a Performance Year as described in this Section 8.01, payment to Participant Providers for telehealth services furnished pursuant to section 1899(l) of the Act is governed by the terms and conditions of Appendix K of the Agreement.

F. If the ACO is a High Needs Population ACO, the ACO may select to participate in the Model as a Standard ACO in advance of the ACO's second Performance Year or any subsequent Performance Year. Such selection must be submitted to CMS in a form and manner and by a date specified by CMS. A selection made pursuant to this Section 8.01.F that is not rejected by CMS pursuant to Section 8.02 will take effect at the start of the subsequent Performance Year and will remain in effect for the remainder of the Agreement Performance Period.

G. If the ACO is a High Needs Population ACO, the ACO may select to participate in the Model as a New Entrant ACO in advance of the ACO's second Performance Year. Such selection must be submitted to CMS in a form and manner and by a date specified by CMS. A selection made pursuant to this Section 8.01.G that is not rejected by CMS pursuant to Section 8.02 will take effect at the start of the ACO's second Performance Year and will remain in effect for the remainder of the Agreement Performance Period, unless and until the ACO accepts an offer pursuant to Section 5.03.B to participate in the Model as a Standard ACO.

Section 8.02 ACO Selection Approval

The ACO's selections made as described in Section 8.01 shall be deemed approved unless rejected in writing by CMS within 30 Days after submission. This paragraph does not preclude CMS from rejecting or requiring amendment of an Implementation Plan (as defined at Section 10.01.B) pursuant to Section 10.01.E or taking any remedial actions described in Section 17.01 after the ACO's selections have been deemed approved.

ARTICLE IX ACO Quality Performance

Section 9.01 Quality Scores

CMS shall use the ACO's quality scores in determining the ACO's Performance Year Benchmark, according to the methodology described in Appendix B.

Section 9.02 Quality Measures

CMS shall assess quality performance using the quality measure data reported for the ACO on the quality measures set forth in Appendix D. CMS may amend Appendix D without the consent of the ACO prior to the beginning of a Performance Year to change the quality measures to be used for the Performance Year. CMS shall notify the ACO of any change in the measures applicable for a Performance Year prior to the beginning of the Performance Year in which such measures take effect. CMS releases additional guidance on its quality measurement methodology for a Performance Year prior to the beginning of the Performance Year in which such measures take effect. CMS reserves the right to update its quality measurement methodology during the Performance Year as necessary, in CMS' sole discretion, to ensure the validity of the measures set forth in Appendix D.

Section 9.03 Quality Measure Reporting

A. Except as set forth in Section 9.03.B, the ACO shall completely and accurately report the quality measures specified in Appendix D for each Performance Year and shall require its Participant Providers to cooperate in quality measure reporting. Complete reporting means that the ACO meets all of the reporting requirements, including timely reporting of the requested data for all measures.

B. The ACO shall not report quality measures data on behalf of its Participant Providers for a Performance Year if the ACO provides notice of termination to CMS of the Agreement Performance Period pursuant to Section 17.03 that its termination is effective no later than 30 Days after the Termination Without Liability Date of a Performance Year.

C. CMS shall use the following sources for quality reporting:

1. Medicare claims submitted for items and services furnished to REACH Beneficiaries. For Performance Year 2023 and each subsequent Performance Year, a claim for a service that CMS determines is SAHS Billing Activity pursuant to Sections I.D.3.d, II.C.2.d, or III.C.2.d of Appendix B will not be used under this Section 9.03.C.

2. Any other relevant data shared between the ACO and CMS pursuant to the Agreement; and

3. For Performance Year 2023 and subsequent Performance Years, results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] or other patient experience surveys.

D. The ACO shall procure a CMS-approved vendor to conduct the CAHPS survey or another patient experience survey specified by CMS. The ACO shall pay for the surveys. In order to meet the reporting requirements of a CAHPS survey, the ACO shall:

1. By a date specified by CMS, execute a contract with a CAHPS survey vendor to complete the CAHPS data collection;

2. Authorize a CAHPS survey vendor on the ACO REACH CAHPS website by the date specified by CMS; and

3. Ensure that the survey results are transmitted to CMS by a date and in a form and manner specified by CMS.

In order to meet the reporting requirements of another patient experience survey specified by CMS, the ACO shall ensure that the survey results are transmitted to CMS by a date and in a form and manner specified by CMS.

Section 9.04 Quality Performance Scoring

A. CMS shall use the ACO's performance on each of the quality measures to calculate the ACO's total quality score according to a methodology determined by CMS.

B. The parties acknowledge that CMS notified the ACO of the methodology for calculating the quality performance benchmarks and the methodology for calculating the ACO's total quality score for the ACO's first Performance Year.

C. Prior to the start of the ACO's second Performance Year and each subsequent Performance Year, CMS shall notify the ACO of the methodology for calculating the quality performance benchmarks and the methodology for calculating the ACO's total quality score for that Performance Year.

D. For Performance Year 2024 and each subsequent Performance Year, CMS shall use the ACO's performance on each of the quality measures described in Section 9.02 to determine whether the ACO meets continuous improvement or sustained exceptional performance ("**CI/SEP**") criteria according to a methodology determined by CMS prior to the start of the relevant Performance Year.

E. Prior to Performance Year 2024 and each subsequent Performance Year, CMS shall notify the ACO of the CI/SEP criteria and methodology to be used in determining whether the ACO meets such criteria for that Performance Year.

F. For Performance Year 2024 and each subsequent Performance Year, CMS shall use the ACO's performance on each of the quality measures described in Section 9.02 and a methodology determined by CMS prior to the start of the relevant Performance Year to determine whether the ACO meets the criteria to earn a

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

quality performance bonus from a notational pool of funds retained by CMS ("**High Performance Pool (HPP) Bonus**") for the Performance Year.

G. Prior to Performance Year 2023 and each subsequent Performance Year, CMS shall notify the ACO of the HPP criteria and methodology to be used in determining whether the ACO meets such criteria for that Performance Year.

H. For Performance Year 2023 and each subsequent Performance Year, CMS shall use the ACO's reporting of demographic and social determinants of health data pursuant to Section 13.01.D of the Agreement to adjust the ACO's Quality Withhold Earn Back according to a methodology determined by CMS ("**Health Equity Data Reporting Adjustment**"). Prior to Performance Year 2023 and each subsequent Performance Year, CMS shall notify the ACO of the methodology for calculating this adjustment to ACO's total quality score for that Performance Year.

I. For Performance Year 2025 and each subsequent Performance Year, CMS may adjust a quality measure to exclude ACO REACH Beneficiaries who are identified as overlapping with the GUIDE Model. CMS shall specify any such adjustment no later than the date on which CMS notifies the ACO of the methodology for calculating the quality performance benchmarks pursuant to Section 9.04.C.

ARTICLE X Benefit Enhancements and Beneficiary Engagement Incentives

Section 10.01 General

A. The ACO may select as described in Section 8.01 to provide one or more Benefit Enhancements and Beneficiary Engagement Incentives for a Performance Year. Appendices I, J, L through Q, and T shall apply to the Agreement for a given Performance Year only if the ACO selected to provide the relevant Benefit Enhancement or Beneficiary Engagement Incentive for that Performance Year as described in Section 8.01 and that selection was not rejected by CMS pursuant to Sections 8.02 or 10.01.E.

B. The ACO shall submit to CMS, in a form and manner and by a date specified by CMS, a plan for implementing each Benefit Enhancement and each Beneficiary Engagement Incentive selected by the ACO as described in Section 8.01 ("**Implementation Plan**") the first time that the Benefit Enhancement or Beneficiary Engagement Incentive is selected by the ACO, in advance of any Performance Year during which a material amendment to a Benefit Enhancement or Beneficiary Engagement Incentive previously selected will take effect, and at such other times specified by CMS. An Implementation Plan shall be consistent with the applicable requirements set forth in Appendices I, J, L through Q, and T, and shall be deemed approved within 30 Days after submission unless rejected in writing by CMS.

C. If the ACO selects to provide a Benefit Enhancement for a Performance Year, the ACO's Participant Providers and Preferred Providers, as indicated on the relevant Participant Provider List and Preferred Provider List under Article IV, may submit claims for services furnished pursuant to such Benefit Enhancement as

described in this Article X during the Performance Year for which the ACO selected to provide the Benefit Enhancement.

D. CMS may require the ACO to report data on the use of Benefit Enhancements and Beneficiary Engagement Incentives to CMS. Such data shall be reported in a form and in a manner and by a date specified by CMS.

E. If CMS determines that the ACO's proposed implementation of a Benefit Enhancement or Beneficiary Engagement Incentive is inconsistent with the terms of the Agreement or likely to result in program integrity concerns, CMS may reject the ACO's selection to provide the Benefit Enhancement or Beneficiary Engagement Incentive or may require the ACO to submit a new Implementation Plan. If CMS rejects the ACO's selection of a Benefit Enhancement or Beneficiary Engagement Incentive, the ACO shall not implement the Benefit Enhancement or Beneficiary Engagement Incentive for the following Performance Year.

Section 10.02 3-Day SNF Rule Waiver Benefit Enhancement

A. Appendix I shall apply to the Agreement for any Performance Year for which the ACO has selected the 3-Day SNF Rule Waiver Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the 3-Day SNF Rule Waiver Benefit Enhancement and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

B. In order to be eligible to submit claims for services furnished to REACH Beneficiaries pursuant to the 3-Day SNF Rule Waiver Benefit Enhancement, an individual or entity must be:

1. A Preferred Provider; and

2. A skilled-nursing facility ("**SNF**") or a hospital or critical access hospital that has swing-bed approval for Medicare post-hospital extended care services ("**Swing-Bed Hospital**"); and

3. Designated on the Preferred Provider List submitted in accordance with Article IV as participating in the 3-Day SNF Rule Waiver Benefit Enhancement; and

4. Approved by CMS according to the criteria described in this Section 10.02.B and Appendix I.

C. If CMS notifies the ACO that a SNF or Swing-Bed Hospital has not been approved for participation in the 3-Day SNF Rule Waiver Benefit Enhancement under this Section 10.02, but the SNF or Swing-Bed Hospital is otherwise eligible to be a Preferred Provider, the ACO may either remove the SNF or Swing-Bed Hospital from the Preferred Provider List, or amend the relevant list to reflect that the SNF or Swing-Bed Hospital will not participate in the 3-Day SNF Rule Waiver Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

D. If the ACO has selected the Global Risk Sharing Option and the ACO intends to utilize the Beneficiary eligibility criteria described in Section IV.A.3 of Appendix

I, the ACO shall describe how the ACO intends to implement this additional flexibility in its Implementation Plan.

Section 10.03 Telehealth Benefit Enhancement

A. Appendix J shall apply to the Agreement for any Performance Year for which the ACO has selected the Telehealth Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Telehealth Benefit Enhancement and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

B. In order to be eligible to submit claims for services furnished to REACH Beneficiaries pursuant to the Telehealth Benefit Enhancement, an individual must be:

1. A physician or non-physician practitioner listed at 42 CFR § 410.78(b)(2) who is a Participant Provider or Preferred Provider; and

2. Authorized under relevant Medicare rules and applicable state law to bill for telehealth services; and

3. Designated on the Participant Provider List or Preferred Provider List submitted in accordance with Article IV as participating in the Telehealth Benefit Enhancement; and

4. Approved by CMS according to the criteria described in this Section 10.03.B and Appendix J of the Agreement.

C. If CMS notifies the ACO that a physician or non-physician practitioner who is a Participant Provider or Preferred Provider has not been approved for participation in the Telehealth Benefit Enhancement under this Section 10.03, but the physician or non-physician practitioner is otherwise eligible to be a Participant Provider or Preferred Provider, the ACO may either remove the physician or non-physician practitioner from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the physician or non-physician practitioner will not participate in the Telehealth Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

D. In order to be eligible to bill for teledermatology or teleophthalmology furnished using asynchronous store and forward technologies, as that term is defined under section 42 CFR § 410.78(a)(1), pursuant to the Telehealth Benefit Enhancement an individual must be:

1. Approved to bill for the telehealth services pursuant to the Telehealth Benefit Enhancement pursuant to Section 10.03.B.4; and

2. A physician; and

3. Enrolled in Medicare with a Medicare physician specialty of dermatologist or ophthalmologist.

E. The ACO shall ensure the Participant Providers and Preferred Providers do not substitute telehealth services for in-person services when in-person services are more clinically appropriate.

F. The ACO shall ensure that Participant Providers and Preferred Providers only furnish Medically Necessary telehealth services and do not use telehealth services to prevent or deter a Beneficiary from seeking or receiving in-person care when such care is Medically Necessary.

Section 10.04 Post-Discharge Home Visits Benefit Enhancement

A. Appendix L shall apply to the Agreement for any Performance Year for which the ACO has selected the Post-Discharge Home Visits Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Post-Discharge Home Visits Benefit Enhancement and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

B. In order to be eligible to submit claims for services furnished to REACH Beneficiaries pursuant to the Post-Discharge Home Visits Benefit Enhancement, the supervising physician or other practitioner must be:

1. A physician or a non-physician practitioner who is authorized by the Act to receive payment for services "incident to" his or her own services, as described in 42 CFR § 410.26(a)(7), who is a Participant Provider or Preferred Provider; and

2. Eligible under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and

3. Designated on the Participant Provider List or Preferred Provider List submitted in accordance with Article IV as participating in the Post-Discharge Home Visits Benefit Enhancement; and

4. Approved by CMS according to the criteria described in this Section 10.04.B and Appendix L of the Agreement.

C. If CMS notifies the ACO that a physician or non-physician practitioner who is a Participant Provider or Preferred Provider has not been approved for participation in the Post-Discharge Home Visits Benefit Enhancement under this Section 10.04, but the physician or non-physician practitioner is otherwise eligible to be a Participant Provider or Preferred Provider, the ACO may either remove the physician or non-physician practitioner from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the physician or non-physician practitioner will not participate in the Post-Discharge Home Visits Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

D. The individual performing services under this Benefit Enhancement must be "auxiliary personnel" as defined at 42 CFR § 410.26(a)(1).

E. The ACO shall ensure that post-discharge home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

Section 10.05 Care Management Home Visits Benefit Enhancement

A. Appendix M shall apply to the Agreement for any Performance Year for which the ACO has selected the Care Management Home Visits Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Care Management Home Visits Benefit Enhancement and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

B. In order to be eligible to submit claims for services furnished to REACH Beneficiaries pursuant to the Care Management Home Visits Benefit Enhancement, the supervising physician or other practitioner must be:

1. A physician or a non-physician practitioner who is authorized by the Act to receive payment for services "incident to" his or her own services, as described in 42 CFR § 410.26(a)(7), who is a Participant Provider or Preferred Provider; and

2. Eligible under Medicare rules to submit for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and

3. Designated on the Participant Provider List or Preferred Provider List submitted in accordance with Article IV as participating in the Care Management Home Visits Benefit Enhancement; and

4. Approved by CMS according to the criteria described in this Section 10.05.B and Appendix M of the Agreement.

C. If CMS notifies the ACO that a physician or non-physician practitioner has not been approved for participation in the Care Management Home Visits Benefit Enhancement under this Section 10.05, but the physician or non-physician practitioner is otherwise eligible to be a Participant Provider or Preferred Provider, the ACO may either remove the physician or non-physician practitioner from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the physician or non-physician practitioner will not participate in the Care Management Home Visits Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

D. The individual performing services under this Benefit Enhancement must be "auxiliary personnel" as defined at 42 CFR § 410.26(a)(1).

E. The ACO shall ensure that care management home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

Section 10.06 Home Health Homebound Waiver Benefit Enhancement

A. Appendix N shall apply to the Agreement for any Performance Year for which the ACO has selected the Home Health Homebound Waiver Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Home Health Homebound Waiver Benefit Enhancement and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

B. The ACO shall require that, in order to be eligible to submit claims for services furnished to REACH Beneficiaries pursuant to the Home Health Homebound Waiver Benefit Enhancement, the individual or entity must be:

1. A home health agency that is a Participant Provider or Preferred Provider; and

2. Designated on the Participant Provider List or Preferred Provider List submitted in accordance with Article IV as participating in the Home Health Homebound Waiver Benefit Enhancement; and

3. Approved by CMS according to the criteria described in this Section 10.06.B and Appendix N of the Agreement.

C. If CMS notifies the ACO that a home health agency that is a Participant Provider or Preferred Provider has not been approved for participation in the Home Health Homebound Waiver Benefit Enhancement under this Section 10.06, but the home health agency is otherwise eligible to be a Participant Provider or Preferred Provider, the ACO may either remove the home health agency from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the home health agency will not participate in the Home Health Homebound Waiver Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

D. The ACO shall ensure the Participant Providers and Preferred Providers do not substitute home health services for inpatient services when inpatient services are more clinically appropriate.

E. The ACO shall ensure that Participant Providers and Preferred Providers only furnish Medically Necessary home health services and do not use home health services to prevent or deter a Beneficiary from seeking or receiving inpatient care when such care is Medically Necessary.

Section 10.07 Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement

A. Appendix O shall apply to the Agreement for any Performance Year for which the ACO has selected the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement and CMS has not rejected the ACO's selection under Section 8.02 or Section 10.01.E.

B. The ACO shall require that, in order to be eligible to submit claims for services furnished to REACH Beneficiaries pursuant to the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement, an individual must be:

1. A provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202) who is a Participant Provider or Preferred Provider; and

2. Designated on the Participant Provider List or Preferred Provider List submitted in accordance with Article IV as participating in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement; and

3. Approved by CMS according to the criteria described in this Section 10.07.B and Appendix O of the Agreement.

C. If CMS notifies the ACO that a provider or supplier who is a Participant Provider or Preferred Provider has not been approved for participation in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement under this Section 10.07, but the provider or supplier is otherwise eligible to be a Participant Provider or Preferred Provider, the ACO may either remove the provider or supplier from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the provider or supplier will not participate in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

D. The ACO shall ensure the Participant Providers and Preferred Providers provide services under the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit only when a Beneficiary has elected Medicare hospice care as described in 42 CFR § 418.24.

E. The ACO shall ensure that Participant Providers and Preferred Providers only furnish Medically Necessary concurrent care services.

Section 10.08 Part B Cost-Sharing Support Beneficiary Engagement Incentive

Appendix P shall apply to the Agreement for any Performance Year for which the ACO has selected the Part B Cost-Sharing Support Beneficiary Engagement Incentive as described in Section 8.01, and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Part B Cost-Sharing Support Beneficiary Engagement Incentive and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

Section 10.09 Chronic Disease Management Reward Beneficiary Engagement Incentive

Appendix Q shall apply to the Agreement for any Performance Year for which the ACO has selected the Chronic Disease Management Reward Beneficiary Engagement Incentive as described in Section 8.01, and for which the ACO has submitted an Implementation Plan under Section 10.01.B for the Chronic Disease Management Reward Beneficiary Engagement Incentive and CMS has not rejected the ACO's selection pursuant to Section 8.02 or Section 10.01.E.

Section 10.10 Requirements for Termination of Benefit Enhancements or Beneficiary Engagement Incentives

A. The ACO must obtain CMS consent before voluntarily terminating a Benefit Enhancement or Beneficiary Engagement Incentive effective during a Performance Year. The ACO shall provide at least 30 Days advance written notice of such termination to CMS. If CMS consents to such termination, the

effective date of such termination will be the date specified in the notice of termination or such other date specified by CMS.

B. If during a Performance Year a Benefit Enhancement or Beneficiary Engagement Incentive will cease to be in effect with respect to the ACO or any Participant Provider or Preferred Provider pursuant to Section 17.01, the effective date of such termination will be the date specified by CMS in the notice to the ACO.

C. CMS shall cease coverage of claims for a terminated Benefit Enhancement 90 Days after the effective date of such termination, unless otherwise specified in Appendices I, J, L through O, and T.

D. If a Benefit Enhancement or Beneficiary Engagement Incentive will be terminated or otherwise cease to be in effect during a Performance Year pursuant to Section 10.10.A or Article XVII, the ACO shall provide written notice to its Participant Providers, Preferred Providers, and REACH Beneficiaries and Beneficiaries who are currently receiving items and services or other remuneration pursuant to a Benefit Enhancement or Beneficiary Engagement Incentive, within 30 Days after the effective date of termination or cessation of the Benefit Enhancement or Beneficiary Engagement Incentive. In the case of a Benefit Enhancement, such notification shall state that following a date that is 90 Days after the effective date of termination, services furnished under the Benefit Enhancement will no longer be covered by Medicare and the Beneficiary may be responsible for the payment of such services. In the case of a Beneficiary Engagement Incentive, such notification shall state that following a date specified by CMS, Beneficiary Engagement Incentives must no longer be provided to the Beneficiary. Any notice to Beneficiaries is subject to review and approval by CMS under Section 5.04 as Marketing Materials.

E. If the ACO selected to offer a Benefit Enhancement or a Beneficiary Engagement Incentive for a Performance Year and does not select to offer the Benefit Enhancement or Beneficiary Engagement Incentive for the next Performance Year, the ACO shall notify all its Participant Providers, Preferred Providers, REACH Beneficiaries and Beneficiaries who are currently receiving services pursuant to a Benefit Enhancement or incentives pursuant to a Beneficiary Engagement Incentive that the Benefit Enhancement or Beneficiary Engagement Incentive will not be offered during the next Performance Year. Such notices must be furnished no later than 30 Days prior to the start of the next Performance Year.

Section 10.11 Termination of Benefit Enhancements upon Termination of Agreement

If the Agreement is terminated by CMS or the Agreement Performance Period is terminated by either party prior to the end of a Performance Year, CMS shall terminate the ACO's Benefit Enhancements on the effective date of the termination and shall terminate the Beneficiary Engagement Incentives on a date specified by CMS.

Section 10.12 Nurse Practitioner and Physician Assistant Services Benefit Enhancement

A. Appendix T shall apply to the Agreement for any Performance Year for which the ACO has selected the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as described in Section 8.01 and for which the ACO has submitted

an Implementation Plan under Section 10.01.B for the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and CMS has not rejected the ACO's selection under Section 8.02 or Section 10.01.E.

B. The ACO shall require that, in order for an individual to certify, establish a plan of care for, or provide a referral for any of the services identified in Section II of Appendix T of the Agreement for REACH Beneficiaries pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement, the individual must be:

1. A nurse practitioner (as described in 42 CFR § 410.75(b)) and either a Participant Provider or Preferred Provider identified on the Participant Provider List or Preferred Provider List as participating in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and approved by CMS according to the criteria described in this Section 10.12 and Appendix T of the Agreement ("**Eligible Nurse Practitioner**"); or

2. Beginning on the date(s) specified by CMS, a physician assistant (as described in 42 CFR § 410.74(a)) and either a Participant Provider or Preferred Provider identified on the Participant Provider List or Preferred Provider List as participating in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and approved by CMS according to the criteria described in this Section 10.12 and Appendix T of the Agreement (**"Eligible Physician Assistant"**).

C. Beginning on the date(s) specified by CMS, if CMS notifies the ACO that a nurse practitioner or physician assistant that is a Participant Provider or Preferred Provider has not been approved for participation in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement under this Section 10.12, but the nurse practitioner or physician assistant is otherwise eligible to be a Participant Provider or Preferred Provider, the ACO may either remove the nurse practitioner or physician assistant from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the nurse practitioner or physician assistant will not participate in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement. The ACO shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

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

ARTICLE XI Performance Year Benchmark

Section 11.01 Prospective Benchmark

A. For each Performance Year, CMS shall determine the ACO's Performance Year Benchmark according to the methodology in Appendix B.

B. For each Performance Year, CMS shall provide the ACO with a report ("**Performance Year Benchmark Report**") consisting of the ACO's preliminary Performance Year Benchmark.

C. On a quarterly basis during each Performance Year, CMS shall provide the ACO with a financial report ("**Quarterly Benchmark Report**"). The Quarterly Benchmark Report may include adjustments to the Performance Year Benchmark resulting from updated information regarding any factors that affect the Performance Year Benchmark calculation described in Appendix B.

Section 11.02 Trend Factor Adjustments

A. CMS may, at CMS' sole discretion, retroactively modify or replace the trend factors as described in Section I.E.4, Section II.D.2, or Section III.E.2 of Appendix B, as applicable.

B. If CMS retroactively modifies or replaces the trend factor used in calculating the Performance Year Benchmark pursuant to Section 11.02.A, CMS will recalculate the Performance Year Benchmark using the new trend factor according to the methodology described in Appendix B of the Agreement.

C. CMS will notify the ACO of any recalculation of the Performance Year Benchmark made pursuant to Section 11.02.B.

D. In order to accommodate recalculation of the Performance Year Benchmark pursuant to Section 11.02.B, CMS may at its sole discretion delay settlement under Section 12.04 of the Agreement for the affected Performance Year for up to 60 Days.

E. Except for calculations made as part of a settlement reopening conducted pursuant to Section 12.04.D, CMS may not recalculate the Performance Year Benchmark under Section 11.02.B after the issuance of the settlement report as described in Section 12.04 for the relevant Performance Year.

ARTICLE XII Payment

Section 12.01 General

For each Performance Year, CMS shall pay the ACO in accordance with (1) the Capitation Payment Mechanism selected by the ACO as described in Section 8.01 and, if selected by the ACO as described in Section 8.01, the APO; (2) the Risk Sharing Option (Global or Professional) that the ACO selected as described in Article VIII; (3) Appendix B; (4) Article XI; and (5) this Article XII.

Section 12.02 Capitation Payment Mechanism and the APO

A. General

1. The ACO must select a Capitation Payment Mechanism for each Performance Year as described in Section 8.01. The ACO may select only one Capitation Payment Mechanism for a Performance Year. If CMS rejects or later terminates the ACO's Capitation Payment Mechanism for a Performance Year, CMS may take remedial action or terminate the Agreement or Agreement Performance Period pursuant to Article XVII.

2. If the ACO has selected the Global Risk Sharing Option, the ACO may select TCC Payment or PCC Payment as its Capitation Payment Mechanism.

3. If the ACO has selected the Professional Risk Sharing Option, the ACO may only select PCC Payment as its Capitation Payment Mechanism.

B. TCC Payment

1. If the ACO wishes to participate in TCC Payment for a Performance Year, it must select TCC Payment as the ACO's Capitation Payment Mechanism as described in Section 8.01.

2. Unless CMS rejects or later terminates the ACO's selection to participate in TCC Payment, CMS shall make TCC Payments to the ACO in accordance with Appendix G. Each party shall comply with the terms of Appendix G that are applicable to that party.

C. PCC Payment

1. If the ACO wishes to participate in PCC Payment for a Performance Year, it must select PCC Payment as the ACO's Capitation Payment Mechanism as described in Section 8.01.

2. Unless CMS rejects or later terminates the ACO's selection to participate in PCC Payment, CMS shall make PCC Payments to the ACO in accordance with Appendix E. Each party shall comply with the terms of Appendix E that are applicable to that party.

3. The ACO shall repay to CMS the Enhanced PCC portion of all PCC Payments it received during a Performance Year as Other Monies Owed at the Performance Year settlement under Section 12.04.A or through settlement reports issued at such other times as provided under Section 12.04.D or in the event of termination, Section 17.04.A.

4. If the ACO selects PCC Payment as its Capitation Payment Mechanism, the ACO must select the maximum Enhanced PCC Percentage as described in Section 8.01 from within the range specified in Appendix E, and may select to participate in the APO as described in Section 8.01.

D. Advanced Payment Option

2. If the ACO wishes to participate in the APO for a Performance Year, it must select to participate in the APO as described in Section 8.01.

3. Unless CMS rejects or later terminates the ACO's selection to participate in the APO, CMS shall make APO payments to the ACO in accordance with the methodology in Appendix F. Each party shall comply with the terms of Appendix F that are applicable to that party.

E. Written Confirmation of Consent to Participate in the ACO's Selected Capitation Payment Mechanism and APO

1. *For the ACO's First Performance Year*

a. If the ACO selected to participate in TCC Payment for the ACO's first Performance Year as described in Section 8.01, the ACO shall certify that the ACO has obtained written confirmation that each individual and entity listed on the Participant Provider List at the start of the ACO's first Performance Year will participate in TCC Payment for that Performance Year, and that each individual and entity listed on the Preferred Provider List as participating in TCC Payment at the start of the ACO's first Performance Year has consented to participate in TCC Payment for that Performance Year in accordance with this Section 12.02.E.

b. If the ACO selected to participate in TCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year, the ACO shall certify that each individual and entity listed on the Participant Provider List at the start of the ACO's first Performance Year has agreed to a TCC Fee Reduction of 100%, and that each individual and entity listed on the Preferred Provider List as participating in TCC Payment at the start of the ACO's first Performance Year has agreed to a TCC Fee Reduction that is a percentage within the range of 1% and 100%.

c. [Reserved]

d. If the ACO selected to participate in PCC Payment for the ACO's first Performance Year as described in Section 8.01, the ACO shall certify that the ACO has obtained written confirmation that each individual and entity listed on the Participant Provider List at the start of the ACO's first Performance Year will participate in PCC Payment for that Performance Year, and that each individual and entity listed on the Preferred Provider List as participating in PCC Payment at the start of the ACO's first Performance Year has consented to participate in PCC Payment for that Performance Year in accordance with this Section 12.02.E.

e. If the ACO selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year, the ACO shall certify that each individual and entity listed on either the Proposed Participant Provider List or the Proposed Preferred Provider List as participating in PCC Payment at the start of the ACO's first Performance Year has agreed to a PCC Fee Reduction that is a percentage within the range of 10% and 100%.

f. If the ACO has selected to participate in the APO for the ACO's first Performance Year as described in Section 8.01, the ACO shall certify that the ACO has obtained written confirmation that each individual and entity listed on either the Proposed Participant Provider List or the Proposed Preferred Provider List as participating in the APO at the start of the ACO's first Performance Year has consented to participate in the APO for that Performance Year in accordance with this Section 12.02.E.

g. If the ACO has selected to participate in the APO for the ACO's first Performance Year, the ACO shall certify that each individual and entity listed on either the Proposed Participant Provider List or the Proposed Preferred Provider List as participating in the APO at the start of the ACO's first Performance Year has agreed to an APO Fee Reduction that is a percentage within the range of 1% and 100%.

2. *For the ACO's Second Performance Year and Each Subsequent Performance Year*

a. For the ACO's second Performance Year and each subsequent Performance Year, by a date specified by CMS, the ACO shall obtain written confirmation that each individual and entity listed on the Participant Provider List at the start of the Performance Year, and that each individual and entity listed on the Preferred Provider List as participating in the ACO's selected Capitation Payment Mechanism at the start of the Performance Year has consented to participate in the ACO's selected Capitation Payment Mechanism for the applicable Performance Year in accordance with this Section 12.02.E.

b. The ACO shall ensure that each individual and entity listed on the Participant Provider List at the start of the Performance Year has agreed to a PCC Fee Reduction or TCC Fee Reduction, as applicable, that satisfies the following requirements:

i. A TCC Fee Reduction of 100%; or

ii. A PCC Fee Reduction from among the following percentages, as applicable:

a) [Reserved]

b) Performance Year 2024: 20-100%

c) Performance Year 2025 and Performance Year 2026: 100%

c. The ACO shall ensure that each individual and entity listed on the Preferred Provider List as participating in the ACO's selected Capitation Payment Mechanism at the start of the Performance Year has agreed to a PCC Fee Reduction or TCC Fee Reduction, as applicable, that is a percentage within the range of 1% and 100%.

d. If the ACO has selected to participate in the APO for a Performance Year as described in Section 8.01, by a date specified by CMS, the ACO shall obtain written confirmation that each individual and entity that is listed on either the Participant Provider List or the Preferred Provider List as participating in the APO at the start of the Performance Year has consented to participate in

the APO for the applicable Performance Year in accordance with this Section 12.02.E.

e. If the ACO has selected to participate in the APO for the relevant Performance Year, the ACO shall ensure that each individual and entity listed on either the Participant Provider List or the Preferred Provider List as participating in the APO at the start of the Performance Year has agreed to an APO Fee Reduction that is a percentage within the range of 1% and 100%.

3. <u>*General*</u>

a. The written confirmation of consent required under this Section 12.02.E must be in the form of a completed ACO REACH Model: Fee Reduction Agreement signed by an individual legally authorized to act for the entity through whose TIN the individual or entity bills Medicare. CMS may provide to the ACO template language for the ACO REACH Model: Fee Reduction Agreement. The ACO shall use any template language for the ACO REACH Model: Fee Reduction Agreement provided by CMS.

b. The ACO shall ensure that the ACO REACH Model: Fee Reduction Agreement specifies the PCC Fee Reduction or TCC Fee Reduction and, if applicable, the APO Fee Reduction agreed upon by the individual or entity from among the applicable percentages specified in this Section 12.02.E.

c. The ACO shall ensure that as part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN an individual or entity included on the Participant Provider List or Preferred Provider List at the start of the applicable Performance Year bills Medicare verifies:

i. The accuracy of the list of individuals and entities billing under that TIN included on the Participant Provider List at the start of the Performance Year; that these individuals and entities have affirmatively consented to participate in the ACO's selected Capitation Payment Mechanism; the amount of the PCC Fee Reduction or TCC Fee Reduction, as applicable, agreed upon by each such individual or entity; and whether these individuals and entities have affirmatively consented to participate in the APO and, if so, the amount of the APO Fee Reduction agreed upon by each such individual or entity.

ii. The accuracy of the list of individuals and entities billing under that TIN included on the Preferred Provider List at the start of the Performance Year; whether these individuals and entities have affirmatively consented to participate in the ACO's selected Capitation Payment Mechanism; the amount of any PCC Fee Reduction or TCC Fee Reduction, as applicable; and whether these individuals

and entities have affirmatively consented to participate in the APO and, if so, the amount of the APO Fee Reduction agreed upon by each such individual or entity.

iii. Consent to participate in the ACO's selected Capitation Payment Mechanism and, if applicable, the APO for a Performance Year must be obtained by a date specified by CMS. Consent to participate in the ACO's selected Capitation Payment Mechanism and the APO must be voluntary and must not be contingent on or related to receipt of referrals from the ACO, its Participant Providers, or Preferred Providers.

Section 12.03 Participation Commitment Mechanism

A. There are two alternative Participation Commitment Mechanisms under the Model (Financial Guarantee Participation Commitment Mechanism or Retention Withhold Participation Commitment Mechanism).

B. If the ACO selects the Financial Guarantee Participation Commitment Mechanism, by a date specified by CMS, the ACO shall either increase the amount of its financial guarantee required under Section 12.05 by an amount calculated in accordance with Section II.B of Appendix H of the Agreement ("**Retention Guarantee Amount**") or secure a separate financial guarantee ("**Retention Guarantee**") for the Retention Guarantee Amount that meets the requirements set forth in Appendix H. If the ACO elects to secure a separate financial guarantee for this purpose, any changes made to the ACO's separate financial guarantee must be approved in advance by CMS.

C. If the ACO does not secure a financial guarantee that meets the requirements set forth in Section 12.03.B and Appendix H by the date specified by CMS, CMS will deem that the ACO has selected the Retention Withhold Participation Commitment Mechanism. If CMS deems that the ACO has selected the Retention Withhold Participation Commitment Mechanism, CMS will withhold the Retention Withhold (described in Appendix B) from the Performance Year Benchmark for the ACO's first Performance Year pursuant to the methodology specified in Appendix B. The ACO will earn back the Retention Withhold Amount (as described in Section V.D.1 of Appendix B) during Final Financial Settlement for the ACO's first Performance Year in accordance with the methodology described in Appendix B, only if the ACO does not provide written notice of termination of the Agreement Performance Period pursuant to Section 17.03 on or before the Termination Without Liability Date of the ACO's second Performance Year.

Section 12.04 Settlement

A. General

1. For any Performance Year for which the ACO selects to participate in Provisional Financial Settlement as described in Section 8.01, CMS will conduct Provisional Financial Settlement and issue a settlement report to the ACO setting forth the provisional amount of Shared Savings or Shared

Losses, and the provisional net amount owed by either CMS or the ACO for the Performance Year. CMS shall calculate the provisional amount of Shared Savings or Shared Losses according to the methodology in Appendix B and shall calculate the provisional amount of Other Monies Owed according to the methodologies in Appendices B, E through G, I, J, L through O, and T.

2. If the ACO selects to participate in Provisional Financial Settlement for a Performance Year, CMS will not conduct Provisional Financial Settlement for that Performance Year if the ACO provides written notice of termination of the Agreement Performance Period during that Performance Year, even if the ACO provides such written notice of termination after the Termination Without Liability Date for that Performance Year.

3. Regardless of whether the ACO selects to participate in Provisional Financial Settlement for a Performance Year, following the end of each Performance Year, and at such other times as may be required under the Agreement, CMS will conduct Final Financial Settlement and issue a settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses, the amount of Other Monies Owed, and the net amount owed by either CMS or the ACO for the Performance Year. CMS shall calculate Shared Savings or Shared Losses according to the methodology in Appendix B and shall calculate the amount of Other Monies Owed according to the methodology in Appendices B, E through G, I, J, L through O, and T.

4. Any amounts determined to be owed as a result of a settlement report or revised settlement report upon reopening shall be paid in accordance with Section 12.04.E.

B. Error Notice

1. A settlement report will be deemed final 30 Days after the date it is issued, unless the ACO submits to CMS written notice of an error in the mathematical calculations in the settlement report within 30 Days after the settlement report is issued (“**Timely Error Notice**”).

2. Upon receipt of a Timely Error Notice, CMS shall review the calculations in question and any mathematical issues raised by the ACO in its written notice.

3. If CMS issues a written determination that the settlement report is correct, the settlement report is final on the date the written determination is issued.

4. If CMS issues a revised settlement report, the revised settlement report is final on the date it is issued.

5. There shall be no further administrative or judicial review of the settlement report or a revised settlement report.

C. Deferred Settlement

1. At its sole discretion, CMS may offer the ACO the option to defer settlement for a period not to exceed 180 Days ("**Deferred Settlement**"). The ACO shall make any such selection in a form and manner and by a deadline specified by CMS.

2. As a condition of Deferred Settlement, CMS may require the ACO, by a date determined by CMS, to increase the amount and duration of its financial guarantee under Section 12.05 in an amount and for a duration determined by CMS.

D. Settlement Reopening

1. For a given Performance Year, for a period of one year following issuance of settlement report for that Performance Year, or until issuance of the settlement report for the subsequent Performance Year, whichever comes earlier, CMS reserves the right to reopen a settlement report to include payments or recoupments that were not included in the initial settlement report, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO.

2. CMS reserves the right, for a period of six years following the expiration or termination of the Agreement, to reopen a final settlement report in order to recalculate the amounts owed, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO, if as a result of a later inspection, evaluation, investigation, or audit, CMS determines that the amount due to the ACO by CMS or due to CMS by the ACO has been calculated in error.

3. CMS may reopen and revise a settlement report at any time in the event of fraud or similar fault.

4. The parties shall pay any amounts determined to be owed as a result of a reopening under this Section 12.04.D in accordance with Section 12.04.E.

E. Payments of Amounts Owed

1. If CMS owes the ACO Shared Savings or Other Monies Owed as a result of a final settlement report, or revised settlement report upon reopening, CMS shall pay the ACO in full on or about 30 Days after the date on which the relevant settlement report is deemed final, except that CMS shall not make any payment of Shared Savings if the Agreement or Agreement Performance Period is terminated by CMS pursuant to Section 17.02, and CMS may reduce amounts owed to the ACO under the Agreement by amounts owed by the ACO under the Agreement or any other CMS program or initiative.

2. If the ACO owes CMS Shared Losses or Other Monies Owed as a result of a final settlement report, or revised settlement report upon reopening, CMS shall issue a demand letter to the ACO and the ACO shall pay CMS in full within 30 Days of the date of a demand letter.

3. If CMS does not timely receive payment in full, the remaining amount owed will be considered a delinquent debt subject to the provisions of Section 12.06.

Section 12.05 Financial Guarantee

A. The ACO must have the ability to repay all Shared Losses and Other Monies Owed for which it may be liable under the terms of the Agreement and shall provide a financial guarantee in accordance with terms set forth in Appendix H.

B. The ACO shall submit documentation of such financial guarantee in accordance with Appendix H.

C. Any changes made to a financial guarantee must be approved in advance by CMS.

D. Nothing in the Agreement or its Appendices shall be construed to limit the ACO's liability to pay any Shared Losses, Other Monies Owed, and/or interest (as described in Section 12.06 of the Agreement) in excess of the amount of the financial guarantee.

Section 12.06 Delinquent Debt

A. If CMS does not receive payment in full by the date the payment is due, CMS shall pursue recovery under available debt collection authorities and this Agreement, including, but not limited to, exercising the financial guarantee and recouping or withholding of any payments otherwise owed to the ACO under the Agreement or any other CMS program or initiative.

B. If the ACO fails to pay the amounts due to CMS in full within 30 Days after the date payment is due, CMS shall assess simple interest on the unpaid balance at the rate applicable to other Medicare debts under 42 CFR § 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.

C. CMS shall refer uncollected debts to the U.S. Treasury for collection, as required by applicable debt collection authorities, and CMS and the U.S. Department of Treasury may use any applicable debt collection tools and procedures available to collect the total amount owed by the ACO, which includes the recovery of any accrued interest on the delinquent debt.

ARTICLE XIII Participation in Evaluation, Shared Learning Activities, and Site Visits

Section 13.01 Evaluation Requirement

A. General

1. The ACO shall participate and cooperate in any independent evaluation activities conducted by or on behalf of CMS aimed at assessing the impact of the Model on the goals of better health, better health care, and lower Medicare per capita costs for REACH Beneficiaries. The ACO shall require its Participant Providers and Preferred Providers to participate and cooperate in any such independent evaluation activities conducted by or on behalf of CMS.

2. The ACO shall ensure that it has written arrangements in place with any individuals and entities performing functions and services related to ACO Activities or Marketing Activities, that are necessary to ensure CMS or its designees can carry out evaluation activities.

B. Primary Data

In its evaluation activities, CMS may collect qualitative and quantitative data from the following sources:

1. Interviews with Beneficiaries and their caregivers;

2. Focus groups of Beneficiaries and their caregivers;

3. Interviews with the ACO, Participant Providers, and Preferred Providers, and their staff;

4. Focus groups with the ACO, Participant Providers, and Preferred Providers, and their staff;

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

6. Surveys; and

7. Site Visits.

C. Secondary Data.

In its evaluation activities, CMS may use data or information submitted by the ACO as well as claims submitted to CMS for items and services furnished to Beneficiaries. This data may include, but is not limited to:

1. Survey data from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys;

2. Clinical data such as lab values;

3. Medical records; and

4. ACO Implementation Plans.

D. The ACO shall collect and report to CMS demographic and social determinants of health data pursuant to 42 CFR § 403.1110(b) for the purpose of monitoring and evaluating the Model. In conducting the collection required under this Section 13.01.D, the ACO shall make a reasonable effort to collect demographic and social determinants of health data from all REACH Beneficiaries but, in the case of a REACH Beneficiary that elects not to provide such data to the ACO, its Participant Providers, or its Preferred Providers, the ACO shall indicate such election by the REACH Beneficiary in its report to CMS. Such data shall be reported in a form and manner and by the date(s) specified by CMS.

Section 13.02 Shared Learning Activities

A. The ACO shall participate in CMS-sponsored learning activities designed to strengthen results and share learning that emerges from participation in the Model.

B. The ACO shall participate in the CMS-sponsored learning activities by attending periodic learning system events and actively sharing tools and ideas.

Section 13.03 Site Visits

A. The ACO shall cooperate and require its Participant Providers and Preferred Providers to cooperate in any site visits conducted by or on behalf of CMS.

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

C. The ACO shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during site visits.

D. Notwithstanding the foregoing, CMS may perform unannounced site visits at the office of any Participant Provider or Preferred Provider at any time to investigate concerns about the health or safety of Beneficiaries or other program integrity issues.

E. Nothing in the Agreement shall be construed to limit or otherwise prevent CMS from performing site visits permitted by applicable law or regulations.

Section 13.04 Rights in Data and Intellectual Property

A. CMS may use any data obtained pursuant to the Model to evaluate the Model and to disseminate quantitative results and successful care management techniques to other providers and suppliers and to the public. Data to be disseminated may include results of patient experience of care and quality of life surveys as well as measures based upon claims and medical records. The ACO will be permitted to comment on evaluation reports for factual accuracy but may not edit conclusions or control the dissemination of reports.

B. Notwithstanding any other provision in the Agreement, all proprietary trade secret information and technology of the ACO or its Participant Providers and Preferred Providers is and shall remain the sole property of the ACO, the Participant Provider, or Preferred Provider and, except as required by federal law, shall not be released by CMS without express written consent. The regulation at 48 CFR § 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 ACO's, Participant Providers', or Preferred Providers' proprietary information or technology.

C. If the ACO maintains any information that should not be publicly disclosed because the ACO considers such information to be proprietary and confidential,

the ACO acknowledges that it has submitted to CMS a form, using either the template attached as Appendix S, or a form substantially the same as Appendix S, identifying specific examples of information the ACO considers to be proprietary and confidential. The ACO must notify CMS, in a form and manner to be specified by CMS, of any updates to this form. If the ACO does not submit such a form, it will be deemed to be confirmed that the ACO has no information it considers proprietary and confidential.

ARTICLE XIV Public Reporting and Release of Information

Section 14.01 ACO Public Reporting and Transparency

The ACO shall report the following organizational information on a publicly accessible website maintained by the ACO.

A. Name and location of the ACO;

B. Primary contact information for the ACO;

C. Identification of all Participant Providers and Preferred Providers;

D. Identification of all joint ventures between or among the ACO and any of its Participant Providers and Preferred Providers;

E. Identification of the ACO’s key clinical and administrative leaders and the name of any company by which they are employed; and

F. Identification of members of the ACO’s governing body and the name of any entity by which they are employed.

G. Shared Savings and Shared Losses information, including:

1. The amount of any Shared Savings or Shared Losses for any Performance Year;
2. The proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for Beneficiaries; and
3. The proportion of Shared Savings distributed to Participant Providers and Preferred Providers.

H. The ACO’s performance on the quality measures described in Section 9.02.

CMS may publish some or all of this information on the CMS website.

Section 14.02 ACO Release of Information

A. The ACO, its Participant Providers, and its Preferred Providers shall obtain prior approval from CMS during the term of the Agreement and for 1 year thereafter for the publication or release of any press release, external report or statistical/analytical material that materially and substantially references the ACO’s participation in the Model. External reports and statistical/analytical material may include, but are not limited to, papers, articles, professional publications, speeches, and testimony.

B. All external reports and statistical/analytical material that are subject to this Section 14.02 must include the following statement on the first page: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

ARTICLE XV Compliance and Oversight

Section 15.01 ACO Compliance Plan

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

1. A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body;
2. Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;
3. A method for employees or contractors of the ACO, its Participant Providers and Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to anonymously report suspected problems related to the ACO to the compliance official;
4. Compliance training for the ACO and its Participant Providers and Preferred Providers; and
5. A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

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

Section 15.02 CMS Monitoring and Oversight Activities

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

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 case-mix or quality measures), efforts to manipulate risk scores or aligned populations, overutilization, and cost-shifting to other payers or populations;
2. Documentation requests sent to the ACO, its Participant Providers, and/or its Preferred Providers, including surveys and questionnaires;
3. Interviews with any individual or entity participating in ACO Activities or Marketing Activities, including but not limited to members of the ACO leadership and management, Participant Providers, and Preferred Providers;

4. Interviews with Beneficiaries and their caregivers;

5. Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Participant Providers, and its Preferred Providers;

6. Site visits to the ACO, Participant Providers, and Preferred Providers; and

7. Documentation requests sent to the ACO, Participant Providers, and/or Preferred Providers, including surveys and questionnaires.

B. In conducting monitoring and oversight 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.

Section 15.03 ACO Compliance with Monitoring and Oversight Activities

The ACO shall cooperate with, and the ACO shall require its Participant Providers, its Preferred Providers and other individuals and entities performing functions and services related to ACO Activities or Marketing Activities to cooperate with all CMS monitoring and oversight requests and activities.

Section 15.04 Compliance with Laws

A. Agreement to Comply

1. The ACO shall comply with, and shall require all Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities, Marketing Activities, or Health Equity Activities to comply with the applicable terms of the Agreement and all applicable statutes, regulations, and guidance, including without limitation: (a) federal criminal laws; (b) the False Claims Act (31 U.S.C. § 3729 et seq.); (c) the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the civil monetary penalties law (42 U.S.C. § 1320a-7a); and (e) the physician self-referral law (42 U.S.C. § 1395nn).

2. The Agreement does not waive any obligation of the ACO or the ACO's Participant Providers or Preferred Providers to comply with the terms of any other CMS contract, agreement, model, or demonstration.

3. For Performance Year 2024 and each subsequent Performance Year, in addition to meeting any other overpayment or fraud reporting obligations of all applicable statutes, regulations, and guidance, the ACO shall notify CMS in the form and manner described by CMS no later than 60 days after the date on which the ACO identified credible evidence to substantiate fraud, and having a reasonable suspicion or belief that a Medicare-enrolled provider or supplier submitted fraudulent claims for Covered Services rendered to a REACH Beneficiary.

B. State Recognition. During the term of the Agreement, the ACO shall be in compliance with applicable state licensure requirements regarding risk-bearing entities in each state in which it operates.

C. Reservation of Rights

1. Nothing contained in the Agreement or in the application process for the Model is intended or can be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, OIG, 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. The Agreement cannot be construed to bind any government agency except CMS and the Agreement binds CMS only to the extent provided herein.

2. The failure by CMS to require performance of any provision of the Agreement does not affect CMS's 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.

D. Office of Inspector General of the Department of Health and Human Services (OIG) Authority. None of the provisions of the Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the ACO, its Participant Providers, Preferred Providers or other individuals and entities performing functions or services related to ACO Activities or Marketing Activities.

E. Other Government Authority. None of the provisions of the Agreement limit or restrict any other government authority that is permitted by law to audit, evaluate, investigate, or inspect the ACO, its Participant Providers, Preferred Providers or other individuals and entities performing functions or services related to ACO Activities or Marketing Activities.

Section 15.05 Certification of Data and Information

A. With respect to data and information generated or submitted to CMS by the ACO, Participant Providers, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, the ACO shall ensure that an individual with the authority to legally bind the individual or entity submitting such data or information certifies the accuracy, completeness, and truthfulness of that data and information to the best of his or her knowledge, information, and belief.

B. At the end of each Performance Year, an individual with the legal authority to bind the ACO must certify to the best of his or her knowledge, information, and belief:

1. That the ACO, its Participant Providers, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities are in compliance with Model requirements; and

2. The accuracy, completeness, and truthfulness of all data and information that are generated or submitted by the ACO, Participant Providers, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, including

any quality data or other information or data relied upon by CMS in determining the ACO's eligibility for, and the amount of Shared Savings, or the amount of Shared Losses or Other Monies Owed.

ARTICLE XVI Audits and Record Retention

Section 16.01 Right to Audit

The ACO agrees, and shall require all of its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to agree, 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 ACO and its Participant Providers, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities that pertain to the following:

A. The ACO's compliance with the terms of the Agreement, including provisions that require the ACO to impose duties or requirements on Participant Providers or Preferred Providers;

B. Whether Participant Providers and Preferred Providers complied with the duties and requirements imposed on them by the ACO pursuant to the terms of the Agreement;

C. The quality of services performed under the Agreement;

D. The ACO's compliance with applicable laws, regulations and Medicare Program requirements;

E. Any activity by the ACO, Participant Provider or Preferred Provider that may pose a potential risk of harm to Beneficiaries or a vulnerability to the integrity of the model test;

F. The ACO's right to, and distribution of, Shared Savings; and

G. The ability of the ACO to bear the risk of potential losses and the obligation and ability of the ACO to repay any Shared Losses or Other Monies Owed to CMS.

Section 16.02 Maintenance of Records

The ACO shall maintain and shall give the government (including CMS, HHS, and the Comptroller General or their designees) access to, and shall require all Participant Providers, Preferred Providers, and other individuals and entities performing functions or services related to ACO Activities or Marketing Activities to maintain, and give the government access to, all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the Model, including the subjects identified in Section 16.01. The ACO shall maintain, and shall require all Participant Providers, Preferred Providers, and individuals and entities performing functions or services related to ACO Activities or Marketing Activities to maintain, such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of the 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 ACO at least 30 Days before the normal disposition date; or

B. There has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its Participant Providers, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities or Marketing Activities, 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.

ARTICLE XVII Remedial Action and Termination

Section 17.01 Remedial Action

A. If CMS determines that any provision of the Agreement may have been violated, CMS may take one or more of the following actions:

1. Notify the ACO and, if appropriate, the Participant Provider, and/or Preferred Provider of the violation;

2. Require the ACO to provide additional information to CMS or its designees;

3. Conduct site visits, interview Beneficiaries, or take other actions to gather information;

4. Place the ACO on a monitoring and/or auditing plan developed by CMS;

5. Require the ACO to remove a Participant Provider or Preferred Provider from the Participant Provider List or Preferred Provider List and to terminate or ensure the termination of the Participant Provider's or Preferred Provider's arrangement with respect to this Model, immediately or within a timeframe specified by CMS;

6. Require the ACO to terminate its relationship with any other individual or entity performing functions or services related to ACO Activities or Marketing Activities;

7. Prohibit the ACO from distributing Shared Savings to a Participant Provider or Preferred Provider;

8. Request a corrective action plan (CAP) from the ACO that is acceptable to CMS, in which case, the following requirements apply:

   a. The ACO shall submit a CAP for CMS approval by a deadline established by CMS; and

   b. The CAP must address what actions the ACO will take (or will require any Participant Provider, Preferred Provider or other individual or entity performing functions or services related to ACO Activities or Marketing Activities to take) within a specified

time period to ensure that all deficiencies will be corrected and that the ACO will be in compliance with the terms of the Agreement;

9. Amend the Agreement without the consent of the ACO to deny, terminate, or amend the use of any Capitation Payment Mechanism or the APO by the ACO, Participant Provider, or Preferred Provider and to require that the ACO terminate or ensure the termination of any agreements effectuating such Capitation Payment Mechanism or the APO by a date determined by CMS, in which case the ACO (and any Participant Provider or Preferred Provider, if applicable) shall be paid under Medicare FFS following the effective date determined by CMS, and Other Monies Owed will be calculated and paid in accordance with Section 12.04 and Appendix B;

10. Amend the Agreement without the consent of the ACO to deny, terminate, or amend the use of Enhanced PCC by the ACO, in which case, CMS will calculate PCC Payment without the Enhanced PCC;

11. Prohibit the ACO from accessing any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act;

12. Amend the Agreement without the consent of the ACO to deny the use of one or more Benefit Enhancements by the ACO or any Participant Provider or Preferred Provider and to require that the ACO terminate or ensure the termination of any agreements effectuating such Benefit Enhancements by a date determined by CMS;

13. Prohibit the ACO, a Participant Provider or a Preferred Provider from furnishing any in-kind remuneration under Section 5.08.C or from implementing one or more Beneficiary Engagement Incentives;

14. Discontinue the provision of data sharing and reports to the ACO under Article VI;

15. Prohibit the ACO from participating in SVA, Distributing Marketing Materials, or conducting Marketing Activities, including Voluntary Alignment Activities;

16. Retroactively reverse the alignment of Beneficiaries to the ACO that is based solely on Voluntary Alignment, to include Prospective Plus Alignment;

17. Retroactively reverse the alignment of Beneficiaries to the ACO that is based on Claims-based Alignment;

18. For Performance Year 2024 and each subsequent Performance Year, withhold monthly payments from the ACO under the ACO's selected Capitation Payment Mechanism in the event the ACO fails, in CMS's sole discretion, to adequately respond to a CMS-issued request for additional information or noncompliance with a remedial action issued by CMS under Section 17.01.A of the Agreement by the deadline established by CMS.

B. CMS may impose additional remedial actions or terminate the Agreement or Agreement Performance Period pursuant to Section 17.02 if CMS determines that remedial actions were insufficient to correct noncompliance with the terms of the Agreement.

C. CMS may require the ACO to remove a Participant Provider or Preferred Provider from the ACO's Participant Provider List or Preferred Provider List and to terminate or ensure the termination of its arrangement with the removed Participant Provider or Preferred Provider if CMS determines that the Participant Provider or Preferred Provider:

1. Has failed to comply with any Medicare program requirement, rule, or regulation;
2. Has failed to comply with the ACO's CAP, the monitoring and/or auditing plan developed by CMS for the ACO, or other remedial action imposed by CMS;
3. Has taken any action that threatens the health or safety of a Beneficiary or other patient;
4. Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency; or
5. Is subject to investigation or action by HHS (including 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 government has intervened, or similar action.

Section 17.02 Termination of Agreement by CMS

CMS may immediately or with advance notice terminate the Agreement or the Agreement Performance Period 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 determines that the ACO:

1. Has failed to comply with any term of the Agreement or any other Medicare program requirement, rule, or regulation;
2. Has failed to comply with a monitoring and/or auditing plan;
3. Has failed to submit, obtain approval for, implement or fully comply with the terms of a CAP;
4. Has failed to demonstrate improved performance following any remedial action;
5. Has taken any action that threatens the health or safety of a Beneficiary or other patient;

6. Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model;

7. [Reserved]

8. 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;

9. Poses significant program integrity risks, including but not limited to:

   a. Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency; or

   b. Is subject to investigation or action by HHS (including 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 government has intervened, or similar action;

10. For Performance Year 2024 and each subsequent Performance Year, has failed to maintain accurate and useable banking information, has a stop-payment order against it from the CMS Office of Financial Management, or is otherwise unable or ineligible to receive Model payments.

D. CMS has rejected or later terminated the ACO's selection to participate in a Capitation Payment Mechanism for a Performance Year;

E. CMS determines that one or more of the ACO's Participant Providers or Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model;

F. The state in which the ACO operates enters into an arrangement with CMS that is based on a statewide global or per-capita Medicare payment; or

G. CMS offers a revised version of this Agreement to take effect at the start of a subsequent Performance Year or such other time specified by CMS, and the ACO does not sign such revised version of this Agreement.

Section 17.03 Termination of Agreement Performance Period by ACO

The ACO may terminate the Agreement Performance Period upon advance written notice to CMS. Such notice must specify the effective date of the termination, and such date may be no sooner than 30 Days following the date of that notice.

Section 17.04 Financial Settlement upon Termination

A. If CMS terminates the Agreement or the Agreement Performance Period is terminated by either party, except as otherwise provided in this Section, CMS shall conduct settlement for the entire Performance Year in which the Agreement is terminated in accordance with Section 12.04 of the Agreement.

B. If the Agreement or Agreement Performance Period is terminated by CMS for any reason described in paragraphs (A) through (E) of Section 17.02, CMS shall not make any payments of Shared Savings to the ACO, and the ACO shall remain liable for any Shared Losses, for the Performance Year in which termination becomes effective.

C. If the ACO selected the Financial Guarantee Participation Commitment Mechanism and the ACO voluntarily terminates the Agreement Performance Period pursuant to Section 17.03 by providing notice to CMS on or before the Termination Without Liability Date of the ACO's second Performance Year, CMS shall pursue payment of the Retention Guarantee Amount under the ACO's financial guarantee required under Section 12.05 or Retention Guarantee described in Section 12.03.B.

D. If CMS deems that the ACO selected the Retention Withhold Participation Commitment Mechanism as described in Section 12.03.C and the ACO voluntarily terminates the Agreement Performance Period pursuant to Section 17.03 by providing notice to CMS on or before the Termination Without Liability Date of the ACO's second Performance Year, CMS will conduct Final Financial Settlement for the ACO's first Performance Year using the Retention Withhold as described in Appendix B, such that the ACO will not earn back the Retention Withhold Amount, as described in Section 12.03.C and Section V.D.1 of Appendix B.

E. Shared Savings and Shared Losses upon Termination

1. If the ACO voluntarily terminates the Agreement Performance Period pursuant to Section 17.03 by providing notice to CMS that its termination is effective no later than 30 Days after the Termination Without Liability Date of a Performance Year, CMS will not conduct Final Financial Settlement for that Performance Year and the ACO shall neither be eligible to receive Shared Savings nor liable for Shared Losses for such Performance Year.

2. If the ACO voluntarily terminates the Agreement Performance Period pursuant to Section 17.03 by providing notice to CMS that its termination is effective more than 30 Days after the Termination Without Liability Date of a Performance Year but prior to the end of a Performance Year, CMS will conduct Final Financial Settlement for the Performance Year in which the ACO voluntarily terminates the Agreement Performance Period; however, the ACO shall not be eligible to receive Shared Savings but shall remain liable for Shared Losses for such Performance Year.

3. If the ACO voluntarily terminates the Agreement Performance Period pursuant to Section 17.03 with an effective date at the end of that Performance Year, CMS will conduct Final Financial Settlement for the Performance Year in which the ACO voluntarily terminates the Agreement Performance Period in accordance with Section 12.04.

F. Upon termination or expiration of the Agreement, the ACO shall immediately pay all Other Monies Owed to CMS and shall remain liable for any amounts included

in a settlement report issued for any Performance Year in accordance with Section 12.04.

Section 17.05 Notifications to Participant Providers, Preferred Providers, and Beneficiaries upon Termination

A. If the Agreement or Agreement Performance Period is terminated under Section 17.02 or Section 17.03, the ACO shall provide written notice of the termination to all Participant Providers and Preferred Providers. The ACO shall also post a notice of the termination on its ACO website. The ACO shall deliver such written notice in a manner determined by CMS and no later than the effective date of termination unless a later date is specified by CMS. The ACO shall include in such notices any content specified by CMS, including information regarding data destruction and the discontinuation of Benefit Enhancements and Beneficiary Engagement Incentives, Marketing Activities, and in-kind incentives and services.

B. The ACO shall provide written notice of the termination to all REACH Beneficiaries. The ACO may provide additional notices to Beneficiaries who are currently receiving items and services or other remuneration pursuant to a Benefit Enhancement or Beneficiary Engagement Incentive, and may provide written notice of the termination to other Beneficiaries. The ACO shall deliver such notices in a manner specified by CMS and no later than the effective date of termination unless a later date is specified by CMS. The ACO shall include in such notices the content specified in Section 10.10.D and any other content specified by CMS. Any notice to Beneficiaries is subject to review and approval by CMS under Section 5.04 as Marketing Materials.

ARTICLE XVIII Limitation 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 organizations, sites, or participants to test models selected for testing or expansion under section 1115A of the Act, including the decision by CMS to terminate the Agreement or Agreement Performance Period or to require the termination of any individual's or entity's status as a Participant Provider or Preferred Provider;

B. The elements, parameters, scope, and duration of such models for testing or dissemination;

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

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

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

F. The selection of quality performance standards by CMS;

G. The assessment of the quality of care furnished by the ACO by CMS;

H. The alignment of Beneficiaries to the ACO by CMS;

I. A final settlement report issued pursuant to Section 12.04, including without limitation the determination by CMS of—

1. The historical baseline expenditures;
2. The Performance Year Benchmark;
3. The ACO Performance Year Expenditures;
4. The ACO's eligibility for Shared Savings or liability for Shared Losses or Other Monies Owed; and
5. The amount of such Shared Savings, Shared Losses, or Other Monies Owed.

Section 18.02 Dispute Resolution

A. Right to Reconsideration. The ACO 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 ACO must satisfy the following criteria:

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

      i. Is authorized to receive such requests; and

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

   b. The request must include a copy of the initial determination issued by CMS and contain a detailed, written explanation of the basis for the dispute, including supporting documentation.

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

2. Requests that do not meet the requirements of Section 18.02.A will 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:

   a. The review procedures; and

   b. A schedule that permits each party to submit documentation in support of the party's position for consideration by the Reconsideration Official.

B. Standards for Reconsideration

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

2. The reconsideration will 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 ACO 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 will be based only upon:

   a. Position papers and supporting documentation that are timely submitted to the Reconsideration Official and meet the standards for submission under Section 18.02.A.1; and

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

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

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

D. CMS Administrator Review. The ACO 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 ACO 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 determine whether the request for review is granted or denied. The CMS Administrator will promptly send the parties a written acknowledgement of receipt of the request for review. Such an acknowledgement will set forth:

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

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

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:

a. The record for review will consist of timely submitted briefs and the evidence contained in the record of the proceedings before the Reconsideration Official. The CMS Administrator will not consider documentation submitted for review other than the documents and data described in Section 18.02.C.1.b.

b. The CMS Administrator will review the record and issue to CMS and to the ACO a written determination.

c. The written determination of the CMS Administrator is final and binding.

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

ARTICLE XIX Miscellaneous

Section 19.01 Notifications and Submission of Reports

Unless otherwise specified in this Agreement or stated in writing after the Effective Date, all notifications and reports required under the Agreement shall be submitted to the parties using the information specified below for that party and delivered (1) by mail, (2) by email, or (3) through 4i.

To CMS:
Mail:

ACO REACH Model

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Mailstop: WB-06-05

Baltimore, MD 21244

Email:

ACOREACH@cms.hhs.gov

4i:

https://4innovation.cms.gov

To ACO: ______________________

Mail: ______________________

____

____

____

Email: ______________________

____

4i:

https://4innovation.cms.gov

Section 19.02 Notice of Bankruptcy

If the ACO has filed a bankruptcy petition, whether voluntary or involuntary, the ACO 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 ACO under the terms of each model tested under section 1115A of the Act in which the ACO is participating or has participated and all administrative or judicial review proceedings relating to any payments under such models have been fully and finally resolved. The notice of bankruptcy must be sent by certified mail no later than 5 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 ACO is participating or has participated. This list need not identify a model tested under section 1115A of the Act in which the ACO 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 ACO and CMS have been fully and finally resolved with respect to that model. 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. This obligation remains in effect after the expiration or termination of the Agreement and until final payment has been made by the ACO under the Agreement.

Section 19.03 Severability

In the event that any one or more of the provisions of the 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 the Agreement, and the Agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been included in the Agreement, unless the deletion of such provision or provisions would result in such a material change to the Agreement so as to cause continued participation under the terms of the Agreement to be unreasonable.

Section 19.04 Entire Agreement; Amendment

A. The Agreement, including all Appendices, constitutes the entire agreement between the parties for the Model Performance Period. In the event of any inconsistency between the Agreement and any agreement previously executed by the parties governing participation in the Model, the terms of the Agreement shall control.

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

Section 19.05 Survival

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

Article VI (Data Sharing and Reports);

Section 9.03 (Quality Measure Reporting);

Article XII (Payment);

Section 13.01 (Evaluation Requirement);

Section 13.04 (Rights in Data and Intellectual Property);

Section 14.02 (ACO Release of Information);

Section 15.03 (ACO Compliance with Monitoring and Oversight Activities);

Section 15.05 (Certification of Data and Information);

Article XVI (Audits and Record Retention);

Section 17.04 (Financial Settlement Upon Termination);

Section 17.05 (Notifications to Participant Providers, Preferred Providers, and Beneficiaries upon Termination);

Section 18.01 (Limitations on Review);

Section 19.02 (Notice of Bankruptcy);

Section 19.05 (Survival);

Section 19.08 (Prohibition on Assignment);

Section 19.09 (Change in Control);

Appendix A (Beneficiary Alignment);

Appendix B (ACO REACH Model Financial Methodology);

Appendix E (Capitation Payment Mechanism: PCC Payment);

Appendix F (Advanced Payment Option);

Appendix G (Capitation Payment Mechanism: TCC Payment);

Appendix H (Financial Guarantee);

Appendix I (3-Day SNF Rule Waiver Benefit Enhancement);

Appendix J (Telehealth Benefit Enhancement);

Appendix L (Post-Discharge Home Visits Benefit Enhancement);

Appendix M (Care Management Home Visits Benefit Enhancement);

Appendix N (Home Health Homebound Waiver Benefit Enhancement);

Appendix O (Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement); and

Appendix T (Nurse Practitioner and Physician Assistant Services Benefit Enhancement).

Section 19.06 Precedence

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

Section 19.07 Change of ACO Name

The ACO shall provide written notice to CMS at least 60 Days before any change in the ACO legal name becomes effective. Subsequent to the change in the ACO's legal name, the ACO shall forward to CMS a copy of the legal document effecting the name change, authenticated by the appropriate state official, and the parties shall execute an agreement reflecting a change in the ACO's name.

Section 19.08 Prohibition on Assignment

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

Section 19.09 Change in Control

CMS may terminate the Agreement or Agreement Performance Period if the ACO undergoes a Change in Control. The ACO shall provide written notice to CMS at least

90 Days before the effective date of any Change in Control. For purposes of this paragraph, a "Change in Control" shall mean: (1) the acquisition by any "person" (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Securities Exchange Act of 1934), directly or indirectly, of voting securities of the ACO representing more than 50% of the ACO's outstanding voting securities or rights to acquire such securities; (2) the acquisition of the ACO by any individual or entity; (3) the sale, lease, exchange or other transfer (in one transaction or a series of transactions) of all or substantially all of the assets of the ACO; or (4) the approval and completion of a plan of liquidation of the ACO, or an agreement for the sale or liquidation of the ACO. This obligation remains in effect after the expiration or termination of the Agreement and until final payment by the ACO under the Agreement has been made.

Section 19.10 Change in TIN

The ACO shall provide CMS at least 60 Days' advance written notice of any change in the ACO's TIN by completing and submitting the change of TIN form provided by CMS. In response to a change in the ACO's TIN, CMS may terminate the Agreement or Agreement Performance Period, demand immediate re-payment of payments made under this Model, or take any other actions consistent with the terms of the Agreement.

Section 19.11 Certification

The executive signing the Agreement on behalf of the ACO ("**Alternative Payment Model Entity (APM) Executive**") certifies to the best of his or her knowledge, information, and belief that the information submitted to CMS and contained in the Agreement (inclusive of appendices), is accurate, complete, and truthful, and that he or she is authorized by the ACO to execute the Agreement and to legally bind the ACO on whose behalf he or she is executing the Agreement to its terms and conditions.

Section 19.12 Execution in Counterpart

The 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. The 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 the 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]

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

ACO: ____

Date: ____________________________ By: ________________________________

____

Name of authorized signatory and

APM Executive

CMS:

Date: ____________________________ By: ________________________________

____

Name of authorized signatory

____

Title

Appendix A: Beneficiary Alignment

I. REACH Beneficiary Alignment Procedures

CMS aligns Beneficiaries to the ACO for each Performance Year to determine the population of REACH Beneficiaries for which the ACO will assume accountability for the total cost of care. A Beneficiary is aligned to the ACO for a Performance Year based on either Claims-Based Alignment or Voluntary Alignment in accordance with this Appendix and the precedence rules described in Section 5.01.C of the Agreement.

Regardless of the Alignment Methodology selected by the ACO, CMS aligns Beneficiaries to the ACO prospectively, prior to the start of the Performance Year, except as otherwise specified in Section IV.C of this Appendix. If the ACO has selected Prospective Plus Alignment for the Performance Year as described in Section 8.01 of the Agreement, CMS will also align Beneficiaries to the ACO at the start of the second through fourth quarters of the Performance Year through Voluntary Alignment.

CMS will automatically run MVA for purposes of Beneficiary alignment, including for Prospective Plus Alignment (if the ACO has selected Prospective Plus Alignment for the Performance Year as described in Section 8.01 of the Agreement). If the ACO selects to participate in SVA for a Performance Year, CMS will use the SVA List submitted to CMS pursuant to Appendix C for purposes of Beneficiary alignment for the subsequent Performance Year. In addition, if the ACO has selected to participate in SVA for the Performance Year, has selected Prospective Plus Alignment as described in Section 8.01 of the Agreement, and submits an SVA List to CMS for the second, third or fourth quarter of that Performance Year, as described in Appendix C, CMS will use such SVA List for purposes of aligning Beneficiaries to the ACO at the start of the relevant calendar quarter of the Performance Year.

CMS also aligns Beneficiaries to the ACO for each Base Year to determine the ACO's historical baseline expenditure for purposes of calculating the Performance Year Benchmark. As described in Appendices E, F, and G, CMS also aligns Beneficiaries to the ACO for the relevant lookback period for purposes of PCC Payment, the APO, and TCC Payment, respectively. In addition, as described in Appendix B, CMS aligns Beneficiaries to the ACO for the relevant reference year for purposes of risk adjustment.

II. Claims-Based Beneficiary Alignment Methodology

A. Definitions

"**Alignment-Eligible Beneficiary**" means a Beneficiary who meets the applicable eligibility criteria listed in Section IV of this Appendix.

"**Alignment Period**" means a 2-year period that includes two consecutive 12-month periods. The Alignment Period ends six months prior to the start of the relevant Performance Year, Base Year, reference year, or lookback period.

"**Alignment Year**" means one of the two consecutive 12-month periods that make up an Alignment Period.

"**Base Year**" means a calendar year in which the expenditures for Beneficiaries who would have been aligned to the ACO via Claims-Based Alignment, or in which the expenditures for REACH Beneficiaries who were aligned to the ACO for the Performance Year, as applicable, are used to establish a historical baseline expenditure

for purposes of calculating the Performance Year Benchmark. The three months immediately following each Base Year are used for claims runout for that Base Year.

"**Base Year One**" means calendar year 2017.

"**Base Year Two**" means calendar year 2018.

"**Base Year Three**" means calendar year 2019.

"**Base Year Four**" means calendar year 2021.

"**Base Year Five**" means calendar year 2022.

"**Base Year Six**" means calendar year 2023.

"**Base Year Seven**" means calendar year 2024.

"**Claims-Alignable Beneficiary**" means an Alignment-Eligible Beneficiary who has had at least one PQEM Service that was paid by Medicare FFS during the Alignment Period.

"**Primary Care Services**" means all health care services and laboratory services customarily furnished by or through a Primary Care Specialist. The list of Primary Care Services for Performance Years 2023 and 2024 is governed by Table E of the version of the Appendix A that was in effect on January 1, 2023. The services described by the codes in Table E will be considered Primary Care Services for purposes of Performance Year 2025. CMS may update the list of codes considered to be Primary Care Services prior to the start of any subsequent Performance Year. CMS shall notify the ACO of any change in the codes considered to be Primary Care Services for a Performance Year prior to the beginning of the Performance Year in which such change will take effect.

In the case of claims submitted by physicians and non-physician practitioners (NPPs), a Primary Care Service is identified by the HCPCS code appearing on the claim line.

In the case of claims submitted by a Critical Access Hospital Method 2 (CAH2) (Type of Bill = 85x) (for Revenue Centers 096x, 097x, or 098x), a Primary Care Service is identified by the HCPCS code appearing on the line-item claim for the service.

"**Primary Care Specialist**" means a physician or NPP who has a primary specialty in primary care, such as general practice, family medicine, internal medicine, obstetrics and gynecology, pediatric medicine, geriatric medicine, nurse practitioner, clinical nurse specialist, psychiatry, or physician assistant. A physician or NPP's specialty is determined based on the CMS specialty code recorded in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). CMS will specify a list of CMS specialty codes for Primary Care Specialists prior to the start of the relevant Performance Year.

"**Selected Non-Primary Care Specialist**" means a physician or NPP who does not have a primary specialty in primary care but may still provide Primary Care Services. A physician or NPP's specialty is determined based on the CMS specialty code recorded in PECOS. CMS will specify a list of CMS specialty codes for Selected Non-Primary Care Specialists prior to the start of the Performance Year.

B. Claims-Based Alignment Eligibility

1. *General*

To be eligible for Claims-Based Alignment to the ACO, the Beneficiary must be a Claims-Alignable Beneficiary at the time CMS runs Claims-Based Alignment for the relevant Performance Year. Except as specified in Section IV.C of this Appendix, a Beneficiary is aligned to the ACO for a Performance Year, Base Year, reference year, or lookback period via Claims-Based Alignment if the plurality of the Beneficiary's PQEM Services during the applicable Alignment Period were received from Participant Providers, as evidenced in Medicare Part B claims data.

2. *Alignment Period*

Each Performance Year, each Base Year, each reference year, and each lookback period is associated with an Alignment Period that consists of two Alignment Years.

Table A of this Appendix specifies the Alignment Years for each Performance Year and Base Year. Alignment Year 1 for each reference year and lookback period is the 12-month period ending 18 months prior to the start of the applicable reference year or lookback period. Alignment Year 2 for each reference year and lookback period is the 12-month period ending 6 months prior to the start of the applicable reference year or lookback period.

Table A. Alignment Years for Each Base Year and Performance Year

	Period Covered	Alignment Year 1	Alignment Year 2
Base Year One	CY2017	7/1/2014 - 6/30/2015	7/1/2015 - 6/30/2016
Base Year Two	CY2018	7/1/2015 - 6/30/2016	7/1/2016 - 6/30/2017
Base Year Three	CY2019	7/1/2016 - 6/30/2017	7/1/2017 - 6/30/2018
Base Year Four	CY2021	7/1/2018 - 6/30/2019	7/1/2019 - 6/30/2020
Base Year Five	CY 2022	7/1/2019 - 6/30/2020	7/1/2020 - 6/30/2021
Base Year Six	CY 2023	7/1/2020 - 6/30/2021	7/1/2021 - 6/30/2022
Base Year Seven	CY 2024	7/1/2021 - 6/30/2022	7/1/2022 - 6/30/2023
Performance Year 2021[2]	April 1, 2021- December 31, 2021	7/1/2018 - 6/30/2019	7/1/2019 - 6/30/2020
Performance Year 2022[3]	CY 2022	7/1/2019 - 6/30/2020	7/1/2020 - 6/30/2021
Performance Year 2023	CY 2023	7/1/2020 - 6/30/2021	7/1/2021 - 6/30/2022
Performance Year 2024	CY 2024	7/1/2021 - 6/30/2022	7/1/2022 - 6/30/2023

[2] This Performance Year 2021, as described in Table A of this Appendix, is not relevant to this Agreement.

[3] This Performance Year 2022, as described in Table A of this Appendix, is not relevant to this Agreement.

	Period Covered	Alignment Year 1	Alignment Year 2
Performance Year 2025	CY 2025	7/1/2022 - 6/30/2023	7/1/2023 - 6/30/2024
Performance Year 2026	CY 2026	7/1/2023 - 6/30/2024	7/1/2024 - 6/30/2025

C. Claims-Based Alignment Process

1. Claims-Based Alignment of a Beneficiary is determined by comparing:

   a. The weighted allowable charges for all PQEM Services that the Beneficiary received from Participant Providers in each REACH ACO participating in the Model; and

   b. The weighted allowable charges for all PQEM Services that the Beneficiary received from each provider or supplier that is not a Participant Provider in a REACH ACO participating in the Model and is identified by a Medicare-enrolled billing TIN.

2. *Weighted Allowable Charges*

   a. The allowable charges on paid claims for PQEM Services received during the two Alignment Years that comprise the relevant Alignment Period will be used to determine the REACH ACO or other provider or supplier from which the Beneficiary received the plurality of PQEM Services. The allowable charges that are used in alignment will be obtained from claims for PQEM Services that are:

      i. Incurred in each Alignment Year as determined by the date-of-service on the claim line-item; and

      ii. Paid within 3 months following the end of the second Alignment Year as determined by the effective date of the claim.

   b. To determine the weighted allowable charges, the allowable charges on every paid claim for PQEM Services received by a Beneficiary during the two Alignment Years that comprise the applicable Alignment Period, will be weighted as follows:

      i. The allowable charges for PQEM Services provided during the first Alignment Year will be weighted by a factor of ⅓.

      ii. The allowable charge for PQEM Services provided during the second Alignment Year will be weighted by a factor of ⅔.

3. *The Two-Stage Algorithm*

   Alignment for a Performance Year, Base Year, reference year, or lookback period uses a two-stage alignment algorithm.

a. Alignment based on PQEM Services provided by Primary Care Specialists. If 10% or more of the allowable charges incurred for PQEM Services received by a Beneficiary during the two Alignment Years are furnished by Primary Care Specialists, then Beneficiary alignment is based on the allowable charges incurred for PQEM Services furnished by Primary Care Specialists.

b. Alignment based on PQEM Services provided by Selected Non-Primary Care Specialists. If less than 10% of the allowable charges incurred for PQEM Services received by a Beneficiary during the two Alignment Years are furnished by Primary Care Specialists, then Beneficiary alignment is based on the allowable charges incurred for PQEM Services furnished by Selected Non-Primary Care Specialists.

4. *Tie-breaker Rules*

In the case of a tie in the dollar amount of the weighted allowed charges for PQEM Services, the Beneficiary will be aligned to the ACO if a Participant Provider billed for the most recent PQEM service received by the Beneficiary in the Alignment Period.

5. *Alignment to the ACO*

Subject to the precedence rules described in Section 5.01.C of the Agreement, CMS will align a Beneficiary to the ACO based on Claims-Based Alignment if CMS determines that: (1) the Beneficiary is a Claims-Alignable Beneficiary; (2) the Beneficiary received the plurality of his or her PQEM Services during the two Alignment Years from the ACO's Participant Providers; and (3) the Beneficiary is not already aligned or assigned to a participant in another Innovation Center model, the Medicare Shared Savings Program, or another Medicare shared savings initiative that takes precedence over the Model for purposes of Beneficiary alignment. CMS will specify the shared savings initiatives that take precedence over the Model for purposes of Beneficiary alignment for a Performance Year in advance of the relevant Performance Year.

III. Voluntary Alignment

A. Signed Attestation-based Voluntary Alignment

If the ACO selects to participate in SVA for a Performance Year as described in Section 8.01 of the Agreement, subject to the precedence rules described in Section 5.01.C of the Agreement, CMS will align a Beneficiary to the ACO for the subsequent Performance Year or, if the ACO has selected Prospective Plus Alignment for the Performance Year pursuant to Section 8.01, a subsequent calendar quarter of that Performance Year, based on SVA if:

1. The Beneficiary is an Alignment-Eligible Beneficiary;

2. The Beneficiary has completed a Voluntary Alignment Form designating a Participant Provider as the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care, provided that the

designation is a Valid Designation (determined in accordance with Section 5.02.A of the Agreement) and more recent than any other Valid Designation made by the Beneficiary; and

3. The ACO has submitted an SVA List for the relevant Performance Year or quarter as described in Appendix C.

CMS will align the Beneficiary to the ACO in accordance with this Section III.A regardless of whether the Beneficiary would be aligned to the ACO based on Claims-Based Alignment.

B. Medicare.gov Voluntary Alignment

Subject to the precedence rules described in Section 5.01.C of the Agreement, CMS will align a Beneficiary to the ACO for the subsequent Performance Year or, if the ACO has selected Prospective Plus Alignment for the Performance Year pursuant to Section 8.01, a subsequent calendar quarter of that Performance Year, based on MVA if the Beneficiary:

1. Is an Alignment-Eligible Beneficiary; and
2. Has designated a Participant Provider as her or his primary clinician through MyMedicare.gov, Medicare.gov, or any successor site, provided that the designation is a Valid Designation (determined in accordance with Section 5.02.A of the Agreement) and more recent than any other Valid Designation made by the Beneficiary.

CMS will align the Beneficiary to the ACO in accordance with this Section III.B regardless of whether the Beneficiary would be aligned to the ACO based on Claims-Based Alignment.

C. Removal of Voluntarily Aligned Beneficiaries

1. A Beneficiary aligned to the ACO for a Performance Year via Voluntary Alignment who was not also eligible to be aligned to the ACO for the Performance Year via Claims-Based Alignment will be removed from alignment for that Performance Year to the ACO for purposes of Final Financial Settlement for any Performance Year if: (1) none of the ACO's Participant Providers or Preferred Providers furnished any Covered Services, with the exception of DME claims (Type of Bill 81, 82, and 72), to the Beneficiary during the Performance Year; and (2) a provider or supplier that is not a Participant Provider or Preferred Provider submitted a claim for PQEM Services furnished to the Beneficiary in the ACO's Service Area (as that term is described in Section 5.04.H of the Agreement) during the Performance Year.
2. In accordance with Section 5.02.C.5 of the Agreement, failure to comply with the requirements of Article V of the Agreement and, if the ACO has selected to participate in SVA, the requirements of Appendix C of the Agreement may result in retroactive reversal of any alignment of Beneficiaries to the ACO that occurred solely pursuant to Voluntary Alignment, to include via Prospective Plus Alignment.

IV. <u>Alignment Eligibility</u>

A. Alignment-Eligible Beneficiaries

1. To be aligned to a REACH ACO, a Beneficiary must meet all the following criteria:

    a. Enrolled in Medicare Parts A and B;

    b. Not enrolled in Medicare Advantage or any other Medicare managed care plan;

    c. Does not have Medicare as a secondary payer;

    d. Resident of the U.S.;

    e. Resides in a county that is included in the ACO Service Area (as defined in Section 5.04.H of the Agreement).

2. If a Beneficiary does not meet all of the eligibility criteria specified in Section IV.A.1 of this Appendix for a given month of a Base Year, Performance Year, reference year, or lookback period, the Beneficiary will be excluded from expenditure calculations for that month and all subsequent months of the Base Year, Performance Year, reference year, or lookback period, as applicable, and will not be re-aligned to the ACO for the Performance Year, even if (1) the ACO has selected Prospective Plus Alignment as described in Section 8.01 of the Agreement and the Beneficiary would otherwise be aligned to the ACO via Voluntary Alignment as described in Section III of this Appendix A or (2) if the beneficiary subsequently meets the eligibility criteria specified in Section IV.A.1 of this Appendix. The Beneficiary will contribute experience only through the last day of the month prior to the month in which the Beneficiary loses alignment eligibility, for purposes of calculating the Performance Year Benchmark, conducting financial settlement, calculating the PCC Payment amount, calculating the APO payment amount, calculating the TCC Payment amount, and calculating Beneficiary risk scores.

B. Additional Eligibility Criteria for Alignment to a High Needs Population ACO

1. If the ACO is a High Needs Population ACO, a Beneficiary must also meet one or more of the following conditions when first aligned to the ACO for a Performance Year, Base Year, reference year, or lookback period, as applicable:

    a. Have one or more developmental or inherited conditions or congenital neurological anomalies that impair the Beneficiary's mobility or the Beneficiary's neurological condition. Such conditions or anomalies could include cerebral palsy, cystic fibrosis, muscular dystrophy, metabolic disorders, or any other condition as specified by CMS. The codes that will be considered for purposes of this Section IV.B.1(a) will be specified by CMS prior to the start of the relevant Performance Year;

b. Have at least one significant chronic or other serious illness (defined as having a risk score of 3.0 or greater for Aged & Disabled (A&D) Beneficiaries or a risk score of 0.35 or greater for ESRD Beneficiaries);

c. Have a risk score between 2.0 and 3.0 for A&D Beneficiaries, or a risk score between 0.24 and 0.35 for ESRD Beneficiaries, and two or more unplanned hospital admissions in the previous 12 months as determined by CMS based on criteria specified by CMS in advance of the relevant Performance Year;

d. Exhibit signs of frailty, as evidenced by a claim submitted by a provider or supplier for a hospital bed (e.g., specialized pressure-reducing mattresses and some bed safety equipment), or transfer equipment (e.g., patient lift mechanisms, safety equipment, and standing systems) for use in the home. The codes that will be considered for purposes of this Section IV.B.1(d) will be specified by CMS prior to the start of the relevant Performance Year; or

e. For Performance Year 2024 and each subsequent Performance Year, have qualified for and received skilled nursing and/or rehabilitation services in a SNF for a minimum of 45 Days or qualified for and received home health services for a minimum of 90 Days in the previous 12 months as determined by CMS.

2. For each Performance Year prior to Performance Year 2024, CMS determines Beneficiary risk scores for the purposes of Section IV.B of this Appendix for A&D Beneficiaries by using the risk score calculated under the CMS-HCC Risk Adjustment Model or the CMMI-HCC Concurrent Risk Adjustment Model (as defined in Appendix B of the Agreement), whichever risk score is higher. Beginning Performance Year 2024, CMS determines Beneficiary risk scores for the purposes of Section IV.B of this Appendix for A&D Beneficiaries by using the risk score calculated under the 2020 CMS-HCC Risk Adjustment Model (Version 24) or the 2024 CMS-HCC Risk Adjustment Model (Version 28) or the CMMI-HCC Concurrent Risk Adjustment Model (as defined in Appendix B of the Agreement), whichever risk score is higher. CMS calculates Beneficiary risk scores for the purposes of Section IV.B of this Appendix for ESRD Beneficiaries by using the CMS-HCC Risk Adjustment Model.

3. Once a Beneficiary is aligned to a High-Needs Population ACO, the Beneficiary will remain aligned to the ACO even if the Beneficiary subsequently ceases to meet the criteria in Section IV.B.1 of this Appendix.

C. Frequency for Determining Whether a Beneficiary Meets Additional Eligibility Criteria for Alignment to a High Needs Population ACO

1. *Claims-Based Alignment*

If the ACO is a High Needs Population ACO and a Beneficiary would have been aligned to the ACO via Claims-Based Alignment effective at

the start of the Performance Year had the Beneficiary met the additional eligibility criteria for alignment to a High Needs Population ACO specified in Section IV.B.1 of this Appendix, CMS will re-determine whether the Beneficiary satisfies the eligibility criteria in Section IV.A.1 and Section IV.B.1 of this Appendix at each of the times listed in the first row of Table B of this Appendix during the Performance Year. CMS will use claims with dates of service incurred during the applicable lookback period listed in Table C or Table D, as applicable, of this Appendix to make such eligibility determinations. CMS will align such a Beneficiary to the ACO effective at the start of the subsequent calendar quarter for the remainder of the Performance Year if CMS determines at one of the applicable times specified in Table B of this Appendix that the Beneficiary meets the additional eligibility criteria specified in Section IV.A.1 and Section IV.B.1 of this Appendix.

2. *Voluntary Alignment*

If the ACO is a High Needs Population ACO and a Beneficiary would be aligned to the ACO via Voluntary Alignment effective at the start of the Performance Year had the Beneficiary met the additional eligibility criteria for alignment to a High Needs Population ACO specified in Section IV.B.1 of this Appendix, CMS will re-determine whether the Beneficiary satisfies the eligibility criteria in Section IV.A.1 and Section IV.B.1 of this Appendix at each of the times listed in the second row of Table B of this Appendix during the Performance Year. CMS will use claims with dates of service incurred during the applicable lookback period listed in Table C or Table D, as applicable, of this Appendix to make such eligibility determinations. CMS will align such a Beneficiary to the ACO effective at the start of the subsequent calendar quarter for the remainder of the Performance Year if CMS determines at one of the applicable times specified in Table B of this Appendix that the Beneficiary meets the additional eligibility criteria specified in Section IV.A.1 and Section IV.B.1 of this Appendix.

3. *Prospective Plus Alignment*

If the ACO is a High Needs Population ACO and selected Prospective Plus Alignment for a Performance Year as described in Section 8.01 of the Agreement, and a Beneficiary would be aligned to the ACO via Voluntary Alignment effective at the start of the second, third, or fourth calendar quarter of the Performance Year had the Beneficiary met the additional eligibility criteria for High Needs Population ACOs specified in Section IV.B.1 of this Appendix, CMS will re-determine whether the Beneficiary satisfies the eligibility criteria in Section IV.A.1 and Section IV.B.1 of this Appendix at each of the times listed in the third, fourth, or fifth rows of Table B of this Appendix, as applicable, during the Performance Year. CMS will use claims with dates of service incurred during the applicable lookback period listed in Table C or Table D, as applicable, of this Appendix to make such eligibility determinations. CMS will align such a Beneficiary to the ACO effective at the start of the subsequent calendar

quarter for the remainder of the Performance Year if CMS determines at one of the applicable times specified in Table B of this Appendix that the Beneficiary meets the additional eligibility criteria specified in Section IV.A.1 and Section IV.B.1 of this Appendix.

Table B. Frequency for Determining Whether a Beneficiary Meets Additional Eligibility Criteria for Alignment to a High Needs Population ACO during a Performance Year

	January 1 of PY	April 1 of PY	July 1 of PY	October 1 of PY
CA[1] prior to PY	Check eligibility	If not eligible for Jan 1, re-check	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
VA[2] prior to PY	Check eligibility	If not eligible for Jan 1, re-check	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
VA for April 1[3]		Check eligibility	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
VA for July 1[3]			Check eligibility	If not eligible for July 1, re-check
VA for October 1[3]				Check eligibility

(1) CA = Claims-Aligned
(2) VA = Voluntarily Aligned
(3) Prospective Plus Alignment Only

Table C. Lookback Periods to Determine Whether a Beneficiary Meets Additional Eligibility Criteria (a)-(c); (e) of Section IV.B.1 of Appendix A for Alignment to a High Needs Population ACO during a Performance Year

	Lookback Period			
	January 1 of PY	**April 1 of PY**	**July 1 of PY**	**October 1 of PY**
PY2022[4]	11/1/20 – 10/31/21	2/1/21 – 1/31/22	5/1/21 – 4/30/22	8/1/21 – 7/31/22
PY2023	11/1/21 – 10/31/22	2/1/22 – 1/31/23	5/1/22 – 4/30/23	8/1/22 – 7/31/23
PY2024	11/1/22 – 10/31/23	2/1/23 – 1/31/24	5/1/23 – 4/30/24	8/1/23 – 7/31/24
PY2025	11/1/23 – 10/31/24	2/1/24 – 1/31/25	5/1/24 – 4/30/25	8/1/24 – 7/31/25
PY2026	11/1/24 – 10/31/25	2/1/25 – 1/31/26	5/1/25 – 4/30/26	8/1/25 – 7/31/26

Table D. Lookback Periods to Determine Whether a Beneficiary Meets Additional Eligibility Criteria (d) of Section IV.B.1 of Appendix A for Alignment to a High Needs Population ACO during a Performance Year

	Lookback Period			
	January 1 of PY	**April 1 of PY**	**July 1 of PY**	**October 1 of PY**
PY2022[5]	11/1/16 – 10/31/21	2/1/17 – 1/31/22	5/1/17 – 4/30/22	8/1/17 – 7/31/22

[4] This Performance Year 2022, as described in Table C of this Appendix, is not relevant to this Agreement.

[5] This Performance Year 2022, as described in Table D of this Appendix, is not relevant to this Agreement.

	Lookback Period			
	January 1 of PY	**April 1 of PY**	**July 1 of PY**	**October 1 of PY**
PY2023	11/1/17 – 10/31/22	2/1/18 – 1/31/23	5/1/18 – 4/30/23	8/1/18 – 7/31/23
PY2024	11/1/18 – 10/31/23	2/1/19 – 1/31/24	5/1/19 – 4/30/24	8/1/19 – 7/31/24
PY2025	11/1/19 – 10/31/24	2/1/20 – 1/31/25	5/1/20 – 4/30/25	8/1/20 – 7/31/25
PY2026	11/1/20 – 10/31/25	2/1/21 – 1/31/26	5/1/21 – 4/30/26	8/1/21 – 7/31/26

Table E. List of Primary Care Service for Performance Year 2025

Administration of HRA	
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
Office or Other Outpatient Visit for New Patient	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
Office or Other Outpatient Visit for Established Patient	
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
Professional Services Provided in a Non-Skilled Nursing Facility (where LINE.CLM_POS_CD does not equal 31)	
99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care

99307	Subsequent Nursing Facility Care
99308	Subsequent Nursing Facility Care
99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive

99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Telephone Visits – Online Digital or Audio Only	
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99424	Principal Care Management (PCM)
99425	Principal Care Management (PCM)
99426	Principal Care Management (PCM)
99427	Principal Care Management (PCM)
99437	Principal Care Management (PCM)
99424	Principal Care Management (PCM)
99441	Phone, Established Patient, 5–10 mins
99442	Phone, Established Patient, 10–20 mins
99443	Phone, Established Patient, 21+ mins
Cognitive Assessment and Care Plan Services	
99483	Cognitive assessment and care plan services
Behavioral Health Integration (BHI) Services	
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, additional ’30 mins

G2214	Psychiatric collaborative care management
Care Management Home Visit	
G0076	Brief (20 minutes) care management home visit for a new patient.
G0077	Limited (30 minutes) care management home visit for a new patient.
G0078	Moderate (45 minutes) care management home visit for a new patient.
G0079	Comprehensive (60 minutes) care management home visit for a new patient.
G0080	Extensive (75 minutes) care management home visit for a new patient.
G0081	Brief (20 minutes) care management home visit for an existing patient.
G0082	Limited (30 minutes) care management home visit for an existing patient.
G0083	Moderate (45 minutes) care management home visit for an existing patient.
G0084	Comprehensive (60 minutes) care management home visit for an existing patient.
G0085	Extensive (75 minutes) care management home visit for an existing patient.
G0086	Limited (30 minutes) care management home care plan oversight.
G0087	Comprehensive (60 minutes) care management home care plan oversight.
Chronic Care Management (CCM) Services	
99421	Chronic care management services each additional 30 minutes by a physician or other qualified health care professional, per calendar month
99422	Principal care management services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99423	Principal care management services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99424	Principal care management services, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
99425	Principal care management services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99439	Non-complex chronic care management services, additional 30 min

99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Additional care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99491	Chronic care monitoring service, moderate
G2058	Non-Complex Chronic Care Management Service
G2064	Comprehensive care management, physician
G2065	Comprehensive care management, clinical staff
G0506	Additional work for the billing provider in face-to-face assessment or CCM planning
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Depression and alcohol misuse	
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
Professional Services Provided in ETA Hospitals	
G0463	Professional Services Provided in ETA Hospitals
Prolonged Care for Outpatient Visit	
99354	Prolonged visit, first hour
99355	Prolonged visit, additional 30 mins
G2212	Prolonged visit, additional 15 mins
Advance Care Planning (where LINE.CLM_POS_CD does not equal 21)	

99497	ACP first 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
99498	ACP additional 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
Virtual check-ins	
G2010	Remote evaluation, Established Patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
G2252	Brief communication technology-based service, 11-20 minutes of medical discussion
GUIDE-Specific G-Codes for DCMP	

Appendix B: ACO REACH Model Financial Methodology

The document following this Appendix B cover sheet represents Appendix B in its entirety for Performance Year 2025. Except as expressly provided otherwise in the Appendix B for Performance Year 2025, the ACO REACH Model Financial Methodology for each Performance Year prior to 2025 is governed by the ACO REACH Model Performance Period Participation Agreement (2023 Starters) as if such document were included as Appendix B in this amended and restated Agreement.

CMS calculates a Performance Year Benchmark for each Performance Year. The Performance Year Benchmark is used during financial settlement to calculate Shared Savings and Shared Losses for the Performance Year and to derive the monthly payments paid to ACOs during the Performance Year under the ACO's selected Capitation Payment Mechanism.

To calculate the Performance Year Benchmark, CMS first calculates the Total Unadjusted Performance Year Benchmark. The methodology CMS uses to calculate the Total Unadjusted Performance Year Benchmark is determined based on whether the ACO is a Standard ACO, New Entrant ACO, or High Needs Population ACO, and certain other criteria specified in this Appendix. Except as otherwise specified in this Appendix, the ACO's Total Unadjusted Performance Year Benchmark is calculated in accordance with Section I of this Appendix if the ACO is a Standard ACO, Section II of this Appendix if the ACO is a New Entrant ACO, or Section III of this Appendix if the ACO is a High Needs Population ACO. To calculate the Performance Year Benchmark, CMS then applies the Quality Withhold and Quality Performance Adjustment (as described in Section V.B of this Appendix), the Discount (if the ACO is participating in the Global Risk Sharing Option) (as described in Section V.C of this Appendix), and the Retention Withhold Participation Commitment Mechanism (if applicable) (as described in Section V.D of this Appendix).

After the Performance Year and at such other times as may be required under the Agreement, CMS conducts financial settlement to determine the sum of Shared Savings or Shared Losses and Other Monies Owed in accordance with Section VI of this Appendix.

Definitions

"**ACO REACH/KCC Rate Book**" means a modified version of the Medicare Advantage (MA) Rate Book that includes adjustments specific to the Model. To establish the ACO REACH/KCC Rate Book for a given Performance Year, CMS follows the same methodological approach used to establish the MA Rate Book, with a series of adjustments to account for differences between MA and the Model in terms of Beneficiary eligibility, expenditure categories for which the ACO is accountable, Base Years used to establish county relative rates, and the application of statutory adjustments. Like the MA Rate Book, the ACO REACH/KCC Rate Book first establishes county-level rates for A&D Beneficiaries and state-level rates for ESRD Beneficiaries; however, the ACO REACH/KCC Rate Book then incorporates GAFs at the county level for both A&D and ESRD rates, resulting in county-level ESRD rates as well. CMS will make the applicable ACO REACH/KCC Rate Book for each Performance Year available to the ACO in advance of the relevant Performance Year.

"**ACO REACH National Reference Population"** means the population of Beneficiaries who were Alignment-Eligible Beneficiaries for a given Base Year, Performance Year, or reference year, as applicable. The ACO REACH National Reference Population is divided into two sub-populations: A&D Beneficiaries and ESRD Beneficiaries.

"**Adjusted FFS USPCC**" stands for "**Adjusted Fee-for-Service United States Per Capita Cost**" and means a modified version of the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year and subject to subsequent updates, adjusted to remove costs associated with uncompensated care and to add hospice expenditures.

“**Adjusted USPCC Trend**” stands for “**Adjusted United States Per Capita Cost Trend**” and means a trend rate calculated by CMS using the Adjusted FFS USPCC calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year.

“**Alignment-Eligible Beneficiary**” has the meaning defined in Section II of Appendix A.

“**Base Year**” has the meaning defined in Section II of Appendix A.

“**CMMI Demographic Risk Adjustment Model**” means the demographic risk score model under which CMS determines a demographic risk score for a Beneficiary based on a prediction of the Beneficiary’s Medicare expenditures using demographic variables that include age, gender, original reason for entitlement code, and Medicaid dual status.

“**CMMI-HCC Concurrent Risk Adjustment Model**” means a method for measuring the health risk of a population with a risk score to reflect the predicted expenditures of that population. The CMMI-HCC Concurrent Risk Adjustment Model has a concurrent model design, which means that risk scores are calculated using diagnoses recorded on claims with dates of service during the calendar year in which the risk scores are used for payment purposes. The CMMI-HCC Concurrent Risk Adjustment Model can be applied to Aged & Disabled (A&D) Beneficiaries; there is a non-End-Stage Renal Disease (ESRD) segment, but no ESRD segment.

“**CMS-HCC Risk Adjustment Model**” means a method for measuring the health risk of a population with a risk score to reflect the predicted expenditures of that population. The CMS-HCC Risk Adjustment Model has a prospective model design, which means that risk scores are calculated using diagnoses recorded on claims with dates of service during the calendar year prior to the calendar year in which the risk scores are used for payment purposes. CMS-HCC Risk Adjustment Model can be applied to A&D Beneficiaries (the non-ESRD segment) and the CMS-HCC ESRD Risk Adjustment Model to ESRD Beneficiaries (the ESRD segment). For Performance Year 2025, the risk score shall be calculated as the sum of 67% of the risk score calculated using the updated 2024 CMS-HCC Risk Adjustment Model (Version 28) with 33% of the risk score calculated using the current 2020 CMS-HCC Risk Adjustment Model (Version 24), as described in the Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.[6]

“**FFS USPCC**” stands for “**Fee-for-Service United States Per Capita Cost**” and means an annual estimate of per-Beneficiary per-month Medicare FFS expenditures developed annually by the CMS Office of the Actuary (OACT) and announced in the annual Announcement of Calendar Year Medicare Advantage Capitation Rates and Part C and Part D Payment Policies released in the prior calendar year and subject to subsequent updates. OACT develops a separate FFS USPCC for the A&D and ESRD sub-populations of Beneficiaries.

“GAF” stands for **“Geographic Adjustment Factor”** and means a factor that is applied by Medicare Fee-for-Service Payment systems to reflect the cost of doing business in a geographic

[6] This document is available at https://www.cms.gov/files/document/2025-announcement.pdf

area. The Geographic Adjustment Factors include Area Wage Indices in the various prospective payment systems and Geographic Practice Cost Indices in the Physician Fee Schedule.

"**Normalization Factor**" means the average risk score for those Beneficiaries included in the ACO REACH National Reference Population, calculated in accordance with Section IV of this Appendix, weighted by the number of months of the Base Year, Performance Year, or reference year, as applicable, during which each Beneficiary was an Alignment-Eligible Beneficiary. A separate Normalization Factor is calculated for each applicable risk adjustment model and for each of the two sub-populations within the ACO REACH National Reference Population: A&D Beneficiaries and ESRD Beneficiaries. Both the A&D Beneficiary and ESRD Beneficiary Normalization Factors for a Performance Year are subject to updates throughout the Performance Year at each of the times specified in Table B of this Appendix using claims data from the applicable period specified in Table B of this Appendix.

"Revised Adjusted USPCC Trend" stands for "**Revised Adjusted United States Per Capita Cost Trend**" and means a trend rate calculated by CMS using the Adjusted FFS USPCC calculated based on updates to the FFS USPCC released after the publication of the ACO REACH/KCC Rate Book for the Performance Year.

"**Total Unadjusted Performance Year Benchmark**" means the ACO's Performance Year Benchmark prior to the adjustments to account for the Quality Withhold and Quality Performance Adjustment (as described in Section V.B of this Appendix), the Discount (if the ACO is participating in the Global Risk Sharing Option) (as described in Section V.C of this Appendix), and the Retention Withhold Participation Commitment Mechanism (if applicable) (as described in Section V.D of this Appendix).

I. Total Unadjusted Performance Year Benchmark Methodology for a Standard ACO

A. CMS calculates the ACO's Total Unadjusted Performance Year Benchmark for a Performance Year in accordance with this Section I if the ACO is a Standard ACO for the Performance Year.

B. Under Section I of this Appendix, the Total Unadjusted Performance Year Benchmark is calculated as the sum of the Total A&D Benchmark, as defined in and calculated in accordance with Section I.E.1 of this Appendix, and the Total ESRD Benchmark, as defined in and calculated in accordance with Section I.E.2 of this Appendix.

1. The Total A&D Benchmark is calculated as the sum of the A&D Beneficiary Claims-Based Aligned Benchmark for A&D REACH Beneficiaries aligned to the ACO via Claims-Based Alignment (as defined and calculated in accordance with Section I.C of this Appendix) and the A&D Beneficiary Voluntarily-Aligned Benchmark for A&D REACH Beneficiaries aligned to the ACO based on Voluntary Alignment (as defined and calculated in accordance with Section I.D of this Appendix) ("**Total Unadjusted A&D Benchmark**"), adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix), if any.

2. The Total ESRD Benchmark is calculated as the sum of the ESRD Beneficiary Claims-Based Aligned Benchmark for ESRD REACH Beneficiaries aligned to the ACO via Claims-Based Alignment (as defined and calculated in accordance with Section I.C of this Appendix) and the ESRD Beneficiary Voluntarily-Aligned Benchmark for ESRD REACH Beneficiaries aligned to the ACO based on Voluntary Alignment (as defined and calculated in accordance with Section I.D of this Appendix) ("**Total Unadjusted ESRD Benchmark**"), adjusted by the applicable retrospective trend adjustment for ESRD Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix), if any.

3. Beneficiaries aligned to the ACO via Voluntary Alignment who were also eligible for alignment to the ACO via Claims-Based Alignment will be included only in the calculation of the applicable Claims-Based Aligned Benchmark.

4. CMS may adjust the Total Unadjusted Performance Year Benchmark Methodology for a Standard ACO to account for or exclude, as applicable, expenditures for REACH Beneficiaries associated with an overlapping model, including the GUIDE Model.

C. Calculation of the Claims-Based Aligned Benchmarks

1. *General*

The methodology for calculating the A&D Claims Aligned Benchmark and the ESRD Claims-Aligned Benchmark includes the steps outlined in this Section I.C.1. CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

a. Calculate historical baseline expenditures in accordance with Section I.C.2 of this Appendix;

b. Risk-standardize historical baseline expenditures in accordance with Section I.C.3 of this Appendix;

c. Apply a prospective trend and GAF adjustment to the risk-standardized historical baseline expenditures in accordance with Section I.C.4 of this Appendix;

d. Calculate historical regional expenditures in accordance with Section I.C.5 of this Appendix;

e. Blend risk-standardized, trended, and GAF-adjusted historical baseline expenditures with historical regional expenditures in accordance with Section I.C.6 of this Appendix;

f. Calculate the A&D Beneficiary Claims-Aligned Benchmark and the ESRD Beneficiary Claims-Aligned Benchmark (each defined and calculated in accordance with Section I.C.7 of this Appendix).

2. *Historical Base Year Expenditures*

a. Prior to the start of each Performance Year, CMS calculates the ACO's historical baseline expenditures separately for each of Base

Year One (2017), Base Year Two (2018), and Base Year Three (2019) (each a "**Historical Base Year**" and collectively the "**Historical Lookback Period**").

b. CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each Beneficiary who would have been aligned to the ACO during the applicable Historical Base Year using the Claims-Based Alignment methodology described in Section II of Appendix A and the Participant Provider List for the Performance Year described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, during each month of the Historical Base Year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year Expenditure**").

c. CMS divides the Historical Base Year Expenditure for each Historical Base Year by the total number of months in which all Beneficiaries who would have been aligned to the ACO during that Historical Base Year via Claims-Based Alignment, as described in Section I.C.2(b) of this Appendix, were Alignment-Eligible Beneficiaries during that Historical Base Year ("**Historical Base Year PBPM Expenditure**").

3. *Risk-Standardization of Historical Base Year PBPM Expenditure*

a. CMS calculates a risk score for each Beneficiary whose expenditures were included in the Historical Base Year PBPM Expenditure calculation for each Historical Base Year in accordance with the applicable risk score methodology outlined in Section IV.A of this Appendix. For each Historical Base Year, CMS then calculates the average risk score for all Beneficiaries included in the Historical Base Year PBPM Expenditure calculation for that Historical Base Year, weighted by the number of months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary. CMS then divides the weighted average risk score for each Historical Base Year by the applicable Normalization Factor for that Historical Base Year ("**Normalized Historical Base Year Risk Score**").

b. CMS risk-standardizes the Historical Base Year PBPM Expenditure for each Historical Base Year by dividing the ACO's Historical Base Year PBPM Expenditure for the Historical Base Year by the Normalized Historical Base Year Risk Score for that Historical Base Year ("**Risk-Standardized Historical Base Year PBPM Expenditure**").

4. *Application of Prospective Trend and GAF Factors*

a. CMS applies the Adjusted USPCC Trend to the ACO's Risk-Standardized Historical Base Year PBPM Expenditure for each Historical Base Year to trend the Risk-Standardized Historical

Base Year PBPM Expenditure forward to Performance Year-equivalent dollars ("**Risk-Standardized and Trended Historical Base Year PBPM Expenditures**").

b. CMS adjusts the Risk-Standardized and Trended Historical Base Year PBPM Expenditures for each Historical Base Year to reflect the anticipated impact of changes between the Historical Base Year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures**").

c. CMS calculates an average of the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for the Historical Lookback Period, weighted as follows: Base Year One (2017) is weighted 10%; Base Year Two (2018) is weighted 30%; and Base Year Three (2019) is weighted 60% ("**Historical Lookback Period PBPM Expenditures**").

d. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for one or more of the three Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Expenditures. If CMS determines that only two Historical Base Years have sufficient claims history, CMS will average the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for those two Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one Historical Base Year has sufficient claims history, CMS will use the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for that Historical Base Year as the Historical Lookback Period PBPM Expenditures.

5. *Calculation of Historical Regional Expenditures*

a. Using the ACO REACH/KCC Rate Book for the relevant Performance Year, CMS calculates an average of the county-level rates for each Historical Base Year based on the counties where Beneficiaries who would have been aligned to the ACO during the applicable Historical Base Year using the Claims-Based Alignment methodology described in Section II of Appendix A and the Participant Provider List for the Performance Year described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, lived during the Historical Base Year, weighted by the number of months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year PBPM Regional Rate**"). CMS then calculates an average of the ACO's Historical Base Year PBPM Regional Rate

for the Historical Lookback Period, weighted as follows: Base Year One (2017) is weighted 10%; Base Year Two (2018) is weighted 30%; and Base Year Three (2019) is weighted 60% (“**Historical Lookback Period PBPM Regional Rate”**).

b. If CMS determines that the ACO does not have sufficient claims history to construct the ACO’s Historical Base Year PBPM Regional Rate for one or more of the three Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Regional Rate. If CMS determines that only two Historical Base Years have sufficient claims history, CMS will average the Historical Base Year PBPM Regional Rate for those two Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one Historical Base Year has sufficient claims history, CMS will use the Historical Base Year PBPM Regional Rate for that one Historical Base Year as the Historical Lookback Period PBPM Regional Rate.

6. *Blending Historical Baseline Expenditures with Historical Regional Expenditures*

a. CMS blends the ACO’s Historical Lookback Period PBPM Regional Rate, described in Section I.C.5 of this Appendix, with the ACO’s Historical Lookback Period PBPM Expenditures, described in Section I.C.4 of this Appendix, weighted using the applicable percentages listed in Table A of this Appendix (“**Blended Historical PBPM Expenditures for Standard ACOs**”).

Table A. Percentages for Weighting the Historical Lookback Period PBPM Expenditures and Historical Lookback Period PBPM Regional Rate for Standard ACOs

Weighting	PY2023	PY 2024, PY 2025, PY 2026
Historical Lookback Period PBPM Expenditures	60%	55%
Historical Lookback Period PBPM Regional Rate	40%	45%

b. If the ACO’s Blended Historical PBPM Expenditures for Standard ACOs exceed the ACO’s Historical Lookback Period PBPM Expenditures by more than three percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for Standard ACOs equal to the ACO’s Historical Lookback Period PBPM

Expenditures plus three percent of the Adjusted FFS USPCC for the Performance Year.

c. If the ACO's Blended Historical PBPM Expenditures for Standard ACOs are less than the ACO's Historical Lookback Period PBPM Expenditures by more than two percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for Standard ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures minus two percent of the Adjusted FFS USPCC for the Performance Year.

d. CMS divides the Blended Historical PBPM Expenditures for Standard ACOs by the ACO's Historical Lookback Period PBPM Regional Rate, described in Section I.C.5 of this Appendix ("**Claims-Aligned Regional Rate Adjustment Factor**").

7. *Calculation of A&D Beneficiary Claims-Aligned Benchmark and ESRD Beneficiary Claims-Aligned Benchmark*

a. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where Beneficiaries aligned to the ACO via Claims-Based Alignment live ("**Performance Year PBPM Claims-Aligned Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Claims-Aligned Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries aligned to the ACO via Claims-Based Alignment live, weighted by the number of Originally Aligned Beneficiaries aligned to the ACO via Claims-Based Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Claims-Aligned Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries aligned to the ACO via Claims-Based Alignment live, weighted by the number of months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

b. CMS multiplies the Claims-Aligned Regional Rate Adjustment Factor, described in Section I.C.6 of this Appendix, by the ACO's Performance Year PBPM Claims-Aligned Regional Rate to ("**Risk-Standardized PBPM Claims-Aligned Benchmark**").

c. CMS calculates the number of months during which Beneficiaries aligned to the ACO via Claims-Based Alignment were Alignment-Eligible Beneficiaries ("**Claims-Aligned Beneficiary Months**"). CMS then multiplies the Risk-Standardized PBPM Claims-Aligned

Benchmark by the number of Claims-Aligned Beneficiary Months ("**Risk-Standardized Total Claims-Aligned Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Claims-Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Claims-Based Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Claims-Aligned Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary aligned to the ACO via Claims-Based Alignment was an Alignment-Eligible Beneficiary.

d. CMS multiplies the Risk-Standardized Total Claims-Aligned Benchmark by the Standard Claims-Aligned A&D Beneficiary ACO Normalized Risk Score and the Standard Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned via Claims-Based Alignment ("**A&D Beneficiary Claims-Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Claims-Based Alignment ("**ESRD Beneficiary Claims-Aligned Benchmark**").

D. Calculation of the Voluntarily Aligned Benchmarks

1. For Performance Years 2021-2024, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark using the steps described in this Section I.D.1. CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

a. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where Beneficiaries aligned via Voluntary Alignment live ("**Risk-Standardized PBPM Voluntarily Aligned Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Risk-Standardized PBPM Voluntarily Aligned Benchmark as the average of the county-level rates for the counties where Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Risk-Standardized PBPM Voluntarily Aligned Benchmark as the average of the

county-level rates for the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

b. CMS multiplies the Risk-Standardized PBPM Voluntarily Aligned Benchmark by the number of months of the Performance Year during which Beneficiaries aligned to the ACO via Voluntary Alignment were Alignment-Eligible Beneficiaries ("**Voluntarily Aligned Beneficiary Months**") to calculate the "**Risk-Standardized Total Voluntarily Aligned Benchmark**." For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Voluntarily Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Voluntarily Aligned Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary aligned to the ACO via Voluntary Alignment was an Alignment-Eligible Beneficiary.

c. CMS multiplies the Risk-Standardized Total Voluntarily Aligned Benchmark by the Standard Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score and the Standard Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned to the ACO via Voluntary Alignment ("**A&D Beneficiary Voluntarily Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Voluntary Alignment ("**ESRD Beneficiary Voluntarily Aligned Benchmark**").

2. For Performance Years 2025 and 2026, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark using the steps described in this Section I.D.2. CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

a. Calculate historical baseline expenditures in accordance with Section I.D.3 of this Appendix;

b. Risk-standardize historical baseline expenditures in accordance with Section I.D.4 of this Appendix;

c. Apply a prospective trend and GAF adjustment to the risk-standardized historical baseline expenditures in accordance with Section I.D.5 of this Appendix;

d. Calculate historical regional expenditures in accordance with Section I.D.6 of this Appendix;

e. Blend risk-standardized, trended, and GAF-adjusted historical baseline expenditures with historical regional expenditures in accordance with Section I.D.7 of this Appendix;

f. Notwithstanding Section I.D.2.e of this Appendix, if ACO has fewer than 500 unique voluntary aligned beneficiaries, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark pursuant to Section I.D.2.g of this Appendix solely using the historical regional expenditures calculated pursuant to Section I.D.6of this Appendix.

g. If the ACO has at least 500 unique voluntary aligned beneficiaries , CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark in accordance with Section I.D.8 of this Appendix.

3. *Historical Base Year Expenditures*

a. For Performance Years 2025 and 2026, prior to the start of the Performance Year, CMS calculates the ACO's historical baseline expenditures separately for each of Base Year Four (2021), Base Year Five (2022), and Base Year Six (2023) (each a "**Historical Base Year**" and collectively the "**Historical Lookback Period**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

b. CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each REACH Beneficiary who was aligned to the ACO via Voluntary Alignment during the Performance Year that corresponds to the relevant Historical Base Years specified in Section I.D.3(a) of this Appendix, during each month of the Historical Base Year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year Expenditure**").

c. CMS divides the Historical Base Year Expenditure for each Historical Base Year by the total number of months in which all REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to that Historical Base Year via Voluntary Alignment were Alignment-Eligible Beneficiaries during that Historical Base Year ("**Historical Base Year PBPM Expenditure**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year

Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

4. *SAHS Billing Activity Exclusion*

Notwithstanding Appendix B for an applicable prior Performance Year, for Performance Year 2024 and subsequent Performance Years, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) and any services that CMS determined, for a specified Base Year, constitute significant, anomalous, and highly suspect billing activity ("**SAHS Billing Activity**"), including intermittent urinary catheters (identified by HCPCS codes A4352 and A4353) (for Base Year Six). In addition, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) that were rendered in calendar years 2021 and 2022. CMS reserves the right to determine that additional services constitute SAHS Billing Activity; any such determination shall be set forth by CMS in guidance for a Performance Year prior to Final Financial Settlement for the Performance Year.

5. *Risk-Standardization of Historical Base Year PBPM Expenditure*

   a. CMS calculates a risk score for each Beneficiary whose expenditures were included in the Historical Base Year PBPM Expenditure calculation for each Historical Base Year in accordance with the applicable risk score methodology outlined in Section IV.A of this Appendix. For each Historical Base Year, CMS then calculates the average risk score for all Beneficiaries included in the Historical Base Year PBPM Expenditure calculation for that Historical Base Year, weighted by the number of months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary. CMS then divides the weighted average risk score for each Historical Base Year by the applicable Normalization Factor for that Historical Base Year ("**Normalized Historical Base Year Risk Score**").

   b. CMS risk-standardizes the Historical Base Year PBPM Expenditure for each Historical Base Year by dividing the ACO's Historical Base Year PBPM Expenditure for the Historical Base Year by the Normalized Historical Base Year Risk Score for that Historical Base Year ("**Risk-Standardized Historical Base Year PBPM Expenditure**").

6. *Application of Prospective Trend and GAF Factors*

   a. CMS applies the Adjusted USPCC Trend to the ACO's Risk-Standardized Historical Base Year PBPM Expenditure for each Historical Base Year to trend the Risk-Standardized Historical Base Year PBPM Expenditure forward to Performance Year-

equivalent dollars ("**Risk-Standardized and Trended Historical Base Year PBPM Expenditures**").

b. CMS adjusts the Risk-Standardized and Trended Historical Base Year PBPM Expenditures for each Historical Base Year to reflect the anticipated impact of changes between the Historical Base Year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures**").

c. CMS calculates an average of the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for all of the three Historical Base Years, weighted as follows: For Performance Years 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Expenditures**").

d. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Expenditures. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for those Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for that Historical Base Year as the Historical Lookback Period PBPM Expenditures.

7. *Calculation of Historical Regional Expenditures*

a. Using the ACO REACH/KCC Rate Book for the relevant Performance Year, CMS calculates an average of the county-level rates for each Historical Base Year based on the counties where REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to the applicable Historical Base Year using Voluntary Alignment lived during the Historical Base Year, weighted by the number of months of the Historical Base Year during which each REACH Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year PBPM Regional Rate**"). CMS then calculates an average of the ACO's Historical Base Year PBPM Regional Rate for the applicable Historical Lookback Period, weighted as follows: For Performance Years 2025 and 2026, Base Year Four (2021) is weighted 10%,

Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% (“**Historical Lookback Period PBPM Regional Rate”**).

b. If CMS determines that the ACO does not have sufficient claims history to construct the ACO’s Historical Base Year PBPM Regional Rate for one or more the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Regional Rate. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average Historical Base Year PBPM Regional Rate for those two Historical Base Years, with the more recent Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Historical Base Year PBPM Regional Rate for that Historical Base Year as the Historical Lookback Period PBPM Regional Rate.

c. If the ACO does not meet the 500 voluntarily aligned beneficiary minimum, described in Section I.D.2.f of this Appendix, to construct the ACO’s Historical Year PBPM Regional Rate for any of the three applicable Historical Base Years, CMS will use a 100% weight of the Risk-Standardized PBPM Voluntarily Aligned Benchmark, as applied in Performance Years 2021-2024, described in Section I.D.1 of this Appendix.

8. *Blending Historical Baseline Expenditures with Historical Regional Expenditures*

a. CMS blends the ACO’s Historical Lookback Period PBPM Regional Rate, described in Section I.D.6 of this Appendix, with the ACO’s Historical Lookback Period PBPM Expenditures, described in Section I.D.5 of this Appendix, weighted using the applicable percentages listed in Table A of this Appendix (“**Blended Historical PBPM Expenditures for Standard ACOs**”).

b. If the ACO’s Blended Historical PBPM Expenditures for Standard ACOs exceed the ACO’s Historical Lookback Period PBPM Expenditures by more than three percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for Standard ACOs equal to the ACO’s Historical Lookback Period PBPM Expenditures plus three percent of the Adjusted FFS USPCC for the Performance Year.

c. If the ACO’s Blended Historical PBPM Expenditures for Standard ACOs are less than the ACO’s Historical Lookback Period PBPM

Expenditures by more than two percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for Standard ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures minus two percent of the Adjusted FFS USPCC for the Performance Year.

d. CMS divides the Blended Historical PBPM Expenditures for Standard ACOs by the ACO's Historical Lookback Period PBPM Regional Rate, described in Section I.D.6 of this Appendix ("**Voluntarily Aligned Regional Rate Adjustment Factor**").

9. *Calculation of A&D Beneficiary Voluntarily-Aligned Benchmark and ESRD Beneficiary Voluntarily-Aligned Benchmark*

a. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live ("**Performance Year PBPM Voluntarily-Aligned Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Voluntarily-Aligned Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Voluntarily-Aligned Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

b. CMS multiplies the Voluntarily Aligned Regional Rate Adjustment Factor by the ACO's Performance Year PBPM Voluntarily-Aligned Regional Rate ("**Risk-Standardized PBPM Voluntarily-Aligned Benchmark**").

c. CMS multiplies the Risk-Standardized PBPM Voluntarily-Aligned Benchmark by the number of Voluntarily-Aligned Beneficiary Months ("**Risk-Standardized Total Voluntarily-Aligned Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Voluntarily Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the

Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Voluntarily Aligned Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary aligned to the ACO via Voluntary Alignment was an Alignment-Eligible Beneficiary.

d. CMS multiplies the Risk-Standardized Total Voluntarily-Aligned Benchmark by the Standard Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score and the Standard Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned via Voluntary Alignment ("**A&D Beneficiary Voluntarily-Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Voluntary Alignment ("**ESRD Beneficiary Voluntarily-Aligned Benchmark**").

E. Calculation of the Total Unadjusted Performance Year Benchmark

1. CMS sums together the A&D Beneficiary Claims-Aligned Benchmark and the A&D Beneficiary Voluntarily Aligned Benchmark to determine the total benchmark for A&D REACH Beneficiaries (**"Total Unadjusted A&D Benchmark"**). CMS multiplies the Total Unadjusted A&D Benchmark by the applicable retrospective trend adjustment for A&D Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix), if any (**"Total A&D Benchmark"**). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

2. CMS sums together the ESRD Beneficiary Claims-Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark to determine the total benchmark for ESRD REACH Beneficiaries (**"Total Unadjusted ESRD Benchmark"**). CMS multiplies the Total Unadjusted ESRD Benchmark by the applicable retrospective trend adjustment for ESRD Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix), if any ("**Total ESRD Benchmark**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

3. CMS sums together the Total A&D Benchmark and the Total ESRD Benchmark to determine the total unadjusted benchmark for all REACH Beneficiaries (**"Total Unadjusted Performance Year Benchmark"**).

4. *Retrospective Trend Adjustment*

a. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted A&D Benchmark if CMS determines there is a greater than 1% difference between the Adjusted USPCC Trend for A&D Beneficiaries calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year and the observed trend in Medicare FFS expenditure growth among the A&D Beneficiary subpopulation of the ACO REACH National Reference Population for the Performance Year. For Performance Year 2024 and each subsequent Performance Year, any such adjustment to the Total Unadjusted A&D Benchmark is subject to symmetric risk corridors as specified in this paragraph and excludes SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, from calculations.

i. If CMS retroactively modifies the Total Unadjusted A&D Benchmark in accordance with this Section I.E.4(a), CMS calculates the trend adjustment ("**Retrospective Trend Adjustment for A&D Beneficiaries**"):

(a) By dividing the observed trend in the ACO REACH National Reference Population for A&D Beneficiaries by the Adjusted USPCC Trend for A&D Beneficiaries ("**Preconstrained Retrospective Trend Adjustment for A&D Beneficiaries**"); and

(b) By applying the risk corridors specified in Table B of this Appendix to determine the maximum amount of the modification to the ACO's Total Unadjusted A&D Benchmark.

Table B: Retrospective Trend Adjustment Risk Corridors

Risk Band	Percent Impact of Preconstrained Retrospective Trend Adjustment to the ACO's Benchmark	Portion of Impact Applied to the ACO's Benchmark
Corridor 1	+/- 0 – 4% of Benchmark	100%
Corridor 2	+/- 4 – 8% of Benchmark	50%
Corridor 3	Greater than +/- 8% of Benchmark	0%

b. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted ESRD Benchmark if CMS determines there is a greater than 1% difference between the Adjusted USPCC Trend calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year for ESRD Beneficiaries and the observed trend in Medicare FFS expenditure

growth among the ESRD Beneficiary subpopulation of the ACO REACH National Reference Population for the Performance Year. For Performance Year 2024 and each subsequent Performance Year, any such adjustment to the Total Unadjusted ESRD Benchmark is subject to symmetric risk corridors as specified in this paragraph and excludes SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, from calculations.

i. If CMS retroactively modifies the Total Unadjusted ESRD Benchmark in accordance with this Section I.E.4(b), CMS calculates the trend adjustment **("Retrospective Trend Adjustment for ESRD Beneficiaries"):**

(a) By dividing the observed trend in the ACO REACH National Reference Population for ESRD Beneficiaries by the Adjusted USPCC Trend for ESRD Beneficiaries **("Preconstrained Retrospective Trend Adjustment for ESRD Beneficiaries")**; and

(b) By applying the risk corridors specified in Table B of this Appendix to determine the maximum amount of the modification to the ACO's Total Unadjusted ESRD Benchmark.

c. Except as specified in Section I.E.4(f) or Section I.E.4(g) of this Appendix, CMS will not apply a retroactive trend adjustment in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, in the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year.

d. CMS may apply the Placeholder Retrospective Trend Adjustment for A&D Beneficiaries (as described and calculated in accordance with this Section I.E.4(f)) in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year if CMS determines, at its sole discretion, that subsequent updates to the FFS USPCC in OACT publications issued after CMS has published the ACO REACH/KCC Rate Book for the Performance Year indicate that CMS will likely apply the Retrospective Trend Adjustment for A&D Beneficiaries pursuant to Section I.E.4(a) of this Appendix. CMS divides the Revised Adjusted USPCC Trend for A&D Beneficiaries, calculated using the updated FFS USPCC, by the Adjusted USPCC Trend for A&D Beneficiaries published by CMS prior to the publication of the ACO REACH/KCC Rate Book for

the Performance Year ("Placeholder Retrospective Trend Adjustment for A&D Beneficiaries")

e. CMS may apply the Placeholder Retrospective Trend Adjustment for ESRD Beneficiaries (as described and calculated in accordance with this Section I.E.4(g)) in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year if CMS determines, at its sole discretion, that OACT publications of the FFS USPCC issued after CMS has published the ACO REACH/KCC Rate Book for the Performance Year indicate that CMS will likely apply the Retrospective Trend Adjustment for ESRD Beneficiaries pursuant to Section I.E.4(b) of this Appendix. CMS divides the Revised Adjusted USPCC Trend for ESRD Beneficiaries, calculated using the updated FFS USPCC, by the Adjusted USPCC Trend for ESRD Beneficiaries published by CMS prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year ("**Placeholder Retrospective Trend Adjustment for ESRD Beneficiaries**").

II. Total Unadjusted Performance Year Benchmark Methodology for a New Entrant ACO

A. CMS calculates the ACO's Total Unadjusted Performance Year Benchmark for any Performance Year in accordance with this Section II if the ACO is a New Entrant ACO for the Performance Year.

B. For Performance Years 2023 and 2024, if the ACO is described in Section II.A of this Appendix, CMS calculates the Total Unadjusted Performance Year Benchmark as the sum of the Total A&D Benchmark (equal to the Total Unadjusted A&D Benchmark calculated as described in this Section II.B, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section II.E of this Appendix) and the Total ESRD Benchmark (equal to the Total Unadjusted ESRD Benchmark calculated as described in this Section II.B, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section II.E of this Appendix). CMS calculates the Total Unadjusted A&D Benchmark and the Total Unadjusted ESRD Benchmark using the steps outlined in this Section II.B. CMS performs each of the steps described in this Section II.B separately A&D Beneficiaries and ESRD Beneficiaries.

1. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries live ("**Performance Year PBPM Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries live, weighted by the

number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement report for Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries live, weighted by the number of months of the applicable reporting period during which each Beneficiary was an Alignment-Eligible Beneficiary.

2. CMS then determines the number of months of the Performance Year during which REACH Beneficiaries aligned to the ACO were Alignment-Eligible Beneficiaries ("**Beneficiary Months**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Beneficiary Months is equal to the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and the settlement reports for Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Beneficiary Months as the number of months of the relevant reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

3. CMS multiplies the Performance Year PBPM Regional Rate by the number of Beneficiary Months (**"Risk-Standardized Total Benchmark**").

4. CMS multiplies the Risk-Standardized Total Benchmark by the New Entrant A&D Beneficiary Average Risk Score and the New Entrant ESRD Beneficiary Average Risk Score, respectively (as defined and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned to the ACO ("**Total Unadjusted A&D Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO ("**Total Unadjusted ESRD Benchmark**").

5. CMS may adjust the Total Unadjusted Performance Year Benchmark Methodology for a New Entrant ACO to account for or exclude, as applicable, expenditures for REACH Beneficiaries associated with an overlapping model, including the GUIDE Model.

C. For Performance Years 2025-2026, if the ACO is described in Section II.A of this Appendix, CMS calculates the Total Unadjusted Performance Year Claims-Aligned Benchmark as the sum of the Total A&D Benchmark (equal to the Total Unadjusted A&D Claims-Aligned Benchmark calculated as described in this Section II.C, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section II.E of this Appendix) and the Total ESRD Claims-Aligned Benchmark (equal to the Total Unadjusted ESRD Benchmark calculated as described in this Section II.C, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section II.E of this Appendix). CMS calculates the Total Unadjusted A&D Claims-Aligned Benchmark and the Total Unadjusted ESRD Benchmark using the steps outlined in Section II.C.1 of this Appendix.

CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

1. *General*

   a. Calculate historical baseline expenditures in accordance with Section II.C.2 of this Appendix;

   b. Risk-standardize historical baseline expenditures in accordance with Section II.C.3 of this Appendix;

   c. Apply a prospective trend and GAF adjustment to the risk-standardized historical baseline expenditures in accordance with Section II.C.4 of this Appendix;

   d. Calculate historical regional expenditures in accordance with Section II.C.5 of this Appendix;

   e. Blend risk-standardized, trended, and GAF-adjusted historical baseline expenditures with historical regional expenditures in accordance with Section II.C.6 of this Appendix;

   f. Calculate the A&D Beneficiary Claims-Aligned Benchmark and the ESRD Beneficiary Claims-Aligned Benchmark (each defined and calculated in accordance with Section II.C.7 of this Appendix);

2. *Historical Base Year Expenditures*

   a. For Performance Years 2025 and 2026, prior to the start of the Performance Year, CMS calculates the ACO's historical baseline expenditures separately for each of Base Year Four (2021), Base Year Five (2022), and Base Year Six (2023) (each a "**Historical Base Year**" and collectively the "**Historical Lookback Period**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

   b. CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each Beneficiary who would have been aligned to the ACO during the applicable Historical Base Year using the Claims-Based Alignment methodology described in Section II of Appendix A and the Participant Provider List for the Performance Year described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, during each month of the Historical Base Year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year Expenditure**").

   c. CMS divides the Historical Base Year Expenditure for each Historical Base Year by the total number of months in which all Beneficiaries who would have been aligned to the ACO during that

Historical Base Year via Claims-Based Alignment, as described in Section II.C.2(b) of this Appendix, were Alignment-Eligible Beneficiaries during that Historical Base Year ("**Historical Base Year PBPM Expenditure**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

3. *SAHS Billing Activity Exclusion*

Notwithstanding Appendix B for an applicable prior Performance Year, for Performance Year 2024 and subsequent Performance Years, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) and any services that CMS determined, for a specified Base Year, constitute significant, anomalous, and highly suspect billing activity ("**SAHS Billing Activity**"), including intermittent urinary catheters (identified by HCPCS codes A4352 and A4353) (for Base Year Six). In addition, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) that were rendered in calendar years 2021 and 2022. CMS reserves the right to determine that additional services constitute SAHS Billing Activity; any such determination shall be set forth by CMS in guidance for a Performance Year prior to Final Financial Settlement for the Performance Year.

4. Risk-Standardization of Historical Base Year PBPM Expenditure

a. CMS calculates a risk score for each Beneficiary whose expenditures were included in the Historical Base Year PBPM Expenditure calculation for each Historical Base Year in accordance with the applicable risk score methodology outlined in Section IV.A of this Appendix. For each Historical Base Year, CMS then calculates the average risk score for all Beneficiaries included in the Historical Base Year PBPM Expenditure calculation for that Historical Base Year, weighted by the months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary. CMS then divides the weighted average risk score for each Historical Base Year by the applicable Normalization Factor for that Historical Base Year ("**Normalized Historical Base Year Risk Score**").

b. CMS risk-standardizes the Historical Base Year PBPM Expenditure for each Historical Base Year by dividing the ACO's Historical Base Year PBPM Expenditure for the Historical Base Year by the Normalized Historical Base Year Risk Score for that Historical Base Year ("**Risk-Standardized Historical Base Year PBPM Expenditure**").

5. *Application of Prospective Trend and GAF Factors*

a. CMS applies the Adjusted USPCC Trend to the ACO's Risk-Standardized Historical Base Year PBPM Expenditure for each Historical Base Year to trend the Risk-Standardized Historical Base Year PBPM Expenditure forward to Performance Year-equivalent dollars ("**Risk-Standardized and Trended Historical Base Year PBPM Expenditures**").

b. CMS adjusts the Risk-Standardized and Trended Historical Base Year PBPM Expenditures for each Historical Base Year to reflect the anticipated impact of changes between the Historical Base Year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures**").

c. CMS calculates an average of the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for all of the three Historical Base Years, weighted as follows: For Performance Year 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Expenditures**").

d. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Expenditures. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for those Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for that Historical Base Year as the Historical Lookback Period PBPM Expenditures.

6. *Calculation of Historical Regional Expenditures*

a. Using the ACO REACH/KCC Rate Book for the relevant Performance Year, CMS calculates an average of the county-level rates for each Historical Base Year based on the counties where Beneficiaries who would have been aligned to the ACO during the applicable Historical Base Year using the Claims-Based Alignment methodology described in Section II of Appendix A and the Participant Provider List for the Performance Year described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, lived during the Historical Base Year, weighted by the

number of months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary ("Historical Base Year PBPM Regional Rate"). CMS then calculates an average of the ACO's Historical Base Year PBPM Regional Rate for the Historical Lookback Period, weighted as follows: Base Year Four (2021) is weighted 10%; Base Year Five (2022) is weighted 30%; and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Regional Rate for New Entrant and High Needs ACOs**").

b. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Historical Base Year PBPM Regional Rate for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Regional Rate for New Entrant and High Needs ACOs. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Historical Base Year PBPM Regional Rate for those two Historical Base Years, with the more recent Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Historical Base Year PBPM Regional Rate for that Historical Base Year as the Historical Lookback Period PBPM Regional Rate for New Entrant and High Needs ACOs.

7. *Blending Historical Baseline Expenditures with Historical Regional Expenditures*

a. CMS blends the ACO's Historical Lookback Period PBPM Regional Rate for New Entrant and High Needs ACOs, described in Section II.C.5 of this Appendix, with the ACO's Historical Lookback Period PBPM Expenditures described in Section II.C.4 of this Appendix, weighted using the applicable percentages listed in Table A.1 of this Appendix ("**Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs**").

Table A.1 Percentages for Weighting the Historical Lookback Period PBPM Expenditures and Historical Lookback Period PBPM Regional Rate for New Entrant and High Needs ACOs

Weighting	PY2021-2024	PY 2025, PY 2026
Historical Lookback Period PBPM Expenditures	0%	50%

Weighting	PY2021-2024	PY 2025, PY 2026
Historical Lookback Period PBPM Regional Rate	100%	50%

b. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs exceed the ACO's Historical Lookback Period PBPM Expenditures by more than five percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures plus five percent of the Adjusted FFS USPCC for the Performance Year.

c. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs are less than the ACO's Historical Lookback Period PBPM Expenditures by more than two percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures minus two percent of the Adjusted FFS USPCC for the Performance Year.

d. CMS divides the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs by the ACO's Historical Lookback Period PBPM Regional Rate, described in Section II.C.5 of this Appendix ("**Regional Rate Adjustment Factor**").

8. *Calculation of Total Unadjusted A&D Claims-Aligned Benchmark and Total Unadjusted ESRD Claims-Aligned Benchmark*

a. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries aligned to the ACO via Claims-Based Alignment live ("**Performance Year PBPM Claims-Aligned Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Claims-Aligned Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries live, weighted by the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Claims-Aligned Regional Rate as the average of the county-level rates for

the counties where REACH Beneficiaries live, weighted by the months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

b. CMS multiplies Claims-Aligned the Regional Rate Adjustment Factor by the ACO's Performance Year PBPM Claims-Aligned Regional Rate ("**Risk-Standardized PBPM** Claims-Aligned **Benchmark**").

c. CMS calculates the number of months of the Performance Year during which Beneficiaries aligned to the ACO via Claims-Based Alignment Beneficiaries were Alignment-Eligible Beneficiaries ("**Claims-Aligned Beneficiary Months**"). CMS then multiplies the Risk-Standardized PBPM Claims-Aligned Benchmark by the number of Claims-Aligned Beneficiary Months ("**Risk-Standardized Total Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Claims-Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Claims-Based Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

d. CMS multiplies the Risk-Standardized Total Claims-Aligned Benchmark by the Claims-Aligned A&D Beneficiary ACO Normalized Risk Score for New Entrant ACOs and the Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score for New Entrant ACOs, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned via Claims-Based Alignment ("**A&D Beneficiary Claims-Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Claims-Based Alignment ("**ESRD Beneficiary Claims-Aligned Benchmark**").

D. <u>Calculation of the Voluntarily Aligned Benchmarks</u>

1. For Performance Years 2025 and 2026, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark using the steps described in this Section II.D.1. CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

a. Calculate historical baseline expenditures in accordance with Section II.D.2 of this Appendix;

b. Risk-standardize historical baseline expenditures in accordance with Section II.D.3 of this Appendix;

c. Apply a prospective trend and GAF adjustment to the risk-standardized historical baseline expenditures in accordance with Section II.D.4 of this Appendix;

d. Calculate historical regional expenditures in accordance with Section II.D.5 of this Appendix;

e. Blend risk-standardized, trended, and GAF-adjusted historical baseline expenditures with historical regional expenditures in accordance with Section II.D.6 of this Appendix;

f. Notwithstanding Section II.D.1.e of this Appendix, if ACO has fewer than 500 unique voluntary aligned beneficiaries, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark pursuant to Section I.D.2.g of this Appendix solely using the historical regional expenditures calculated pursuant to Section II.D.1.d of this Appendix.

g. If the ACO has at least 500 unique voluntary aligned beneficiaries, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark in accordance with Section II.D.7 of this Appendix.

2. *Historical Base Year Expenditures*

a. For Performance Years 2025 and 2026, prior to the start of the Performance Year, CMS calculates the ACO's historical baseline expenditures separately for each of Base Year Four (2021), Base Year Five (2022), and Base Year Six (2023) (each a "**Historical Base Year**" and collectively the "**Historical Lookback Period**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

b. CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each REACH Beneficiary who was aligned to the ACO via Voluntary Alignment during the Performance Year that corresponds to the relevant Historical Base Years specified in Section II.D.3(a) of this Appendix, during each month of the Historical Base Year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year Expenditure**").

c. CMS divides the Historical Base Year Expenditure for each Historical Base Year by the total number of months in which all REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to that Historical Base Year via

Voluntary Alignment were Alignment-Eligible Beneficiaries during that Historical Base Year ("**Historical Base Year PBPM Expenditure**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

3. *SAHS Billing Activity Exclusion*

Notwithstanding Appendix B for an applicable prior Performance Year, for Performance Year 2024 and subsequent Performance Years, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) and any services that CMS determined, for a specified Base Year, constitute significant, anomalous, and highly suspect billing activity ("**SAHS Billing Activity**"), including intermittent urinary catheters (identified by HCPCS codes A4352 and A4353) (for Base Year Six). In addition, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) that were rendered in calendar years 2021 and 2022. CMS reserves the right to determine that additional services constitute SAHS Billing Activity; any such determination shall be set forth by CMS in guidance for a Performance Year prior to Final Financial Settlement for the Performance Year.

4. *Risk-Standardization of Historical Base Year PBPM Expenditure*

a. CMS calculates a risk score for each Beneficiary whose expenditures were included in the Historical Base Year PBPM Expenditure calculation for each Historical Base Year in accordance with the applicable risk score methodology outlined in Section IV.A of this Appendix. For each Historical Base Year, CMS then calculates the average risk score for all Beneficiaries included in the Historical Base Year PBPM Expenditure calculation for that Historical Base Year, weighted by the number of months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary. CMS then divides the weighted average risk score for each Historical Base Year by the applicable Normalization Factor for that Historical Base Year ("**Normalized Historical Base Year Risk Score**").

b. CMS risk-standardizes the Historical Base Year PBPM Expenditure for each Historical Base Year by dividing the ACO's Historical Base Year PBPM Expenditure for the Historical Base Year by the Normalized Historical Base Year Risk Score for that Historical Base Year ("**Risk-Standardized Historical Base Year PBPM Expenditure**").

5. *Application of Prospective Trend and GAF Factors*

a. CMS applies the Adjusted USPCC Trend to the ACO's Risk-Standardized Historical Base Year PBPM Expenditure for each Historical Base Year to trend the Risk-Standardized Historical Base Year PBPM Expenditure forward to Performance Year-equivalent dollars ("**Risk-Standardized and Trended Historical Base Year PBPM Expenditures**").

b. CMS adjusts the Risk-Standardized and Trended Historical Base Year PBPM Expenditures for each Historical Base Year to reflect the anticipated impact of changes between the Historical Base Year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures**").

c. CMS calculates an average of the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for all of the three Historical Base Years, weighted as follows: For Performance Years 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Expenditures**").

d. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Expenditures. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for those Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for that Historical Base Year as the Historical Lookback Period PBPM Expenditures.

6. *Calculation of Historical Regional Expenditures*

a. Using the ACO REACH/KCC Rate Book for the relevant Performance Year, CMS calculates an average of the county-level rates for each Historical Base Year based on the counties where REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to the applicable Historical Base Year using Voluntary Alignment lived during the Historical Base Year, weighted by the number of months of the Historical Base Year during which each REACH Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year PBPM**

Regional Rate"). CMS then calculates an average of the ACO's Historical Base Year PBPM Regional Rate for the applicable Historical Lookback Period, weighted as follows: For Performance Years 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Regional Rate"**).

b. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Historical Base Year PBPM Regional Rate for one or more the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Regional Rate. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average Historical Base Year PBPM Regional Rate for those two Historical Base Years, with the more recent Base Year weighted two-thirds and the less recent Historical Base Year weighted one- third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Historical Base Year PBPM Regional Rate for that Historical Base Year as the Historical Lookback Period PBPM Regional Rate.

c. If the ACO does not meet the 500 voluntarily aligned beneficiary minimum, described in Section II.D.1.f of this Appendix, to construct the ACO's Historical Year PBPM Regional Rate for any of the three applicable Historical Base Years, CMS will use a 100% weight of the Risk-Standardized PBPM Voluntarily Aligned Benchmark, as applied in Performance Years 2021-2024, described in Section II.D.1 of this Appendix.

7. *Blending Historical Baseline Expenditures with Historical Regional Expenditures*

a. CMS blends the ACO's Historical Lookback Period PBPM Regional Rate, described in Section II.D.5 of this Appendix, with the ACO's Historical Lookback Period PBPM Expenditures, described in Section II.D.4 of this Appendix, weighted using the applicable percentages listed in Table A.1 of this Appendix ("**Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs**").

a. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs exceed the ACO's Historical Lookback Period PBPM Expenditures by more than five percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical

Lookback Period PBPM Expenditures plus five percent of the Adjusted FFS USPCC for the Performance Year.

b. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs are less than the ACO's Historical Lookback Period PBPM Expenditures by more than two percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures minus two percent of the Adjusted FFS USPCC for the Performance Year.

c. CMS divides the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs by the ACO's Historical Lookback Period PBPM Regional Rate, described in Section II.D.6 of this Appendix ("**Voluntarily Aligned Regional Rate Adjustment Factor**").

8. *Calculation of A&D Beneficiary Voluntarily-Aligned Benchmark and ESRD Beneficiary Voluntarily-Aligned Benchmark*

a. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live ("**Performance Year PBPM Voluntarily-Aligned Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Voluntarily-Aligned Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Voluntarily-Aligned Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

b. CMS multiplies the Voluntarily Aligned Regional Rate Adjustment Factor by the ACO's Performance Year PBPM Voluntarily-Aligned Regional Rate ("**Risk-Standardized PBPM Voluntarily-Aligned Benchmark**").

c. CMS multiplies the Risk-Standardized PBPM Voluntarily-Aligned Benchmark by the number of Voluntarily-Aligned Beneficiary

Months ("**Risk-Standardized Total Voluntarily-Aligned Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Voluntarily Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Voluntarily Aligned Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary aligned to the ACO via Voluntary Alignment was an Alignment-Eligible Beneficiary.

d. CMS multiplies the Risk-Standardized Total Voluntarily-Aligned Benchmark by the Standard Voluntarily Aligned A&D Beneficiary ACO Normalized New Entrant Score and the New Entrant Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned via Voluntary Alignment ("**A&D Beneficiary Voluntarily-Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Voluntary Alignment ("**ESRD Beneficiary Voluntarily-Aligned Benchmark**").

E. Calculation of the Total Unadjusted Performance Year Benchmark

1. *General*

a. CMS multiplies the Total Unadjusted A&D Benchmark calculated in accordance with Section II.B or Section II.C of this Appendix, as applicable, by the applicable retrospective trend adjustment for A&D Beneficiaries (calculated in accordance with Section II.E.2 of this Appendix), if any ("**Total A&D Benchmark**").

b. CMS multiplies the Total Unadjusted ESRD Benchmark calculated in accordance with Section II.B or Section II.C of this Appendix, as applicable, by the applicable retrospective trend adjustment for ESRD Beneficiaries (calculated in accordance with Section II.E.2 of this Appendix), if any ("**Total ESRD Benchmark**").

c. CMS sums together the Total A&D Benchmark and the Total ESRD Benchmark to determine the total unadjusted benchmark for all REACH Beneficiaries (**"Total Unadjusted Performance Year Benchmark"**).

2. *Retrospective Trend Adjustment*

a. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted A&D

Benchmark if CMS determines there is a greater than 1% difference between the Adjusted USPCC Trend for A&D Beneficiaries calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year and the observed trend in Medicare FFS expenditure growth among the A&D Beneficiary subpopulation of the ACO REACH National Reference Population for the Performance Year. For Performance Year 2024 and each subsequent Performance Year, any such adjustment to the Total Unadjusted A&D Benchmark is subject to symmetric risk corridors as specified in this paragraph and excludes SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, from calculations.

i. If CMS retroactively modifies the Total Unadjusted A&D Benchmark in accordance with this Section II.E.2(a), CMS calculates the trend adjustment ("Retrospective Trend Adjustment for A&D Beneficiaries"):

(a) By dividing the observed trend in the ACO REACH National Reference Population for A&D Beneficiaries by the Adjusted USPCC Trend for A&D Beneficiaries ("**Preconstrained Retrospective Trend Adjustment for A&D Beneficiaries**"); and

(b) By applying the risk corridors specified in Table B of this Appendix to determine the maximum amount of the modification to the ACO's Total Unadjusted A&D Benchmark.

b. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted ESRD Benchmark if CMS determines there is a greater than 1% difference between the Adjusted USPCC Trend calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year for ESRD Beneficiaries and the observed trend in Medicare FFS expenditure growth among the ESRD Beneficiary subpopulation of the ACO REACH National Reference Population for the Performance Year. For Performance Year 2024 and each subsequent Performance Year, any such adjustment to the Total Unadjusted ESRD Benchmark is subject to symmetric risk corridors as specified in this paragraph and excludes SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, from calculations.

i. If CMS retroactively modifies the Total Unadjusted ESRD Benchmark in accordance with this Section II.E.2(b), CMS

calculates the trend adjustment (“Retrospective Trend Adjustment for ESRD Beneficiaries”):

(a) By dividing the observed trend in the ACO REACH National Reference Population for ESRD Beneficiaries by the Adjusted USPCC Trend for ESRD Beneficiaries (“**Preconstrained Retrospective Trend Adjustment for ESRD Beneficiaries**”); and

(b) By applying the risk corridors specified in Table B of this Appendix to determine the maximum amount of the modification to the ACO’s Total Unadjusted ESRD Benchmark.

c. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted A&D Benchmark by applying the Alternative Retrospective Trend Adjustment for A&D Beneficiaries (as described and calculated in accordance with this Section II.E.2(c)) if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change or other similarly unforeseen circumstance during the Performance Year renders the Adjusted USPCC Trend for A&D Beneficiaries invalid in the ACO’s Service Area described in Section 5.04.H of the Agreement. CMS calculates the observed trend in Medicare FFS expenditure growth among A&D Beneficiaries in the ACO REACH National Reference Population for the Performance Year who reside in the counties in which REACH Beneficiaries live, weighted by the number of months of the Performance Year during which each such Beneficiary was an Alignment-Eligible Beneficiary (“Observed Regional Trend for A&D Beneficiaries”). CMS then divides the Observed Regional Trend for A&D Beneficiaries by the Adjusted USPCC Trend for A&D Beneficiaries (“Alternative Retrospective Trend Adjustment for A&D Beneficiaries”).

d. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted ESRD Benchmark by applying the Alternative Retrospective Trend Adjustment for ESRD Beneficiaries (as described and calculated in accordance with this Section II.D.2(d)) if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change or other similarly unforeseen circumstance during the Performance Year renders the Adjusted USPCC Trend for ESRD Beneficiaries invalid in the ACO’s Service Area described in Section 5.04.H of the Agreement. CMS calculates the observed trend in Medicare FFS expenditure growth among ESRD Beneficiaries in the ACO REACH National

Reference Population for the Performance Year who reside in the counties in which REACH Beneficiaries live, weighted by the number of months of the Performance Year during which each such Beneficiary was an Alignment-Eligible Beneficiary ("Observed Regional Trend for ESRD Beneficiaries"). CMS then divides the Observed Regional Trend for ESRD Beneficiaries by the Adjusted USPCC Trend for ESRD Beneficiaries ("Alternative Retrospective Trend Adjustment for ESRD Beneficiaries").

e. Except as specified in Section II.E.1(f) or Section II.E.1(g) of this Appendix, CMS will not apply a retroactive trend adjustment in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, in the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year.

f. CMS may apply the Placeholder Retrospective Trend Adjustment for A&D Beneficiaries (as described and calculated in accordance with this Section II.E.2(f)) in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year if CMS determines, at its sole discretion, that subsequent updates to the FFS USPCC in OACT publications issued after CMS has published the ACO REACH/KCC Rate Book for the Performance Year indicate that CMS will likely apply the Retrospective Trend Adjustment for A&D Beneficiaries pursuant to Section II.E.2(a) of this Appendix. CMS divides the Revised Adjusted USPCC Trend for A&D Beneficiaries, calculated using the updated FFS USPCC, by the Adjusted USPCC Trend for A&D Beneficiaries published by CMS prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year ("**Placeholder Retrospective Trend Adjustment for A&D Beneficiaries**").

g. CMS may apply the Placeholder Retrospective Trend Adjustment for ESRD Beneficiaries (as described and calculated in accordance with this Section II.E.2(g)) in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year if CMS determines, at its sole discretion, that OACT publications of the FFS USPCC issued after CMS has published the ACO REACH/KCC Rate Book for the Performance Year indicate that CMS will likely apply the Retrospective Trend Adjustment for ESRD Beneficiaries pursuant to Section II.E.2(b) of this Appendix. CMS divides the Revised Adjusted USPCC Trend for ESRD Beneficiaries, calculated using

the updated FFS USPCC, by the Adjusted USPCC Trend for ESRD Beneficiaries published by CMS prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year ("**Placeholder Retrospective Trend Adjustment for ESRD Beneficiaries**").

III. Total Unadjusted Performance Year Benchmark Methodology for a High Needs Population ACO

A. CMS calculates the ACO's Total Unadjusted Performance Year Benchmark for a Performance Year in accordance with this Section III of this Appendix if the ACO is a High Needs Population ACO.

B. For Performance Years 2025 and 2026, if the ACO is a High Needs Population ACO, CMS calculates the Total Unadjusted Performance Year Benchmark as the sum of the Total A&D Benchmark (equal to the Total Unadjusted A&D Benchmark calculated as described in this Section III.B, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section III.E of this Appendix) and the Total ESRD Benchmark (equal to the Total Unadjusted ESRD Benchmark calculated as described in this Section III.B, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section III.E of this Appendix). CMS calculates the Total Unadjusted A&D Benchmark and the Total Unadjusted ESRD Benchmark using the steps outlined in this Section III.B. CMS performs each of the steps described in this Section III.B separately for A&D Beneficiaries and ESRD Beneficiaries.

1. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries live ("**Performance Year PBPM Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries live, weighted by the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement report for Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries live, weighted by the number of months of the applicable reporting period during which each Beneficiary was an Alignment-Eligible Beneficiary.

2. CMS then determines the number of months of the Performance Year during which REACH Beneficiaries aligned to the ACO were Alignment-Eligible Beneficiaries ("**Beneficiary Months**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Beneficiary Months is equal to the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and the settlement reports for

Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Beneficiary Months as the number of months of the relevant reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

3. CMS multiplies the Performance Year PBPM Regional Rate by the number of Beneficiary Months ("**Risk-Standardized Total Benchmark**").

4. CMS multiplies the Risk-Standardized Total Benchmark by the High Needs A&D Beneficiary ACO Normalized Risk Score and the High Needs ESRD Beneficiary ACO Normalized Risk Score, respectively (as described and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned to the ACO ("**Total Unadjusted A&D Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO ("**Total Unadjusted ESRD Benchmark**").

5. CMS may adjust the Total Unadjusted Performance Year Benchmark Methodology for a High Needs Population ACO to account for or exclude, as applicable, expenditures for REACH Beneficiaries associated with an overlapping model, including the GUIDE Model.

C. For Performance Years 2025 and 2026, if the ACO is described in Section III.A of this Appendix, CMS calculates the Total Unadjusted Performance Year Claims-Aligned Benchmark as the sum of the Total A&D Claims-Aligned Benchmark (equal to the Total Unadjusted A&D Claims-Aligned Benchmark calculated as described in this Section III.C, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section III.E of this Appendix) and the Total ESRD Claims-Aligned Benchmark (equal to the Total Unadjusted ESRD Claims-Aligned Benchmark calculated as described in this Section III.C, adjusted by the applicable retrospective trend adjustment for A&D Beneficiaries, if any, calculated in accordance with Section III.E of this Appendix). CMS calculates the Total Unadjusted A&D Claims-Aligned Benchmark and the Total Unadjusted ESRD Claims-Aligned Benchmark using the steps outlined in Section III.C.1 of this Appendix. CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

1. *General*

a. Calculate historical baseline expenditures in accordance with Section III.C.2 of this Appendix;

b. Risk-standardize historical baseline expenditures in accordance with Section III.C.3 of this Appendix;

c. Apply a prospective trend and GAF adjustment to the risk-standardized historical baseline expenditures in accordance with Section III.C.4 of this Appendix;

d. Calculate historical regional expenditures in accordance with Section III.C.5 of this Appendix;

e. Blend risk-standardized, trended, and GAF-adjusted historical baseline expenditures with historical regional expenditures in accordance with Section III.C.6 of this Appendix;

f. Calculate the A&D Beneficiary Claims-Aligned Benchmark and the ESRD Beneficiary Claims-Aligned Benchmark (each as defined and calculated in accordance with Section III.C.7 of this Appendix);

2. *Historical Base Year Expenditures*

a. For Performance Year 2025 and 2026, prior to the start of the Performance Year, CMS calculates the ACO's historical baseline expenditures separately for each of Base Year Four (2021), Base Year Five (2022), and Base Year Six (2023) (each a "**Historical Base Year**" and collectively the "**Historical Lookback Period**").

b. CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to Beneficiary who would have been aligned to the ACO during the applicable Historical Base Year using the Claims-Based Alignment methodology described in Section II of Appendix A and the Participant Provider List for the Performance Year described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, during each month of the Historical Base Year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year Expenditure**").

c. CMS divides the Historical Base Year Expenditure for each Historical Base Year by the total number of months in which all REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to that Historical Base Year were Alignment-Eligible Beneficiaries during that Historical Base Year ("**Historical Base Year PBPM Expenditure**").

3. *SAHS Billing Activity Exclusion*

Notwithstanding Appendix B for an applicable prior Performance Year, for Performance Year 2024 and subsequent Performance Years, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) and any services that CMS determined, for a specified Base Year, constitute significant, anomalous, and highly suspect billing activity ("**SAHS Billing Activity**"), including intermittent urinary catheters (identified by HCPCS codes A4352 and A4353) (for Base Year Six). In addition, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) that were rendered in calendar years 2021 and 2022. CMS reserves the right to determine that additional services constitute SAHS Billing Activity; any such determination shall be

set forth by CMS in guidance for a Performance Year prior to Final Financial Settlement for the Performance Year.

4. *Risk-Standardization of Historical Base Year PBPM Expenditure*

   a. CMS calculates a risk score for each Beneficiary whose expenditures were included in the Historical Base Year PBPM Expenditure calculation for each Historical Base Year in accordance with the applicable risk score methodology outlined in Section IV.A of this Appendix. For each Historical Base Year, CMS then calculates the average risk score for all Beneficiaries included in the Historical Base Year PBPM Expenditure calculation for that Historical Base Year, weighted by the months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary. CMS then divides the weighted average risk score for each Historical Base Year by the applicable Normalization Factor for that Historical Base Year ("**Normalized Historical Base Year Risk Score**").

   b. CMS risk-standardizes the Historical Base Year PBPM Expenditure for each Historical Base Year by dividing the ACO's Historical Base Year PBPM Expenditure for the Historical Base Year by the Normalized Historical Base Year Risk Score for that Historical Base Year ("**Risk-Standardized Historical Base Year PBPM Expenditure**").

5. *Application of Prospective Trend and GAF Factors*

   1. CMS applies the Adjusted USPCC Trend to the ACO's Risk-Standardized Historical Base Year PBPM Expenditure for each Historical Base Year to trend the Risk-Standardized Historical Base Year PBPM Expenditure forward to Performance Year-equivalent dollars ("**Risk-Standardized and Trended Historical Base Year PBPM Expenditures**").

   2. CMS adjusts the Risk-Standardized and Trended Historical Base Year PBPM Expenditures for each Historical Base Year to reflect the anticipated impact of changes between the Historical Base Year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures**").

   3. CMS calculates an average of the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for all of the three Historical Base Years, weighted as follows: For Performance Year 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six(2023) is weighted 60%; For Performance Year 2026, Base Year Five (2022) is weighted 10%, Base Year Six (2023) is weighted 30%, and Base Year Seven (2024) is weighted 60% ("**Historical Lookback Period PBPM Expenditures**").

4. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Expenditures. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for those Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for that Historical Base Year as the Historical Lookback Period PBPM Expenditures

6. *Calculation of Historical Regional Expenditures*

a. Using the ACO REACH/KCC Rate Book for the relevant Performance Year, CMS calculates an average of the county-level rates for each Historical Base Year based on the counties where Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to the applicable Historical Base Year lived during the Historical Base Year, weighted by the months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year PBPM Regional Rate**"). CMS then calculates an average of the ACO's Historical Base Year PBPM Regional Rate for the applicable Historical Lookback Period, weighted as follows: For Performance Year 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60%; ("**Historical Lookback Period PBPM Regional Rate"**).

b. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Historical Base Year PBPM Regional Rate for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Regional Rate. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Historical Base Year PBPM Regional Rate for those two Historical Base Years, with the more recent Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Historical Base Year PBPM Regional Rate for that Historical Base Year as the Historical Lookback Period PBPM Regional Rate.

7. *Blending Historical Baseline Expenditures with Historical Regional Expenditures*

a. CMS blends the ACO's Historical Lookback Period PBPM Regional Rate, described in Section III.C.5 of this Appendix, with the ACO's Historical Lookback Period PBPM Expenditures described in Section III.C.4 of this Appendix, weighted using the applicable percentages listed in Table A.1 of this Appendix ("**Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs**").

b. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs exceed the ACO's Historical Lookback Period PBPM Expenditures by more than nine percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures plus nine percent of the Adjusted FFS USPCC for the Performance Year.

c. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs are less than the ACO's Historical Lookback Period PBPM Expenditures by more than two percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures minus two percent of the Adjusted FFS USPCC for the Performance Year.

d. CMS divides the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs by the ACO's Historical Lookback Period PBPM Regional Rate, described in Section III.C.5 of this Appendix, ("**Claims-Aligned Regional Rate Adjustment Factor**").

8. *Calculation of Total Unadjusted A&D Benchmark and Total Unadjusted ESRD Benchmark*

a. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries aligned to the ACO via either Claims-Based Alignment or Voluntary Alignment live ("**Performance Year PBPM Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries live, weighted by the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly

Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries live, weighted by the months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

b. CMS multiplies the Regional Rate Adjustment Factor by the ACO's Performance Year PBPM Regional Rate ("**Risk-Standardized PBPM Benchmark**").

c. CMS calculates the number of months during which Beneficiaries aligned to the ACO via Claims-Based Alignment were Alignment-Eligible Beneficiaries ("**Claims-Aligned Beneficiary Months**"). CMS then multiplies the Risk-Standardized PBPM Claims-Aligned Benchmark by the number of Claims-Aligned Beneficiary Months ("**Risk-Standardized Total Claims-Aligned Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Claims-Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Claims-Based Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Claims-Aligned Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary aligned to the ACO via Claims-Based Alignment was an Alignment-Eligible Beneficiary.

d. CMS multiplies the Risk-Standardized Total Claims-Aligned Benchmark by the High Needs Claims-Aligned A&D Beneficiary ACO Normalized Risk Score and the High Needs Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned via Claims-Based Alignment ("**A&D Beneficiary Claims-Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Claims-Based Alignment ("**ESRD Beneficiary Claims-Aligned Benchmark**").

D. Calculation of the Voluntarily Aligned Benchmarks

1. For Performance Years 2025 and 2026, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark using the steps described in this Section III.D.1. CMS performs each of these steps separately for A&D Beneficiaries and ESRD Beneficiaries.

a. Calculate historical baseline expenditures in accordance with Section III.D.2 of this Appendix;

b. Risk-standardize historical baseline expenditures in accordance with Section III.D.3 of this Appendix;

c. Apply a prospective trend and GAF adjustment to the risk-standardized historical baseline expenditures in accordance with Section III.D.4 of this Appendix;

d. Calculate historical regional expenditures in accordance with Section III.D.5 of this Appendix;

e. Blend risk-standardized, trended, and GAF-adjusted historical baseline expenditures with historical regional expenditures in accordance with Section III.D.6 of this Appendix;

f. Notwithstanding Section III.D.2.e of this Appendix, if ACO has fewer than 250 unique voluntary aligned beneficiaries, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark pursuant to Section III.D.2.g of this Appendix solely using the historical regional expenditures calculated pursuant to Section III.D.2.d of this Appendix.

g. If the ACO has at least 250 unique voluntary aligned beneficiaries, CMS calculates the A&D Beneficiary Voluntarily Aligned Benchmark and the ESRD Beneficiary Voluntarily Aligned Benchmark in accordance with Section III.D.7 of this Appendix

2. *Historical Base Year Expenditures*

a. For Performance Years 2025 and 2026, prior to the start of the Performance Year, CMS calculates the ACO's historical baseline expenditures separately for each of Base Year Four (2021), Base Year Five (2022), and Base Year Six (2023) (each a "**Historical Base Year**" and collectively the "**Historical Lookback Period**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

b. CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each REACH Beneficiary who was aligned to the ACO via Voluntary Alignment during the Performance Year that corresponds to the relevant Historical Base Years specified in Section III.D.3(a) of this Appendix, during each month of the Historical Base Year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year Expenditure**").

c. CMS divides the Historical Base Year Expenditure for each Historical Base Year by the total number of months in which all REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to that Historical Base Year via Voluntary Alignment were Alignment-Eligible Beneficiaries during that Historical Base Year ("**Historical Base Year PBPM Expenditure**"). To account for Base Year Four consisting of a Performance Year with nine months, the Benchmark for Base Year Four will be computed using the Base Year Voluntary Aligned population pre-eligibility and applying full year eligibility checks on the population.

3. SAHS *Billing Activity Exclusion*

Notwithstanding Appendix B for an applicable prior Performance Year, for Performance Year 2024 and subsequent Performance Years, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) and any services that CMS determined, for a specified Base Year, constitute significant, anomalous, and highly suspect billing activity ("**SAHS Billing Activity**"), including intermittent urinary catheters (identified by HCPCS codes A4352 and A4353) (for Base Year Six). In addition, CMS shall exclude from the calculation of the Historical Base Year Expenditures Covid-19 Over the Counter (OTC) Tests (identified by HCPCS code K1034) that were rendered in calendar years 2021 and 2022. CMS reserves the right to determine that additional services constitute SAHS Billing Activity; any such determination shall be set forth by CMS in guidance for a Performance Year prior to Final Financial Settlement for the Performance Year.

4. *Risk-Standardization of Historical Base Year PBPM Expenditure*

a. CMS calculates a risk score for each Beneficiary whose expenditures were included in the Historical Base Year PBPM Expenditure calculation for each Historical Base Year in accordance with the applicable risk score methodology outlined in Section IV.A of this Appendix. For each Historical Base Year, CMS then calculates the average risk score for all Beneficiaries included in the Historical Base Year PBPM Expenditure calculation for that Historical Base Year, weighted by the number of months of the Historical Base Year during which each Beneficiary was an Alignment-Eligible Beneficiary. CMS then divides the weighted average risk score for each Historical Base Year by the applicable Normalization Factor for that Historical Base Year ("**Normalized Historical Base Year Risk Score**").

b. CMS risk-standardizes the Historical Base Year PBPM Expenditure for each Historical Base Year by dividing the ACO's Historical Base Year PBPM Expenditure for the Historical Base Year by the Normalized Historical Base Year Risk Score for that

Historical Base Year ("**Risk-Standardized Historical Base Year PBPM Expenditure**").

5. *Application of Prospective Trend and GAF Factors*

   a. CMS applies the Adjusted USPCC Trend to the ACO's Risk-Standardized Historical Base Year PBPM Expenditure for each Historical Base Year to trend the Risk-Standardized Historical Base Year PBPM Expenditure forward to Performance Year-equivalent dollars ("**Risk-Standardized and Trended Historical Base Year PBPM Expenditures**").

   b. CMS adjusts the Risk-Standardized and Trended Historical Base Year PBPM Expenditures for each Historical Base Year to reflect the anticipated impact of changes between the Historical Base Year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures**").

   c. CMS calculates an average of the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for all of the three Historical Base Years, weighted as follows: For Performance Years 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Expenditures**").

   d. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Risk-Standardized, Trended, and GAF-Adjusted Historical Baseline PBPM Expenditures for one or more of the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Expenditures. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for those Base Years, with the more recent Historical Base Year weighted two-thirds and the less recent Historical Base Year weighted one-third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Risk-Standardized, Trended, and GAF-Adjusted Historical Base Year PBPM Expenditures for that Historical Base Year as the Historical Lookback Period PBPM Expenditures.

6. *Calculation of Historical Regional Expenditures*

   a. Using the ACO REACH/KCC Rate Book for the relevant Performance Year, CMS calculates an average of the county-level rates for each Historical Base Year based on the counties where REACH Beneficiaries who were aligned to the ACO during the Performance Year that corresponds to the applicable Historical

Base Year using Voluntary Alignment lived during the Historical Base Year, weighted by the number of months of the Historical Base Year during which each REACH Beneficiary was an Alignment-Eligible Beneficiary ("**Historical Base Year PBPM Regional Rate**"). CMS then calculates an average of the ACO's Historical Base Year PBPM Regional Rate for the applicable Historical Lookback Period, weighted as follows: For Performance Years 2025 and 2026, Base Year Four (2021) is weighted 10%, Base Year Five (2022) is weighted 30%, and Base Year Six (2023) is weighted 60% ("**Historical Lookback Period PBPM Regional Rate"**).

b. If CMS determines that the ACO does not have sufficient claims history to construct the ACO's Historical Base Year PBPM Regional Rate for one or more the three applicable Historical Base Years, CMS will not use such Historical Base Year(s) in the calculation of the Historical Lookback Period PBPM Regional Rate. If CMS determines that only two of the applicable Historical Base Years have sufficient claims history, CMS will average Historical Base Year PBPM Regional Rate for those two Historical Base Years, with the more recent Base Year weighted two-thirds and the less recent Historical Base Year weighted one- third. If CMS determines that only one of the applicable Historical Base Years has sufficient claims history, CMS will use the Historical Base Year PBPM Regional Rate for that Historical Base Year as the Historical Lookback Period PBPM Regional Rate.

c. If the ACO does not meet the 250 voluntarily aligned beneficiary minimum, described in Section III.D.1.f of this Appendix to construct the ACO's Historical Year PBPM Regional Rate for any of the three applicable Historical Base Years, CMS will use a 100% weight of the Risk-Standardized PBPM Voluntarily Aligned Benchmark, as applied in Performance Years 2021-2024, described in Section III.D.1 of this Appendix.

7. *Blending Historical Baseline Expenditures with Historical Regional Expenditures*

a. CMS blends the ACO's Historical Lookback Period PBPM Regional Rate, described in Section III.D.5 of this Appendix, with the ACO's Historical Lookback Period PBPM Expenditures, described in Section III.D.4 of this Appendix, weighted using the applicable percentages listed in Table A.1 of this Appendix ("**Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs**").

b. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs exceed the ACO's Historical Lookback Period PBPM Expenditures by more than nine percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year,

CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures plus nine percent of the Adjusted FFS USPCC for the Performance Year.

c. If the ACO's Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs, ACOs are less than the ACO's Historical Lookback Period PBPM Expenditures by more than two percent of the Adjusted FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year, CMS will set the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs equal to the ACO's Historical Lookback Period PBPM Expenditures minus two percent of the Adjusted FFS USPCC for the Performance Year.

d. CMS divides the Blended Historical PBPM Expenditures for New Entrant and High Needs ACOs by the ACO's Historical Lookback Period PBPM Regional Rate, described in Section III.D.6 of this Appendix ("**Voluntarily Aligned Regional Rate Adjustment Factor**").

8. *Calculation of A&D Beneficiary Voluntarily-Aligned Benchmark and ESRD Beneficiary Voluntarily-Aligned Benchmark*

d. Using the ACO REACH/KCC Rate Book for the applicable Performance Year, CMS calculates an average of the county-level rates based on the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live ("**Performance Year PBPM Voluntarily-Aligned Regional Rate**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the Performance Year PBPM Voluntarily-Aligned Regional Rate as the average of the county-level rates for the counties where Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the Performance Year PBPM Voluntarily-Aligned Regional Rate as the average of the county-level rates for the counties where REACH Beneficiaries aligned to the ACO via Voluntary Alignment live, weighted by the number of months of the applicable reporting period during which each such Beneficiary was an Alignment-Eligible Beneficiary.

e. CMS multiplies the Voluntarily Aligned Regional Rate Adjustment Factor by the ACO's Performance Year PBPM Voluntarily-Aligned Regional Rate ("**Risk-Standardized PBPM Voluntarily-Aligned Benchmark**").

f. CMS multiplies the Risk-Standardized PBPM Voluntarily-Aligned Benchmark by the number of Voluntarily-Aligned Beneficiary Months ("**Risk-Standardized Total Voluntarily-Aligned Benchmark**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the number of Voluntarily Aligned Beneficiary Months is equal to the number of Originally Aligned Beneficiaries aligned to the ACO via Voluntary Alignment. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the number of Voluntarily Aligned Beneficiary Months based on the number of months of the applicable reporting period during which each REACH Beneficiary aligned to the ACO via Voluntary Alignment was an Alignment-Eligible Beneficiary.

g. CMS multiplies the Risk-Standardized Total Voluntarily-Aligned Benchmark by the High Needs Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score and the High Needs Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, respectively (as described, defined, and calculated in accordance with Section IV.F of this Appendix) to determine a benchmark for A&D Beneficiaries aligned via Voluntary Alignment ("**A&D Beneficiary Voluntarily-Aligned Benchmark**") and a benchmark for ESRD Beneficiaries aligned to the ACO via Voluntary Alignment ("**ESRD Beneficiary Voluntarily-Aligned Benchmark**").

E. <u>Calculation of the Total Unadjusted Performance Year Benchmark</u>

1. *General*

a. CMS multiplies the Total Unadjusted A&D Benchmark calculated in accordance with Section III.B, Section III.C, or Section III.D of this Appendix, as applicable, by the applicable retrospective trend adjustment for A&D Beneficiaries (calculated in accordance with Section III.E.2 of this Appendix), if any ("**Total A&D Benchmark**").

b. CMS multiplies the Total Unadjusted ESRD Benchmark calculated in accordance with Section III.B, Section III.C, or Section III.D of this Appendix, as applicable, by the applicable retrospective trend adjustment for ESRD Beneficiaries (calculated in accordance with Section III.E.2 of this Appendix), if any ("**Total ESRD Benchmark**").

c. CMS sums together the Total A&D Benchmark and the Total ESRD Benchmark to determine the total unadjusted benchmark for all REACH Beneficiaries (**"Total Unadjusted Performance Year Benchmark"**).

2. *Retrospective Trend Adjustment*

a. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted A&D Benchmark if CMS determines there is a greater than 1% difference between the Adjusted USPCC Trend for A&D Beneficiaries calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year and the observed trend in Medicare FFS expenditure growth among the A&D Beneficiary subpopulation of the ACO REACH National Reference Population for the Performance Year. For Performance Year 2024 and each subsequent Performance Year, any such adjustment to the Total Unadjusted A&D Benchmark is subject to symmetric risk corridors as specified in this paragraph and excludes SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, from calculations.

i. If CMS retroactively modifies the Total Unadjusted A&D Benchmark in accordance with this Section III.E.2(a), CMS calculates the trend adjustment ("**Retrospective Trend Adjustment for A&D Beneficiaries**"):

a. By dividing the observed trend in the ACO REACH National Reference Population for A&D Beneficiaries by the Adjusted USPCC Trend for A&D Beneficiaries ("**Preconstrained Retrospective Trend Adjustment for A&D Beneficiaries**"); and

b. By applying the risk corridors specified in Table B of this Appendix to determine the maximum amount of the modification to the ACO's Total Unadjusted A&D Benchmark.

b. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted ESRD Benchmark if CMS determines there is a greater than 1% difference between the Adjusted USPCC Trend calculated based on the FFS USPCC available prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year for ESRD Beneficiaries and the observed trend in Medicare FFS expenditure growth among the ESRD Beneficiary subpopulation of the ACO REACH National Reference Population for the Performance Year. For Performance Year 2024 and each subsequent Performance Year, any such adjustment to the Total Unadjusted ESRD Benchmark is subject to symmetric risk corridors as specified in this paragraph and excludes SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, from calculations.

i. If CMS retroactively modifies the Total Unadjusted ESRD Benchmark in accordance with this Section III.E.2(b), CMS calculates the trend adjustment ("Retrospective Trend Adjustment for ESRD Beneficiaries"):

a. By dividing the observed trend in the ACO REACH National Reference Population for ESRD Beneficiaries by the Adjusted USPCC Trend for ESRD Beneficiaries ("Preconstrained Retrospective Trend Adjustment for ESRD Beneficiaries"); and

b. By applying the risk corridors specified in Table B of this Appendix to determine the maximum amount of the modification to the ACO's Total Unadjusted ESRD Benchmark.

c. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted A&D Benchmark by applying the Alternative Retrospective Trend Adjustment for A&D Beneficiaries (as described and calculated in accordance with this Section III.E.2(c)) if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change or other similarly unforeseen circumstance during the Performance Year renders the Adjusted USPCC Trend for A&D Beneficiaries invalid in the ACO's Service Area described in Section 5.04.H of the Agreement. CMS calculates the observed trend in Medicare FFS expenditure growth among A&D Beneficiaries in the ACO REACH National Reference Population for the Performance Year who reside in the counties in which REACH Beneficiaries live, weighted by the number of months of the Performance Year during which each such Beneficiary was an Alignment-Eligible Beneficiary ("**Observed Regional Trend for A&D Beneficiaries**"). CMS then divides the Observed Regional Trend for A&D Beneficiaries by the Adjusted USPCC Trend for A&D Beneficiaries ("**Alternative Retrospective Trend Adjustment for A&D Beneficiaries**").

d. For purposes of the Performance Year Benchmark reported in the settlement report for Final Financial Settlement, CMS may, at its sole discretion, retroactively modify the Total Unadjusted ESRD Benchmark by applying the Alternative Retrospective Trend Adjustment for ESRD Beneficiaries (as described and calculated in accordance with this Section III.E.2(d)) if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change or other similarly unforeseen circumstance during the Performance Year renders the Adjusted USPCC Trend for ESRD Beneficiaries invalid in the ACO's Service Area described in Section 5.04.H of the Agreement. CMS

calculates the observed trend in Medicare FFS expenditure growth among ESRD Beneficiaries in the ACO REACH National Reference Population for the Performance Year who reside in the counties in which REACH Beneficiaries live, weighted by the number of months of the Performance Year during which each such Beneficiary was an Alignment-Eligible Beneficiary ("**Observed Regional Trend for ESRD Beneficiaries**"). CMS then divides the Observed Regional Trend for ESRD Beneficiaries by the Adjusted USPCC Trend for ESRD Beneficiaries ("**Alternative Retrospective Trend Adjustment for ESRD Beneficiaries**").

e. Except as specified in Section III.E.2(f) or Section III.E.2(g) of this Appendix, CMS will not apply a retroactive trend adjustment in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, in the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year.

f. CMS may apply the Placeholder Retrospective Trend Adjustment for A&D Beneficiaries (as described and calculated in accordance with this Section III.E.2(f)) in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year if CMS determines, at its sole discretion, that subsequent updates to the FFS USPCC in OACT publications issued after CMS has published the ACO REACH/KCC Rate Book for the Performance Year indicate that CMS will likely apply the Retrospective Trend Adjustment for A&D Beneficiaries pursuant to Section III.E.2(a) of this Appendix. CMS divides the Revised Adjusted USPCC Trend for A&D Beneficiaries, calculated using the updated FFS USPCC, by the Adjusted USPCC Trend for A&D Beneficiaries published by CMS prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year ("**Placeholder Retrospective Trend Adjustment for A&D Beneficiaries**").

g. CMS may apply the Placeholder Retrospective Trend Adjustment for ESRD Beneficiaries (as described and calculated in accordance with this Section III.E.2(g)) in calculating the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports or, if applicable, the settlement report for Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year if CMS determines, at its sole discretion, that OACT publications of the FFS USPCC issued after CMS has published the ACO REACH/KCC Rate Book for the Performance Year indicate that CMS will likely apply the

Retrospective Trend Adjustment for ESRD Beneficiaries pursuant to Section III.E.2(b) of this Appendix. CMS divides the Revised Adjusted USPCC Trend for ESRD Beneficiaries, calculated using the updated FFS USPCC, by the Adjusted USPCC Trend for ESRD Beneficiaries published by CMS prior to the publication of the ACO REACH/KCC Rate Book for the Performance Year ("**Placeholder Retrospective Trend Adjustment for ESRD Beneficiaries**").

IV. Calculation of Beneficiary Risk Scores

A. For purposes of this Appendix, CMS calculates Beneficiary risk scores using the following methodologies:

1. If the ACO is a Standard ACO or New Entrant ACO, CMS calculates Beneficiary risk scores using the CMS-HCC Risk Adjustment Model (using the HCC model software for A&D Beneficiaries and the ESRD model software for ESRD Beneficiaries). For Performance Year 2025, for non-ESRD Beneficiaries, the risk score shall be calculated as the sum of 67% of the risk score calculated using the updated 2024 CMS-HCC Risk Adjustment Model (Version 28) with 33% of the risk score calculated using the current 2020 CMS-HCC Risk Adjustment Model (Version 24).

2. If the ACO is a High Needs Population ACO, CMS calculates Beneficiary risk scores using the CMMI-HCC Concurrent Risk Adjustment Model for A&D Beneficiaries (using the new CMMI-HCC model software) and the CMS-HCC Risk Adjustment Model for ESRD Beneficiaries (using the ESRD model software).

3. For Performance Year 2024 and each subsequent Performance Year, if the ACO is a Standard ACO or New Entrant ACO, CMS also calculates Beneficiary demographic risk scores using the CMMI Demographic Risk Adjustment Model (using the CMMI Demographic A&D model software for A&D Beneficiaries and the CMMI Demographic ESRD model software for ESRD Beneficiaries) for the purpose of calculating the Risk Score Cap, if any, in accordance with Section IV.G of this Appendix.

B. For each Performance Year, at each of the times specified in Table C of this Appendix, CMS calculates a weighted average of the risk score calculated under Section IV.A.1 or Section IV.A.2 of this Appendix, as applicable, for each REACH Beneficiary using claims data from the applicable period specified in Table C of this Appendix ("**ACO Raw Risk Score**"). For Standard ACOs and New Entrant ACOs and High Needs ACOs, for Performance Year 2024 and each subsequent Performance Year, CMS calculates a separate ACO Raw Risk Score for A&D REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were not aligned to the ACO in the previous Performance Year ("**Newly Voluntarily Aligned A&D Beneficiary ACO Raw Risk Score**"), for A&D REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were aligned to the ACO in the previous Performance Year ("**Continuously Voluntarily Aligned A&D Beneficiary ACO Raw Risk Score**"), for A&D REACH Beneficiaries aligned to the ACO via Claims-Based Alignment

("**Claims-Aligned A&D Beneficiary ACO Raw Risk Score**"), for ESRD REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were not aligned to the ACO in the previous Performance Year ("**Newly Voluntarily Aligned ESRD Beneficiary ACO Raw Risk Score**"), for ESRD REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were aligned to the ACO in the previous Performance Year ("**Continuously Voluntarily Aligned ESRD Beneficiary ACO Raw Risk Score"),** and for ESRD REACH Beneficiaries aligned to the ACO via Claims-Based Alignment ("**Claims-Aligned ESRD Beneficiary ACO Raw Risk Score**").

Table C: Performance Year Schedule for Risk Score Calculation Updates[1]

Risk Score	**Performance Year Benchmark reported in:**	**Diagnosis Measurement Period (Dates of Service)**	**Claims Runout through**	**Diagnosis Measurement Period (Dates of Service)**	**Claims Runout Through**
Performance Year 2023 and each subsequent Performance Year		**CMS-HCC Risk Adjustment Models[2]**		**CMMI-HCC Concurrent Risk Adjustment Model**	
Preliminary	Performance Year Benchmark Report	July of Calendar Year (CY) two years prior to Performance Year (PY) – June of CY prior to PY	September of CY prior to PY	July of CY two years prior to PY – June of CY prior to PY[3]	September of CY prior to PY
Mid-Year Q1	Q1 Quarterly Benchmark Report	CY prior to PY	March of PY	CY prior to PY[4]	March of PY
Mid-Year Q2	Q2 Quarterly Benchmark Report	CY prior to PY	June of PY	April of CY prior to PY – March of PY[4]	June of PY
Mid-Year Q3	Q3 Quarterly Benchmark Report	CY prior to PY	September of PY	July of CY prior to PY – June of PY[4]	September of PY
Mid-Year Q4	Q4 Quarterly Benchmark Report and Provisional Financial Settlement	CY prior to PY	December of PY	October of CY prior to PY – September of PY[4]	December of PY
Final	Final Financial Settlement	CY prior to PY	January of CY after PY	CY equal to the PY	March of CY after PY

[1] CMS reserves the right to adjust these dates in order to improve payment accuracy and/or due to operational considerations, including system capacity and processing times over holidays and weekends. Table C shows the schedule for the production of risk score updates that will be provided in each Performance Year. Risk scores will be finalized with diagnoses on claims with dates of service that fall within the Diagnosis Measurement Period and which are submitted and processed by CMS prior to the Claims Runout date.

[2] For Performance Year 2025, CMS will use a blend of two different Risk Adjustment Models as follows: the risk score shall be calculated as the sum of 67% of the risk score calculated using the updated 2024 CMS-HCC Risk Adjustment Model (Version 28) with 33% of the risk score calculated using the current 2020 CMS-HCC Risk Adjustment Model (Version 24).

[3]CMS reserves the right to use proxy risk scores based on a reference population of Beneficiaries that would have aligned to the ACO in a 12-month reference period ending prior to the Performance Year instead of the preliminary

risk scores described in this Table C. Proxy risk scores may be applied if CMS determines that the proxy risk scores will more closely reflect the final risk scores used for Final Financial Settlement.

[4] CMS reserves the right to continue to use the proxy risk scores described in footnote #3 of this Table C if it determines that the proxy risk scores will more closely reflect the final risk scores used for Final Financial Settlement.

C. For the Performance Year Benchmark reported in the Performance Year Benchmark Report, each ACO Raw Risk Score is based on preliminary risk scores for Originally Aligned Beneficiaries, weighted by the number of Originally Aligned Beneficiaries. For the Quarterly Benchmark Reports in all Performance Years and for the purposes of Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year, each ACO Raw Risk Score is based on preliminary and mid-year risk scores for REACH Beneficiaries, weighted by the months of the applicable reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary. For the purposes of Final Financial Settlement for each Performance Year, each ACO Raw Risk Score is based on final risk scores for REACH Beneficiaries, weighted by the number of months of the Performance Year during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

D. CMS divides each ACO Raw Risk Score by the applicable Normalization Factor for the Performance Year to calculate a normalized average risk score ("**ACO Normalized Risk Score**"). For Standard ACOs and New Entrant ACOs and High Needs ACOs, for Performance Year 2024 and each subsequent Performance Year, CMS calculates a separate ACO Normalized Risk Score for A&D REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were not aligned to the ACO in the previous Performance Year ("**Newly Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score**"), for A&D REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were aligned to the ACO in the previous Performance Year ("**Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score**"), for A&D REACH Beneficiaries aligned to the ACO via Claims-Based Alignment ("**Claims-Aligned A&D Beneficiary ACO Normalized Risk Score**"), for ESRD REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were not aligned to the ACO in the previous Performance Year ("**Newly Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score**"), for ESRD REACH Beneficiaries aligned to the ACO via Voluntary Alignment that were aligned to the ACO in the previous Performance Year ("**Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score**"), and for ESRD REACH Beneficiaries aligned to the ACO via Claims-Based Alignment ("**Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score**").

E. For the purposes of this Section IV, Beneficiaries aligned to the ACO via Voluntary Alignment who were also eligible for alignment to the ACO via Claims-Based Alignment will be considered aligned to the ACO via Claims-Based Alignment for the Performance Year.

F. Each ACO Normalized Risk Score is subject to some or all of the adjustments described in Section IV.G and Section IV.H of this Appendix, depending on the

ACO Type and the method by which the REACH Beneficiary is aligned to the ACO.

1. If the ACO is a High-Needs Population ACO, for Performance Year 2024 and each subsequent Performance Year, CMS applies the adjustments described in Section IV.G and Section IV.H of this Appendix, if applicable, to the Claims-Aligned A&D Beneficiary ACO Normalized Risk Score ("**Adjusted Claims-Aligned A&D Beneficiary ACO Normalized Risk Score**"), the Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score ("**Adjusted Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score**"), the Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score ("**Adjusted Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score**") and the Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score ("**Adjusted Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score**"). CMS then calculates a weighted average of the Adjusted Claims-Aligned A&D Beneficiary ACO Normalized Risk Score, the Adjusted Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score, and the Newly Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score ("**High Needs A&D Beneficiary Average Risk Score**") and calculates a weighted average of the Adjusted Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score, the Adjusted Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, and the Newly Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score ("**High Needs ESRD Beneficiary Average Risk Score**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the weighted averages of the High Needs A&D Beneficiary Average Risk Score and High Needs ESRD Beneficiary Average Risk Score weighted by the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and for the purposes of Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the weighted averages of the High Needs A&D Beneficiary Average Risk Score and High Needs ESRD Beneficiary Average Risk Score weighted by the number of months of the relevant reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

2. If the ACO is a New Entrant ACO, CMS applies the adjustments described in Section IV.G and Section IV.H of this Appendix, if applicable, to the Claims-Aligned A&D Beneficiary ACO Normalized Risk Score ("**Adjusted Claims-Aligned A&D Beneficiary ACO Normalized Risk Score**"), the Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score ("**Adjusted Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score**"), the Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score ("**Adjusted Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score**"), and the Continuously Voluntarily Aligned ESRD Beneficiary

ACO Normalized Risk Score ("**Adjusted Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score**"). CMS then calculates a weighted average of the Adjusted Claims-Aligned A&D Beneficiary ACO Normalized Risk Score, the Adjusted Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score, and the Newly Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score ("**New Entrant A&D Beneficiary Average Risk Score**") and calculates a weighted average of the Adjusted Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score, the Adjusted Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, and the Newly Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score ("**New Entrant ESRD Beneficiary Average Risk Score**"). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the weighted averages of the New Entrant A&D Beneficiary Average Risk Score and New Entrant ESRD Beneficiary Average Risk Score weighted by the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and for the purposes of Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the weighted averages of the New Entrant A&D Beneficiary Average Risk Score and New Entrant ESRD Beneficiary Average Risk Score weighted by the number of months of the relevant reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

3. If the ACO is a Standard ACO, for Performance Year 2024 and each subsequent Performance Year, CMS applies the adjustments described in Section IV.G and Section IV.H of this Appendix, if applicable, to the Claims-Aligned A&D Beneficiary ACO Normalized Risk Score ("**Adjusted Claims-Aligned A&D Beneficiary ACO Normalized Risk Score**"), the Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score ("**Adjusted Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score**"), the Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score ("**Adjusted Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score**"), and the Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score ("**Adjusted Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score**"). CMS then calculates a weighted average of the Adjusted Claims-Aligned A&D Beneficiary ACO Normalized Risk Score, the Adjusted Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score, and the Newly Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score ("**Standard A&D Beneficiary Average Risk Score**") and calculates a weighted average of the Adjusted Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score, the Adjusted Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score, and the Newly Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score ("**Standard ESRD Beneficiary Average Risk Score**"). For the

Performance Year Benchmark reported in the Performance Year Benchmark Report, CMS calculates the weighted averages of the Standard A&D Beneficiary Average Risk Score and the Standard ESRD Beneficiary Average Risk Score weighted by the number of Originally Aligned Beneficiaries. For the Performance Year Benchmark reported in the Quarterly Benchmark Reports and for the purposes of Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the weighted averages of the Standard A&D Beneficiary Average Risk Score and Standard ESRD Beneficiary Average Risk Score weighted by the number of months of the relevant reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

G. *Risk Score Cap*

1. If the ACO is a Standard ACO or a New Entrant ACO or a High Needs ACO, CMS will apply an adjustment to the ACO's Claims-Aligned A&D Beneficiary ACO Normalized Risk Score and/or Claims-Aligned ESRD Beneficiary ACO Normalized Risk Score (each a "**Claims-Aligned ACO Normalized Risk Score**"), and an adjustment to the ACO's Continuously Voluntarily Aligned A&D Beneficiary ACO Normalized Risk Score and/or Continuously Voluntarily Aligned ESRD Beneficiary ACO Normalized Risk Score (each a "**Continuously Voluntarily Aligned ACO Normalized Risk Score**"), if needed to ensure that the Claims-Aligned ACO Normalized Risk Score or Continuously Voluntarily Aligned ACO Normalized Risk Score is within a specified range of the Reference Year Normalized Risk Score as described and calculated in accordance with Section IV.G.2, below ("**Risk Score Cap**"). Newly Voluntarily Aligned Beneficiary ACO Normalized Risk Scores are excluded from this calculation.

Table D. Reference Year for the Risk Score Cap by Performance Year

Performance Year	Reference Year
PY 2023	2021[1]
PY 2024	2022[2]
PY 2025	2022[2]
PY 2026	2022[2]

(1) If CMS determines that Beneficiary risk scores for PY2021 using the CMS HCC Risk Adjustment Model, which uses diagnoses from calendar year 2020, are not suitable to be used as a reference year, CMS will use the reference year of 2020.

(2) If CMS determines that Beneficiary risk scores for PY2022 using the CMS HCC Risk Adjustment Model, which uses diagnoses from calendar year 2021, are not suitable to be used as a reference year, CMS will use the reference year of 2020 (or, if suitable, 2021).

2. CMS follows these steps to determine whether to apply the Risk Score Cap for a Performance Year:

a. CMS calculates a weighted average of the risk scores for Beneficiaries who would have been aligned to the ACO via Claims-Based Alignment for the applicable reference year specified in Table D of this Appendix based on the Participant Provider List described in Section 4.02.K or Section 4.04.B.7, as

applicable, weighted by the number of months in the relevant reference year during which the Beneficiary was an Alignment-Eligible Beneficiary ("**Reference Year Raw Risk Score**").

b. CMS divides the Reference Year Raw Risk Score by the applicable Normalization Factor for the applicable reference year ("**Reference Year Normalized Risk Score**").

c. If the ACO is a Standard ACO or New Entrant ACO, CMS compares the Reference Year Normalized Risk Score to the applicable Claims-Aligned ACO Normalized Risk Score and the applicable Continuously Voluntarily Aligned ACO Normalized Risk Score.

   i. For Performance Year 2023 and each subsequent Performance Year, if the Claims-Aligned ACO Normalized Risk Score is greater than 3% higher or lower than the Reference Year Normalized Risk Score, CMS will constrain the Claims-Aligned ACO Normalized Risk Score to 103% or 97%, respectively, of the Reference Year Normalized Risk Score ("**Symmetrically-Capped Claims-Aligned ACO Normalized Risk Score**"). If the Continuously Voluntarily Aligned ACO Normalized Risk Score is greater than 3% higher or lower than the Reference Year Normalized Risk Score, CMS will constrain the Continuously Voluntarily Aligned ACO Normalized Risk Score to 103% or 97%, respectively, of the Reference Year Normalized Risk Score ("**Symmetrically-Capped Continuously Voluntarily Aligned ACO Normalized Risk Score**").

d. If the ACO is a High Needs ACO, for Performance Year 2024 and each subsequent Performance Year, CMS compares the Reference Year Normalized Risk Score to the applicable Claims-Aligned ACO Normalized Risk Score and the applicable Continuously Voluntarily Aligned ACO Normalized Risk Score.

   i. If the Claims-Aligned ACO Normalized Risk Score for A&D, as calculated Section IV.G.1 of this Appendix, is greater than 10% higher or lower than the Reference Year Normalized Risk Score, CMS will constrain the Claims-Aligned ACO Normalized Risk Score to 110% or 90%, respectively, of the Reference Year Normalized Risk Score ("**Symmetrically-Capped Claims-Aligned ACO Normalized A&D Risk Score**"). If the Continuously Voluntarily Aligned ACO Normalized Risk Score for A&D is greater than 10% higher or lower than the Reference Year Normalized Risk Score, CMS will constrain the Continuously Voluntarily-Aligned ACO Normalized Risk Score to 110% or 90%, respectively, of the Reference Year Normalized Risk Score ("**Symmetrically-**

Capped Continuously Voluntarily-Aligned ACO Normalized A&D Risk Score”).

ii. If the Claims-Aligned ACO Normalized Risk Score for ESRD, as calculated Section IV.G.1 of this Appendix, is greater than 3% higher or lower than the Reference Year Normalized Risk Score, CMS will constrain the Claims-Aligned ACO Normalized Risk Score to 103% or 97%, respectively, of the Reference Year Normalized Risk Score (“**Symmetrically-Capped Claims-Aligned ACO Normalized ESRD Risk Score**”). If the Continuously Voluntarily Aligned ACO Normalized Risk Score for ESRD is greater than 3% higher or lower than the Reference Year Normalized Risk Score, CMS will constrain the Continuously Voluntarily-Aligned ACO Normalized Risk Score to 103% or 97%, respectively, of the Reference Year Normalized Risk Score ("**Symmetrically-Capped Continuously Voluntarily-Aligned ACO Normalized ESRD Risk Score**”).

3. CMS will not apply the Risk Score Cap for a Performance Year to the applicable ACO Normalized Risk Score under the following circumstances:

   a. For Performance Year 2025, if the ACO is a Standard ACO or a New Entrant ACO, and CMS determines that—

      i. The ACO does not have sufficient claims history for A&D Aligned Beneficiaries to calculate the Reference Year Normalized Risk Score for a Performance Year;

      ii. There are less than 1500 A&D Aligned Beneficiaries in the Reference Year to calculate the Reference Year Normalized Risk Score for a Performance Year;

      iii. The Performance Year A&D population subject to the Risk Score Cap is more than three times as large as the historical reference population used to establish the Risk Score Cap;

      iv. The ACO does not have sufficient claims history for ESRD Aligned Beneficiaries to calculate the Reference Year Normalized Risk Score for a Performance Year;

      v. The ACO has less than 50 ESRD Aligned Beneficiaries in the Reference Year to calculate the Reference Year Normalized Risk Score for a Performance Year;

      vi. The ACO does not have sufficient claims history for ESRD Aligned Beneficiaries to calculate the Performance Year Normalized Risk Score for a Performance Year; or

      vii. The ACO has less than 50 ESRD Aligned Beneficiaries in the Performance Year to calculate the Performance Year Normalized Risk Score for a Performance Year.

b. For Performance Year 2025, if the ACO is a High Needs ACO, and CMS determines that—

i. The ACO has less than 750 A&D Aligned Beneficiaries in the Reference Year to calculate the Reference Year Normalized Risk Score for a Performance Year;

ii. The ACO has less than 750 A&D Aligned Beneficiaries in the Performance Year to calculate the Performance Year Normalized Risk Score for a Performance Year;

iii. The ACO has less than 50 ESRD Aligned Beneficiaries in the Reference Year to calculate the Reference Year Normalized Risk Score for a Performance Year;

iv. The ACO has less than 50 ESRD Aligned Beneficiaries in the Performance Year to calculate the Performance Year Normalized Risk Score for a Performance Year.

v. All participating High Needs ACOs do not have sufficient claims history for A&D Aligned Beneficiaries to calculate the Reference Year Normalized Risk Score for a Performance Year;

vi. All participating High Needs ACOs do not have sufficient claims history for A&D Aligned Beneficiaries to calculate the Performance Year Normalized Risk Score for a Performance Year;

vii. All participating High Needs ACOs do not have sufficient claims history for ESRD Aligned Beneficiaries to calculate the Reference Year Normalized Risk Score for a Performance Year; or

viii. All participating High Needs ACOs do not have sufficient claims history for ESRD Aligned Beneficiaries to calculate the Performance Year Normalized Risk Score for a Performance Year.

4. If CMS constrains a Claims-Aligned ACO Normalized Risk Score using the Risk Score Cap for a Performance Year, CMS uses the Symmetrically-Capped Claims-Aligned ACO Normalized Risk Score or the Demographically-Capped Claims-Aligned ACO Normalized Risk Score (each a "**Capped Claims-Aligned ACO Normalized Risk Score**") instead of that Claims-Aligned ACO Normalized Risk Score in the calculation of the Performance Year Benchmark. If CMS constrains a Continuously Voluntarily Aligned ACO Normalized Risk Score using the Risk Score Cap for a Performance Year, CMS uses the Symmetrically-Capped Continuously Voluntarily Aligned ACO Normalized Risk Score or the Demographically-Capped Continuously Voluntarily Aligned ACO Normalized Risk Score (each a "**Capped Continuously Voluntarily Aligned ACO Normalized Risk Score**") instead of that Continuously

Voluntarily Aligned ACO Normalized Risk Score in the calculation of the Performance Year Benchmark.

H. *Coding Intensity Factor*

1. If the ACO is a Standard ACO or a New Entrant ACO or a High Needs ACO, for purposes of Final Financial Settlement for Performance Year 2024 and each subsequent Performance Year, CMS adjusts the ACO's Claims-Aligned ACO Normalized Risk Scores or the ACO's Capped Claims-Aligned ACO Normalized Risk Scores (if the ACO is subject to the Risk Score Cap), and the ACO's Continuously Voluntarily Aligned ACO Normalized Risk Scores or the ACO's Capped Continuously Voluntarily Aligned ACO Normalized Risk Scores (if the ACO is subject to the Risk Score Cap) in accordance with Section IV.F if CMS determines in accordance with this Section IV.H that the average risk score for Beneficiaries aligned to all REACH ACOs participating in the Model during the Performance Year ("**ACO REACH Model Normalized Performance Year Risk Score**") exceeds the risk score for those Beneficiaries who would have been aligned to such REACH ACOs during Base Year Three (2019) ("**ACO REACH Model Normalized 2019 Risk Score**"). CMS calculates the ACO REACH Model Normalized Performance Year Risk Score and the ACO REACH Model Normalized 2019 Risk Score separately by risk adjustment model described in Section IV.A of this Appendix for A&D Beneficiaries and for ESRD Beneficiaries, using the CMS-HCC Risk Adjustment Model A&D model, if the ACO is a Standard ACO or New Entrant ACO, which for Performance Year 2025 shall be calculated as the sum of 67% of the risk score calculated using the updated 2024 CMS-HCC Risk Adjustment Model (Version 28) with 33% of the risk score calculated using the current 2020 CMS-HCC Risk Adjustment Model (Version 24) or the CMMI-HCC Concurrent Risk Adjustment model (if the ACO is a High Needs Population ACO) to calculate risk scores for A&D Beneficiaries, and using the CMS-HCC Risk Adjustment Model ESRD model to calculate risk scores for ESRD Beneficiaries (for all ACOs).

2. To calculate the ACO REACH Model Normalized Performance Year Risk Score, CMS calculates an average of the applicable ACO Normalized Risk Scores or, for Standard ACOs and New Entrant ACOs and High Needs ACOs subject to the Risk Score Cap, the Capped Claims-Aligned ACO Normalized Risk Scores and Capped Continuously Voluntarily Aligned ACO Normalized Risk Scores, for all REACH ACOs participating in the Model during the relevant Performance Year ("**ACO REACH Model Normalized Performance Year Risk Score**"), weighted by the number of months of the Performance Year during which each Beneficiary aligned to a REACH ACO participating in the Model for the Performance Year was an Alignment-Eligible Beneficiary. Newly Voluntarily Aligned Beneficiary ACO Normalized Risk Scores are excluded from this calculation.

3. To calculate the ACO REACH Model Normalized 2019 Risk Score, CMS calculates an average of the risk scores for all Beneficiaries who would have been aligned via Claims-Based Alignment to any REACH ACO participating in the Model during the relevant Performance Year for Base Year Three (2019) (using the Claims-Based Alignment methodology described in Section II of Appendix A and the final list of Participant Providers for the Performance Year for each such REACH ACO), weighted by the number of months of Base Year Three (2019) in which each Beneficiary who would have been aligned to a REACH ACO participating in the Model during the relevant Performance Year was an Alignment-Eligible Beneficiary, and divides that weighted average risk score by the applicable Normalization Factor for Base Year Three (2019).

4. CMS divides the applicable ACO REACH Model Normalized Performance Year Risk Score by the applicable ACO REACH Model Normalized 2019 Risk Score ("**Coding Intensity Factor (CIF)**") for the Performance Year.

5. For Performance Year 2025, if the applicable CIF is greater than 1.010, CMS will constrain the applicable CIF to no greater than 1.010. CMS divides the ACO's Claims-Aligned ACO Normalized Risk Scores or the ACO's Capped Claims-Aligned ACO Normalized Risk Scores (if the ACO is subject to the Risk Score Cap), and the ACO's Continuously Voluntarily Aligned ACO Normalized Risk Scores or the ACO's Capped Continuously Voluntarily Aligned ACO Normalized Risk Scores (if the ACO is subject to the Risk Score Cap) by the applicable CIF.

6. For the Performance Year Benchmark in the Performance Year Benchmark Report, the Quarterly Benchmark Reports, and for the purposes of Provisional Financial Settlement for Performance Year 2023 and each subsequent Performance Year (if applicable), CMS uses a placeholder CIF of 1.000.

7. Separately for each risk adjustment model described in Section IV.A of this Appendix, if CMS determines that there is not a sufficient number of Beneficiaries that would have been aligned via Claims-Based Alignment to all REACH ACOs participating in the Performance Year to calculate a reliable ACO REACH Model Normalized 2019 Risk Score or if CMS determines that there is not a sufficient number of REACH ACOs participating in the Model for a Performance Year to apply the Coding Intensity Factor, CMS does not apply the Coding Intensity Factor for the Performance Year for the applicable risk adjustment model(s).

V. Adjustments to Total Unadjusted Performance Year Benchmark to calculate the Performance Year Benchmark for a Performance Year.

A. CMS makes each of the following adjustments to the ACO's Total Unadjusted Performance Year Benchmark, as applicable, to calculate the Performance Year Benchmark for a Performance Year:

1. Application of Quality Withhold Amount and Quality Withhold Earn Back Amount (or, if applicable, Estimated Quality Withhold Earn Back Amount) as described in Section V.B of this Appendix;

2. Application of the applicable Discount Amount (if the ACO is participating in the Global Risk Sharing Option) as described in Section V.C of this Appendix; and

3. Application of Retention Withhold Participation Commitment Mechanism Amount (for the ACO's first Performance Year, if applicable) as described in Section V.D of this Appendix.

4. Application of the Heath Equity Benchmark Adjustment as described in Section V.E of this Appendix.

Specifically, CMS calculates the ACO's Performance Year Benchmark as the ACO's Total Unadjusted Performance Year Benchmark less the Quality Withhold Amount, plus the Quality Withhold Earn Back Amount (or, if applicable, Estimated Quality Withhold Earn Back Amount), less the Discount Amount, less the Retention Withhold Amount (as described in Section V.D.1 of this Appendix), as applicable, and plus the amount of the Health Equity Benchmark Adjustment.

B. Quality Withhold and Quality Performance Adjustment

1. In calculating the Performance Year Benchmark for Performance Year 2023 and subsequent Performance Years, CMS applies a 2% withhold to the Total Unadjusted Performance Year Benchmark that the ACO may earn back in whole or in part depending on the ACO's quality performance during the Performance Year ("**Quality Withhold**").

2. CMS multiplies the Quality Withhold by the ACO's Total Unadjusted Performance Year Benchmark to determine the adjustment applied to the ACO's Total Unadjusted Performance Year Benchmark (**"Quality Withhold Amount"**).

3. For purposes of Final Financial Settlement, CMS calculates the portion of the Quality Withhold the ACO will earn back for the Performance Year ("**Quality Withhold Earn Back**") as follows:

    a. If the ACO is in its first Performance Year in the Model, or if the ACO is in its second or subsequent Performance Year in the Model and meets the CI/SEP criteria, CMS multiplies the ACO's total quality score for the Performance Year, calculated according to the methodology described in Section 9.04 of the Agreement, by the full (i.e., 2%) Quality Withhold. If the ACO is in its second or subsequent Performance Year in the Model and does not meet the CI/SEP criteria for the applicable Performance Year, CMS multiplies the ACO's total quality score for the Performance Year, calculated according to the methodology described in Section 9.04 of the Agreement, by half of the Quality Withhold (i.e., 1%).

    b. CMS adds the Health Equity Data Reporting Adjustment, calculated according to the methodology described in Section 9.04

of the Agreement, to the amount calculated in Section V.B.3(a) of this Appendix.

c. If the amount calculated in Section V.B.3(b) of this Appendix is less than 0, then CMS constrains the amount to 0. If the amount calculated in Section V.B.3(b) of this Appendix is greater than 1, then CMS constrains the amount to 1. The resulting value is the ACO's Quality Withhold Earn Back.

4. CMS multiplies the Quality Withhold Earn Back by the ACO's Total Unadjusted Performance Year Benchmark to determine the adjustment applied to the ACO's Total Unadjusted Performance Year Benchmark based on the ACO's quality performance during the Performance Year (**"Quality Withhold Earn Back Amount"**).

5. For the Performance Year Benchmark reported in the Performance Year Benchmark Report and the Quarterly Benchmark Reports, and for purposes of Provisional Financial Settlement (if applicable), CMS uses a placeholder total quality score to estimate the Quality Withhold Earn Back Amount for the Performance Year ("**Placeholder Quality Score**"). CMS multiplies the Placeholder Quality Score by the full (i.e., 2%) Quality Withhold to estimate the portion of the Quality Withhold the ACO will earn back for the Performance Year ("**Estimated Quality Withhold Earn Back**"). CMS multiplies the Estimated Quality Withhold Earn Back by the ACO's Total Unadjusted Performance Year Benchmark to estimate the adjustment applied to the ACO's Total Unadjusted Performance Year Benchmark based on the ACO's quality performance during the Performance Year (**"Estimated Quality Withhold Earn Back Amount"**). For the Performance Year Benchmark reported in the Performance Year Benchmark Report, the Quarterly Benchmark Reports, and the settlement report for Provisional Financial Settlement (if applicable), CMS will initially use a Placeholder Quality Score of 100%, but once the ACO's total quality score from the most recent Performance Year with a complete total quality score is available, CMS will use the ACO's total quality score from the most recent completed Performance Year as the Placeholder Quality Score.

C. Discount

If the ACO is participating in the Global Risk Sharing Option, CMS applies the applicable discount specified in Table E of this Appendix ("**Discount**") to the Total Unadjusted Performance Year Benchmark. CMS multiplies the Discount by the ACO's Total Unadjusted Performance Year Benchmark to determine the Discount adjustment applied to the ACO's Total Unadjusted Performance Year Benchmark (**"Discount Amount"**). The Performance Year Benchmark reported in the Performance Year Benchmark Report, Quarterly Benchmark Reports, and settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement is calculated with the applicable Discount Amount applied.

Table E. Applicable Discount by Performance Year

PY	Discount for Global ACOs
2023	3%
2024	3%
2025	3.5%
2026	4.0%

D. Retention Withhold Participation Commitment Mechanism

1. For the ACO's first Performance Year, if the ACO selects the Retention Withhold Participation Commitment Mechanism as described in Section 12.03 of the Agreement, CMS applies a withhold equal to 2 percent of the Total Unadjusted Performance Year Benchmark ("**Retention Withhold**") to the ACO's Total Unadjusted Performance Year Benchmark. CMS multiplies the Retention Withhold by the ACO's Total Unadjusted Performance Year Benchmark to determine the adjustment applied to the ACO's Total Unadjusted Performance Year Benchmark (**"Retention Withhold Amount"**). For the ACO's first Performance Year, the Retention Withhold is applied to the Performance Year Benchmark reported in each Quarterly Benchmark Report, and at such other times specified in this Section V.D.

2. If CMS has applied the Retention Withhold Participation Commitment Mechanism as described in Section V.D.1 of this Appendix, and the ACO voluntarily terminates the Agreement Performance Period pursuant to Section 17.03 of the Agreement by providing notice to CMS on or before the Termination Without Liability Date of the ACO's second Performance Year, CMS will apply the Retention Withhold to the ACO's Total Unadjusted Performance Year Benchmark in calculating the Performance Year Benchmark used for purposes of Final Financial Settlement for the ACO's first Performance Year, such that the ACO does not "earn back" the Retention Withhold.

3. If CMS has applied the Retention Withhold Participation Commitment Mechanism as described in Section V.D.1 of this Appendix, and the ACO does not voluntarily terminate the Agreement Performance Period pursuant to Section 17.03 of the Agreement by providing notice to CMS on or before the Termination Without Liability Date of the ACO's second Performance Year, CMS will not apply the Retention Withhold to the ACO's Total Unadjusted Performance Year Benchmark in calculating the Performance Year Benchmark used for purposes of Final Financial Settlement for the ACO's first Performance Year, such that the ACO "earns back" the Retention Withhold.

4. If the ACO's first Performance Year is 2023, and if the ACO selects to participate in Provisional Financial Settlement as described in Section 8.01, and if CMS has applied the Retention Withhold Participation Commitment Mechanism as described in Section V.D.1 of this Appendix, CMS will apply the Retention Withhold Participation Commitment Mechanism to the Performance Year Benchmark used for the purpose of Provisional Financial Settlement. However, if Provisional Financial

Settlement results in the ACO owing between zero and two percent of the Performance Year Benchmark in gross losses, CMS will not demand that amount from the ACO at Provisional Financial Settlement.

E. Health Equity Benchmark Adjustment

1. For Performance Year 2023 and each subsequent Performance Year, CMS assigns each Beneficiary aligned to a REACH ACO with at least one Beneficiary Month a score that reflects the degree to which the Beneficiary has been disadvantaged or underserved in regards to the Beneficiary's ability to access health care services and attain optimal health ("**Equity Score**").

2. CMS calculates the Equity Score as described in Section V.E.3 of this Appendix. CMS may amend this Appendix B to add, remove, or modify the variables used to calculate the Equity Score prior to the start of Performance Year 2025 or any subsequent Performance Year. CMS shall notify the ACO of any change in the variables used to calculate the Equity Score prior to the beginning of the Performance Year in which such change will take effect.

3. Except as provided in Section V.E.2, CMS calculates the Equity Score for each Beneficiary aligned to a REACH ACO as follows:

    a. CMS determines the standardized community deprivation index (CDI) that corresponds to the census block in which the Beneficiary resides on the first Day of their first month of alignment to a REACH ACO in the applicable Performance Year.

        i. If the Beneficiary does not have an address on the first Day of their first month as of alignment to a REACH ACO in the applicable Performance Year or the Beneficiary has incomplete data such that their census block group, census tract, county, and state cannot be determined, CMS uses the average of the national CDIs for all Beneficiaries aligned to the REACH ACO to which the Beneficiary is also aligned by dividing the sum of the national CDIs for all Beneficiaries aligned to the REACH ACO to which the Beneficiary is also aligned by the number of Beneficiaries who have addresses on the first Day of their first month of alignment to the REACH ACO to which the Beneficiary is also aligned in the Performance Year.

        ii. If the Beneficiary's address has a suppressed national CDI, CMS will use the average national CDI of the most granular geographic unit for which a national CDI is available, either census tract, county, or state.

b. CMS determines an Individual-level score for the Beneficiary as follows:

   i. If the Beneficiary is fully or partially eligible for Medicaid, or fully or partially eligible for the Medicare Part D Low-Income Subsidy (LIS), for at least one month during the Performance Year the Beneficiary receives an Individual-level score of 50.

   ii. If the Beneficiary is not fully or partially eligible for Medicaid, or is not fully or partially eligible for the Medicare Part D LIS, for at least one month during the Performance Year the Beneficiary receives an Individual-level score of zero.

c. The Equity Score for the Beneficiary equals the sum of the Individual-level score and the national CDI value.

4. CMS calculates the Equity Score at each percentile that is a multiple of 10, from 0 to 90 from the distribution of Equity Scores for all Beneficiaries aligned to REACH ACOs for the applicable Performance Year.

5. CMS adjusts a REACH ACO's Performance Year Benchmark for health equity ("**Health Equity Benchmark Adjustment**") by the sum of the product of the total number of REACH Beneficiary months for REACH Beneficiaries with Equity Scores falling between each set of calculated percentiles by the corresponding per-Beneficiary, per-month dollar amount shown in Table F below.

Table F. Equity Score Distribution and Corresponding Adjustment

Distribution of Beneficiary Equity Scores	Adjustment per-Beneficiary, per-month
At or above the 90th percentile	+$30
Between 80th and 89th percentile, inclusive	+$20
Between 70th and 79th percentile, inclusive	+$10
Between 60th and 69th percentile, inclusive	$0
Between 50th and 59th percentile, inclusive	$0
Between 40th and 49th percentile, inclusive	$0
Between 30th and 39th percentile, inclusive	$0
Between 20th and 29th percentile, inclusive	-$10
Between 10th and 19th percentile, inclusive	-$10

Distribution of Beneficiary Equity Scores	**Adjustment per-Beneficiary, per-month**
Between 0th and 9th percentile, inclusive	-$10

VI. Financial Settlement

General

A. Financial settlement is the process by which CMS determines the sum of the Shared Savings or Shared Losses and Other Monies Owed ("**Total Monies Owed**").

B. CMS calculates the amount of Shared Savings CMS owes to the ACO or the amount of Shared Losses the ACO owes to CMS by comparing actual Medicare expenditures during the Performance Year ("**Performance Year Expenditure**") to the Performance Year Benchmark, calculated according to Section VI.E of this Appendix.

Performance Year Expenditure

C. The Performance Year Expenditure is the total payment that has been made by Medicare fee-for-service for services furnished to REACH Beneficiaries during months of the Performance Year during which the REACH Beneficiaries were aligned to the ACO. The Performance Year Expenditure includes the Actual Annual Base PCC Payment Amount (as that term is defined in Appendix E of the Agreement) or the Actual Annual TCC Payment Amount (as that term is defined in Appendix G of the Agreement), as applicable, made to the ACO pursuant to the ACO's selected Capitation Payment Mechanism, as well as FFS payments made to providers and suppliers for services furnished to REACH Beneficiaries, including payments made to PCC Payment- or TCC Payment-participating Participant Providers and Preferred Providers, less any TCC Fee Reductions and PCC Fee Reductions. APO Fee Reductions are not subtracted from FFS payments made to APO-participating Participant Providers or Preferred Providers for purposes of determining the Performance Year Expenditure. The Performance Year Expenditure includes, for each REACH Beneficiary who is also a GUIDE Beneficiary, the GUIDE Model's monthly Dementia Care Management Payment (DCMP) (as the term is defined in the GUIDE Model Participation Agreement) for the GUIDE Beneficiary but excludes GUIDE Overlap Services, GUIDE Respite Payments (as the term is defined in the GUIDE Model Participation Agreement), and GUIDE Infrastructure Payments (as the term is defined in the GUIDE Model Participation Agreement). Notwithstanding Appendix B for an applicable Performance Year, for Performance Year 2024 and each subsequent Performance Year, CMS shall exclude from the calculation of the Performance Year Expenditure any SAHS Billing Activity applicable to the Performance Year.

Stop-Loss Arrangement

D. The Performance Year Expenditure is adjusted for the net impact of the Stop-Loss Arrangement as described in this Section VI.D if the ACO selects to participate in the Stop-Loss Arrangement for the Performance Year.

1. If the ACO wishes to participate in the Stop-Loss Arrangement for a Performance Year, the ACO must timely submit to CMS its selection of the Stop-Loss Arrangement as described in Section 8.01 of the Agreement. If selected by the ACO, the Stop-Loss Arrangement removes partial financial liability for individual REACH Beneficiary expenditures that are above certain thresholds established by CMS, referred to herein as "**Stop-Loss Bands**."

2. The Stop-Loss Bands are calculated based on the attachment point established prior to the start of each Performance Year and subject to the Retrospective Trend Adjustments described in Section I.E.4 of this Appendix, as applicable.

3. CMS calculates the attachment point for a Performance Year ("**Performance Year Attachment Point**") as follows:

   a. For each Beneficiary in the ACO REACH National Reference Population for the applicable reference year specified in Table G of this Appendix, CMS calculates predicted Medicare Parts A and B expenditures ("**Individual Predicted Reference Year Expenditures**") by summing:

      i. The product of the A&D county-level rate from the ACO REACH / KCC Rate Book for the Performance Year, trended to the applicable reference year using the Adjusted USPCC ("**A&D Reference Year County-Level Rate**"), based on the county where the Beneficiary lived during the first month the Beneficiary was an Alignment-Eligible Beneficiary, the number of months during the applicable reference year that the Beneficiary was an Alignment-Eligible Beneficiary with entitlement for Medicare on the basis of age and disability, and the Beneficiary's risk score for the reference year, calculated using the applicable risk adjustment model for A&D Beneficiaries described in Section IV.A of this Appendix ("**A&D Risk Score**"); and

      ii. The product of the ESRD county-level rate from the ACO REACH / KCC Rate Book for the Performance Year, trended to the applicable reference year using the Adjusted USPCC ("**ESRD Reference Year County-Level Rate**") based on the county where the Beneficiary lived during the first month the Beneficiary was an Alignment-Eligible Beneficiary for the applicable reference year, the number of months during the applicable reference year that the Beneficiary was an Alignment-Eligible Beneficiary with entitlement for Medicare on the basis of ESRD, and the Beneficiary's risk score for the reference year, calculated

using the applicable risk adjustment model for ESRD Beneficiaries described in Section IV.A of this Appendix ("**ESRD Risk Score**").

b. For each Beneficiary in the ACO REACH National Reference Population, CMS subtracts the Individual Predicted Reference Year Expenditures from the total Medicare Parts A and B expenditures accrued by the Beneficiary during the applicable reference year specified in Table G of this Appendix including any payment adjustments and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, and adds in any reductions due to sequestration, ("**Individual Residual Reference Year Expenditures**").

c. CMS determines a historical attachment point ("**Reference Year Attachment Point**") for the applicable reference year specified in Table G of this Appendix as follows:

i. CMS calculates the total Medicare Parts A and B expenditures accrued by all the Beneficiaries in the ACO REACH National Reference Population for the applicable reference year ("**Total Reference Year Expenditures**") and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable.

ii. CMS estimates the stop-loss payout for an individual Beneficiary in the ACO REACH National Reference Population ("**Individual Reference Year Stop-Loss Payout**") for the applicable reference year by using a placeholder attachment point ("**Initial Estimated Reference Year Attachment Point**") and organizing the Beneficiary's Individual Residual Reference Year Expenditures into Stop-Loss Bands, each of which has an applicable stop-loss payout rate ("**Payout Rate**") specified in Table H of this Appendix.

iii. The Individual Reference Year Stop-Loss Payout is equal to the amount of Individual Residual Reference Year Expenditures incurred by the Beneficiary within a given Stop-Loss Band, multiplied by the Payout Rate for the applicable Stop-Loss Band, summed across all applicable Stop-Loss Bands. The total payout for the applicable reference year is equal to the sum of the Individual Reference Year Stop-Loss Payout for all Beneficiaries in the ACO REACH National Reference Population ("**Aggregate Reference Year Stop-Loss Payout**").

iv. CMS performs the calculations described in Section VI.D.3(c)(iii)-(iv), using different Estimated Reference

Year Attachment Points, to determine the appropriate Reference Year Attachment Point. CMS establishes the Reference Year Attachment Point at the point where the Aggregate Reference Year Stop-Loss Payout is equal to a specified percentage (“**Reference Year Attachment Point Percentage**”) of the Total Reference Year Expenditures for the applicable reference year. In advance of each Performance Year, CMS shall notify the ACO of the Reference Year Attachment Point Percentage for the Performance Year. For Performance Year 2023, the Reference Year Attachment Point Percentage is 2%.

d. CMS applies the Adjusted USPCC Trend to trend the Reference Year Attachment Point to the Performance Year to calculate the Performance Year Attachment Point.

Table G. Reference Years for the Performance Year Attachment Point Calculation

Performance Year	Reference Year
PY 2023	2021[1]
PY 2024	2022
PY 2025	2023
PY 2026	2024

(1) If CMS determines that historical expenditures for calendar year 2021 are not suitable to be used as a reference year, CMS will use the reference year of 2019 for PY2023

Table H. Expenditure Ranges (Based on Attachment Point) and Payout Rates for each Stop Loss Band.

Stop-Loss Band	Start of Band Expenditure Range	End of Band Expenditure Range	Payout Rate
Band 1	Attachment Point	200% of Attachment Point	80%
Band 2	200% Attachment Point	No Upper Limit	100%

4. CMS calculates the stop-loss payout for each individual REACH Beneficiary for a Performance Year as follows:

a. For each REACH Beneficiary, CMS calculates predicted Medicare Parts A and B expenditures for the applicable Performance Year (“**Individual Predicted Performance Year Expenditures**”) by summing:

i. The product of the A&D Reference Year County-Level Rate based on the county where the REACH Beneficiary lived during the first month the Beneficiary was a REACH Beneficiary for the Performance Year, the number of months the Beneficiary was aligned to the ACO with entitlement for Medicare on the basis of age and disability during the Performance Year, the REACH Beneficiary’s A&D Risk Score for the Performance Year, and any applicable Regional Rate Adjustment Factor; and

ii. The product of the ESRD Reference Year County-Level Rate based on the county where the REACH Beneficiary lived during the first month the Beneficiary was a REACH Beneficiary for the Performance Year, the number of months the Beneficiary was aligned to the ACO with entitlement for Medicare on the basis of ESRD during the Performance Year, the REACH Beneficiary's ESRD Risk Score for the Performance Year, and any applicable Regional Rate Adjustment Factor.

b. For each REACH Beneficiary, CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each Beneficiary and subtracts the Individual Predicted Performance Year Expenditures ("**Individual Residual Performance Year Expenditures**").

c. For each REACH Beneficiary, CMS calculates the stop-loss payout for the Performance Year using the Performance Year Attachment Point and organizes the Individual Residual Performance Year Expenditures into Stop-Loss Bands, each of which has an applicable Payout Rate specified in Table H of this Appendix.

d. The stop-loss payout for an individual REACH Beneficiary is equal to the amount of Individual Residual Performance Year Expenditures incurred by the Beneficiary within a given Stop-Loss Band, multiplied by the Payout Rate for the applicable Stop-Loss Band, summed across all applicable Stop-Loss Bands ("Stop-Loss Payout"). The aggregate payout under the Stop-Loss Arrangement is equal to the sum of the Stop-Loss Payout for all REACH Beneficiaries aligned to the ACO for the Performance Year ("**Aggregate Stop-Loss Payout**").

5. [Reserved]

6. Except as described in Section VI.D.7 of this Appendix, CMS calculates a stop-loss charge ("**Stop-Loss Charge**") as follows:

a. CMS calculates Reference Year Attachment Points for a given Beneficiary for each of the applicable reference years specified in Table I of this Appendix, separately for each reference year, using the methodology described in Section VI.D.3(a)-(c) of this Appendix. In applying the provisions of Section VI.D.3(a)-(c), references to Table G shall be deemed references to Table I.

Table I. Reference Years for the Reference Year Stop-Loss Payout Percentage

Performance Year	Reference Years
PY 2023	2019, 2020[1], 2021[1]

Performance Year	Reference Years
PY 2024	2020[1], 2021[1], 2022
PY 2025	2021[1], 2022, 2023
PY 2026	2022, 2023, 2024

(1) If CMS determines that historical expenditures for calendar year 2020 or 2021 are not suitable to be used as a reference year, CMS will use an alternative reference year in its place.

b. CMS determines into which Stop-Loss Band specified in Table H of this Appendix each of the Reference Year Attachment Points for each Beneficiary will fall. Each Stop-Loss Band has an applicable Payout Rate, specified in Table H of this Appendix.

c. For each Beneficiary who would have been aligned to the ACO during each of the applicable reference years specified in Table I of this Appendix using the Claims-Based Alignment methodology described in Section II of Appendix A and the Participant Provider List for the Performance Year described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, CMS aggregates the Medicare Parts A and B expenditures, including any payment adjustments and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to each such Beneficiary during each month of the applicable reference year in which the Beneficiary was an Alignment-Eligible Beneficiary ("**Individual Reference Year Expenditures**"). The Stop-Loss Payout for an individual Beneficiary is equal to the amount of Individual Reference Year Expenditures incurred by the Beneficiary within a given Stop-Loss Band, using the Stop-Loss Bands associated with the applicable reference years specified in Table I of this Appendix, multiplied by the Payout Rate for the applicable Stop-Loss Band, summed across all applicable Stop-Loss Bands. CMS calculates an estimated Aggregate Stop-Loss Payout for each applicable reference year by summing the Stop-Loss Payout for all Beneficiaries who would have been aligned to the ACO during the applicable reference year. (**"Reference Year Stop-Loss Payout"**). CMS divides the Reference Year Stop-Loss Payout by the total Medicare Parts A and B expenditure accrued by all Beneficiaries who would have been aligned to the ACO during the applicable reference year (**"Reference Year Stop-Loss Expenditure"**) to estimate the percentage of expenditures that would have been paid out under the Stop Loss Arrangement for that reference year (**"Reference Year Stop-Loss Payout Percentage"**).

d. CMS then calculates an average of the Reference Year Stop-Loss Payout Percentages across the three applicable reference years in Table I of this Appendix (**"Average ACO Stop-Loss Payout Percentage"**).

e. Separately for A&D and ESRD Beneficiaries, CMS calculates the total Medicare Parts A and B expenditures, including any payment adjustments and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to all Beneficiaries who would have been aligned to the ACO during each reference year and divides it by the total number of months in which all Beneficiaries who would have been aligned to the ACO during the applicable reference year were Alignment-Eligible Beneficiaries ("**Reference Year PBPM Stop-Loss Expenditure**").

f. CMS then applies the Adjusted USPCC Trend to trend each Reference Year PBPM Stop-Loss Expenditure to the Performance Year and applies adjustments to reflect the anticipated impact of changes between the applicable reference year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS (**"Trended, GAF-Adjusted Reference Year PBPM Expenditure")**.

g. CMS then calculates an average of the Trended, GAF-Adjusted Reference Year PBPM Expenditure across the three applicable reference years (**"Trended, GAF-Adjusted Average Reference Period PBPM Expenditure"**).

h. CMS then multiplies the Trended, GAF-Adjusted Average Reference Period PBPM Expenditure by the total number of months in the Performance Year in which each REACH Beneficiary was an Alignment-Eligible Beneficiary and, if applicable, the retrospective trend adjustment for A&D Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix) or, if applicable, the retrospective trend adjustment for ESRD Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix) ("**Trended, GAF-Adjusted Average Reference Period Expenditure**").

i. CMS then sums the Trended, GAF-Adjusted Average Reference Period Expenditure for A&D Beneficiaries and the Trended, GAF-Adjusted Average Reference Period Expenditure for ESRD Beneficiaries ("**Total Trended, GAF-Adjusted Reference Period Expenditure**").

j. CMS then multiplies the Total Trended, GAF-Adjusted Reference Period Expenditure by the Average ACO Stop-Loss Payout Percentage to determine the Stop-Loss Charge.

7. If CMS determines that the ACO does not have sufficient claims history for one or more of the applicable reference years specified in Table I of this Appendix to calculate the Stop-Loss Charge for the ACO in

accordance with Section VI.D.6 of this Appendix, CMS will calculate the Stop-Loss Charge for the ACO as follows:

a. For counties with at least 3,000 Beneficiaries in the ACO REACH National Reference Population who reside in the county for any of the three applicable reference years specified in Table I of this Appendix, CMS estimates the Aggregate Stop-Loss Payout, in accordance with the methodology outlined in Section VI.D.4(d) of this Appendix and using the Stop-Loss Bands associated with the applicable reference years specified in Table I of this Appendix (calculated in accordance with Section VI.D.6 of this Appendix), for each county by summing the Stop-Loss Payout for all Beneficiaries in the ACO REACH National Reference Population who reside in each county during each of the applicable reference years specified in Table I of this Appendix ("**County Reference Year Stop-Loss Payout**"). CMS then sums the total the Medicare Parts A and B expenditures, including any payment adjustments and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this Appendix, as applicable, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to all such Beneficiaries during months in which they were Alignment-Eligible Beneficiaries in each county during each reference year ("**County Reference Year Stop-Loss Expenditure**"). Next, CMS divides the County Reference Year Stop-Loss Payout by the County Reference Year Stop-Loss Expenditure ("**County Reference Year Stop-Loss Payout Percentage**").

b. Except as described in Section VI.D.7(c) of this Appendix, for counties with fewer than 3,000 Beneficiaries in the ACO REACH National Reference Population who reside in the county for all three of the applicable reference years specified in Table I of this Appendix, CMS estimates the Aggregate Stop-Loss Payout, in accordance with the methodology outlined in Section VI.D.4(d) of this Appendix and using the Stop-Loss Bands associated with the applicable reference years specified in Table I of this Appendix (calculated in accordance with Section VI.D.6 of this Appendix), for each county by summing the Stop-Loss Payout for all Beneficiaries in the ACO REACH National Reference Population who reside in all counties in the state with fewer than 3,000 Beneficiaries for each of the applicable reference years specified in Table I of this Appendix ("**State-Level County Reference Year Stop-Loss Payout**"). CMS then sums the total expenditure accrued by all such Beneficiaries during months in which they were Alignment-Eligible Beneficiaries in the applicable counties in the state with fewer than 3,000 Beneficiaries during each reference year ("**State-Level County Reference Year Stop-Loss Expenditure**"). CMS next divides the State-Level County Reference Year Stop-Loss Payout by the State-Level County

Reference Year Stop-Loss Expenditure ("**State-Level County Reference Year Stop-Loss Payout Percentage**").

c. For counties with fewer than 3,000 Beneficiaries in the ACO REACH National Reference Population who reside in the county for all three applicable reference years in states in which the aggregate number of Beneficiaries in the ACO REACH National Reference Population who reside in counties in the state with fewer than 3,000 Beneficiaries is fewer than 3,000, CMS estimates the Aggregate Stop-Loss Payout, in accordance with the methodology outlined in Section VI.D.4(d) of this Appendix and using the Stop-Loss Bands associated with the applicable reference years specified in Table I of this Appendix (calculated in accordance with Section VI.D.6 of this Appendix), for each such county by summing the Stop-Loss Payout for all Beneficiaries in the ACO REACH National Reference Population who reside in all counties in the state for each of the applicable reference years specified in Table I of this Appendix ("**Alternative State-Level County Reference Year Stop-Loss Payout**"). CMS then sums the total expenditure accrued by all such Beneficiaries during months in which they were Alignment-Eligible Beneficiaries in the applicable state during each reference year ("**Alternative State-Level County Reference Year Stop-Loss Expenditure**"). CMS next divides the Alternative State-Level County Reference Year Stop-Loss Payout by the Alternative State-Level County Reference Year Stop-Loss Expenditure ("**Alternative State-Level County Reference Year Stop-Loss Payout Percentage**").

d. For each county, CMS calculates an average of the County Reference Year Stop-Loss Payout Percentage, the State-Level County Reference Year Stop-Loss Payout Percentage, or the Alternative State-Level County Reference Year Stop-Loss Payout Percentage, as applicable, across the three applicable reference years ("**County Reference Period Stop-Loss Payout Percentage**").

e. CMS calculates an average of the County Reference Period Stop-Loss Payout Percentage for all counties in which Originally Aligned Beneficiaries reside during the Performance Year, weighted by the number of Originally Aligned Beneficiaries residing in each county ("**Alternative Average ACO Stop-Loss Payout Percentage**").

f. For counties with at least 3,000 Beneficiaries in the ACO REACH National Reference Population who reside in the county for any of the three reference years, CMS calculates separately for A&D and ESRD Beneficiaries and separately for each reference year the Medicare Parts A and B expenditures, including any payment adjustments and excluding SAHS Billing Activity as defined in accordance with Sections I.D.4, II.C.3, and III.D.3 of this

Appendix, as applicable, and adds in any reductions due to sequestration, for all claims for Covered Services furnished to all Beneficiaries in the ACO REACH National Reference Population during months in which they were Alignment-Eligible Beneficiaries who reside in each county and divides by the total number of months in which all such Beneficiaries were Alignment-Eligible Beneficiaries during the applicable reference year ("**County Reference Year PBPM Stop-Loss Expenditure**").

g. Except as described in Section VI.D.7(h) of this Appendix, for counties with fewer than 3,000 Beneficiaries in the ACO REACH National Reference Population who reside in the county for all three reference years, CMS calculates separately for A&D and ESRD Beneficiaries and separately for each reference year the total Medicare Parts A and B expenditure accrued by all Beneficiaries in the ACO REACH National Reference Population who reside in counties in the state with fewer than 3,000 Beneficiaries and divides by the total number of months in which all such Beneficiaries were Alignment-Eligible Beneficiaries during the applicable reference year ("**State-Level County Reference Year PBPM Stop-Loss Expenditure**").

h. For counties with fewer than 3,000 Beneficiaries in the ACO REACH National Reference Population who reside in the county for all three reference years in states in which the aggregate number of Beneficiaries in the ACO REACH National Reference Population who reside in counties in the state with fewer than 3,000 Beneficiaries is fewer than 3,000, CMS calculates separately for A&D and ESRD Beneficiaries and separately for each reference year the total Medicare Parts A and B expenditure accrued by all Beneficiaries in the ACO REACH National Reference Population who reside in the state and divides by the total number of months in which all such Beneficiaries were Alignment-Eligible Beneficiaries during the applicable reference year ("**Alternative State-Level County Reference Year PBPM Stop-Loss Expenditure**").

i. CMS then applies the Adjusted USPCC Trend to trend each County Reference Year PBPM Stop-Loss Expenditure, State-Level County Reference Year PBPM Stop-Loss Expenditure, and Alternative State-Level County Reference Year PBPM Stop-Loss Expenditure to the Performance Year and applies adjustments to reflect the anticipated impact of changes between the applicable reference year and the Performance Year in the regional GAFs applied to payment amounts under Medicare FFS ("**Trended, GAF-Adjusted County Reference Year PBPM Expenditure**", "**Trended, GAF-Adjusted State-Level County Reference Year PBPM Expenditure**", and "**Trended, GAF-Adjusted**

Alternative State-Level County Reference Year PBPM Expenditure", respectively).

j. For each county, CMS calculates an average of the Trended, GAF-Adjusted County Reference Year PBPM Expenditure, the Trended, GAF-Adjusted State-Level County Reference Year PBPM Expenditure, or the Trended, GAF-Adjusted Alternative State-Level County Reference Year PBPM Expenditure, as applicable, across the three applicable reference years (**"Trended, GAF-Adjusted County Reference Period PBPM Expenditure"**).

k. CMS then calculates an average of the Trended, GAF-Adjusted County Reference Period PBPM Expenditure based on the counties in which REACH Beneficiaries reside during the Performance Year ("**Alternative Trended, GAF-Adjusted Average Reference Period PBPM Expenditure**"). For the Alternative Trended, GAF-Adjusted Average Reference Period PBPM Expenditure reported in the Performance Year Benchmark Report, CMS calculates the average based on the number of Originally Aligned Beneficiaries residing in each county. For the Alternative Trended, GAF-Adjusted Average Reference Period PBPM Expenditure reported in the Quarterly Benchmark Reports and in the settlement reports for both Provisional Financial Settlement (if applicable) and Final Financial Settlement, CMS calculates the average based on the number of months of the applicable reporting period during which each REACH Beneficiary was an Alignment-Eligible Beneficiary.

l. CMS then multiplies the Alternative Trended, GAF-Adjusted Average Reference Period PBPM Expenditure by the total number of months in the Performance Year in which each REACH Beneficiary was an Alignment-Eligible Beneficiary and, if applicable, the retrospective trend adjustment for A&D Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix) or, if applicable, the retrospective trend adjustment for ESRD Beneficiaries (calculated in accordance with Section I.E.4 of this Appendix) ("**Alternative Trended, GAF-Adjusted Average Reference Period Expenditure")**.

m. CMS then sums the Alternative Total Trended, GAF-Adjusted Average Reference Period Expenditure for A&D Beneficiaries and the Alternative Total Trended, GAF-Adjusted Average Reference Period Expenditure for ESRD Beneficiaries ("**Alternative Total Trended, GAF-Adjusted Reference Period Expenditure**").

n. CMS then multiplies the Alternative Total Trended, GAF-Adjusted Reference Period Expenditure by the Alternative Average ACO Stop-Loss Payout Percentage to determine the Stop-Loss Charge.

8. CMS aggregates the Stop-Loss Charge across all REACH Beneficiaries by multiplying the Stop-Loss Charge by the total number of months each

REACH Beneficiary was aligned to the ACO during the Performance Year ("**Aggregate Stop-Loss Charge**").

9. [Reserved]

10. CMS makes a uniform adjustment to the Aggregate Stop-Loss Payout such that the sum of Aggregate Stop-Loss Payouts to all REACH ACOs that participated in the Stop-Loss Arrangement in the Performance Year is equal to the sum of Aggregate Stop-Loss Charges for all REACH ACOs that participated in the Stop-Loss Arrangement in the Performance Year ("**Adjusted Aggregate Stop-Loss Payout**")

11. The net difference of the Aggregate Stop-Loss Charge minus the Adjusted Aggregate Stop-Loss Payout ("**Aggregate Stop-Loss Impact**") is added to the ACO's total Performance Year Expenditure.

Gross Savings (Losses)

E. Gross savings (losses) are calculated based upon the difference between: (1) the Performance Year Benchmark; and (2) the Performance Year Expenditure after the Aggregate Stop-Loss Impact is included, if applicable.

Risk Sharing Option

F. The ACO's Risk Sharing Option and the Risk Sharing Option's applicable risk corridors will affect the calculation of Shared Savings or Shared Losses.

1. The two Risk Sharing Options determine the portion of gross savings or losses that accrue to the ACO as Shared Savings or Shared Losses. Under the Global Risk Sharing Option, the ACO assumes 100% risk of any savings or losses. Under the Professional Risk Sharing Option, the ACO assumes 50% risk of any gross savings or losses.

2. CMS uses the risk corridors specified in Table J of this Appendix to determine the maximum allowable percentage of the ACO's Performance Year Benchmark that may be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, subject to the Risk Sharing Option selected by the ACO.

Table J: Risk Corridors

	Risk Sharing Option			
	Global (Full Risk)		**Professional (Partial Risk)**	
Risk Band	% of Performance Year Benchmark	Savings/Losses Rate	% of Performance Year Benchmark	Savings/Losses Rate
Corridor 1	Less than 25%	100%	Less than 5%	50%
Corridor 2	25% to 35%	50%	5% to 10%	35%
Corridor 3	35% to 50%	25%	10% to 15%	15%
Corridor 4	More than 50%	10%	More than 15%	5%

Extreme and Uncontrollable Circumstances

G. After the application of the ACO's Risk Sharing Option, in the event of extreme and uncontrollable circumstances, such as a public health emergency, CMS may reduce Shared Losses, if any, prior to recoupment by an amount determined by multiplying the Shared Losses by the percentage of total months during the Performance Year affected by an extreme and uncontrollable circumstance, and the percentage of REACH Beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance. CMS applies determinations made under the Quality Payment Program with respect to whether an extreme and uncontrollable circumstance has occurred and the affected areas. CMS has the sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of REACH Beneficiaries residing in affected areas.

Application of Sequestration

H. For payments, including any related adjustments, that result from a settlement report that is initially issued in a period during which budget sequestration is in effect, budget sequestration will apply to the payment of Shared Savings, but does not apply to the repayment of Shared Losses. Budget sequestration does not apply to Other Monies Owed that result from a settlement report.

Other Monies Owed

I. As part of financial settlement, CMS also calculates Other Monies Owed in accordance with this Section VI.I. For Performance Year 2023 and Performance Year 2024, Other Monies Owed are calculated only for Final Financial Settlement and at such other times specified in the Agreement. For Performance Years 2025 and Performance Year 2026, Other Monies Owed are calculated for Provisional Settlement, Final Financial Settlement, and at such other times specified in the Agreement. The total amount of Other Monies Owed will be the sum of the following:

1. Other Monies Owed as the result of the reconciliation of the monthly PCC Payments in accordance with Appendix E of the Agreement or the reconciliation of monthly TCC Payments in accordance with Appendix G of the Agreement, as applicable.
2. Other Monies Owed to recoup the Actual Annual Enhanced PCC Payment Amount (as defined in Appendix E of the Agreement) the ACO received during the Performance Year calculated in accordance with Appendix E.
3. Other Monies Owed as a result of the reconciliation of monthly APO payments calculated in accordance with Appendix F of the Agreement.
4. Other Monies Owed for Performance Year 2023 and each subsequent Performance Year for earning a quality performance bonus from a notational pool of funds retained by CMS based on the ACO's performance on each of the quality measures described in Section 9.02 of the Agreement and a methodology determined by CMS prior to the start of the relevant Performance Year ("**High Performance Pool Bonus"** or "**HPP Bonus**") for the Performance Year.

5. Other Monies Owed as a result of the ACO's participation in one or more Benefit Enhancements calculated in accordance with Appendix I, Appendix J, and Appendices L through O, and T as applicable.

6. Other Monies Owed as a result of CMS pursuing payment for the Retention Guarantee Amount in accordance with Section 17.04.C of the Agreement.

7. At Final Financial Settlement only, the amount of the difference between the amount of Shared Savings distributed to the ACO (or Shared Losses received from the ACO) at the time of Provisional Financial Settlement (if applicable) and the amount of Shared Savings (or Shared Losses) calculated at the time of Final Financial Settlement.

8. For 2022 and subsequent Performance Years 2023, 2024, and 2025, Other Monies Owed as a result of APO Fee Reductions, PCC Fee Reductions, and TCC Fee Reductions occurring after the claims runout period for the Performance Year in accordance with Section VII.K of this Appendix B.

Provisional Financial Settlement and Final Financial Settlement

J. Provisional Financial Settlement and Final Financial Settlement

1. [Reserved]

2. Performance Years 2023-2026

a. Provisional Financial Settlement

i. If the ACO wishes to participate in Provisional Financial Settlement for Performance Year 2023 or any subsequent Performance Year, the ACO must timely submit to CMS its selection to participate in Provisional Financial Reconciliation for the Performance Year as described in Section 8.01 of the Agreement.

ii. Provisional Financial Settlement for each of Performance Years 2023 through 2026 will occur approximately one month after the end of the Performance Year.

iii. For purposes of Provisional Financial Settlement for each of Performance Years 2023 through 2026, the Performance Year Expenditure will include claims experience through December 31st of the Performance Year, with claims runout through December 31st of the Performance Year. The Performance Year Benchmark will be calculated using Beneficiary alignment information current as of January 1st of the following calendar year, will include interim risk scores, and as described in Section V.B.5 of this Appendix, will use a Placeholder Total Quality Score of 100% or, if available, a Placeholder Total Quality Score based on the ACO's total quality score from the most recent Performance Year with a complete total quality score to calculate the Quality Withhold Earn Back.

b. Final Financial Settlement

i. Final Financial Settlement for each of Performance Years 2023 through 2026 will be conducted approximately seven months after the end of the Performance Year.

ii. For purposes of Final Financial Settlement for each of Performance Years 2023 through 2026, the Performance Year Expenditure will include claims experience through December 31st of the Performance Year, with claims runout through three months following the end of the Performance Year. The Performance Year Benchmark will be calculated using final Beneficiary alignment information, final risk scores, and a total quality score calculated based on actual quality performance to calculate the Quality Withhold Earn Back.

Table K: PY2023-PY2026 Provisional Financial Settlement and Final Financial Settlement

Data/Timing	Provisional Financial Settlement	Final Financial Settlement
Date for Reconciliation	January 31 of the calendar year following the Performance Year	July 31 of the calendar year following the Performance Year
Claims Included in Reconciliation	Performance Year Expenditure incurred through December 31 of the Performance Year	Performance Year Expenditure incurred through December 31 of the Performance Year
Claims Runout	Through December 31 of the Performance Year	Through March 31 of the calendar year following the Performance Year
Risk Scores	Interim risk scores	Final risk scores
Quality Scores	Placeholder Total Quality Score	Final total quality score

Settlement Adjustments for Late Fee Reductions

K. Settlement Adjustments for Late Fee Reductions

1. For Performance Year 2022 and each Performance Year 2023, 2024, and 2025, CMS shall calculate Other Monies Owed as described in Section VI.I.8 of this Appendix B using the methodology described in Section VI.K.(2) through (5) of this Appendix B:

a. One year after Final Financial Settlement and at the same time that CMS issues a settlement report for the subsequent Performance Year; and

b. Two years after Final Financial Settlement and at the same time that CMS issues a settlement report for the second subsequent Performance Year.

2. CMS shall calculate a Late Fee Reduction Adjustment for the ACO's Capitation Payment Mechanism and, if applicable, for the APO as follows:

   a. If the ACO selected to participate in the APO for the Performance Year, CMS will determine the Late Fee Reduction Adjustment for the APO as the difference between the amount of the APO Fee Reduction calculated using claims runout through the applicable lookback period as described in Section VI.K.3, and the APO Fee Reduction calculated using three months of claims runout immediately following the Performance Year.

   b. If the ACO selected TCC Payment as its Capitation Payment Mechanism for the Performance Year, CMS will determine the Late Fee Reduction Adjustment for the TCC as the difference between the amount of the TCC Fee Reduction calculated using claims runout through the applicable lookback period as described in Section VI.K.3, and the TCC Fee Reduction calculated using three months of claims runout immediately following the Performance Year.

   c. If the ACO selected PCC Payment as its Capitation Payment Mechanism for the Performance Year, CMS will calculate the Late Fee Reduction Adjustment for the PCC as the product of the difference between the amount of the PCC Fee Reduction, calculated using claims runout through the applicable lookback period as described in Section VI.K.3, and the PCC Fee Reduction calculated using three months of claims runout immediately following the Performance Year, and the marginal risk sharing rate under the ACO's Risk Sharing Option (Global or Professional) for the applicable Performance Year as selected by the ACO as described in Section 8.01.

3. CMS shall calculate each Late Fee Reduction Adjustment under Section VI.K.2 using a lookback period beginning on the first day of the applicable Performance Year and ending on the last day for which claims information is available at the time of the calculation.

4. If the net amount of Late Fee Reduction Adjustment for the TCC calculated under Section VI.K.1.b or the total net amount of Late Fee Reduction Adjustment for the PCC calculated under Section VI.K.1.c and Late Fee Reduction Adjustment for the APO calculated under Section VI.K.1.a, if applicable, is greater than or equal to $1,000, then:

   a. This amount is Other Monies Owed calculated pursuant to Section VI.I.8 of this Appendix B;

   b. CMS shall issue a settlement report to the ACO setting forth the amount of Other Monies Owed calculated pursuant to Section VI.I.8; and

c. CMS shall pay the ACO or the ACO shall pay CMS, as applicable, the amount of Other Monies Owed calculated pursuant to Section VI.I.8 in accordance with Section 12.04.E of the Agreement.

Appendix C: Signed Attestation-based Voluntary Alignment

I. General

This Appendix will apply only if the ACO selects participation in SVA as described in Section 8.01 of the Agreement.

II. Signed Attestation-based Voluntary Alignment

A. The ACO may send a form (the "**Voluntary Alignment Form**") and a cover letter including instructions on how to complete the Voluntary Alignment Form ("**Letter**") electronically or by mail to a Beneficiary in a manner consistent with the requirements of Article V of the Agreement and this Appendix.

B. CMS shall determine the content of the Voluntary Alignment Form and shall provide templates to the ACO for both the Voluntary Alignment Form and the Letter.

C. The ACO shall make no changes to the template Voluntary Alignment Form provided by CMS, with the exception of changes made solely for the insertion of the following information where indicated:

1. The name of the Participant Provider that the ACO believes may be the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care;
2. The logo of the ACO or Participant Provider; and
3. Instructions for how the Beneficiary can submit the Voluntary Alignment Form to the ACO.

D. The ACO shall make no changes to the template Letter where CMS has indicated content that the ACO cannot amend or remove. The ACO may otherwise make changes, subject to the ACO obtaining CMS approval of the final Letter content pursuant to Section 5.04.J of the Agreement, including:

1. Formatting for electronic distribution;
2. Inserting the name of the Participant Provider that the ACO believes may be the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary received care;
3. Inserting the logo of the ACO or Participant Provider;
4. The addition of instructions for how the Beneficiary can submit the Voluntary Alignment Form to the ACO;
5. The insertion of information about unique care coordination and preventative services offered by the ACO; and
6. Inserting the ACO's contact information for answering Beneficiaries' questions.

E. The ACO shall submit to CMS, by a time and in a form and manner specified by CMS, a document describing how the ACO will conduct its Voluntary Alignment Activities specific to SVA in accordance with this Appendix during the Performance Year, including the criteria for determining which Beneficiaries will receive the Voluntary Alignment Form and Letter.

F. The ACO shall not, and shall require its Participant Providers and Preferred Providers not to, send or distribute the Voluntary Alignment Form outside the ACO Service Area (as defined in Section 5.04.H of the Agreement). The ACO may provide the Voluntary Alignment Form at the point of care only in the offices of Participant Providers. The ACO shall notify CMS by a date specified by CMS if the ACO elects to provide the Voluntary Alignment Form at the point of care.

G. Form Requests

1. The ACO shall permit any Beneficiary who receives care from a Participant Provider to receive a Voluntary Alignment Form, upon request. The ACO shall permit the Beneficiary to request a Voluntary Alignment Form in person at the office of the Participant Provider or by calling the ACO.
2. The ACO shall permit any Beneficiary who has received a Voluntary Alignment Form to request another Voluntary Alignment Form that identifies a different Participant Provider as the Beneficiary's main doctor, main provider, and/or main place the Beneficiary receives care; or that identifies a physician or other individual or entity that is not a Participant Provider as the Beneficiary’s main doctor, main provider, or main place the Beneficiary receives care; or otherwise reverses the Beneficiary’s SVA. The ACO shall permit such requests to be made by calling the ACO.
3. The ACO shall permit the appointed representative of a Beneficiary who has received a Voluntary Alignment Form to complete and sign the Voluntary Alignment Form on behalf of the Beneficiary.

H. Maintenance of Records. In accordance with Section 16.02 of the Agreement, the ACO shall maintain and shall provide to the government upon request a list of all Beneficiaries to whom the ACO has sent the Voluntary Alignment Form and Letter, copies of all Voluntary Alignment Forms sent or otherwise furnished to Beneficiaries (including copies of the Letter sent with such forms), and, as applicable, original executed Voluntary Alignment Forms, envelopes in which Voluntary Alignment Forms were returned to the ACO, written documentation of any oral communications with a Beneficiary or his or her appointed representative regarding the potential or actual reversal of a Voluntary Alignment Form, all electronic data and files associated with the distribution and submission of Voluntary Alignment Forms, and all other documents and records regarding the ACO’s participation in SVA, including documents and records pertaining to Beneficiary communications.

III. SVA Process

A. The ACO shall submit to CMS a list (“**SVA List**”) that contains the following:

1. The name, Medicare Beneficiary Identifier (MBI), and, to the extent required by CMS, any other identifying information of each Beneficiary who returned a valid Voluntary Alignment Form to the ACO identifying a Participant Provider or a physician or other

individual or entity that is not a Participant Provider as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care. The ACO must include on the SVA List all Beneficiaries who have submitted a valid Voluntary Alignment Form to the ACO. A Voluntary Alignment Form is valid only if it has been signed and dated by the Beneficiary or his or her appointed representative and was returned to the ACO on or before the date on which the ACO submits its SVA List to CMS. If a Beneficiary returns more than one valid Voluntary Alignment Form to the ACO, the ACO should include only the information from the latest submitted valid Voluntary Alignment Form. A Voluntary Alignment Form submitted to a Participant Provider is considered to have been returned to the ACO;

2. For each Beneficiary identified pursuant to Section III.A.1 of this Appendix, the date on which the Beneficiary executed the Voluntary Alignment Form and the identity of the Participant Provider or physician or other individual or entity that is not a Participant Provider that the Beneficiary has identified as his or her main doctor, main provider, and/or main place the Beneficiary receives care, and, if the Beneficiary identified a Participant Provider that is not an ACO Professional, the identity of an ACO Professional associated with that Participant Provider; and

3. A certification by an executive of the ACO made in accordance with Section 15.05 of the Agreement that, to the best of his or her knowledge, information, and belief, the information contained on the SVA List is true, accurate, and complete and identifies only those Beneficiaries who have submitted a valid Voluntary Alignment Form to the ACO.

B. The ACO shall submit the SVA List to CMS in advance of the subsequent Performance Year in a form and manner and by a date specified by CMS. CMS will use the SVA List to conduct alignment of Beneficiaries for the subsequent Performance Year. In addition, if the ACO has selected Prospective Plus Alignment for the Performance Year as described in Section 8.01 of the Agreement, the ACO may submit the SVA List to CMS in advance of each subsequent calendar quarter of the Performance Year by a date specified by CMS. CMS will use these SVA Lists, if submitted, to conduct alignment of Beneficiaries for the second through fourth calendar quarters of the Performance Year.

C. CMS may monitor and/or audit the ACO's SVA Lists for accuracy in accordance with Section 15.02 of the Agreement. This audit, including any surveys of Beneficiaries conducted pursuant to Section III.D of this Appendix, may take place during the Performance Year or at a later time, as determined by CMS.

D. CMS may survey Beneficiaries as a part of the audit process described in Section III.C of this Appendix.

Appendix D: Quality Measures

The following quality measures are the measures for use in establishing quality performance standards. Any references to quality measures for Performance Year 2021 and Performance Year 2022 shall apply only if the ACO participated in the Model Performance Period in Performance Year 2021 or Performance Year 2022, as applicable.

Domain	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance
Care Coordination/Patient Safety	Risk-Standardized, All Condition Readmission	Claims	PY2021: P & R PY2022: P & R PY2023-2026: P
	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	PY2021: P & R PY2022: P & R PY2023-2026: P
	Days at Home (for High Needs Population ACO)	Claims	PY2021-2022: R PY2023-2026: P
	Timely Follow-Up After Acute Exacerbations of Chronic Conditions (for Standard ACO or New Entrant ACO)	Claims	PY2021: N/A PY2022: R PY2023-2026: P
A Patient/Caregiver Experience (if the ACO is not a High Needs ACO)	Consumer Assessment of Healthcare Providers and Systems® (CAHPS)	Survey	PY2021: N/A PY2022: R PY2023-2026: P
Patient/Caregiver Experience (if the ACO is a High Needs ACO)	Consumer Assessment of Healthcare Providers and Systems® (CAHPS)	Survey	PY2021: N/A PY2022: R PY2023: R PY2024-PY2026: To be determined by CMS*

* In advance of each of Performance Years PY2024-PY2026, CMS will notify the ACO whether this measure will be pay for reporting or pay for performance.

Appendix E: Capitation Payment Mechanism: PCC Payment

I. PCC Payment Selection

A. If the ACO wishes to participate in PCC Payment for a Performance Year, the ACO must, by a date and in a form and manner specified by CMS:

1. Timely submit to CMS its selection of PCC Payment as its Capitation Payment Mechanism for the Performance Year as described in Section 8.01 of the Agreement;

2. [Reserved]

3. For Performance Year 2023 and each subsequent Performance Year:

   a. Timely submit as described in Article IV of the Agreement a true, accurate, and complete list of all Participant Providers to be included on the Participant Provider List at the start of the Performance Year and a true, accurate, and complete list of those Preferred Providers that have agreed to participate in PCC Payment at the start of the Performance Year.

   b. Timely submit by a date and in a form and manner specified by CMS a certification that the ACO has obtained a fully executed "ACO REACH Model: Fee Reduction Agreement" (as described in Section 12.02.E of the Agreement) for each Participant Provider that is identified on the Participant Provider List submitted in accordance with Section I.A.3(a) of this Appendix, and for each Preferred Provider that is identified as participating in PCC Payment, as set forth on the Preferred Provider List submitted in accordance with Section I.A.3(a) of this Appendix; and

4. Timely submit by a date and in a form and manner certified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.A of this Appendix.

B. CMS may reject or later terminate the ACO's selection to participate in PCC Payment for the Performance Year in accordance with Section 8.02 or Section 17.01 of the Agreement if:

1. CMS has taken any remedial actions pursuant to Section 17.01 of the Agreement;

2. CMS has taken any remedial actions against the ACO in connection with the ACO's participation in another Medicare shared savings initiative during either of the ACO's last two performance years in that initiative; or

3. CMS determines on the basis of a Program Integrity Screening or other information that the ACO's participation in PCC Payment might compromise the integrity of the Model.

C. If CMS rejects or later terminates the ACO's selection to participate in PCC Payment for a Performance Year (in accordance with Section 8.02 or Section 17.01 of the Agreement), payments to the ACO's PCC Payment-participating Participant Providers and Preferred Providers that would otherwise be subject to

PCC Payment will default to traditional FFS for the Performance Year or for the remainder of the Performance Year, as applicable. The ACO will not have the ability to choose another Capitation Payment Mechanism for the Performance Year. CMS may terminate the Agreement or the Agreement Performance Period in accordance with Section 17.02 of the Agreement if CMS has rejected or later terminated the ACO's selection to participate in PCC Payment for a Performance Year.

D. CMS may prohibit the ACO from having a PCC Payment Arrangement (as defined in Section III of this Appendix) with a Participant Provider or Preferred Provider if:

1. The conduct of the Participant Provider or Preferred Provider has caused CMS to impose remedial action pursuant to Section 17.01 of the Agreement or to impose a sanction under any CMS administrative authority; or

2. CMS determines on the basis of a Program Integrity Screening or other information that the Participant Provider's or Preferred Provider's participation in PCC Payment might compromise the integrity of the Model.

E. As described in Section 8.01 of the Agreement, the ACO must, by a date and in a form and manner specified by CMS, select the maximum Enhanced PCC Percentage it would like to receive within the range of 0% and 7% ("**ACO-Selected Enhanced PCC Percentage**"). If the ACO wishes to receive the Enhanced PCC for a Performance Year, it must select a maximum Enhanced PCC Percentage greater than 0%. If the ACO selects a maximum Enhanced PCC Percentage equal to 0%, the ACO will not receive the Enhanced PCC.

F. CMS may reject the ACO's selection of a maximum Enhanced PCC Percentage of greater than 0% for a Performance Year if:

1. CMS has taken any remedial actions pursuant to Section 17.01 of the Agreement;

2. CMS has taken any remedial actions against the ACO in connection with its participation in another Medicare shared savings initiative during either of the ACO's last two performance years in that initiative; or

3. CMS determines on the basis of a Program Integrity Screening or other information that the ACO's receipt of the Enhanced PCC might compromise the integrity of the Model.

G. If CMS rejects the ACO's selection of a maximum Enhanced PCC Percentage of greater than 0% for a Performance Year, the ACO will not receive the Enhanced PCC portion of the PCC Payment for that Performance Year.

II. PCC Fee Reduction

A. If the ACO selects to participate in PCC Payment for a Performance Year in accordance with Section I.A of this Appendix, the ACO shall, by a date specified by CMS, notify and educate all Participant Providers and Preferred Providers about the ACO's intended participation in PCC Payment and the associated PCC

Fee Reduction for PCC Payment-participating Participant Providers and Preferred Providers. Providing a copy of the ACO REACH Model: Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in PCC Payment for a Performance Year is rejected or later terminated, the ACO shall notify all Participant Providers and Preferred Providers that it is not participating in PCC Payment for that Performance Year or for the remainder of that Performance Year, as applicable. The ACO shall provide such notice in writing no later than 10 Days after such rejection or termination.

B. A Participant Provider or Preferred Provider may participate in PCC Payment for a Performance Year only if the Participant Provider or Preferred Provider was included on the Participant Provider List or Preferred Provider List, respectively, at the start of the relevant Performance Year.

C. [Reserved]

D. [Reserved]

E. Participant Providers who were included on the final Participant Provider List at the start of the relevant Performance Year must agree to participate in PCC Payment and to receive the PCC Fee Reduction for a Performance Year in accordance with Section 12.02.E of the Agreement.

F. For each Participant Provider, with the exception of those Participant Providers with whom the ACO is prohibited under Section I.D of this Appendix from having a PCC Payment Arrangement, CMS will reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries by the PCC Fee Reduction Percentage agreed to by the Participant Provider as specified on the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

G. Not all Preferred Providers must agree to participate in PCC Payment, even if other Participant Providers or Preferred Providers that bill under the same TIN participate in PCC Payment.

H. For each Preferred Provider that has consented to participate in PCC Payment pursuant to Section 12.02.E of the Agreement, with the exception of those Preferred Providers with whom the ACO is prohibited under Section I.D of this Appendix from having a PCC Payment Arrangement, CMS will reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries by the PCC Fee Reduction percentage agreed to by the Preferred Provider as specified on the final Preferred Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

I. PCC Payment-participating Participant Providers and Preferred Providers that bill under the same TIN do not have to agree to the same PCC Fee Reduction percentages.

J. A Participant Provider or Preferred Provider may not participate in PCC Payment for a Performance Year if the Participant Provider or Preferred Provider was not included on the Participant Provider List or Preferred Provider List at the start of that Performance Year.

K. CMS will reduce all FFS payments for PCC Eligible Services furnished to REACH Beneficiaries that are billed under the CCN and organizational NPI of a PCC-Payment participating Participant Provider or Preferred Provider that is an FQHC (Type of Bill 77x) or RHC (Type or Bill 71x) by the PCC Fee Reduction percentage agreed upon by that Participant Provider or Preferred Provider regardless of whether the individual NPI rendering the service is a Participant Provider or Preferred Provider and regardless of whether the individual is identified as participating in PCC Payment. All institutional providers other than FQHCs and RHCs are ineligible for PCC Payment.

L. CMS will not reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries who elect to decline data sharing or for services related to the diagnosis and treatment of substance use disorder furnished to REACH Beneficiaries.

M. CMS will not reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries for which Medicare FFS is not the primary payer.

N. CMS will not reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries by providers enrolled in Periodic Interim Payments (PiP) program or other Medicare programs or initiatives specified by CMS prior to the start of the Performance Year or the relevant subsequent quarter.

O. [Reserved]

P. CMS will not reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries by a home health agency if the claim is for an episode period for which the home health agency has submitted a Request for Anticipated Payment (RAP).

Q. CMS will not reduce FFS payments on claims furnished to REACH Beneficiaries by a Participant Provider or Preferred Provider who is a nonparticipating supplier, as that term is defined in 42 CFR § 400.202, that is not accepting assignment on the claim.

R. CMS will not reduce FFS payments on claims furnished to REACH Beneficiaries for the provision of COVID-19 tests, or other such services as defined by CMS.

S. CMS will not reduce GUIDE Payments.

III. Primary Care Capitation Payment Arrangement

A. The ACO shall have a written payment arrangement with each Participant Provider and Preferred Provider participating in PCC Payment that establishes how the ACO will compensate the Participant Provider or Preferred Provider for PCC Eligible Services furnished to REACH Beneficiaries ("**PCC Payment Arrangement**").

B. PCC Payment Arrangements must comply with all requirements of Section 3.04 of the Agreement.

C. Remuneration furnished by the ACO under a PCC Payment Arrangement must be negotiated in good faith and be consistent with fair market value.

D. The ACO shall maintain, in accordance with Section 16.02 of the Agreement, records of all remuneration made or received pursuant to each PCC Payment Arrangement.

E. The PCC Payment Arrangement must:

1. Require the Participant Provider or Preferred Provider to make Medically Necessary Covered Services available to REACH Beneficiaries in accordance with all applicable laws and regulations.
2. Prohibit the ACO from requiring prior authorization for services furnished to REACH Beneficiaries.
3. Prohibit the ACO and the Participant Provider or Preferred Provider from interfering with a REACH Beneficiary's freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in PCC Payment or with the ACO.
4. Require the ACO to compensate the Participant Provider or Preferred Provider for PCC Eligible Services no later than 30 Days after receiving notice of the processed claim for such Services, as indicated in claims data sent by CMS to the ACO, as described in Section 6.02.C of the Agreement, unless a different number of Days is specified in the PCC Payment Arrangement.
5. Require the Participant Provider or Preferred Provider to maintain records regarding the PCC Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section 16.02 of the Agreement.
6. Require the Participant Provider or Preferred Provider to provide the government with access to records regarding the PCC Payment Arrangement (including records of any compensation made or received under the arrangement) in accordance with Section 16.02 of the Agreement.
7. Meet the requirements under Section 3.04 of the Agreement.

F. The ACO shall ensure that it has and will retain the capability and funds to compensate Participant Providers and Preferred Providers participating in PCC Payment for PCC Eligible Services that they furnish, and that it will promptly make such payments, in accordance with the PCC Payment Arrangement.

G. The ACO must establish procedures under which Participant Providers and Preferred Providers may request reconsideration by the ACO of a determination regarding compensation pursuant to a PCC Payment Arrangement. The procedures for requesting reconsideration must be included in the written PCC Payment Arrangement between the ACO and the PCC Payment-participating Participant Providers and Preferred Providers.

IV. Beneficiary Disputes

A. CMS will process all claims submitted by Participant Providers and Preferred Providers participating in PCC Payment, and assess coverage for such services and any Beneficiary liability using the same standards that apply under traditional Medicare FFS.

B. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claims appeals process at 42 CFR Part 405, subpart I.

V. PCC Payment Amount

A. General

1. CMS shall estimate, update, adjust, and reconcile the amount of the monthly PCC Payment in accordance with this Appendix.

2. CMS uses one of two methodologies to estimate the monthly PCC Payment amount:

   a. Except specified in Section V.A.2(b) of this Appendix, CMS estimates the monthly PCC Payment amount for each month during the first quarter of the Performance Year in accordance with Section V.B of this Appendix ("**Default Monthly PCC Payment Calculation**").

   b. If CMS determines the ACO does not have sufficient claims history to estimate the monthly PCC Payment amount prior to the start of the Performance Year in accordance with Section V.B of this Appendix, CMS estimates monthly PCC Payment amount for each month during the first, second, and third quarters of the Performance Year in accordance with Section V.C of this Appendix ("**Alternative Monthly PCC Payment Calculation**"), unless CMS determines it is appropriate to use the most recently calculated Base PCC Percentage, Hypothetical Base PCC Percentage, and Average Retention Rate (as those terms are described in Section V.B of this Appendix) from the prior Performance Year to calculate the monthly PCC Payment amount, in which case CMS calculates the monthly PCC Payment amount for each month during the first quarter of the Performance Year under the Default Monthly PCC Payment Calculation using the most recently calculated Base PCC Percentage, Hypothetical Base PCC Percentage, and Average Retention Rate from the prior Performance Year.

3. CMS updates the monthly PCC Payment amount for each month during each subsequent quarter in accordance with Section V.D of this Appendix.

4. CMS will make a monthly PCC Payment to the ACO for each month that the ACO participates in PCC Payment during the Performance Year, beginning in the first month of the Performance Year, regardless of the methodology used to calculate monthly PCC Payments.

5. CMS will calculate the monthly PCC Payment amount for each month in a calendar quarter prior to the start of that calendar quarter and will provide

a report to the ACO containing the monthly PCC Payment amount for each month in the upcoming calendar quarter.

6. CMS shall not make any monthly PCC Payments to the ACO after the effective date of termination of the Agreement Performance Period.

7. CMS shall not make any monthly PCC Payments after the effective date of CMS' termination (in accordance with Section 8.02 or Section 17.01 of the Agreement) of the ACO's selection to participate in PCC Payment.

8. The PCC Payment is subject to budget sequestration, if budget sequestration is in effect for the period in which the PCC Payment is made.

9. CMS will review the PCC Fee Reductions applied to FFS payments made to PCC Payment-participating Participant Providers and Preferred Providers during each Performance Year. If, during a Performance Year, CMS determines based on claims data that the Base PCC portion of the PCC Payments paid to the ACO is at least 5% greater or at least 5% lower than the total amount of PCC Fee Reductions actually applied to FFS payments made to PCC Payment-participating Participant Providers or Preferred Providers, or if one or more PCC Payment-participating Participant Providers or a PCC Payment-participating Preferred Providers ceases to be a PCC Payment-participating Participant Provider or a Preferred Provider, respectively, or if CMS specifies that it will not reduce FFS payments on claims for PCC Eligible Services furnished to REACH Beneficiaries by providers enrolled in a Medicare programs or initiative during the Performance Year, in accordance with Section II.M of this Appendix, CMS may recalculate the monthly PCC Payment amount, or any updates thereto, in accordance with Section V.B, Section V.C, or Section V.D of this Appendix, as applicable. If CMS recalculates the monthly PCC Payment amount pursuant to this Section V.A.9, CMS will provide a report of the recalculated amounts to the ACO and will make monthly PCC Payments in the revised amount for future months of the Performance Year, subject to any quarterly updates and adjustments described in Section V.D of this Appendix.

10. CMS may increase the monthly PCC Payment amount for the first month of the first quarter of the Performance Year in which monthly PCC Payments are made to the ACO by 20% if CMS determines, at CMS's sole discretion, that the applicable PCC Payment methodology described in Section V.A.2 of this Appendix may result in an underestimate of the monthly PCC Payment amount for that quarter. If CMS applies this adjustment, CMS will subtract the amount added to the first monthly PCC Payment for the Performance Year pursuant to this Section V.A.10 from the last monthly PCC Payment for the Performance Year.

B. Default Monthly PCC Payment Calculation

General

1. Under the Default Monthly PCC Payment Calculation, the monthly PCC Payment amount for a given month of the first quarter of the Performance Year is the sum of the Default Base PCC Amount for that month (calculated in accordance with Section V.B.4 of this Appendix) and the Default Enhanced PCC Amount for that month (calculated in accordance with Section V.B.7 of this Appendix).

Default Base PCC Amount

2. To calculate the Default Base PCC Amount for a given month during the first quarter of the Performance Year, CMS first estimates the total portion of claims-based payments that will be subject to PCC Fee Reductions during that month ("**Default Base PCC Percentage**") as follows:

    a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 1 of this Appendix to calculate the total amount of claims-based payments for all Covered Services furnished to those Beneficiaries who would have been aligned to the ACO during the applicable lookback period using the Claims-based Alignment methodology described in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

Figure 1. Applicable Lookback Periods for Calculating the Default Base PCC Percentage for the First Quarter of a Performance Year

PY	Applicable Lookback Period	Alignment methodology
2023	Q1-Q3 2022	Claims-Based Alignment
2024	Q1-Q3 2023	Claims-Based Alignment
2025	Q1-Q3 2024	Claims-Based Alignment
2026	Q1-Q3 2025	Claims-Based Alignment

    b. CMS estimates the portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix that would be subject to PCC Fee Reductions ("**Default Per-Provider Base PCC Reduced Claims Amount**") by calculating, for each PCC Payment-participating Participant Provider and Preferred Provider, the product of: (1) the total claims-based payments for PCC Eligible Services made to the Participant Provider or Preferred Provider during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix; and (2) the PCC Fee Reduction percentage agreed to by the Participant Provider or Preferred Provider.

    c. To calculate the Default Base PCC Percentage, the Default Per-Provider Base PCC Reduced Claims Amount is aggregated across

all PCC Payment-participating Participant Providers and Preferred Providers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix.

d. In calculating the Default Base PCC Percentage as described in this Section V.B.2, CMS may make additional adjustments to the Default Per-Provider Base PCC Reduced Claims Amount to account for changes in the Medicare Physician Fee Schedule made between the lookback period and the Performance Year such that the Default Base PCC Percentage reflects what the Default Base PCC Percentage would have been in the lookback period had such changes to the Medicare Physician Fee Schedule been in place during the lookback period in which it was calculated.

3. CMS then converts the Default Base PCC Percentage to a per-Beneficiary per-month (PBPM) amount ("**Default PBPM Base PCC Amount**") by multiplying the Default Base PCC Percentage by a PBPM version of the Performance Year Benchmark ("**Default PBPM Benchmark Amount**"). CMS calculates the Default PBPM Benchmark Amount by dividing the ACO's Performance Year Benchmark as specified in the Performance Year Benchmark Report, by the number of Originally Aligned Beneficiaries reported in the Performance Year Benchmark Report.

4. CMS calculates the Default Base PCC Amount for each month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for that month, calculated in accordance with the applicable provision of Section V.B.9 of this Appendix, by the Default PBPM Base PCC Amount.

Default Enhanced PCC Amount

5. To calculate the Default Enhanced PCC Amount for a given month during the first quarter of the Performance Year, CMS first estimates the total portion of the Performance Year Benchmark that the ACO will receive as Enhanced PCC ("**Default Enhanced PCC Percentage**") as follows:

a. CMS estimates the hypothetical portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix that would be subject to the PCC Fee Reductions if all Participant Providers elected to participate in PCC Payment and agreed to a PCC Fee Reduction of 100% ("**Default Per-Provider Enhanced PCC Reduced Claims Amount**") by calculating the total claims-based payments for PCC Eligible Services made to each Participant Provider during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix and, for each PCC Payment-participating Preferred Provider, the product of: (1) the total claims-based payments for PCC Eligible Services made to the Preferred Provider during the applicable

lookback period calculated in accordance with Section V.B.2(a) of this Appendix; and (2) the PCC Fee Reduction percentage agreed to by the Preferred Provider.

b. The Default Per-Provider Enhanced PCC Reduced Claims Amount is aggregated across all Participant Providers and PCC Payment-participating Preferred Providers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix to generate the estimated percentage of claims-based payments that would be subject to PCC Fee Reduction if all Participant Providers elected to participate in PCC Payment and agreed to a PCC Fee Reduction of 100% ("**Default Hypothetical Base PCC Percentage**").

c. In calculating the Default Enhanced PCC Percentage as described in this Section V.B.5, CMS may make additional adjustments to the Default Per-Provider Enhanced PCC Reduced Claims Amount to account for changes in the Medicare Physician Fee Schedule made between the lookback period and the Performance Year such that the Default Hypothetical Base PCC Percentage reflects what the Default Hypothetical Base PCC Percentage would have been in the lookback period had such changes to the Medicare Physician Fee Schedule been in place during the lookback period in which it was calculated.

d. CMS then subtracts the Default Hypothetical Base PCC Percentage from 7%.

e. The "**CMS-Calculated Maximum Enhanced PCC Percentage**" is equal to the greater of 2% or the amount described in Section V.B.5(d) of this Appendix.

f. The "**Default Enhanced PCC Percentage**" will be the lesser of the maximum Enhanced PCC Percentage selected by the ACO as described in Section 8.01 of the Agreement or the CMS-Calculated Maximum Enhanced PCC Percentage.

6. CMS multiplies the Default Enhanced PCC Percentage by the Default PBPM Benchmark Amount ("**Default PBPM Enhanced PCC Amount**").

7. CMS calculates the Default Enhanced PCC Amount for each month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for that month, calculated in accordance with the applicable section of Section V.B.9 of this Appendix, by the Default PBPM Enhanced PCC Amount.

Estimated Number of REACH Beneficiaries

8. To calculate the estimated number of REACH Beneficiaries for a given month during the first quarter of the Performance Year for purposes of the Default Monthly PCC Payment Calculation, CMS first estimates the

average number of Beneficiaries who will remain aligned to the ACO from one month to the following month during the Performance Year ("**Default Average Retention Rate**") as follows:

a. CMS determines the number of Beneficiaries who would have been aligned to the ACO for each month of the applicable lookback period listed in Figure 2 of this Appendix using the Claims-based Alignment methodology described in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

Figure 2. Applicable Lookback Periods for Calculating the Default Average Retention Rate

PY	Applicable Lookback Period	Alignment methodology
2023	Q1-Q3 2022	Claims-Based Alignment
2024	Q1-Q3 2023	Claims-Based Alignment
2025	Q1-Q3 2024	Claims-Based Alignment
2026	Q1-Q3 2025	Claims-Based Alignment

b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of Beneficiaries who would have been aligned to the ACO in the month by the number of Beneficiaries who would have been aligned to the ACO in the previous month of the applicable lookback period ("**Default Retention Rate**"). For example, for Performance Year 2023, the second month of the applicable lookback period is February 2022. To calculate the Default Retention Rate for February 2022, CMS divides the number of Beneficiaries who would have been aligned to the ACO in February 2022 by the number of Beneficiaries who would have been aligned to the ACO in January 2022.

c. CMS sums the Default Retention Rate for each month in the applicable lookback period and divides the sum of such Default Retention Rates by the number of months in the applicable lookback period for which a Default Retention Rate was calculated to establish the Default Average Retention Rate.

9. CMS estimates the number of REACH Beneficiaries for each month of the first quarter of the Performance Year for purposes of the Default Monthly PCC Payment Calculation as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the first quarter of the Performance Year by multiplying the estimated number of Alignment-Eligible Beneficiaries for the month prior to the first month of the Performance Year, as specified in the report that will be shared with the ACO in

accordance with Section 6.03.B of the Agreement, by the Average Default Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries in the first month of the first quarter of the Performance Year, calculated in accordance with Section V.B.9(a) of this Appendix, by the Average Default Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries in the second month of the first quarter of the Performance Year, calculated in accordance with Section V.B.9(b) of this Appendix, by the Average Default Retention Rate.

C. Alternative Monthly PCC Payment Calculation

First Two Quarters - General

1. Under the Alternative Monthly PCC Payment Calculation, for each month of the first two quarters of the Performance Year, monthly PCC Payments are lump-sum and do not have separate Base PCC Amount and Enhanced PCC Amount components.

2. To calculate the PCC Payment amount for each of these months, CMS first multiplies the Default PBPM Benchmark Amount calculated as described in Section V.B.3 of this Appendix by 7% ("**Alternative PBPM PCC Lump-Sum Amount**").

3. CMS then calculates the monthly PCC Payment for each month of the first two quarters of the Performance Year by multiplying the estimated number of REACH Beneficiaries for that month, calculated in accordance with the applicable provision of Section V.C.5 of this Appendix, by the Alternative PBPM PCC Lump-Sum Amount.

First Two Quarters – Estimated Number of REACH Beneficiaries

4. To calculate the estimated number of REACH Beneficiaries for a given month during the first two quarters of the Performance Year for purposes of the Alternative Monthly PCC Payment Calculation, CMS first estimates the average number of Beneficiaries who will remain aligned to the ACO from one month to the following month during the Performance Year using a general retention rate ("**General Average Retention Rate**"). If the ACO is a High Needs Population ACO, the General Average Retention Rate is 100%. If the ACO is a Standard ACO or New Entrant ACO, CMS calculates the General Average Retention Rate as follows:

a. CMS determines the number of Beneficiaries in the ACO REACH National Reference Population (as that term is defined in Appendix B of the Agreement) for each month of the applicable lookback period listed in Figure 3 of this Appendix.

Figure 3. Applicable Lookback Periods for Calculating the General Average Retention Rate

PY	Applicable Lookback Period
2023	Q1-Q3 2022
2024	Q1-Q3 2023
2025	Q1-Q3 2024
2026	Q1-Q3 2025

b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of Beneficiaries in the ACO REACH National Reference Population by the number of Beneficiaries in the ACO REACH National Reference Population in the previous month of the applicable lookback period ("**General Retention Rate**"). For example, for Performance Year 2023, the second month of the applicable lookback period is February 2022. To calculate the General Retention Rate for February 2022, CMS divides the number of Beneficiaries in the ACO REACH National Reference Population in February 2022 by the number of Beneficiaries in the ACO REACH National Reference Population in January 2022.

c. CMS sums the General Retention Rate for each month of the applicable lookback period and divides the sum of General Retention Rates by the number of months in the applicable lookback period for which a General Retention Rate was calculated to establish the General Average Retention Rate.

5. CMS estimates the number of REACH Beneficiaries for each month in the first two quarters of the Performance Year for purposes of the Alternative Monthly PCC Payment Calculation as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the Performance Year by multiplying the estimated number of Alignment-Eligible Beneficiaries for the month prior to the first month of the Performance Year, as specified in the report that will be shared with the ACO in accordance with Section 6.03.B of the Agreement, by the General Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the first month of the Performance Year, calculated in accordance with Section V.C.5(a) of this Appendix, by the General Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the Performance Year by multiplying the number of REACH Beneficiaries for the second month of the Performance Year, calculated in accordance with Section V.C.5(b) of this Appendix, by the General Average Retention Rate.

d. CMS estimates the number of REACH Beneficiaries for the fourth month of the Performance Year by multiplying the number of REACH Beneficiaries for the third month of the Performance Year, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the General Average Retention Rate.

e. CMS estimates the number of REACH Beneficiaries for the fifth month of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the fourth month of the Performance Year, calculated in accordance with Section V.C.5(d) of this Appendix, by the General Average Retention Rate.

f. CMS estimates the number of REACH Beneficiaries for the sixth month of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the fifth month of the Performance Year, calculated in accordance with Section V.C.5(e) of this Appendix, by the General Average Retention Rate.

Third Quarter - General

6. Under the Alternative Monthly PCC Payment Calculation, for each month in the third quarter of the Performance Year, the monthly PCC Payment for a given month is the sum of the Alternative Base PCC Amount for that month (calculated in accordance with Section V.C.9 of this Appendix) and the Alternative Enhanced PCC Amount for that month (calculated in accordance with Section V.C.12 of this Appendix), plus the PCC Payment Adjustment Amount for that month (calculated in accordance with Section V.C.15 of this Appendix).

Third Quarter - Alternative Base PCC Amount

7. To calculate the Alternative Base PCC Amount for a given month during the third quarter of the Performance Year, CMS first estimates the total portion of claims-based payments that would be subject to the PCC Fee Reductions during that month ("**Alternative Base PCC Percentage**") as follows:

   a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 4 of this Appendix to calculate the total amount of claims-based payments for all Covered Services furnished to those REACH Beneficiaries who were aligned to the ACO during the applicable lookback period through either Claims-based Alignment or Voluntary Alignment.

Figure 4. Applicable Lookback Periods for Calculating Alternative Base PCC Percentage for the third quarter of the Performance Year

PY	Relevant calendar quarter in PY for Alternative Base PCC Percentage calculations	Applicable Lookback Period	Alignment Methodology
2023	Q3	Q1 2023	Claims-Based Alignment and Voluntary Alignment
2024	Q3	Q1 2024	Claims-Based Alignment and Voluntary Alignment
2025	Q3	Q1 2025	Claims-Based Alignment and Voluntary Alignment
2026	Q3	Q1 2026	Claims-Based Alignment and Voluntary Alignment

b. CMS estimates the portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix that would be subject to the PCC Fee Reductions ("**Alternative Per-Provider Base PCC Reduced Claims Amount**") by calculating, for each PCC Payment-participating Participant Provider and Preferred Provider, the product of: (1) the total claims-based payments for PCC Eligible Services made to the Participant Provider or Preferred Provider during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix; and (2) the PCC Fee Reduction percentage agreed to by the Participant Provider or Preferred Provider.

c. To calculate the Alternative Base PCC Percentage, the Alternative Per-Provider Base PCC Reduced Claims Amount is aggregated across all PCC Payment-participating Participant Providers and Preferred Providers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix.

8. CMS then converts the Alternative Base PCC Percentage to a per-Beneficiary per-month (PBPM) amount ("**Alternative PBPM Base PCC Amount**") by multiplying the Alternative Base PCC Percentage by a PBPM version of the Performance Year Benchmark ("**Alternative PBPM Benchmark Amount**"). To calculate the Alternative PBPM Benchmark Amount, CMS first sums the number of months during which each REACH Beneficiary was aligned to the ACO during the reporting period covered by the most recent Quarterly Benchmark Report ("**Beneficiary-Months**"), and then divides the ACO's Performance Year Benchmark reported in the most recent Quarterly Benchmark Report by the number of Beneficiary-Months.

9. CMS calculates the Alternative Base PCC Amount for each month of the third quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for that month, calculated in accordance with the applicable provision of Section V.C.14 of this Appendix, by the Alternative PBPM Base PCC Amount.

Third Quarter - Alternative Enhanced PCC Amount

10. To calculate the Alternative Enhanced PCC Amount for a given month during the third quarter of the Performance Year, CMS first estimates the total portion of the Performance Year Benchmark that the ACO will receive as Enhanced PCC ("**Alternative Enhanced PCC Percentage**") as follows:

    a. CMS estimates the hypothetical portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix that would be subject to the PCC Fee Reductions if all Participant Providers elected to participate in PCC Payment and agreed to a PCC Fee Reduction of 100% ("**Alternative Per-Provider Enhanced PCC Reduced Claims Amount**") by calculating the total claims-based payments for PCC Eligible Services made to each Participant Provider during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix and, for each PCC Payment-participating Preferred Provider, the product of: (1) the total claims-based payments for PCC Eligible Services made to the Preferred Provider during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix; and (2) the PCC Fee Reduction percentage agreed to by the Preferred Provider.

    b. The Alternative Per-Provider Enhanced PCC Reduced Claims Amount is aggregated across all Participant Providers and PCC Payment-participating Preferred Providers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.C.7(a) of this Appendix to generate the estimated percentage of claims-based payments that would be subject to PCC Fee Reduction if all Participant Providers elected to participate in PCC Payment and agreed to a PCC Fee Reduction of 100% ("**Alternative Hypothetical Base PCC Percentage**").

    c. CMS then subtracts the Alternative Hypothetical Base PCC Percentage from 7%.

    d. CMS then takes the greater of 2% or the amount described in Section V.C.10(c) of this Appendix ("**CMS-Calculated Maximum Enhanced PCC Percentage**").

    e. The "**Alternative Enhanced PCC Percentage**" will be the lesser of the maximum Enhanced PCC Percentage selected by the ACO as described in Section 8.01 of the Agreement or the CMS-Calculated Maximum Enhanced PCC Percentage.

11. CMS multiplies the Alternative Enhanced PCC Percentage by the Alternative PBPM Benchmark Amount ("**Alternative PBPM Enhanced PCC Amount**").

12. CMS calculates the Alternative Enhanced PCC Amount for each month of the third quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for that month, calculated in accordance with the applicable provision of Section V.C.14 of this Appendix, by the Alternative PBPM Enhanced PCC Amount.

Third Quarter – Estimated Number of REACH Beneficiaries

13. To calculate the estimated number of REACH Beneficiaries for a given month during the third quarter of the Performance Year for purposes of the Alternative Monthly PCC Payment Calculation, CMS first estimates the average number of Beneficiaries who will remain aligned to the ACO from one month to the following month during the Performance Year ("**Alternative Average Retention Rate**") as follows:

    a. CMS first determines the number of REACH Beneficiaries who were aligned to the ACO through Claims-Alignment or Voluntary Alignment during each month of the applicable lookback period in Figure 5 of this Appendix.

Figure 5. Applicable Lookback Periods for Calculating the Alternative Average Retention Rate

PY	Relevant calendar quarter in PY for Average Retention Rate Calculation	Applicable Lookback Period	Alignment Methodology
2023	Q3	Q1 2023	Claims and Voluntary Alignment
2024	Q3	Q1 2024	Claims and Voluntary Alignment
2025	Q3	Q1 2025	Claims and Voluntary Alignment
2026	Q3	Q1 2026	Claims and Voluntary Alignment

    b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of REACH Beneficiaries for the month by the number of REACH Beneficiaries for the previous month ("**Alternative Retention Rate**"). For example, the applicable lookback period for Performance Year 2023 is the first calendar quarter of 2023, the second month of which is February 2023. CMS therefore divides the number of REACH Beneficiaries for February 2023 by the number of REACH Beneficiaries for January 2023 to calculate the Alternative Retention Rate for February 2023. CMS also divides the number of REACH Beneficiaries for March 2023 by the number of REACH Beneficiaries for February 2023 to calculate the Alternative Retention Rate for March 2023.

    c. CMS sums the Alternative Retention Rate for each month in the applicable lookback period and divides by the number of months in the applicable lookback period for which an Alternative Retention

Rate is calculated to establish the Alternative Average Retention Rate.

14. CMS estimates the number of REACH Beneficiaries for each month of the third quarter of the Performance Year for purposes of the Alternative Monthly PCC Payment Calculation as follows:

    a. CMS estimates the number of REACH Beneficiaries for the first month of the third quarter of the Performance Year by multiplying the number of REACH Beneficiaries for the last month of the second quarter of the Performance Year, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Alternative Average Retention Rate.

    b. CMS estimates the number of REACH Beneficiaries for the second month of the third quarter of the Performance Year by multiplying the number of estimated REACH Beneficiaries for the first month of the third quarter of the Performance Year, calculated in accordance with Section V.C.14(a) of this Appendix, by the Alternative Average Retention Rate.

    c. CMS estimates the number of REACH Beneficiaries for the third month of the third quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the second month of the third quarter of the Performance Year, calculated in accordance with Section V.C.14(b) of this Appendix, by the Alternative Average Retention Rate.

Third Quarter - Adjustments to Account for Prior Under (Over) Estimates

15. To account for under or over estimates of the Alternative Monthly PCC Payment Amount for prior months of the Performance Year, CMS calculates the amount by which the monthly PCC Payments were over or under estimated during the Performance Year to date for each month of the third quarter of the Performance Year ("**PCC Payment Adjustment Amount**").

    a. CMS sums the amount of monthly PCC Payments made to the ACO in prior months of the Performance Year (**"Actual PCC Payments Year-To-Date (YTD)"**).

    b. CMS multiplies the Alternative PBPM Base PCC Amount, calculated in accordance with Section V.C.8 of this Appendix, by the number of Beneficiary-Months year-to-date, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Revised Base PCC Payments YTD**").

    c. CMS multiplies the Alternative PBPM Enhanced PCC Amount, calculated in accordance with Section V.C.11, by the number of Beneficiary-Months year-to-date, as specified in the report that

will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Revised Enhanced PCC Payments YTD**").

d. CMS sums the Revised Base PCC Payments YTD and the Revised Enhanced PCC Payments YTD ("**Revised PCC Payments YTD**").

e. CMS subtracts the Actual PCC Payments YTD from the Revised PCC Payments YTD ("**Under (Over) PCC Payment Amount YTD**").

f. To calculate the PCC Payment Adjustment Amount for a given month, CMS divides the Under (Over) PCC Payment Amount YTD by the number of months remaining in the Performance Year at the time the calculation is performed.

D. Quarterly Updates to Monthly PCC Payment Amount

General

1. CMS updates the monthly PCC Payment amount calculated in accordance with Section V.B or Section V.C of this Appendix, as applicable, for each month of the calendar quarters specified in Figure 6 of this Appendix by multiplying the Updated PBPM PCC Payment Amount for that month (calculated in accordance with Section V.D.3 or Section V.D.4 of this Appendix, as applicable) by the estimated number of REACH Beneficiaries for that month (calculated in accordance with the relevant provision of Section V.D.5 or Section V.D.6 of this Appendix, as applicable), and adding the Updated PCC Payment Adjustment Amount for that month (calculated in accordance with Section V.D.8 or Section V.D.9 of this Appendix, as applicable).

Figure 6. Schedule of quarterly updates to monthly PCC Payment amounts

PY	Quarterly updates if the ACO's PCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly PCC Payment Calculation in Section V.B of this Appendix (calendar quarters)	Quarterly updates if the ACO's PCC Payment amount for the first, second, and third quarters of the Performance Year was calculated in accordance with the Alternative Monthly PCC Payment Calculation in Section V.C of this Appendix (calendar quarters)
2023	Q2, Q3, Q4	Q4
2024	Q2, Q3, Q4	Q4
2025	Q2, Q3, Q4	Q4
2026	Q2, Q3, Q4	Q4

Updated PBPM PCC Payment Amount

2. In order to calculate a PBPM version of the updated monthly PCC Payment Amount for a given month ("**Updated PBPM PCC Payment Amount**"), CMS first calculates an updated PBPM version of the Performance Year Benchmark for the relevant quarter ("**Updated PBPM Benchmark Amount**"):

a. To calculate the Updated PBPM Benchmark Amount, except as specified in Section V.D.2(b), CMS divides the ACO's Performance Year Benchmark reported in the most recent Quarterly Benchmark Report by the number of Beneficiary-Months reported in the most recent Quarterly Benchmark Report.

b. If CMS has not yet distributed a Quarterly Benchmark Report for the Performance Year, CMS uses the following amounts as the Updated PBPM Benchmark Amount:

i. The Default PBPM Benchmark Amount, described in Section V.B.3 of this Appendix, if the ACO's PCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly PCC Payment Calculation described in Section V.B of this Appendix; or

ii. The Alternative PBPM Benchmark Amount, described in Section V.C.8 of this Appendix, if the ACO's PCC Payment amount for the first, second, and third quarters of the Performance Year was calculated in accordance with the Alternative Monthly PCC Payment Calculation described in Section V.C of this Appendix.

3. If the ACO's PCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly PCC Payment Calculation described in Section V.B of this Appendix, CMS updates the Default PBPM Base PCC Amount for a given quarter by multiplying the Default Base PCC Percentage, calculated in accordance with Section V.B.2 of this Appendix, by the Updated PBPM Benchmark Amount ("**Updated PBPM Base PCC Amount**"), and CMS updates the Default PBPM Enhanced PCC Amount for a given quarter by multiplying the Default Enhanced PCC Percentage, calculated in accordance with Section V.B.5 of this Appendix, by the Updated PBPM Benchmark Amount ("**Updated PBPM Enhanced PCC Amount**"). CMS then sums the Updated PBPM Base PCC Amount and the Updated PBPM Enhanced PCC Amount to calculate the "**Updated PBPM PCC Payment Amount.**"

4. If the ACO's PCC Payment amount for the first, second, and third quarters of the Performance Year was calculated in accordance with the Alternative Monthly PCC Payment Calculation described in Section V.C of this Appendix, CMS updates the Alternative PBPM Base PCC Amount for a given quarter by multiplying the Alternative Base PCC Percentage, calculated in accordance with Section V.C.7 of this Appendix, by the Updated PBPM Benchmark Amount ("**Updated PBPM Base PCC Amount**"), and CMS updates the Alternative PBPM Enhanced PCC Amount for a given quarter by multiplying the Alternative Enhanced PCC Percentage, calculated in accordance with Section V.C.10 of this Appendix, by the Updated PBPM Benchmark Amount ("**Updated PBPM Enhanced PCC Amount**"). CMS then sums the Updated PBPM Base

PCC Amount and the Updated PBPM Enhanced PCC Amount to calculate the "**Updated PBPM PCC Payment Amount.**"

Estimated Number of REACH Beneficiaries

5. If the ACO's PCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly PCC Payment Calculation described in Section V.B of this Appendix, CMS estimates the number of REACH Beneficiaries for each month of a quarter for which CMS updates the PCC Payment amount in accordance with this Section V.D, as follows:

   a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant quarter by multiplying the estimated number of REACH Beneficiaries for the month immediately prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Default Average Retention Rate.

   b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant quarter, calculated in accordance with Section V.D.5(a) of this Appendix, by the Default Average Retention Rate.

   c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant quarter, calculated in accordance with Section V.D.5(b) of this Appendix, by the Default Average Retention Rate.

6. If the ACO's PCC Payment amount for the first, second, and third quarters of the Performance Year was calculated in accordance with the Alternative Monthly PCC Payment Calculation described in Section V.C of this Appendix, CMS estimates the number of REACH Beneficiaries for each month of the relevant quarter of the Performance Year for which CMS updates the PCC Payment amount in accordance with this Section V.D as follows:

   a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant quarter by multiplying the estimated number of REACH Beneficiaries for the month immediately prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Alternative Average Retention Rate.

   b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant quarter, calculated in accordance with Section V.D.6(a) of this Appendix, by the Alternative Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant quarter, calculated in accordance with Section V.D.6(b) of this Appendix, by the Alternative Average Retention Rate.

Adjustments to Account for Prior Under (Over) Estimates

7. To account for under or over estimates of the PCC Payment amount for prior months of the Performance Year, CMS calculates the amount by which the monthly PCC Payments were over or under estimated during the Performance Year to date for each month of the relevant quarter of the Performance Year for which CMS updates the PCC Payment amount in accordance with this Section V.D ("**Updated PCC Payment Adjustment Amount**").

8. If the ACO's PCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly PCC Payment Calculation described in Section V.B of this Appendix, CMS calculates the Updated PCC Payment Adjustment Amount as follows:

   a. CMS sums the amount of monthly PCC Payments made to the ACO in prior months of the Performance Year ("**Default Actual PCC Payments YTD**").

   b. CMS multiplies the Default PBPM Base PCC Amount by the number of Beneficiary-Months year-to-date, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Default Revised Base PCC Payments YTD**)."

   c. CMS multiplies the Default PBPM Enhanced PCC Amount by the number of Beneficiary-Months year-to-date, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Default Revised Enhanced PCC Payments YTD**").

   d. CMS sums the Default Revised Base PCC Payments YTD and the Default Revised Enhanced PCC Payments YTD ("**Default Revised PCC Payments YTD**").

   e. CMS subtracts the Default Actual PCC Payments YTD from the Default Revised PCC Payments YTD ("**Default Under (Over) PCC Payment Amount YTD**").

   f. To calculate the Updated PCC Payment Adjustment Amount, CMS divides the Default Under (Over) PCC Payment Amount YTD by the number of months remaining in the Performance Year at the time the calculation is performed.

9. If the ACO's PCC Payment amount for the first, second, and third quarters of the Performance Year was calculated using the Alternative Monthly PCC Payment Calculation described in Section V.C of this Appendix,

CMS calculates the Updated PCC Payment Adjustment Amount as follows:

a. CMS sums the amount of monthly PCC Payments made to the ACO in prior months of the Performance Year ("**Alternative Actual PCC Payments YTD**").

b. CMS multiplies the Alternative PBPM Base PCC Amount by the number of Beneficiary-Months year-to-date, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Alternative Revised Base PCC Payments YTD**").

c. CMS multiplies the Alternative PBPM Enhanced PCC Amount by the number of Beneficiary-Months year-to-date, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Alternative Revised Enhanced PCC Payments YTD**").

d. CMS sums the Alternative Revised Base PCC Payments YTD and the Alternative Revised Enhanced PCC Payments YTD ("**Alternative Revised PCC Payments YTD**").

e. CMS subtracts the Alternative Actual PCC Payments YTD from the Alternative Revised PCC Payments YTD ("**Alternative Under (Over) PCC Payment Amount YTD**").

f. To calculate the Updated PCC Payment Adjustment Amount, CMS divides the Alternative Under (Over) PCC Payment Amount YTD by the number of months remaining in the Performance Year at the time the calculation is performed.

E. Calculating Actual Annual PCC Payment Amount After Each Performance Year

1. If the ACO's PCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly PCC Payment Calculation described in Section V.B of this Appendix:

a. CMS multiplies the Default Base PCC Percentage, calculated in accordance with Section V.B, by the Performance Year Benchmark reported in the settlement report for Final Financial Settlement ("**Actual Annual Base PCC Payment Amount**").

b. CMS multiplies the Default Enhanced PCC Percentage, calculated in accordance with Section V.B, by the Performance Year Benchmark reported in the settlement report for Final Financial Settlement ("**Actual Annual Enhanced PCC Payment Amount**").

2. If the ACO's PCC Payment amount for the first, second, and third quarters of the Performance Year was calculated in accordance with the Alternative Monthly PCC Payment Calculation described in Section V.C of this Appendix:

a. CMS multiplies the Alternative Base PCC Percentage, calculated in accordance with Section V.C of this Appendix, by the Performance Year Benchmark reported in the settlement report for Final Financial Settlement ("**Actual Annual Base PCC Payment Amount**"); and

b. CMS multiplies the Alternative Enhanced PCC Percentage, calculated in accordance with Section V.C of this Appendix, by the Performance Year Benchmark reported in the settlement report for Final Financial Settlement ("**Actual Annual Enhanced PCC Payment Amount**").

3. CMS sums the Actual Annual Base PCC Payment Amount and the Actual Annual Enhanced PCC Payment Amount ("**Actual Annual PCC Payment Amount**").

VI. Reconciliation of the PCC Payment

A. During Final Financial Settlement for each Performance Year in which the ACO participates in PCC Payment, CMS will reconcile the total monthly PCC Payments made to the ACO during the Performance Year by calculating the difference between:

1. The total monthly PCC Payments CMS made to the ACO during the Performance Year calculated in accordance with Section V.B or Section V.C of this Appendix, as applicable, including any quarterly updates and adjustments described in Section V.D of this Appendix; and

2. The Actual Annual PCC Payment Amount calculated in accordance with Section V.E.3 of this Appendix.

B. Any difference between the amounts calculated under Section VI.A.1 and Section VI.A.2 of this Appendix will constitute Other Monies Owed and will be paid or collected during Final Financial Settlement under Section 12.04.A.3 and Appendix B of the Agreement.

C. CMS will include any Other Monies Owed, including Other Monies Owed due to reconciliation of the total monthly PCC Payments, on the settlement report issued for Final Financial Settlement under Section 12.04.A.3 of the Agreement, such that the settlement report will set forth the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.

D. During Final Financial Settlement for each Performance Year in which the ACO participates in PCC Payment, the Actual Annual Base PCC Payment Amount will be counted as Performance Year Expenditures in accordance with Appendix B.

E. The ACO shall repay CMS the Actual Annual Enhanced PCC Payment Amount as Other Monies Owed at the Performance Year settlement under Section 12.04 of the Agreement or through settlement reports issued as such other times as provided under Section 12.04 of the Agreement. The Actual Annual Enhanced PCC Payment Amount does not affect the calculation of Shared Savings or Shared Losses, which will continue to be based on Performance Year

Expenditures as calculated in accordance with Appendix B. The reconciliation of the Enhanced PCC portion of PCC Payments does not affect and is not affected by the ACO's selected Risk-Sharing Option.

F. In the event that the ACO elects to terminate the Agreement Performance Period pursuant to Article XVII of the Agreement prior to the end of a Performance Year in which the ACO participates in PCC Payment by providing notice to CMS that its termination is effective no later than 30 Days after the Termination Without Liability Date of that Performance Year, there will be no annual financial settlement for that Performance Year in accordance with Section 17.04 of the Agreement, CMS will reconcile the total monthly PCC Payments with the total actual amount of PCC Fee Reductions as part of the annual settlement report for the previous Performance Year, and the ACO must pay any Other Monies Owed to CMS in accordance with Section 12.04.E of the Agreement.

Appendix F: Advanced Payment Option

I. Advanced Payment Option Selection

A. If the ACO wishes to participate in the APO for a Performance Year, the ACO must:

1. Timely select PCC Payment as its Capitation Payment Mechanism for the Performance Year as described in Section 8.01 of the Agreement;

2. Timely submit to CMS its selection to participate in the APO for the Performance Year as described in Section 8.01 of the Agreement;

3. Timely submit as described in Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the APO at the start of the Performance Year, and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the APO at the start of the Performance Year;

4. Timely submit by a date and in a form and manner specified by CMS a certification that the ACO has obtained a fully executed "ACO REACH Model: Fee Reduction Agreement" (as described in Section 12.02.E of the Agreement) from each Participant Provider and Preferred Provider that is identified as participating in the APO, as set forth on the lists submitted in accordance with Section I.A.3 of this Appendix; and

5. Timely submit by a date and in a form and manner specified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.A of this Appendix.

B. CMS may reject or later terminate the ACO's selection to participate in the APO for the Performance Year in accordance with Section 8.02 or Section 17.01 of the Agreement if:

1. CMS has taken any remedial actions pursuant to Section 17.01 of the Agreement;

2. CMS has taken any remedial actions against the ACO in connection with the ACO's participation in another Medicare shared savings initiative during either of the ACO's last two performance years in that initiative; or

3. CMS determines on the basis of a Program Integrity Screening or other information that the ACO's participation in the APO might compromise the integrity of the Model.

C. If CMS rejects or later terminates the ACO's selection to participate in APO for a Performance Year (in accordance with Section 8.02 or Section 17.01 of the Agreement), payments to the ACO's APO-participating Participant Providers and Preferred Providers that would otherwise be subject to the APO will default to traditional FFS for the Performance Year or for the remainder of the Performance Year, as applicable.

D. CMS may prohibit the ACO from having an APO Payment Arrangement (as defined in Section III of this Appendix) with a Participant Provider or Preferred Provider if:

1. The conduct of the Participant Provider or Preferred Provider has caused CMS to impose remedial action pursuant to Section 17.01 of the Agreement or to impose a sanction under any CMS administrative authority; or

2. CMS determines on the basis of a Program Integrity Screening or other information that the Participant Provider's or Preferred Provider's participation in the APO might compromise the integrity of the Model.

II. APO Fee Reduction

A. If the ACO selects to participate in the APO for a Performance Year in accordance with Section I of this Appendix, the ACO shall, by a date specified by CMS, notify and educate all Participant Providers and Preferred Providers about the ACO's intended participation in the APO and the associated APO Fee Reduction for those Participant Providers and those Preferred Providers that agree to participate in the APO. Providing a copy of the ACO REACH Model: Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in the APO for a Performance Year is rejected or later terminated, the ACO shall notify all Participant Providers and Preferred Providers that it is not participating in the APO for that Performance Year or for the remainder of that Performance Year, as applicable. The ACO shall provide such notice in writing no later than 10 Days after such rejection or termination.

B. A Participant Provider or Preferred Provider may participate in the APO for a Performance Year only if the Participant Provider or Preferred Provider was included on the Participant Provider List or Preferred Provider List, respectively, at the start of that Performance Year.

C. Not all Participant Providers or Preferred Providers must agree to participate in the APO, even if other Participant Providers and Preferred Providers who bill under the same TIN participate in the APO. APO-participating Participant Providers and Preferred Providers that bill under the same TIN do not have to agree to the same APO Fee Reduction percentages.

D. For each Participant Provider and Preferred Provider that has consented to participate in APO Payment for a Performance Year pursuant to Section 12.02.E of the Agreement, with the exception of those Participant Providers and Preferred Providers with whom the ACO is prohibited under Section I.D of this Appendix from having an APO Payment Arrangement, CMS will reduce FFS payments on claims for all APO Eligible Services furnished to REACH Beneficiaries by the APO Fee Reduction percentage agreed to by the Participant Provider or Preferred Provider as specified on the final Participant Provider List and final Preferred Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

E. A hospital paid under the Inpatient Prospective Payment System that is a Participant Provider or Preferred Provider that is participating in the APO and receiving the APO Fee Reduction will continue to receive Medicare Indirect Medical Education (IME), Medicare Disproportionate Share Hospital (DSH), inpatient outlier, and inpatient new technology add-on payments calculated in

accordance with the applicable statutory and regulatory provisions for services furnished to REACH Beneficiaries.

F. For all institutional providers that are Participant Providers or Preferred Providers participating in the APO, CMS will reduce by the agreed to APO Fee Reduction all FFS payments for all APO Eligible Services furnished to REACH Beneficiaries that are billed under that institution's CCN and organizational NPI regardless of whether the individual NPI rendering the service is a Participant Provider or Preferred Provider or is identified as participating in the APO.

G. CMS will not reduce FFS claims-based payments for services furnished to REACH Beneficiaries who elect to decline data sharing or for services related to the diagnosis and treatment of substance use disorder furnished to REACH Beneficiaries.

H. CMS will not reduce FFS claims-based payments for services furnished to REACH Beneficiaries for which Medicare FFS is not the primary payer.

I. CMS will not reduce FFS claims-based payments associated with the Periodic Interim Payments (PiP) program or other Medicare programs or initiatives specified by CMS prior to the start of the Performance Year or the relevant subsequent quarter.

J. [Reserved]

K. CMS will not reduce FFS payments on claims for services furnished to REACH Beneficiaries by a home health agency if the claim is for an episode period for which the home health agency has submitted a Request for Anticipated Payment (RAP).

L. CMS will not reduce FFS claims for APO Payment-participating Participant Providers or Preferred Providers during any month of a Performance Year prior to the first month of the Performance Year for which CMS makes a monthly APO Payment to the ACO in accordance with this Appendix.

M. CMS will not reduce FFS payments on claims furnished to REACH Beneficiaries by a Participant Provider or Preferred Provider who is a nonparticipating supplier, as that term is defined in 42 CFR § 400.202, that is not accepting assignment on the claim.

N. CMS will not reduce FFS payments on claims furnished to REACH Beneficiaries for the provision of COVID-19 tests, or other such services as defined by CMS.

O. CMS will not reduce GUIDE Payments.

III. APO Payment Arrangement

A. The ACO shall have a written payment arrangement with each Participant Provider and Preferred Provider participating in the APO that establishes how the ACO will compensate the Participant Provider or Preferred Provider for Covered Services that are subject to the APO Fee Reduction ("**APO Payment Arrangement**").

B. APO Payment Arrangements must comply with all requirements of Section 3.04 of the Agreement.

C. Remuneration furnished by the ACO under an APO Payment Arrangement must be negotiated in good faith and be consistent with fair market value.

D. The ACO shall maintain, in accordance with Section 16.02 of the Agreement, records of all remuneration paid or received pursuant to each APO Payment Arrangement.

E. The APO Payment Arrangement must:

1. Require the Participant Provider or Preferred Provider to make Medically Necessary Covered Services available to REACH Beneficiaries in accordance with all applicable laws and regulations.

2. Prohibit the ACO from requiring prior authorization for services furnished to REACH Beneficiaries.

3. Prohibit the ACO and the Participant Provider or Preferred Provider from interfering with a REACH Beneficiary's freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in the APO or with the ACO.

4. Require the ACO to compensate the Participant Provider or Preferred Provider for APO Eligible Services no later than 30 Days after receiving notice of the processed claim for such services, as indicated in claims data sent by CMS to the ACO, as described in Section 6.02.C of the Agreement, unless a different number of Days is specified in the APO Payment Arrangement.

5. Require the Participant Provider or Preferred Provider to maintain records regarding the APO Payment Arrangement (including records of any compensation received or paid under the arrangement) in accordance with Section 16.02 of the Agreement.

6. Require the Participant Provider or Preferred Provider to provide the government with access to records regarding the APO Payment Arrangement (including records of any compensation received or paid under the arrangement) in accordance with Section 16.02 of the Agreement.

7. Meet the requirements under Section 3.04 of the Agreement.

F. The ACO shall ensure that it has and will retain the capability and funds to compensate Participant Providers and Preferred Providers participating in the APO for APO Eligible Services that they furnish, and that it will promptly make such payments in accordance with the APO Payment Arrangement.

G. The ACO must establish procedures under which Participant Providers and Preferred Providers participating in the APO may request reconsideration by the ACO of a determination regarding compensation pursuant to an APO Payment Arrangement. The procedures for requesting reconsideration must be included in the written APO Payment Arrangement between the ACO and the APO-participating Participant Providers and Preferred Providers.

IV. Beneficiary Disputes

A. CMS will process all claims submitted by Participant Providers and Preferred Providers participating in the APO, and assess coverage and payment for such services and any Beneficiary liability using the same standards that apply under traditional Medicare FFS.

B. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claims appeals process at 42 CFR Part 405, subpart I.

V. APO Payment Amount Calculation

A. General

1. CMS shall estimate, update, and reconcile the monthly APO payment in accordance with this Appendix.

2. CMS uses one of two methodologies to estimate the monthly APO Payment amount:

   a. Except as specified in Section V.A.2(b) of this Appendix, CMS calculates the monthly APO payment amount prior to the start of the Performance Year in accordance with Section V.B of this Appendix ("**Default Monthly APO Payment Calculation**").

   b. If CMS determines that the ACO does not have sufficient claims history to calculate monthly APO payment amount prior to the start of the Performance Year in accordance with Section V.B of this Appendix, CMS calculates monthly APO Payments in accordance with Section V.C of this Appendix ("**Alternative Monthly APO Payment Calculation**"), unless CMS determines that it is appropriate to use the Default PBPM APO Payment Amount and Default Average Retention Rate (as those terms are described in Section V.B of this Appendix) or, if applicable, the Alternative PBPM APO Payment Amount and Alternative Average Retention Rate (as those terms are described in Section V.C of this Appendix) from the prior Performance Year, in which case CMS calculates the monthly APO Payment amount under the Default Monthly APO Payment Calculation using the Default PBPM APO Payment Amount and Default Average Retention Rate or, if applicable, the Alternative PBPM APO Payment Amount and Alternative Average Retention Rate from the prior Performance Year.

3. CMS updates the monthly APO Payment amount for each subsequent quarter in accordance with Section V.D of this Appendix.

4. CMS will make a monthly APO payment to the ACO for each of the following months that the ACO participates in the APO during the Performance Year:

   a. If CMS calculates the ACO's APO payment amounts using the Default Monthly APO Payment Calculation, CMS makes a monthly APO Payment to the ACO beginning for the first month

of the Performance Year (i.e., the first calendar quarter of Performance Year 2023 and each subsequent Performance Year).

b. If CMS calculates the ACO's APO payment amounts using the Alternative Monthly APO Payment Calculation, CMS makes a monthly APO payment to the ACO beginning for the first month of the third quarter of the Performance Year (i.e., the third calendar quarter of Performance Year 2023 and each subsequent Performance Year).

5. CMS will calculate the monthly APO payment amount for each month in a calendar quarter prior to the start of that calendar quarter and provide a report to the ACO containing the monthly APO payment amounts for each month in the upcoming calendar quarter.

6. CMS shall not make any monthly APO payments to the ACO after the effective date of termination of the Agreement Performance Period.

7. CMS shall not make any monthly APO payments after the effective date of CMS' termination (in accordance with Section 8.02 or Section 17.01 of the Agreement) of the ACO's selection to participate in the APO.

8. The APO payment amount is subject to budget sequestration, if budget sequestration is in effect for the period in which the APO payment is made.

9. CMS will review APO Fee Reductions applied to FFS payments made to APO-participating Participant Providers and Preferred Providers during the Performance Year. If, during a Performance Year, CMS determines based on claims data that the total amount of monthly APO payments paid to the ACO is at least 5% greater or at least 5% lower than the total amount of APO Fee Reductions actually applied to FFS payments made to APO-participating Participant Providers or Preferred Providers, or if one or more APO Payment-participating Participant Providers or Preferred Providers ceases to be an APO-participating Participant Provider or Preferred Provider, respectively, or if CMS specifies that it will not reduce FFS payments on claims for APO Eligible Services furnished to REACH Beneficiaries by providers enrolled in a Medicare programs or initiative during the Performance Year, in accordance with Section II.I of this Appendix, CMS may recalculate the monthly APO payment amount, or any updates thereto, in accordance with Section V.B, Section V.C, or Section V.D of this Appendix, as applicable. If CMS recalculates the monthly APO Payment amount pursuant to this Section V.A.9, CMS will provide a report of the recalculated amounts to the ACO and will make monthly APO Payments in the revised amount for future months of the Performance Year, subject to the quarterly updates and adjustments described in Section V.D of this Appendix.

10. CMS may increase the monthly APO Payment amount for the first month of the first quarter of the Performance Year in which monthly APO Payments are made to the ACO by 20% if CMS determines, at CMS's sole discretion, that the applicable APO Payment methodology described in

Section V.A.2 of this Appendix may result in an underestimate of the monthly APO Payment amount for that quarter. If CMS applies this adjustment, CMS will subtract the amount added to the first monthly APO Payment for the Performance Year pursuant to this Section V.A.10 from the last monthly APO Payment for the Performance Year.

B. Default Monthly APO Payment Calculation

General

1. Under the Default Monthly APO Payment Calculation, CMS calculates the monthly APO payment amount for each month of the first quarter of the Performance Year by multiplying the Default PBPM APO Payment Amount (calculated in accordance with Section V.B.3 of this Appendix) by the estimated number of REACH Beneficiaries for the relevant month (calculated in accordance with the relevant provision of Section V.B.5 of this Appendix).

Default PBPM APO Payment Amount

2. To calculate the Default PBPM APO Payment Amount, CMS first estimates the total amount by which claims-based payments will be subject to APO Fee Reductions during that month ("**Default APO Reduced Claims Amount**") as follows:

   a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 1 of this Appendix to calculate the total amount of claims-based payments for all Covered Services furnished to those Beneficiaries who would have been aligned to the ACO during the applicable lookback period using the Claims-Based Alignment methodology described in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

Figure 1. Applicable Lookback Periods for Calculating the Default PBPM APO Payment Amount for the First Quarter of the Performance Year

PY	First calendar quarter of monthly APO Payments in PY	Applicable Lookback Period	Alignment Methodology
2023	Q1	Q1-Q3 2022	Claims-Based Alignment
2024	Q1	Q1-Q3 2023	Claims-Based Alignment
2025	Q1	Q1-Q3 2024	Claims-Based Alignment
2026	Q1	Q1-Q3 2025	Claims-Based Alignment

   b. CMS estimates the amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix that would have been subject to APO

Fee Reductions ("**Default Per-Provider APO Reduced Claims Amount**") by calculating, for each APO Payment-participating Participant Provider and Preferred Provider, the product of: (1) the total claims-based payments for APO Eligible Services made to the Participant Provider or Preferred Provider during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix; and (2) the APO Fee Reduction percentage agreed to by the Participant Provider or Preferred Provider.

c. CMS aggregates the Default Per-Provider APO Reduced Claims Amount across all APO Payment-participating Participant Providers and Preferred Providers to calculate the Default APO Reduced Claims Amount.

3. CMS then divides the Default APO Reduced Claims Amount by the number of months that each Beneficiary who would have been aligned to the ACO during the applicable lookback period in Figure 1 of this Appendix using the Claims-Based Alignment methodology outlined in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable, was eligible for alignment to the ACO during the applicable lookback period in accordance with Section IV of Appendix A of the Agreement ("**Default PBPM APO Payment Amount**").

Estimated Number of REACH Beneficiaries

4. To calculate the estimated number of REACH Beneficiaries for a given month during the first quarter of the Performance Year for purposes of the Default Monthly APO Payment Calculation, CMS first estimates the average number of Beneficiaries who will remain aligned to the ACO from one month to the following month during the Performance Year ("**Default Average Retention Rate**") as follows:

a. CMS determines the number of Beneficiaries who would have been aligned to the ACO during each month of the applicable lookback period listed in Figure 2 of this Appendix using the Claims-Based Alignment methodology described in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

Figure 2. Applicable Lookback Periods for Calculating the Default Average Retention Rate

PY	First calendar quarter of monthly APO Payments in PY	Applicable Lookback Period	Alignment Methodology
2023	Q1	Q1-Q3 2022	Claims-Based Alignment
2024	Q1	Q1-Q3 2023	Claims-Based Alignment
2025	Q1	Q1-Q3 2024	Claims-Based Alignment

PY	First calendar quarter of monthly APO Payments in PY	Applicable Lookback Period	Alignment Methodology
2026	Q1	Q1-Q3 2025	Claims-Based Alignment

b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of Beneficiaries who would have been aligned to the ACO in the month by the number of Beneficiaries who would have been aligned to the ACO in the previous month of the applicable lookback period ("**Default Retention Rate**"). For example, for Performance Year 2023, the second month of the applicable lookback period is February 2022. To calculate the Default Retention Rate for February 2022, CMS divides the number of Beneficiaries who would have been aligned to the ACO in February 2022 by the number of Beneficiaries who would have been aligned to the ACO in January 2022.

c. CMS sums the Default Retention Rate for each month in the applicable lookback period and divides the sum of such Default Retention Rates by the number of months of the applicable lookback period for which a Default Retention Rate was calculated to establish the Default Average Retention Rate.

5. CMS estimates the number of REACH Beneficiaries for each month in the first quarter of the Performance Year for purposes of the Default Monthly APO Payment Calculation as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the first quarter of the Performance Year by multiplying the estimated number of Alignment-Eligible Beneficiaries for the month prior to the first month of the Performance Year, as specified in the report that will be shared with the ACO in accordance with Section 6.03.B of the Agreement, by the Default Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the first month of the first quarter of the Performance Year, calculated in accordance with Section V.B.5(a) of this Appendix, by the Default Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the second month of the first quarter of the Performance Year, calculated in accordance with Section V.B.5(b) of this Appendix, by the Default Average Retention Rate.

C. Alternative Monthly APO Payment Calculation

General

1. Under the Alternative Monthly APO Payment Calculation, CMS calculates the monthly APO payment amount for each month of the first calendar quarter of the Performance Year for which monthly APO payments are made, as described in Section V.A.4(b) of this Appendix, by multiplying the Alternative PBPM APO Payment Amount (calculated in accordance with Section V.C.3 of this Appendix) by the estimated number of REACH Beneficiaries for the relevant month (calculated in accordance with the relevant provision of Section V.C.5 of this Appendix).

Alternative PBPM APO Payment Amount

2. To calculate the Alternative PBPM APO Payment Amount for a given month, CMS first estimates the total amount by which claims-based payments will be subject to APO Fee Reductions during that month ("**Alternative APO Reduced Claims Amount**") as follows:

   a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 3 of this Appendix to calculate the total amount of claims-based payments for all Covered Services furnished to those REACH Beneficiaries who were aligned to the ACO during the applicable lookback period through either Claims-Based Alignment or Voluntary Alignment.

Figure 3. Applicable Lookback Periods Used to Calculate the Alternative PBPM APO Payment Amount

PY	First calendar quarter of monthly APO Payments in PY	Applicable Lookback Period (calendar quarter)	Alignment Methodology
2023	Q3	Q1 2023	Claims-Based Alignment and Voluntary Alignment
2024	Q3	Q1 2024	Claims-Based Alignment and Voluntary Alignment
2025	Q3	Q1 2025	Claims-Based Alignment and Voluntary Alignment
2026	Q3	Q1 2026	Claims-Based Alignment and Voluntary Alignment

   b. CMS estimates the amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.C.2(a) of this Appendix that would have been subject to APO Fee Reductions ("**Alternative Per-Provider APO Reduced Claims Amount**") by calculating, for each APO Payment-participating Participant Provider and Preferred Provider, the product of: (1) the total claims-based payments for APO Eligible Services made to the Participant Provider or Preferred Provider during the applicable lookback period calculated in accordance with Section V.C.2(a) of this Appendix; and (2) the APO Fee Reduction percentage agreed to by the Participant Provider or Preferred Provider.

c. CMS aggregates the Alternative Per-Provider APO Reduced Claims Amount across all APO Payment-participating Participant Providers and Preferred Providers to calculate the Alternative APO Reduced Claims Amount.

3. CMS then divides the Alternative APO Reduced Claims Amount by the number of months during the reporting period covered by the most recent Quarterly Benchmark Report for which each REACH Beneficiary was aligned to the ACO through either Claims-based Alignment or Voluntary Alignment ("**Alternative PBPM APO Payment Amount**").

Estimated Number of REACH Beneficiaries

4. To calculate the estimated number of REACH Beneficiaries for a month of the first calendar quarter of the Performance Year in which monthly APO payments are made, as described in Section V.A.4(b) of this Appendix, CMS first estimates the average number of Beneficiaries who will remain aligned to the ACO from one month to the following month during the Performance Year ("**Alternative Average Retention Rate**") as follows:

a. CMS first determines the number of REACH Beneficiaries who were aligned to the ACO through Claims-Based Alignment or Voluntary Alignment during each month of the applicable lookback period in Figure 4 of this Appendix.

Figure 4. Applicable Lookback Periods for Calculating the Alternative Average Retention Rate

PY	First calendar quarter of monthly APO Payments in PY	Applicable Lookback Period (calendar quarter)	Alignment Methodology
2023	Q3	Q1 2023	Claims-Based Alignment and Voluntary Alignment
2024	Q3	Q1 2024	Claims-Based Alignment and Voluntary Alignment
2025	Q3	Q1 2025	Claims-Based Alignment and Voluntary Alignment
2026	Q3	Q1 2026	Claims-Based Alignment and Voluntary Alignment

b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of REACH Beneficiaries for the month by the number of REACH Beneficiaries for the previous month ("**Alternative Retention Rate**"). For example, the applicable lookback period for Performance Year 2023 is the first calendar quarter of 2023, the second month of which is February 2023. CMS therefore divides the number of REACH Beneficiaries for February 2023 by the number of REACH Beneficiaries for January 2023 to calculate the Alternative Retention Rate for February 2023. CMS also divides the number of REACH Beneficiaries for March 2023 by the

number of REACH Beneficiaries for February 2023 to calculate the Alternative Retention Rate for March 2023.

c. CMS sums the Alternative Retention Rate for each month of the applicable lookback period and divides that amount by the number of months in the applicable lookback period for which an Alternative Retention Rate is calculated to establish the Alternative Average Retention Rate.

5. CMS estimates the number of REACH Beneficiaries for each month of the first calendar quarter of the Performance Year in which monthly APO payments are made, as described in Section V.A.4(b) of this Appendix as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant calendar quarter by multiplying the number of REACH Beneficiaries for the month prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Alternative Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant calendar quarter, calculated in accordance with Section V.C.5(a) of this Appendix, by the Alternative Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant calendar quarter, calculated in accordance with Section V.C.5(b) of this Appendix, by the Alternative Average Retention Rate.

D. Quarterly Updates to Monthly APO Payment Amount

1. CMS updates the monthly APO payment amount calculated in accordance with Section V.B or Section V.C of this Appendix, as applicable, for each month of the calendar quarters specified in Figure 5 of this Appendix in accordance with Section V.D.2 or Section V.D.3 of this Appendix, as applicable.

Figure 5. Schedule of quarterly updates to monthly APO payment amounts

PY	Quarterly updates if the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Default Monthly APO Payment Calculation	Quarterly updates if the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Alternative Monthly APO Payment Calculation
2023	Q2, Q3, Q4	Q4
2024	Q2, Q3, Q4	Q4
2025	Q2, Q3, Q4	Q4

PY	Quarterly updates if the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Default Monthly APO Payment Calculation	Quarterly updates if the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Alternative Monthly APO Payment Calculation
2026	Q2, Q3, Q4	Q4

2. If the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Default Monthly APO Payment Calculation, CMS calculates the monthly APO Payment amount for each month of the calendar quarters specified in Figure 5 of this Appendix by multiplying the Default PBPM APO Payment Amount by the estimated number of REACH Beneficiaries for that month (calculated in accordance with the relevant provision of Section V.D.4 of this Appendix).

3. If the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Alternative Monthly APO Payment Calculation, CMS calculates the monthly APO Payment amount for each month of the calendar quarters specified in Figure 5 of this Appendix by multiplying the Alternative PBPM APO Payment Amount by the estimated number of REACH Beneficiaries for that month (calculated in accordance with the relevant provision of Section V.D.5 of this Appendix, as applicable).

Estimated Number of REACH Beneficiaries

4. If the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Default Monthly APO Payment Calculation, CMS estimates the number of REACH Beneficiaries for each month of each calendar quarter specified in Figure 5 of this Appendix as follows:

    a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant calendar quarter by multiplying the number of REACH Beneficiaries for the month immediately prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Default Average Retention Rate.

    b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant calendar quarter, calculated in accordance with Section V.D.4(a), by the Default Average Retention Rate.

    c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant calendar quarter, calculated in accordance with Section V.D.4(b), by the Default Average Retention Rate.

5. If the ACO's APO payment amount for the first quarter of the Performance Year for which APO payments were made to the ACO was calculated using the Alternative Monthly APO Payment Calculation, CMS estimates the number of REACH Beneficiaries for each month of each calendar quarter specified in Figure 5 of this Appendix as follows:

   a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant calendar quarter by multiplying the number of REACH Beneficiaries for the month immediately prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Alternative Average Retention Rate.

   b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant calendar quarter, calculated in accordance with Section V.D.4(a), by the Alternative Average Retention Rate.

   c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant calendar quarter, calculated in accordance with Section V.D.4(b), by the Alternative Average Retention Rate.

VI. Reconciliation of APO Payments

A. During Final Financial Settlement for each Performance Year the ACO participates in APO Payment, CMS will reconcile the total monthly APO Payments made to the ACO during the Performance Year by calculating the difference between:

   1. The total monthly APO Payments CMS made to the ACO during the Performance Year calculated in accordance with Section V.B or Section V.C of this Appendix, as applicable, including any quarterly updates and adjustments described in Section V.D of this Appendix; and

   2. The total amount of claims-based payments that were reduced during the Performance Year by APO Fee Reductions.

B. Any difference between the amounts calculated under Section VI.A.1 and Section VI.A.2 of this Appendix will constitute Other Monies Owed and will be paid or collected during Final Financial Settlement under Section 12.04.A.3 and Appendix B of the Agreement.

C. CMS will include any Other Monies Owed, including Other Monies Owed due to reconciliation of the total monthly APO payments, on the settlement report issued for Final Financial Settlement under Section 12.04.A.3 of the Agreement, such that the settlement report will set forth the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.

D. APO payments do not affect the calculation of Shared Savings or Shared Losses, which will continue to be based on Performance Year expenditures as calculated in accordance with Appendix B.

E. The reconciliation of APO Payments does not affect and is not affected by the ACO's selected Risk-Sharing Option.

F. In the event that the ACO elects to terminate the Agreement Performance Period pursuant to Article XVII of the Agreement prior to the end of a Performance Year in which the ACO participates in APO Payment by providing notice to CMS that its termination is effective no later than 30 Days after the Termination Without Liability Date of that Performance Year, there will be no annual financial settlement for that Performance Year in accordance with Section 17.04 of the Agreement, CMS will reconcile the total monthly APO Payments with the total actual amount of APO Fee Reductions as part of the annual settlement report for the previous Performance Year, and the ACO must pay any Other Monies Owed to CMS in accordance with Section 12.04.E of the Agreement.

Appendix G: Capitation Payment Mechanism: TCC Payment

I. TCC Payment Election

A. If the ACO wishes to participate in TCC Payment for a Performance Year, the ACO must be participating in the Global Risk Sharing Option and must:

1. Timely select TCC Payment as its Capitation Payment Mechanism for the Performance Year as described in Section 8.01 of the Agreement;

2. Timely submit as described in Article IV of the Agreement a true, accurate, and complete list of Participant Providers to be included on the Participant Provider List at the start of the Performance Year and a true, accurate, and complete list of Preferred Providers that identifies those Preferred Providers that have agreed to participate in TCC Payment at the start of the Performance Year;

3. Timely submit by a date and in a form and manner specified by CMS a certification that the ACO has obtained a fully executed "ACO REACH Model: Fee Reduction Agreement" (as described in Section 12.02.E of the Agreement) for each Participant Provider identified on the Participant Provider List submitted in accordance with Section I.A.2 of this Appendix, and for each Preferred Provider that is identified on the Preferred Provider List submitted in accordance with Section I.A.2 of this Appendix as participating in TCC Payment; and

4. Timely submit by a date and in a form and manner specified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.A of this Appendix.

B. CMS may reject or later terminate the ACO's selection to participate in TCC Payment for the Performance Year in accordance with Section 8.02 or Section 17.01 of the Agreement if:

1. CMS has taken any remedial actions pursuant to Section 17.01 of the Agreement;

2. CMS has taken any remedial actions against the ACO in connection with the ACO's participation in another Medicare shared savings initiative during either of the ACO's last two performance years in that initiative; or

3. CMS determines on the basis of a Program Integrity Screening or other information that the ACO's participation in TCC Payment might compromise the integrity of the Model.

C. If CMS rejects or later terminates the ACO's selection to participate in TCC Payment for a Performance Year (in accordance with Section 8.02 or Section 17.01 of the Agreement), payments to the ACO's Participant Providers and those Preferred Providers that have elected to participate in TCC Payment will default to traditional FFS for the Performance Year or for the remainder of the Performance Year, as applicable. The ACO will not have the ability to choose a different Capitation Payment Mechanism for the remainder of the Performance Year. CMS may terminate the Agreement or the Agreement Performance Period in accordance with Section 17.02 of the Agreement if CMS has rejected or later

terminated the ACO's selection to participate in TCC Payment for a Performance Year.

D. CMS may prohibit the ACO from having a TCC Payment Arrangement (as defined in Section III of this Appendix) with a Participant Provider or Preferred Provider if:

1. The conduct of the Participant Provider or Preferred Provider has caused CMS to impose remedial action pursuant to Section 17.01 of the Agreement or to impose a sanction under any CMS administrative authority; or

2. CMS determines on the basis of a Program Integrity Screening or other information that the Participant Provider's or Preferred Provider's participation in TCC Payment might compromise the integrity of the Model.

II. TCC Fee Reduction

A. If the ACO selects to participate in TCC Payment for a Performance Year in accordance with Section I.A of this Appendix, the ACO shall, by a date specified by CMS, notify and educate all Participant Providers and Preferred Providers about the ACO's intended participation in TCC Payment and the associated TCC Fee Reduction for all Participant Providers and those Preferred Providers that agree to participate in TCC Payment. Providing a copy of the ACO REACH Model: Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in TCC Payment for a Performance Year is rejected or later terminated, the ACO shall notify all Participant Providers and Preferred Providers that it is not participating in TCC Payment for that Performance Year or for the remainder of that Performance Year, as applicable. The ACO shall provide such notice in writing no later than 10 Days after such rejection or termination.

B. All Participant Providers that are included on the Participant Provider list at the start of a Performance Year must agree to participate in TCC Payment for that Performance Year in accordance with Section 12.02.E of the Agreement. A Participant Provider may not participate in TCC Payment for a Performance Year if the Participant Provider was not included on the Participant Provider List at the start of that Performance Year.

C. CMS will reduce FFS payments on claims for Covered Services furnished to REACH Beneficiaries by 100% for each Participant Provider included on the Participant Provider List at the start of the Performance Year, with the exception of those Participant Providers with whom the ACO is prohibited under Section I.D of this Appendix from having a TCC Payment Arrangement.

D. A Preferred Provider may participate in TCC Payment for a Performance Year only if the Preferred Provider was included on the Preferred Provider List at the start of that Performance Year.

E. Not all Preferred Providers must agree to participate in TCC Payment, even if other Participant Providers or Preferred Providers who bill under the same TIN

participate in TCC Payment. TCC Payment-participating Preferred Providers that bill under the same TIN do not have to agree to the same TCC Fee Reduction percentages.

F. For each Preferred Provider that has consented to participate in TCC Payment for the Performance Year pursuant to Section 12.02.E of the Agreement, with the exception of those Preferred Providers with whom the ACO is prohibited under Section I.D of this Appendix from having a TCC Payment Arrangement, CMS will reduce FFS payments on claims for Covered Services furnished to REACH Beneficiaries by the TCC Fee Reduction percentage agreed to by the Preferred Provider as specified on the final Preferred Provider List as described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

G. A hospital paid under the Inpatient Prospective Payment System that is a Participant Provider or Preferred Provider that is participating in the APO and receiving the APO Fee Reduction will continue to receive Medicare Indirect Medical Education (IME), Medicare Disproportionate Share Hospital (DSH), inpatient outlier, and inpatient new technology add-on payments calculated in accordance with the applicable statutory and regulatory provisions for services furnished to REACH Beneficiaries.

H. For all institutional providers that are TCC Payment-participating Participant Providers or Preferred Providers, CMS will reduce by the agreed to TCC Fee Reduction all FFS payments for Covered Services furnished to REACH Beneficiaries that are billed under that institution's CCN, TIN, and organizational NPI regardless of whether the individual NPI rendering the service is a Participant Provider or Preferred Provider and regardless of whether the individual is identified as participating in TCC Payment.

I. CMS will not reduce FFS payments on claims for services furnished to REACH Beneficiaries who elect to decline data sharing or for services related to the diagnosis and treatment of substance use disorder furnished to REACH Beneficiaries.

J. CMS will not reduce FFS payments on claims for services furnished to REACH Beneficiaries for which Medicare FFS is not the primary payer.

K. CMS will not reduce FFS payments on claims for services furnished to REACH Beneficiaries by providers enrolled in the Periodic Interim Payments (PiP) program or other Medicare programs or initiatives specified by CMS prior to the start of the Performance Year or the relevant subsequent quarter.

L. [Reserved]

M. CMS will not reduce FFS payments on claims for services furnished to REACH Beneficiaries by a home health agency if the claim is for an episode period for which the home health agency has submitted a Request for Anticipated Payment (RAP).

N. CMS will not reduce FFS claims for TCC Payment-participating Participant Providers or Preferred Providers during any month of a Performance Year prior to the first month of the Performance Year for which CMS makes a monthly TCC Payment to the ACO in accordance with this Appendix.

O. CMS will not reduce FFS payments on claims furnished to REACH Beneficiaries by a Participant Provider or Preferred Provider who is a nonparticipating supplier, as that term is defined in 42 CFR § 400.202, that is not accepting assignment on the claim.

P. CMS will not reduce FFS payments on claims furnished to REACH Beneficiaries for the provision of COVID-19 tests, or other such services as defined by CMS.

Q. CMS will not reduce GUIDE Payments.

III. TCC Payment Arrangement

A. The ACO shall have a written payment arrangement with each Participant Provider and Preferred Provider participating in TCC Payment that establishes how the ACO will compensate the Participant Provider or Preferred Provider for Covered Services that are subject to the TCC Fee Reduction ("**TCC Payment Arrangement**").

B. TCC Payment Arrangements must comply with all requirements of Section 3.04 of the Agreement.

C. Remuneration furnished by the ACO under a TCC Payment Arrangement must have been negotiated in good faith and be consistent with fair market value.

D. The ACO shall maintain, in accordance with Section 16.02 of the Agreement, records of all remuneration paid or received pursuant to each TCC Payment Arrangement.

E. The TCC Payment Arrangement must:

1. Require the Participant Provider or Preferred Provider to make Medically Necessary Covered Services available to REACH Beneficiaries in accordance with all applicable laws and regulations.
2. Prohibit the ACO from requiring prior authorization for services furnished to REACH Beneficiaries.
3. Prohibit the ACO and the Participant Provider or Preferred Provider from interfering with a REACH Beneficiary's freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in TCC Payment or with the ACO.
4. Require the ACO to compensate the Participant Provider or Preferred Provider for Covered Services no later than 30 Days after receiving notice of the processed claim for such services, as indicated by claims data sent by CMS to the ACO and described in Section 6.02.C of the Agreement, unless a different number of Days is specified in the TCC Payment Arrangement.
5. Require the Participant Provider or Preferred Provider to maintain records regarding the TCC Payment Arrangement (including records of any compensation paid or received under the arrangement) in accordance with Section 16.02 of the Agreement.

6. Require the Participant Provider or Preferred Provider to provide the government with access to records regarding the TCC Payment Arrangement (including records of any compensation paid or received under the arrangement) in accordance with Section 16.02 of the Agreement.

7. Meet the requirements under Section 3.04 of the Agreement.

F. The ACO shall ensure that it has and will retain the capability and funds to compensate Participant Providers and Preferred Providers participating in TCC Payment for Covered Services that they furnish, and that it will promptly make such payments in accordance with the TCC Payment Arrangement.

G. The ACO must establish procedures under which Participant Providers and Preferred Providers participating in TCC Payment may request reconsideration by the ACO of a determination regarding compensation pursuant to a TCC Payment Arrangement. The procedures for requesting reconsideration must be included in the written TCC Payment Arrangement between the ACO and the TCC Payment-participating Participant Providers and Preferred Providers.

IV. Beneficiary Disputes

A. CMS will process all claims submitted by Participant Providers and Preferred Providers participating in TCC Payment, and assess coverage and payment for such services and any Beneficiary liability using the same standards that apply under traditional Medicare FFS.

B. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claims appeals process at 42 CFR Part 405, subpart I.

V. TCC Payment Amount Calculation

A. General

1. CMS shall estimate, update, and reconcile the monthly TCC payment in accordance with this Appendix.

2. CMS uses one of two methodologies to estimate the monthly TCC Payment amount:

a. Except as specified in Section V.A.2(b) of this Appendix, CMS calculates the monthly TCC Payment amount prior to the start of the Performance Year in accordance with Section V.B of this Appendix (“**Default Monthly TCC Payment Calculation**”).

b. If CMS determines that the ACO does not have sufficient claims history to calculate monthly TCC Payment amount prior to the start of the Performance Year in accordance with Section V.B of this Appendix, CMS calculates monthly TCC Payments in accordance with Section V.C of this Appendix (“**Alternative Monthly TCC Payment Calculation**”), unless CMS determines that it is appropriate to use the most recently calculated TCC Withhold Percentage and Average Retention Rate (as those terms are described in Section V.B of this Appendix) from the prior

Performance Year, in which case CMS calculates the monthly TCC Payment amount under the Default Monthly TCC Payment Calculation using the most recently calculated TCC Withhold Percentage and Average Retention Rate from the prior Performance Year.

3. CMS updates the monthly TCC Payment amount for each subsequent quarter in accordance with Section V.D of this Appendix.

4. CMS will make a monthly TCC payment to the ACO for each of the following months that the ACO participates in the TCC during the Performance Year:

   a. If CMS calculates the ACO's TCC Payment amounts using the Default Monthly TCC Payment Calculation, CMS makes a monthly TCC Payment to the ACO beginning for the first month of the Performance Year (i.e., the first month of Performance Year 2023 and each subsequent Performance Year).

   b. If CMS calculates the ACO's TCC Payment amounts using the Alternative Monthly TCC Payment Calculation, CMS makes a monthly TCC payment to the ACO beginning for the first month of the third quarter of the Performance Year (i.e., the third calendar quarter of Performance Year 2023 and each subsequent Performance Year).

5. CMS will calculate the monthly TCC Payment amount for each month in a calendar quarter prior to the start of that calendar quarter and provide a report to the ACO containing the monthly TCC Payment amounts for each month in the upcoming calendar quarter.

6. CMS shall not make any monthly TCC Payments to the ACO after the effective date of termination of the Agreement Performance Period.

7. CMS shall not make any monthly TCC Payments after the effective date of CMS' termination (in accordance with Section 8.02 or Section 17.01 of the Agreement) of the ACO's selection to participate in TCC Payment.

8. The TCC Payment is subject to budget sequestration, if budget sequestration is in effect for the period in which the TCC Payment is made.

9. CMS will review TCC Fee Reductions applied to FFS payments made to TCC Payment-participating Participant Providers and Preferred Providers during the Performance Year. If, during a Performance Year, CMS determines based on claims data that the total amount of monthly TCC Payments paid to the ACO is at least 5% greater or at least 5% lower than the total amount of TCC Fee Reductions actually applied to FFS payments made to TCC Payment-participating Participant Providers or Preferred Providers, or if one or more TCC Payment-participating Participant Providers or Preferred Providers ceases to be a TCC Payment-participating Participant Provider or Preferred Provider, respectively, or if CMS specifies that it will not reduce FFS payments on claims for Covered

Services furnished to REACH Beneficiaries by providers enrolled in a Medicare programs or initiative during the Performance Year, in accordance with Section II.K of this Appendix, CMS may recalculate the monthly TCC Payment amount, or any updates thereto, in accordance with Section V.B, Section V.C, or Section V.D of this Appendix, as applicable. If CMS recalculates the monthly TCC Payment amount pursuant to this Section V.A.9, CMS will provide a report of the recalculated amounts to the ACO and will make monthly TCC Payments in the revised amount for future months of the Performance Year, subject to the quarterly updates and adjustments described in Section V.D of this Appendix.

10. CMS may increase the monthly TCC Payment amount for the first month of the first quarter of the Performance Year in which monthly TCC Payments are made to the ACO by 20% if CMS determines, at CMS's sole discretion, that the applicable TCC Payment methodology described in Section V.A.2 of this Appendix may result in an underestimate of the monthly TCC Payment amount for that quarter. If CMS applies this adjustment, CMS will subtract the amount added to the first monthly TCC Payment for the Performance Year pursuant to this Section V.A.10 from the last monthly TCC Payment for the Performance Year.

B. Default Monthly TCC Payment Calculation

General

1. Under the Default Monthly TCC Payment Calculation, CMS calculates the monthly TCC payment amount for each month of the first quarter of the Performance Year by multiplying the Default PBPM TCC Payment Amount (calculated in accordance with Section V.B.3 of this Appendix) by the estimated number of REACH Beneficiaries for the relevant month (calculated in accordance with the relevant provision of Section V.B.5 of this Appendix).

Default PBPM TCC Payment Amount

2. To calculate the Default PBPM TCC Payment Amount for a given month during the first quarter of the Performance Year, CMS first estimates the total portion of claims-based payments that will not be subject to TCC Fee Reductions during that month ("**Default TCC Withhold Percentage**") as follows:

   a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 1 of this Appendix to calculate the total amount of claims-based payments for all Covered Services furnished to those Beneficiaries who would have been aligned to the ACO during the applicable lookback period using the Claims-Based Alignment methodology described in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

Figure 1. Applicable Lookback Periods for Calculating the Default TCC Withhold Percentage for the First Quarter of the Performance Year

PY	First calendar quarter of monthly TCC Payments in PY	Applicable Lookback Period	Alignment Methodology
2023	Q1	Q1-Q3 2022	Claims-Based Alignment
2024	Q1	Q1-Q3 2023	Claims-Based Alignment
2025	Q1	Q1-Q3 2024	Claims-Based Alignment
2026	Q1	Q1-Q3 2025	Claims-Based Alignment

b. CMS estimates the portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix that would not have been subject to TCC Fee Reductions ("**Default Per-Provider TCC Non-Reduced Claims Amount**") by calculating the total claims-based payments made to each non-TCC Payment-participating provider and supplier during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix and, for each TCC Payment-participating Preferred Provider, the product of: (1) the total claims-based payments for Covered Services made to the Preferred Provider during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix; and (2) one minus the TCC Fee Reduction percentage agreed to by the Preferred Provider.

c. To calculate the Default TCC Withhold Percentage, the Default Per-Provider TCC Non-Reduced Claims Amount is aggregated across all providers and suppliers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.B.2(a) of this Appendix.

3. CMS then converts the Default TCC Withhold Percentage to a per-Beneficiary per-month (PBPM) amount ("**Default PBPM TCC Payment Amount**") by multiplying the Default TCC Withhold Percentage by a PBPM version of the Performance Year Benchmark ("Default PBPM Benchmark Amount") and then subtracting that amount from the Default PBPM Benchmark Amount. CMS calculates the Default PBPM Benchmark Amount by dividing the ACO's Performance Year Benchmark as specified in the Performance Year Benchmark Report, by the number of Originally Aligned Beneficiaries reported in the Performance Year Benchmark Report.

Estimated Number of REACH Beneficiaries

4. To calculate the estimated number of REACH Beneficiaries for a given month during the first quarter of the Performance Year for purposes of the

Default Monthly TCC Payment Calculation, CMS first estimates the average number of Beneficiaries who will remain aligned to the ACO from one month to the following month during the Performance Year ("Default Average Retention Rate") as follows:

a. CMS determines the number of Beneficiaries who would have been aligned to the ACO during each month of the applicable lookback period listed in Figure 2 of this Appendix using the Claims-Based Alignment methodology described in Section II of Appendix A of the Agreement and the final Participant Provider List described in Section 4.02.K or Section 4.04.B.7 of the Agreement, as applicable.

Figure 2. Applicable Lookback Periods for Calculating the Default Average Retention Rate

PY	First calendar quarter of monthly TCC Payments in PY	Applicable Lookback Period	Alignment Methodology
2023	Q1	Q1-Q3 2022	Claims-Based Alignment
2024	Q1	Q1-Q3 2023	Claims-Based Alignment
2025	Q1	Q1-Q3 2024	Claims-Based Alignment
2026	Q1	Q1-Q3 2025	Claims-Based Alignment

b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of Beneficiaries who would have been aligned to the ACO in the month by the number of Beneficiaries who would have been aligned to the ACO in the previous month of the applicable lookback period ("**Default Retention Rate**"). For example, for Performance Year 2023, the second month of the applicable lookback period is February 2022. To calculate the Default Retention Rate for February 2022, CMS divides the number of Beneficiaries who would have been aligned to the ACO in February 2022 by the number of Beneficiaries who would have been aligned to the ACO in January 2022.

c. CMS sums the Default Retention Rate for each month in the applicable lookback period and divides the sum of such Default Retention Rates by the number of months of the applicable lookback period for which a Default Retention Rate was calculated to establish the Default Average Retention Rate.

5. CMS estimates the number of REACH Beneficiaries for each month in the first quarter of the Performance Year for purposes of the Default Monthly TCC Payment Calculation as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the first quarter of the Performance Year by multiplying the estimated number of Alignment-Eligible Beneficiaries for the month prior to the first month of the Performance Year, as

specified in the report that will be shared with the ACO in accordance with Section 6.03.B of the Agreement, by the Default Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the first month of the first quarter of the Performance Year, calculated in accordance with Section V.B.5(a) of this Appendix, by the Default Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the first quarter of the Performance Year by multiplying the estimated number of REACH Beneficiaries for the second month of the first quarter of the Performance Year, calculated in accordance with Section V.B.5(b) of this Appendix, by the Default Average Retention Rate.

C. Alternative Monthly TCC Payment Calculation

General

1. Under the Alternative Monthly TCC Payment Calculation, CMS calculates the monthly TCC Payment amount for each month of the first calendar quarter of the Performance Year for which monthly TCC payments are made, as described in Section V.A.4(b) of this Appendix, by multiplying the Alternative PBPM TCC Payment Amount (calculated in accordance with Section V.C.3 of this Appendix) by the estimated number of REACH Beneficiaries for the relevant month (calculated in accordance with the relevant provision of Section V.C.5 of this Appendix).

Alternative PBPM TCC Payment Amount

2. To calculate the Alternative PBPM TCC Payment Amount for a given month, CMS first estimates the total portion of claims-based payments that will not be subject to TCC Fee Reductions during that month ("**Alternative TCC Withhold Percentage**") as follows:

a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 3 of this Appendix to calculate the total amount of claims-based payments for all Covered Services furnished to those REACH Beneficiaries who were aligned to the ACO during the applicable lookback period through either Claims-Based Alignment or Voluntary Alignment.

Figure 3. Applicable Lookback Periods Used to Calculate the Alternative PBPM TCC Payment Amount

PY	First calendar quarter of monthly TCC Payments in PY	Applicable Lookback Period (calendar quarter)	Alignment Methodology
2023	Q3	Q1 2023	Claims-Based Alignment and Voluntary Alignment

PY	First calendar quarter of monthly TCC Payments in PY	Applicable Lookback Period (calendar quarter)	Alignment Methodology
2024	Q3	Q1 2024	Claims-Based Alignment and Voluntary Alignment
2025	Q3	Q1 2025	Claims-Based Alignment and Voluntary Alignment
2026	Q3	Q1 2026	Claims-Based Alignment and Voluntary Alignment

b. CMS estimates the portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.C.2(a) of this Appendix that would not have been subject to TCC Fee Reductions ("**Alternative Per-Provider TCC Non-Reduced Claims Amount**") by calculating the total claims-based payments made to each non-TCC Payment-participating provider and supplier during the applicable lookback period calculated in accordance with Section V.C.2(a) of this Appendix and, for each TCC Payment-participating Preferred Provider, the product of: (1) the total claims-based payments for Covered Services made to the Preferred Provider during the applicable lookback period calculated in accordance with Section V.C.2(a) of this Appendix; and (2) one minus the TCC Fee Reduction percentage agreed to by the Preferred Provider.

c. To calculate the Alternative TCC Withhold Percentage, the Alternative Per-Provider TCC Non-Reduced Claims Amount is aggregated across all providers and suppliers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.C.2(a) of this Appendix.

3. CMS then converts the Alternative TCC Withhold Percentage to a per-Beneficiary per-month (PBPM) amount ("**Alternative PBPM TCC Payment Amount**") by multiplying the Alternative TCC Withhold Percentage by a PBPM version of the Performance Year Benchmark ("**Alternative PBPM Benchmark Amount**") and then subtracting that amount from the Alternative PBPM Benchmark Amount. To calculate the Alternative PBPM Benchmark Amount, CMS first sums the number of months during which each REACH Beneficiary was aligned to the ACO during the reporting period covered by the most recent Quarterly Benchmark Report ("**Beneficiary-Months**"), and then divides the ACO's Performance Year Benchmark reported in the most recent Quarterly Benchmark Report by the number of Beneficiary-Months.

Estimated Number of REACH Beneficiaries

4. To calculate the estimated number of REACH Beneficiaries for a month of the first calendar quarter of the Performance Year in which monthly TCC Payments are made, as described in Section V.A.4(b) of this Appendix, CMS first estimates the average number of Beneficiaries who

will remain aligned to the ACO from one month to the following month during the Performance Year ("**Alternative Average Retention Rate**") as follows:

a. CMS first determines the number of REACH Beneficiaries who were aligned to the ACO through Claims-Based Alignment or Voluntary Alignment during each month of the applicable lookback period in Figure 4 of this Appendix.

Figure 4. Applicable Lookback Periods for Calculating the Alternative Average Retention Rate

PY	First calendar quarter of monthly TCC Payments in PY	Applicable Lookback Period (calendar quarter)	Alignment Methodology
2023	Q3	Q1 2023	Claims-Based Alignment and Voluntary Alignment
2024	Q3	Q1 2024	Claims-Based Alignment and Voluntary Alignment
2025	Q3	Q1 2025	Claims-Based Alignment and Voluntary Alignment
2026	Q3	Q1 2026	Claims-Based Alignment and Voluntary Alignment

b. For each month of the applicable lookback period, beginning with the second month, CMS divides the number of REACH Beneficiaries for the month by the number of REACH Beneficiaries for the previous month ("**Alternative Retention Rate**"). For example, the applicable lookback period for Performance Year 2023 is the first calendar quarter of 2023, the second month of which is February 2023. CMS therefore divides the number of REACH Beneficiaries for February 2023 by the number of REACH Beneficiaries for January 2023 to calculate the Alternative Retention Rate for February 2023. CMS also divides the number of REACH Beneficiaries for March 2023 by the number of REACH Beneficiaries for February 2023 to calculate the Alternative Retention Rate for March 2023.

c. CMS sums the Alternative Retention Rate for each month of the applicable lookback period and divides that amount by the number of months in the applicable lookback period for which an Alternative Retention Rate is calculated to establish the Alternative Average Retention Rate.

5. CMS estimates the number of REACH Beneficiaries for each month of the first calendar quarter of the Performance Year in which monthly TCC payments are made, as described in Section V.A.4(b) of this Appendix as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant calendar quarter by multiplying the number of REACH Beneficiaries for the month prior to the relevant calendar quarter, as specified in the report that will be shared with

the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Alternative Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant calendar quarter, calculated in accordance with Section V.C.5(a) of this Appendix, by the Alternative Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant calendar quarter, calculated in accordance with Section V.C.5(b) of this Appendix, by the Alternative Average Retention Rate.

D. Quarterly Updates to Monthly TCC Payment Amount

1. CMS updates the monthly TCC Payment amount calculated in accordance with Section V.B or Section V.C of this Appendix, as applicable, for each month of the calendar quarters specified in Figure 5 of this Appendix as follows:

a. CMS multiplies the Updated PBPM TCC Payment Amount for that month (calculated in accordance with Section V.D.4 of this Appendix) by the estimated number of REACH Beneficiaries for that month (calculated in accordance with the relevant provision of Section V.D.5 or Section V.D.6 of this Appendix, as applicable), and adds the Updated TCC Payment Adjustment Amount for that month (calculated in accordance with Section V.D.9 of this Appendix, as applicable) ("**Unconstrained Updated Monthly TCC Payment Amount**").

b. CMS determines the updated monthly TCC Payment amount by comparing 1) the product of 0.75 and the average of the amounts of monthly TCC Payments made to the ACO for the previous quarter ("**Updated Monthly TCC Payment Floor**") to 2) the Unconstrained Updated Monthly TCC Payment Amount. The updated monthly TCC Payment amount is the greater of the Updated Monthly TCC Payment Floor or the Unconstrained Updated Monthly TCC Payment Amount. The difference between the Updated Monthly TCC Payment Floor and the Unconstrained Updated Monthly TCC Payment Amount is an overpayment of the TCC Payment amount for purposes of Section V.D.7.

Figure 5. Schedule of quarterly updates to monthly TCC payment amounts

PY	Quarterly updates if the ACO's TCC payment amount for the first quarter of the Performance Year for which TCC payments were made to the ACO was calculated using the Default Monthly TCC Payment Calculation	Quarterly updates if the ACO's TCC payment amount for the first quarter of the Performance Year for which TCC payments were made to the ACO was calculated using the Alternative Monthly TCC Payment Calculation
2023	Q2, Q3, Q4	Q4
2024	Q2, Q3, Q4	Q4
2025	Q2, Q3, Q4	Q4
2026	Q2, Q3, Q4	Q4

Updated PBPM TCC Payment Amount

2. In order to calculate a PBPM version of the updated monthly TCC Payment Amount for a given month ("**Updated PBPM TCC Payment Amount**"), CMS first re-estimates the total portion of claims-based payments that will not be subject to TCC Fee Reductions during the relevant quarter ("**Updated TCC Withhold Percentage**") as follows:

   a. CMS uses historical Medicare FFS claims from the applicable lookback period listed in Figure 6 or Figure 7 of this Appendix, as applicable, to calculate the total amount of claims-based payments for all Covered Services furnished to those REACH Beneficiaries who were aligned to the ACO during the applicable lookback period through either Claims-based Alignment or Voluntary Alignment.

   b. If the ACO's TCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly TCC Payment Calculation described in Section V.B of this Appendix, CMS calculates the Updated TCC Withhold Percentage using the applicable lookback periods specified in Figure 6 of this Appendix.

Figure 6. Applicable Lookback Periods to Calculate the Updated TCC Withhold Percentage if the ACO's TCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly TCC Payment Calculation

PY	Q2	Q3	Q4	Alignment methodology for lookback period
2023	TCC Withhold Percentage not updated[1]	TCC Withhold Percentage updated using Q1 2023 as lookback period	Updated TCC Withhold Percentage calculated using Q1-Q2 2023 as lookback period	Claims-Based Alignment and Voluntary Alignment
2024	TCC Withhold Percentage not updated[1]	TCC Withhold Percentage updated using Q1 2024 as lookback period	Updated TCC Withhold Percentage calculated using Q1-Q2 2024 as lookback period	Claims-Based Alignment and Voluntary Alignment
2025	TCC Withhold Percentage not updated[1]	TCC Withhold Percentage updated using Q1 2025 as lookback period	Updated TCC Withhold Percentage calculated using Q1-Q2 2025 as lookback period	Claims-Based Alignment and Voluntary Alignment
2026	TCC Withhold Percentage not updated[1]	TCC Withhold Percentage updated using Q1 2026 as lookback period	Updated TCC Withhold Percentage calculated using Q1-Q2 2026 as lookback period	Claims-Based Alignment and Voluntary Alignment

[1] Default TCC Withhold Percentage is used.

c. If the ACO's TCC Payment amount for the third quarter of the Performance Year was calculated using the Alternative Monthly TCC Payment Calculation described in Section V.C of this Appendix, CMS calculates the Updated TCC Withhold Percentage using the applicable lookback periods specified in Figure 7 of this Appendix.

Figure 7. Applicable Lookback Periods to Calculate the Updated TCC Withhold Percentage Calculations if the ACO's TCC Payment amount for the third quarter of the Performance Year was calculated using the Alternative Monthly TCC Payment Calculation

PY	Q2	Q3	Q4	Alignment methodology
2023	N/A (No TCC Payments made)	N/A (first TCC Payments made for PY)	Updated TCC Withhold Percentage calculated using Q1-Q2 2023 as lookback period	Claims-Based Alignment and Voluntary Alignment
2024	N/A (No TCC Payments made)	N/A (first TCC Payments made for PY)	Updated TCC Withhold Percentage calculated using Q1-Q2 2024 as lookback period	Claims-Based Alignment and Voluntary Alignment

PY	Q2	Q3	Q4	Alignment methodology
2025	N/A (No TCC Payments made)	N/A (first TCC Payments made for PY)	Updated TCC Withhold Percentage calculated using Q1-Q2 2025 as lookback period	Claims-Based Alignment and Voluntary Alignment
2026	N/A (No TCC Payments made)	N/A (first TCC Payments made for PY)	Updated TCC Withhold Percentage calculated using Q1-Q2 2026 as lookback period	Claims-Based Alignment and Voluntary Alignment

d. CMS estimates the portion of the total amount of claims-based payments during the applicable lookback period calculated in accordance with Section V.D.2(a) of this Appendix that were not subject to TCC Fee Reductions ("**Updated Per-Provider TCC Non-Reduced Claims Amount**") by calculating the total claims-based payments made to each non-TCC Payment-participating provider and supplier during the applicable lookback period calculated in accordance with Section V.D.2(a) of this Appendix and, for each TCC Payment-participating Preferred Provider, the product of: (1) the total claims-based payments for Covered Services made to the Preferred Provider during the applicable lookback period calculated in accordance with Section V.D.2(a) of this Appendix; and (2) one minus the TCC Fee Reduction percentage agreed to by the Preferred Provider.

e. To calculate the Updated TCC Withhold Percentage, the Updated Per-Provider TCC Non-Reduced Claims Amount is aggregated across all providers and suppliers and then divided by the total amount of historical claims-based payments for all Covered Services during the applicable lookback period calculated in accordance with Section V.D.2(a) of this Appendix.

f. If the ACO's TCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly TCC Payment Calculation described in Section V.B of this Appendix, CMS uses the Default TCC Withhold Percentage calculated in accordance with Section V.B of this Appendix as the Updated TCC Withhold Percentage for each quarter in which CMS makes monthly TCC Payments but for which CMS does not calculate an Updated TCC Withhold Percentage.

3. In order to calculate a PBPM version of the updated monthly TCC Payment Amount for a given month ("**Updated PBPM TCC Payment Amount**"), CMS first calculates an updated PBPM version of the Performance Year Benchmark for that quarter ("**Updated PBPM Benchmark Amount**") as follows:

a. To calculate the Updated PBPM Benchmark Amount, except as specified in Section V.D.3(b) of this Appendix, CMS divides the ACO's Performance Year Benchmark reported in the most recent Quarterly Benchmark Report by the number of Beneficiary-Months reported in the most recent Quarterly Benchmark Report.

b. If CMS has not yet distributed a Quarterly Benchmark Report for the Performance Year, CMS uses the following amounts as the Updated PBPM Benchmark Amount:

i. The Default PBPM Benchmark Amount, described in Section V.B.3 of this Appendix, if the ACO's TCC Payment amount for the first quarter of the Performance Year was calculated using the Default Monthly TCC Payment Calculation described in Section V.B of this Appendix; or

ii. The Alternative PBPM Benchmark Amount, described in Section V.C.3 of this Appendix, if the ACO's TCC Payment amount for the third quarter of the Performance Year was calculated using the Alternative Monthly TCC Payment Calculation described in Section V.C of this Appendix.

4. CMS then calculates the Updated PBPM TCC Payment Amount for a given month by multiplying the most recently calculated Updated TCC Withhold Percentage, calculated in accordance with Section V.D.2 of this Appendix, by the applicable Updated PBPM Benchmark Amount, calculated in accordance with Section V.D.3 of this Appendix, and subtracts the resulting amount from the applicable Updated PBPM Benchmark Amount.

Estimated Number of REACH Beneficiaries

5. If the ACO's TCC payment amount for the first quarter of the Performance Year for which TCC Payments were made to the ACO was calculated using the Default Monthly TCC Payment Calculation, CMS estimates the number of REACH Beneficiaries for each month of each calendar quarter specified in Figure 5 of this Appendix as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant calendar quarter by multiplying the number of REACH Beneficiaries for the month immediately prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Default Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant calendar quarter, calculated in accordance with

Section V.D.5(a) of this Appendix, by the Default Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant calendar quarter, calculated in accordance with Section V.D.5(b) of this Appendix, by the Default Average Retention Rate.

6. If the ACO's TCC payment amount for the first quarter of the Performance Year for which TCC Payments were made to the ACO was calculated using the Alternative Monthly TCC Payment Calculation, CMS estimates the number of REACH Beneficiaries for each month of each calendar quarter specified in Figure 5 of this Appendix as follows:

a. CMS estimates the number of REACH Beneficiaries for the first month of the relevant calendar quarter by multiplying the number of REACH Beneficiaries for the month immediately prior to the relevant calendar quarter, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement, by the Alternative Average Retention Rate.

b. CMS estimates the number of REACH Beneficiaries for the second month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the first month of the relevant calendar quarter, calculated in accordance with Section V.D.6(a) of this Appendix, by the Alternative Average Retention Rate.

c. CMS estimates the number of REACH Beneficiaries for the third month of the relevant calendar quarter by multiplying the estimated number of REACH Beneficiaries for the second month of the relevant calendar quarter, calculated in accordance with Section V.D.6(b) of this Appendix, by the Alternative Average Retention Rate.

Adjustments to Account for Prior Under (Over) Estimates and Overpayments

7. To account for under or over estimates and overpayments of the TCC Payment amount for prior months of the Performance Year, CMS calculates the amount by which the monthly TCC Payments were over or under estimated and the amount by which the monthly TCC Payments were overpaid during the Performance Year to date for each month of the relevant quarter of the Performance Year for which CMS updates the TCC Payment amount in accordance with this Section V.D ("**Updated TCC Payment Adjustment Amount**").

8. CMS calculates the Updated TCC Payment Adjustment Amount as follows:

a. CMS sums the amount of monthly TCC Payments made to the ACO in prior months of the Performance Year ("**Actual TCC Payments YTD**").

b. CMS multiplies the Updated PBPM TCC Payment Amount, calculated in accordance with Section V.D.4 of this Appendix, by the number of Beneficiary-Months year-to-date, as specified in the report that will be shared with the ACO in accordance with Section 6.02.C.1 of the Agreement ("**Revised TCC Payments YTD**").

c. CMS subtracts the Actual TCC Payments YTD from the Revised TCC Payments YTD ("**Under (Over) TCC Payment Amount YTD**").

9. To calculate the Updated TCC Payment Adjustment Amount, CMS divides the Under (Over) TCC Payment Amount YTD by the number of months remaining in the Performance Year at the time the calculation is performed.

E. Calculating Actual Annual TCC Payment Amount After Each Performance Year

1. To calculate the actual annual TCC Payment amount for a Performance Year, CMS uses Medicare FFS claims from the entire Performance Year to calculate the total amount of claims-based payments for all Covered Services furnished to those REACH Beneficiaries who were actually aligned to the ACO during the Performance Year through either Claims-Based Alignment or Voluntary Alignment.

2. CMS calculates the actual portion of claims-based payments subject to the TCC Withhold Percentage during the Performance Year using the aggregate amount of the claims-based payments calculated in accordance with Section V.E.1 of this Appendix that were not subject to a TCC Fee Reduction, divided by the total amount of claims-based payments calculated in accordance with Section V.E.1 of this Appendix ("**Actual TCC Withhold Percentage**"). Claims-based payments that were not subject to a TCC Fee Reduction are identified using claims data shared with the ACO and described in Section 6.02.C of the Agreement.

3. CMS multiplies the Actual TCC Withhold Percentage by the Performance Year Benchmark reported in the settlement report for Final Financial Settlement to calculate the "**Actual Annual TCC Withhold Amount**." CMS then subtracts the Actual Annual TCC Withhold Amount from the Performance Year Benchmark reported in the settlement report for Final Financial Settlement to calculate the "**Actual Annual TCC Payment Amount**."

VI. Reconciliation of TCC Payments

A. During Final Financial Settlement for each Performance Year the ACO participates in TCC Payment, CMS will reconcile the total monthly TCC Payments made to the ACO during the Performance Year by calculating the difference between:

1. The total monthly TCC Payments CMS made to the ACO during the Performance Year calculated in accordance with Section V.B or Section V.C of this Appendix, as applicable, including any quarterly updates and adjustments described in Section V.D of this Appendix; and

2. The Actual Annual TCC Payment Amount calculated in accordance with Section V.E of this Appendix

B. Any difference between the amounts calculated under Section VI.A.1 and Section VI.A.2 of this Appendix will constitute Other Monies Owed and will be paid or collected during Final Financial Settlement under Section 12.04.A.3 and Appendix B of the Agreement.

C. CMS will include any Other Monies Owed, including Other Monies Owed due to reconciliation of the total monthly TCC Payments, on the settlement report issued for Final Financial Settlement under Section 12.04.A.3 of the Agreement, such that the settlement report will set forth the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.

D. During Final Financial Settlement for each Performance Year in which the ACO participates in TCC Payment, the Actual Annual TCC Payment Amount will be counted as Performance Year Expenditures in accordance with Appendix B.

E. In the event that the ACO elects to terminate the Agreement Performance Period pursuant to Article XVII of the Agreement prior to the end of a Performance Year in which the ACO participates in TCC Payment by providing notice to CMS, that its termination is effective no later than 30 Days after the Termination Without Liability Date of that Performance Year, there will be no annual financial settlement for that Performance Year in accordance with Section 17.04 of the Agreement, CMS will reconcile the total monthly TCC Payments with the total actual amount of TCC Fee Reductions as part of the annual settlement report for the previous Performance Year, and the ACO must pay any Other Monies Owed to CMS in accordance with Section 12.04.E of the Agreement.

Appendix H: Financial Guarantee

This Appendix provides requirements regarding the ACO's financial guarantee required under Section 12.05 of the Agreement for repayment of amounts owed to CMS: (1) as Shared Losses and/or Other Monies Owed, including interest described in Section 12.06 of the Agreement; and (2) if the ACO selects the Financial Guarantee Participation Commitment Mechanism but does not secure a separate Retention Guarantee described in Section 12.03.B of the Agreement, the Retention Guarantee Amount. If the ACO selects the Financial Guarantee Participation Commitment Mechanism and elects to pursue a separate Retention Guarantee described in Section 12.03.B of the Agreement for repayment of the Retention Guarantee Amount, this Appendix provides requirements regarding the ACO's separate Retention Guarantee.

I. Form of Financial Guarantee

A. A financial guarantee must be in one of the following forms:

1. Funds placed in an escrow;
2. A line of credit as evidenced by a letter of credit upon which CMS may draw; or
3. A surety bond.

B. CMS may reject any financial guarantee that does not comply with the terms of Section 12.05 of the Agreement and this Appendix.

C. Consistent with Section 12.05 and Section 12.03.B of the Agreement, any changes made to a financial guarantee must be approved in advance by CMS.

II. Calculation of the Base Financial Guarantee Amount and the Retention Guarantee Amount

A. CMS calculates the base amount that must be funded by the financial guarantee required under Section 12.05 of the Agreement by:

1. Dividing the Performance Year Benchmark reported in the Performance Year Benchmark Report by the number of Originally Aligned Beneficiaries reported in the Performance Year Benchmark Report ("**FG PBPM Benchmark Amount**");
2. Multiplying the FG PBPM Benchmark Amount by the estimated number of Alignment-Eligible Beneficiaries for the month prior to the first month of the Performance Year, as specified in the report described in Section 6.03.B of the Agreement, and by the number of months in the Performance Year ("**FG Total Benchmark Amount**"); and
3. For each Performance Year prior to Performance Year 2024, multiplying the FG Total Benchmark Amount by the applicable percentage specified in Table 1 of this Appendix ("**Base Financial Guarantee Amount**"); and for Performance Year 2024 and each subsequent Performance Year, multiplying the FG Total Benchmark Amount by the applicable percentage specified in Table 2 of this Appendix ("Base Financial Guarantee Amount").

Table 1: Original Financial Guarantee Amount Requirement (PY2021 – PY2023)

	Primary Care Capitation Payment	Total Care Capitation Payment
Professional	2.5%	N/A
Global	3.0%	4.0%

Table 2: Revised Financial Guarantee Amount Requirement (PY2025 and PY2026)

Risk Arrangement	Primary Care Capitation Payment	Enhanced Primary Care Capitation Payment and/or Advance Payment	Total Care Capitation Payment
Professional	2.5%	4.0% in 2025 (3.75% in 2026)	N/A
Global	3.0%	4.0% in 2025 (3.75% is 2026)	4.0%

B. CMS calculates the Retention Guarantee Amount by multiplying the FG Total Benchmark Amount by 2 percent.

III. Amount of the Financial Guarantee Required Under Section 12.05 of the Agreement

A. The financial guarantee required under Section 12.05 of the Agreement must be in an amount equal to the Base Financial Guarantee Amount, as calculated in Section II.A of this Appendix, and, if the ACO selected the Financial Guarantee Participation Commitment Mechanism as described in Section 12.03.B of the Agreement and elects to increase the amount of the financial guarantee required under Section 12.05 of the Agreement to cover the Retention Guarantee Amount described in Section 12.03.B of the Agreement and calculated in accordance with Section II.B of this Appendix, the amount of the financial guarantee required under Section 12.05 of the Agreement must also include the Retention Guarantee Amount.

B. For the ACO's first Performance Year, the parties acknowledge that CMS provided written notice to the ACO specifying the Base Financial Guarantee Amount that must be funded by the ACO's financial guarantee required under Section 12.05 of the Agreement and the Retention Guarantee Amount described in Section 12.03.B of the Agreement and calculated in accordance with Section II.B of this Appendix.

C. By the Start Date or such later date as specified by CMS, and in a form and manner specified by CMS, the ACO shall submit to CMS written documentation of the form, duration, and amount of its financial guarantee required under Section 12.05 of the Agreement.

D. If the ACO selected the Financial Guarantee Participation Commitment Mechanism as described in Section 12.03.B of the Agreement and elects to increase the amount of the financial guarantee required under Section 12.05 of the

Agreement to cover the Retention Guarantee Amount described in Section 12.03.B of the Agreement and calculated in accordance with Section II.B of this Appendix, the written documentation of the form, duration, and amount of the financial guarantee submitted to CMS pursuant to Section III.C of this Appendix must demonstrate that the financial guarantee is in an amount that includes the Retention Guarantee Amount.

E. Before the Termination Without Liability Date for the second Performance Year, and each subsequent Performance Year, CMS will provide written notice to the ACO specifying the Base Financial Guarantee Amount that must be funded for the relevant Performance Year by the ACO's financial guarantee required under Section 12.05 of the Agreement.

F.

1. During the second Performance Year and during each Performance Year thereafter, the ACO shall adjust the amount of the financial guarantee required under Section 12.05 of the Agreement to reflect the updated Base Financial Guarantee Amount plus the Retention Guarantee Amount, if applicable, and the Base Financial Guarantee Amount for the previous Performance Year if directed by CMS (e.g., because the ACO has not yet paid in full the amount of Shared Losses, accrued interest, and/or Other Monies Owed for the previous Performance Year, as set forth in a settlement report that has been deemed final). In a form and manner and by a deadline specified by CMS, the ACO shall submit to CMS documentation demonstrating its compliance with the requirement set forth in this Section III.F.1.

2. For a Performance Year for which the ACO selects to participate in Provisional Financial Settlement as described in Section 8.01, if the ACO has fully paid the provisional amount of Total Monies Owed, or received Shared Savings, as set forth in a settlement report to the ACO after CMS conducts Provisional Financial Settlement, the ACO shall only be required to adjust its Financial Guarantee to include the amount required for the current Performance Year (i.e., updated Base Financial Guarantee Amount plus the Retention Guarantee Amount, if applicable).

G. If the ACO does not submit to CMS the documentation required in Section III.C, Section III.D, Section III.F.1, or Section III.I of this Appendix, CMS will withhold monthly payments to the ACO under the ACO's selected Capitation Payment Mechanism until the ACO has submitted such documentation, and CMS may take other remedial action or terminate the Agreement or Agreement Performance Period in accordance with Article XVII of the Agreement.

H. If CMS does not approve the ACO's financial guarantee documentation, CMS may withhold monthly payments to the ACO under the ACO's selected Capitation Payment Mechanism until the ACO has submitted revised financial guarantee documentation that complies with the terms of this Appendix H, and CMS may take other remedial action or terminate the Agreement or Agreement Performance Period in accordance with Article XVII of the Agreement.

I. If CMS draws on the ACO's financial guarantee to repay Shared Losses, accrued interest, and/or Other Monies Owed to CMS for a Performance Year, the ACO shall, within 60 Days of the date CMS draws on the financial guarantee: (1) replenish its financial guarantee or establish another financial guarantee to ensure it maintains coverage equal to the Financial Guarantee Amount; and (2) submit to CMS documentation demonstrating its compliance with this provision.

IV. Amount of the Separate Financial Guarantee Described in Section 12.03.B of the Agreement

If the ACO selects the Financial Guarantee Participation Commitment Mechanism as described in Section 12.03.B of the Agreement and selects to secure a Retention Guarantee for the Retention Guarantee Amount as described in Section 12.03.B of the Agreement and calculated in accordance with Section II.B of this Appendix, the ACO shall submit to CMS written documentation of the form, duration, and amount of its Retention Guarantee described in Section 12.03.B of the Agreement in a form and manner and by the Start Date or such later date as specified by CMS.

V. Duration of Financial Guarantee

A. Except as set forth in Section V.B of this Appendix, the financial guarantee required under Section 12.05 of the Agreement must remain in effect for at least 24 months following the last day of the ACO's first Performance Year and must provide for automatic, annual 12-month extensions starting on December 31 of the ACO's first Performance Year, such that the financial guarantee will remain in effect for 24 months after the end of the ACO's final Performance Year.

B. The ACO may terminate the financial guarantee required under Section 12.05 of the Agreement prior to the end of the term specified in Section V.A of this Appendix only under the following circumstances:

1. The ACO may terminate such financial guarantee on or after the date on which the settlement report for Final Financial Settlement for the ACO's final Performance Year is deemed final, if the settlement report indicates that the ACO does not owe any Shared Losses, accrued interest, and/or Other Monies Owed for any Performance Year and CMS has not notified the ACO that it intends to reopen any settlement report pursuant to Section 12.04.D of the Agreement; or

2. The ACO may terminate such financial guarantee on or after the date on which the ACO has made payment in full to CMS for all Shared Losses, accrued interest, and/or Other Monies Owed for every Performance Year in which the ACO has participated; or

3. For the purpose of carrying out Section III.F.1 and III.F.2 of this Appendix, the ACO may terminate its financial guarantee so long as the ACO immediately provides a new financial guarantee consistent with the terms of Section 12.05 and this Appendix.

C. If the ACO selected the Financial Guarantee Participation Commitment Mechanism as described in Section 12.03.B of the Agreement and selected to increase the amount of the financial guarantee required under Section 12.05 of the

Agreement to cover the Retention Guarantee Amount specified in Section 12.03.B of the Agreement and calculated in Section II.B of this Appendix:

1. The amount of the ACO's financial guarantee may be reduced by the amount of the Retention Guarantee Amount only after the Termination Without Liability Date for the ACO's second Performance Year, except as specified in Section V.C.2 of this Appendix.

2. If the ACO gives notice of termination of the Agreement Performance Period before the Termination Without Liability Date for the ACO's second Performance Year, the ACO's financial guarantee may not be reduced by the Retention Guarantee Amount until the date on which the settlement report for Final Financial Settlement for the ACO's first Performance Year is deemed final, at which point CMS will pursue payment in the amount of the Retention Guarantee Amount under the Retention Guarantee.

D. If the ACO selected the Financial Guarantee Participation Commitment Mechanism as described in Section 12.03.B of the Agreement and selected to secure a Retention Guarantee for the Retention Guarantee Amount as described in Section 12.03.B of the Agreement and calculated in accordance with Section II.B of this Appendix:

1. The Retention Guarantee must remain in effect until the Termination Without Liability Date for the ACO's second Performance Year except as specified in Section V.D.2 of this Appendix.

2. If the ACO gives notice of termination of the Agreement Performance Period before the Termination Without Liability Date for the ACO's second Performance Year, the Retention Guarantee must remain in effect until the date on which the settlement report for Final Financial Settlement for the ACO's first Performance Year is deemed final at which point CMS will pursue payment in the amount of the Retention Guarantee Amount under the Retention Guarantee.

VI. Other Requirements

A. Beneficiary/Obligee: The ACO shall designate CMS as the sole beneficiary or obligee of the financial guarantee. CMS' address is 7500 Security Blvd., Baltimore, MD 21244.

B. Condition for calling funds: The financial guarantee should indicate that the ACO is obligated to repay money it owes to CMS as a result of participation in the ACO REACH Model, citing the ACO REACH Model Performance Period Participation Agreement.

Example:

> The ACO is obligated to repay money it owes to CMS under the ACO REACH Model, as required by the ACO REACH Model Performance Period Participation Agreement. The amount of Shared Losses, accrued interest, and/or Other Monies Owed will be specified in a demand letter to the ACO from CMS.

C. Demand Letter: The financial guarantee must allow for payment to CMS in response to a demand letter from CMS.

D. Account Fees: Account fees or other fees associated with establishing, maintaining, or cancelling a financial guarantee are the responsibility of the ACO and must not be paid out of the principal of the financial guarantee.

E. Force Majeure: The terms of the financial guarantee shall not remove or limit CMS' right to draw upon the financial guarantee in the event of a force majeure.

VII. Requirements for Funds placed in Escrow

A. [Reserved]

B. CMS must approve the escrow agreement and the instructions for disbursement of the assets held in escrow. Generally, CMS will accept an escrow agreement under the following conditions:

1. For each Performance Year prior to Performance Year 2024, the institution is insured; and for Performance Year 2024 and each subsequent Performance Year, the institution is insured by the Federal Deposit Insurance Corporation (FDIC), except as otherwise specified by CMS;
2. The funds are invested in Treasury-backed securities or a money market fund;
3. The instructions for disbursement of the assets are consistent with CMS' escrow instructions (See Escrow Instructions in Exhibit A);
4. The costs, fees, and expenses associated with the escrow account, including any legal expenses incurred by the escrow agent or the ACO, are not borne by CMS and are not charged to principal;
5. The principal cannot be encumbered for any purpose other than repaying Shared Losses, accrued interest, and/or Other Monies Owed by the ACO to CMS;
6. CMS is not required to indemnify any person or entity against any loss, claim, damages, liabilities, or expenses, including the costs of litigation arising from the escrow agreement or the subject of the agreement;
7. CMS will receive 90 Days advance written notice of early termination of the escrow account and any change in the amount of funds held in escrow;
8. CMS will receive 90 Days advance written notice if the term of the escrow agreement is not extended as required under Section V.A of this Appendix; and
9. For Performance Year 2024 and each subsequent Performance Year, CMS will receive monthly account statements by either mail or electronic delivery to the addresses specified in Section 19.01 of this Agreement.

VIII. Requirements for Letters of Credit

A. CMS will generally accept a Letter of Credit under the following conditions:

1. For each Performance Year prior to Performance Year 2024, the letter of credit is issued by an insured institution; and for Performance Year 2024 and each subsequent Performance Year, the letter of credit is issued by an institution insured by the Federal Deposit Insurance Corporation (FDIC), except as otherwise specified by CMS;
2. The letter of credit is irrevocable;
3. CMS is designated as the sole beneficiary;
4. The appropriate credit amount is specified;
5. The terms allow an authorized official of CMS to draw on the letter of credit upon submission to the issuing bank of the following items: (a) a certification that "The amount of the drawing under this credit represents funds due to CMS from [ACO Name] under the ACO REACH Model and which have remained unpaid for at least 30 Days"; and (b) a copy of the appropriate written notice to the ACO of the amount owed;
6. The letter of credit permits partial and multiple drawings;
7. The letter of credit states that CMS will receive 90 Days advance written notice if the letter of credit is terminated or withdrawn or if there is any change in the amount of credit;
8. A statement that the issuer will provide 90 Days advance written notice to CMS if the duration of the letter of credit will not be extended in accordance with Section V.A of this Appendix; and
9. Sanctioned entity clauses: The bank issuing the letter of credit must omit these clauses entirely, or, if included, exclude from the definition of "sanctioned entity" entities sanctioned by a federal health care program (as defined in Section 1128B(f) of the Act) or by any federal agency.

IX. Requirements for Surety Bonds

A. Surety Companies: The surety bond must be issued from a company included on the U.S. Department of Treasury's Listing of Certified (Surety Bond) Companies, available at https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm ("**Surety**").

B. Surety Bond Terms: The bond must contain:

1. A statement that the Surety is liable for assessments that occur during the term of the bond;
2. The Surety's name, street address or post office box number, city, state, and zip code (which should be identical to the Surety's legal entity name and address as listed on the U.S. Department of the Treasury's List of Certified (Surety Bond) Companies);
3. A statement naming the ACO as the Principal, CMS as the Obligee, and the insurance company as Surety;
4. The appropriate surety bond amount ("**Penal Sum**");

5. A statement that the Surety is liable under the bond for Shared Losses, accrued interest, and/or Other Monies Owed, as determined by CMS, up to the Penal Sum;
6. A statement that the Surety agrees to pay the amount demanded by CMS, up to the Penal Sum, within 30 days of receiving written notice from CMS demonstrating that the ACO has failed to pay the specified amount of Shared Losses, accrued interest, and/or Other Monies Owed;
7. A statement that the Surety agrees to not contest the amount owed as reflected in the documents provided by CMS to the ACO;
8. A statement that the Surety will notify CMS promptly in writing if there is a lapse in the surety bond coverage or a change in the amount of the bond;
9. A statement that the Surety will notify CMS in writing at least 90 days in advance of cancellation or termination of the bond; and
10. A statement that the Surety will provide 90 Days advance written notice to CMS if the duration of the bond will not be extended in accordance with Section V.A of this Appendix.

Exhibit A

Escrow Instructions

1) The Escrow Agent ("Agent") shall dispose of the Assets only upon written instruction from an authorized representative of CMS. Such written instructions shall:
   a) Identify the amount, if any, of Shared Losses, accrued interest, and/or Other Monies Owed incurred by the ACO for the relevant Performance Year, as determined by CMS and set forth in a final settlement report, as revised if applicable, issued by CMS pursuant to Section 12.04 of the ACO REACH Model Performance Period Participation Agreement ("Participation Agreement").
   b) Identify the amount of such Shared Losses, accrued interest, and/or Other Monies Owed that the ACO has failed to pay (the "Debt") within 30 Days of the date of the settlement report.
   c) Instruct Agent to convert the Assets to cash and pay the amount of the Debt to CMS. If the Assets will be zero after delivering the amount of the Debt to CMS, Agent shall notify CMS, and CMS shall provide further instructions, in consultation with ACO, for the replenishment of assets or closure of the Account.
   d) In the event of the expiration or termination of the ACO's Participation Agreement or other circumstances requiring closure of the Account, the CMS will notify the Agent and instruct Agent to convert the Assets to cash and dispose of them as follows:
      i) If the Debt is zero, Agent shall return the full cash value of the Assets to the ACO, less Agent's unpaid fees, costs and expenses.
      ii) If the cash value of the Assets is less than or equal to the amount of the Debt, Agent shall deliver to CMS payment by check or wire transfer in the amount of the full cash value of the Assets.
      iii) If the cash value of the Assets exceeds the amount of the Debt, Agent shall deliver to CMS payment by check or wire transfer in the amount of the Debt and shall return the remaining Assets to the ACO, less Agent's unpaid fees, costs and expenses.
2) Upon disposition of the Assets as specified in paragraph 1(d), Agent shall close the Account and the Escrow Agreement shall terminate.
3) Unless otherwise specified by written notice of the Parties, the following persons are authorized to provide instructions from the ACO or CMS, as the case may be, to Agent, consistent with the terms of the Agreement:

ACO

Name: ________________________________ ________________________________

Specimen Signature

Title: ________________________________

CMS

Name: ________________________________ ________________________________

Specimen Signature

Title: ________________________________

Appendix I: 3-Day SNF Rule Waiver Benefit Enhancement

I. Election of the 3-Day SNF Rule Waiver Benefit Enhancement

If the ACO wishes to offer the 3-Day SNF Rule Waiver Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the 3-Day SNF Rule Waiver Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the 3-Day SNF Rule Waiver Benefit Enhancement; and

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Preferred Providers that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement and, for Performance Years prior to PY 2025, a true, accurate, and complete list of Participant Providers that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement.

II. Waiver

CMS waives the requirement in section 1861(i) of the Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services ("**SNF Services**") furnished under the terms and conditions set forth in this Appendix ("**3-Day SNF Rule Waiver Benefit Enhancement**").

III. Eligible SNFs

A. For purposes of this waiver, an "**Eligible SNF**" is a SNF or a Swing-Bed Hospital that is a Preferred Provider that has (i) entered into a written arrangement with the ACO to provide SNF Services in accordance with the SNF 3-Day Rule Waiver Benefit Enhancement under Section II of this Appendix; (ii) been identified by the ACO as having agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement in accordance with Section I.B of this Appendix; and (iii) been approved by CMS to participate under the 3-Day SNF Rule Waiver Benefit Enhancement following a review of the qualifications of the SNF or Swing-Bed Hospital to accept admissions without a prior inpatient hospital stay ("**Direct SNF Admissions**") and admissions after an inpatient stay of fewer than three Days.

B. CMS review and approval of a SNF or Swing-Bed Hospital to provide services in accordance with the 3-Day SNF Rule Waiver Benefit Enhancement includes consideration of the program integrity history of the SNF or Swing-Bed Hospital and any other factors that CMS determines may affect the qualifications of the SNF or Swing-Bed Hospital to provide SNF Services under the terms and conditions of the 3-Day SNF Rule Waiver Benefit Enhancement. Beginning on a date specified by CMS, at the time of CMS review and approval of a SNF to participate under the 3-Day SNF Rule Waiver Benefit Enhancement, the SNF must have an overall rating of three or more stars under the CMS 5-Star Quality Rating System in the applicable number of months listed in Table A of this Appendix.

Table A. Required Number of Months with a Rating of Three or More Stars based on Experience.

Number of Months Reported on the Nursing Home Compare Website	Number of Months Required with a Rating of Three or More Stars
6[1]	5
7	5
8	6
9	6
10	7
11	7
12+	7

(1) SNFs with fewer than 6 reported months on the Nursing Home Compare Website are ineligible to participate.

C. Eligibility of SNFs and Swing-Bed Hospitals to provide services under this 3-Day SNF Rule Waiver Benefit Enhancement will be reassessed by CMS annually, prior to the start of each Performance Year.

D. The ACO shall maintain and provide to its Participant Providers and Preferred Providers an accurate and complete list of Eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF or Swing-Bed Hospital eligibility. The ACO shall also furnish these lists to a REACH Beneficiary, upon request.

E. The ACO must provide written notification to CMS within 10 Days of any changes to its list of Eligible SNFs. Within 10 Days following the removal of any Eligible SNF from the list of Eligible SNFs, the ACO must also provide written notification to the SNF or Swing-Bed Hospital that it has been removed from the list and that it no longer qualifies to use this 3-Day SNF Rule Waiver Benefit Enhancement.

F. The ACO shall provide a copy of this Appendix to each Eligible SNF to which Beneficiaries are referred by Participant Providers and Preferred Providers.

IV. Beneficiary Eligibility Requirements

A. Except as specified in Section IV.A.3, to be eligible to receive services covered under the terms of the waiver under Section II of this Appendix, the Beneficiary must meet the criteria described in paragraphs (1) and (2) of this Section IV.A:

1. Be a REACH Beneficiary at the time of admission to an Eligible SNF under this waiver or within the grace period under Section V of this Appendix; and

2. Not reside in a SNF or long-term care facility at the time of admission to an Eligible SNF under this waiver. For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities.

3. Beginning on a date specified by CMS, if the ACO has selected the Global Risk Sharing Option, the Beneficiary need not meet the requirement described in Section IV.A.2 to be eligible to receive services covered under the terms of the waiver under Section II of this Appendix so long as the ACO has an approved Implementation Plan describing how the ACO will implement the additional flexibility under this Section IV.A.3.

B. A Direct SNF Admission will be covered under the terms of the waiver under Section II of this Appendix only if, at the time of admission, in addition to meeting the eligibility requirements under Section IV.A of this Appendix, the Beneficiary:

1. Is medically stable;

2. Has confirmed diagnoses;

3. Has been evaluated by a physician or other practitioner licensed to perform the evaluation within three Days prior to admission to the Eligible SNF;

4. Does not require inpatient hospital evaluation or treatment; and

5. Has a skilled nursing or rehabilitation need that is identified by the evaluating physician or other practitioner and cannot be provided as an outpatient.

C. A SNF or Swing Bed-Hospital admission will be covered under the terms of the waiver under Section II of this Appendix for a Beneficiary who is discharged to an Eligible SNF after fewer than three Days of inpatient hospitalization only if, at the time of admission, the Beneficiary:

1. Is medically stable;

2. Has confirmed diagnoses;

3. Does not require further inpatient hospital evaluation or treatment; and

4. Has a skilled nursing or rehabilitation need that has been identified by a physician or other practitioner during the inpatient hospitalization and that cannot be provided on an outpatient basis.

V. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section V.B of this Appendix, CMS shall make payment for SNF Services furnished by an Eligible SNF to such Beneficiary without a prior 3-Day inpatient hospitalization under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as if the Beneficiary were still a REACH Beneficiary aligned to the ACO, provided that admission to the Eligible SNF occurs within 90 Days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

B. Notwithstanding the requirements of Section V.A of this Appendix, CMS will not make payment for SNF Services furnished to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;
2. Medicare is no longer primary payer;
3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or
4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

VI. SNF Services Provided to Non-Eligible Beneficiaries

If an Eligible SNF provides SNF Services under this 3-Day SNF Rule Waiver Benefit Enhancement to a Beneficiary who does not meet the Beneficiary Eligibility Requirements in Section IV of this Appendix, the following rules shall apply:

A. CMS shall make no payment to the Eligible SNF for such services;

B. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services;

C. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Responsibility for Denied Claims

A. [Reserved]

B. If a claim for any SNF Services furnished to a Beneficiary by an Eligible SNF is denied for any reason other than a CMS error and CMS determines that that the Eligible SNF did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

1. CMS shall, notwithstanding such determination, pay for such SNF Services under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for SNF Services furnished to a Beneficiary by an Eligible SNF is denied and the Eligible SNF knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

1. CMS shall not make payment to the Eligible SNF for such services;

2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Participant Provider or Preferred Provider that is not an Eligible SNF submits a claim for SNF Services under this 3-Day SNF Rule Waiver Benefit Enhancement for which CMS only would have made payment if the Participant Provider or Preferred Provider was an Eligible SNF participating in the 3-Day SNF Rule Waiver Benefit Enhancement at the time of service:

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

2. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VIII. Compliance and Enforcement

A. CMS may revoke its approval of a Participant Provider or Preferred Provider to participate as an Eligible SNF under the 3-Day SNF Rule Waiver Benefit Enhancement at any time if the Participant Provider or Preferred Provider's continued participation in this 3-Day SNF Rule Waiver Benefit Enhancement might compromise the integrity of the Model.

B. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. CMS will monitor the ACO's use of the 3-Day SNF Rule Waiver Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

D. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend the waiver under Section II of this Appendix or take other remedial action, as appropriate, if the ACO or any of its Participant Provider or Preferred Providers fails to comply with the terms and conditions of the 3-Day SNF Rule Waiver Benefit Enhancement.

Appendix J: Telehealth Benefit Enhancement

Appendix K of the Agreement governs payment pursuant to section 1899(l) of the Act for telehealth services furnished on or after January 1, 2023, by a physician or other practitioner who is a Participant Provider. If the ACO has selected the Telehealth Benefit Enhancement in accordance with Section I of this Appendix, this Telehealth Benefit Enhancement further increases the availability to Beneficiaries of otherwise covered telehealth services furnished via interactive telecommunications systems while also providing flexibility for Beneficiaries to receive certain teledermatology and teleophthalmology services furnished using asynchronous store and forward technologies.

I. Election of the Telehealth Benefit Enhancement

If the ACO wishes to offer the Telehealth Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the Telehealth Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the Telehealth Benefit Enhancement; and

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the Telehealth Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Telehealth Benefit Enhancement.

II. Waiver

A. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to otherwise covered telehealth services furnished by an Eligible Telehealth Provider (as that term is defined in Section III.A of this Appendix) in accordance with the terms and conditions set forth in this Appendix:

1. 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.

2. 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.

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

B. Waiver of Interactive Telecommunications System Requirement: CMS waives the following requirements with respect to otherwise covered teledermatology and teleophthalmology services furnished by an Eligible Asynchronous Telehealth Provider (as that term is defined in Section III.B of this Appendix), using

asynchronous store and forward technologies, in accordance with the terms and conditions set forth in this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirement in Section 1834(m)(4)(C)(i) of the Act regarding the location of the originating site and the requirements of 42 CFR § 410.78(b)(4) with respect to covered teledermatology and teleophthalmology services furnished using asynchronous store and forward technologies in accordance with this Appendix.

2. Waiver of Interactive Telecommunications System Requirement: CMS waives the requirement under Section 1834(m)(1) of the Act and 42 CFR § 410.78(b) that telehealth services be furnished via an "interactive telecommunication system," as that term is defined under 42 CFR § 410.78(a)(3), when such services are furnished in accordance with this Appendix.

C. The waivers described in Sections II.A and II.B of this Appendix are collectively referred to as the "**Telehealth Benefit Enhancement**".

III. Eligible Telehealth Providers and Eligible Asynchronous Telehealth Providers

A. For purposes of this Telehealth Benefit Enhancement, an "**Eligible Telehealth Provider**" is a Preferred Provider who meets the requirements under Section 10.03.B of the Agreement.

B. For the purposes of this Telehealth Benefit Enhancement, an "**Eligible Asynchronous Telehealth Provider**" is a Participant Provider or Preferred Provider who meets the requirements under Section 10.03.D of the Agreement.

C. CMS review and approval of a Participant Provider or a Preferred Provider to provide services in accordance with the Telehealth Benefit Enhancement under Section II of this Appendix includes consideration of the program integrity history of the Participant Provider or Preferred Provider and any other factors that CMS determines may affect the qualifications of the Participant Provider or Preferred Provider to provide telehealth services under the terms of the Telehealth Benefit Enhancement.

IV. Eligibility Requirements

A. In order for telehealth services to be eligible for reimbursement under the terms of the waivers under Section II.A of this Appendix, the Beneficiary must be:

1. A REACH Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and

2. 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 Beneficiary's home or place of residence.

B. In order for telehealth services to be eligible for reimbursement under the terms of the waiver under Section II.B of this Appendix, the Beneficiary must be:

1. A REACH Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and

2. Located at an originating site that is one of the sites listed in Section 1834(m)(4)(C)(ii) of the Act.

C. Claims for telehealth services furnished under the terms of the waiver under Section II.A of this Appendix for which the originating site is a Beneficiary's home or place of residence will be denied unless submitted using one of the HCPCS codes G9481-G9489, G0438, or G0439.

D. Claims for asynchronous teledermatology and teleophthalmology services furnished under the terms of the waiver under Section II.B of this Appendix will be denied unless submitted using one of the HCPCS codes G9868-G9870.

E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider shall not submit a claim for such telehealth services.

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

G. An Eligible Telehealth Provider or an Eligible Asynchronous Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knows or should know in person services are medically necessary.

V. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section V.B of this Appendix, CMS shall make payment for telehealth services furnished to such Beneficiary under the terms of the Telehealth Benefit Enhancement as if the Beneficiary were still a REACH Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 Days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

B. Notwithstanding the requirements of Section V.A of this Appendix, CMS will not make payment for telehealth services furnished to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;

2. Medicare is no longer primary payer;

3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or

4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

VI. Responsibility for Denied Claims

A. [Reserved]

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

1. CMS shall, notwithstanding such denial, pay for such telehealth services under the terms of the Telehealth Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

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

1. CMS shall not make payment to the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider for such services;

2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Participant Provider or Preferred Provider that is not an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider submits claims for telehealth services for which CMS only would have made payment if the Participant Provider or Preferred Provider was an Eligible Telehealth Provider or

Eligible Asynchronous Telehealth Provider participating in this Telehealth Benefit Enhancement at the time of service:

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

2. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Compliance and Enforcement

A. CMS may reject the ACO's designation of a Participant Provider or Preferred Provider as an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider at any time if the Participant Provider or Preferred Provider's participation in this Telehealth Benefit Enhancement might compromise the integrity of the Model.

B. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. CMS will monitor the ACO's use of the Telehealth Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.

D. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend one or more of the waivers under Section II of this Appendix or take other remedial action if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Telehealth Benefit Enhancement.

Appendix K: Payment for Telehealth Services under Section 1899(l)

Section 50324 of the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123) (codified at Section 1899(l) of the Act) provides for Medicare payment for certain telehealth services furnished by a physician or other practitioner participating in an applicable ACO to Beneficiaries who are prospectively aligned to that ACO without regard for the geographic requirements under Section 1834(m)(4)(C)(i) of the Act, effective January 1, 2020. This Appendix sets forth the terms and conditions under which Participant Providers may receive payment for telehealth services furnished to REACH Beneficiaries pursuant to Section 1899(l) of the Act, which provides for a waiver of the originating site requirements to allow for Medicare payment for otherwise covered telehealth services furnished to Beneficiaries by Participant Providers during a grace period, and incorporates Beneficiary safeguards to ensure Beneficiaries are not charged for certain non-covered telehealth services furnished by a Participant Provider. REACH ACOs are applicable ACOs under the definition at Section 1899(l)(2)(A) of the Act.

I. General

Payment is available for otherwise covered telehealth services, without regard for the geographic requirements of Section 1834(m)(4)(C)(i) of the Act in accordance with the following requirements:

A. The telehealth service must be furnished by a physician or other practitioner who is a Participant Provider.

B. The Beneficiary must be:

1. A REACH Beneficiary at the time the telehealth services are furnished or within the grace period under Section II.A of this Appendix; and

2. 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 place of residence used as the home of the Beneficiary (the "Beneficiary's home").

C. Claims for telehealth services for which the originating site is the Beneficiary's home will be denied if such services are inappropriate to furnish in the home setting, such as services that are typically furnished in inpatient settings.

D. CMS does not pay a facility fee under Section 1834(m)(2)(B) when the originating site is the Beneficiary's home.

E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to furnish such telehealth services, the Participant Provider shall not submit a claim for such telehealth services.

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

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

II. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section II.B of this Appendix, CMS shall make payment for telehealth services furnished to such Beneficiary under Section 1899(l) as if the Beneficiary were still a REACH Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 Days following the date of the alignment exclusion and all requirements under Section I of this Appendix are met.

B. Notwithstanding the requirements of Section II.A of this Appendix, CMS will not make payment for telehealth services furnished to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;

2. Medicare is no longer primary payer;

3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or

4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

C. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to telehealth services furnished in accordance with Section I of this Appendix solely as necessary to allow for Medicare payment for such telehealth services furnished during the grace period under Section II.A of this Appendix:

1. 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).

2. 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."

3. 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 in the Beneficiary's home.

III. Responsibility for Denied Claims

A. In the event CMS makes no payment for a telehealth service furnished by a physician or practitioner who is a Participant Provider, and the only reason the claim was non-covered is that the Beneficiary is not a REACH Beneficiary or in the 90-Day grace period under Section II.A of this Appendix at the time the telehealth service was furnished, the following Beneficiary protections apply:

1. The ACO shall ensure that the Participant Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

2. The ACO shall ensure that the Participant Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

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

1. CMS shall not make payment to the Participant Provider for such services;

2. The ACO shall ensure that the Participant Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

Appendix L: Post-Discharge Home Visits Benefit Enhancement

This Post-Discharge Home Visits Benefit Enhancement increases the availability to Beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or SNF by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions.

I. Post-Discharge Home Visits Benefit Enhancement Election

If the ACO wishes to offer the Post-Discharge Home Visits Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the Post-Discharge Home Visits Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the Post-Discharge Home Visits Benefit Enhancement; and

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the Post-Discharge Home Visits Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Post-Discharge Home Visits Benefit Enhancement.

II. Waiver and Terms

CMS waives the requirement in 42 CFR § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) ("incident to" services) must be furnished under the direct supervision of the physician (or other practitioner)[7], provided that such services are furnished as follows and in accordance with all other terms and conditions set forth in this Appendix ("**Post-Discharge Home Visits Benefit Enhancement**"):

A. The services are furnished to a Beneficiary who either does not qualify for Medicare coverage of home health services under 42 CFR § 409.42 or who qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 § 60.4; and

B. The services are furnished in the Beneficiary's home after the Beneficiary has been discharged from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or SNF; and

C. The services are furnished by "auxiliary personnel," as defined in 42 CFR § 410.26(a)(1), under the general supervision, as defined in 42 CFR § 410.26(a)(3) of a Participant Provider or Preferred Provider identified on the Participant Provider List or Preferred Provider List in accordance with

[7] For additional guidance on "incident to" billing, the ACO may refer to the Medicare Benefit Policy Manual, Chapter 15 § 60, found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf, excepting the references therein to direct supervision.

Article IV of the Agreement as participating in the Post-Discharge Home Visits Benefit Enhancement under the terms of this Appendix who is a physician or other practitioner and meets the requirements under Section 10.04.B of the Agreement; and

D. The claims for such services are submitted by the supervising Participant Provider or Preferred Provider who satisfies the criteria outlined in Section 10.04.B of the Agreement; and

E. The services are furnished not more than nine times in the first ninety (90) Days following discharge. The nine services described in this Section II.E cannot be accumulated across multiple discharges: if the Beneficiary is readmitted within ninety (90) Days of the initial discharge, following the subsequent discharge the Beneficiary may receive only the nine services described in this Section II.E in connection with the most recent discharge; and

F. The provision of such services is documented in records maintained by the ACO in accordance with Section 16.02 of the Agreement; and

G. The claims for services furnished under the terms of the Post Discharge Home Visits Benefit Enhancement are submitted using one of the HCPCS codes G2001-G2009, or G2013-G2015; and

H. The services are furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 CFR § 410.26(b); and

I. The services are furnished to a Beneficiary who is not receiving services under the Care Management Home Visits Benefit Enhancement, as described in Appendix M of the Agreement or the Home Health Homebound Waiver Benefit Enhancement, as described in Appendix N of the Agreement; and

J. The Beneficiary is a REACH Beneficiary at the time the services are furnished or within the grace period under Section III of this Appendix.

CMS also waives the direct supervision requirement in 42 CFR § 410.26(b)(5) under such other circumstances as provided in this Appendix.

III. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section III.B of this Appendix, CMS shall make payment for the post-discharge home visits services furnished to such a Beneficiary under the terms of the Post-Discharge Home Visits Benefit Enhancement as if the Beneficiary were still aligned to the ACO, provided that the post-discharge home visits services were furnished within 90 Days following the date of the alignment exclusion and all requirements under Section II of this Appendix are met.

B. Notwithstanding the requirements of Section III.A of this Appendix, CMS will not make payment for the post-discharge home visits services furnished to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;

2. Medicare is no longer primary payer;

3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or

4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

IV. Responsibility for Denied Claims

A. [Reserved]

B. If a claim for any post-discharge home visits services submitted by a Participant Provider or Preferred Provider who has been identified as participating in the Post-Discharge Home Visits Benefit Enhancement pursuant to Article IV of the Agreement is denied for any reason other than a CMS error and the Participant Provider or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

1. CMS shall, notwithstanding such denial, pay for such post-discharge home visits services under the terms of the Post-Discharge Home Visits Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the post-discharge home visits services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the post-discharge home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for any post-discharge home visits services submitted by a Participant Provider or Preferred Provider who has been identified as participating in this Benefit Enhancement pursuant to Article IV of the Agreement is denied and the Participant Provider or Preferred Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

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

2. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the post-discharge home visits services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the post-discharge home visits services

returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Participant Provider or Preferred Provider who has not been identified as participating in this Benefit Enhancement pursuant to Article IV of the Agreement submits a claim for post-discharge home visits services for which CMS only would have made payment if the Participant Provider or Preferred Provider had been identified as participating in this Benefit Enhancement at the time of service:

1. CMS shall make no payment to the Participant Provider or Preferred Provider for such services;
2. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the post-discharge home visits services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the post-discharge home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

V. Compliance and Enforcement

A. The ACO shall ensure that each Participant Provider and each Preferred Provider who will be participating in the Post-Discharge Home Visits Benefit Enhancement will require their respective auxiliary personnel to comply with the terms of the Agreement and this Appendix.

B. CMS may remove a Participant Provider or Preferred Provider from the list of Participant Providers or Preferred Providers who may participate in this Post-Discharge Home Visits Benefit Enhancement at any time if the Participant Provider or Preferred Provider's participation in this Post-Discharge Home Visits Benefits Enhancement might compromise the integrity of the Model.

C. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

D. CMS will monitor the ACO's use of the Post-Discharge Home Visits Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

E. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend this Benefit Enhancement or take other remedial action if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Post-Discharge Home Visits Benefit Enhancement.

Appendix M: Care Management Home Visits Benefit Enhancement

This Care Management Home Visits Benefit Enhancement increases the availability of in-home care to Beneficiaries determined by the ACO to be at risk of hospitalization and for whom a Participant Provider or Preferred Provider has initiated a care treatment plan by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions.

I. Care Management Home Visits Benefit Enhancement Election

If the ACO wishes to offer the Care Management Home Visits Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the Care Management Home Visits Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the Care Management Home Visits Benefit Enhancement; and

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the Care Management Home Visits Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Care Management Home Visits Benefit Enhancement.

II. Waiver and Terms

CMS waives the requirement in 42 CFR § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) ("incident to" services) must be furnished under the direct supervision of the physician (or other practitioner),[8] provided that such services are furnished as follows and in accordance with all other terms and conditions set forth in this Appendix ("**Care Management Home Visits Benefit Enhancement**"):

A. The services are furnished to a Beneficiary who is determined to be at risk of hospitalization, for whom a Participant Provider or Preferred Provider has initiated a care treatment plan and either does not qualify for Medicare coverage of home health services under 42 CFR § 409.42 or qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 § 60.4; and

B. The services are furnished in the Beneficiary's home by "auxiliary personnel," as defined in 42 CFR § 410.26(a)(1), under the general supervision, as defined in 42 CFR § 410.32(b)(3)(i), of a Participant Provider or Preferred Provider identified on the Participant Provider List or Preferred Provider List submitted in accordance with Article IV of the Agreement as participating in the Care Management Home Visits Benefit Enhancement under the terms of this Appendix

[8] For additional guidance on "incident to" billing, the ACO may refer to the Medicare Benefit Policy Manual, Chapter 15 § 60, found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf, excepting the references therein to direct supervision.

who is a physician or other practitioner and meets the requirements under Section 10.05.B of the Agreement; and

C. The claims for such services are submitted by the supervising Participant Provider or Preferred Provider who satisfies the criteria outlined in Section 10.05.B of the Agreement; and

D. The services are furnished not more than 20 times within the Performance Year; and

E. No additional care management home visits services beyond those described in Section II.D of this Appendix are furnished to the Beneficiary until the completion of the Performance Year, after which time additional care management home visits services are furnished to the Beneficiary only in accordance with the terms and conditions of this Appendix; and

F. The provision of services under the Care Management Home Visits Benefit Enhancement is documented in records maintained by the ACO in accordance with Section 16.02 of the Agreement; and

G. The claims for services furnished under the terms of the Care Management Home Visits Benefit Enhancement are submitted using one of the HCPCS codes G0076-G0087; and

H. The services are furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 CFR § 410.26(b); and

I. The services are furnished to a Beneficiary who is not receiving services under the Post-Discharge Home Visits Benefit Enhancement, as described in Appendix L of the Agreement or the Home Health Homebound Waiver Benefit Enhancement, as described in Appendix N of the Agreement; and

J. The Beneficiary is a REACH Beneficiary at the time the services are furnished or within the grace period under Section III of this Appendix.

CMS also waives the direct supervision requirement in 42 CFR § 410.26(b)(5) under such other circumstances as provided in this Appendix.

III. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section III.B of this Appendix, CMS shall make payment for the care management home visits services furnished to such a Beneficiary under the terms of the Care Management Home Visits Benefit Enhancement as if the Beneficiary were still aligned to the ACO, provided that the care management home visits services were furnished within 90 Days following the date of the alignment exclusion and all requirements under Section II of this Appendix are met.

B. Notwithstanding the requirements of Section III.A of this Appendix, CMS will not make payment for the care management home visits services furnished to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;

2. Medicare is no longer primary payer;

3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or

4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

IV. Responsibility for Denied Claims

A. [Reserved]

B. If a claim for any care management home visits services submitted by a Participant Provider or Preferred Provider that has been identified as participating in the Care Management Home Visits Benefit Enhancement pursuant to Article IV of the Agreement is denied for any reason other than a CMS error and the Participant Provider or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

1. CMS shall, notwithstanding such denial, pay for such care management home visits services under the terms of the Care Management Home Visits Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Participant Provider or Preferred Provider that submitted the claim for the care management home visits services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider that submitted the claim for the care management home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for any care management home visits services submitted by a Participant Provider or Preferred Provider who has been identified as participating in this Benefit Enhancement pursuant to Article IV of the Agreement is denied and the Participant Provider or Preferred Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

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

2. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the care management home visits services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the care management home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Participant Provider or Preferred Provider who has not been identified as participating in this Benefit Enhancement pursuant to Article IV of the Agreement submits a claim for care management home visits services for which CMS only would have made payment if the Participant Provider or Preferred Provider had been identified as participating in this Benefit Enhancement at the time of service:

1. CMS shall make no payment to the Participant Provider or Preferred Provider for such services;

2. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the care management home visits services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider who submitted the claim for the care management home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

V. Compliance and Enforcement

A. The ACO shall ensure that each Participant Provider and each Preferred Provider who will be participating in the Care Management Home Visits Benefit Enhancement will require their respective auxiliary personnel to comply with the terms of the Agreement and this Appendix.

B. CMS may remove a Participant Provider or Preferred Provider from the list of Participant Providers or Preferred Providers who may participate in this Care Management Home Visits Benefit Enhancement at any time if the Participant Provider or Preferred Provider's participation in this Care Management Home Visits Benefit Enhancement might compromise the integrity of the Model.

C. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

D. CMS will monitor the ACO's use of the Care Management Home Visits Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

E. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend this Benefit Enhancement or take other remedial action if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Care Management Home Visits Benefit Enhancement.

Appendix N: Home Health Homebound Waiver Benefit Enhancement

I. Election of the Home Health Homebound Waiver Benefit Enhancement

If the ACO wishes to offer the Home Health Homebound Waiver Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the Home Health Homebound Waiver Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the Home Health Homebound Waiver Benefit Enhancement; and

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the Home Health Homebound Waiver Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Home Health Homebound Waiver Benefit Enhancement.

II. Waiver of the Homebound Requirement for the Reimbursement of Home Health Services

CMS waives the following requirements with respect to otherwise covered home health services furnished by an Eligible Home Health Provider (as that term is defined in Section III.A of this Appendix) in accordance with the terms and conditions set forth in this Appendix:

A. CMS waives the requirements of 42 CFR 409.42(a) that a beneficiary must be confined to the home or in an institution that is not a hospital, SNF, or nursing facility to qualify for Medicare coverage of home health services.

B. CMS waives the requirements of §1814(a)(2)(C) and §1835(a)(2)(a) that the certification (or recertification) for home health services include a certification (or recertification) that such services are or were required because the individual is or was confined to his home as defined at 42 CFR § 409.42(a).

III. Eligible Providers

A. For purposes of this Home Health Homebound Waiver Benefit Enhancement, an "**Eligible Home Health Provider**" is a Participant Provider or Preferred Provider who meets the requirements under Section 10.06.B of the Agreement.

B. CMS review and approval of a Participant Provider or a Preferred Provider to provide services in accordance with the Home Health Homebound Waiver Benefit Enhancement under Section II of this Appendix includes consideration of the program integrity history of the Participant Provider or Preferred Provider and any other factors that CMS determines may affect the qualifications of the Participant Provider or Preferred Provider to certify home health services under the terms of the Home Health Homebound Waiver Benefit Enhancement.

IV. Eligibility Requirements

A. In order for home health services to be eligible for reimbursement under the terms of the waiver under Section II of this Appendix, the Beneficiary must:

1. Be a REACH Beneficiary at the time of the home health certification or within the grace period under Section V of this Appendix;

2. Be a Beneficiary who is not currently receiving services under the Post Discharge Home Visits Benefit Enhancement, as described in Appendix L of the Agreement, or the Care Management Home Visits Benefit Enhancement, as described in Appendix M of the Agreement;

3. Otherwise qualify for home health services under 42 CFR § 409.42 except that the Beneficiary is not confined to the home under subsection (a); and

4. Meet the following criteria:

   a. Have two or more chronic conditions; and

   b. Have at least one of the following three criteria:

      i. Inpatient service utilization, defined as at least one unplanned inpatient admission or emergency department visit within the last 12 months.

      ii. Frailty, defined as a score that meets or exceeds the threshold established by CMS on a frailty scale specified by CMS.

      iii. Social isolation, defined as the absence or weakness of a social network (i.e., social interactions and relationships), and the absence or weakness of resources provided by other persons or institutions.

B. CMS will provide the ACO with a template form for purposes of documenting the criteria in Section IV.A.4 of this Appendix ("**Home Health Homebound Waiver Form**"). The ACO shall ensure that a completed and certified "Home Health Homebound Waiver Form" is maintained in the Beneficiary's medical records.

C. An Eligible Home Health Provider shall not furnish home health services in lieu of inpatient services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive home health services in lieu of inpatient services when the Eligible Home Health Provider knows or should know inpatient services are medically necessary.

V. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section V.B of this Appendix, CMS shall make payment for home health services furnished to such Beneficiary under the terms of the Home Health Homebound Waiver Benefit Enhancement as if the Beneficiary were still a REACH Beneficiary aligned to the ACO, provided that the home health services were furnished within 90 Days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

B. Notwithstanding the requirements of Section V.A of this Appendix, CMS will not make payment for payment for home health services furnished to a Beneficiary

who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;
2. Medicare is no longer primary payer;
3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or
4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

VI. Responsibility for Denied Claims

A. [Reserved]

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

1. CMS shall, notwithstanding such denial, pay for such home health services under the terms of the Home Health Homebound Waiver Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
2. The ACO shall ensure that the Eligible Home Health Provider that provided the home health services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Eligible Home Health Provider that provided the home health services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for any home health services furnished by an Eligible Home Health Provider that has been identified as participating in this Benefit Enhancement pursuant to Article IV of the Agreement is denied and the Eligible Home Health Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII of the Act:

1. CMS shall not make payment to the Eligible Home Health Provider for such services;
2. The ACO shall ensure that the Eligible Home Health Provider that provided the home health services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Eligible Home Health Provider that that provided the home health services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Participant Provider or Preferred Provider that is not an Eligible Home Health Provider submits claims for home health services for which CMS only would have made payment if the Participant Provider or Preferred Provider was an Eligible Home Health Provider participating in this Home Health Homebound Waiver Benefit Enhancement at the time of service:

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

2. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the home health services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the home health service returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Compliance and Enforcement

A. CMS may reject the ACO's designation of a Participant Provider or Preferred Provider as an Eligible Home Health Provider at any time if CMS determines that the Participant Provider or Preferred Provider's participation in this Home Health Homebound Waiver Benefit Enhancement might compromise the integrity of the Model.

B. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. CMS will monitor the ACO's use of the Home Health Homebound Waiver Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.

D. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend one or more of the waivers under Section II of this Appendix or take other remedial action if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Home Health Homebound Waiver Benefit Enhancement.

Appendix O: Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement

I. Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement

If the ACO wishes to offer the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement;

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement; and

C. Select Global as its Risk Sharing Option, as described in Section 8.01 of the Agreement.

II. Waiver

CMS waives the requirement in Section 1812 of the Act (and the implementing regulations at 42 CFR § 418.24(e)(2)) to forgo curative care as a condition of electing the hospice benefit and instead receive care with respect to their terminal illness ("**Concurrent Care**") furnished under the terms and conditions set forth in this Appendix ("**Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement**").

III. Eligible Providers

A. For purposes of this Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement, an "**Eligible Concurrent Care Provider**" is a Participant Provider or Preferred Provider that has (i) entered into a written agreement with the ACO or, in the case of an Individual Participant Provider (as defined in Section 3.04.G.17 of the Agreement) or Individual Preferred Provider (as defined in Section 3.04.G.18 of the Agreement) entered into a written arrangement that meets the requirements of Sections 3.04.G.17 or 3.04.G.18 of the Agreement, as applicable, to provide Concurrent Care services in accordance with the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement under Section II of this Appendix; (ii) been identified by the ACO as having agreed to participate in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement in accordance with Section I.B of this Appendix; and (iii) been approved by CMS to participate under the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement following a review of the qualifications of the provider or supplier to provide Concurrent Care for a Beneficiary that has elected the Medicare hospice benefit.

B. Eligibility of an Eligible Concurrent Care Provider to provide services under this Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement will be reassessed by CMS annually, prior to the start of each Performance Year.

C. The ACO shall maintain and provide to its Participant Providers and Preferred Providers an accurate and complete list of Eligible Concurrent Care Providers and shall furnish updated lists as necessary to reflect any changes in eligibility. The ACO shall also furnish these lists to a REACH Beneficiary, upon request.

D. The ACO shall provide a copy of this Appendix to each Eligible Concurrent Care Provider to which Beneficiaries are referred by Participant Providers and Preferred Providers.

IV. Beneficiary Eligibility Requirements

To be eligible to receive services covered under the terms of the waiver under Section II of this Appendix the Beneficiary must:

A. Be a REACH Beneficiary at the time of receiving Concurrent Care under this Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement or within the grace period under Section V of this Appendix; and

B. Meet the requirements of, and have elected, the Medicare hospice benefit.

V. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section V.B of this Appendix, CMS shall make payment for Concurrent Care furnished by an Eligible Concurrent Care Provider to such Beneficiary under the terms of the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement as if the Beneficiary were still a REACH Beneficiary aligned to the ACO, provided that the Concurrent Care occurs within 90 Days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

B. Notwithstanding the requirements of Section V.A of this Appendix, CMS will not make payment for Concurrent Care furnished by an Eligible Concurrent Care Provider to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following:

1. Transition to Medicare Advantage or other Medicare managed care plan;
2. Medicare is no longer primary payer;
3. Loss of Medicare coverage for Part A, if the furnished service has been reimbursed under Medicare Part A; or
4. Loss of Medicare coverage for Part B, if the furnished service has been reimbursed under Medicare Part B.

VI. Responsibility for Denied Claims

A. [Reserved]

B. If a claim for any Concurrent Care furnished to a Beneficiary by an Eligible Concurrent Care Provider is denied for any reason other than a CMS error and

CMS determines that that the Eligible Concurrent Care Provider did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. CMS shall, notwithstanding such determination, pay for such Concurrent Care under the terms of the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Eligible Concurrent Care Provider that provided the Concurrent Care Services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Eligible Concurrent Care Provider that provided the Concurrent Care Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for Concurrent Care furnished to a Beneficiary by an Eligible Concurrent Care Provider is denied and the Eligible Concurrent Care Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. CMS shall not make payment to the Eligible Concurrent Care Provider for such services;

2. The ACO shall ensure that the Eligible Concurrent Care Provider that provided the Concurrent Care does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Eligible Concurrent Care Provider that provided the Concurrent Care Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Participant Provider or Preferred Provider that is not an Eligible Concurrent Care Provider submits a claim for Concurrent Care under this Concurrent Care Benefit Enhancement for which CMS only would have made payment if the Participant Provider or Preferred Provider was an Eligible Concurrent Care Provider participating in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement at the time of service:

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

2. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the Concurrent Care does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Participant Provider or Preferred Provider that provided the Concurrent Care returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Compliance and Enforcement

A. CMS may revoke its approval of a Participant Provider or Preferred Provider to participate as an Eligible Concurrent Care Provider under the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement at any time if the Participant Provider or Preferred Provider's continued participation in this Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement might compromise the integrity of the Model.

B. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. CMS will monitor the ACO's use of the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

D. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend the waiver under Section II of this Appendix or take other remedial action, as appropriate, if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement.

Appendix P: Part B Cost-Sharing Support Beneficiary Engagement Incentive

This Beneficiary Engagement Incentive ("**Part B Cost-Sharing Support Beneficiary Engagement Incentive**") allows the ACO, subject to certain conditions and safeguards, to enter into Cost-Sharing Support Arrangements with Participant Providers and Preferred Providers, pursuant to which the Participant Providers and Preferred Providers reduce or eliminate cost sharing for those categories of Part B services and REACH Beneficiaries identified by the ACO. The ACO shall implement the Part B Cost-Sharing Support Beneficiary Engagement Incentive in accordance with the terms of this Appendix and the applicable terms of the Agreement.

I. Definitions

"**Cost-Sharing Support**" means the reduction or elimination of a Cost-Sharing Support Eligible Beneficiary's Medicare Part B cost-sharing obligation for an Eligible Service.

"**Cost-Sharing Support Eligible Beneficiary**" means a REACH Beneficiary who is in a category identified in the ACO's Implementation Plan as eligible for Cost-Sharing Support under the Part B Cost-Sharing Support Beneficiary Engagement Incentive at the time the services for which Cost-Sharing Support is made available are rendered. For Performance Year 2024 and all subsequent Performance Years, this shall exclude a REACH Beneficiary who has secondary insurance (e.g., Medigap) that covers the relevant Part B cost-sharing obligation.

"**Eligible Service**" means a Part B service in a category identified, in the ACO's Implementation Plan, as eligible for Cost-Sharing Support under the Part B Cost-Sharing Support Beneficiary Engagement Incentive.

II. Election and Implementation

A. If the ACO wishes to offer the Part B Cost-Sharing Support Beneficiary Engagement Incentive during a Performance Year, it must –

1. Timely submit to CMS its selection of the Part B Cost-Sharing Support Beneficiary Engagement Incentive as described in Section 8.01 of the Agreement;

2. Timely submit an Implementation Plan in accordance with Section 10.01.B of the Agreement that includes the information specified in Section II.B of this Appendix; and

3. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers who have entered into a Cost-Sharing Support Arrangement (as defined in Section III.A of this Appendix) to participate in the Part B Cost-Sharing Support Beneficiary Engagement Incentive and a true, accurate, and complete list of Preferred Providers who have entered into a Cost Sharing Support Arrangement to participate in the Cost Sharing Support Beneficiary Engagement Incentive.

B. The ACO's Implementation Plan must set forth the following information:

1. The categories of Eligible Services, which must not include durable medical equipment, prosthetics, orthotics, supplies, or prescription drugs.

2. The categories of Cost-Sharing Support Eligible Beneficiaries, which may include:

a. For each Performance Year prior to Performance Year 2024, without limitation, one or more of the following:

i. REACH Beneficiaries without Medicare supplemental insurance (i.e., Medigap) that covers the relevant Part B cost-sharing obligations,

ii. REACH Beneficiaries experiencing high health care costs, or

iii. REACH Beneficiaries who require certain primary care or specialty care Part B services, the receipt of which could improve the individual's overall health.

b. For Performance Year 2024 and each subsequent Performance Year, without limitation, one or both of the following:

i. REACH Beneficiaries experiencing high health care costs, or

ii. REACH Beneficiaries who require certain primary care or specialty care Part B services, the receipt of which could improve the individual's overall health.

3. The procedures that will be implemented to ensure that Participant Providers and Preferred Providers have access to the most current information regarding Beneficiary alignment to the ACO.

4. Such other information required by CMS.

C. CMS may reject the ACO's selection of the Part B Cost-Sharing Support Beneficiary Engagement Incentive for a Performance Year on the basis of the following:

1. The ACO's history of noncompliance with the terms of the Agreement (including prior noncompliance that has been corrected or otherwise resolved);

2. The contents of the Implementation Plan, including whether the Implementation Plan complies with the terms of this Appendix and contains adequate safeguards against abuse; and

3. Such other factors as CMS deems reasonable to protect the integrity of the Model.

D. If the ACO wishes to change its implementation of the Part B Cost-Sharing Support Beneficiary Engagement Incentive, such as the categories of Cost-Sharing Support Eligible Beneficiaries and Eligible Services for which Cost-Sharing Support will be provided, the ACO must submit a revised Implementation Plan to CMS in accordance with Section 10.01.B of the Agreement that includes the information specified in Section II.B of this Appendix. The revised Implementation Plan is subject to CMS review and may be rejected in accordance with Section II.C of this Appendix.

III. Cost-Sharing Support Arrangement

A. Except as specified in Section III.A.1 and Section III.A.2 of this Appendix, the ACO shall have an arrangement with each Participant Provider and Preferred Provider that has agreed to provide Cost-Sharing Support pursuant to this Part B Cost-Sharing Support Beneficiary Engagement Incentive (a "**Cost-Sharing Support Arrangement**").

1. The ACO need not have a Cost-Sharing Support Arrangement with an Individual Participant Provider (described in Section 3.04.G.17 of the Agreement) if all the following requirements are met:

    a. The ACO has a Cost-Sharing Support Arrangement with a Participant Provider Contracting Entity (described in Section 3.04.G.17(a) of the Agreement);

    b. The Cost-Sharing Support Arrangement between the ACO and the Participant Provider Contracting Entity satisfies the requirements of Section III.B of this Appendix, identifies the Individual Participant Provider, and documents the Individual Participant Provider's agreement to comply with the applicable terms of the arrangement between the ACO and the Participant Provider Contracting Entity;

    c. The Individual Participant Provider is employed by, or under contract with the Participant Provider Contracting Entity and has reassigned his or her Medicare billing rights to the Participant Provider Contracting Entity; and

    d. The Participant Provider Contracting Entity and the Individual Participant Provider enter into an arrangement that binds the Individual Participant Provider to the applicable terms of the Cost-Sharing Support Arrangement between the ACO and the Participant Provider Contracting Entity.

2. The ACO need not have a Cost-Sharing Support Arrangement with an Individual Preferred Provider (described in Section 3.04.G.18 of the Agreement) if all the following requirements are met:

    a. The ACO has a Cost-Sharing Support Arrangement with a Preferred Provider Contracting Entity (described in Section 3.04.G.18(a) of the Agreement);

    b. The Cost-Sharing Support Arrangement between the ACO and the Preferred Provider Contracting Entity satisfies the requirements of Section III.B of this Appendix, identifies the Individual Preferred Provider, and documents the Individual Preferred Provider's agreement to comply with the applicable terms of the arrangement between the ACO and the Preferred Provider Contracting Entity;

    c. The Individual Preferred Provider is employed by, or under contract with the Preferred Provider Contracting Entity and has reassigned his or her Medicare billing rights to the Preferred Provider Contracting Entity; and

d. The Preferred Provider Contracting Entity and the Individual Preferred Provider enter into an arrangement that binds the Individual Preferred Provider to the applicable terms of the Cost-Sharing Support Arrangement between the ACO and the Preferred Provider Contracting Entity.

B. The terms of the Cost-Sharing Support Arrangement must specify the following:

1. The categories of Cost-Sharing Support Eligible Beneficiaries and Eligible Services for which the Participant Provider or Preferred Provider may provide Cost-Sharing Support;

2. A requirement that the Participant Provider or Preferred Provider provide Cost-Sharing Support in accordance with the ACO's Implementation Plan; and

3. The amount and frequency with which the ACO will reimburse the Participant Provider or Preferred Provider for the cost sharing amounts not collected.

C. The ACO shall not condition the Participant Provider or Preferred Provider's participation in the ACO on their participation in the Part B Cost-Sharing Support Beneficiary Engagement Incentive.

D. Not all Participant Providers and Preferred Providers must agree to participate in the Part B Cost-Sharing Support Beneficiary Engagement Incentive for the ACO to participate in the Part B Cost-Sharing Support Beneficiary Engagement Incentive.

E. Not all Participant Providers and Preferred Providers billing under a single TIN must agree to participate in the Part B Cost-Sharing Support Beneficiary Engagement Incentive for other Participant Providers and Preferred Providers billing under the same TIN to participate in the Part B Cost-Sharing Support Beneficiary Engagement Incentive.

F. The ACO shall finance entirely out of its own funds all payments made to Participant Providers and Preferred Providers pursuant to a Cost-Sharing Support Arrangement.

IV. Cost-Sharing Support Requirements

A. The Cost-Sharing Support must be provided in accordance with the Agreement (including this Appendix), the ACO's Implementation Plan, and the applicable Cost-Sharing Support Arrangement.

B. The Cost-Sharing Support must advance one or more of the following clinical goals:

1. Adherence to a treatment regime;

2. Adherence to a drug regime;

3. Adherence to a follow-up care plan; or

4. Management of a chronic disease or condition.

V. Record Retention, Compliance, and Enforcement

A. In accordance with Section 16.02 of the Agreement, the ACO must maintain copies of the written Cost-Sharing Support Arrangements with Participant Providers and Preferred Providers, as well as records that document the following:

   1. The identity of the Beneficiary for whom Cost-Sharing Support has been provided;

   2. The nature and date of the Part B service for which Cost-Sharing Support was provided;

   3. The dollar amount of the Cost-Sharing Support; and

   4. The Participant Provider or Preferred Provider who furnished the service for which Cost-Sharing Support was provided.

B. At any time, CMS may suspend or prohibit the ACO, a Participant Provider, or a Preferred Provider from participating in this Part B Cost-Sharing Support Beneficiary Engagement Incentive if CMS determines that the ACO's, Participant Provider's, or Preferred Provider's participation in this Part B Cost-Sharing Support Beneficiary Engagement Incentive might compromise the integrity of the Model.

C. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend this Part B Cost-Sharing Support Beneficiary Engagement Incentive or take other remedial action if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Part B Cost-Sharing Support Beneficiary Engagement Incentive.

D. If CMS identifies noncompliance with the terms of the Agreement, including this Appendix, CMS may suspend or prohibit the ACO's future participation in this Part B Cost-Sharing Support Beneficiary Engagement Incentive, regardless of whether the ACO has corrected or otherwise resolved the noncompliance.

E. The ACO shall submit reports to CMS, in a form and manner specified by CMS, regarding its use of the Part B Cost-Sharing Support Beneficiary Engagement Incentive. The ACO shall provide CMS with supplemental information upon request regarding its use of this incentive.

Appendix Q: Chronic Disease Management Reward Beneficiary Engagement Incentive

This Beneficiary Engagement Incentive ("**Chronic Disease Management Reward Beneficiary Engagement Incentive**") allows the ACO, subject to certain conditions and safeguards, to provide a gift card reward to certain REACH Beneficiaries for the purpose of incentivizing participation in a qualifying Chronic Disease Management Program. The ACO shall implement the Chronic Disease Management Reward Beneficiary Engagement Incentive in accordance with the terms of this Appendix and the applicable terms of the Agreement.

I. Election and Implementation

A. If the ACO wishes to offer the Chronic Disease Management Reward Beneficiary Engagement Incentive during a Performance Year, it must –

1. Timely submit to CMS its selection of the Chronic Disease Management Reward Beneficiary Engagement Incentive as described in Section 8.01 of the Agreement; and

2. Timely submit an Implementation Plan in accordance with Section 10.01.B of the Agreement that includes the information specified in Section I.B of this Appendix.

B. The Implementation Plan must set forth the following information:

1. The nature and scope of each qualifying Chronic Disease Management Program (as defined in Section III of this Appendix), including the chronic conditions targeted by each such program. Such chronic conditions may include, but need not be limited to, diabetes, mood disorders, coronary artery disease, hypertension, and congestive heart failure.

2. The nature, amount, and frequency of the gift card reward that may be obtained by a Reward Eligible Beneficiary (as defined in Section II of this Appendix) for participation in a qualifying Chronic Disease Management Program.

3. The criteria that a Reward Eligible Beneficiary must satisfy to obtain a gift card reward for participation in a qualifying Chronic Disease Management Program, including activities or other conduct that the Reward Eligible Beneficiary must engage in (e.g., activities completed, such as the number of smoking cessation counseling sessions attended).

4. The procedures that will be implemented to ensure that Participant Providers and Preferred Providers have access to the most current information regarding Beneficiary alignment to the ACO.

5. Such other information required by CMS.

C. CMS may reject the ACO's selection of the Chronic Disease Management Reward Beneficiary Engagement Incentive for a Performance Year on the basis of the following:

1. The ACO's history of noncompliance with the terms of the Agreement (including prior noncompliance that has been corrected or otherwise resolved);

2. The contents of the Implementation Plan, including whether the Implementation Plan complies with the terms of this Appendix and contains adequate safeguards against abuse; and

3. Such other factors as CMS deems reasonable to protect the integrity of the Model, including the medical appropriateness of the qualifying Chronic Disease Management Program.

D. If the ACO wishes to change the terms of its implementation of the Chronic Disease Management Reward Beneficiary Engagement Incentive, such as the chronic diseases targeted, the ACO must submit a revised Implementation Plan to CMS in accordance with Section 10.01.B of the Agreement that includes the information specified in Section I.B of this Appendix. The revised Implementation Plan is subject to CMS review and may be rejected in accordance with Section I.C of this Appendix.

II. Beneficiary Eligibility Requirements

For purposes of this Appendix, a "**Reward Eligible Beneficiary**" is a REACH Beneficiary who has a chronic disease, as identified by a clinical diagnosis that is targeted by a qualifying Chronic Disease Management Program identified in the ACO's Implementation Plan.

III. Qualifying Chronic Disease Management Program

For purposes of this Appendix, a "**Chronic Disease Management Program**" is a program described in the ACO's Implementation Plan that focuses on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources for individuals with the chronic diseases targeted by the program.

A. For instance, a Chronic Disease Management Program may include utilizing particular services or preventive screening benefits, adhering to prescribed treatment regimens, attending education or self-care management lessons, and meeting nutritional goals.

B. Completing a survey without other activities does not constitute a Chronic Disease Management Program.

IV. Chronic Disease Management Reward

A. Pursuant to this Appendix, the ACO may offer a Reward Eligible Beneficiary the opportunity to receive a gift card as a reward for participating in a Chronic Disease Management Program.

B. A gift card may be provided to a Beneficiary under this Chronic Disease Management Reward Beneficiary Engagement Incentive only if:

1. The Beneficiary was a Reward Eligible Beneficiary at the time he or she was enrolled in, or otherwise began participating in, the Chronic Disease Management Program;

2. The Beneficiary satisfied all criteria for obtaining a gift card reward, as set forth in the ACO's Implementation Plan;

3. The gift card is provided to the Beneficiary directly by the ACO;

4. The cost of the gift card is funded entirely by the ACO;

5. The gift card is programmed to prevent the purchase of, or is otherwise unable to be used to purchase, tobacco, alcohol, and firearm products; and

6. The aggregate value of any and all gift cards provided by the ACO to the Beneficiary during a Performance Year does not exceed $75.

V. Record Retention, Compliance and Enforcement

A. In accordance with Section 16.02 of the Agreement, the ACO shall maintain the following records regarding the Chronic Disease Management Reward Beneficiary Engagement Incentive:

1. The identity of each Beneficiary who received a gift card reward;

2. The Chronic Disease Management Program(s) in which the Beneficiary's participation is being rewarded;

3. The nature and date(s) of the activities or other conduct engaged in by the Beneficiary to qualify for the gift card reward; and

4. The nature and amount of each gift card received by the Beneficiary.

B. At any time, CMS may suspend or prohibit the ACO from participating in this Chronic Disease Management Reward Beneficiary Engagement Incentive if CMS determines that the ACO's participation in this Chronic Disease Management Reward Beneficiary Engagement Incentive might compromise the integrity of the Model.

C. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend this Beneficiary Engagement Incentive or take other remedial action if the ACO fails to comply with the terms and conditions of the Chronic Disease Management Reward Beneficiary Engagement Incentive.

D. If CMS identifies noncompliance with the terms of the Agreement, including this Appendix, CMS may suspend or prohibit the ACO's future participation in this Beneficiary Engagement Incentive, regardless of whether the ACO has corrected or otherwise resolved the noncompliance.

E. The ACO shall submit reports to CMS, in a form and manner and by a date specified by CMS, regarding its use of the Chronic Disease Management Reward Beneficiary Engagement Incentive. The ACO shall provide CMS with supplemental information upon request regarding its use of the Chronic Disease Management Reward Beneficiary Engagement Incentive.

Appendix R: Non-Duplication Waiver and Participant Overlap

I. Waiver

CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and in the implementing regulations at 42 CFR § 425.114(a) and (b) as they apply to Preferred Providers, subject to the requirements set forth in this Appendix. This waiver is necessary to support the ACO's ability to enter into agreements with Medicare-enrolled providers and suppliers to participate as Preferred Providers, and thus enable the ACO to better care for its REACH Beneficiaries in an environment where increasing numbers of providers and suppliers are participating in ACOs under the Medicare Shared Savings Program and in other Medicare shared savings initiatives.

II. ACO Overlap

A. The ACO may not simultaneously participate in any other Medicare shared savings initiatives, except as otherwise specified by CMS.

B. If the ACO is otherwise eligible, the ACO may participate in other Medicare demonstrations, programs, or models. CMS may issue guidance or work directly with the ACO in determining how participation in certain demonstrations or models can be combined with participation in the Model.

C. The ACO may participate simultaneously in the Guiding an Improved Dementia Experience (GUIDE) Model.

III. Participant Provider and Preferred Provider Overlap

A. Pursuant to section 1899(b)(4)(A) of the Act, a Participant Provider may not be an ACO participant, ACO provider/supplier, or ACO professional in an ACO in the Medicare Shared Savings Program.

B. A Participant Provider may not: (a) be identified as a Participant Provider by another REACH ACO (except as otherwise specified by CMS); (b) participate in another Medicare shared savings initiative, except as expressly permitted by CMS; or (c) participate in the Maryland Total Cost of Care Model, the Primary Care First Model, or the Independence at Home Demonstration.

C. A Preferred Provider may not participate in the Maryland Total Cost of Care Model.

D. A Preferred Provider may serve in the following roles provided all other applicable requirements are met:

1. Preferred Provider for one or more other REACH ACOs participating in this Model;
2. Subject to Section III.B of this Appendix, Participant Provider in one or more other REACH ACOs participating in this Model;
3. Pursuant to the waiver in Section I of this Appendix, an ACO participant, ACO provider/supplier, or ACO professional in an ACO in the Medicare Shared Savings Program; and
4. A role similar in function to a Participant Provider or Preferred Provider in another shared savings initiative.

E. A Participant Provider and a Preferred Provider may participate in the GUIDE Model.

1. A Participant Provider and a Preferred Provider who participates in the GUIDE Model should refer to the GUIDE Participation Agreement for billing guidance resulting from overlapping participation.

2. A Participant Provider and a Preferred Provider who participates in the GUIDE Model may not bill CMS for any of the GUIDE Overlap Services for a REACH Beneficiary that is also a GUIDE Beneficiary (as that term is defined in the GUIDE Model Participation Agreement).

Appendix S: ACO Proprietary and Confidential Information

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

1)

2)

3)

In accordance with Section 13.04 of the Agreement, this information shall remain the sole property of the ACO and, except as required by federal law, shall not be released by CMS without the express written consent of the ACO.

Appendix T: Nurse Practitioner and Physician Assistant Services Benefit Enhancement

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

If the ACO wishes to offer the Nurse Practitioner and Physician Assistant Services Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its selection of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the Nurse Practitioner and Physician Assistant Services Benefit Enhancement; and

B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.

II. Waiver

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

A. The requirement in section 1814(a)(7)(A)(i)(I) of the Act that an attending physician must certify that a Beneficiary is terminally ill for hospice care;

B. The requirement in section 1861(s)(12)(A) of the Act and the implementing regulations at 42 CFR § 410.12 that a physician must certify a Beneficiary's need for extra-depth shoes with inserts or custom molded shoes with inserts under a comprehensive plan of care related to the Beneficiary's diabetic condition (diabetic shoes);

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

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

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

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

III. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, except as provided in Section III.B of this Appendix, CMS shall make payment for the services furnished to such a Beneficiary under the terms of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as if the Beneficiary were still aligned to the ACO, provided that the services were furnished within 90 Days following the date of the alignment exclusion and all requirements under Section II of this Appendix are met.

B. Notwithstanding the requirements of Section III.A of this Appendix, CMS will not make payment for the services furnished to a Beneficiary who is excluded from alignment to the ACO during the Performance Year for any of the following reasons:

1. Transition to Medicare Advantage or other Medicare managed care plan;
2. Medicare is no longer primary payer;
3. Loss of Medicare coverage for Part A, if the furnished service would have been reimbursed by Medicare Part A; or
4. Loss of Medicare coverage for Part B, if the furnished service would have been reimbursed by Medicare Part B.

IV. Responsibility for Denied Claims

A. [Reserved]

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

1. CMS shall, notwithstanding such determination, pay for such claims under the terms of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
2. If the Billing Provider that provided the items or services is a Participant Provider or Preferred Provider, the ACO shall ensure that the Billing Provider does not charge the Beneficiary for the expenses incurred for such items or services;
3. If the Billing Provider that provided the items or services is a Participant Provider or Preferred Provider, the ACO shall ensure that the Billing

Provider returns to the Beneficiary any monies collected from the Beneficiary related to such items or services; and

4. If the Billing Provider that provided the items or services is not a Participant Provider or Preferred Provider, the ACO shall ensure that the Beneficiary is made whole for the expenses incurred for such items or services (**"Beneficiary Refund"**).

C. If a claim based on a certification, plan of care, or referral made pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and submitted by a Billing Provider is denied and the Billing Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

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

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

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

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

V. Compliance and Enforcement

A. CMS may revoke its approval of a Participant Provider or Preferred Provider to participate as either an Eligible Nurse Practitioner or an Eligible Physician Assistant under the Nurse Practitioner and Physician Assistant Services Benefit Enhancement at any time if the Participant Provider or Preferred Provider's continued participation in this Nurse Practitioner and Physician Assistant Services Benefit Enhancement might compromise the integrity of the Model.

B. The ACO must have appropriate procedures in place to ensure that Participant Providers and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. CMS will monitor the ACO's use of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement to ensure that services furnished pursuant to a certification, referral, or plan of care established by an Eligible Nurse Practitioner or an Eligible Physician Assistant under this Benefit

Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

D. In accordance with Section 17.01 of the Agreement, CMS may terminate or suspend the waiver under Section II of this Appendix or take other remedial action, as appropriate, if the ACO or any of its Participant Providers or Preferred Providers fails to comply with the terms and conditions of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.