Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Seamless Care Models Group
7205 Windsor Blvd
Baltimore, MD 21244

ACO Realizing Equity, Access, and Community Health Model
Implementation Period Participation Agreement

Last Modified: June 30, 2022

Contents

PARTICIPATION AGREEMENT

This Participation Agreement ("**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.

A REACH 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 Global and Professional Direct Contracting (GPDC) 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. On February 24, 2022, the Center for Medicare and Medicaid Innovation announced that it is redesigning the Model and renaming it the ACO Realizing Equity, Access, and Community Health (REACH) Model. The first Performance Year of the redesigned Model will begin 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 will select 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.

This Agreement outlines the rights and obligations of the parties during the Implementation Period, during which the ACO may engage in Marketing Activities, including Voluntary Alignment Activities; care coordination; quality improvement; and other activities as needed to prepare for participation in the Model Performance Period. The ACO's participation in the Model Performance Period will be governed by a separate agreement between CMS and the ACO.

The parties therefore agree as follows:

ARTICLE I Agreement Term

Section 1.01 This Agreement will become effective upon execution by both parties (the "**Effective Date**").

Section 1.02 The Implementation Period will begin on August 1, 2022 (the "**Start Date**"), and end on December 31, 2022.

Section 1.03 This Agreement will automatically expire upon the conclusion of the Implementation Period. The ACO must sign a new agreement with CMS for the Model Performance Period in order to participate in the Model Performance Period. If CMS and the ACO execute such an agreement, the ACO's first Performance Year will be the third Performance Year of the Model Performance Period. Any such agreement will authorize CMS to take remedial action against the ACO for non-compliance with the terms of this Agreement, regardless of when the non-compliance is discovered by CMS.

ARTICLE II Definitions

The parties agree that the following definitions apply for purposes of the Implementation 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 this 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; 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; 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:

   a. Physician assistant who satisfies the qualifications set forth at 42 CFR § 410.74(a)(2)(i)-(ii);

   b. Nurse practitioner who satisfies the qualifications set forth at 42 CFR § 410.75(b);

   c. Clinical nurse specialist who satisfies the qualifications set forth at 42 CFR § 410.76(b);

   d. Certified registered nurse anesthetist (as defined at 42 CFR § 410.69(b));

   e. Certified nurse midwife who satisfies the qualifications set forth at 42 CFR § 410.77(a);

   f. Clinical psychologist (as defined at 42 CFR § 410.71(d));

   g. Clinical social worker (as defined at 42 CFR § 410.73(a)); or

h. Registered dietician or nutritional professional (as defined at 42 CFR § 410.314).

"**Alignment Methodology**" means the methodology selected by the ACO pursuant to Section 8.02 that determines the frequency with which REACH Beneficiaries are aligned to the ACO for the ACO's first Performance Year. 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 the ACO's first Performance Year pursuant to Section 8.02 if the ACO also selects PCC Payment for that Performance Year. If the ACO selects the APO for its first Performance Year, 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 during the ACO's first Performance Year. The amount of the monthly APO payment will be calculated in accordance with the agreement described in Section 1.03 of this 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. The ACO may select one or more Beneficiary Engagement Incentives for the ACO's first Performance Year pursuant to Section 8.02.

"**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 Services Benefit Enhancement. The ACO may select one or more Benefit Enhancements for the ACO's first Performance Year pursuant to Section 8.02.

"**Capitation Payment Mechanism**" means a payment mechanism that may be selected by the ACO for the ACO's first Performance Year pursuant to Section 8.02, under which CMS will make periodic payments to the ACO during that 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 used to align Beneficiaries to the ACO as described in Section 5.01.

"**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 will be calculated using the maximum Enhanced PCC Percentage selected by the ACO for the ACO's first Performance Year pursuant to Section 8.02.

"**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 described in Section 1.03 of this Agreement.

"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.

"**Implementation Period**" means the period of time described in Section 1.02 during which the ACO may engage in Marketing Activities, including Voluntary Alignment Activities; care coordination; quality improvement; and other activities as needed to prepare for participation in the Model Performance Period.

"**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.

"**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 Medicare.gov Voluntary Alignment in performing Beneficiary alignment as described in Section 5.01.

"**Model Performance Period**" means the period that began on April 1, 2021, and ends on December 31 of the final Performance Year.

"**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 Effective Date.

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

"**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 the Implementation Period or for a Performance Year.

"**PCC Eligible Services**" means (1) for services billed on professional claim formats, Primary Care Services billed by Primary Care Specialists, 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.

"PCC Payment" stands for "**Primary Care Capitation Payment**" and means a Capitation Payment Mechanism available for selection by the ACO for the ACO's first Performance Year pursuant to Section 8.02. If the ACO selects PCC Payment, the ACO may also select its maximum Enhanced PCC Percentage pursuant to Section 8.02 and may select to participate in the APO pursuant to Section 8.02. 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 during the ACO's first Performance Year.

"**PY**" stands for **"Performance Year" and** means the 12-month period beginning on January 1 of each year during the Model Performance Period, except in the case of the first Performance Year of the Model Performance Period, which began on April 1, 2021 and ended on December 31, 2021. If CMS and the ACO execute the agreement described in Section 1.03 allowing the ACO to participate in the Model Performance Period, the ACO's first Performance Year will begin on January 1, 2023.

"**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.

"**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 the Implementation Period or a Performance Year.

"Primary Care Qualified Evaluation & Management (PQEM) Services" means a Primary Care Service furnished by a Primary Care Specialist or a Selected Non-Primary Care Specialist.

"**Primary Care Services**" means all health care services and laboratory services customarily furnished by or through a Primary Care Specialist. CMS will provide the ACO with a list of codes that will be considered Primary Care Services for purposes of the ACO's first Performance Year prior to January 1, 2023.

"**Primary Care Specialist**" means a physician or a non-physician practitioner (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 National Plan & Provider Enumeration System (NPPES) or the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). CMS will provide the ACO with a list of codes that will be considered Primary Care Services for purposes of the ACO's first Performance Year prior to January 1, 2023.

"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; affilitations 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 Beneficiary alignment is performed only prospectively prior to the start of a Performance Year based on both Claims-Based Alignment and Voluntary Alignment.

"**Prospective Plus Alignment**" refers to the Alignment Methodology in which Beneficiary alignment is performed prospectively prior to the start of a Performance Year, based on both Claims-Based Alignment and Voluntary Alignment, and performed 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.

"**REACH Beneficiary**" means a Beneficiary who is aligned to the ACO for a Performance Year as described in Section 5.01 and who has not subsequently been excluded from the aligned population of the ACO.

"**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.

"**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 the NPPES or PECOS. CMS will provide the ACO with a list of specialty codes that will be used to identify Selected Non-Primary Care Specialists for purposes of the ACO's first Performance Year prior to January 1, 2023.

"**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 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 the Risk Sharing Option and Capitation Payment Mechanism selected by the ACO.

"**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 will use the Beneficiary's Voluntary Alignment Form in performing Beneficiary alignment for the ACO's first Performance Year as described in Section 5.01 and Appendix C.

"Start-up Arrangement" means an arrangement between the ACO and one or more Participant Providers or Preferred Providers or both, for items, services, facilities, or goods (including non-medical items, services, facilities, or goods) that are used to create, develop, or operate the ACO.

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

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

"**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.

"TCC Payment" stands for "**Total Care Capitation Payment**" and means a Capitation Payment Mechanism available for selection by the ACO for the ACO's first Performance Year pursuant to Section 8.02 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 the Performance Year and those Preferred Providers that have opted to participate in TCC Payment.

"**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 identified by a TIN formed under applicable state, federal, or tribal law, and authorized to undertake the activities required under this Agreement in each state in which it operates.

B. If the ACO was formed by two or more Participant Providers, the ACO shall be a legal entity separate from the legal entity of any of its Participant Providers or Preferred Providers.

C. If the ACO was formed by a single Participant Provider, 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 11.01.

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

B. Composition and Control of the Governing Body

1. The ACO governing body shall include at least one Beneficiary served by the ACO 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 their 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 described in Section 3.02.B.1 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 their 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 or Consumer Advocate representation on the ACO governing body is prohibited by state law, 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 shall be held by individual Participant Providers or 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. The Beneficiary representative and Consumer Advocate required under this Section 3.02 shall 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, Management, and Ownership

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.G.

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.G.

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

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

2. Has an indirect ownership interest equal to 5 percent or more in the subject entity;

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

4. 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 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 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, and shall impose this requirement on its Participant Providers and Preferred Providers.

F. The ACO shall notify CMS within 15 Days after becoming aware that any Participant Provider or 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 a Participant Provider or 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 13.01.

G. By the date specified in Section 3.04.H, below, except as specified in Sections 3.04.G.11 and 3.04.G.12, 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 (10):

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 Implementation Period, to engage in ACO Activities, to comply with the applicable terms of the Model as set forth in this Agreement, and to comply with all applicable laws and regulations (including, but not limited to, those specified in Section 11.04). The ACO shall provide each Participant Provider and

Preferred Provider with a copy of this 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 this Agreement, including any provisions regarding the following: participant exclusivity; quality measure reporting; 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. 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).

7. 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 this Agreement or program integrity issues identified by CMS.

8. The arrangement is for a term that ends no earlier than December 31, 2022, but permits early termination if CMS requires the ACO to remove the Participant Provider or Preferred Provider pursuant to Section 13.01.A.

9. 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.

10. 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.

11. The ACO need not have an arrangement that complies with the requirements of Section 3.04.G.1 through Section 3.04.G.10 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 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 Section 3.04.G.10, 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 their 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.

12. The ACO need not have an arrangement that complies with the requirements of Section 3.04.G.1 through Section 3.04.G.10 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 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 Section 3.04.G.10, 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 their 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 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 approved by CMS to be Participant Providers and Preferred Providers during the Implementation Period.

2. By the start of the ACO's first Performance Year, 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 first Performance Year, if the ACO wishes to participate in the Model Performance Period.

I. The ACO shall maintain, in accordance with Section 12.02, records of all payments made or received pursuant to the arrangements described in Section 3.04.G.

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 13.01, or has been removed from the Participant Provider List or Preferred Provider List pursuant to Section 4.04.B, as applicable, does not engage in any Marketing Activities, including Voluntary Alignment Activities, after the effective date of such termination.

Section 3.05 ACO Start-up Arrangements

A. Start-up Arrangement Requirements. A Start-up Arrangement must comply with the following requirements:

1. All parties enter into, and undertake, the Start-up Arrangement with the good faith intent to participate in PY2023, pursuant to the agreement described in Section 1.03.

2. In establishing the terms of the Start-up Arrangement, no party gives or receives remuneration in return for, or to induce the referral of, items or services furnished to Federal health care program beneficiaries who are not aligned to the ACO.

3. For Start-up Arrangements involving the exchange of information technology used predominantly to create, maintain, transmit, or receive electronic health records, such information technology is interoperable (as defined in 42 CFR § 411.351) or satisfy 42 CFR § 411.357(w)(2) (related to interoperability).

4. The ACO's governing body has made a *bona fide* determination, consistent with each governing body member's fiduciary duty to the ACO, that the arrangement is reasonably related to the performance of ACO Activities and has authorized the arrangement.

5. The Start-up Arrangement and its authorization by the governing body are documented. The documentation must be contemporaneous with the establishment of the arrangement and the documentation of the authorization must be contemporaneous with the authorization. All such documentation must be retained by the ACO, ACO Participant Provider, and Preferred Provider, as applicable, for at least 10 years following completion of the arrangement and promptly made available to the Secretary upon request. The documentation must identify at least the following:

    i. A description of the Start-up Arrangement, including all parties to the arrangement; the effective date of the arrangement; the purpose(s) of the arrangement; the items, services, facilities, and goods covered by the arrangement (including nonmedical items, services, facilities, or goods); evidence of the public disclosure of the arrangement; and the financial or economic terms of the arrangement.

    ii. The date and manner of the governing body's authorization of the Start-up Arrangement. The documentation of the authorization must include the basis for the *bona fide* determination by the ACO's governing body that the arrangement is reasonably related to the performance of ACO Activities during the Implementation Period.

6. A description of the Start-up Arrangement is publicly disclosed and maintained on a public-facing website belonging to the ACO no later than 60 Days after the

effective date of the Start-up Arrangement, through the earlier of the effective date of expiration or termination of this Agreement.

B. CMS provides no opinion on the legality of any Start-up 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.

C. Availability of Safe Harbor Protection for Start-up Arrangements. 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 Start-up Arrangements reasonably related to the performance of ACO Activities, provided that such arrangements comply with:

1. Section 3.05.A(1)-(6); and

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

Article IV Participant Providers and Preferred Providers

Section 4.01 General

A. 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 that complies with the requirements of Section 3.04;

6. Is identified on the Participant Provider List in accordance with this Article IV.

B. 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 that complies with 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 12.02.

F. CMS may periodically monitor the program integrity history of the ACO's Participant Providers or 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 13.01, 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 for the Implementation Period

A. The parties acknowledge that the ACO submitted to CMS a proposed list of Participant Providers for the Implementation Period, identified by name, NPI, TIN, CCN (if applicable), or Legacy TIN or CCN (if applicable). Such proposed list was submitted in a form and manner and by a date specified by CMS.

B. CMS states that it has conducted a Program Integrity Screening on each individual or entity identified on the proposed list of Participant Providers, produced a revised proposed list of Participant Providers for the Implementation Period, and identified individuals and entities on the proposed list that did not qualify for Model participation or that required further action before they could be approved for Model participation.

C. By a date specified by CMS, the ACO shall review and make any necessary corrections to the revised proposed list of Participant Providers, including removing any individuals or entities that have not agreed to participate in the Model as of the Start Date pursuant to a written arrangement meeting the requirements of Section 3.04.G. The ACO shall not add any individuals or

entities to its proposed list of Participant Providers for the Implementation Period at this time.

D. The ACO shall submit to CMS, by a date specified by CMS, a final Participant Provider List for the Implementation Period that the ACO has certified is a true, accurate, and complete list identifying all of the individuals and entities that have agreed to participate in the Implementation Period as of the Start Date pursuant to a fully executed written arrangement meeting the requirements of Section 3.04.G.

E. CMS shall submit to the ACO a final Participant Provider List for the Implementation Period of all individuals and entities that it has approved to be Participant Providers for the Implementation Period.

F. The ACO shall update the Participant Provider List for the Implementation Period in accordance with Section 4.04.

Section 4.03 Preferred Provider List for the Implementation Period

A. The parties acknowledge that the ACO submitted to CMS a proposed list of Preferred Providers for the Implementation Period, identified by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable). Such proposed list was submitted in a form and manner and by a date specified by CMS.

B. CMS states that it has conducted a Program Integrity Screening on each individual or entity identified on the proposed list of Preferred Providers, produced a revised proposed list of Preferred Providers for the Implementation Period, and identified individuals and entities on the proposed list that did not qualify for Model participation or that required further action before they could be approved for Model participation.

C. By a date specified by CMS, the ACO shall review and make any necessary corrections to the revised proposed list of Preferred Providers, including the removal of any individuals or entities that have not agreed to participate in the Model as of the Start Date pursuant to a written arrangement meeting the requirements of Section 3.04.G. The ACO shall not add any individuals or entities to its proposed list of Preferred Providers for the Implementation Period at this time.

D. The ACO shall submit to CMS, by a date specified by CMS, a final Preferred Provider List for the Implementation Period that the ACO has certified is a true, accurate, and complete list identifying all of the individuals and entities that have agreed to participate in the Implementation Period as of the Start Date pursuant to a fully executed written arrangement meeting the requirements of Section 3.04.G.

E. CMS shall submit to the ACO a final Participant Provider List for the Implementation Period of all individuals and entities that it has approved to be Preferred Providers for the Implementation Period.

F. The ACO shall update the Preferred Provider List for the Implementation Period in accordance with Section 4.04.

Section 4.04 Updating Lists during the Implementation Period

A. Additions to a List
The ACO may not make additions to its Participant Provider List or Preferred Provider List to take effect during the Implementation Period.

B. Removals from a List

1. General. In a form and manner specified by CMS, the ACO shall notify CMS no later than 30 Days 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). Except as specified in Section 4.04.B.2, the removal of the individual or entity from the Participant Provider List or Preferred Provider List will be effective on the last Day of the month in which the individual or entity ceases to be a Participant Provider or Preferred Provider.

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

C. Updating Enrollment Information
The ACO shall ensure that all changes to enrollment information for Participant Providers and Preferred Providers, including changes to reassignment of the right to receive Medicare payment, are reported to CMS consistent with 42 CFR § 424.516.

Section 4.05 Participant Provider List and Preferred Provider List for the First Performance Year

A. Proposed Participant Provider List. If the ACO wishes to participate in the Model Performance Period, the ACO shall submit to CMS by a date and in a form and manner specified by CMS, a proposed list identifying each individual or entity that the ACO expects to participate in the Model as a Participant Provider effective at the start of the ACO's first Performance Year ("**Proposed Participant Provider List**"). The Proposed Participant Provider List must:

1. Identify each individual or entity by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable);

2. Specify the Benefit Enhancements and Beneficiary Engagement Incentives, if any, in which each individual or entity has agreed to participate;

3. If the ACO has selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year pursuant to Section 8.02, identify the applicable PCC Fee Reduction for each individual or entity on the Proposed Participant Provider List;

4. If the ACO has selected to participate in the APO for the ACO's first Performance Year pursuant to Section 8.02, identify which individuals and entities on the Proposed Participant Provider List, if any, have agreed to participate in the APO and the applicable APO Fee Reduction for each such individual or entity.

CMS will specify one or more submission deadlines to add the information specified in paragraphs (1) through (4) to the Proposed Participant Provider List. By a date specified by CMS, the ACO shall certify 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. Proposed Preferred Provider List. If the ACO wishes to participate in the Model Performance Period, the ACO shall submit to CMS by a date and in a form and manner specified by CMS, a proposed list identifying each individual or entity that the ACO expects to participate in the Model as a Preferred Provider effective at the start of the ACO's first Performance Year ("**Proposed Preferred Provider List**"). The Proposed Preferred Provider List must:

1. Identify each individual or entity by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable);

2. Specify the Benefit Enhancements and Beneficiary Engagement Incentives, if any, in which each individual or entity has agreed to participate;

3. If the ACO has selected TCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year pursuant to Section 8.02, identify each individual or entity that has agreed to participate in TCC Payment with the ACO, as well as the applicable TCC Fee Reduction for each such individual or entity;

4. If the ACO has selected PCC Payment as its Capitation Payment Mechanism for the ACO's first Performance Year pursuant to Section 8.02, identify each individual or entity that has 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 has selected to participate in the APO for the ACO's first Performance Year pursuant to Section 8.02, identify which individuals and entities, if any, have agreed to participate in the APO as well as the applicable APO Fee Reduction for each such individual or entity.

CMS will specify one or more submission deadlines to add the information specified in paragraphs (1) through (5) to the Proposed Preferred Provider List.

By a date specified by CMS, the ACO shall certify 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. 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 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 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 All-Payer ACO Model, 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 has selected to participate in TCC Payment for the ACO's first Performance Year pursuant to Section 8.02, state that the individual's or entity's agreement to participate in TCC Payment pursuant to Section 4.05.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. If the ACO has selected to participate in PCC Payment pursuant to Section 8.02, state that the individual's or entity's agreement to participate in PCC Payment pursuant to Section 4.05.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 PCC Payment 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.

5. If the ACO has selected to participate in the APO pursuant to Section 8.02, state that the individual's or entity's agreement to participate in the APO pursuant to Section 4.05.F 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.

D. 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 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 Preferred Provider List.

2. State that the individual or entity may agree in accordance with the requirements of Section 4.05.E to participate in the Capitation Payment Mechanism selected by the ACO, 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 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.

3. If the ACO has selected to participate in the APO pursuant to Section 8.02, state that the individual or entity may agree in accordance with the requirements of Section 4.05.F to participate in the APO, 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.

E. Written Confirmation of Consent to Participate in a Capitation Payment Mechanism

1. ***Participant Providers.*** The ACO shall obtain written confirmation that each individual and entity identified on the Proposed Participant Provider List has consented to participate in the ACO's selected Capitation Payment Mechanism.

2. ***Preferred Providers.*** The ACO shall obtain written confirmation that each individual and entity that is identified on the Proposed Preferred Provider List as participating in the ACO's selected Capitation Payment Mechanism has consented to participate in the ACO's selected Capitation Payment Mechanism.

3. The written confirmation of consent required under this Section 4.05.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 Participant Provider or Preferred Provider 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. The ACO REACH Model: Fee Reduction Agreement must specify the TCC Fee Reduction percentage or PCC Fee Reduction percentage, as applicable, agreed upon by the individual or entity from among the applicable percentages specified by CMS.

4. As part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN the Participant Provider or Preferred Provider bills Medicare must verify the accuracy of the list of Participant Providers and Preferred Providers billing under that TIN that have affirmatively consented to participate in the ACO's selected Capitation Payment Mechanism and the amount of the PCC Fee Reduction or TCC Fee Reduction, as applicable, agreed upon by each such individual or entity.

5. Consent to participate in the ACO's selected Capitation Payment Mechanism for the ACO's first Performance Year must be obtained prior to the start of the ACO's first Performance Year. Consent to participate in the ACO's selected Capitation Payment Mechanism must be voluntary and must not be contingent on or related to receipt of referrals from the ACO, its Participant Providers, or Preferred Providers.

F. Written Confirmation of Consent to Participate in the APO

1. If the ACO has selected to participate in the APO for the ACO's first Performance Year pursuant to Section 8.02, the ACO shall obtain written confirmation that each individual and entity identified on the Proposed Participant Provider List and the Proposed Preferred Provider List as having opted to participate in the APO has consented to participate in the APO.

2. Such written confirmation of consent 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 Participant Provider or Preferred Provider bills Medicare. CMS may provide the ACO with 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. The ACO REACH Model: Fee Reduction Agreement must specify the APO Fee Reduction percentage agreed upon by the individual or entity.

3. As part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN the Participant Provider or Preferred Provider bills Medicare must verify the accuracy of the list of Participant Providers and Preferred Providers billing under that TIN that have affirmatively consented to participate in the APO and the amount of the APO Fee Reduction agreed upon by such individual or entity.

4. Consent to participate in the APO for the ACO's first Performance Year must be obtained prior to the start of the ACO's first Performance Year. Consent to participate in 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.

G. 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 Participant Provider List or Proposed 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 Participant Provider List or Proposed Preferred Provider List as billing through the entity's TIN;

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 All-Payer ACO Model, 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, the Primary Care First Model, and the Independence at Home Demonstration; and

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.

H. Review, Certification, and Finalization of the Participant Provider List and Preferred Provider List for the first Performance Year

1. With respect to each individual and entity identified on the Proposed Participant Provider List and Proposed Preferred Provider List, CMS shall conduct a Program Integrity Screening.

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

   a. For any individual or entity on a Proposed Participant Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraphs (1) through (5) of Section 4.01.A; or

   b. For any individual or entity on a Proposed Preferred Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraphs (1) through (5) of Section 4.01.B.

3. CMS will provide the ACO with a list of individuals and entities that CMS has tentatively approved to be Participant Providers and Preferred Providers effective at the start of the ACO's First Performance Year.

4. In a form and manner and by a date specified by CMS, the ACO may propose to add individuals and entities to its Proposed Participant Provider List and its Proposed Preferred Provider List. CMS shall conduct a Program Integrity Screening for each individual or entity the ACO proposes to add to the Proposed Participant Provider List and Preferred Provider List, and may reject any individual or entity proposed for inclusion on the basis of the criteria described in Section 4.05.H.2.

5. CMS will provide the ACO with revised lists of the individuals and entities that CMS has tentatively approved to be Participant Providers and Preferred Providers effective at the start of the ACO's first Performance Year, to include individuals and entities added to the Proposed Participant Provider List or Proposed Preferred Provider List pursuant to Section 4.05.H.4 that CMS did not reject on the basis of criteria described in Section 4.05.H.2.

6. 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 Participant Provider List and of the revised Proposed Preferred Provider List and make any necessary corrections, including the removal of any individuals or entities that have not agreed to participate in the Model pursuant to a written arrangement meeting the requirements of Section 3.04.G, that have failed to satisfy the requirements of Section 4.01.A(1)-(4) or Section 4.01.B(1)-(4), as applicable, or that are otherwise ineligible to participate in the Model as a Participant Provider or Preferred Provider, as applicable. The ACO shall remove any individuals or entities that 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 4.05.E from its Proposed Participant Provider List.

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

    a. That the revised Proposed Participant Provider List and the revised Proposed 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 ACO's first Performance Year;

    b. That each individual and entity identified on the revised Proposed Participant Provider List and the revised Proposed 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 each individual and entity identified on the revised Proposed Participant Provider List and the revised Proposed Preferred Provider List will have a fully executed written arrangement meeting the requirements of Section 3.04.G;

d. That each individual and entity identified on the revised Proposed Participant Provider List and the revised Proposed 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 Participant Provider List and the revised Proposed 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 Reductions or TCC Fee Reductions, participation in the APO, the amount of the APO Fee Reductions, Benefit Enhancements, and Beneficiary Engagement Incentives, as applicable, effective at the start of the ACO's first Performance Year.

The ACO may not add individuals or entities to the revised Proposed Participant Provider List or Preferred Provider List at this time.

8. CMS will remove from the Participant Provider List and 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 All-Payer ACO 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) 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.

9. CMS will provide 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 effective at the start of the ACO's first Performance Year (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).

10. CMS will use the final Participant Provider List 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 the final Participant Provider List will not affect Claims-Based Beneficiary alignment for the ACO's first Performance Year.

11. The ACO shall update such lists in accordance with the terms of the agreement described in Section 1.03.

Section 4.06 Non-Duplication and Exclusivity of Participation

A. 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 the ACO, Participant Providers, and Preferred Providers for the duration of the Implementation Period, subject to the conditions and requirements set forth in Appendix A.

B. Consistent with the requirements set forth in Appendix A, the ACO, Participant Providers, and Preferred Providers may participate in the Independence at Home Medical Practice Demonstration Program under section 1866E of the Act, the Maryland Total Cost of Care Model, the Vermont All-Payer ACO Model, or any other Medicare initiative that involves shared savings during the Implementation Period.

ARTICLE V Beneficiary Alignment, Beneficiary Engagement, and Beneficiary Protections

Section 5.01 Beneficiary Alignment

CMS shall align Beneficiaries to the ACO for the ACO's first Performance Year using both Claims-Based Alignment and Voluntary Alignment according to the ACO's selected Alignment Methodology for the ACO's first Performance Year using the methodology set forth in the agreement described in Section 1.03.

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) will be valid for the ACO's first 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

The implementation of Prospective Plus Alignment during the Model Performance Period will be governed by the agreement described in Section 1.03.

C. Signed Attestation-based Voluntary Alignment

Appendix C shall apply to this Agreement if the ACO selects to participate in SVA during the Implementation Period pursuant to Section 8.01.

D. 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 if they have 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 Beneficiaries may designate a clinician on MyMedicare.gov, Medicare.gov, or any successor site as their primary clinician for purposes of MVA. If the ACO 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.

Section 5.03 Alignment Minimum

The applicable alignment minimum for the ACO's first Performance Year and each subsequent Performance Year will be governed by the terms of the agreement described in Section 1.03.

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 this 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 this Agreement ("**Marketing Plan**"). CMS shall use reasonable efforts to approve or reject a Marketing Plan within 10 business days of submission.

C. If CMS determines that the ACO's proposed Marketing Plan, including any amendments described in Section 5.04.D, does not satisfy the applicable requirements of the Agreement, including Appendix C, 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 rejects any material changes to the ACO's Marketing Plan described in an amendment described in Section 5.04.D, 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.

D. 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 within 10 business days after submission, unless rejected in writing by CMS.

E. 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.

F. 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.G.

G. ACO Service Area

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

2. The Core Service Area includes the counties in which the ACO's Participant Providers have physical office locations. 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.

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 proposes an alternative service area definition which CMS approves, the ACO's ACO Service Area shall be the alternative service area so approved by CMS.

H. 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.

I. 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 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.I.2.

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

a. 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 this Agreement; and

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

3. In addition to the actions available under Article XIII, if the ACO has falsely certified compliance with all applicable requirements under this Section 5.04 and, if applicable, Appendix C of this Agreement, CMS may retroactively reverse any alignment of Beneficiaries to the ACO that occurred solely pursuant to Voluntary Alignment, including 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 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 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.I.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 12.02.

J. 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 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 their 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.

K. The ACO must translate Marketing Materials into any non-English language that is the primary language of at least 5 percent of the individuals in the ACO Service Area as defined in Section 5.04.G.)

L. Unsolicited Contacts

1. Except as otherwise specified in this 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 the 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 or 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.L and, if the ACO has selected to participate in SVA pursuant to Section 8.01, the applicable requirements in Appendix C.

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.L, 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 this Agreement.

M. 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 the ACO's first Performance Year or a subsequent 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 is was solicited. For example, Beneficiary contact information provided for a raffle or other drawing must be 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 [Reserved]

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 not to, 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 the ACO's first Performance Year or 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

Except as otherwise permitted by applicable law, 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.

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.

ARTICLE VI Data Sharing and Reports

Section 6.01 General

CMS is not offering the ACO an opportunity to request Beneficiary identifiable data in connection with its participation in the Implementation Period under this Agreement. Data sharing for purposes of the ACO's first Performance Year will be governed by the terms of the agreement described in Section 1.03 of this Agreement.

Section 6.02 De-Identified Reports

During the Implementation Period, CMS may provide reports to the ACO, which will be de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b). This aggregate information will not include individually identifiable health information.

ARTICLE VII [Reserved]

ARTICLE VIII ACO Selections and Approval

Section 8.01 ACO Selection for the Implementation Period

A. For the Implementation Period, in a form and manner and by a deadline specified by CMS, the ACO shall submit to CMS its decision with respect to participation in SVA.

B. The ACO's decision to participate in SVA for the Implementation Period refers to the ACO's decision to participate in Voluntary Alignment Activities specific to SVA in accordance with Appendix C during the Implementation Period for purposes of aligning Beneficiaries to the ACO for the ACO's first Performance Year.

Section 8.02 ACO Selections for the Model Performance Period

A. If the ACO wishes to participate in the Model Performance Period, by a time and in a form and manner specified by CMS, the ACO shall submit its selected Risk Sharing Option (Professional or Global) for the ACO's first Performance Year. This Risk Sharing Option selection may differ from the Risk Sharing Option selected by the ACO as part of its application to participate in the Model. If the ACO selects Professional as its Risk Sharing Option for the ACO's first Performance Year, 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 the agreement described in Section 1.03 of this Agreement. If the ACO selects Global as its Risk Sharing Option for the ACO's first Performance Year, the ACO's selection of Global as its Risk Sharing Option will remain in effect for the duration of the ACO's participation in the Model Performance Period.

B. If the ACO wishes to participate in the Model Performance Period, by a time and in a form and manner specified by CMS, the ACO shall submit its selections for the following for the ACO's first Performance Year:

1. The ACO's selected Capitation Payment Mechanism. If the ACO has selected to participate in Global for the ACO's first Performance Year, the ACO may select either TCC Payment or PCC Payment as its Capitation Payment Mechanism for its first Performance Year. If the ACO has selected to participate in Professional for the ACO's first Performance Year, the ACO may select only PCC Payment as its ACO Capitation Payment Mechanism for its first Performance Year;

2. If the ACO selects to participate in PCC Payment for its first Performance Year, whether the ACO selects to participate in the APO;

3. The maximum Enhanced PCC Percentage for the ACO's first Performance Year within the range specified by CMS, if the ACO selects PCC Payment as its Capitation Payment Mechanism for its first Performance Year;

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

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

6. The ACO's decision with respect to participation in SVA for the ACO's first Performance Year. The ACO's decision to participate 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 its 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

7. The ACO's decision with respect to any other selections CMS may offer for the ACO's first Performance Year.

C. Benefit Enhancements and Beneficiary Engagement Incentives

1. The ACO may select to provide one or more Benefit Enhancements and may select to provide one or more Beneficiary Engagement Incentives for the ACO's first Performance Year pursuant to Section 8.02.B.

2. 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 pursuant to Section 8.02.B ("**Implementation Plan**").

3. If CMS determines that the ACO's proposed implementation of one or more Benefit Enhancements or Beneficiary Engagement Incentives is inconsistent with the terms of the agreement described in Section 1.03 or

likely to result in abuse or program integrity concerns, CMS may reject the ACO's selection to provide one or more Benefit Enhancements or Beneficiary Engagement Incentives or may reject (or require the amendment of) the ACO's Implementation Plan. If CMS rejects an Implementation Plan for a Benefit Enhancement or Beneficiary Engagement Incentive, the ACO shall not implement the Benefit Enhancement or Beneficiary Engagement Incentive for the ACO's first Performance Year.

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

Section 9.01 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 other 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®)[1] surveys;
2. Clinical data such as lab values;
3. ACO Implementation Plans; and
4. Medical records.

Section 9.02 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 resources, tools and ideas.

Section 9.03 Site Visits

A. The ACO shall cooperate and require its Participant Providers and Preferred Providers to cooperate in site visits by or on behalf of CMS in order to facilitate evaluation, shared learning activities, or compliance monitoring.

B. CMS shall schedule 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 this Agreement shall be construed to limit or otherwise prevent CMS from performing site visits permitted by applicable law or regulations.

Section 9.04 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

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

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 this 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 this 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, which is attached as Appendix D, or a form substantially the same as Appendix D, identifying specific examples of what the ACO considers to be proprietary and confidential. The ACO must notify CMS, in a form and manner 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 X Public Reporting and Release of Information

Section 10.01 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.

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

Section 10.02 ACO Release of Information

A. The ACO, its Participant Providers, and its Preferred Providers shall obtain prior approval from CMS during the term of this 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 10.02 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 XI Compliance and Oversight

Section 11.01 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's compliance plan must be in compliance with all applicable laws and regulations and be updated periodically to reflect changes in those laws and regulations.

Section 11.02 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 this 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 11.03 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 11.04 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 or Marketing Activities to comply with, the applicable terms of this 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. This 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.

B. State Recognition

During the term of this 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 this 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 this Agreement or any other provision of law. This Agreement cannot be construed to bind any government agency except CMS and this Agreement binds CMS only to the extent provided herein.

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

D. Office of Inspector General of the Department of Health and Human Services (OIG) Authority

None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the 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 this 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 11.05 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 the individual's knowledge, information, and belief.

B. At the end of the Implementation Period, an individual with the legal authority to bind the ACO must certify to the best of the individual's 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.

ARTICLE XII Audits and Record Retention

Section 12.01 Right to Audit

The ACO agrees, and must 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 this 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 this Agreement;

C. The quality of services performed under this Agreement;

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

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

Section 12.02 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 12.01. 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 Market Activities to maintain, such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:

A. CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the 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 XIII Remedial Action and Termination

Section 13.01 Remedial Action

A. If CMS determines that any provision of this 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 any arrangements, immediately or within a timeframe specified by CMS, with such Participant Provider or Preferred Provider with respect to this Model;
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. 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 this Agreement;

8. Prohibit the ACO from accessing any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act;

9. Discontinue the provision of reports to the ACO under Article VI of this Agreement;

10. Prohibit the ACO from participating in SVA, distributing Marketing Materials, or conducting Marketing Activities, including Voluntary Alignment Activities.

11. Require the ACO to suspend or terminate a Start-up Arrangement.

B. CMS may impose additional remedial actions or terminate this Agreement pursuant to Section 13.02 if CMS determines that remedial actions were insufficient to correct noncompliance with the terms of this 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 any arrangements with the removed Participant Provider or Preferred Provider with respect to this Model 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 13.02 Termination of Agreement by CMS

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

A. CMS determines that the Agency 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 this 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. Assigns or purports to assign any of the rights or obligations under this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS.

8. Poses significant program integrity risks, including but not limited to:

i. Is subject to sanctions or other actions of an accrediting organization or a federal, state, or local government agency; or

ii. 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.

D. CMS determines that one or more of the Participant Providers or Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model; or

E. 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.

Section 13.03 Termination of Agreement by ACO

The ACO may terminate this Agreement upon advance written notice to CMS. Such notice must specify the effective date of the termination, which date must be no sooner than 30 Days following the date of that notice.

Section 13.04 Notifications to Participant Providers and Preferred Providers upon Termination

A. If this Agreement is terminated under Sections 13.02 or 13.03, the ACO shall post a notice of the termination on its ACO website and provide written notice of the termination to all Participant Providers and Preferred Providers. The ACO shall deliver such written notice no later than 30 Days before 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 Marketing Activities.

B. The ACO may provide written notice of the termination to Beneficiaries. Any notice to Beneficiaries is subject to review and approval by CMS under Section 5.04 as Marketing Materials.

ARTICLE XIV Limitation on Review and Dispute Resolution

Section 14.01 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 this Agreement 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); and

Section 14.02 Dispute Resolution

A. Right to Reconsideration

The ACO may request reconsideration of a determination made by CMS pursuant to this Agreement only if such reconsideration is not precluded by section 1115A(d)(2) of the Act or this 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;

ii. Did not participate in the determination that is the subject of the reconsideration request; and

iii. May be, but does not have to be, an Inferior Officer.

b. The request must contain a detailed, written explanation of the basis for the dispute, including supporting documentation.

a. The request must be made within 30 Days of the date of the determination for which reconsideration is being requested via email to CMS at the address specified in Section 15.01 or such other address as may be specified by CMS.

2. Requests that do not meet the requirements of Section 14.02.A.1 will be denied by the Reconsideration Official.

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

a. The review procedures; and

b. A schedule that permits each party to submit documentation in support of the party's position for consideration by the Reconsideration Official.

B. Standards for Reconsideration

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

2. The reconsideration 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 14.02.A.1 and the Reconsideration Official's written acknowledgement under Section 14.01.A.3; 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 notification of the reconsideration determination. Absent unusual

circumstances, such written notification will be issued within 60 Days of receipt of timely filed position papers and supporting documentation.

3. Effect of the Reconsideration Determination

   a. The determination of the Reconsideration Official is final and binding.

   b. The reconsideration review 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 XV Miscellaneous

Section 15.01 Notifications and Submission of Reports

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

CMS: ACO REACH Model
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: WB-06-05
Baltimore, MD 21244
Email: ACOREACH@cms.hhs.gov

ACO: _____

Address: _____

_____

_____

_____

Email: _____

Section 15.02 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 this Agreement.

Section 15.03 Severability

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

Section 15.04 Entire Agreement; Amendment

This Agreement, including all Appendices, constitutes the entire agreement between the parties for the Implementation Period of the Model. The parties may amend this Agreement or any Appendix hereto at any time by mutual written agreement; provided, however, that CMS may amend this Agreement or any Appendix hereto without the consent of the ACO as specified in this Agreement or any Appendix hereto, or for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, accreditation standards 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 15.05 Survival

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

Section 3.05 (Start-up Arrangements);

Section 9.01 (Evaluation Requirement);

Section 9.04 (Rights in Data and Intellectual Property);

Section 10.02 (ACO Release of Information);

Section 11.03 (ACO Compliance with Monitoring and Oversight Activities);

Section 11.05 (Certification of Data and Information);

Article XII (Audits and Record Retention);

Section 13.04 (Notifications to Participant Providers, Preferred Providers, and Beneficiaries upon Termination);

Section 14.01 (Limitations on Review);

Section 15.02 (Notice of Bankruptcy);

Section 15.05 (Survival);

Section 15.08 (Prohibition on Assignment); and

Section 15.09 (Change in Control).

Section 15.06 Precedence

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

Section 15.07 Change of ACO Name

The ACO will provide written notice to CMS at least 60 Days before any change in the ACO legal name becomes effective. The notice of legal name change shall be in a form and manner specified by CMS. 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 15.08 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 this Agreement; (2) any right that it has to satisfy a condition under this Agreement; (3) any remedy that it has under this Agreement; or (4) any obligation imposed on it under this Agreement. The 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 this Agreement. Any purported transfer in violation of this Section is voidable at the discretion of CMS.

Section 15.09 Change in Control

CMS may terminate this Agreement 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. The written notification must be furnished in a form and manner specified by CMS. 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. If the ACO does not participate in the Model Performance Period, this obligation remains in effect until December 31, 2028.

Section 15.10 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 take any other actions consistent with the terms of the Agreement.

Section 15.11 Certification

The executive signing this Agreement on behalf of the ACO ("**Alternative Payment Model Entity (APM) Executive**") certifies to the best of their 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 15.12 Execution in Counterpart

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

[SIGNATURE PAGE FOLLOWS]

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

ACO: _____

Date: _____ By: _____

_____

Name of Authorized Signatory

_____

APM Executive

CMS:

Date: _____ By: _____

_____

Name of Authorized Signatory

_____

CMS Executive

Appendix A: Implementation Period 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 the ACO, Participant Providers, and Preferred Providers for the duration of the Implementation Period, subject to the requirements set forth in this Appendix A. This waiver is necessary to support the ACO's ability to prepare for participation in the Model Performance Period, while winding down the ACO's participation in the Medicare Shared Savings Program, as applicable, and to enable the ACO to enter into arrangements with Medicare-enrolled providers and suppliers to participate in the Model as Participant Providers and Preferred Providers, and thus enable the ACO to better care for Beneficiaries in an environment where an increasing number 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. Consistent with the waiver in Section I of this Appendix A, during the Implementation Period, the ACO and its Participant Providers and Preferred Providers may simultaneously participate in the Model and the Medicare Shared Savings Program.

B. If otherwise eligible, the ACO and its Participant Providers and Preferred Providers may participate in other Medicare demonstrations, programs, or models during the Implementation Period, to the extent permitted under the terms of such demonstration, program, or model, including the Primary Care First Model, the Independence at Home Medical Practice Demonstration Program under section 1866E of the Act, the Maryland Total Cost of Care Model, Vermont All-Payer ACO Model, or another Medicare initiative that involves shared savings.

C. If the ACO wishes to participate in the Model Performance Period, any requirements regarding overlapping participation during the Model Performance Period will be specified in the agreement described in Section 1.03 of this Agreement, including a requirement that the ACO and its Participant Providers may not simultaneously participate in the Model and the Medicare Shared Savings Program or any other initiative that involves shared savings for the remaining duration of the Model Performance Period.

Appendix B: [Reserved]

Appendix C: Signed Attestation-based Voluntary Alignment

I. General

This Appendix will apply only if the ACO selects participation in SVA for the Implementation Period pursuant to 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.I 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 Implementation Period, 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.G 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 12.02 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 the Beneficiary's 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. Signed Attestation-based Voluntary Alignment 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 as the Beneficiary's main doctor, main provider, and the main place the Beneficiary receives care. A Voluntary Alignment Form is valid only if it has been signed and dated by the Beneficiary or the Beneficiary's 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, the identity of the Participant Provider that the Beneficiary has identified as their 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 11.05 of the Agreement that, to the best of the executive's 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 ACO's first Performance Year in a form and manner and by one or more dates specified by CMS. CMS will use the SVA List to conduct alignment of Beneficiaries for the ACO's first Performance Year.

C. CMS may monitor and/or audit the ACO's SVA Lists for accuracy in accordance with Section 12.01 of the Agreement. This audit, including any surveys of Beneficiaries conducted pursuant to Section III.D of this Appendix, may take place during the Implementation Period 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: 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 9.04 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.