



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

Beneficiary Notices: Reference Language

Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
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I. Beneficiary Notice: Reference Language

This section provides optional language to assist Participants in satisfying the ACCESS model-specific disclosure requirements applicable prior to an eligibility check and prior to Beneficiary alignment, as described in the Request for Applications (RFA) and the Participation Agreement. Participants are not required to use this language.

This language is not intended to be comprehensive. It does not address all disclosures or consents that may be required under applicable law or regulation, and it does not satisfy other legal or regulatory obligations that may apply to Participants — including, but not limited to, requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), state privacy laws, or other federal requirements. Participants are responsible for ensuring that their disclosures and consent processes comply with all applicable requirements beyond those addressed here. Participants should consult with their own counsel prior to use.

BLOCK 1 — Prior to Eligibility Check

Display at the point of checking a Beneficiary's eligibility, prior to submitting to the CMS ACCESS Eligibility API. May appear as inline disclosure text or as part of a terms and conditions checkbox flow.

Notice Regarding Participation in a CMS Payment Model

The services offered by [Participant Name] are provided as part of a new federal payment model test being conducted by the Centers for Medicare & Medicaid Services (CMS), known as the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model. By proceeding, you acknowledge that you have been informed of the following:

- **Data Sharing.** In connection with ACCESS, [Participant Name] may share your health information with CMS. CMS may also access or request your health information — including through Health Information Exchanges (HIEs) or other sources — in connection with the program's evaluation. Any such sharing is subject to applicable federal privacy and security protections.
- **Control Group Assignment.** You may be randomly assigned to a control group and be ineligible to enroll in ACCESS with any participating health care provider for 12 months, unless otherwise stated by CMS. *Assignment to the control group will not otherwise affect your Medicare benefits, rights, or coverage.*

BLOCK 2 — Prior to Alignment

Display at the point of enrollment or alignment, prior to submitting to the CMS ACCESS Alignment API. May appear as inline disclosure text or as part of a terms and conditions

checkbox flow. Consent to align to the Participant may be obtained verbally or in writing, including through a Beneficiary's acceptance of terms and conditions.

Consent to Receive ACCESS Services

The services offered by [Participant Name] are provided as part of a new federal payment model test being conducted by the Centers for Medicare & Medicaid Services (CMS), known as the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model. By enrolling, or aligning, with [Participant Name] to receive ACCESS services, you acknowledge the following:

1. Voluntary Alignment.

Your alignment with [Participant Name] in the ACCESS model is entirely voluntary. You are not required to align, and your Medicare benefits will not be affected by your decision to align or not align.

2. Cost-Sharing.

Your cost-sharing amount associated with these services is up to \$[Amount] per month for the duration of your alignment with [Participant Name].

3. Right to Disenroll (Unalign).

You may end your alignment with [Participant Name] — and, if you choose, align with another participating health care provider — at any time beginning 90 days after your initial alignment date.

4. One Provider Per Clinical Track.

You may only be aligned with one participating health care provider per ACCESS clinical track at any given time. However, you may be aligned in multiple *different* clinical tracks simultaneously — with the same or different health care providers — for each clinical track in which you have a qualifying condition. See the ACCESS Model Webpage for a list of clinical tracks and associated policies.

5. Claims Data Sharing. (Include if applicable, based on Participant's DRA selections)

Your Medicare claims data may be shared with [Participant Name], subject to all applicable privacy and security protections, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

6. TEMPO Pilot Device Disclosure. *(Include if applicable — only if a device participating in the TEMPO Pilot is being used)*

[Participant Name] is utilizing a device — [Device Name and Brief Description] — that is participating in a U.S. Food and Drug Administration (FDA) pilot program known as Technology-Enabled Meaningful Patient Outcomes for Digital Health Devices (TEMPO). By aligning, you acknowledge the following regarding this device:

- a) The device is part of an FDA pilot program.
- b) Use of the device is subject to a plan by [Participant Name] for the collection, monitoring, analysis, and reporting of real-world performance data associated with the device's participation in that pilot.
- c) The effectiveness of this device for the intended use for which it is participating in the pilot has not yet been evaluated by the FDA.
- d) Data related to your use of the device may be shared with the FDA, consistent with applicable federal privacy and security requirements.

II. Control Group Standardized Language

Required language. Participants must display this notification to a beneficiary upon receiving a control group result from the CMS ACCESS Eligibility API. Participants may not modify this language.

You are not eligible to enroll.

These services are part of a federal payment model test being conducted by the Centers for Medicare & Medicaid Services (CMS). To evaluate the model, some individuals are assigned to a comparison group and are not eligible to enroll for 12 months. This is a random assignment made by CMS for evaluation purposes only and is not based on anything about you or your health. You may continue to receive other services as usual and your Medicare coverage, benefits, and rights are not affected in any way. If you have questions, you may call 1-800-MEDICARE (1-800-633-4227). Teletypewriter (TTY) users call 1-877-486-2048.