A working session for ACO leaders

ACCESS Before 2028

The two years that don’t count against your benchmark

September 3, 2026 · 1:00 PM ET

Limbic · Nuna · Flagler Health

VBCExhibitHall.com

Educational Webinar Series

This session is being recorded. Use the questions panel at any time.

Who’s on the call

Nuna

A Digital Health Coach For Cardio-Metabolic Conditions

David Chen
Co-founder, Chief Strategy Officer

Rob Bruggner
Principal, Commercial Strategy

`eCKM and CKM`

Flagler Health

AI operating system for musculoskeletal care

Albert Katz
Co-founder, Chief Executive Officer

`MSK`

Limbic

Clinical AI for behavioral health

Sebastiaan de Vries
Co-founder, Chief Technology Officer

`Behavioral Health track`

What we’ll answer

ACCESS payments don’t touch your benchmark in 2026 or 2027.
From 2028, they do.

01 Deep dive into the CMS ACCESS Model, who its for and how it works

03 What’s in it for you

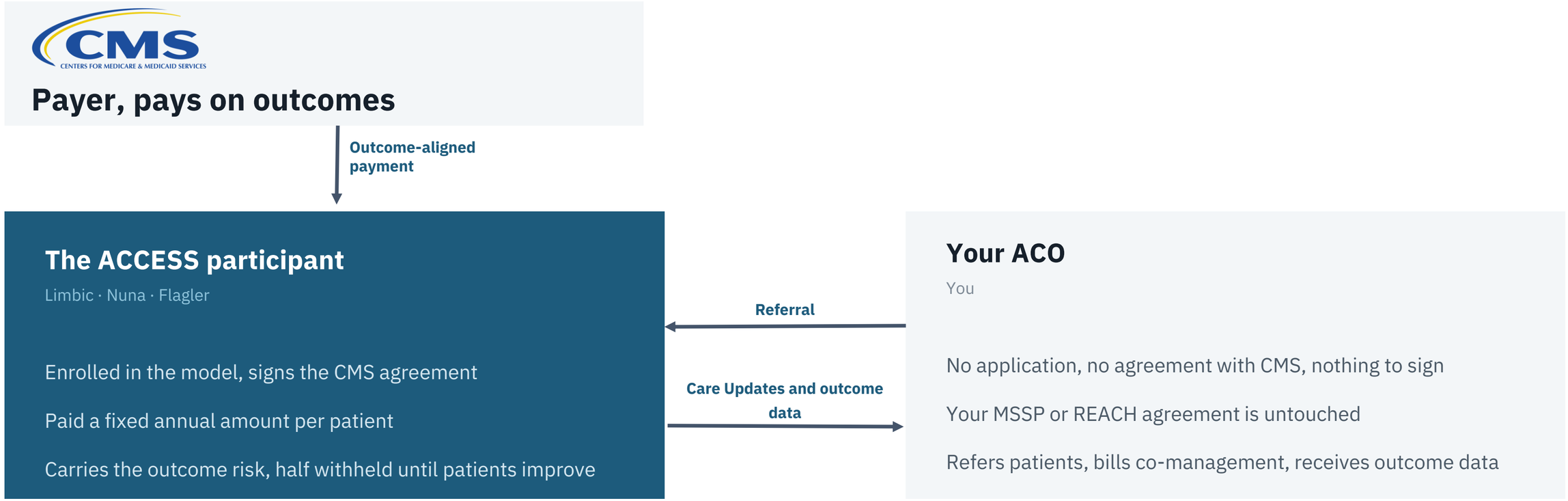
04 Your unmet need in chronic care; who we are and what are our offerings

The model

01

What ACCESS is, who it’s for, and how it pays.

Who it’s for, what you can do, and what it isn’t



Your patients are already eligible, whether or not you engage.

ACCESS pays a fixed annual amount per patient, across four tracks

Ten-year voluntary nationwide Medicare model, live since July 5, 2026. · Participants are Medicare Part B enrolled providers and suppliers

Roughly 70% of beneficiaries have a qualifying condition. · CMS does not prescribe how care is delivered.

TRACK	QUALIFIES ON	OUTCOME MEASURE
Early CKM	Hypertension, or two or more of dyslipidemia, obesity or overweight with central obesity, prediabetes	Control or minimum improvement in BP, lipids, weight, HbA1c
CKM	Diabetes, CKD stage 3a to 3b, or atherosclerotic cardiovascular disease	Same as Early CKM, plus eGFR and UACR submission for CKD and diabetes
MSK	Chronic musculoskeletal pain lasting more than three months	Minimum improvement in pain intensity, interference and function, via validated PROM
Behavioral Health	Depression or anxiety	Minimum improvement on PHQ-9 and GAD-7, plus WHODAS 2.0 12-item submission

Initial-period amounts. Follow-on periods are optional and paid at roughly half rate, except MSK, which has none. A rural add-on of $15 for Early CKM and CKM in the initial period is widely reported but not stated on CMS’s published pages.

CMS pays us directly on patient outcomes, not on services rendered

And half of it is at risk

Half, paid monthly	50% withheld
No contracts No invoices CMS pays us directly	Contingent on outcome attainment

What CMS Pay Us

$180–$420

per patient, per year, by track

What unmanaged care costs

$2,000–$4,000

added spend per year, one unmanaged hypertension

+$19,900

one early-CT low back pathway

+$4,800

added spend from patients with depression

We are paid for recovery, not for visits. More utilization earns us nothing, improvement is the only way we collect in full.

03

What’s in it for you

What your clinicians can earn in referral and co-management fees as well as how you can work with CMS ACCESS participants

ACCESS moves the two numbers you are actually measured on

↑ QUALITY SCORES

Conditions you aren’t staffed to treat get treated.

Behavioral health, MSK and cardio-kidney-metabolic and improvement is measured on validated instruments, not engagement metrics.

↓ TOTAL COST OF CARE

Unmanaged chronic conditions drive avoidable acute spend.

The participant carries the outcome risk, not you and nothing enters your benchmark before 2028.

No cost to you. CMS pays the participant directly, and you sign nothing.

CMS Pays You For Performing Care Coordination

$30

per service

Three times a year, per patient, per track

~$90

per patient, per track, per year

Nothing charged to the patient

Five minutes to earn it

01 Read the update we send

02 Do one thing with it

03 Note it in the chart

Your staff can do the work. Your clinician can still bill it

- Physicians, NPs, PAs and most licensed clinical professionals can bill co-management. The work itself can be furnished by auxiliary personnel under general supervision, with your NPI reported as both rendering and supervising.
- Auxiliary personnel means anyone working under your supervision, employed, leased or contracted: a medical assistant, RN or LPN, care coordinator or care manager, community health worker, pharmacist or licensed social worker.

Coordination stops being unpaid work.

You have eighteen months to test this with no benchmark consequence

Your patients are ready reaching out to ACCESS participants, but you should play an active role in ACCESS. IF YOU PLAY AN ACTIVE ROLE:

You pick the provider

On the outcomes CMS publishes, instead of whoever advertises hardest.

You have access to the data

PHQ-9s, blood pressures and HbA1cs, instead of someone else's system.

Your clinicians get paid

Co-management billed, instead of coordination done unpaid.

> Passive, it's a blind spot on your panel.
>
> **Active, it's a new service you offer, at no cost to you.**

Who we are and the Key unmet needs

03

Cardio-kidney-metabolic, behavioral health, musculoskeletal and why participants are built for them.

Three ways in

You can partner with CMS ACCESS participants with minimal effort

01

You signpost it, patients enroll themselves

Point patients at a participant you've checked, through your newsletter, portal or care management calls.

02

We find them in claims/patient directory

We identify candidates from claims and eligibility data. No workflow change and minimal effort on your part

03

Referral at point of care

Your clinicians get somewhere to send someone. A named service at the point of the visit, instead of a waitlist

Unmanaged eCKM/CKM Conditions Drive >50% of Medicare Costs *But Nearly Half Of Those Costs Are Avoidable*

+70%

of Medicare beneficiaries have an eligible eCKM or CKM condition

$2k-$4k

Annual cost difference between patients with managed vs. unmanaged hypertension [1]

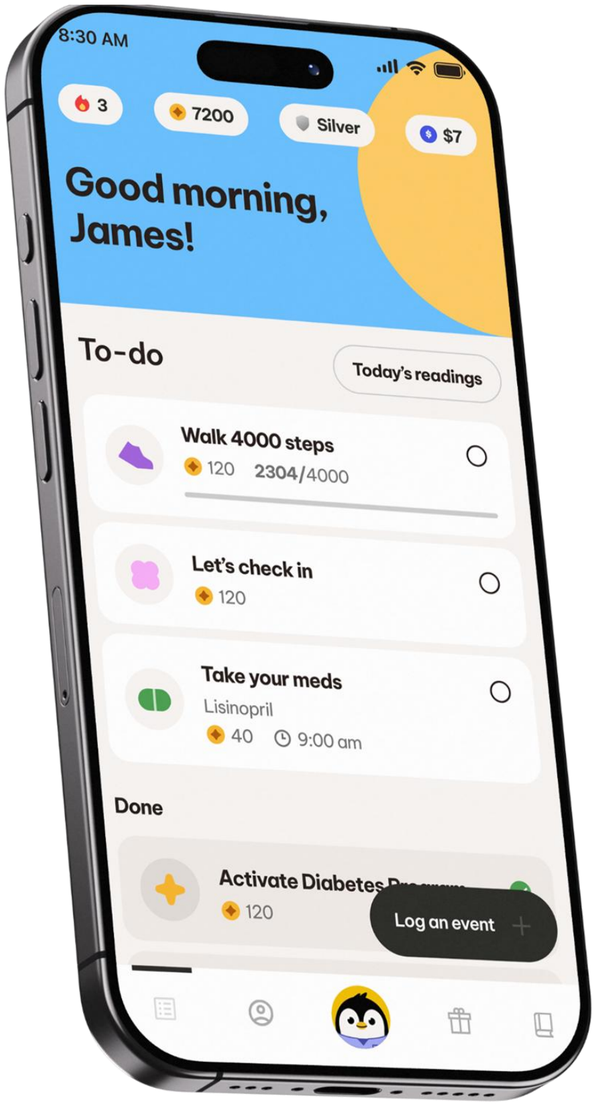
$4.5k

Average 2-Year reduction in medical costs for patients in diabetes prevention programs [2]

The benchmark battle is won or lost before the hospitalization

1: https://www.cdc.gov/nccdphp/priorities/high-blood-pressure.html
2: https://coveragetoolkit.org/cost-value-elements/

A Digital Health Coach That Helps Patients **Self-Manage** Cardio-Metabolic Conditions Affecting 7 in 10 US Seniors



Key App Capabilities

AI-Native Health Coach + Connected Devices
Always on, helping the patient take the next step to better health

Configurable, Proactive Care Prompts
Guides patients to seek care with their established care team as needed

Gamification & Habit-Formation Features
Builds long-lasting engagement & behavior change

All ACCESS Conditions Supported: eCKM & CKM
Free app access for aligned Medicare beneficiaries

Hypertension | Pre-Diabetes | Obesity | Dislipidemia — *eCKM Track*

Diabetes | CKD (3a/3b) | ASCVD — *CKM Track*

See The Rush+Nuna impact paper on 9/9 in Journal of General Internal Medicine

The first thirty days set the cost, **and nobody owns them**

For a newly diagnosed low back pain, the pathway chosen at the first visit decides the Medicare spend.

US SPEND ON MSK, A YEAR

$381bn

The largest single disease category in US health spending — ahead of diabetes ($309bn) and cardiovascular disease ($255bn).

All-payer. Per-patient figures at right are from Medicare claims analyses.

NEW LOW BACK PAIN

at the first PCP visit, before a specialist is involved

IMAGING FIRST · TODAY'S DEFAULT

+$19,900 per patient

one early-CT pathway · MRI adds +$2,500

CONSERVATIVE FIRST · THE GUIDELINE

$362M Medicare savings a year

CMS's estimate for guideline-concordant care — exercise and education first, imaging only when indicated.

The unmet need is ownership of that first month — and owning it is what Flagler's ACCESS model is built around

FLAGLER

Flagler's ACCESS model is **built around your patient**

Your referring PCP, Flagler as the ACCESS provider, and MSK specialists work as one team around the patient, with the capabilities and outcome monitoring

Flagler's AI care counselor runs day-to-day care with live staff step-in, serving as the convener of PCPs and the MSK specialists

Care Delivery Capabilities

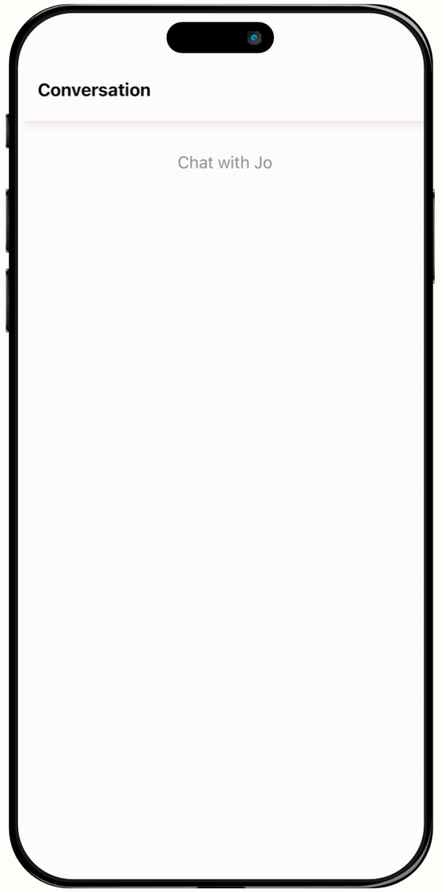
Remote monitoring infrastructure that connects patients with the right resources and guides their care, and proactively escalates to MSK specialists.

Patient Engagement and Interventions

Guided exercise therapy, education and self-management coaching address the patient's physical, behavioral and functional needs.

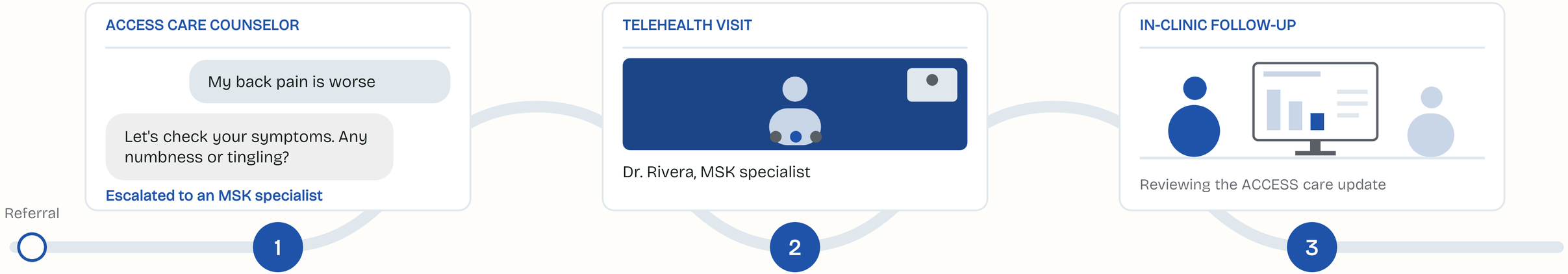
Outcomes and PROM Monitoring

Validated PROMs (ODI, KOOS, PROMIS) captured on CMS's cadence, an outcome engine, and care updates back to the treating clinician.



How it works!

Once a patient is referred, Flagler ensures care plan adherement and achieves improvement in patient outcomes and escalates to the treating clinician as needed



AI Care Counselor

Once referred, patients message our AI counselor for onboarding, questions and coaching, with live staff step-in.

Telehealth-based specialist routing

Escalations become a scheduled video visit. The specialist evaluates, adjusts the care plan and decides what needs in-person care.

ACO closed feedback loop

Patients return with care updates at escalation and completion. Remote monitoring tracks outcomes in between.

Untreated behavioral health costs you twice as much in your medical line

32%

of traditional Medicare beneficiaries, about 10 million people, have depression, anxiety, or both.

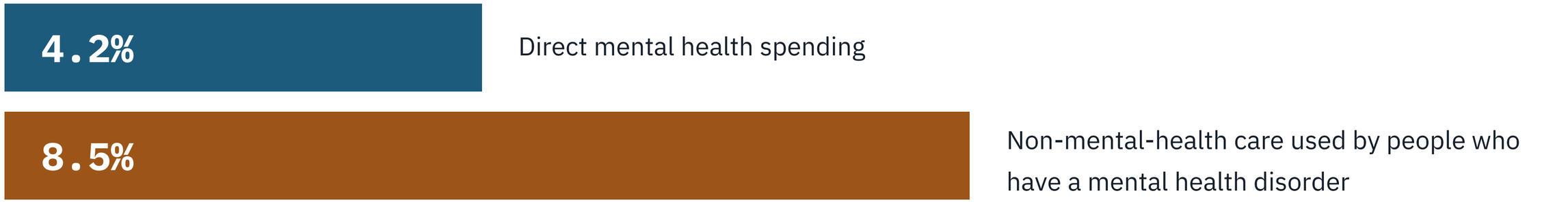
40 to 50%

receive any treatment at all.

6 to 7

weeks, the national average wait.

Share of Medicare spending

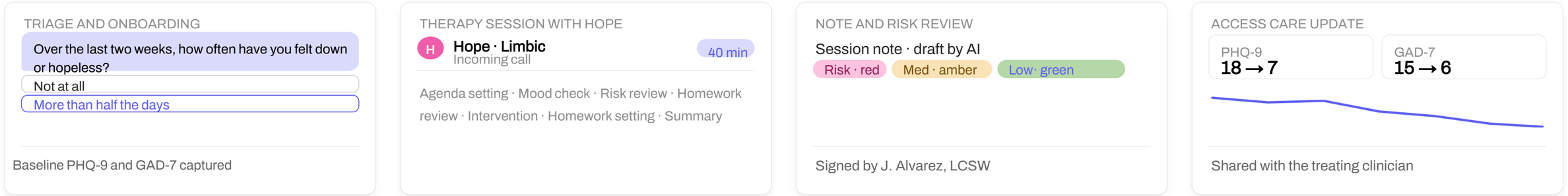


Twice as much again, and none of it shows up in your behavioral health line.

Spending split: JAMA Network Open analysis of Medicare claims.

An AI-led behavioral health provider, **accessible 24/7**

Unpacked by Limbic treats depression and anxiety with a structured course of therapy delivered by phone



1. Clinically validated triage and onboarding

Suitability, consent and a baseline measure before care begins. Only clinical-level depression or anxiety is accepted.

2. Structured CBT sessions with Hope

A 40-minute call on a fixed clinical agenda written by licensed clinicians. Weekly through the acute phase, then monthly.

3. Every session reviewed, every note signed

The AI drafts the note. Over 40 auto-labelers push safety flags to the EHR in real time. A licensed clinician reviews and signs.

4. Care updates go back to the PCP

An ACCESS Care Update to the treating clinician: score movement, flags, actions. At escalation and at completion.

CLINICAL EXCELLENCE

First AI-led mental healthcare company selected for **FDA TEMPO**

Licensed clinicians wrote the protocol and sign every note against the transcript.

DEPLOYED AT SCALE

820,000+ patients · **65%** of the NHS · **5** studies, N over 250,000

+25% reliable recovery · **–23%** dropouts · **–40%** time to recovery

limbic

How we propose working with your ACO

We do the identification, the outreach and the enrollment. What we need from you is a patient list.

GETTING SET UP

1 Your PCPs know who we are first

Informational materials to every participant provider organization before any patient hears from us.

2 We engage your patients

Names and phone numbers for your attributed beneficiaries, from claims, CMS files or your participant providers' EHRs, whichever is easier for you.

GETTING PATIENTS INTO CARE

3 Patients tell us if they need care

We ask rather than infer from a diagnosis code. Our clinic only accepts clinical-level depression or anxiety, confirmed at intake

4 We confirm the PCP and get consent

Consent to share and the named PCP is verified against provider directories

CARE AND WHAT COMES BACK

5 We treat

A full course of therapy by phone, mild to severe. No new tool for your clinicians to learn.

6 Outcomes come back, referrals follow

An ACCESS Care Update per patient: PHQ-9 and GAD-7 movement, flags, actions.

WHAT THIS COSTS YOU

Nothing. Limbic is paid through CMS's Outcome-Aligned Payment. No ACO payment, no per-visit fee.

Nothing against your benchmark, through 2027. ACCESS payments sit outside MSSP benchmark calculations in 2026 and 2027.

One thing from you. A contact list for your attributed beneficiaries. We do the rest of the outreach, screening and enrollment.

Every recovery earns the next referral. We don't wait on PCP engagement to show results.

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AUDIENCE QUESTIONS

Q & A

Limbic · Nuna · Flagler Health

Stop by our virtual exhibit booth!

VBCExhibitHall.com

Enter Virtual Booth

THANK YOU!

We’d love to hear from you

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