Unlocking a New Era of Chronic Care

A Strategic Overview of the CMS ACCESS Model

The Problem: Payment Models Are a Barrier to Innovation in Chronic Care

The current system is poorly aligned with the continuous, technology-enabled care that patients with chronic conditions need.

Hypertension

~$2,500

Mean annual healthcare cost per capita.

Diabetes w/ Complications

$5,876

Median annual cost per person.

Chronic Low Back Pain

$10,156

Median cost in the first year after diagnosis.

Fee-for-Service (FFS) Barriers

Covers a limited set of activities... poorly aligned with evolving technology-enabled care, which is often continuous and remote.

"Rewards activity volume while technology-enabled care is less supply-constrained," risking cost inflation.

Value-Based Care (VBC) Hurdles

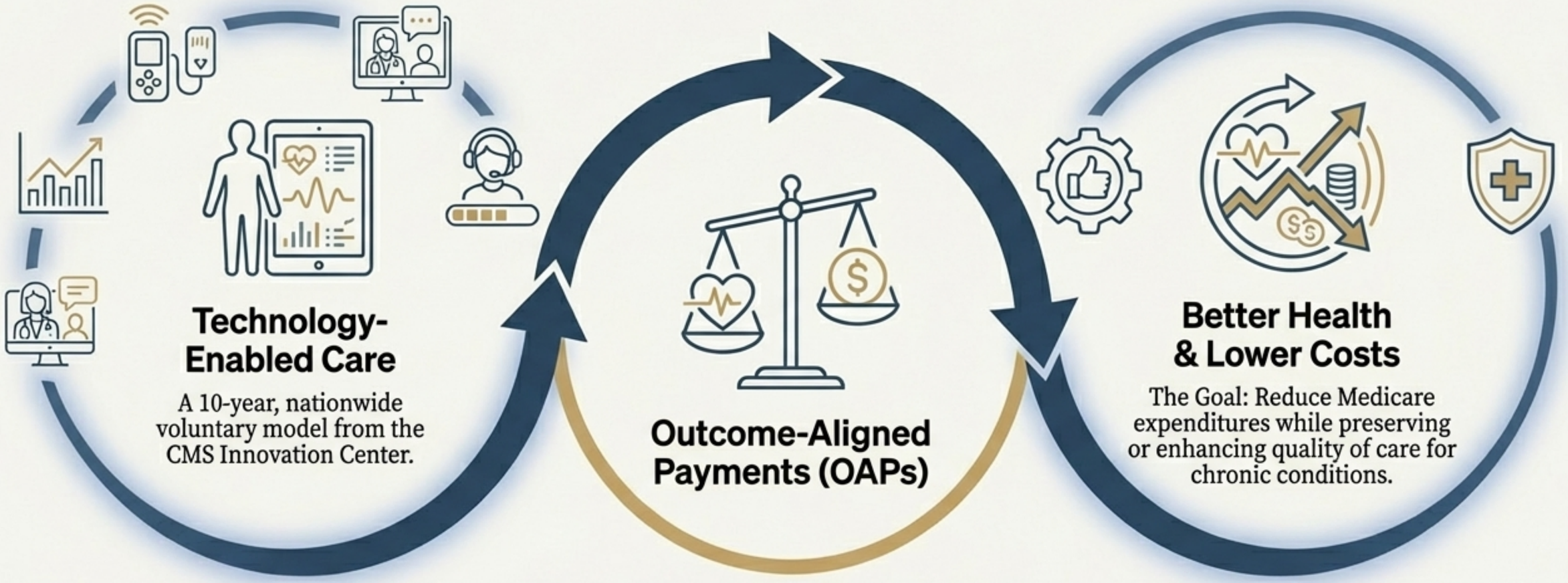
Complexity presents challenges for technology-enabled care organizations.

Shared savings models can create a "winner-take-all" dynamic.

Difficulties in "attributing condition-specific savings."

The ACCESS Model: Paying for Outcomes in Technology-Enabled Chronic Care

CMS is launching a new model to directly address payment barriers, creating a viable pathway for innovative care.



Technology-Enabled Care

A 10-year, nationwide voluntary model from the CMS Innovation Center.

Outcome-Aligned Payments (OAPs)

Tests a new methodology that links fixed payments directly to achieving track-specific clinical and patient-reported outcomes.

Better Health & Lower Costs

The Goal: Reduce Medicare expenditures while preserving or enhancing quality of care for chronic conditions.

How the ACCESS Model is Structured

1. Duration & Timeline

10-Year Model: July 5, 2026 – June 30, 2036.

Applications are accepted on a rolling basis through April 1, 2033.

2. Participants

Medicare Part B–enrolled TINs eligible to bill under the Physician Fee Schedule (PFS). Excludes DMEPOS and laboratory suppliers.

3. Beneficiaries

Original Medicare beneficiaries with qualifying chronic conditions. Enrollment is voluntary and prospective, aligned directly with a participant.

4. Payment Mechanism

Fixed Outcome-Aligned Payments (OAPs) for managing over 12-month care periods. Full payment is contingent on achieving outcome targets.

Targeting High-Burden Conditions Across Four Clinical Tracks

eCKM (Early Cardio-kidney-metabolic)

Qualifying Conditions: Hypertension, OR two or more of: dyslipidemia, obesity/overweight with central obesity, prediabetes.

Key OAP Measure: Control or improvement in BP, lipids, weight, and HbA1c.

CKM (Cardio-kidney-metabolic)

Qualifying Conditions: One or more of: diabetes mellitus, chronic kidney disease (Stage 3a/3b), atherosclerotic cardiovascular disease disease (ASCVD).

Key OAP Measure: Control or improvement in BP, lipids, weight, HbA1c. Submission of eGFR/UACR data for CKD/Diabetes.

MSK (Musculoskeletal)

Qualifying Conditions: Chronic musculoskeletal pain (lasting >3 months).

Key OAP Measure: Improvement in pain intensity, interference, and function (via PROMs).

BH (Behavioral Health)

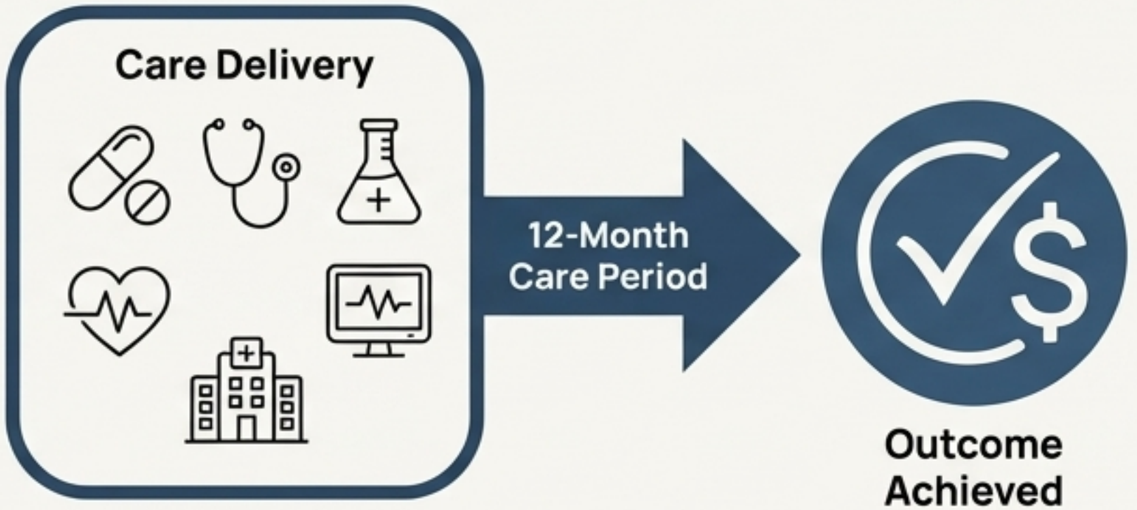
Qualifying Conditions: One or more of: depression, anxiety.

Key OAP Measure: Control or improvement in symptoms (via PHQ-9/GAD-7). Submission of WHODAS 2.0.

Shifting from Paying for *Activity* to Paying for *Results*

The Old Way: Fee-for-Service

The New Way: Outcome-Aligned Payment (OAP)



Predictable Revenue

Participants receive fixed payments for managing beneficiaries' qualifying conditions over 12-month periods.

Clear Accountability

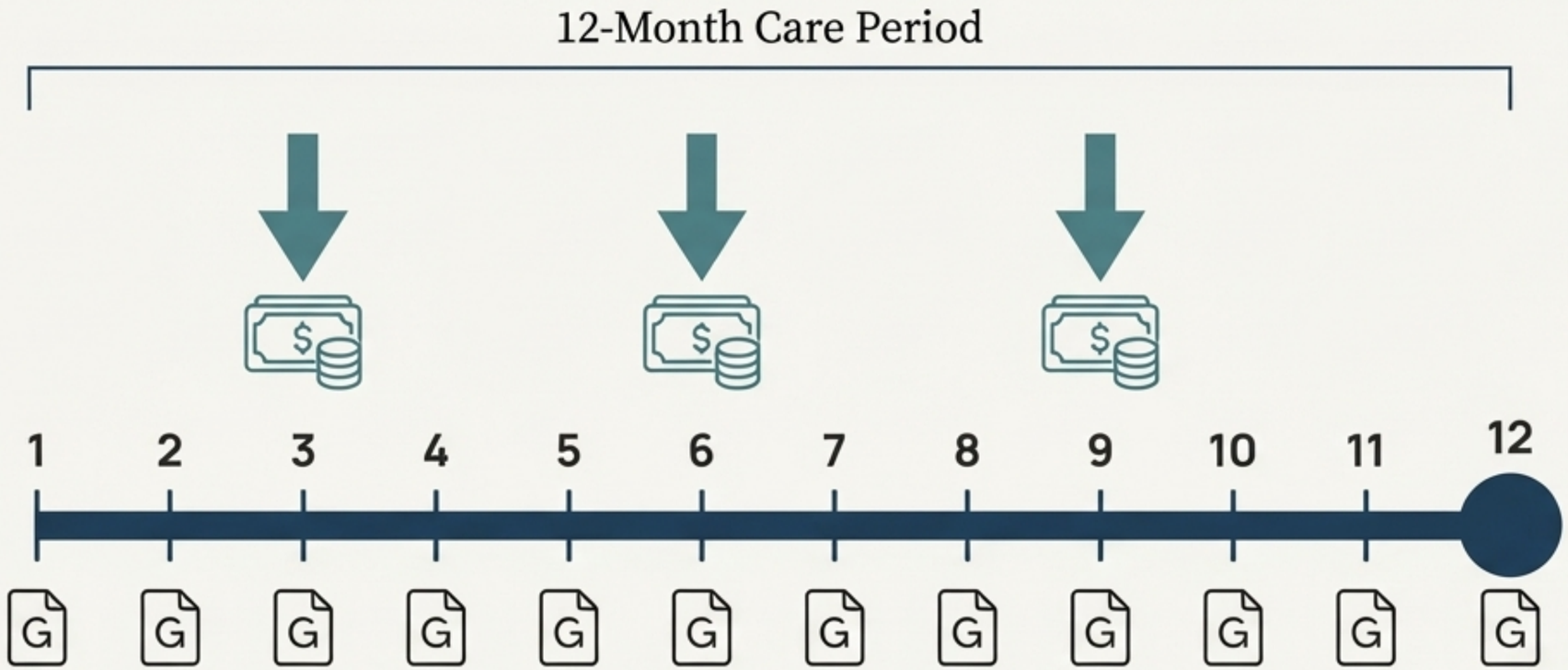
Full payment is contingent on achieving track-specific clinical outcome (OAP Measure) targets.

Example: a 10-mmHg reduction in systolic BP or final systolic BP below 130 mmHg for hypertension.

Unprecedented Flexibility

The model emphasizes accountability for *outcomes* rather than specific *activities*, allowing ACCESS Participants to adapt their care delivery approach to achieve results.

The OAP Lifecycle: From Billing to Reconciliation



Step 2: Quarterly Payments (Prospective)

Receive up to 50% of the total annual OAP amount in quarterly installments during the 12-month care period.

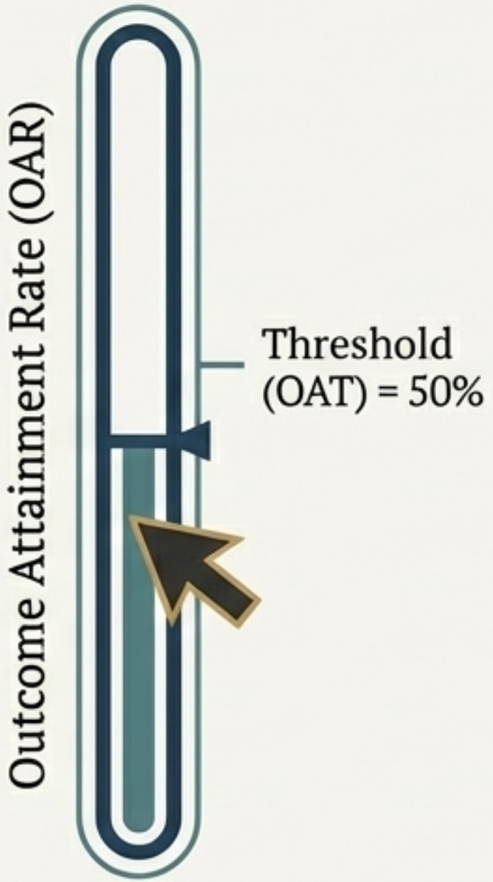
Step 3: End-of-Period Reconciliation (Retrospective)

The remaining 50% of the total annual OAP amount will be withheld and reconciled **after the 12-month care period concludes based on performance.**

Ensuring Value: How Performance Adjusts Final Payments

CMS will apply only the larger of the two potential downward adjustments, preventing compounded penalties.

Clinical Outcome Adjustment



Compares participant's Outcome Attainment Rate (OAR) to a CMS-set Outcome Attainment Threshold (OAT).

First-Year Threshold:

OAT is set at 50%.

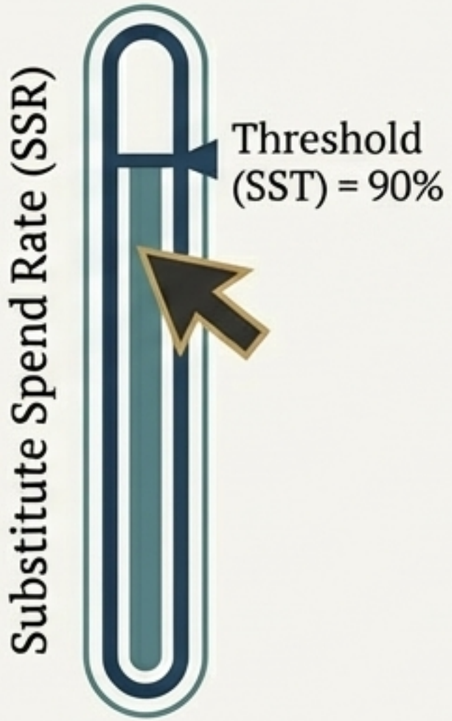
Formula:

If OAR < OAT, payment is adjusted by

$$1 - \left(\frac{\text{OAR}}{\text{OAT}}\right).$$

Capped at a 50% reduction.

Substitute Spend Adjustment



Compares participant's Substitute Substitute Spend Rate (SSR) to a CMS-set Substitute Spend Threshold (SST).

First-Year Threshold:

SST is set at 90%.

Formula:

If SSR < SST, payment is adjusted by

$$1 - \left(\frac{\text{SSR}}{\text{SST}}\right).$$

Capped at a 25% reduction.

Structuring Payments for Both Improvement and Maintenance

Initial Period (First 12 months)

Higher rate.

Reflects higher resource needs for “onboarding, establishing care relationships, and achieving initial clinical improvement.”

Qualifies When:
It’s the first time the participant is treating the beneficiary in that track (in last 2 years) AND at least one OAP measure is not at target.

Follow-On Period (Subsequent 12-month periods)

Lower rate.

Reflects lower resource needs for “continued management of beneficiaries already established in care or whose OAP measures are well controlled at baseline.”

Qualifies When:
Continuing care from an Initial Period, or initiating care for a beneficiary whose OAP measures are all at target.

Who Can Participate? Key Eligibility Criteria

- ✓ **Be a Medicare Part B–enrolled TIN** eligible to bill under the PFS (excluding DMEPOS/labs).
- ✓ **Be a legal entity** authorized to conduct business in each state of operation.
- ✓ **Designate a Medicare-enrolled physician as Medical Director** responsible for oversight of care.
- ✓ **Ensure all practitioners are individually Medicare-enrolled** and have reassigned billing rights to the TIN.
- ✓ **Comply with all applicable federal and state laws,** including HIPAA as a covered entity and FDA requirements for any regulated technologies used.
- ✓ **Successfully complete CMS program integrity screening.**

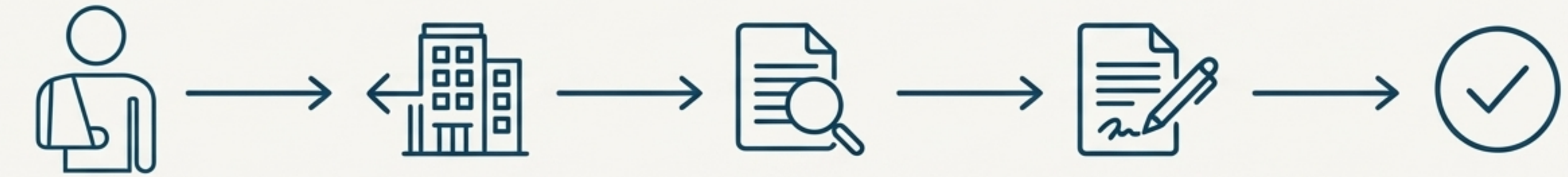
Serving the Patient: Beneficiary Eligibility and Alignment

Who is Eligible?

- Enrolled in Original Medicare (Parts A & B).
- Has a track-specific qualifying condition.
- Not enrolled in Medicare Advantage, PACE, or hospice.

Patient Protections

- Informed consent must be documented before enrollment.
- Beneficiaries can switch to a different participant or disenroll any time after 90 days.



How Does Alignment Work?

Alignment is **voluntary and prospective**. Beneficiaries enroll directly with the participant. Participant confirms eligibility via CMS APIs and obtains informed consent.

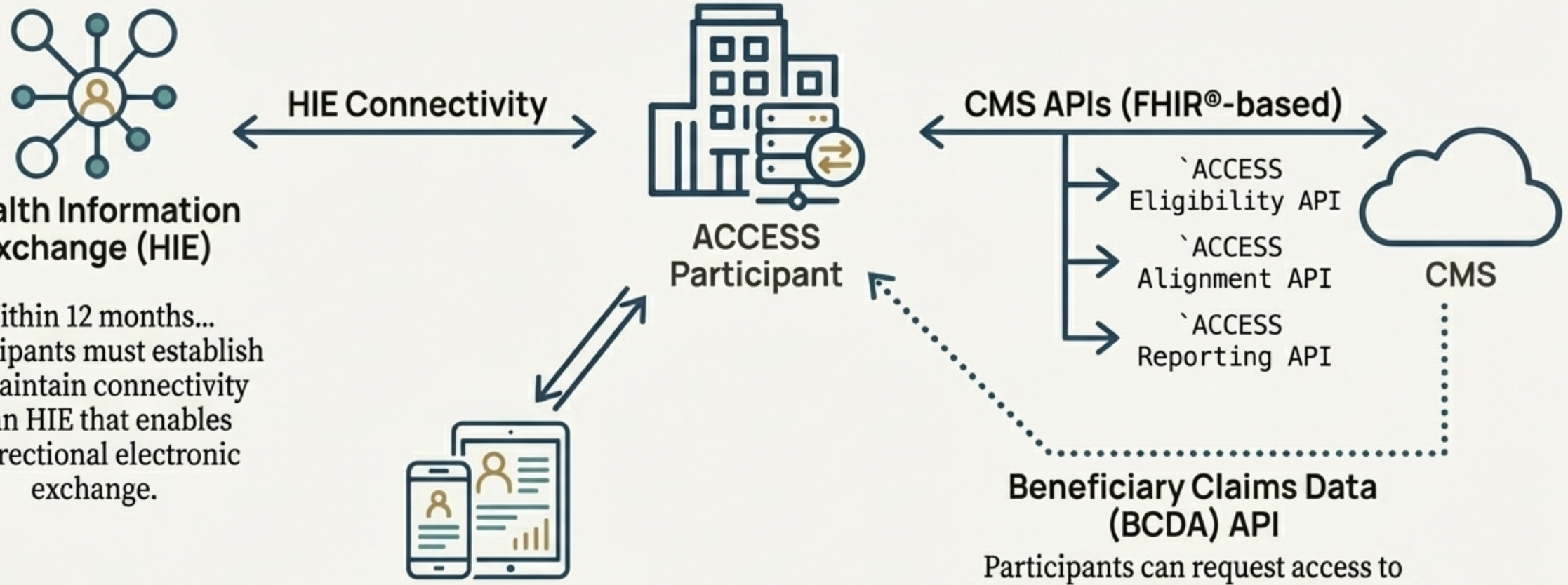
Integrating Care, Not Fragmenting It

The ACCESS Model is designed to function as a collaborative specialty service, working *with* a beneficiary's existing Primary Care Practitioner (PCP) and other clinicians.

Must make "reasonable, good-faith effort" to proactively share standardized clinical updates at key moments (Initiation, Completion, Escalation) using secure electronic methods.

A new payment of approximately $30 is available for "documented review of ACCESS updates and care coordination activities," encouraging collaboration.

Built on a Modern, Interoperable Technology Backbone



Health Information Exchange (HIE)

Within 12 months... participants must establish or maintain connectivity to an HIE that enables bidirectional electronic exchange.

Participant APIs

Must implement standardized APIs for patient and population services (45 CFR § 170.315(g)(10)).

Beneficiary Claims Data (BCDA) API

Participants can request access to beneficiary Medicare Parts A, B, and D claims data to support care coordination.

Your Roadmap to Participation

Jan 12, 2026: Applications Open

Apr 1, 2026: Initial Application Deadline

Jul 5, 2026: First Cohort Begins

Jan 1, 2027: Subsequent Cohorts Begin (Quarterly thereafter)

Apr 1, 2033: Applications Close

Jun 30, 2036: Model Performance Period Ends

Applications received after April 1, 2026 and before October 1, 2026 will be considered for participation beginning January 1, 2027.

The ACCESS Model: A New Pathway for Growth and Impact

The Strategic Opportunity

- **Predictable Revenue:** Move away from FFS uncertainty with stable, recurring OAPs.

- **Focus on Outcomes:** Get paid directly for improving patient health, not just for delivering services.

- **Expand Patient Access:** Serve the large Original Medicare population with a viable payment model.

- **Drive Competition on Quality:** A public-facing directory will highlight top performers based on risk-adjusted outcomes.

Your Next Steps

1. **Review** the full Request for Applications (RFA) and Participation Agreement.
2. **Assess** your organization's clinical and technical readiness against the model requirements.
3. **Prepare** application materials via the online portal.

For more information and to sign up for updates, visit: https://innovation.cms.gov/innovation-models/access