Executive Summary: ACCESS Model Payment Framework

Effective Period: July 5, 2026 – December 31, 2027

The ACCESS Model establishes a new outcome-aligned payment structure for organizations managing chronic conditions across four clinical tracks: Early Cardio-Kidney-Metabolic (eCKM), Cardio-Kidney-Metabolic (CKM), Musculoskeletal (MSK), and Behavioral Health (BH). Rather than paying per visit or procedure, CMS introduces recurring annual, per-beneficiary payments tied to measurable clinical and patient-reported outcomes.

The model is designed to support integrated, longitudinal management of chronic disease, with payment calibrated to condition complexity and expected resource intensity.

I. New Payment Rates (Outcome-Aligned Payment – OAP)

Annual Allowed Amounts Per Beneficiary

The ACCESS Model pays an annual per-beneficiary "Allowed Amount" that includes both Medicare payment (80%) and beneficiary coinsurance (20%).

1. Early Cardio-Kidney-Metabolic (eCKM)

- **Initial Period:** $360 per beneficiary per year
- **Follow-On Period:** $180 per beneficiary per year

2. Cardio-Kidney-Metabolic (CKM)

- **Initial Period:** $420 per beneficiary per year
- **Follow-On Period:** $210 per beneficiary per year

3. Musculoskeletal (MSK)

- **Initial Period Only:** $180 per beneficiary per year
- No Follow-On tier

4. Behavioral Health (BH)

- **Initial Period:** $180 per beneficiary per year
- **Follow-On Period:** $90 per beneficiary per year

Rural Adjustment

For eCKM and CKM beneficiaries in rural areas (Initial Period only), CMS provides an **additional $15 fixed payment** to offset higher operational costs (e.g., remote monitoring devices).

Payment Structure and Cash Flow

Monthly Payment Mechanics

- CMS pays **monthly installments equal to 1/12 of the Medicare portion (80%)** of the annual allowed amount.
- **50% of the Medicare payment is paid prospectively.**
- **50% is withheld and reconciled at year-end** based on performance.

This is a change from earlier quarterly payment frequency; CMS is now issuing monthly payments to improve predictability.

Example (CKM Initial Period – $420 annual allowed):

- Medicare portion = $336
- 50% paid monthly across 12 months
- Remaining 50% reconciled after performance review

II. Performance-Based Payment Adjustments

Although the annual amounts above represent maximum payment, ACCESS introduces two potential downward adjustments.

1. Clinical Outcome Adjustment

To earn full payment, organizations must meet an **Outcome Attainment Threshold (OAT)** of:

50% of aligned beneficiaries meeting all required clinical and PROM targets.

If at least 50% of beneficiaries achieve required outcome targets, the organization may receive 100% of the withheld amount. Performance below threshold triggers payment reductions.

This design balances accountability with patient engagement realities.

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2. Substitute Spend Adjustment (SST)

The model also reduces payments if beneficiaries receive defined "substitute services" outside the ACCESS participant.

- **Substitute Spend Threshold (SST): 90%**
- If spending on defined substitute services exceeds 90% of benchmark levels, payment is reduced.

For Behavioral Health, included substitute services include:

- Psychiatric diagnostic evaluations (90791, 90792)
- Collaborative care management (99492)
- Remote therapeutic monitoring (98975)
- Digital device supply/treatment codes (G0552, G0553)

This mechanism discourages duplicative or fragmented care outside the participant organization.

III. Multi-Track Discount

If a beneficiary is aligned to multiple tracks under the same ACCESS participant:

- CMS applies a **5% discount to the lowest-cost track(s)** during overlapping months.
- The discount reflects assumed administrative efficiencies.
- The discount does **not** apply to beneficiary coinsurance.

Example:
If a patient is enrolled in MSK ($180) and CKM ($360), the 5% reduction applies to the MSK payment.

IV. What These Payment Rates Mean Operationally

1. Not Fee-for-Service

These are not procedure-based payments. Medications, labs, imaging, and DME remain separately billable under existing Medicare rules.

OAP payments are intended to support:

- Care coordination
- Remote monitoring
- Clinical integration
- Outcome measurement infrastructure
- Digital device deployment
- Behavioral health integration
- Longitudinal chronic care management

2. Higher Initial Period Payments

The model recognizes onboarding intensity:

- Initial Period payments are exactly double Follow-On payments for eCKM, CKM, and BH.
- MSK has only a single-year model focused on functional restoration.

3. Modest Absolute Dollar Levels

Compared to traditional chronic care management or specialty episode models, the per-beneficiary annual amounts are relatively modest:

- $420 max for CKM
- $360 for eCKM
- $180 for MSK and BH

Financial viability depends heavily on:

- Scale
- Strong outcome performance (to avoid withholds)
- Avoidance of substitute spend penalties

V. Track-Specific Clinical Focus

Although payment amounts are uniform per track, required outcome measures differ:

eCKM & CKM

Targets include:

- Blood pressure control (<130 systolic or 15 mm Hg reduction)
- BMI control or 5% weight loss
- HbA1c targets (prediabetes/diabetes specific)
- LDL-C reduction (30 mg/dL reduction or control)
- CKM adds ASCVD-specific LDL thresholds (<70 mg/dL)
- Kidney monitoring (eGFR, uACR baseline reporting)

Behavioral Health

- PHQ-9 (5-point reduction if ≥10 baseline)
- GAD-7 (4-point reduction if ≥10 baseline)
- PGIC end-of-period submission required

Musculoskeletal

Focuses entirely on functional improvement and pain reduction using PROM-based targets:

- PROMIS Physical Function & Pain Interference (2-point change)
- ODI (8-point reduction)
- NDI (8-point reduction)
- QuickDASH (10-point reduction)
- HOOS JR / KOOS JR (10-point improvement)
- Pain intensity cannot worsen by >2 points

MSK has no "control" target—only minimum improvement thresholds.

VI. Strategic Implications

1. **Performance Risk Is Material**
   50% of Medicare payment is at risk until year-end reconciliation.
2. **Scale Is Essential**
   With modest annual amounts, participant viability depends on sufficient beneficiary volume.

3. **Infrastructure Investment Required**
   Reporting cadence includes:
   - Baseline within 60 days
   - Quarterly submissions
   - End-of-period reporting by Day 425
4. **Designed for Multi-Payer Alignment**
   CMS is offering standardized G-codes and FHIR-based reporting infrastructure to encourage Medicare Advantage and commercial adoption.

Conclusion

The ACCESS Model introduces a modest but highly structured outcome-aligned payment system for chronic disease management. Payment rates range from $90 to $420 annually per beneficiary depending on track and period, with 50% tied directly to outcome performance and potential reductions for substitute service spending.

Financial success will depend less on volume of visits or procedures and more on:

- Demonstrable clinical improvement,
- Care integration,
- Prevention of duplicative services,
- Effective beneficiary engagement,
- Strong reporting infrastructure.

The model represents a deliberate shift toward scalable, population-based chronic care accountability at relatively low per-beneficiary investment levels.

If helpful, I can next provide:

- A financial modeling example showing revenue under different performance scenarios,
- A comparison to Chronic Care Management (CCM) and Principal Care Management (PCM),
- Or an assessment of implications for Medicare Advantage plans.