

CMS Extends ACCESS Approach To MA, Medicaid, Private Insurers; Adds Physician Pay Incentives

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CMS has extended its new digital health outcomes-based payment experiment beyond the voluntary Medicare ACCESS demo to include Medicaid, Medicare Advantage and private insurers, and has added a new payment incentive for physicians to review digital technology progress reports.

Major public and private health care insurers have agreed to adopt a payment structure aligned with CMS' Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model that focuses on an outcome-based payments for technology-supported chronic care, indicating that payers are increasingly interested in incorporating digital health tools into treatment services. The Trump administration is making efforts to rebrand the Medicare fee-for-service pilot program into a broader payment reform across both private and public health care.

Earlier this week, CMS announced plans to add four additional tracks to ACCESS, including technology options for Medicare beneficiaries who have heart failure, chronic obstructive pulmonary disease (COPD), substance use disorders and nicotine dependence. The current model only covers technology used for early cardio, kidney and metabolic diseases like hypertension and diabetes, depression and anxiety, and musculoskeletal pain.

Representatives from Medicare Advantage, Medicaid and private health insurance including Blue Shield of California, Cigna, CVS Health and UnitedHealthcare also agreed to adopt an outcome-based payment system, the agency also revealed.

CMS also established a co-management payment (CMP) that compensates a physician for reviewing the ACCESS progress reports and for performing at least one care coordination activity. CMP will compensate eligible Medicare Part B practitioners that include physicians, nurse practitioners, physician assistants, nurse specialists, psychologists, clinical social workers, dietitians, physical and occupational therapists in private practice and mental marriage and family therapists, among others.

Federally Qualified Health Centers, Rural Health Clinics and Pharmacies will be eligible for CMP beginning Oct. 1.

“CMS pays approximately \$30 per instance through three condition-based billing codes, plus \$10 for initial onboarding and device setup, payable up to three times per year per beneficiary per track,” the American Medicine Association wrote about the program. “Critically, the CMP is additive -- it does not replace or affect existing billing for office visits or other covered services, carries no beneficiary cost-sharing, and requires documentation of the review.”

The care coordination activities include adjusting or reconciling medications, updating the problem list, establishing, modifying or monitoring follow-up instructions, coordinating care with other clinicians, communicating with ACCESS providers and documenting clinical agreement or disagreement with ACCESS recommendations. Beneficiary cost-sharing does not apply to CMP.

CMS said onboarding support and device application setup may include supporting the beneficiary in identifying an appropriate ACCESS health care provider for their needs, supporting enrollment with the ACCESS provider, and assisting with device, application or data-sharing setup. -- *Cara Smith*(csmith@iwpnews.com)