Advancing Chronic Care with Effective, Scalable Solutions (ACCESS)

Financial Structure and Clinical Performance Webinar

March 4, 2026

Centers for Medicare & Medicaid Services | Center for Medicare & Medicaid Innovation

Housekeeping and Logistics

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Agenda

1. Welcome and Introductions
2. ACCESS Model Overview
3. Participant Eligibility Criteria
4. Outcome-Aligned Payment Measures
5. Payment Operational Details
6. Q&A Session
7. Closing and Resources

CMS Remarks

Welcome and Introductions

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Today's Presenters

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ACCESS Model Overview

Model Overview

PROBLEM: Despite evidence of the effectiveness of technology-supported care solutions, **Original Medicare patients have limited access to them because of a lack of viable payment pathways.** Additionally, Medicare-enrolled practitioners who want to offer technology-supported care delivery models are often constrained by existing payment structures.

SOLUTION: Through ACCESS, CMS is testing a **new Outcome-Aligned Payment (OAP) option** that emphasizes outcomes over activities, enabling clinicians to offer innovative technology-supported care that improves patient health and complements traditional care.

Model Goals

- Empower patients to **achieve health goals** by improving access to new technology-supported care options.
- Promote technology-supported care that is **clinician guided**, **accountable, and coordinated.**
- Expand clinicians' **ability to offer innovative, technology-supported care** through a straightforward payment pathway.
- Encourage **transparency** by publishing risk-adjusted health outcomes of technology-supported care.

Clinical Tracks

The ACCESS Model focuses on four clinical tracks addressing many of the most common chronic conditions.

Track Overview

Early cardio-kidney-metabolic (eCKM): Hypertension, dyslipidemia (high or abnormal lipids, including cholesterol), obesity or overweight with marker of central obesity, and prediabetes

Cardio-kidney-metabolic (CKM): Diabetes, chronic kidney disease (CKD) (3a or 3b), and atherosclerotic cardiovascular disease (ASCVD), including heart disease

Musculoskeletal (MSK): Chronic musculoskeletal pain

Behavioral Health (BH): Depression and anxiety

Payment Framework

The ACCESS Model establishes a novel payment framework designed to expand Medicare beneficiary access to supported chronic care management, while maintaining accountability for clinical outcomes and coordinated care delivery.

Outcome-Aligned Payment (OAP) Framework Features

OAP Measure Targets

Specifies the clinical outcomes that participants must achieve to earn full payment, with personalized targets defined relative to each beneficiary's baseline clinical status.

OAP Amounts and Performance Thresholds

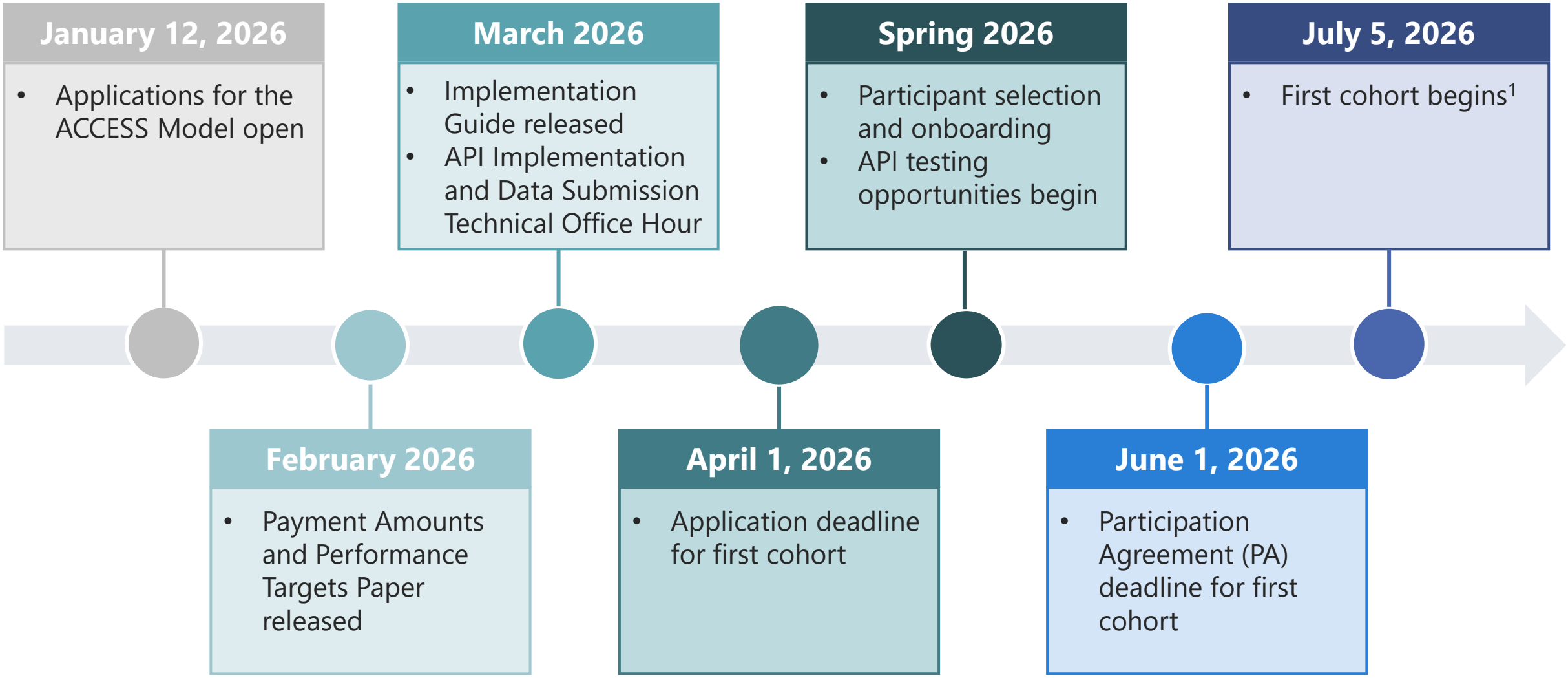
Defines the accountability standards through which participants earn payments, including the Substitute Spend Adjustment and Clinical Outcome Adjustment.

OAPs

Establishes fixed annual payment rates differentiated by clinical track and Care Period.[1]

[1]A Care Period refers to the 12 months during which an ACCESS Participant is responsible for delivering care for the attributed conditions and achieving specified clinical outcomes. A Care Period may refer to either the Initial Period or the Follow-On Period.

Timeline



[1]Subsequent cohorts begin January 1, 2027, and quarterly thereafter through July 1, 2033.

Participant Eligibility Criteria

Participant Eligibility Criteria

Organizations must meet the following criteria to participate in the ACCESS Model.

Be a Medicare Part B-enrolled organization, identifiable by a single tax identification number (TIN), that is eligible to bill under the Medicare Physician Fee Schedule (PFS).[1]

Be a legal entity formed under applicable state, federal, or Tribal law, and authorized to conduct business in each state in which it operates.

Designate and maintain a Medicare-enrolled physician as **Medical Director**, responsible for oversight of care delivery and model performance.

Ensure that all **physicians and non-physicians** who furnish or supervise care are **individually enrolled in Medicare** as participating providers or suppliers, have **reassigned their Medicare billing rights to the participating TIN**, and practice in accordance with applicable licensure and scope-of-practice requirements.

Submit and maintain an **up-to-date roster of all Medicare-enrolled practitioners** with National Provider Identifications (NPIs) furnishing or supervising care under the TIN.

[1]Excluding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and laboratory suppliers.

Enrolling in Medicare Part B

ACCESS Participants must be a Medicare Part B-enrolled organizational entity, identifiable by a single TIN and meet the criteria listed previously. **All practitioners furnishing or supervising care must also be individually Medicare-enrolled** and have reassigned their billing rights to the ACCESS Participant organization.

Step 1: Health care providers and suppliers need an NPI to enroll in Medicare Part B. To apply for an NPI, please visit the National Plan and Provider Enumeration System (NPPES) website.

Step 2: Complete the Medicare Enrollment Application

- **Enroll using Provider Enrollment, Chain, and Ownership System (PECOS),** the online Medicare enrollment system.
- PECOS has video and print tutorials for the enrollment process to ensure that applicant information is accurate.

Step 3: Work with Medicare Administrative Contractor (MAC)

- Based on the application type and practice location, PECOS will display the appropriate MAC and its address, which applicants should record for future reporting purposes.
- Applicants should check in with their MAC regarding their enrollment status. **See Contact Your MAC for more information.**

✓ **ACCESS Participants must also meet all standard Medicare participation requirements,** such as accepting Medicare assignment.

Outcome-Aligned Payment Measures

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Measure Target Framework

OAP Measure targets apply per Care Period, regardless of whether a beneficiary aligns with the same ACCESS Participant or a different ACCESS Participant in a subsequent Care Period. For each new Care Period, the applicable target is Minimum Improvement or Control relative to baseline.

Minimum Improvement

Minimum improvement reflects a minimum change relative to the baseline that is clinically meaningful, not the beneficiary's ultimate goal. OAP Measure targets operate alongside other model features, including public reporting of risk-adjusted outcomes, to support care quality.

Control

Control is defined as a guideline-directed target within the ACCESS Model that indicates a greater improvement in, or maintenance of, the qualifying condition. Patients may achieve control during the Care Period or have a baseline measurement at or below the model-defined control threshold at alignment. The ACCESS Participant's responsibility for these patients is achieving and/or maintaining control.

Example Paths to Success for Blood Pressure

The below example details paths to success for the Blood Pressure Improvement or Control measure for patients entering the model at different baseline values. Blood Pressure Control is defined as systolic blood pressure <130 mm Hg.

Baseline Systolic Blood Pressure	*Path to Success*	End-of-Period Systolic Blood Pressure
126 mm Hg	*Maintenance of Control*	<130 mm Hg
140 mm Hg	*Achievement of Control*	<130 mm Hg
152 mm Hg	*Minimum Improvement*	≤137 mm Hg

eCKM and CKM OAP Measures and Targets

Payment is contingent on achieving track-specific clinical outcomes (OAP Measures).

OAP Measure Name	eCKM Track	CKM Track
Blood Pressure (BP) Reduction or Control	• ***Control*:** Final systolic BP <130 mmHg • ***Min. Improvement*:** 15 mmHg reduction in systolic BP	• *See criteria for eCKM Track*
Weight Reduction or Control	• ***Control*:** Final BMI <30 kg/m^2 AND no more than 5% weight gain from baseline BMI[1] • ***Min. Improvement*:** 5% weight reduction	• *See criteria for eCKM Track*
Hemoglobin A1c (HbA1c) Reduction or Control	• ***Control*:** Prediabetes only: final HbA1c <6.5%; for all other beneficiaries, this is not applicable • ***Min. Improvement:*** Not applicable	• ***Control*:** Diabetes only: final HbA1c <7.5%; for all other beneficiaries, this is not applicable • ***Min. Improvement:*** Diabetes only: 1% point reduction; for all other beneficiaries, this is not applicable
Low Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	• ***Control:*** Dyslipidemia only: final LDL-C <100 mg/dL; for all other beneficiaries, this is not applicable • ***Min. Improvement*:** Dyslipidemia only: 30 mg/dL reduction; for all other beneficiaries, this is not applicable	• ***Control:*** Dyslipidemia only: final LDL-C <100 mg/dL; ASCVD only: final LDL-C <70 mg/dL; for all other beneficiaries, this is not applicable • ***Min. Improvement*:** Dyslipidemia or ASCVD only: 30 mg/dL reduction in LDL-C; for all other beneficiaries, this is not applicable
Kidney Health (eGFR and uACR)	• *Not applicable*	• Diabetes or CKD only: success is defined as submission of each baseline measure; for all other beneficiaries, this is not applicable

[1]BMI <30 kg/m^2 indicates absence of obesity and does not imply an ultimate clinical goal.

MSK OAP Measures and Targets

Payment is contingent on achieving track-specific clinical outcomes (OAP Measures).

OAP Measure	MSK Track	
Musculoskeletal Pain: Improvement in Physical Function (PF) and Pain Interference (PI)[1]	• **This track does not establish control targets for pain and function measures**, as the track is designed to incentivize minimum improvement rather than maintenance of existing symptom levels.	
	Any site or multiple sites of pain: Patient Reported Outcome Measurement Information System (PROMIS) PF short form (6b) or Version 2.0 Computer Adaptive Test (CAT) AND PROMIS PI short form (6a) or Version 2.0 Computer CATP15F	***Min. Improvement:*** 2-point reduction in PROMIS PI; AND 2-point increase in PROMIS PF (using T-score not raw)
	Lower back: Oswestry Disability Index (ODI)	***Min. Improvement:*** 8-point reduction (using score scale of 100 points)
	Neck: Neck Disability Index (NDI)	***Min. Improvement:*** 8-point reduction (using score scale of 50 points)
	Shoulder, arm, hand: Quick Disabilities of Arm, Shoulder & Hand (QuickDASH)	***Min. Improvement:*** 10-point reduction (using score scale of 100 points)
	Knee: Knee Injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS JR)	***Min. Improvement:*** 10-point increase (using score scale of 100 points)
	Hip: Hip Dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS JR)	***Min. Improvement:*** 10-point increase (using score scale of 100 points)
Pain Intensity	• ***Min. Improvement*:** No more than a 2-point increase in the Numeric Rating Scale (NRS) or PROMIS NRS v1.0 - Pain Intensity 1a	
Patient Global Impression of Change (PGIC)	• ***Min. Improvement*:** Not applicable • ***Note**:* Success is defined as submission of the end-of-period measure.	

[1]Participants must report one Patient Reported Outcome Measure (PROM) from the listed options in this OAP Measure, according to the beneficiary's anatomical site of pain.

BH OAP Measures and Targets

Payment is contingent on achieving track-specific clinical outcomes (OAP Measures).

OAP Measure	BH Track
Depression Reduction or Control	• ***Control*:** If baseline Patient Health Questionnaire-9 (PHQ-9) <10: Final PHQ-9 <10 • ***Min. Improvement*:** If baseline PHQ-9 ≥10: 5-point reduction
Anxiety Reduction or Control	• ***Control*:** If baseline General Anxiety Disorder-7 (GAD-7) <10: Final GAD-7 <10 • ***Min. Improvement*:** If baseline GAD-7 ≥10: 4-point reduction
PGIC	• ***Control*:** Not applicable • ***Min. Improvement*:** Not applicable • ***Note:*** Success is defined as submission of the end-of-period measure.
Overall Function (Optional)	• ***Control*:** Not applicable • ***Min. Improvement*:** Not applicable • ***Note:*** This measure -- the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) -- is optional for reporting for the Effective Period (July 5, 2026 – December 31, 2027).

Defining Success for Measures Without Measure Targets

Certain ACCESS Model measures require data submission, but do not require achievement of minimum improvement or control measure targets. The below measures support refinement of measure targets, while fulfilling monitoring requirements essential to comprehensive chronic disease management.

Kidney Health Monitoring

Required for: CKM track patients with diabetes or CKD at the start of each Care Period. Success is defined as submission of each baseline measure.

Purpose: Focusing on kidney health measures for patients with diabetes or CKD, especially the eGFR measure, ensures appropriate monitoring of kidney function progression in high-risk populations.

Success criteria: Timely submission of baseline eGFR and uACR measurements at the start of each Care Period. These measures have a clinical validity window of up to 1 year.[1]

Patient Global Impression of Change (PGIC)

Required for: All patients in the BH and MSK tracks.

Purpose: A one-question patient check-in on whether a patient is better, worse, or unchanged since treatment started. The PGIC is used to validate and set meaningful improvement thresholds on PROMs using PHQ-9, GAD-7, and MSK PROMs.

Success criteria: Submission of response data for the one-question PGIC assessment at the end-of-period only. All PROMs have a clinical validity window of up to 15 days.[1]

[1]The clinical validity window is defined as the maximum allowable time between the OAP Measure's collection date and submission date to CMS.

Payment Operational Details

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OAP Allowed Payment Amounts

ACCESS Participants receive recurring payments (OAPs) for managing beneficiaries' qualifying conditions, with full payment tied to achieving measurable health outcomes. The model establishes annual allowed payment amounts for Initial Periods and Follow-On Periods for each of the four clinical tracks.

Initial Period

- The Initial Period payment tier corresponds to the first time a participant is treating a beneficiary in the clinical track within the past two years and at least one OAP Measure is not at target.
- For beneficiaries in **rural areas** enrolled in eCKM or CKM tracks during the Initial Period, CMS will provide an additional fixed payment of $15 to account for higher operational costs for a connected BP cuff.

Follow-On Period

- The Follow-On Period payment tier reflects **lower resource needs** for continued management of beneficiaries already established in care or whose OAP Measures are well controlled at baseline.
- The MSK track is focused on reducing or resolving chronic pain during the Initial Period and does not include an optional Follow-On Period.

Payment Allowed Amounts Per Track[1]		
Clinical Track	**Initial Period**	**Follow-On Period**
eCKM	$360 per year	$180 per year
CKM	$420 per year	$210 per year
MSK	$180 per year	N/A (No Follow-On Period)
BH	$180 per year	$90 per year

[1]OAPs are calibrated to reflect expected resource needs for ACCESS Participants to provide integrated, technology-enabled care for each clinical track.

Payment Frequency and Multi-Track Discount

CMS reimburses participants with monthly payments and periodic reconciliations and applies payment discounts when beneficiaries are enrolled in multiple clinical tracks managed by the same ACCESS Participant.

Payment Frequency

- CMS issues **monthly** payments on eligible monthly claims submitted by participants, up to 50% of the Medicare portion of the annual OAP allowed amount (months 1-6).
- Each monthly payment is equal to one-twelfth of the Medicare portion of the annual OAP allowed amount.
- The withheld payments (months 7-12) are reconciled after the 12-month Care Period concludes through the Clinical Outcome Adjustment and Substitute Spend Adjustment processes.

Multi-Track Discount

- If a beneficiary is enrolled in **multiple** tracks managed by the **same** ACCESS Participant, CMS applies a 5% payment discount to the monthly OAP amount of the lowest cost track(s).
  - **If the overlap occurs in the first six months**, CMS applies the 5% discount to the monthly OAP payments of the lowest cost track(s), regardless of whether measure targets are met. If the overlap occurs in the last six months of a beneficiary's alignment, CMS applies the discount through the reconciled OAP.
- The multi-track discount is not applied to the beneficiary's coinsurance responsibility for ACCESS services.
- If a beneficiary is enrolled in different tracks with different ACCESS Participants, no multi-track discount applies.

Multi-Track Discount Example

When a beneficiary is enrolled in multiple tracks with the same ACCESS Participant, CMS applies a 5% payment discount to the Medicare paid amount of the lowest cost track(s) for the duration of the overlap.

1

eCKM Enrollment

Months 1-12:

Patient Enrolls with ACCESS Participant

Medicare annual payment amount: $288 ($24/month)

2

MSK Enrollment

Month 7:

Enrolls with same ACCESS Participant

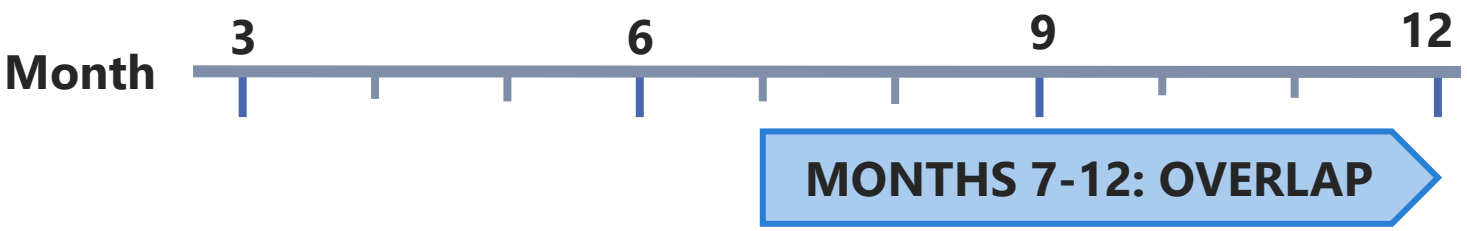
Medicare annual payment amount: $144 ($12/month)

3

Reconciliation

CMS applies 5% discount to MSK for overlap months (7-12)

Calculation: (5% x ($144 / 12) x 6) = $3.60 Total



- ✓ **Total Adjustment for Months 7-12 of Overlap: $3.60 ($0.60 per month)**
- ✓ CMS applies the discount for each month of overlap (total 6 months in this example) for the lowest cost track(s) in the Care Period (MSK in this example) if the OAP withheld payment is greater than zero

OAP Performance-Based Adjustment Thresholds

The ACCESS Model uses an OAP methodology that links payment to achieving measurable outcomes. Payment amounts are subject to two potential downward adjustments: a Clinical Outcome Adjustment and a Substitute Spend Adjustment, the greater of which will be applied to the OAP.

Substitute Spend Adjustment

- The Substitute Spend Adjustment reduces OAPs when aligned beneficiaries receive duplicative substitute services from other Medicare providers above a defined **Substitute Spend Threshold (SST).**
- Each clinical track includes a **Substitute Spend List** identifying services considered substitutes if provided by another Medicare entity for any condition in the clinical track.
- Slide 27 details how the Substitute Spend Adjustment is calculated and applied.

Clinical Outcome Adjustment

- To determine the Clinical Outcome Adjustment, CMS calculates the ACCESS Participant's success rate (the **Outcome Attainment Rate**) and compares it to a defined performance threshold for success (the **Outcome Attainment Threshold**).
- Slide 30 will provide further details on how clinical outcome adjustment is calculated and applied.

Substitute Spend Adjustment

The Substitute Spend Adjustment reduces OAPs when aligned beneficiaries receive duplicative substitute services from other Medicare providers above a defined Substitute Spend Threshold (SST).

Substitute Spend Rate (SSR) =

$$\frac{\text{Number of aligned beneficiaries who did not receive listed substitute services from other providers or suppliers for any conditions in the clinical track for which the beneficiary is enrolled}}{\text{Total number of aligned beneficiaries}}$$

The Substitute Spend Threshold (SST) is established at 90% for the model's Effective Period,[1] which represents the minimum SSR needed to earn full payment.

If the SSR is below 90%, then the participant will receive a proportional payment, calculated as (SSR ÷ SST) multiplied by the total annual OAP amount. **The maximum reduction will be 25% of the OAP.**

Care provided by non-ACCESS entities for services on the Substitute Spend List will continue to be reimbursed under standard Medicare payment rules.

[1]The Effective Period is defined as July 5, 2026 – December 31, 2027.

CKM and eCKM Services in Substitute Spend Adjustment

This list of included services for the CKM and eCKM tracks is generally limited to services that represent the initiation of new care and which CMS considers to be substitutes.

CKM and eCKM Tracks Service Type	HCPCS/CPT® Codes
Ambulatory Blood Pressure Monitoring	93784, 93786, 93788, 93790
Ambulatory Continuous Glucose Monitoring	95249-95251
Remote Physiologic Monitoring (RPM) (includes Self-Measured Blood Pressure Monitoring (SMBP)): Device Set-up	99453, 99473
Diabetes Self-Management Training (DSMT)	G0108
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease	G0446
Intensive Behavioral Therapy (IBT) for Obesity	G0447
Medical Nutrition Therapy (MNT): Individual Initial Visit	97802
Remote Therapeutic Monitoring (RTM): Patient Education and Device Set-up	98975
Medicare Diabetes Prevention Program (MDPP)	G9880, G9881, G9886, G9887

MSK and BH Services in Substitute Spend Adjustment

This list of included services for the MSK and BH tracks is generally limited to services that represent the initiation of new care and which CMS considers to be substitutes.

MSK Track Service Type	HCPCS Codes
Physical Therapy (PT) Evaluation	97161-97163
Occupational Therapy (OT) Evaluation	97165-97167
Remote Therapeutic Monitoring (RTM): Patient Education and Device Set-up	98975

BH Track Service Type[1]	HCPCS/CPT® Codes
DHMT: Supply of Digital Device and Monthly Treatment	G0552, G0553
Psychiatric Diagnostic Evaluation	90791, 90792
Remote Therapeutic Monitoring (RTM): Patient Education and Device Set-up	98975
Initial Psychiatric Collaborative Care Management	99492

[1]The BH Track Service Type table replaces version 1 of the RFA's Appendix Table 3 for the list of services included in the Substitute Spend Adjustment for the BH Track.

Clinical Outcome Adjustment: Outcome Attainment Rate

To determine the Clinical Outcome Adjustment, the ACCESS Participant's success rate, known as the Outcome Attainment Rate (OAR), is calculated and compared to a defined performance threshold for success, the Outcome Attainment Threshold (OAT).

The **Outcome Attainment Rate (OAR)** is the percentage of beneficiaries who completed their period and met all outcome targets and submission requirements.

$$\text{OAR} = \frac{\text{Number of Successful Episodes}}{\text{Total Number of Episodes}} \times 100$$

The **number of successful episodes** is defined as the number of nonexcluded beneficiaries who have achieved all measure targets and submission requirements.

For an aligned beneficiary to be counted toward a Participant's OAR, all their required OAP Measures for the applicable track **must be reported on time and their targets met.**

The **total number of episodes** is defined as the number of nonexcluded beneficiaries aligned to the ACCESS Participant's track for the applicable time period.

Beneficiaries who relocate outside an ACCESS Participant's licensed service area and beneficiaries who become ineligible during the Care Period are excluded from the numerator and denominator of the OAR calculation.

Clinical Outcome Adjustment

CMS calculates the Clinical Outcome Adjustment by comparing the ACCESS Participant's success rate (the OAR) and comparing it to the Outcome Attainment Threshold (OAT), which is the minimum OAR that ACCESS Participants must achieve to receive the full withheld payment amount.

The OAT will be 50% from July 2026 through the end of 2027 for all ACCESS Participants.

≥ **If OAR ≥ 50%**, then the participant receives **100% of the withheld amount** for all eligible OAP amounts for the assessed patient panel.

< **If OAR < 50%,** then the participant receives a proportionally reduced payment calculated as:

$$\textbf{Clinical Outcome Adjustment} = \frac{\text{OAR}}{\text{OAT}}$$

Q&A Session

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Open Q&A

Please type your question in the **Q&A box.**

If we do not get to your question, we welcome you to email the ACCESS Team at **ACCESSModelTeam@cms.hhs.gov**. We will aim to answer unaddressed questions via email and upcoming FAQs.

Closing and Resources

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What's Next?

Mid-March

Join us for an **API Implementation and Data Submission Technical Office Hour** that will discuss the Implementation Guide, data submission requirements, and APIs.

Upcoming

Scoring methodology, denominator exclusions, billing guidelines, and additional operational details will be included in a forthcoming paper.

Resources

Email: ACCESSModelTeam@cms.hhs.gov

Visit: ACCESS Model Webpage; Applications must be submitted via the **Participant Portal** by April 1, 2026.

ACCESS Resources: Refer to the Implementation Guide (coming soon), **Model Payment Amounts and Performance Targets Paper**, and the **Request for Applications** (RFA) for more information.

MAC Resources: Many MACs, such as **Novitas**, **Noridian**, **First Coast Service Options**, and **Wisconsin Physician Services** have more information on Medicare Part B enrollment on YouTube.

Listserv: Sign up for updates via the **ACCESS Model Listserv.**

Thank You

We appreciate your time and interest!

Please share your feedback via the survey following this event.

Questions? Email **ACCESSModelTeam@cms.hhs.gov**