# Advancing Chronic Care with Effective, Scalable Solutions (ACCESS)

## Meeting ACCESS' Health IT and Interoperability Requirements

July 23, 2026

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

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- A Q&A summary will be distributed after the webinar.

# Agenda

1. Welcome & Introductions
2. Sharing Care Updates
3. Connecting to Health Information Exchange
4. Making API(s) Available
5. Referrals: Digital Contact Information & 360X
6. Questions & Answers

# Introductions

**Nora Connor**

*ACCESS Model Co-Lead, CMS Innovation Center*

**Jacob Shiff**

*Chief AI & Technology Officer, CMS Innovation Center*

**Denise St. Clair**

*Vice President, Health Policy & Interoperability Global Alliant*

**Brett Andriesen**

*Deputy Director, Standards Division, ONC*

# Care Coordination in ACCESS

**Primary Care Practitioner (PCP) or Referring Clinician**

**Patient**

**ACCESS Participant**
***(Medicare-enrolled Provider or Supplier)***


**1**

**Patient enrolls in ACCESS for chronic care** by signing up directly with ACCESS Participant, with optional enrollment support from PCP or referring clinician.

Use the **ACCESS Participant Directory** to find an appropriate option.

**2**

**CARE UPDATES ARE SHARED**
at key points in care

**Start of Care**
Care plan and baseline measures

**Escalation**
If care is transitioned

**Completion**
Summary at the end of care period

*Received via HIPAA-compliant secure electronic method (e.g., Direct Secure Messaging, network-supported push mechanism, or complaint eFax)*

**CLINICAL DATA ARE ACCESSIBLE**
in EHR workflow

**Biomarkers**
BP, HbA1c, LDL-C, weight

**PROMs**
e.g., PHQ-9

**Medications**
where applicable

*Accessible by querying a CMS Aligned Network or Health Information Exchange*

**3**

**PCP and referring clinician bills** co-management payment for reviewing updates and care coordination activity (e.g., problem or medication list update).

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**3**

**ACCESS Participant bills** outcome-aligned payments for treating qualifying chronic conditions.

# Sharing Care Updates

*From Section 4.05 of the Participation Agreement*

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# Identifying the Care Team

Annually determines whether each beneficiary has an Identified Care Team: PCP, a coordinating or referring clinician or entity, and any other clinician CMS identifies.

- This requirement is met when the Participant:
  - Reviews any CMS-supplied information provided at alignment or realignment, which may list Medicare providers or suppliers associated with the beneficiary *[not currently available]*
  - Asks the beneficiary at alignment to provide or confirm their current PCP *and* any clinicians or entities that referred them or furnish care for their Qualifying Condition(s) — and documents the results.
- If these two requirements have been met and the ACCESS Beneficiary does not identify or confirm a current Identified Care Team, CMS considers this obligation satisfied.
- Participants must obtain consent to proactively share Care Updates with the Identified Care Team

# Identifying the Care Team

**Tip 1**

Sharing Care Updates with the Identified Care Team supports care coordination. Only practitioners that receive Care Updates can bill the Co-Management Payment.

Review "ACCESS Co-Management Payment (CMP) Billing Guidance" for all eligible practitioners types

## Who can bill the Co-Management Payment?

- All Physicians
- Nurse Practitioners
- Physician Assistants
- Certified Clinical Nurse Specialists
- Clinical Psychologists / Psychologists Billing Independently
- Licensed Clinical Social Workers
- Registered Dietitians / Nutrition Professionals
- Physical Therapists in Private Practice
- Occupational Therapists in Private Practice
- Speech Language Pathologists in Private Practice
- Marriage and Family Therapists
- Mental Health Counselors

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) – beginning October 2026
- Pharmacists

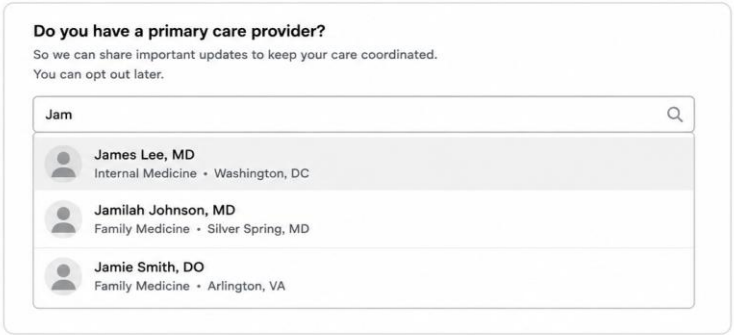
# Identifying the Care Team

## Tip 2

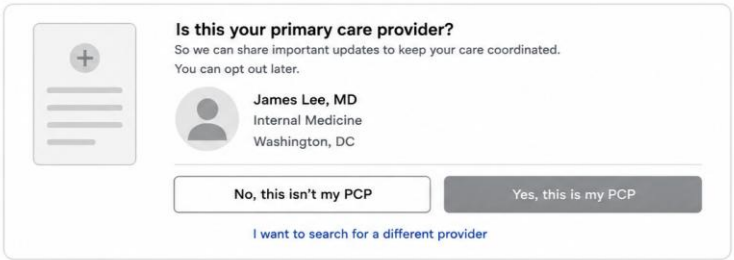
Consider tools like CMS Provider Directory API (Beta) and medical records to make it easy for patients to identify and confirm their Identified Care Team.

Sample User Flow

**1) "Do you have a primary care provider?" auto-complete**




**2) "Is this your PCP? Based on your medical records"**



# Identifying the Care Team

## Makes a reasonable effort to determine how to contact the Identified Care Team

- For example, by referencing a Health Information Exchange (HIE), geographic directory of providers, DirectTrust directory, National Plan and Provider Enumeration System (NPPES) endpoint listing or Health Information Service Provider
- Verify the information is sent only to the recipient by confirming the provider's or supplier's name, NPI, and practice affiliation in a trusted directory, or NPPES listing.
- If the Participant cannot confirm the Identified Care Team’s identity or secure endpoint or no valid contact information is available after making a reasonable effort to do so, then then CMS considers this obligation satisfied;

# Sharing Care Updates

## Proactively sends or attempts to send required Care Updates through a HIPAA-compliant secure electronic method

- For example, via Direct Secure Messaging, a HIE-supported push mechanism, a subscription-based mechanism, or an electronic fax solution
- Documents the outcome of the attempt;
- Must use the template form provided by CMS, or a substantially equivalent format that includes all required elements and information contained in the CMS template
- Note: If the Participant sends the Care Update to a HIPAA-compliant portal maintained by the Participant, CMS will not deem this requirement fulfilled unless the portal is part of an established data-sharing relationship or technical integration with the Identified Care Team

# Sharing Care Updates

## Required Care Updates

**Baseline Data Submission**. Within 10 Days of submission of all baseline OAP Measures.

**Care Completion**. Within 30 Days after the end of the Care Period.

**Care Escalation**. Within 10 Days of any transition of the ACCESS Beneficiary to another practitioner or care setting due to clinical needs exceeding the scope of ACCESS services.

## Sample Care Update

**Subject:** ACCESS Care Update — Care Initiation — J. Doe

This Care Update is part of ACCESS, a Centers for Medicare & Medicaid Services (CMS) model designed to support patients with chronic conditions alongside their existing care. The patient below has enrolled in ACCESS with CKMCo, a Medicare-enrolled health care provider. You are receiving this update as a clinician associated with this patient. No action is required. You may be eligible to bill a co-management payment by reviewing this update and completing at least one care coordination activity. Learn more: go.cms.gov/access

**Patient:** Jane Doe | DOB: 03/14/1957

**From:** CKMCo | ckmco.com | Dr. Richard Roe, MD | ckmco@direct.ckmco.com

**Track:** Early Cardio-Kidney-Metabolic (eCKM)

**Qualifying Conditions:** Prediabetes (R73.09), Dyslipidemia (E78.5)

**Care Start:** 02/03/2026 | **Update Date:** 02/10/2026

**Clinical Measures**

BP: Baseline 118/74 mmHg | Most Recent 118/74 mmHg | Target SBP <130 mmHg

Weight: Baseline 172 lbs | Most Recent 172 lbs | Target No >5% gain from baseline

HbA1c: Baseline 6.2% | Most Recent 6.2% | Target <6.5%

LDL-C: Baseline 128 mg/dL | Most Recent 128 mg/dL | Target <100 mg/dL

**Assessment:** Ms. Doe is a 68-year-old woman with prediabetes and dyslipidemia enrolled in the eCKM track following referral from her primary care physician. She reports a sedentary schedule and a diet high in processed foods but is motivated to make changes. LDL-C is elevated above target. HbA1c is consistent with prediabetes and at risk of progression without intervention. BP and weight are within acceptable range at initiation.

**Plan**

*HbA1c:* No medication indicated at this time. Care plan focuses on lifestyle intervention to prevent progression to Type 2 diabetes. Ms. Doe is engaged in nutrition and behavioral coaching through the ACCESS program, with emphasis on reducing refined carbohydrates, increasing fiber intake, and building sustainable habits. HbA1c to be monitored throughout the care period.

*LDL-C:* Rosuvastatin 10mg daily initiated. LDL-C target <100 mg/dL. Labs monitored by CKMCo care team; results will be shared with referring clinician upon receipt.

Participant must make the contents of each Care Update shared with the Identified Care Team reasonably accessible to the ACCESS Beneficiary for viewing.

# Connecting to Health Information Exchange

*From Section 4.07(B)(1) of the Participation Agreement*

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- **PROMs** — e.g., PHQ-9
- **Medications** — where applicable

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# Connecting to Health Information Exchange

- By July 6, 2027, establish or maintain connectivity to an HIE, a CMS Aligned Network, or a similar trusted network that enables bidirectional electronic exchange across the geographic areas where Participants deliver services.
    - Designated QHINs for TEFCA exchange also meet this requirement.
- Make the following available for access and query by other providers involved in the beneficiary's care:
    - Outcome-Aligned Payment (OAP) Measures with the most recent value and collection date and time, the baseline value, and the outcome target.
    - Data for any medications managed under the Model, consistent with the United States Core Data for Interoperability (USCDI) standard (45 CFR § 170.213).

# How do I satisfy the HIE query access requirement for OAP Measures?

- Participants may use a range of approaches, provided the data are electronically accessible by other providers participating in that network. Examples include:
  - Making data available for query within an HIE, including through API-based exchange; or
  - Including OAP Measure data in clinical documents shared through an HIE, such as a C-CDA document
- Participants must make available all OAP Measures for the track(s) in which a beneficiary is enrolled. At a minimum, this includes the most recent value and collection date and time and the baseline value.

**Tip** Making OAP Measure data accessible to coordinating clinicians supports integrated care and establishes you as a trusted partner.

# Making APIs Available

*From Section 4.07(B)(2) of the Participation Agreement*

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# Make Available a (g)(10) Standardized API

- By July 6, 2027, make available one or more APIs that meet the ONC "Standardized API for patient and population services" criterion at 45 CFR § 170.315(g)(10).
  - Formal certification to (g)(10) is not required — the API must meet the criterion's capabilities.
  - Support at minimum the most recent version of USCDI adopted by ONC (45 CFR § 170.213).
- This requirement ensures that patients and authorized providers access and exchange electronic health information using FHIR®-based standards.
- This requirement is distinct from the requirement that ACCESS organizations are capable of connecting to CMS' ACCESS APIs.

# Referrals

*Digital contact information and 360X closed-loop electronic referrals*

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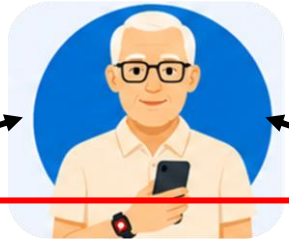

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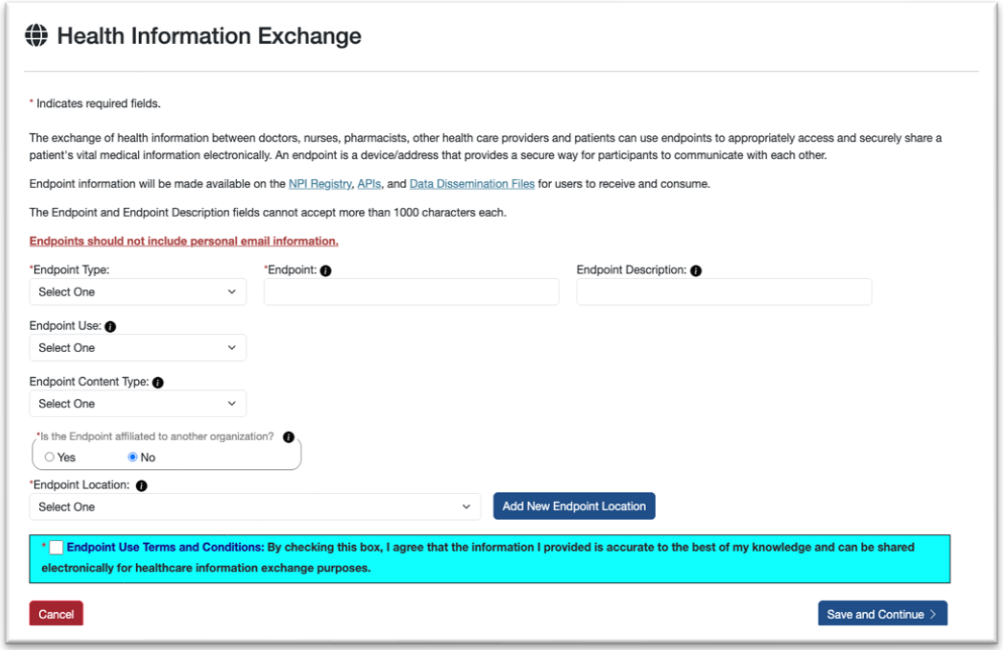
# Referrals: Digital Contact Information

- To help clinicians identify and refer patients to ACCESS services, CMS will make Participants' digital contact information available through the ACCESS Participant Directory.
- The directory will be maintained using information from NPPES.
- **Participants should review their organization's NPPES record and confirm digital contact information is accurate, active, and appropriate for the exchange methods they support:**
  - Direct Secure Messaging addresses;
  - FHIR / API service endpoints; or
  - Other applicable electronic exchange endpoints.

**Tip** Accurate digital contact information makes it easier for referring clinicians to identify your organization and send you referrals

# Referrals: Digital Contact Information



# What is 360X?

## A workflow standard; not new infrastructure

- Launched by ONC in 2012 to support referral exchange across different EHRs and HISPs.
- Published through IHE Patient Care Coordination as a 360X Referral Management profile.
- Designed for production workflows where each referral has persistent patient and referral identifiers.

## Closing the Loop isn’t always simple

Real-world questions that come up constantly:

- What if the need is urgent?
- What if the patient doesn't show up?
- How does the referring provider know if the patient was even scheduled?
- What if there are multiple encounters, or the referral is no longer needed?

**No proprietary referral network is required.**

# How 360X Works

## Built on existing standards

| | |
|---|---|
| **Clinical Content** | **C-CDA** |
| **Workflow/Status** | **HL7 v2** |
| **Metadata/Context** | **XDM** |
| **Secure Transport** | **Direct: SMTP + S/MIME** |

## Workflow Overview

| Step | Direction | Data & Documentation |
|---|---|---|
| Referral Request | Initiator → Recipient | Patient, Referral Identifier, Priority, Reason, etc. / Referral Note |
| Referral Request Response (Accept/Decline) | Recipient → Initiator | Patient, Referral Identifier, Status (Accept/Decline) |
| Referral Scheduled Notification (optional) | Recipient → Initiator | Patient, Referral Identifier, Date/time of appointment, Location, Provider |
| Referral No-Show Notification (optional) | Recipient → Initiator | Patient, Referral Identifier, Status (No-Show) |
| Referral Findings ("Close the Loop") | Recipient → Initiator | Patient, Referral Identifier, Status / Consult Note |

**A referral isn't a single message, it's a workflow with defined states.**

**A defined message structure for each state and persistent identifiers (Patient ID, Referral ID – both established by Initiator) ensure both sides stay in sync.**

# Alignment with ACCESS

| | |
|---|---|
| **Identify Care Team contact info via HIE, DirectTrust, NPPES — 4.05(C)(2)(i)** | 360X referrals travel via Direct and are discoverable through the same DirectTrust/HIE directories already named in ACCESS guidance |
| **Confirm identity / secure endpoint before sending — 4.05(C)(2)(ii)** | Direct Secure Messaging uses verified, X.509 certificate-based endpoints as a built-in property of the transport layer |
| **Send via HIPAA-compliant secure electronic method — 4.05(C)(2)(iii)** | Direct + S/MIME is one of the methods named explicitly in ACCESS guidance |
| **Document outcome of attempt — 4.05(C)(2)(iv)** | HL7 v2 status messages (accept/decline, scheduled, no-show, findings) create a documentable trail as part of 360X workflow |
| **Care Escalation (10 days) & Care Completion (30 days) timing — 4.05(D(2)(ii)-(iii)** | 360X tracks state transitions in real time, so deadlines are measured against actual referral events, not reconstructed after the fact |

**ACCESS Participants can leverage required connectivity instead of creating or purchasing referral tracking tools**

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## Reach out via phone or web

202-690-7151

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## Learn more

360X Project and Implementation Guide
bit.ly/360Xreferrals

IHE Patient Care Coordination 360X Referral Management Profile
IHE PCC Technical Framework Supplement 360X Trial Implementation

## Contact

Brett Andriesen
Brett.Andriesen@hhs.gov

# Questions and Answers

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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 a Q&A summary distributed following the webinar.

# Helpful Resources on the CMS Website

| Resources | Link to Materials |
|---|---|
| ACCESS Model Request for Applications (RFA) | https://www.cms.gov/priorities/innovation/files/access-rfa.pdf |
| ACCESS Model Payment Amounts and Performance Targets | https://www.cms.gov/priorities/innovation/files/access-payments-amts-perf-targets.pdf |
| ACCESS Model Application Programming Interface (API) Implementation Guide | https://github.com/DSACMS/cmmi-access-model |
| ACCESS API Operations Manual | https://github.com/DSACMS/cmmi-access-model/blob/main/ACCESS%20API%20Operations%20Manual.pdf |
| ACCESS OAP Billing Guidelines | https://www.cms.gov/priorities/innovation/files/access-oap-billing-guidelines.pdf |
| ACCESS Care Update Template and Samples | https://www.cms.gov/priorities/innovation/files/access-care-update-template.pdf |
| ACCESS Beneficiary Notices Reference | https://www.cms.gov/priorities/innovation/files/access-bene-notices-reference.pdf |

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Please take the survey following this webinar so we can learn how to make our events better.

Questions?  Email ACCESSModelTeam@cms.hhs.gov