



Centers for Medicare & Medicaid Services
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**Advancing Chronic Care with Effective, Scalable
Solutions (ACCESS) Model**

Model Payment Amounts and Performance Targets
Effective Period: July 5, 2026 – December 31, 2027*

*This document provides guidance on technical policy related to payment and performance for this Effective Period based on the requirements established in the ACCESS Model's [Request for Applications](#).

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Outcome-Aligned Payment (OAP) Annual Allowed Amounts

ACCESS Participants receive recurring payments (OAPs) for managing beneficiaries' qualifying conditions, with full payment tied to achieving measurable health outcomes. The Initial Period payment tier reflects the higher resource needs associated with onboarding, establishing care relationships, and achieving initial clinical improvement. Participants qualify for the Initial Period payment when it is the first time the organization is treating the beneficiary in the clinical track within the past two years and at least one required OAP Measure is not at target. 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. 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 for the Initial and Follow-On Period (where applicable) for all tracks.

Allowed amounts represent the maximum annual payment per beneficiary for each track and include both the Medicare program payment (80 percent) and beneficiary coinsurance (20 percent).¹ Allowed amounts do not reflect potential downward payment adjustments resulting from the Clinical Outcome Adjustment or Substitute Spend Adjustment applied to the Medicare paid amount. Table 1 displays the annual payment allowed amounts by track for the Effective Period.

Table 1: Annual Payment Allowed Amounts by Track

Clinical Track	Initial Period	Follow-On Period
Early Cardio-Kidney-Metabolic (eCKM)	\$360	\$180
Cardio-Kidney-Metabolic (CKM)	\$420	\$210
Musculoskeletal (MSK)	\$180	N/A - No Follow-On Period
Behavioral Health (BH)	\$180	\$90

For beneficiaries residing in rural areas aligned to the Early Cardio-Kidney-Metabolic (eCKM) or Cardio-Kidney-Metabolic (CKM) tracks during the Initial Period, CMS will provide an additional fixed payment of \$15 to offset higher operational costs related to connected device distribution and support.

OAPs are calibrated to reflect expected resource needs for Participants to provide integrated care for each clinical track. Medications, laboratory tests, imaging, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) may be prescribed, ordered, or coordinated by Participants but are billed separately under applicable Medicare payment methodologies by financially unaffiliated entities, as described in the RFA. Additional guidelines regarding how OAPs may support the use of clinical devices, such as connected blood pressure cuffs and wearables, are described in the [Technical FAQs](#).

CMS will issue instructions to Participants on billing for the ACCESS Model, including the specific G-codes, in advance of model launch.

¹ ACCESS Participants may adopt a uniform policy to waive collection of beneficiary coinsurance, consistent with model requirements.

Payment Frequency

CMS will issue monthly payments equal to one-twelfth of the Medicare portion of the annual OAP allowed amount for valid monthly claims submitted by ACCESS Participants. This represents a change from the quarterly payment frequency described in version 1 of the RFA, providing Participants with more frequent and predictable payments. The sum of monthly payments may not exceed 50 percent of the Medicare portion of the annual OAP allowed amount. The remaining 50 percent will be withheld and reconciled after the 12-month care period concludes through the Clinical Outcome Adjustment and Substitute Spend Adjustment processes.

Multi-Track Discount

When a beneficiary is aligned to multiple tracks with the same ACCESS Participant, CMS applies a 5 percent discount to the monthly OAP (or through the reconciled OAP if the overlap occurs in the last 6 months of a beneficiary's alignment) of the lowest cost track(s) to reflect administrative and operational efficiencies associated with delivering integrated care. For example, if a beneficiary is enrolled with the same ACCESS Participant in the MSK track (annual allowed amount \$180) and, seven months later, enrolls in the eCKM track (annual allowed amount \$360), CMS applies a 5 percent discount to the MSK track for each month the two tracks overlap, because MSK has the lower allowed amount. If a beneficiary is aligned to three tracks with the same ACCESS Participant, during any overlapping months CMS will apply the discount to the two lowest cost tracks. The multi-track discount is not applied to the beneficiary's coinsurance responsibility for ACCESS services. If a beneficiary is aligned to different clinical tracks with different ACCESS Participants, no multi-track discount applies, and each ACCESS Participant receives the full Medicare portion of the allowed amount for their respective track(s).

OAP Performance-Based Adjustment Thresholds

The ACCESS Model uses an OAP methodology that links payment to achieving measurable clinical and patient-reported outcomes. Payment amounts are subject to two potential downward adjustments: a Clinical Outcome Adjustment and a Substitute Spend Adjustment.

Clinical Outcome Adjustment

An ACCESS Participant's Outcome Attainment Threshold (OAT) represents the minimum percentage of their aligned beneficiaries who must complete their Care Period and meet all required OAP Measure targets (i.e., minimum improvement or control) to earn full payment. During the Effective Period, the OAT will be 50 percent for all ACCESS Participants.² In other words, an organization can potentially earn 100 percent of payment for their aligned beneficiaries if at least 50 percent of their beneficiaries meet the required OAP Measure targets.

Substitute Spend Adjustment

The Substitute Spend Adjustment in the ACCESS Model reduces OAPs when aligned beneficiaries receive defined substitute services from other Medicare providers above a defined Substitute Spend

² This includes Participants in their first and subsequent year of participation. The first year of participation refers to the first year that an organization or financially affiliated entities participates in the ACCESS Model or a given track.

Threshold (SST). During the Effective Period, the SST will be 90 percent for all ACCESS Participants.² The list of services included in the Substitute Spend Adjustment for the eCKM, CKM, and MSK tracks are available in the Request for Applications (RFA). Table 2 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.

Table 2: Update to RFA v. 1 Appendix Table 3: Services Included in Substitute Spend Adjustment for BH Track

Service Type	HCP/CS / 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

To be included in the Substitute Spend Adjustment calculation, these services must be furnished by another Medicare-enrolled provider or supplier during the beneficiary’s ACCESS Care Period, and the principal diagnosis code on the claim must match any qualifying condition in the beneficiary’s ACCESS track. This initial list of included services is generally limited to services that represent the initiation of new care for the same ACCESS diagnosis which CMS believes could reasonably be considered substitutes.

OAP Measures Details

Quality Measurement in ACCESS

All OAP Measure specifications are designed specifically for use in the ACCESS Model. CMS will regularly evaluate and may update OAP Measures and OAP Measure targets based on model data, evolving clinical guidelines, and changes in the evidence base to ensure they remain clinically relevant, evidence-based, and consistent with model goals and accessibility.

Each OAP Measure has an associated Control target and Minimum Improvement target, unless otherwise specified, and the measure is met if either is achieved. These targets are described in Tables 3 to 6. Minimum Improvement, as defined for these targets, reflects a minimum change that is clinically meaningful, not the beneficiary’s ultimate clinical goal. For example, if an eCKM beneficiary begins the Initial Period with a systolic blood pressure (SBP) of 160 mm Hg, they would have a minimum improvement target of 145 mm Hg by the end of the 12-month period; however, the ultimate clinical goal is to bring SBP below 130 mm Hg. OAP Measure targets operate alongside other model features—including public reporting of risk-adjusted outcomes—to support care quality. Setting the minimum result required to earn payment relative to each beneficiary’s starting point reduces incentives to avoid beneficiaries who are far from control targets at baseline.

Outcome Attainment

For an aligned beneficiary to be counted toward a Participant’s Outcome Attainment Rate (OAR), all their required OAP Measures for the applicable track must be reported on time and their targets met. Partial target attainment does not constitute success. Failure to submit a valid measure for any

required OAP Measure within the end-of-period reporting window constitutes non-attainment for that beneficiary for that Care Period. Optional measures do not affect outcome attainment and may be reported at the participant’s discretion, though they may inform public reporting and future measure refinement. Overall payment is determined at the organization level through the OAT, set at 50 percent, which allows ACCESS Participants to earn full payment based on strong overall performance even if some beneficiaries do not meet all targets—balancing patient-level accountability with model accessibility.

$$OAR = \frac{\text{number of nonexcluded beneficiaries who have achieved all measure targets and submission requirements}}{\text{number of nonexcluded beneficiaries aligned to the Participant's track for the applicable time period}}$$

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 Control (if not yet achieved) or Minimum Improvement relative to the new baseline.

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. Beneficiaries who initiate unalignment or who are lost to follow-up remain in the denominator for inclusion in the OAR calculation. The 50 percent OAT is intended to provide ACCESS Participants with flexibility to achieve success despite some level of beneficiary disengagement.

OAP Measure Validity

An OAP Measure submission is considered “valid” if it meets the Data Collection Requirements (as specified in Appendix C of the RFA or amended in this document) and has a collection date that satisfies the applicable clinical validity window.

Each OAP Measure has a clinical validity window, defined as the maximum allowable time between the OAP Measure’s collection date and submission date to CMS, as follows:

- LDL-C: Up to 1 year for beneficiaries with dyslipidemia; up to 2 years for all other beneficiaries
- HbA1c: Up to 1 year for beneficiaries with prediabetes or diabetes; up to 2 years for all other beneficiaries
- Blood pressure: Up to 15 days
- Weight and BMI: Up to 15 days
- eGFR: Up to 1 year
- uACR: Up to 1 year
- All PROMs: Up to 15 days

OAP Measures may be obtained from external sources, such as Health Information Exchanges or CMS Aligned Networks, provided that the collection date, data source, and measurement methodology meet

model requirements.³ For example, an ACCESS Participant aligning a beneficiary without prediabetes to the eCKM track may submit an HbA1c value collected up to 24 months prior to the date of submission as a baseline OAP Measure, provided it meets data collection standards.

Data Reporting

Baseline Reporting

Valid baseline OAP Measures must be submitted within 60 days of alignment via the Data Reporting Application Programming Interface (API).⁴ If baseline data are not received within this timeframe, the beneficiary will be unaligned, and the ACCESS Participant may not provide services under the model. If reporting was delayed and the ACCESS Participant wishes to initiate care, the ACCESS Participant must resubmit the beneficiary for alignment via the Alignment API.

Valid baseline OAP Measures are required at the start of each Care Period. A previously submitted OAP Measure does not need to be re-submitted if it continues to meet all validity requirements at the start of the new Care Period. For example, for a beneficiary in the eCKM track without prediabetes, an HbA1c collected within two years satisfies the baseline requirement. If an HbA1c collected six months prior to the Initial Period was submitted at baseline, that same value remains valid at the start of a subsequent Follow-On Period. However, if the HbA1c submitted at the start of the Initial Period was already 13 months old, a new HbA1c would be required at the start of the Follow-On Period, as the prior value would exceed the two-year clinical validity window.

Quarterly Reporting

Valid quarterly OAP Measures must be submitted 70 to 110 days after the prior OAP Measure submission. Timely submission of all required quarterly OAP Measures is considered in calculating OAR attainment and is also required to satisfy the active care delivery requirement for continued billing, as described in the RFA. Quarterly OAP Measure values are not used for payment determination and are collected for monitoring, auditing, and evaluation purposes only.

End-of-Period Reporting

Valid end-of-period measures must be submitted no later than 425 days from the date of alignment (365 days plus an additional 60 days) and may be submitted up to 90 days prior to Day 365 for the eCKM and CKM tracks or up to 180 days prior to Day 365 for the BH and MSK tracks (“early success reporting”).

Payment is limited to months for which ACCESS claims are submitted. Early success reporting does not itself entitle the ACCESS Participant to payment for remaining months. If an ACCESS Participant submits final OAP Measures before Day 365, that ACCESS Participant may continue submitting monthly ACCESS claims for the beneficiary for the remainder of the 12 months, provided that that

³ Except for weight and PROMs, patient self-reported values are not permitted for OAP Measures; OAP Measures must meet the Data Collection Requirements as specified in Appendix C of the RFA or amended in this document. In general, lab values obtained from established clinical data sources such as Health Information Exchanges or CMS Aligned Networks may be presumed to meet Data Collection Requirements, absent reason to believe otherwise.

⁴ Additional technical guidance will be released before model launch regarding FHIR[®] API specifications and data submission processes.

ACCESS Participant continues to deliver active care as defined in the RFA.⁵ This includes the requirement that ACCESS Participants continue to report quarterly and end-of-period OAP Measures, as applicable. Worsening of OAP Measure values after early success reporting will not negate earlier success; however, CMS will use these values for monitoring, auditing, and evaluation.

⁵ Per the RFA, active care delivery refers to ongoing provision of services consistent with ACCESS Model requirements as described in this application, including patient engagement, monitoring, and timely collection and reporting of applicable OAP Measures. Patient engagement may include periodic check-ins with the beneficiary and does not require a specific type or intensity of encounter beyond what is clinically appropriate.

Table 3: OAP Measures List for the eCKM Track

Measure Name	Type	Metric	OAP Measure Target		Reporting Frequency	Notes
			Control	Minimum Improvement		
Blood Pressure (BP) Reduction or Control	Clinical Measure	BP (Systolic and Diastolic)	Final systolic BP < 130 mm Hg	15 mm Hg reduction in systolic BP	Baseline, quarterly, and end of period	Both systolic and diastolic BP must be reported. OAP determination is based on systolic BP only.
Weight Reduction or Control	Clinical Measure	Weight and Body Mass Index (BMI) Optional: waist circumference	Final BMI < 30 kg/m ² AND no more than 5% weight gain from baseline. ⁶	5% weight reduction	Baseline, quarterly, and end of period	Not Applicable
Hemoglobin A1c (HbA1c) Reduction or Control	Clinical Measure	HbA1c	Prediabetes only: Final HbA1c < 6.5% All other beneficiaries: Not Applicable	Not Applicable	Baseline (all beneficiaries); end-of-period (prediabetes only)	Baseline HbA1c is required for all beneficiaries at the start of each Care Period. For beneficiaries without prediabetes, success is defined as submission of the baseline measure.
Low-Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	Clinical Measure	LDL-C Optional: triglycerides, total cholesterol, High-Density Lipoprotein (HDL)	Dyslipidemia only: Final LDL-C < 100 mg/dL All other beneficiaries: Not Applicable	Dyslipidemia only: 30 mg/dL reduction All other beneficiaries: Not Applicable	Baseline (all beneficiaries); end-of-period (dyslipidemia only)	Baseline LDL-C is required for all beneficiaries at the start of each Care Period. For beneficiaries without dyslipidemia, success is defined as submission of the baseline measure.

In future model years CMS may consider adding a measure of physical fitness or activity to the eCKM/CKM tracks.

⁶ BMI <30 kg/m² indicates absence of obesity and does not imply an ultimate clinical goal.

Table 4: OAP Measures List for the CKM Track

Measure Name	Type	Metric	OAP Measure Target		Reporting Frequency	Notes
			Control	Minimum Improvement		
Blood Pressure (BP) Reduction or Control	Clinical Measure	BP (Systolic and Diastolic)	Final systolic BP < 130 mm Hg	15 mm Hg reduction in systolic BP	Baseline, quarterly, and end of period	Both systolic and diastolic BP must be reported. OAP determination is based on systolic BP only.
Weight Reduction or Control	Clinical Measure	Weight and BMI Optional: waist circumference	Final BMI < 30 kg/m ² AND no more than 5% weight gain from baseline. ⁷	5% weight reduction	Baseline, quarterly, and end of period	Not Applicable
Hemoglobin A1c (HbA1c) Reduction or Control	Clinical Measure	HbA1c	Diabetes only: Final HbA1c < 7.5% All other beneficiaries: Not Applicable	Diabetes only: 1% point reduction All other beneficiaries: Not Applicable	Baseline (all beneficiaries); end-of-period (diabetes only)	Baseline HbA1c is required for all beneficiaries. For beneficiaries without diabetes, success is defined as submission of the baseline measure.
Low-Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	Clinical Measure	LDL-C Optional: triglycerides, total cholesterol, HDL	Dyslipidemia only: Final LCL-C < 100 mg/dL; or, for those with Atherosclerotic Cardiovascular Disease (ASCVD), Final LDL-C < 70 mg/dL All other beneficiaries: Not Applicable	Dyslipidemia or ASCVD only: 30 mg/dL reduction in LDL-C All other beneficiaries: Not Applicable	Baseline (all beneficiaries); end-of-period (dyslipidemia and ASCVD only)	Baseline LDL-C is required for all beneficiaries at the start of each Care Period. For beneficiaries without dyslipidemia or ASCVD, success is defined as submission of the baseline measure.

⁷ BMI <30 kg/m² indicates absence of obesity and does not imply an ultimate clinical goal.

Measure Name	Type	Metric	OAP Measure Target		Reporting Frequency	Notes
			Control	Minimum Improvement		
Kidney Health Monitoring: eGFR ⁸	Clinical Measure	eGFR ⁹	Not Applicable	Not Applicable	Baseline (diabetes and chronic kidney disease (CKD) only)	Baseline eGFR and uACR are only required for beneficiaries with a diagnosis of diabetes, CKD at the start of each Care Period. Success is defined as submission of each baseline measure.
Kidney Health Monitoring: uACR	Clinical Measure	uACR ¹⁰	Not Applicable	Not Applicable		

⁸ Estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR) are essential markers for detecting and staging CKD, which strongly influences cardiovascular and metabolic risk. By initially focusing on beneficiaries with diabetes and CKD, this measure encourages appropriate monitoring of kidney function progression in high-risk populations. Performance targets were not set given disease trajectory variability and insufficient clinical consensus on a performance target methodology. Measure data will also be used for monitoring, evaluation, and public reporting.

⁹ eGFR should be estimated calculated using clinically validated methods appropriate to the patient population and clinical context. For adults, accepted methods include serum creatinine-based eGFR equations (e.g., 2021 Chronic Kidney Disease Epidemiology Collaboration [CKD-EPI 2021]), cystatin C based eGFR when creatinine is unreliable and testing is unavailable, combined creatinine–cystatin C eGFR when greater precision is clinically indicated, or 24 hour urine eGFR (utilizing a creatinine clearance calculation) (e.g., 24-hour urine collection) when estimation equations are unreliable or impractical.

¹⁰ Only quantitative uACR tests are compliant for reporting. Point-of-care semi-quantitative dipstick tests, urine protein-to-creatinine ratio (uPCR), and total urine protein (UP) tests do not meet the measure requirements. A positive result from any of these screening tests should prompt further evaluation with a confirmatory quantitative test which result can be used for reporting. For the purpose of the measure, the recorded result must come from either a direct quantitative uACR, or a quantitative urine albumin test and a quantitative urine creatinine test from the same specimen. A first-morning urine sample is preferred clinically, but for the measure, any valid quantitative uACR performed during the measurement period is acceptable.

Table 5: OAP Measures List for the BH Track

Measure Name	Type	Metric	OAP Measure Target		Reporting Frequency	Notes
			Control	Minimum Improvement		
Depression Reduction or Control	Patient-Reported Outcome Measure (PROM)	Patient Health Questionnaire-9 (PHQ-9)	If Baseline PHQ-9 < 10: Final PHQ-9 < 10	If Baseline PHQ-9 ≥ 10: 5 point reduction	Baseline, quarterly, and end of period	Beneficiary must have a minimum baseline score of 10 on the PHQ-9 to be included in the Initial Period on the basis of depression only. ¹¹
Anxiety Reduction or Control	PROM	General Anxiety Disorder (GAD)-7	If Baseline GAD-7 < 10: Final GAD-7 < 10	If Baseline GAD-7 ≥ 10: 4 point reduction	Baseline, quarterly, and end of period	Beneficiary must have a minimum baseline score of 10 on the GAD-7 to be included in the Initial Period on the basis of anxiety only. ¹¹
Patient Global Impression of Change (PGIC)	PROM	PGIC ¹²	Not Applicable	Not Applicable	End of period	Success is defined as submission of the end-of-period measure.
Overall Function	PROM	Optional: World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) 12-item	Not Applicable	Not Applicable	Baseline and end of period	<i>This measure is optional for reporting in the Effective Period.</i> ¹³

¹¹ Beneficiaries who score 0 – 9 in the PHQ-9 and GAD-7 at baseline are not eligible for the Initial Period; these beneficiaries are eligible to align directly in the Follow-on Period, if the beneficiary was referred by a provider and has a documented history of depression in the past 18 months (either with prior clinical documentation, or an International Classification of Diseases (ICD)-10 code indicating a qualifying diagnosis).

¹² The PGIC questionnaire is a one-question, patient-reported measure that captures a person’s global assessment of improvement or worsening since the start of treatment. This assessment will provide anchor-based validation and calibration of patient-reported outcome-performance measure (PRO-PM) improvement targets by linking patients’ subjective ratings of change to score changes on other PROMs in each track. Measure data will also be used for monitoring and evaluation.

¹³ The WHODAS 2.0 12-item is a PROM that assesses overall function and disability. CMS aims to introduce an OAP Measure of functional improvement for patients with anxiety or depression, serving as a complement to standard measures of symptoms (PHQ-9/GAD-7). Data from this measure will inform a potential future OAP Measure.

Table 6: OAP Measures List for the MSK Track

Measure Name	Type	Metric	OAP Measure Target		Reporting Frequency	Notes
			Control ¹⁴	Minimum Improvement		
Musculoskeletal Pain: Improvement in Physical Function and Pain Interference <i>Participants must report <u>one</u> PROM from the listed options in this OAP Measure, according to the beneficiary's anatomical site of pain.¹⁵</i>	PROM	Any site or multiple sites of pain: PROMIS Physical Function (PF) short form (6b) or Version 2.0 Computer Adaptive Test (CAT) <u>AND</u> PROMIS Pain Interference (PI) short form (6a) or Version 2.0 Computer CAT. ¹⁶	Not Applicable	2 point reduction in PROMIS PI; AND 2 point increase in PROMIS PF (using T-score not raw)	Baseline, quarterly, and end of period	The minimum improvement target is the same whether the designated short form or CAT is used.
		Lower back: Oswestry Disability Index (ODI)	Not Applicable	8 point reduction (using score scale of 100 points)	Baseline, quarterly, and end of period	Not Applicable
		Neck: Neck Disability Index (NDI)	Not Applicable	8 point reduction (using score scale of 50 points)	Baseline, quarterly, and end of period	Not Applicable
		Shoulder, arm, hand: Quick Disabilities of Arm, Shoulder & Hand (QuickDASH)	Not Applicable	10 point reduction (using score scale of 100 points)	Baseline, quarterly, and end of period	Not Applicable

¹⁴ The MSK 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. This design reflects the model's focus on achieving functional restoration within a single 12-month Care Period.

¹⁵ ACCESS Participants must use the same PROM for each beneficiary throughout the period. The PROMIS instruments may be used for all sites of pain.

¹⁶ CMS is seeking to make available an optional, CMS-hosted application that Participants may elect to use to administer PROMIS CAT instruments within their own applications or workflows.

Measure Name	Type	Metric	OAP Measure Target		Reporting Frequency	Notes
			Control ¹⁴	Minimum Improvement		
		Knee: Knee Injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS JR)	Not Applicable	10 point increase (using score scale of 100 points)	Baseline, quarterly, and end of period	Not Applicable
		Hip: Hip Dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS JR)	Not Applicable	10 point increase (using score scale of 100 points)	Baseline, quarterly, and end of period	Not Applicable
Pain Intensity	PROM	NRS ¹⁷ or PROMIS NRS v1.0 - Pain Intensity 1a	Not Applicable	No more than 2 point increase	Baseline, quarterly, and end of period	Required for all beneficiaries in the MSK track, regardless of qualifying condition.
Patient Global Impression of Change (PGIC)	PROM	PGIC	Not Applicable	Not Applicable	End of period	Required for all beneficiaries in the MSK track, regardless of qualifying condition. Success is defined as submission of the end-of-period measure.

¹⁷ The Numeric Rating Scale (NRS), sometimes referred to as the Numeric Pain Rating Scale (NPRS), and equivalent PROMIS Pain Intensity 1a, is a one-question/single-item survey that assesses pain intensity on an 11-point scale of 0 is "no pain" and 10 is the "worst imaginable pain."

Additional Related Policies

Outreach and Awareness

ACCESS Participants may engage in direct outreach to potentially eligible beneficiaries and referring healthcare providers consistent with applicable marketing and other legal requirements, including the Anti-Kickback Statute and the Physician Self-Referral Law. Beneficiaries may align directly with an ACCESS Participant or by following a referral from a clinician; a referral is not required.

CMS will support beneficiary and referring clinician awareness of the ACCESS Model. This support may include awareness campaigns among beneficiaries and clinicians; and a CMS-hosted public directory of ACCESS Participants and their risk-adjusted outcomes once model data becomes available.

Multi-Payer Alignment

The ACCESS Model is designed to support potential adoption by other payers, including Medicare Advantage, Medicaid, commercial plans, enabling alignment across payers, reducing health care provider burden, and scaling impact. Specifically, CMS is making available new resources to facilitate alignment with the ACCESS Model, including:

- Reference Documents: Provider agreement template and payment adjustment code (including Clinical Outcome Adjustment and Substitute Spend Adjustment calculations)
- Standardized Billing Codes: Track-specific G-codes useable by any payer for consistency in billing and performance analytics
- Fast Healthcare Interoperability Resources (FHIR®)-Based Reporting Infrastructure: FHIR®-based reporting API for payers that wish to align on CMS' OAP Measures, where payers can instruct providers to submit OAP Measures to CMS' API. CMS will seek to deliver the data to payers, within our operational capabilities and legal authorities, on recurring basis for their own payment determinations

Appendix A: Patient-Reported Outcome Measure (PROM) Details

Patient Global Impression of Change (PGIC)

The Patient Global Impression of Change (PGIC) is a single-item patient-reported outcome measure that captures a person's overall perception of improvement or worsening since the start of treatment.

- **Number of items:** 1
- **Recall window:** Since the start of treatment
- **Measure steward / distributor:** Public domain.
- **Required version:** Original Guy/Farrar version.
- **Scoring:** The PGIC is scored as a single ordinal item with response options on a 7-point Likert Scale ranging from “very much improved” (1) to “very much worse” (7) (Original Guy/Farrar version).

World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

The WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) 12-item is a patient-reported outcome measure assessing disability and functioning across six domains: cognition, mobility, self-care, interpersonal interactions, life activities, and participation.

- **Number of items:** 12
- **Recall window:** Past 30 days
- **Measure steward / distributor:** World Health Organization (WHO).
 - The measure is free for non-commercial, clinical, and research purposes, including by participants in the ACCESS Model. Users must submit a permission request form through WHO (see [Licensing WHO Classifications](#)). WHODAS is also included in the new [ICD-11](#) under the V Supplementary section for functioning assessment.
- **Required version:** WHODAS 2.0 (12-item version). © World Health Organization 2010
- **Scoring:** Simple scoring sums responses (0–4: None, Mild, Moderate, Severe, Extreme) for a total range of 0–48, with higher scores indicating greater disability.
- **More information:** [WHODAS resources website](#)

Numeric Rating Scale (NRS)

The Numeric Rating Scale (NRS), sometimes referred to as the Numeric Pain Rating Scale (NPRS), and equivalent PROMIS Pain Intensity 1a, is a single-item patient-reported outcome measure

assessing pain intensity. Patients rate their pain on an 11-point numeric scale ranging from 0 ("no pain") to 10 ("worst imaginable pain"), reflecting pain experienced over a specified recall period.

- **Anatomical site of pain:** Multiple sites of pain or any site of pain.
- **Number of items:** 1
- **Recall window:** Past 7 days
- **Measure steward / distributor:**
 - **NRS:** Public domain. The original pain rating scale was developed by [Melzack and Torgerson \(1971\)](#), and later by [Downie et. al \(1978\)](#).
 - **PROMIS:** HealthMeasures (PROMIS®, National Institutes of Health). The original English-language PROMIS measures are publicly available without license fees for non-commercial research, education, and clinical practice. [HealthMeasures.net](#) is the central hub for accessing and managing PROMIS measures, requiring registration and adherence to terms. Integrating PROMIS into digital platforms (like EHRs, apps) requires HealthMeasures Electronic Administration Permission (HEAP).
- **Required version:**
 - **NRS:** Not versioned
 - **PROMIS:** PROMIS Numeric Rating Scale v1.0 – Pain Intensity 1a
 - **More information:** [HealthMeasures.net: PROMIS Numeric Rating Scale version 1.0 - Pain Intensity 1a](#)
- **Scoring:** Patients select a whole number from 0 (“no pain”) to 10 (“worst imaginable pain”) representing pain intensity over a specified recall period. The selected value is the score; higher scores indicate greater pain intensity.

PROMIS Physical Function (PF) (Short Form 6b or CAT)

PROMIS Physical Function (PROMIS PF) is a patient-reported outcome measure assessing an individual’s self-reported capability to perform physical activities, including upper- and lower-extremity function, central (trunk) activities, and instrumental activities of daily living. PROMIS Physical Function can be administered as a fixed-length short form (6b) or via computer adaptive testing (CAT) to efficiently estimate physical functioning across a wide range of ability levels.

- **Anatomical site of pain:** Multiple sites of pain or any site of pain. This PROM is to be combined with PROMIS Pain Interference (PI) for administration.
- **Number of items:**
 - **Short Form 6b:** 6
 - **CAT:** Variable (typically 4–12 items). Full Version 2.0 item bank includes 165 items.
- **Recall window:** Current ability
- **Measure steward / distributor:** HealthMeasures (PROMIS®, National Institutes of Health). The original English-language PROMIS measures are publicly available without license fees

for non-commercial research, education, and clinical practice. [HealthMeasures.net](https://www.healthmeasures.net) is the central hub for accessing and managing PROMIS measures, requiring registration and adherence to terms. Integrating PROMIS into digital platforms (like EHRs, apps) requires HealthMeasures Electronic Administration Permission or HEAP.

- CMS is seeking to acquire a license for use by participants in the model. The optional CAT administration is also dependent on meeting technical requirements.
- **Required version:**
 - **Short Form:** PROMIS Short Form v2.0 – Physical Function 6b
 - **CAT:** PROMIS Bank v2.0 – Physical Function
 - **More information:** [HealthMeasures.net: Obtain and Administer Measures](https://www.healthmeasures.net/obtain-and-administer-measures)
- **Scoring:** Responses are scored using item-response theory (IRT) to produce a standardized T-score (mean = 50, SD = 10) based on the U.S. general population. Higher scores indicate better physical function. CAT administration dynamically selects items to optimize precision. Please see the PROMIS Physical Function Scoring Manual for requirements regarding scoring, including how to convert the raw summed score to the T-Score:
 - **More information:**
[HealthMeasures.net: PROMIS Physical Function, User Manual and Scoring Instructions \(PDF\)](https://www.healthmeasures.net/promis-physical-function-user-manual-and-scoring-instructions-pdf)

PROMIS Pain Interference (PI) (Short Form 6a or CAT)

PROMIS Pain Interference (PROMIS PI) is a patient-reported outcome measure assessing the extent to which pain interferes with physical, emotional, and social functioning, including daily activities, work, sleep, and enjoyment of life. PROMIS Pain Interference may be administered as a fixed-length short form (6a) or via computer adaptive testing (CAT) to provide precise measurement with reduced respondent burden.

- **Anatomical site of pain:** Multiple sites of pain or any site of pain. This PROM is to be combined with PROMIS Physical Function (PF) for administration.
- **Number of items:**
 - **Short Form 6a:** 6
 - **CAT:** Variable (typically 4–12 items). Full item bank includes around 173 items.
- **Recall window:** Past 7 days
- **Measure steward / distributor:** HealthMeasures (PROMIS®, National Institutes of Health). The original English-language PROMIS measures are publicly available without license fees for non-commercial research, education, and clinical practice. [HealthMeasures.net](https://www.healthmeasures.net) is the central hub for accessing and managing PROMIS measures, requiring registration and adherence to terms. Integrating PROMIS into digital platforms (like EHRs, apps) requires HealthMeasures Electronic Administration Permission or HEAP.
 - CMS is seeking to acquire a license for use by participants in the model. The optional CAT administration is also dependent on meeting technical requirements.

- **Required version:**
 - **Short Form:** PROMIS Short Form v1.1 – Pain Interference 6a
 - **CAT:** PROMIS Item Bank v1.1 – Pain Interference
 - **More information:**
[HealthMeasures.net: Obtain and Administer Measures](#)
- **Scoring:** Responses are scored using IRT to generate a standardized T-score (mean = 50, SD = 10). Higher scores indicate greater interference of pain with daily activities and functioning. CAT administration tailors item selection to the respondent’s level of pain interference. Please see the PROMIS Pain Interference Scoring Manual for requirements regarding scoring, including how to convert the raw summed score to the T-Score:
 - **More information:** [HealthMeasures.net: PROMIS Pain Interference Scoring Manual, December 5th, 2023 \(PDF\)](#)

Quick Disabilities of the Arm, Shoulder and Hand (*QuickDASH*)

The *QuickDASH* is a patient-reported outcome measure that assesses physical function and symptoms in people with upper-limb musculoskeletal disorders. It is a shortened version of the DASH and evaluates the degree of difficulty in performing specific activities and the severity of symptoms over the preceding week.

- **Anatomical site of pain:** Arm, shoulder, or hand
- **Number of items:** 11
- **Recall window:** Past 7 days
- **Measure steward / distributor:** © Institute for Work & Health.
 - The measure is free for non-commercial, clinical, and research purposes, including by participants in the ACCESS Model. The instruments may not be changed, sold or incorporated into a product to be sold ([The DASH Outcome Measure: Terms and Conditions](#)).
- **Required version:** Current standard *QuickDASH* (no separate numbered version)
- **Scoring:** The *QuickDASH* disability/symptom section is 11 items, with items scored on a 5-point Likert scale. At least 10 of 11 items must be completed. Scores are calculated by averaging completed items, subtracting 1, and multiplying by 25, yielding a score from 0 to 100. Higher scores indicate greater disability.
 - **More information:** [The DASH Outcome Measure: Scoring Instructions](#)

Neck Disability Index (NDI)

The Neck Disability Index (NDI) is a patient-reported outcome measure used to assess neck-specific disability. It evaluates how neck pain affects daily activities, including personal care, work, recreation, and concentration, providing an overall measure of perceived functional limitation.

- **Anatomical site of pain:** Neck
- **Number of items:** 10
- **Recall window:** Current or usual functioning
- **Measure steward / distributor:** MAPI Research Trust.
 - CMS is seeking to acquire a license for use by participants in the model.
- **Required version:** Version 2.2 © Jeremy Fairbank and Paul Pynsent.
- **Scoring:** Each item is scored from 0 to 5. Item scores are summed for a total score ranging from 0 to 50, which may be converted to a percentage (0–100%). Higher scores indicate greater disability due to neck pain.
 - **More information:** [eProvide by Mapi Research Trust: Neck Disability Index](#)

Oswestry Disability Index (ODI)

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is a patient-reported outcome measure designed to assess disability related to low back pain. It consists of 10 patient-completed items with six response options each.

- **Anatomical site of pain:** Low back
- **Number of items:** 10
- **Recall window:** Current or usual functioning
- **Distributor:** MAPI Research Trust.
 - CMS is seeking to acquire a license for use by participants in the model.
- **Required version:** 2.1b © Jeremy Fairbank, 1980.
- **Scoring:** Each item is scored from 0 to 5. Scores are summed and divided by the maximum possible score, then multiplied by 100 to yield a percentage score from 0% (no disability) to 100% (most severe disability). Higher scores indicate greater disability due to low back pain.
 - **More information:** [eProvide by Mapi Research Trust: Oswestry Disability Index](#)

Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS JR)

The HOOS JR is a joint-replacement-relevant short form of the HOOS (Hip dysfunction and Osteoarthritis Outcome Score) survey developed at Hospital for Special Surgery. The survey tracks how a patient feels about their hip and how well they are able to do their usual activities.

- **Anatomical site of pain:** Hip
- **Number of items:** 6
- **Recall window:** Past 7 days

- **Measure steward / distributor:** © Hospital for Special Surgery (HSS), developed by Stephen Lyman
 - This instrument is nonproprietary and free to use
 - **More information:** [HSS.edu - Osteoarthritis and Joint Replacement Outcome Surveys](https://www.hss.edu/osteoarthritis-and-joint-replacement-outcome-surveys)
- **Required version:** Version 1.0
- **Scoring:** The HOOS, JR contains 6 items from the original HOOS survey. Items are coded from 0 to 4, then the raw responses are summed (range 0-24). The raw score is then converted to an interval score. The interval score ranges from 0 to 100 where 0 represents total hip disability and 100 represents perfect hip health.
 - **More information:** [HSS.edu - Hoos, Jr. Scoring Instructions \(PDF\)](https://www.hss.edu/hoos-jr-scoring-instructions)

Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS JR)

The KOOS JR is a joint-replacement-relevant short form of the KOOS (Knee injury and Osteoarthritis Outcome Score) survey developed at Hospital for Special Surgery. The survey tracks how a patient feels about their knee and how well they are able to do their usual activities.

- **Anatomical site of pain:** Knee
- **Number of items:** 7
- **Recall window:** Past 7 days
- **Measure steward / distributor:** © Hospital for Special Surgery (HSS), developed by Stephen Lyman
 - This instrument is nonproprietary and free to use
 - **More information:** [HSS.edu: Osteoarthritis & Joint Replacement Outcome Surveys](https://www.hss.edu/osteoarthritis-and-joint-replacement-outcome-surveys)
- **Required version:** Version 1.0
- **Scoring:** The KOOS, JR contains 7 items from the original KOOS survey. Items are coded from 0 to 4, then the raw responses are summed (range 0-28). The raw score is then converted to an interval score. The interval score ranges from 0 to 100 where 0 represents total knee disability and 100 represents perfect knee health.
 - **More information:** [HSS.edu - Kooos, Jr. Scoring Instructions \(PDF\)](https://www.hss.edu/koo-jr-scoring-instructions)