Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Primary Care Practitioner (PCP) and Referring Clinician Webinar

Center for Medicare and Medicaid Innovation

June 4, 2026

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Housekeeping and Logistics

DIAL IN

It is recommended that you listen via your computer speakers.

Options for audio only:
Dial-In (US): +1 929 436 2866 or +1 669 900 6833
Webinar ID: 942 3170 4972
ID/Passcode: 311344

PARTICIPATE

If you have questions for the ACCESS Team, please use the Q&A box at the bottom of your screen.

SHARE FEEDBACK

Please complete a short survey that will be available at the end of the event.

Closed captioning is available at the bottom of the screen.

Agenda

1. Welcome and Introductions
2. ACCESS Model Overview
3. Care Coordination
4. Co-Management Payment Approach
5. Q&A Session
6. Closing and Resources

CMS Remarks

Today's Presenters

Puja Nair

ACCESS Model
Co-Lead,
CMS Innovation Center

Anna Rabil

ACCESS Model
Quality Lead,
CMS Innovation Center

Colman Adams

ACCESS Model
Payment Lead,
CMS Innovation Center

ACCESS Model Overview

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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, or two or more of the following conditions: dyslipidemia (high or abnormal lipids, including cholesterol), obesity or overweight with marker of central obesity, and prediabetes

Cardio-kidney-metabolic (CKM): One or more of the following conditions: 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

Primary Care Practitioners and Referring Clinicians

Primary Care Practitioners (PCPs) and referring clinicians are central partners in the ACCESS Model. ACCESS gives PCPs and referring clinicians new ways to support patients with chronic conditions while remaining actively involved in their ongoing care management.

Referring Patients

PCPs and referring clinicians can refer patients to ACCESS Participants,[1] which they can identify via a CMS directory of participating organizations, including the conditions that they treat, and their risk-adjusted outcomes.

Care Integration

Several mechanisms ensure that PCPs and other clinicians can seamlessly integrate care from ACCESS organizations into their patient care plans, for example:

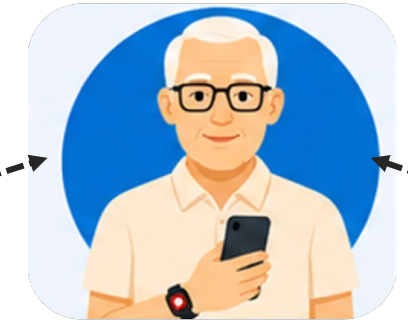
- To support care coordination, ACCESS Participants will be required to send care updates to patients' PCPs or referring clinicians at care initiation, care completion, and at any instances of clinical escalation, via HIPAA-compliant methods (including Direct Secure Message and eFax).
- ACCESS Participants will be required to connect to Health Information Exchanges or CMS Aligned Networks by July 2027, to enable structured updates to PCPs and referring clinicians while also facilitating provider access to patient information through a trusted network.
- PCPs and referring clinicians can bill for an ACCESS co-management payment for documented review of patient updates from associated ACCESS Participants.

[1]CMS will monitor ACCESS Participants on a regular, ongoing basis to ensure integrity and support patient safety.

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 HIPPA-compliant secure electronic method (e.g., Direct Source Messaging, network-supported push mechanism, or compliant 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).

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

3

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

How ACCESS Supports Patient Care - Example

The patient-provider journey illustrates how ACCESS provides patients and PCPs with new, covered options to support effective, coordinated care. **For example:**

1 Patient Visits PCP

- Patient with low back pain and moderate depression comes for a regular check-up.
- PCP has already written the patient a script for SSRIs, encouraged them to find a therapist, and provided medication for the back pain, but the **patient still needs additional support**.

2 PCP Introduces ACCESS

- PCP shares new, covered options that the patient may elect through the ACCESS Model.
- PCP uses the **ACCESS Participant Directory** to identify organizations in the MSK and BH Tracks that would be the best fit for the patient.

3 Patient Enrolls in ACCESS

- Together, the PCP and patient enroll the patient in the ACCESS Model by signing up directly with the ACCESS Participant.

4 PCP Coordinates Care

- PCP receives **Care Plan** pushed to them by the ACCESS Participant and can **access patient data** via HIEs or CMS Aligned Network for continuing updates on their patient.
- PCP **bills ACCESS for co-management payment** (+ additional payment for assisting with the set-up and onboarding processes).

Timeline

Model Lifecycle

The model will launch on July 5, 2026, and run for 10 years.

- Accepted applicants for the model's July launch can be found on the ACCESS Model webpage, which CMS continues to update.[1,2]
- ACCESS Participants and beneficiaries will be able to view the full list of ACCESS Participants in a forthcoming ACCESS Participant Directory.
- Coordinating clinicians, including PCPs and referring clinicians, do not need to apply or enroll.
- Beneficiaries may enroll throughout the model.

[1]For a list of accepted applicants, please visit the model webpage.
[2]The model allows for rolling admissions for Participants.

Care Coordination

Care Coordination

ACCESS creates an opportunity to offer patients additional affordable care options while allowing PCPs to remain the central coordinator of care.

Coordinating Care:

- Referring clinician or PCP may help patients select an appropriate option using the **ACCESS Participant Directory** and support enrollment directly with Participant.
- ACCESS Participants will establish connectivity to a Health Information Exchange, CMS Aligned Network, or equivalent trusted network that supports **transparent exchange and monitoring of clinical data** with the PCP and referring clinicians.

Care Updates

ACCESS allows the PCP and referring clinicians to receive updates on aligned beneficiaries' health status from ACCESS Participants through secure information sharing methods, mitigating fragmentation and supporting continuity of care.

- ACCESS Participants must **share care updates** with the PCP and referring clinicians using secure, nationally recognized health information exchange methods.[1]
- Clinicians may establish **data-sharing arrangements** to support care coordination, compliant with applicable law including Anti-Kickback Statute (AKS).[2]
- The PCP and referring clinicians will receive the minimum required updates **through a secure electronic method** such as Direct Secure Messaging or a HIPAA-compliant exchange method.[3]

[1]Before sharing updates, Participants must obtain the beneficiary's consent to proactively share care updates with their Identified PCP and referring clinician.
[2]The federal AKS, codified at 42 U.S.C. § 1320a-7b, makes it a felony to pay or receive anything of value in exchange for referring patients to services covered by Medicare, Medicaid, or other federal healthcare programs.
[3]CMS will provide a concise, standardized update template that ACCESS Participants must use to ensure consistency and minimize burden.

Care Updates, *continued*

ACCESS allows the PCP and referring clinicians to receive both Required Care Updates.

The PCP and referring clinicians receive **Required Care Updates** from ACCESS Participants, as defined by CMS. The PCP and referring clinicians may still receive **additional updates**, as needed, and are encouraged to establish more frequent data-sharing arrangements with ACCESS Participants.

Required Care Updates from ACCESS Participants

- **Upon Baseline Data Submission**: **Within 10 days** of submission of all baseline OAP measures.
  - ACCESS Participants will communicate care plan, baseline measures, responsible contact, and initial goals.
- **Upon Care Completion**: **Within 30 days** after the end of the 12-month Care Period, or sooner if the ACCESS beneficiary is no longer aligned.
  - ACCESS Participants will summarize achieved outcomes, medications, and follow-up recommendations.
- **Upon 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.

Care Plan Components

The ACCESS Model requires each Participant to include specific details within the Care Plan to ensure **the PCP or referring clinician is informed of the details of their beneficiary's treatment plan**. The Care Plan template will include the following elements:

1. Patient and Sender Information: Beneficiary's name and date of birth, the ACCESS Participant's contact details, monitored clinical contact, and Medical Director's name for oversight.

2. Clinical Status and Goals: Beneficiary's aligned clinical track(s), qualifying condition(s), care start date, and OAP Measures such as baseline values, target goals, and follow-up/end-of-period results.

3. Treatment and Care Approach: Current medications and any changes, narrative description of symptom management, lifestyle interventions, medication adherence/side-effect monitoring, and planned follow-up.

4. Coordination and Transmission: Guidance on CMP billing for PCPs and information about the model; must be sent through a HIPAA-compliant secure electronic method.

Co-Management Payment Approach

Eligible Providers and Billing Parameters

Medicare Part B clinicians receive the Co-Management Payment (CMP) for reviewing a documented ACCESS Care Update, and any related care coordination activities, for a beneficiary assigned to an ACCESS track.

Billing Parameters

Eligible clinicians can bill CMP HCPCS codes if they:

- ✓ Co-manage the beneficiary's condition
- ✓ Review an ACCESS Care Update for that beneficiary and track

The CMP is payable for one (1) unit of service, requiring a minimum of five (5) minutes of clinician time spent reviewing an ACCESS Care Update and performing any associated care-coordination activity.

Eligible Clinician Specialty Types[1]

These Medicare Part B-enrolled clinician types are eligible to bill CMP HCPCS codes:

- All Physicians
- Speech Language Pathologist in Private Practice
- Nurse Practitioner
- Psychologist (Billing Independently)
- Physical Therapist in Private Practice
- Occupational Therapist in Private Practice
- Clinical Psychologist
- Registered Dietician/Nutrition Professional
- Licensed Clinical Social Worker
- Certified Clinical Nurse Specialist
- Physician Assistant
- Marriage and Family Therapist
- Mental Health Counselor

[1]Providers in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may bill CMPs beginning October 1, 2026. Billing guidelines for FQHCs and RHCs is forthcoming.

Future Eligible Entities

We plan to allow these entities to bill through Medicare Parts A and B, respectively, beginning in October 2026.[1]

Medicare Part A

- Federally Qualified Health Centers (FHQCs)
- Rural Health Clinics (RHCs)

Medicare Part B

- Medical Supply Company with Pharmacist
- Pharmacy

[1]The clinicians and organizations on this slide are additive to the providers already eligible to bill the CMPs outlined on the previous slide.

Co-Management Payment Frequency and Amounts

Clinicians who are eligible to bill CMPs can receive established payment amounts per service at a defined billing cadence. Clinicians may continue to bill non-ACCESS services as normal. Beneficiary cost-sharing does not apply to the CMP.

Payment Frequency

- The CMP is payable up to **three times per twelve-month care period** per beneficiary per ACCESS track.
- Clinicians **may bill CMPs for different ACCESS tracks for the same beneficiary** when distinct review and care coordination activities are performed for each track.

Payment Amounts

- ACCESS Model CMPs will be **paid at $30 per service,** subject to the geographic adjustment.
- Clinicians who assist a beneficiary with onboarding and initial setup activities may also bill the CMP code with a CMS-specified **modifier** the first time they bill for that beneficiary to receive an additional payment of **$10** per track.
- CMS pays **100%** of the Medicare-allowed amount for CMP services.

CMP Allowed Amount G-Codes

To bill the CMP, the eligible clinician must review an ACCESS Care Update and perform at least one care-coordination activity, such as a medication change or reconciliation, updating the problem list, monitoring instruction, or referral.

ACCESS CMP G-Codes:

HCPCS G-Code	Clinical Track	Allowed Amount	Description
G0676	eCKM/CKM	$30	Review of clinical updates from ACCESS Participant managing CKM conditions (eCKM/CKM), and at least one care coordination activity.
G0677	MSK	$30	Review of clinical updates from ACCESS Participant managing MSK conditions, and at least one care coordination activity.
G0678	BH	$30	Review of clinical updates from ACCESS Participant managing BH conditions (depression, anxiety), and at least one care coordination activity.

ACCESS CMP Modifier:

- The **Initial Onboarding Payment** is an enhancement to the first CMP billed for a beneficiary and track.

Modifier	Billing Frequency	Allowed Amount	Description
AC	First CMP G-Code only; Once per beneficiary per track	$10	Initial onboarding support payment for ACCESS beneficiary enrollment support and device/application setup.

CMP Claim Submission Guidelines

Eligible providers should follow these guidelines for accurate CMP billing and payment. Documentation of the review of clinical updates electronically shared by the ACCESS Participant to the billing clinician is required to support each CMP claim.

Date of Service, Place of Service, Diagnosis Code

- The **Date of Service (DOS)** must correspond to the date of the documented review and care-coordination activity.
- The **Place of Service (POS)** code for CMP claims should reflect the reviewing clinician's practice setting, including telehealth settings, as appropriate.
- The **diagnosis code** on the billed CMP HCPCS code must correspond to one of the qualifying conditions for the beneficiary's ACCESS track.[1] The beneficiary's ACCESS track must also align with the CMP HCPCS code used for billing. **CMP claims will be denied if a corresponding diagnosis code is not included.**

Provider NPI / TIN

- The **rendering clinician**[2] on the CMP claim must be the Medicare-enrolled professional who performed the documented review, identified by NPI.
- The **rendering clinician's** practice TIN and NPI must be reported as the billing provider on the CMP claim.
- The **referring provider** can be optionally be reported on CMP claims.

Geographic Adjustments

- CMP G-codes and Initial Onboarding Payment modifier (Modifier AC) amounts will be adjusted based on the Medicare Physician Fee Schedule Geographic Adjustment Factor (GAF).
- This means that actual payments will vary from the national rates based on each eligible clinician's location.

[1]The model webpage includes the qualifying diagnosis codes for each ACCESS track.
[2]CMP services may be furnished by auxiliary personnel under general supervision, provided the auxiliary personnel are employees, leased employees, or contractors of the billing providers.

Q&A Session

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Open Q&A

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

If we do not get to your question, please email your question to the ACCESS Team at **ACCESSModelTeam@cms.hhs.gov**.

Closing and Resources

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Resources

Email: ACCESSModelTeam@cms.hhs.gov

Visit: ACCESS Model Webpage

ACCESS Resources: Refer to the **ACCESS CMP Billing Guidelines** (coming soon) and the **ACCESS Participant Directory** (coming soon) for more information.

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**