



CMS ACCESS MODEL · PROVIDER & HOSPITAL PLAYBOOK

Your Patients Are Already There. Now You Can Get Paid — and Get Credit — for Managing Them Better.

The CMS ACCESS Model creates a new co-management payment stream, quality measure alignment, and chronic disease workflow infrastructure for PCPs and specialists who refer patients to tech-enabled care — with zero disruption to your existing FFS billing.

~\$40

co-management payment per patient per review

\$222–\$318

combined CCM + RPM + BHI revenue per patient/mo

+9%

MIPS positive adjustment for top performers 2026

16.7%

lower diabetes costs when A1C controlled <7%

eCKM: Hypertension, Dyslipidemia, Pre-diabetes

CKM: Diabetes, CKD, CVD

MSK: Musculoskeletal Pain

BH: Depression & Anxiety

WHAT'S IN IT FOR PROVIDERS

Four revenue and quality streams you unlock today

New Co-Management Payment

PCPs and specialists who refer patients to ACCESS organizations can bill a new CMS co-management G-code **G0678** (~\$30/service + \$10 onboarding bonus) for reviewing ACCESS patient updates and documenting a coordination action. No extra visits required.

FFS Billing Continues Uninterrupted

Unlike ACCESS participants, referring clinicians are NOT subject to FFS billing exclusions. You continue billing all your standard codes (E&M, CCM, RPM) while also receiving co-management payments for your referred patients.

MIPS Quality Score Improvement

ACCESS outcome data flows directly into your quality measure numerators for diabetes (HbA1c control), CKD, and hypertension — the three biggest gaps in most Medicare practices. Better scores = positive payment adjustments.

New Patient Pipeline

The ACCESS participant directory and referral infrastructure creates a structured new channel for patient acquisition. Tech companies actively seek referring PCPs — you become a preferred partner, not just a passive referral source.

HOW PROVIDERS PARTICIPATE

Your three paths into the ACCESS ecosystem

01 Refer patients to an ACCESS technology participant (lowest effort, immediate return)

Identify eligible Medicare patients with qualifying conditions. Refer them to a CMS-enrolled ACCESS technology organization. Receive structured electronic updates on their progress. Review those updates + document a coordination action → bill the co-management G-code **G0678**. Takes under 10 minutes per patient per review cycle. No enrollment required.

02 Become an ACCESS participant yourself (highest control, highest risk)

Enroll as a Medicare Part B ACCESS participant. Choose your clinical track(s). Deliver technology-enabled chronic care management. Receive OAP payments (\$6–\$14/mo per patient) + outcomes bonus. Requires physician Clinical Director designation, FHIR API integration, FDA approval (TEMPO pilot) and outcome performance. Appropriate for large groups, ACOs, and health systems with existing infrastructure.

03 Hybrid: Partner as both referrer and co-manager (optimal for most practices)

Structure a formal co-management arrangement with an ACCESS tech participant. Your clinicians provide clinical oversight, medication management, and escalation; the tech partner handles continuous monitoring, patient engagement, and data reporting. Leverage their technology infrastructure without building it yourself.

MONEY ON THE TABLE TODAY — FFS BILLING STACK

What you can bill right now for your chronic disease patients

Code	Program	Requirements	What You Do	Rate / Month	Notes
ACCESS Co-Mgmt G-code G0678 +modifier AC	ACCESS Co-Management	Document review of ACCESS patient update + care coordination action (e.g. med adjustment, problem list update)	Document review of ACCESS patient update + care coordination action (e.g. med adjustment, problem list update)	~\$30/service + \$10 onboarding bonus	No cost-sharing from patient
99490	CCM Base (20 min staff)	2+ chronic conditions; structured care plan; 20 min non-face-to-face per month	2+ chronic conditions; structured care plan; 20 min non-face-to-face per month	\$66.30/mo	+\$50/additional 20 min (99439)
99491	CCM Physician-led (30 min)	30 min direct physician time per month	30 min direct physician time per month	\$117.53/mo	Higher complexity patients
99454	RPM Device Supply (16+ days)	FDA-cleared device; 16+ days transmission in 30-day period	FDA-cleared device; 16+ days transmission in 30-day period	~\$52/mo	New 99445 code for 2–15 days also ~\$52/mo
99457	RPM Clinical Time (20 min)	20 min interactive mgmt per month	20 min interactive mgmt per month	~\$51.90/mo	+\$41.52 per add'l 20 min (99458)
99484	BHI Care Management	20 min clinical staff; behavioral health condition integrated with primary care	20 min clinical staff; behavioral health condition integrated with primary care	~\$57/mo	Compatible with CCM same month
GPCM1/2/3	APCM BHI Add-ons (new 2026)	APCM base code reported same month; CoCM or BHI services provided	APCM base code reported same month; CoCM or BHI services provided	\$57–\$134/mo	New 2026; replaces separate CoCM codes for APCM practices

Revenue stacking example: A Medicare patient with hypertension, Type 2 diabetes, and comorbid depression qualifies for CCM (99490 + 99439) ~\$116/mo + RPM (99454 + 99457) ~\$104/mo + BHI (99484) ~\$57/mo = **\$222–\$318/month from a single patient**. Time must be tracked separately per program. CMS permits concurrent billing when clinical time is not double-counted. Source: Nsight Health / CCNHealth 2026 billing analysis.

MONEY ON THE TABLE TOMORROW — TOTAL COST OF CARE

What A1C and BP control actually saves — with citations

This is the long game. When your patients' chronic conditions are better managed through ACCESS, the total cost of care in your ACO or MSSP reconciliation drops — and your shared savings go up. Here is what the evidence shows.

Clinical Scenario	Outcome Evidence	Est. Cost Savings/Patient	Source
A1C reduced by 1 point (any level)	2% reduction in all-cause costs; 13% reduction in diabetes-related costs	~\$900–\$1,169/patient/yr savings	Lage & Boye, 2020 (N=77,622)
A1C brought below 7% (from ≥7%)	16.7% lower annual diabetes-related costs	~\$536–\$2,756 savings vs. uncontrolled	Springer/PMC, 2022 (Optum DB)
A1C >9% reduced by ≥1 point	Largest savings tier; nonlinear — higher A1C = steeper drop in costs	~\$1,169+/yr; \$56.4M per 700K-pt plan	Value in Health, 2013
Sustained glycemic control (2+ yrs)	Reduced physician visits + inpatient utilization; complication prevention compounds over time	~\$900/yr sustained over 2 yrs = \$1,800	Menzen et al., 2001 (sustained control)
Intensive control (A1C ~7.0% vs 7.9%)	25% reduction in microvascular complications (UKPDS)	Avoids dialysis, retinopathy, neuropathy — cost avoided = \$10K–\$100K+ per event	UKPDS landmark trial

Provider implication: When your ACCESS tech partner manages your highest-A1C patients, you benefit twice — improved MIPS quality scores on diabetes measures AND reduced total cost of care that directly improves your ACO/MSSP shared savings reconciliation.

QUALITY BONUS ALIGNMENT

How ACCESS improves your MIPS score — measure by measure

MIPS accounts for 30% quality + 25% Promoting Interoperability + 15% Improvement Activities + 30% cost. ACCESS directly improves performance across all four categories for practices treating diabetes, CKD, and hypertension.

MIPS Measure	Category	How ACCESS Helps You Score	Payment Adj.
Diabetes: HbA1c Poor Control (>9%)	Quality (outcome)	ACCESS tech partner lowers A1C in your shared patients — your denominator performance improves	+MIPS Quality
Diabetes: Eye Exam	Quality (process)	Structured chronic care protocols in ACCESS include annual eye exam referrals and tracking	+MIPS Quality
CKD: Blood Pressure Control	Quality (outcome)	eCKM/CKM tracks target BP management — RPM integration keeps your patients in control range	+MIPS Quality
Kidney Health Evaluation for Diabetes (KED)	Quality (process)	CKM track requires eGFR/uACR testing — systematizes what should already happen	+MIPS Quality
Controlling High Blood Pressure	Quality (outcome)	eCKM track directly targets BP in your Medicare patients — most impactful measure for PCPs	+MIPS Quality
Promoting Interoperability (PI)	MIPS Category (25%)	ACCESS requires FHIR API data exchange — fulfills CMS interoperability requirements for EHR reporting	+MIPS PI Score

Care Coordination / Complex Patient Mgmt	Improvement Activity	ACCESS co-management workflow = documented care coordination activity for MIPS IA credit	+MIPS IA Score
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MIPS Payment Impact 2026: 87% of eligible clinicians received a positive payment adjustment in 2026 based on 2024 performance. Scores above 75 points earn positive adjustments; the top performers share a bonus pool funded by penalty dollars from low scorers. ACCESS-aligned providers should systematically pick up 3–4 measures automatically.

CLINIC INTEGRATION DESIGN — WHAT CMS REQUIRES

How ACCESS plugs into your clinical workflow

CMS built ACCESS to **complement — not replace — your clinical workflow**. Here is exactly how the model is designed to integrate, and what it replaces in your current chronic care process.

Workflow Step	Without ACCESS	With ACCESS Tech Partner	Provider Effort
Patient Identification	Manual chart review or care manager time	ACCESS partner provides eligibility list from claims + EHR data; pre-identified by condition and track	~15 min/wk vs hours
Enrollment & Consent	Staff-led phone outreach; low conversion	Tech partner handles direct enrollment, consent, and device onboarding for your patients, ensure data feeds into EMR	Near-zero staff burden
Chronic Disease Monitoring	Episodic lab reviews at quarterly visits	Continuous RPM data streamed to care team dashboard; alerts for out-of-range values; physicians are not required to respond to alerts; RPM data is for education and coaching	Real-time, integrated
Care Updates to PCP	Discharge summaries, ad hoc calls	Structured electronic updates sent to your EHR after each ACCESS care period; CMS-required API-based data exchange	Automated via FHIR
Co-Management Billing	No reimbursement for coordination review	Document review of ACCESS update + one coordination action → bill co-management G-code (~\$30)	<10 min per patient
MIPS Reporting	Manual data abstraction for quality measures	ACCESS outcomes (A1C, BP, eGFR) feed directly into quality measure numerators via interoperable EHR	Automated reporting
Panel Management	No systematic chronic condition follow-up	ACCESS extends care team capacity — your panel gets continuous management between visits	No new hires needed

Required EHR & interoperability design under ACCESS

CMS mandates that ACCESS organizations use secure, interoperable systems that support FHIR API-based data exchange with referring clinicians and CMS. For your practice, this means:

- ▶ Receive structured patient progress updates in your EHR automatically — no portals, no faxes
- ▶ ACCESS tech partners must transmit data via CMS-compliant APIs; your EHR must be able to receive it (most major EHRs support this)
- ▶ 21st Century Cures Act compliance (already required of your EHR vendor) enables this exchange — no additional certification needed on your end in most cases
- ▶ Patient ADT notifications, care plan updates, and lab data flow bidirectionally — fulfilling your Promoting Interoperability MIPS category requirements
- ▶ The ACCESS Tools Directory (hosted in the CMS participant portal) lists vetted software and devices — making it easy to identify interoperable partners

WHAT YOUR PATIENTS GAIN

Why your Medicare patients benefit — and why that matters to you

Continuous Monitoring Between Visits

ACCESS extends your care team's reach between quarterly appointments. Blood pressure, glucose, and behavioral health metrics are tracked daily via FDA-authorized devices — with alerts escalated back to your practice when action is needed.

Access to Technology They Can't Get Otherwise

Most Medicare patients do not have access to digital health coaching, remote monitoring, or tech-enabled care coordination. ACCESS funds this for your highest-need patients — at no out-of-pocket cost to them (beneficiary cost-share can and should be waived).

Reduced Admissions and ED Visits

Sustained glycemic control reduces microvascular complications — the primary drivers of hospitalizations and ED visits in your Medicare population. Better-managed patients mean fewer emergency calls, better patient satisfaction, and lower utilization in your ACO reconciliation.

Transparent, Patient-Centered Outcomes

CMS publicly reports risk-adjusted ACCESS outcomes so patients can make informed choices. Your practice's referral network — and reputation — benefits when the tech partners you refer to perform well publicly.

HEALTH TRANSFORMATION ADVISORY

Where HTA Helps Providers Win with ACCESS

We help PCPs, specialists, and health systems build the co-management workflows, billing infrastructure, and partner relationships to maximize every dollar the ACCESS Model puts on the table.

Co-Management Workflow Design

We map your clinical workflow, template design, and billing capture for remote patient monitoring so staff burden is relieved and revenue is captured day 1.

ACCESS Partner Matching & Contracting

We identify and vet ACCESS tech participants across your relevant tracks, structure co-management agreements, and negotiate referral and data-sharing terms.

VBC Contract Alignment Strategy

We audit your current VBC performance, identify exactly which measures ACCESS partnerships will improve, identify ROI opportunity, and quantify the positive payment adjustment opportunity.

Patient Panel Prioritization

We analyze your Medicare population to identify the highest-value ACCESS candidates by track, risk score, and current quality gap — maximizing both patient benefit and revenue.

Ready to build your ACCESS provider strategy?

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