CMS ACCESS MODEL PARTICIPANT FACTS

Advancing Chronic Care with Effective, Scalable Solutions

1. What the ACCESS Model Is

ACCESS is a **10-year voluntary alternative payment model** run by the CMS Innovation Center (CMMI), testing whether paying for measurable health outcomes — rather than for individual services — can improve chronic-condition care in **Original (fee-for-service) Medicare**. Medicare Advantage enrollees are excluded, though MA plans may offer similar programs.

- **Mechanism:** Outcome-Aligned Payments (OAPs) — recurring payments for managing a beneficiary's qualifying condition, paid in full only when enough patients hit defined outcome targets relative to their own baseline.
- **Enrollment:** Patients enroll voluntarily — directly with a participating organization or by clinician referral — rather than being assigned, as in an ACO.
- **Eligible patients:** Original Medicare beneficiaries with qualifying chronic conditions, **including those dually eligible for Medicare and Medicaid**. Alignment is voluntary and prospective; beneficiaries may switch or disenroll any time after a 90-day minimum.
- **Scope of need:** Targets conditions affecting roughly two-thirds of Medicare beneficiaries.

2. Key Dates

Date	Milestone
Dec 1, 2025	Model announced by CMS
Jan 12, 2026	Applications open (online portal)
Apr 1, 2026	Initial application deadline for the first cohort (11:59 PM PDT)
Apr 13, 2026	CMS posts 150+ accepted applicants; deadline later extended to May 15, 2026
Jul 5, 2026	Model launch / first performance period begins
Jan 1, 2027+	Subsequent cohorts begin, quarterly through Jul 1, 2033
Apr 1, 2033	Applications close
Jun 30, 2036	Model performance period ends (10-year run)

3. The Four Clinical Tracks

Organizations may participate in one or several tracks and must manage all qualifying conditions within a chosen track.

Track	Focus	Conditions
eCKM	Early Cardio-Kidney-Metabolic	Hypertension, dyslipidemia, obesity/overweight with central-obesity marker, prediabetes
CKM	Cardio-Kidney-Metabolic	Diabetes, chronic kidney disease, atherosclerotic cardiovascular disease

MSK	Musculoskeletal	Chronic musculoskeletal pain (initial care period only; no follow-on period — goal is pain resolution)
BH	Behavioral Health	Depression, anxiety

Outcome measures by track (CMS RFA, Appendix B): eCKM/CKM use clinical biomarkers — blood pressure, LDL-C, weight/BMI, HbA1c (CKM adds eGFR and uACR for CKD/diabetes). MSK uses validated PROMs for pain intensity, interference, and function (PROMIS, plus joint-specific instruments). BH uses PHQ-9 (depression) and GAD-7 (anxiety). Targets are set relative to each patient's baseline; CMS will publish the numeric targets separately.

Track-supply note (from the 150+ accepted applicants): coverage skews cardiometabolic — roughly three-quarters of accepted organizations list eCKM and about two-thirds CKM, while MSK is the least-covered track at under 40%.

4. Who Can Participate — and Who Cannot

Eligible: Organizations enrolled in Medicare Part B as providers or suppliers (excluding DME and laboratory suppliers), under a single TIN, with an active physician Clinical/Medical Director accountable for quality and compliance.

Explicitly NOT eligible to participate directly:

- Purely technology or analytics vendors without an associated clinical entity
- Manufacturers or distributors that only sell devices, software, or diagnostics
- Entities unable to enroll as a Medicare Part B provider or supplier
- Organizations that cannot assume responsibility for care coordination, beneficiary engagement, and CMS reporting

Key implication: CMS designed ACCESS around **clinically accountable care delivery, not standalone products**. Pure-tech vendors enter through a separate channel (the Tools Directory, below) or by partnering with — or standing up — a Part B clinical entity.

5. How Payment Works

- **Outcome-Aligned Payments (OAPs):** recurring per-patient payments; full payment depends on the share of patients meeting outcome targets (the Outcome Attainment Rate) versus a minimum threshold that rises each year.
- **Tiering:** higher rate for the initial year of care; a lower rate for an optional follow-on/maintenance period (MSK has no follow-on period).
- **Substitute Spend Adjustment:** CMS also tracks whether enrolled patients avoided receiving equivalent services elsewhere, measured against a benchmark.
- **Rural adjustment:** a fixed upward adjustment applies to rural patients in qualifying tracks.
- **Payment flow & withhold (CMS RFA):** the full annual OAP is paid in monthly installments across the first 6 months; the remaining 50% (months 7–12) is withheld and reconciled after the 12-month care period against the two adjustments below.
- **Clinical Outcome Adjustment:** payment turns on the Outcome Attainment Rate (OAR) — the share of completed patients meeting all targets — versus the Outcome Attainment Threshold (OAT), set at 50% for the first 18 months. At or above 50% earns full payment; below, payment is proportional (OAR ÷ OAT), capped at a 50% reduction.
- **Substitute Spend Adjustment:** Substitute Spend Threshold set at 90% for the first 18 months, capped at a 25% reduction. Only one adjustment — the larger of the two — applies per semi-annual reconciliation, to avoid compounding penalties.
- **Co-management payment (CMS RFA):** referring PCPs/clinicians bill $30 per documented review (geographically adjusted, no patient cost-sharing), plus a ~$10 onboarding payment once; capped at ~$100/year per beneficiary per track.

- **Multi-track discount:** when a beneficiary is enrolled in multiple tracks with the same participant, a 5% discount applies to the lower-cost track(s) for the ACCESS participant, not the PCP.

6. Technology & Interoperability Requirements

- ACCESS presumes API-driven, FHIR-based data exchange for eligibility, consent, claims/clinical data integration, and bidirectional sharing with the patient's broader care team.
- Participants must electronically share care plans and updates at key milestones and connect to a Health Information Exchange or similar trusted network.
- Care may be delivered in person, virtually, asynchronously, or via other technology-enabled methods — the model does not prescribe a specific care model.

7. The Two Directories (Often Confused)

Participant Directory	ACCESS Tools Directory
Public. Lists each **care organization**, the conditions/tracks it treats, and its risk-adjusted clinical outcomes. Intended to help patients, PCPs, and ACOs choose. Outcomes data depends on care being delivered, so it populates *after launch*.	Internal to the participant portal. A **vendor-self-listed** catalog of optional software/hardware (interoperability, identity verification, connected devices like BP cuffs, HIPAA tools). **Non-endorsing; CMS does not verify clinical performance.** Vendors may add promotional offers, subject to beneficiary-inducement law.

8. Related: FDA TEMPO Pilot

Running alongside ACCESS, the FDA's **TEMPO (Technology-Enabled Meaningful Patient Outcomes)** pilot lets up to ~40 digital-health device manufacturers offer products under FDA enforcement discretion while collecting real-world performance data. It is a complementary pipeline for tech that is not yet fully FDA-authorized, not part of ACCESS payment itself.

9. Evaluation Design (Worth Knowing)

ACCESS is evaluated using **beneficiary-level randomization**. A share of patients who try to enroll are assigned to a control group: the ratio **starts at 90:10 (intervention-to-control) in year one** and may be adjusted or eliminated later. Control-group patients keep all usual Medicare benefits but are ineligible for that track for the following 12 months. Participants must use CMS-provided standardized language when notifying patients of control assignment.