HEALTH
TRANSFORMATION ADVISORY

CMS ACCESS MODEL · TECHNOLOGY COMPANY PLAYBOOK

# The Medicare Market Just Opened for Technology Companies.

The ACCESS Model lets technology organizations bill Medicare directly as providers — paid for outcomes, not office visits. Payments have been released. The window is open now.

| ⅔ | 10 yr | 500+ | 4 Tracks |
|---|---|---|---|
| of Medicare FFS beneficiaries targeted | model runway (Jul 2026 – 2035) | orgs filed intent to apply | now with published payments |

| Hypertension & Cardiometabolic | Musculoskeletal Pain | Depression & Anxiety | Diabetes & Kidney Disease |
|---|---|---|---|

WHAT CHANGED

## Why this model is a breakthrough for tech

### Direct Medicare Billing

For the first time, technology companies can enroll as Medicare Part B providers and receive reimbursement without going through a hospital or physician practice.

### Outcome-Aligned Payments

Recurring flat payments tied to measurable population health improvements — not CPT codes, activity logs, or time thresholds. Better outcomes, full payment.

### Technology-First Care Delivery

Apps, wearables, telehealth, and asynchronous tools are the delivery vehicle — not an add-on. CMS explicitly designed ACCESS around continuous, tech-enabled care.

### Direct Patient Enrollment

Beneficiaries can enroll directly or via provider referral, giving tech companies their own patient acquisition channel inside Medicare.

OFFICIAL CMS PAYMENT RATES — NOW PUBLISHED

# What you get paid by track

Payments are structured as annual allowable amounts split between Medicare (80%) and beneficiary cost-share (20%). Of the Medicare portion, 50% flows monthly to the tech participant and 50% is withheld pending outcome verification at the end of the performance period. Rural providers receive an additional $15/year per patient to offset distribution costs.

**INITIAL ENROLLMENT PERIOD**

| Clinical Track | Annual Amt | Medicare portion | Participant pmpm | $$s Withheld | Example 80% Yr 1 Bonus | Total Mo. Payment | Rural Add-On |
|---|---|---|---|---|---|---|---|
| **eCKM** | **$360** | $24/mo | **$12/mo** | $12/mo | **$9.60/mo** | **$21.60/mo** | +$15/yr |
| **CKM** | **$420** | $28/mo | **$14/mo** | $14/mo | **$11.20/mo** | **$25.20/mo** | +$15/yr |
| **MSK** | **$180** | $12/mo | **$6/mo** | $6/mo | **$4.80/mo** | **$10.80/mo** | +$15/yr |
| **BH** | **$180** | $12/mo | **$6/mo** | $6/mo | **$4.80/mo** | **$10.80/mo** | +$15/yr |

*Initial period: 80% Medicare / 20% beneficiary cost-share (beneficiary portion can/should be waived). 50% of Medicare portion paid monthly; 50% withheld for outcomes. Year 1 bonus based on % population meeting clinical outcomes. If 40% meet of the yr 1 OAP threshold of 50%, then 80% would be paid.*

**FOLLOW-ON PERIOD (patients who continue)**

| Clinical Track | Annual Amt | Medicare portion | Participant pmpm | $$s Withheld | Example 80% Yr 2 Bonus | Total Mo. Payment | Rural Add-On |
|---|---|---|---|---|---|---|---|
| **eCKM** | **$180** | $12/mo | **$6/mo** | $6/mo | **$4.80/mo** | **$10.80/mo** | +$15/yr |
| **CKM** | **$210** | $14/mo | **$7/mo** | $7/mo | **$5.60/mo** | **$12.60/mo** | +$15/yr |
| **MSK** | **N/A** | — | **—** | — | **—** | **—** | — |
| **BH** | **$90** | $6/mo | **$3/mo** | $3/mo | **$2.40/mo** | **$5.40/mo** | +$15/yr |

*Follow-on period: Same 80/20 split and 50% holdback structure. MSK has no follow-on period. Rural add-on applies to eCKM, CKM, and BH follow-on periods.*

**Key insight:** The CKM track offers the highest total monthly payment at $25.20/patient/month — $14/mo paid immediately plus an $11.20/mo Year 1 bonus when outcome thresholds are met. Enrolling 1,000 CKM patients during the initial period could generate up to $302,400/year in total tech participant payments. eCKM follows at $21.60/mo ($259,200/yr per 1,000 patients). Rural providers stack an additional $15,000/yr per 1,000 patients on top.

MUST-DO PRIORITIES

# What tech companies must get right to succeed

### 01 Enroll in Medicare Part B — correctly and now

You must be enrolled as a Medicare Part B provider or supplier with a valid TIN, meet state licensure in every operating state, and designate a physician Clinical Director. This is the non-negotiable gate — and it takes time.

### 02 Build a population-level outcome strategy

Payment depends on the share of your enrolled population hitting outcome targets. Optimize cohort selection, engagement protocols, and clinical escalation pathways to drive population performance — not individual patient results.

### 03 Architect your data and reporting infrastructure now

ACCESS has strict performance reporting obligations. You need interoperable systems, outcome tracking at the patient and population level, and the ability to submit data to CMS on a recurring basis.

### 04 Secure primary care relationships proactively

PCP buy-in drives referral volume, data completeness, and avoidable utilization reduction. **The goal is for an integrated model.** Without strong provider partnerships, your patient pipeline and outcomes will both suffer.

### 05 Address FDA regulatory status for your tools

Devices or software used in ACCESS may be FDA-regulated. If not pre-authorized, apply through the TEMPO pilot (up to 40 manufacturers) for enforcement discretion — but act before the April 2026 application deadline.

### 06 Model the 50% payment holdback in your financial plan

ACCESS withholds 50% of the Medicare portion monthly pending outcome verification. Your cash-flow model, staffing budget, and investment planning must account for this — the model will not subsidize your operating costs.

REVENUE OPPORTUNITY

## What this unlocks financially

**New Recurring Revenue**

Outcome-aligned payments create a predictable, subscription-like revenue stream from Medicare — independent of fee-for-service billing restrictions.

**Outcome Bonus: Full Payment Released**

The withheld 50% is released when you hit outcome targets. Outperformers receive higher total payments — rewarding clinical and operational excellence.

**National Scale Without Location Limits**

Virtual-first delivery across all Medicare FFS geographies eliminates the per-market expansion cost that constrains traditional care models.

**Payer Contract Leverage**

Proven Medicare performance data strengthens commercial payer negotiations — ACCESS outcomes become your value proof point for broader contracts.

**ACO and MSSP Alignment**

ACCESS complements existing ACO arrangements. Tech companies can partner with ACOs to generate shared savings and quality bonuses on top of OAPs.

**Proprietary Real-World Data Assets**

A 10-year model generates outcomes data that can support FDA authorization, commercial differentiation, and future product development.

VALID INDUSTRY CONCERNS

## What companies are worried about — and what to know

***"We can't bill fee-for-service for the same diagnosis while enrolled in ACCESS."***

This is real and significant. If a patient is enrolled in ACCESS for a condition, traditional FFS billing for that diagnosis is excluded during the episode. Organizations must model this revenue trade-off carefully — especially against the newly published OAP rates — before committing to specific tracks.

***"Now that payment amounts are out, margins look thin for smaller companies."***

At $6–$14/month to participants before the holdback, cash-flow planning is critical. Smaller organizations should assess minimum viable patient volume, compliance cost load, and whether a provider partnership model (vs. direct enrollment) makes more financial sense in year one.

***"The 50% holdback could create real cash-flow pressure."***

With monthly participant payments of $6–$14 per patient and 50% withheld, organizations need meaningful enrolled volume before the model becomes self-sustaining. Model your break-even point carefully and plan bridge funding accordingly.

***"We're not currently enrolled as Medicare providers — this is a big lift."***

Many health tech companies are not Part B enrolled. Medicare enrollment, state licensure alignment, and designating a Clinical Director are real requirements with lead times. Early movers will have an advantage; waiting risks missing cohort one in July 2026.

***"How do we get PCPs to actually refer patients to us?"***

Primary care buy-in is the make-or-break factor. Without referral volume from PCPs and EHR workflow integration, ACCESS functions as a limited-reach add-on. This requires an active partnership strategy — not passive outreach — and ideally a co-management payment structure with PCPs.