Provider FAQs now that CMS ACCESS Launched July 5th

What is the high-level overview for Providers?

ACCESS is a **10-year voluntary alternative payment model.** It is 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**. Part C Medicare and Medicare Advantage enrollees are excluded.

The CMS ACCESS model launched July 5, 2026 for patients with the first round of **157 accepted participants**. There will be rolling applications quarterly until 2033and so more companies will become available for your patients to participate.

The chronic condition tracks targeted are early Cardio-Kidney-Metabolic (eCKM) (i.e., hypertension, dyslipidemia, pre-diabetes), Cardio-Kidney-Metabolic (CKM) (i.e., Diabetes, CKD, CVD), Musculoskeletal pain (MSK), and behavioral health (i.e., Depression and Anxiety).

- **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.
- **Mechanism:** Outcome-Aligned Payments (OAPs) — recurring payments to the CMS approved company Participant for managing a beneficiary's qualifying condition, paid in full only when enough patients hit defined outcome targets relative to their own baseline. These results will be published annually but are not available this first year.

For more details, view our articles on ACCESS FACTS or Participant revenue opportunities by track here: https://healthtransformationadvisory.com/category/hta-articles/

How does the ACCESS model work for Providers?

If you are or want to be an ACCESS participant, there are some technical specifications that you should understand about how the payments will flow. We have done a simple overview here: https://healthtransformationadvisory.com/category/hta-articles/

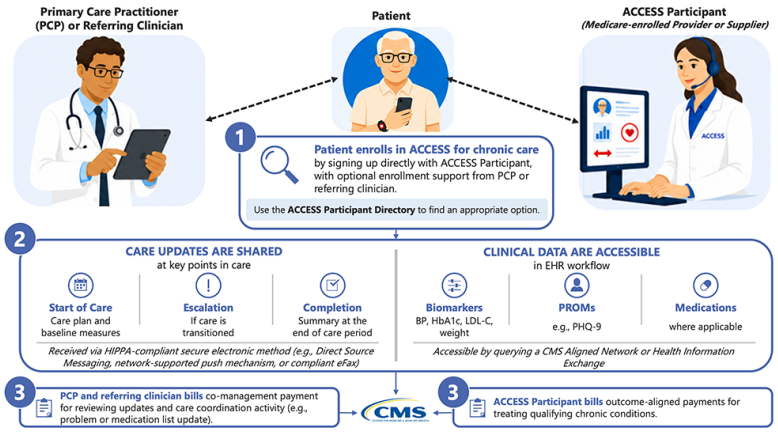
There are strong financial incentives for medical groups to evaluate if they can be a participant themselves. Currently, there are approximately 61 medical groups who were accepted. The remaining 96 are digital health or remote patient monitoring companies.

If you are **not** an ACCESS participant, then your patients may enroll themselves or you can also promote the high-value participants to your patients to simplify your workflows.

Patients can enroll themselves by contacting any one of the companies directly. Is that simple yet? No. Can they easily wade through the companies and brands? No. But, they can sign up and you will start receiving care updates through FHIR EMR connections if they do. **More information here:** https://www.medicare.gov/providers-services/coordinating-care/support-chronic-health-conditions-access

Doctors and practices can learn more here: https://www.cms.gov/priorities/innovation/access-primary-care-providers-referring-clinicians

How It Works



1. **Connect Your Patient with an ACCESS Health Care Provider**

   Patients sign up directly with a participating health care provider. You can use the ACCESS Directory (launching July 2026) to find the right fit by condition and location and optionally support your patient through enrollment. You can also direct patients to Medicare.gov/ACCESS to learn more about these new care options. ACCESS is currently available only for people with Original Medicare.

Source: CMS

Who does ACCESS cover? How does it relate to my payer mix?

Starting out, ACCESS covers Medicare FFS or Original Medicare patients. This is approximately 30 million seniors. The conditions target 2/3 of the Medicare FFS population. Another 30+ million seniors are in Medicare Advantage plans. **14 major health plans** (which include 8 Blue Cross Blue Shield plans) signed a pledge to align their payment structures with the Centers for Medicare & Medicaid Services (CMS) ACCESS model. Depending on how exactly they do that for providers (i.e., Medicare Advantage, Commercial, Medicaid, pmpm payments, co-management fees), this may provide enough of a tipping point in your payer mix to fully incorporate this into your value-based population health care models.

Starting out, this is how many Medicare FFS and Medicare Advantage members live in your state: Medicare FFS vs Med Adv at KFF.org

Why should I participate in ACCESS? Is there a lot of money here?

There is significant FFS revenue to be had today with the ACCESS model. Once you add up the co-management fees, the Complex Care Management codes, possible remote patient

monitoring or behavioral health integration codes, the FFS revenue alone can be significant for your Medicare population. If you are also participating in ACO models such as MSSP or ACO Lead, then there is even more significant revenue opportunities aligned.

This can be amplified even more as companies align their Medicare Advantage models, possibly their Commercial models, to ACCESS or if you decide to become a participant yourself.

See our hospital and provider billing playbook: https://healthtransformationadvisory.com/cms-access-model-a-provider-hospital-playbook/

We can also model for you your own expected revenue for either becoming a participant or if you maximize adoption as a referring provider. Contact us here if you want to discuss an opportunity analysis or how to plan integrating workflows: contact@healthtransformationadvisory.com

What's the level of effort for my team or are there expenses to participating?

It depends on if you want to be a direct participant in the model or if you are only operating as the referring physician. If you are or want to be a direct participant, you can contact us for more details at contact@healthtransformationadvisory.com.

For referring physicians, you will receive the care plan update from the ACCESS participant through a FHIR connection to your EMR. This is a requirement for Participants. You will then need to meet the billing documentation guidelines for the co-management fee. It's fairly straightforward and we estimate will take less than 10 minutes.

Billing guidelines for co-management fees by track can be found here: https://www.cms.gov/priorities/innovation/access-primary-care-providers-referring-clinicians

You will also need to know whether this patient is in your Complex Care Management program, whether they should be, and if you should also be billing Complex Care Management, remote patient monitoring, or Integrated Behavioral Health codes for this patient. If you already have these resources in place, then it is a matter of slotting this information into your already stratified population and interventions.

It will be critical to determine how you want to include this information into care plans. A recent AMA survey showed that 97% of physicians had reviewed wearable information but less than 6% included it into their care plans. At HTA, we have integrated digital health with clinical

workflows and some of the Participants are better at planning for your clinician dashboards and workflows than others. Choose wisely.

AMA wearables survey

Is digital health technology truly clinically meaningful for my patients?

The short answer is it can be. It's not unreasonable to expect ACCESS participants to meet our current standard of care level of evidence. Outcomes-based digital health technology can be a great way to scale outreach to more of your population, help manage members in between visits (per PCMH requirements), help improve quality scores, and lift value-based contracting performance. In ACCESS, the engagement is incumbent on the participant; they are only paid once they are engaged. However, the goal is to be an integrated model with providers. Partnerships with providers will be highly sought after as each Participant's outcomes will be published in a public directory, like STARS, at the end of each year.

We were only able to find 11 ACCESS participants that have peer-reviewed published literature. Also, there are only a handful of widely known companies who also have peer-reviewed literature, and long-term successful implementations. Examples included Welldoc, Evergreen Nephrology, Somatus, and Lark.

There are questions about large consumer brands like Noom, Headspace and Weight Watchers and how they will fully integrate into clinical workflows.

Does participating in ACCESS cost my patient anything?

The payment to the ACCESS participant company is broken down into the typical 80% Medicare benefit coverage and 20% patient coverage. However, the Participants had a chance to waive the 20% patient portion. Most companies did this so they would be competitive and remove barriers to adoption, so that they meet their outcomes goals. The referring physician is not barred from billing anything relevant to the care of the patient. Anything additional that the referring physician bills will follow typical payment and coverage processes.

Where do I refer my patients to participate?

Today, patients can enroll themselves by contacting any one of the companies directly; CMS is encouraging direct enrollment. We were able to find enrollment instructions and/or eligibility

quizzes on various Participants' websites. **We expect an announcement from CMS any day now to make this process simpler for patients.** Be aware that this is NOT the same thing as the Health Tech Ecosystem or CMS App library. These can be the same and/or different participants. If you enroll through ACCESS vs simply downloading from the App library, **your patient can save money. For now, go straight to the approved Participants' websites.**

With rolling quarterly applications through 2033, our general advice is to first evaluate if you want to become an ACCESS participant. There are remote patient monitoring and digital health apps that you can partner with to take control of a closed system that could benefit you, if you're large enough.

If you do not want to participate in ACCESS directly, then it will benefit you to promote one or more of the apps to centralize your Medicare FFS population into beneficial, proven technologies. We suggest that you look for:

1) Well-known brand names

2) Peer-reviewed literature (not only company claims)

3) Companies with more than 10 years' experience

If you do this, it will whittle 157 companies down to less than 20 companies.

For more assistance, reach out to evaluate if you would benefit from being an ACCESS Participant or how to better arrange your clinical integration as a referring provider to: contact@healthtransformationadvisory.com