



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.

2/3

of Medicare FFS
beneficiaries targeted

10 yr

model runway (Jul 2026 –
2035)

350+

orgs filed intent to apply

8 Tracks

Hypertension &
Cardiometabolic

Heart Failure (NEW
4/1/27)

Musculoskeletal Pain

COPD (NEW 4/1/27)

Depression & Anxiety

Substance Use Disorder
(NEW 4/1/27)

Diabetes & Kidney
Disease

Tobacco Cessation (NEW
4/1/27)

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.

What you get paid by track, including the four new condition tracks

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 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
HF (NEW, est.)	\$420	\$28/mo	\$14/mo	\$14/mo	\$11.20/mo	\$25.20/mo	+\$15/yr
COPD (NEW, est.)	\$360	\$24/mo	\$12/mo	\$12/mo	\$9.60/mo	\$21.60/mo	+\$15/yr
SUD (NEW, est.)	\$180	\$12/mo	\$6/mo	\$6/mo	\$4.80/mo	\$10.80/mo	+\$15/yr
Tobacco Cessation (NEW, est.)	\$90	\$6/mo	\$3/mo	\$3/mo	\$2.40/mo	\$5.40/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. HF, COPD, SUD, and Tobacco Cessation rows are HTA estimates modeled on CMS's published methodology — CMS had not yet published official per-track dollar rates for these four new tracks (effective 4/1/27) as of this update. % 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 (follow-on NEW, est.)	\$90	\$6/mo	\$3/mo	\$3/mo	\$2.40/mo	\$5.40/mo	+\$15/yr
BH	\$90	\$6/mo	\$3/mo	\$3/mo	\$2.40/mo	\$5.40/mo	+\$15/yr
HF (NEW, est.)	\$210	\$14/mo	\$7/mo	\$7/mo	\$5.60/mo	\$12.60/mo	+\$15/yr
COPD (NEW, est.)	\$180	\$12/mo	\$6/mo	\$6/mo	\$4.80/mo	\$10.80/mo	+\$15/yr
SUD (NEW, est.)	\$90	\$6/mo	\$3/mo	\$3/mo	\$2.40/mo	\$5.40/mo	+\$15/yr
Tobacco Cessation (NEW, est.)	N/A	—	—	—	—	—	—

Follow-on period: Same 80/20 split and 50% holdback structure. Tobacco Cessation has no follow-on period. MSK's follow-on period is new effective 4/1/27 (previously N/A). HF, COPD, SUD, and the MSK follow-on figures are HTA estimates — CMS had not yet published official rates for these as of this update. 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. Current participants and applicants do not need to reapply to add the four new tracks when they go live in April 2027.

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.

07 Track the four new condition launches (HF, COPD, SUD, Tobacco Cessation) — April 1, 2027

CMS has not yet published official OAP rates, co-management codes, or FDA/TEMPO treatment for these tracks. Current participants and applicants do not need to reapply; model your 2027 track mix now using the published methodology and revisit once CMS confirms final rates.

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.

HEALTH TRANSFORMATION ADVISORY

Where HTA Helps You Win

We partner with technology and data companies navigating the ACCESS Model — from strategy to execution. Five areas of focused support.

Readiness Assessment

We evaluate your Medicare enrollment status, technology stack, clinical model, and governance — and map exactly what needs to happen before your application.

Strategic Track Selection & OAP Modeling

We help you select the right clinical track(s), model your OAP revenue and holdback scenarios using the published rates, and define a population strategy built for outcome performance.

Governance Design

We build the governance structures and Clinical Director accountability frameworks CMS requires — and that your leadership team needs to manage risk across a 10-year program.

Data & Reporting Infrastructure

We support the design of interoperable data systems, performance tracking pipelines, and CMS reporting workflows that close the gap between your product and ACCESS compliance.

Provider Partnership Strategy

We help you structure PCP referral relationships, ACO partnerships, and EHR integration strategies that drive referral volume and shared accountability.

Financial Alignment & Holdback Planning

We model incentive structures, holdback cash-flow planning using the published payment rates, and performance optimization approaches — ensuring your participation is built to sustain and scale.

Ready to position your organization for ACCESS success?

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