Weekly Checkup

Medicare's ACCESS Model Goes Live

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On July 5, the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMMI) officially launched its 10-year, Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model. The first cohort – including more than 180 organizations – has begun transitioning away from traditional fee-for-service billing and toward a **new Outcome-Aligned Payment (OAP) structure intended to reward measurable clinical improvements for Medicare beneficiaries with certain chronic conditions**. As AAF has previously covered, the model represents an ambitious shift in the original Medicare program, and recognition that technology-supported care models can deliver consistent, population-level health improvements while potentially reducing overall health care costs. **Achieving these goals at scale will likely depend on whether ACCESS participants can sustainably engage Medicare beneficiaries, avoid duplicative services, and lessen administrative burden on primary care providers, who remain integral to patient engagement and downstream clinical success.**

Rather than reimbursing providers based on the volume of services, **ACCESS ties payment to whether a sufficient share of an organization's aligned beneficiaries meet condition-specific outcome targets across one or more clinical tracks**: in early cardio-kidney-metabolic, cardio-kidney-metabolic, musculoskeletal, and behavioral health. CMS will distribute half of each clinical track's total allowed payment through monthly installments over the first six months of the performance year, with the remaining half withheld until reconciliation at the end of the 12-month care period. Organizations participating in ACCESS that achieve the required clinical performance threshold – at least half of all aligned beneficiaries meeting the applicable outcome targets – will receive the full OAP, while those falling below receive proportionally reduced payment. **CMS may further reduce payments for organizations whose aligned beneficiaries collectively received an excess of duplicative Medicare-covered services for the same chronic condition.**

Although ACCESS organizations are responsible for delivering technology-supported care through tools such as remote patient monitoring or app-based coaching, **primary care providers (PCPs) remain central to beneficiary engagement and care coordination**. While Medicare beneficiaries can enroll in ACCESS tracks directly, many are likely to rely on their existing primary care teams to recommend care options and communicate with ACCESS organizations once they enroll. Moreover, CMS requires ACCESS organizations to proactively share health data with PCPs and their aligned beneficiaries following important milestones in the patient's care plan. To compensate clinicians for reviewing and acting on these updates, CMS allows PCPs to bill a limited number of Co-Management Payments (CMP) for each beneficiary and clinical track during the care period. These payments reward PCPs for their role in coordinating this new asynchronous chronic care management model, but the relatively flat rate may not be sufficient to offset the new administrative responsibilities.

Ensuring that Medicare patients properly engage with new technology across all clinical tracks will also be a critical test. A recent report found that outcome-based payment arrangements can produce consistent measures of clinical value as well as real-world evidence on which technologies improve chronic disease outcomes. It also shows the benefit of technology-supported interventions in many of the clinical areas included in ACCESS. But **Medicare-aged adults have historically been slow to adopt digital health technologies, so many beneficiaries may require additional in-person support** to enroll in clinical tracks, navigate digital tools, and remain engaged throughout the care period. This is where active engagement from the PCP could prove both valuable and important. **ACCESS organizations that carefully integrate technology into the existing patient-provider relationship – rather than on top of it – may therefore be best positioned to succeed.**

Translating this collaborative approach into practice may prove challenging given ACCESS' current reimbursement structure. Because full payment is partially contingent on meeting both clinical outcome targets and avoiding duplicative Medicare spending, participating organizations will need to coordinate closely with each beneficiary's existing care teams while ensuring patients continue to receive clinically appropriate services outside the ACCESS model when necessary. Concurrently, CMS' requirements for organizations to electronically update PCPs with pertinent health data may increase the administrative burden if updates are too frequent or poorly integrated into existing workflows. Combined with relatively modest CMP reimbursement, these operational challenges may limit clinician participation.

The launch of ACCESS marks one of original Medicare's most ambitious tests of outcome-

based reimbursement. The model has the potential to demonstrate that technology-supported care can improve chronic disease outcomes while reducing overall Medicare spending. **Whether ACCESS achieves that promise will likely depend not only on participants meeting CMS' defined clinical benchmarks, but also on their ability to engage beneficiaries, coordinate with primary care teams efficiently, and use technology to supplement – rather than replace – existing models of care.**