Persivia

The CMS ACCESS Model:
What It Requires, What It Pays, and How to Prepare

A technical guide for Medicare Part B providers and care delivery organizations preparing to participate in the ACCESS Model launching July 5, 2026

The CMS ACCESS Model is the most direct test of outcome-based payment Medicare has attempted to date. Unlike CCM, RPM, or APCM, the ACCESS Model does not pay providers for documenting time or completing tasks. It pays when patients' chronic conditions measurably improve. For organizations that have built real care management infrastructure, that is an opportunity. For those still running on activity-based workflows, it is a significant gap to close before July 2026.

This guide covers the payment mechanics, clinical track requirements, technical infrastructure obligations, and what your organization needs to have in place before applying. For a broader look at what ACCESS signals for value-based care strategy, see our blog: The CMS ACCESS Model Reveals What Value-Based Care Has Been Missing.

CMS ACCESS Model: Key Facts

Model type: Voluntary, 10-year CMS Innovation Center program

Payment mechanism: Outcome-Aligned Payments (OAPs), tied to measurable clinical improvement

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Launch date: July 5, 2026

First cohort application deadline: April 1, 2026

Rolling applications: Accepted through 2033 for later cohorts

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Eligible providers: Medicare Part B physicians, NPs, PAs, CNSs, and qualifying suppliers (DME, labs, prosthetics excluded)

1. How Outcome-Aligned Payments Work

The ACCESS Model replaces per-service billing with a recurring Outcome-Aligned Payment (OAP) for each enrolled patient. That payment has two components, and understanding the split is critical to making the economics work.

Payment Component	What Triggers It	What You Lose If Missed
Base OAP	Enrollment and active care delivery, regardless of clinical outcome	Forfeited if the patient disengages or care delivery lapses
Outcome OAP	Patient meets CMS-defined clinical improvement threshold for their assigned track	Forfeited for that patient in that performance period, cannot be recovered retroactively

An organization that keeps patients enrolled but fails to move clinical markers will recover base payments only. The full financial case for ACCESS closes only when outcomes are consistently achieved, which means the delivery model, not just the enrollment volume, determines revenue.

2. ACCESS vs. CCM, RPM, and APCM: The Key Difference

Organizations can use similar tools and workflows under ACCESS as they do for CCM or RPM. The difference is in what CMS pays for at the end of the period.

Payment Component	CCM / APCM	RPM	ACCESS OAP
Pays for	Documented minutes and care plan activity	Device setup, data transmission, review time	Patient meeting defined clinical improvement threshold
Billing logic	Per-service CPT codes	Per-service CPT codes	Recurring outcome-linked monthly payment
Health improvement required for full payment?	No	No	Recurring outcome-linked monthly payment
Scales without more staff?	Difficult	Moderate	Yes, by design

Note:

ACCESS is not a replacement for CCM or RPM billing. Organizations can continue billing for those services under their existing CPT codes. ACCESS sits on top of that structure and adds an outcome-linked payment layer for eligible chronic care patients.

3. The Four Clinical Tracks: What Participation Requires

ACCESS launches with four tracks, each targeting a specific chronic condition population. Patients are enrolled in one track based on their primary condition. Below are the clinical markers that must be documented at baseline and tracked throughout the performance period.

Track	Target Conditions	Clinical Markers	Outcome Thresholds
eCKM	Hypertension, dyslipidemia, prediabetes, obesity	Blood pressure, HbA1c, BMI, LDL-C	SBP < 130 mmHg; prevention T2D progression; LDL-C reduction targets
CKM	Type 2 diabetes, CKD stages 1–4, atherosclerotic CVD	HbA1c, eGFR, UACR, LDL-C, blood pressure	Defined % HbA1c reduction; eGFR stabilization or improveme-ment; UACR reduction
MSK	Chronic musculoskeletal pain	PROMIS Pain Interference, PEG scale	Minimum clinically important difference (MCID) on validated pain scales
BH	Depression, anxiety	PHQ-9, GAD-7	Defined point reduction in PHQ-9 or GAD-7 from documented baseline

Baseline documentation is not optional:

CMS measures patient improvement against the specific baseline captured at enrollment. If baseline data is incomplete or inconsistent, there is no valid starting point for outcome calculation, and the Outcome OAP for that patient is effectively at risk from day one.

4. Technical Requirements: What You Must Have in Place

The ACCESS Model has non-negotiable infrastructure requirements. Organizations should treat these as qualification criteria, not implementation details.

1. FHIR R4 API Compliance

Participants must exchange data through FHIR R4-compliant APIs. This is a hard CMS requirement covering:

- **Outcome reporting** to CMS within defined submission windows each performance period
- **Electronic care plan sharing** with the patient's referring and primary care providers
- **Structured clinical data exchange** for all enrolled patient records

If your platform does not support FHIR R4 natively, third-party middleware can bridge the gap but introduces integration overhead, potential data latency, and additional vendor dependency. Resolving this before you apply is strongly advisable.

2. Physician Clinical Director

Every participating organization must designate a single physician Clinical Director who is personally accountable for:

- Clinical quality oversight across all enrolled patients and tracks
- Compliance with CMS reporting and documentation timelines
- Serving as the primary contact for CMS during audits or program reviews

This is not a committee or a team function. It is an individual obligation. Identify and confirm your Clinical Director before submitting an application.

3. Outcome Reporting Cadence

- Clinical outcome data must be submitted to CMS at defined intervals throughout each performance period
- Submissions must comply with CMS technical specifications for the ACCESS Model, including structured coding for each track's relevant markers
- Late or incomplete submissions affect payment processing for that period and cannot be resubmitted retroactively

4. Provider Eligibility

All providers enrolled through the ACCESS Model must be active Medicare Part B participants. Ineligible providers enrolled in error create compliance exposure. Organizations participating across multiple sites or clinical groups should run eligibility verification before finalizing their application.

5. Are You Ready? A Pre-Application Checklist

Use this checklist to identify gaps before the April 1, 2026, application deadline for the first ACCESS Model cohort.

CMS ACCESS Model Readiness Checklist

- ✓ **Patient identification:** Can you surface eligible patients across all four ACCESS tracks without manual chart review?
- ✓ **Baseline capture:** Is there a structured process to document clinical baselines for every enrolled patient before their first performance period?
- ✓ **Continuous monitoring:** Can your platform track HbA1c, eGFR, UACR, blood pressure, PHQ-9, and GAD-7 continuously, not just at episodic visits?
- ✓ **FHIR R4 readiness:** Does your platform support FHIR R4 API reporting to CMS and care plan sharing with referring providers?
- ✓ **Clinical Director:** Have you identified and formally confirmed your physician Clinical Director?
- ✓ **Attribution verification:** Do you understand how CMS assigns patients to your organization, and how to dispute misattributions?
- ✓ **Care team alignment:** Are care managers, clinical leads, and referring providers working from a shared patient record?
- ✓ **Scalable engagement:** Can you sustain continuous patient engagement across your enrolled population without a proportional staffing increase?
- ✓ **SDOH integration:** Do you have a process to flag and prioritize patients most likely to miss outcome thresholds due to social risk factors?

6. What CareSpace Covers, Track by Track

Persivia's CareSpace® platform is purpose-built for value-based care models like the CMS ACCESS Model, where payment depends on outcomes, not activity. Every capability below maps directly to an ACCESS requirement.

ACCESS Requirement	What CareSpace Delivers
Multi-track eligibility and risk stratification	Population health analytics surfaces eligible patients across all four tracks, ranked by risk level and care gap severity before the first performance period opens.
Baseline clinical data capture at enrollment	Structured workflows capture pre-enrollment vitals, labs, and validated assessment scores for every enrolled patient before their first performance period.
Continuous outcome monitoring between visits	AI-driven analytics track HbA1c, eGFR, UACR, blood pressure, PHQ-9, and GAD-7 scores continuously, flagging patients driffting from thresholds while there is still time to intervene.
FHIR R4 API reporting to CMS	Native FHIR-based data exchange supports outcome reporting to CMS and electronic care plan sharing with referring providers, without custom integration.
Coordinated care team workflows	Clinical directors, care managers, and referring providers operate from a shared patient record, reducing handoff gaps and supporting the team-based model ACCESS requires.
Scalable patient engagement without added headcount	Agentic AI conducts natural-language SMS and voice outreach for follow-ups, medication adherence, appointment reminders, and chronic care education, keeping patients engaged between visits.
SDOH risk prioritization	Social determinant flags surface patients most likely to miss outcome thresholds, enabling targeted outreach before a performance period closes.

CareSpace® also supports organizations already participating in CCM, RPM, or APCM, meaning the transition to ACCESS Model workflows does not require replacing existing infrastructure. It builds on it.

For a broader strategic perspective on the ACCESS Model and what it means for value-based care: The CMS ACCESS Model Reveals What Value-Based Care Has Been Missing.

The organizations that get into Cohort 1 won't just be participating in a new payment model. They'll be a year ahead on outcome data, workflow refinement, and CMS relationship-building by the time everyone else is still applying. The April 1 deadline is not a soft closing, applications submitted after that date move to a January 2027 start. That's a full performance year lost.

At this point we know which gaps show up most often and how long they take to close. If you're considering Cohort 1, the conversation needs to happen now.

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