SMARTMETER
Engaging Health Data

CMS ACCESS

Advancing Chronic Care with Effective, Scalable Solutions

Disclaimer: The information provided herein is based on Smart Meter's analysis and interpretation of CMS documentation related to the ACCESS program. Please always consult your billing specialist, local MAC office, or applicable legal counsel.

MODEL START	DURATION	INITIAL APPLICATION DEADLINE	SCOPE
July 5, 2026	10 Years	April 1, 2026	Nationwide

01 | WHAT IS THE CMS ACCESS MODEL?

A new CMS payment model replacing fee-for-service with Outcome-Aligned Payments (OAPs) — paying for RESULTS, not visits. Explicitly designed for technology-enabled, digital health chronic care delivery.

1

New Payment Method

OAPs replace traditional FFS billing. Fixed recurring monthly payments tied to measurable clinical outcomes — not visit volume or service codes.

2

4 Clinical Tracks

Early Cardio-Kidney-Metabolic (eCKM), CKM, Musculoskeletal (MSK), and Behavioral Health (BH) — covering the highest-burden chronic conditions.

3

Technology-First

Virtual care, remote monitoring, AI-assisted delivery, FDA-cleared software devices all explicitly permitted.

4

10-Year Nationwide

July 5, 2026 – June 30, 2036. Voluntary, all 50 states + territories. Rolling applications through April 1, 2033. Cohort 1 begins July 2026.

10,000+ digital health companies · $10B+ invested in 2024 · Most currently serve commercial only — ACCESS opens Medicare for the first time

02 | CLINICAL TRACKS & BENEFICIARY ELIGIBILITY

eCKM — Early Cardio-Kidney-Metabolic

Qualifying Conditions:

Hypertension OR 2+ of: dyslipidemia, obesity/overweight (central), prediabetes

OAP Measures:

BP, LDL-C, Weight/BMI, HbA1c

⚑ Stage 0 CKM — prevention focus. Cannot enroll with CKM simultaneously.

CKM — Cardio-Kidney-Metabolic

Qualifying Conditions:

1+ of: Diabetes mellitus, CKD Stage 3a/3b, Atherosclerotic cardiovascular disease (ASCVD)

OAP Measures:

BP, LDL-C, Weight/BMI, HbA1c + eGFR & uACR (if diabetes/CKD)

⚑ Highest OAP rate ($420/$210). Largest Smart Meter opportunity.

MSK — Musculoskeletal

Qualifying Conditions:

Chronic musculoskeletal pain (3+ months) — bones, joints, muscles, connective tissue

OAP Measures:

NRS pain, PROMIS PF+PI, site-specific PROMs (QuickDASH, KOOS, HOOS, ODI, NDI), PGIC

⚑ Single 12-month period only — no Follow-On. No rural add-on.

BH — Behavioral Health

Qualifying Conditions:

1+ of: Depression (min. PHQ-9 ≥10 for Initial Period), Anxiety (min. GAD-7 ≥10 for Initial Period)

OAP Measures:

PHQ-9, GAD-7, PGIC. Optional: WHODAS 2.0 12-item

⚑ Low scorers (<10) go directly to Follow-On with referral + diagnosis history.

Beneficiary Requirements: Original Medicare Parts A & B (primary payer) · No Medicare Advantage/PACE/Hospice · Not in control group · Not already aligned for same track within 3 months

03 | REIMBURSEMENT STRUCTURE — HOW PARTICIPANTS GET PAID

Clinical Track	Initial Period (Annual)	Follow-On Period (Annual)	Rural Add-On (Initial)	Follow-On Available?
eCKM	$360	$180	+$15	✓ Yes
CKM	$420	$210	+$15	✓ Yes
MSK	$180	N/A	None	✗ No
BH	$180	$90	None	✓ Yes

80/20 Split: Shown amounts are TOTAL allowed (Medicare 80% + beneficiary coinsurance 20%). Participants may waive beneficiary cost-sharing as a uniform policy.

Multi-Track Discount: 5% discount on the lower-cost track(s) when beneficiary enrolls in multiple tracks with the same Participant.

Payment Schedule: Monthly installments = 1/12 of Medicare portion. MONTHS 1–6: 100% of monthly installments paid. MONTHS 7–12: Withheld; reconciled after 12-month care period based on outcome performance.

MAXIMUM OAP — MULTI-TRACK BENEFICIARY ENROLLMENT

Key Rule: Beneficiaries may enroll in up to 3 tracks simultaneously — eCKM OR CKM (never both) + MSK + BH. Maximum value uses CKM (highest rate) + MSK + BH in the Initial Period.

TRACK-BY-TRACK BREAKDOWN — INITIAL PERIOD

Track	Annual Allowed	Medicare (80%)	Multi-Track Discount	Adjusted Allowed
CKM	$420	$336	—	**$420**
MSK	$180	$144	−$9	**$171**
BH	$180	$144	−$9	**$171**
TOTAL	$780	$624	−$18	**$762**

+ Rural Add-On (eCKM/CKM Initial only): +$15 → Grand Maximum with rural: $777 allowed / $621.60 Medicare

Max Annual Allowed
(CKM + MSK + BH Initial)
$762
after 5% multi-track discount

Max Medicare Portion
(80% of adjusted allowed)
$609.60
if cost-sharing collected

If Cost-Sharing Waived
(participant absorbs 20%)
$609.60
participant receives Medicare portion only

LIFETIME VALUE — SINGLE BENEFICIARY (CKM + BH multi-track, same participant)

Year 1 — All Initial
$762
CKM + MSK + BH

Year 2+ — Follow-On (MSK ends)
$295.50
CKM FO $210 + BH FO $90, after 5% BH discount

10-Year Total (1 Initial + 9 FO)
$2,617.50
CKM + BH multi-track, single beneficiary

03 | INITIAL vs. FOLLOW-ON PERIOD — PAYMENT TIERS

INITIAL PERIOD — 12 Months

- First time this organization treats beneficiary in this track within past 2 years
- At least ONE required OAP Measure is NOT at target at baseline
- Higher rate — reflects onboarding, establishing care relationships, achieving initial improvement
- eCKM/CKM exception: If beneficiary was referred by another clinician, qualifies for Initial Period even if ALL baseline measures are at target (include referring NPI on claim)
- Beneficiary stays enrolled full 12 months even if targets achieved early
- New Initial Period begins immediately if beneficiary switches to a different Participant

FOLLOW-ON PERIOD — 12 Months each

- Continuing management of beneficiary already treated by the same organization in this track within past 2 years
- OR: Initiating care when ALL OAP measures are already at target at baseline
- Lower rate — reflects sustained management & maintenance, reduced onboarding burden
- NOT available for MSK track — MSK is a single care period only
- Requires: renewed consent (≤60 days prior), validated medical necessity, new baseline if validity window expired
- Full payment still contingent on meeting OAP Measure targets at end of the 12-month period

04 | REQUIREMENTS FOR REIMBURSEMENT

PARTICIPANT ELIGIBILITY

- Medicare Part B–enrolled organization (single TIN), PFS-eligible
- Excludes DMEPOS suppliers and laboratory suppliers
- Designate a Medicare-enrolled physician as Medical Director
- All clinicians individually Medicare-enrolled; billing rights reassigned to TIN
- Active state licensure; scope-of-practice compliance in every operating state
- Pass CMS program integrity screening and enrollment review

BILLING & CLAIMS

- Monthly claims using track-specific ACCESS G-codes
- List ALL qualifying condition ICD-10 codes at highest specificity
- Submit within 90 days of date of service
- Claims 'zero-paid' by MACs; Innovation Payment Contractor (IPC) issues payment
- Each claim = attestation of active care delivery & compliance
- Cannot submit FFS claims for aligned beneficiaries during care periods

DATA & REPORTING

- Submit baseline OAP Measures via FHIR API within 60 days of alignment
- Quarterly OAP Measures every 70–110 days from prior submission
- End-of-period measures within 425 days of alignment (365 + 60 grace)
- Early reporting window: 90 days early (eCKM/CKM), 180 days (BH/MSK)
- HIE connectivity required within 12 months of model start
- FHIR-based standardized API (USCDI, §170.315(g)(10))

CARE COORDINATION

- Identify beneficiary's PCP and referring clinician at enrollment
- Electronically share standardized care updates (Direct Secure Messaging or HIE)
- Required moments: Care Initiation (10 days), Completion (30 days), Escalation (10 days)
- Use CMS-provided standardized care plan template for all updates
- Make care updates accessible to beneficiaries directly
- Beneficiary consent required before sharing information with care team

05 | PERFORMANCE-BASED PAYMENT ADJUSTMENTS

Only ONE downward adjustment applied per semi-annual reconciliation — the LARGER of the two. Adjustments are calculated against total annual OAP, applied to the withheld 50%.

Clinical Outcome Adjustment (COA)

Metric: Outcome Attainment Rate (OAR) = % of beneficiaries meeting ALL required OAP targets

Threshold (OAT): 50% during Effective Period (July 2026 – Dec 2027)

OAR ≥ 50%: → Full payment earned — no adjustment applied

OAR < 50%: → Payment = (OAR ÷ OAT) × full OAP amount

Maximum Reduction: 50% cap — never lose more than 50% of total OAP from COA

Example: OAR = 40%, OAT = 50% → earn 80% of OAP (40 ÷ 50)

Substitute Spend Adjustment (SSA)

Metric: Substitute Spend Rate (SSR) = % of beneficiaries who did NOT receive listed substitute services from OTHER Medicare providers

Threshold (SST): 90% during Effective Period (July 2026 – Dec 2027)

SSR ≥ 90%: → Full payment earned — no adjustment applied

SSR < 90%: → Payment = (SSR ÷ SST) × full OAP amount

Maximum Reduction: 25% cap — never lose more than 25% of total OAP from SSA

Example: SSR = 80%, SST = 90% → earn 89% of OAP (80 ÷ 90)

OAP PAYMENT LAYERS — BENEFICIARY LEVEL vs. PATIENT PANEL LEVEL

The ACCESS payment system operates on two distinct layers — monthly payments are calculated at the individual beneficiary + track level; performance adjustments are calculated across the full participant panel, blending all tracks together.

1 LAYER 1 — INDIVIDUAL BENEFICIARY

Monthly Payment Mechanics

Independent care period per beneficiary

Each patient has their own 12-month clock from enrollment date — completely independent of all other beneficiaries.

Monthly installment = 1/12 of annual OAP

Calculated per track, per beneficiary. CKM: $336 ÷ 12 = $28/month. Multi-track beneficiaries generate parallel streams.

Months 1–6: 100% of installments paid

All monthly installments in the first half of the care period are paid in full as care is delivered.

Months 7–12: Withheld (50% of annual OAP)

No payments issued months 7–12. This withheld balance absorbs any end-of-period performance adjustments.

Multi-track: each track calculated separately

A beneficiary in CKM + BH generates two independent payment streams on independent 12-month schedules.

1	2	3	4	5	6	7	8	9	10	11	12

Paid (Months 1–6) — Withheld (Months 7–12)

2 LAYER 2 — FULL PARTICIPANT PANEL

Semi-Annual Performance Adjustment

OAR = Beneficiaries meeting ALL OAP targets ÷ All beneficiaries completing care period

All tracks blended into one OAR

CKM, MSK, BH — all beneficiaries completing periods in the 6-month window counted together. Strong CKM performance offsets weak MSK.

OAT threshold: 50% — COA if below

OAR ≥ 50% → full payment. OAR < 50% → proportional reduction. Maximum COA capped at 50% of total OAP across the panel.

SST threshold: 90% — SSA if below

SSR ≥ 90% (beneficiaries avoiding substitute services) → full payment. SSA capped at 25% of total OAP.

Only the larger adjustment applies — no compounding

Example — 500 completing beneficiaries across all tracks:

- MSK 100 → 40 met (40%)
- CKM 200 → 160 met (80%)
- eCKM 150 → 90 met (60%)
- BH 50 → 20 met (40%)

Blended OAR = 310 ÷ 500 = 62% → Exceeds 50% OAT → FULL PAYMENT EARNED

Key implication: MSK and BH at 40% would fail if assessed individually — but CKM and eCKM pull the blended OAR to 62%, so all tracks earn full payment. Track mix strategy matters.

COA and SSA never stack. CMS takes whichever is larger. The withheld 50% absorbs it — months 1–6 are protected.

03 | PAYMENT CALCULATION EXAMPLES

Example 1
Full Payment Earned

- OAR = 80% ≥ 50% OAT → No COA
- SSR = 95% ≥ 90% SST → No SSA
- Result: 100% of annual OAP earned
- Full withheld 50% released at reconciliation

Example 2
Clinical Outcome Adjustment

- OAR = 40% < 50% OAT
- COA = 1 – (40 ÷ 50) = 20% reduction
- SSR = 95% → No SSA applies
- Result: 80% of annual OAP earned
- Release 30% of withheld (50% paid – 20% COA)

Example 3
Substitute Spend Adjustment

- OAR = 95% → No COA applies
- SSR = 88% < 90% SST
- SSA = 1 – (88 ÷ 90) ≈ 2.2% reduction
- Result: ~98% of annual OAP earned
- Release remaining 48% of withheld

⚑ **Only the LARGER of COA or SSA is applied — they never compound. Caps: COA max 50% | SSA max 25% of gross annual OAP.**

05 | OAP MEASURE TARGETS — KEY CLINICAL THRESHOLDS

Measure	Track(s)	Control Target	Minimum Improvement	Reporting Frequency
Blood Pressure	eCKM, CKM	**Systolic < 130 mm Hg**	15 mm Hg reduction in systolic	Baseline, Quarterly, EOP
Weight / BMI	eCKM, CKM	**BMI < 30 AND ≤5% weight gain**	5% weight reduction	Baseline, Quarterly, EOP
HbA1c	eCKM (prediabetes) / CKM (diabetes)	**eCKM: <6.5% | CKM: <7.5%**	CKM: 1 percentage point reduction	Baseline + EOP (condition only)
LDL-C	eCKM (dyslipidemia) / CKM	**<100 mg/dL (or <70 if ASCVD)**	30 mg/dL reduction	Baseline + EOP (condition only)
eGFR / uACR	CKM (diabetes / CKD only)	**Submission only — no numeric target**	N/A	Baseline only
PHQ-9 / GAD-7	BH	**Score < 10 (if baseline <10)**	≥5 pt reduction (PHQ-9); ≥4 pt (GAD-7)	Baseline, Quarterly, EOP
PROMIS PF + PI	MSK	**No control target for MSK**	+2 pt PROMIS PF AND −2 pt PROMIS PI	Baseline, Quarterly, EOP

EOP = End of Period | All targets apply per beneficiary relative to their individual baseline | BP clinical validity window: 15 days; lab values: up to 1–2 years

06 | EXCEPTIONS, NUANCES & CRITICAL EDGE CASES

⚠ White-Coat Hypertension (eCKM Only)

May align based on patient-attested HTN diagnosis. If follow-up home/ambulatory readings confirm NO hypertension and no other qualifying conditions → beneficiary disenrolled. Retain up to 2 months payments IF non-qualifying readings submitted to CMS. Otherwise ALL payments recouped. Applies ONLY to eCKM/HTN — not other tracks or conditions.

⚠ FFS Exclusion — No Dual Billing

ACCESS Participants AND affiliated entities (5%+ ownership, operational control, or reassignment relationships) CANNOT submit Medicare FFS claims for aligned beneficiaries during care periods. CMS systems auto-suppress FFS billing. Does NOT restrict beneficiary access — only affects payment routing.

⚠ eCKM ↔ CKM Cannot Overlap

Beneficiaries cannot be enrolled in BOTH eCKM and CKM simultaneously (CKM encompasses all eCKM measures and care). If already in eCKM and later qualifies for CKM, beneficiary may switch immediately — the normal 3-month lock-in does NOT apply to this specific track switch.

⚠ Randomized Evaluation / Control Group

Beneficiary-level randomization at 90:10 (intervention:control). Control group beneficiaries are ineligible for 12 months. Participants MUST inform beneficiaries about possible control assignment before querying the eligibility API. CMS provides exact standardized language — use it verbatim.

⚠ MSK — Single Period, No Follow-On

MSK is one 12-month period only — no Follow-On Period. No rural device add-on. No 'control' target — only minimum improvement is measured. After 90 days, beneficiaries may switch or disenroll freely. No additional periods offered by same Participant.

⚠ BH Baseline Scores & Period Eligibility

BH beneficiaries with PHQ-9 <10 AND GAD-7 <10 at baseline are NOT eligible for the Initial Period on that basis alone. They may enroll directly in Follow-On Period only with a provider referral AND documented diagnosis history within the past 18 months.

06 | REQUIRED CLINICAL EXCLUSIONS — WHO CANNOT ENROLL

MANDATORY: These exclusions cannot be waived. Participants may propose additional exclusions for their service model but cannot exclude an entire condition from a track.

eCKM / CKM Track

- ✗ Severe heart failure (NYHA Class III–IV)
- ✗ Active unstable angina / acute coronary syndrome
- ✗ Unstable complex secondary hypertension
- ✗ CKD Stage 4–5 / ESRD / receiving dialysis
- ✗ Severe valvular disease
- ✗ Active thyrotoxicosis or severe electrolyte imbalances
- ✗ Active eating disorders (anorexia, bulimia, binge-eating)
- ✗ Moderate–severe dementia / acute psychiatric instability
- ✗ Pregnancy
- ✗ Age 81+ with frailty indicator
- ✗ Receiving hospice or palliative care
- ✗ Age 66+ entering long-term nursing home care

MSK Track

- ✗ Inability to bear weight on affected limb
- ✗ Significant surgery/trauma to area within 3 months
- ✗ Peri- or post-surgical period (e.g., post-joint replacement)
- ✗ Severe arthritis limiting mobility
- ✗ Unstable fractures or severe osteoporosis with fracture risk
- ✗ High fall risk
- ✗ Pain from non-MSK cause (cancer, autoimmune, infection)
- ✗ Primary neurological disorders (stroke, Parkinson's, MS)
- ✗ Severe heart failure (NYHA Class III–IV)
- ✗ Suicidal/homicidal ideation; moderate–severe dementia
- ✗ Pregnancy
- ✗ Age 81+ with frailty; hospice/palliative; LTC nursing home

BH Track

- ✗ Suicidal or homicidal ideation
- ✗ Moderate–severe dementia or severe cognitive impairment
- ✗ Schizophrenia, MDD with psychosis, Bipolar I Disorder
- ✗ Active severe eating disorders
- ✗ Pregnancy
- ✗ Age 81+ with frailty indicator
- ✗ Receiving hospice or palliative care
- ✗ Age 66+ in long-term nursing home care
- ✗ Enrolled in a CCBHC (Certified Community Behavioral Health Clinic) program

06 | SUBSTITUTE SPEND LISTS — CODES THAT TRIGGER THE SSA

Only triggered if billed by ANOTHER Medicare provider during the beneficiary's ACCESS care period AND the claim's principal diagnosis matches the beneficiary's ACCESS qualifying condition.

eCKM / CKM Track — Substitute Spend List

- Ambulatory Blood Pressure Monitoring (93784, 93786, 93788, 93790)
- Ambulatory Continuous Glucose Monitoring (95249–95251)
- **RPM / SMBP Device Set-up (99453, 99473)** ←
- Diabetes Self-Management Training — DSMT (G0108)
- Intensive Behavioral Therapy — Cardiovascular (G0446), Obesity (G0447)
- Medical Nutrition Therapy — Initial Visit (97802)
- RTM Patient Education / Device Set-up (98975)
- Medicare Diabetes Prevention Program — MDPP (G9880, G9881, G9886, G9887)

MSK Track

- PT Evaluation (97161–97163)
- OT Evaluation (97165–97167)
- RTM Patient Ed./Device Set-up (98975)

BH Track

- DHMT Digital Device + Treatment (G0552, G0553)
- Psychiatric Diagnostic Eval (90791, 90792)
- RTM Patient Ed./Device Set-up (98975)
- Initial Psych Collaborative Care Mgmt (99492)

🎯 RPM — SSA IMPACT & OPPORTUNITY

RPM device set-up codes (99453, 99473) are on the eCKM/CKM Substitute Spend List. This means if another provider bills RPM device set-up for the same condition during an ACCESS care period, it counts AGAINST the Participant's SSR — potentially triggering a payment reduction.

04 | CO-MANAGEMENT PAYMENT — PARTNERING WITH PCPs

PCPs and referring clinicians earn a new Co-Management Payment for reviewing ACCESS clinical updates — billed separately from OAP by the clinician, not the ACCESS Participant.

Base Payment

$30 per service, subject to geographic adjustment factor (GAF). Amount varies by locality.

Onboarding Bonus

First claim: add CMS modifier → +~$10 for assisting beneficiary with initial onboarding/setup.

Frequency Cap

Max once every 4 months per beneficiary per track. Up to approximately $100/year per beneficiary.

No Cost-Sharing

Zero Part B beneficiary cost-sharing. No advance consent required from the beneficiary.

Documentation Req.

Review ACCESS Care Update + brief EHR note documenting assessment and care coordination action (med change, reconciliation, referral, etc.).

Who Bills

PCPs and referring clinicians via G-codes. Subject to all standard Medicare adjustments (sequestration, non-physician reductions, etc.).

07 | BENEFITS — FOR ACCESS PARTICIPANTS (PROVIDERS)

Predictable Revenue

Monthly recurring OAP payments replace unpredictable FFS volume — enables revenue forecasting and investment.

Medicare Market Access

Opens Medicare to digital health companies that couldn't access it through FFS — biggest barrier removed.

Outcomes, Not Volume

Flexibility to choose care delivery methods. No visit/code justification required — focus on measurable health outcomes.

Technology Supported

FDA-cleared SaMD, RPM, AI-assisted care, virtual/async delivery all explicitly permitted and designed for.

Public Outcome Reporting

CMS publishes risk-adjusted outcomes per participant — strong performers gain referrals and brand differentiation.

ACO & Multi-Payer Ready

Compatible with ACOs. Designed for MA, Medicaid, and commercial adoption of same codes — one infrastructure.

Built-in Flexibility

50% OAT means up to half of patients can miss targets and still earn full payment. Downside capped at 50% COA / 25% SSA.

Claims Data Access

Participants can request Medicare claims data (BCDA) for aligned beneficiaries — enabling proactive care management.

07 | BENEFITS — FOR MEDICARE BENEFICIARIES

Care at Home

Access to continuous, technology-enabled chronic disease management without leaving home — remote monitoring, virtual check-ins, app-based therapy.

Integrated Care

Participants manage ALL qualifying conditions in the track holistically — not just one condition at a time.

Potential $0 Cost-Sharing

Participants may waive beneficiary cost-sharing as a uniform policy — many digital health companies expected to adopt this.

Freedom of Choice

Voluntary enrollment. Switch or disenroll after 90 days. ACCESS never limits access to any other Medicare-covered services.

Transparent Outcomes

CMS publishes risk-adjusted participant outcomes publicly — beneficiaries can compare performance before choosing a provider.

PCP Stays Involved

ACCESS Participants are required to coordinate with existing PCPs — beneficiaries' regular care team stays informed and engaged.

08 | KEY DATES & NEXT STEPS

1	2	3	4	5
Jan 12, 2026	**Apr 1, 2026**	**Jul 5, 2026**	**Jan 1, 2027**	**Jun 30, 2036**
Applications Open	Cohort 1 Deadline	Model Begins	Cohort 2 Start	Model Ends

URGENT: Cohort 1 application deadline was April 1, 2026 and was extended to May 15, 2026. Organizations should be applying NOW — or already in the process – as CMS will continue to evaluate applications.

SMARTMETER
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ACCESS MODEL — QUICK REFERENCE CHEAT SHEET

OAP Payment Amounts	
eCKM Initial / Follow-On	**$360 / $180**
CKM Initial / Follow-On	**$420 / $210**
MSK (Initial Period only)	**$180**
BH Initial / Follow-On	**$180 / $90**
Rural Add-On (eCKM/CKM Initial)	**+$15**
Multi-Track Discount	**5% on lower-cost track(s)**
Co-Management Payment	**$30 base (+~$10 onboarding)**

Key Thresholds & Mechanics	
Outcome Attainment Threshold (OAT)	**50%**
Substitute Spend Threshold (SST)	**90%**
Max COA payment reduction	**50% of OAP**
Max SSA payment reduction	**25% of OAP**
Months 1–6 payment rate	**100% monthly installment**
Months 7–12 withheld for reconciliation	**50% of annual OAP**
Baseline OAP Measures submission deadline	**60 days of alignment**

Source: CMS ACCESS Model RFA v1.1 (Feb 12, 2026) + Payment Amounts & Performance Targets (Effective July 5, 2026 – December 31, 2027)