ConnectedHealthInitiative

January 28, 2025

The Honorable Dr. Mehmet Oz
Administrator
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Abe Sutton, JD
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Outstanding Questions and Opportunities to Maximize the ACCESS Model's Potential

Dear Administrator Oz and Deputy Administrator Sutton:

The Connected Health Initiative (CHI)[1] shares your commitment to fostering the development and adoption of innovative, cutting edge digital health and wellness technologies to measure and promote better health for all Americans. We are greatly encouraged by the recent announcement by the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) of the Advancing Care Coordination and Empowering Self-Management Services (ACCESS) Model, a 10-year voluntary program designed to expand access to new technology-supported options for care for Americans who rely on Medicare.

CHI is the leading multistakeholder policy and legal advocacy effort dedicated to improving health outcomes while reducing costs, representing the consensus of leading providers, health technology developers, patients, and others across the healthcare ecosystem. CHI aims to realize an environment in which Americans can see improvements in their health through policies that allow for digital and connected technologies to advance the Quadruple Aim – improving individual patient outcomes, reducing costs, augmenting population health management, and supporting the healthcare workforce. We advocate before Congress, numerous U.S. federal agencies, and state legislatures and agencies to achieve responsible pro-digital health policy and law changes in areas including payment and coverage policy, privacy and security, effectiveness and quality assurance to enable efficacious technologies to positively transform healthcare. For more information, see www.connectedhi.com.

CHI believes that the ACCESS model represents a major advancement towards unlocking the untapped potential of digital healthcare tools in Medicare, including telehealth, remote monitoring, AI, digital coaching, wearable devices, and other digital health modalities into the management of chronic conditions like hypertension, diabetes, chronic pain, and depression. While traditional Medicare payment policies have only begun to leverage the incredible power that these tools offer to improve outcomes and reduce costs, the ACCESS Model puts CMS on a clear path to truly empowering physicians and other health professionals and patients to realize a more connected care continuum.

[1] www.connectedhi.com.

The CHI community greatly appreciates the details CMMI has provided already on how the ACCESS Model will operate in its recently-released Request for Applications (RFA). As our community explores the potential of participation in (and support of providers participating in) the ACCESS Model as the April 1, 2026 application deadline approaches, CHI has identified several areas in which additional clarity would be helpful:

- **How will eligibility and payments be structured?**
    - CHI appreciates the details provided in the RFA on critical payment details thus far, and requests that CMMI provide further information including the base OAP amounts per condition track, any tiered payment levels based on performance, and the frequency of reconciliation or adjustments. We urge CMMI to ensure its approach to ACCESS Model payments adequately cover technology costs (devices, software platforms, data transmission), clinical staff time for care coordination and monitoring, patient engagement and education resources, and support outreach to particularly underserved populations in rural America.
    - CHI urges CMMI to publish illustrative OAP rate ranges (per track and per beneficiary) in early 2026 technical guidance or FAQs, including examples that show the impact of rural add-ons and multi-track discounts, to improve financial predictability and support participant planning.
    - CHI recommends that CMMI establish minimum guaranteed floors for Follow-On Period OAP rates (e.g., no more than a specified percentage reduction from Initial Period rates) to ensure long-term sustainability for participants investing in technology-enabled care models.
    - CHI recommends that CMMI commit to phased, transparent increases in the Outcome Attainment Threshold (OAT) and Substitute Spend Threshold (SST) for later model years with opportunities for stakeholder input via public comment before final values are set.
    - CMMI should clarify the data sources and rationale CMS will use to determine future OAT and SST adjustments, and establish hard caps on downward adjustments (e.g., maintaining the initial 50% OAT and 25% SST floors as model-wide minimums) to reduce excessive financial risk for innovative participants.
    - CMMI should disclose the multi-track discount formula or range in advance of 2026 rate publication, including examples of net payment impact, to enable accurate financial modeling by participants.
    - CMMI should allow participants to opt out of multi-track discounts for high-complexity cases (with appropriate justification) to avoid disincentivizing comprehensive, multi-condition care delivery.
    - CMMI should provide detailed substitute service attribution rules for the Substitute Spend Adjustment (SSA) in forthcoming guidance and establish a clear process for participants to submit evidence disputing attributions during reconciliation.
    - CMMI should specify precise semi-annual reconciliation calendars (e.g., Q1 and Q3) and clearly define the “prior 6 months” panel inclusion criteria to improve predictability for participants.
    - CHI recommends that CMMI limit overpayment recovery in the first 1–2 model years to prospective offsets rather than lump-sum demands, with interest waivers for good-faith errors, to reduce financial strain during the early implementation phase.
    - CHI urges CMMI to confirm that final co-management service payment amounts (currently approximated at ~$30 plus ~$10 onboarding, max ~$100/year) will be

indexed to inflation or the Physician Fee Schedule and include a reasonable floor to ensure referring clinicians remain appropriately incentivized.
    - CHI encourages CMMI to clarify whether non-qualified health care provider owned or operated entities (Professional Corporations, medical practices) can be the primary recipient of funds from the program, and, if so, whether CMMI recommends enrolling with Medicare and obtaining an NPI number.

- **How does the ACCESS Model avoid duplicative payments/overlapping treatments?**
    - CHI believes that a reasonable approach could restrict FFS billing solely for services related to conditions actively managed by the ACCESS participant, while permitting standard billing for diagnosis and treatment of completely unrelated symptoms that patients develop. We are concerned that a blanket prohibition on billing for any services beyond the OAP could make it difficult for physicians participating in ACCESS to maintain continuity in caring for their patients. Another key example is that CMMI should clarify that providers can bill traditional RPM/RTM codes for conditions outside the clinical track being managed through ACCESS, as Medicare beneficiaries often have multiple chronic conditions and restricting all remote monitoring to ACCESS enrollment could inadvertently limit access to care for conditions not covered by the model.
    - CHI views the Substitute Spend Adjustment as an adequate mechanism specifically designed to address instances where patients receive identical services from multiple providers (CMMI illustrates this with a scenario involving a patient aligned with an ACCESS participant in the MSK track receiving low back pain management from the ACCESS participant while simultaneously being evaluated for the same condition by a separate PT provider). CHI does not believe that a blanket prohibition preventing ACCESS participants from submitting Medicare FFS claims is a necessary feature given the safeguards already established through the SSA.

- **Can providers billing under the same TIN as an ACCESS Model Participant continue to bill Medicare fee-for-service for services unrelated to the beneficiary's ACCESS clinical track?**
    - CHI requests that CMMI provide clarity about situations where a beneficiary is enrolled in the ACCESS Model and managed by an organization for a particular clinical track and whether primary care providers and specialists who bill under the same TIN but are not directly involved in delivering ACCESS services for that track may continue to provide, manage, and bill Medicare fee-for-service for conditions unrelated to or outside the scope of the ACCESS track. Based on the details CMMI has provided so far, it appears that providers billing under the ACCESS Participant TIN may be prohibited from submitting Medicare FFS claims for aligned beneficiaries during an active care period, regardless of the condition involved, with this restriction applying broadly across the TIN. CHI asks CMMI to confirm the intended scope of this exclusion and to affirm that it permits FFS billing by non-ACCESS-involved providers within the same TIN for unrelated services and conditions.

- **How will beneficiary consent and transparency be ensured?**

- CMMI should develop standardized, plain-language consent templates or scripts (e.g., at a 6th-grade reading level, per NIH guidelines) that include visual aids like icons for key concepts (e.g., a calendar for the 90-day period).
- The RFA allows verbal consent but requires documentation in the patient's record without specifying what constitutes sufficient proof. CMMI should clarify that documentation can be a simple templated EHR note with optional audio recording integrations for high-risk cases, ensuring patients understand via upfront notice. CMMI should also encourage the use of AI-assisted transcription tools for verbal sessions, which summarize and log consent automatically.

- **How will disputes or appeals be resolved if outcomes are contested, such as those related to data inaccuracies or external factors affecting patient adherence?**
  - CHI recommends that a dispute resolution process resemble that used in the MSSP in accordance with 42 CFR Part 425 Subpart I.

- **How will intellectual property and data ownership be addressed in the ACCESS Model?**
  - CMMI should confirm that participants fully retain ownership and all IP rights in any software, algorithms, care delivery protocols, customized apps, or other tools developed or adapted for use in the model.
  - CMMI should provide an assurance that CMS does not claim any implied license, non-exclusive rights, or future access to participant IP (e.g., there is no requirement to grant CMS or other participants rights to use proprietary tech for model dissemination, replication, or scaling).
  - CMMI could provide guidance on how the ACCESS Model handles scenarios where participants integrate third-party proprietary tools (e.g., licensed SaMD or AI platforms), and how CMMI views the risk of model requirements conflicting with vendor licensing terms.

- **How can administrative/paperwork burdens be minimized?**
  - CHI requests that CMMI develop further guidance on acceptable electronic collection methods for PROMs/PRO-PMs (e.g., Patient Global Impression of Change, depression/anxiety scales) that preserve scoring fidelity while minimizing provider/clinician workflow interruptions, such as patient-facing mobile apps, automated text/email prompts, or integration with existing EHR portals. CHI suggests that CMMI publish best-practice examples or validated low-burden workflows to prevent variability that could increase administrative effort.
  - CHI recommends that CMMI affirm that it is taking a risk-based audit approach (e.g., targeted sampling) to avoid blanket reviews that recreate paperwork burdens the model aims to eliminate.

- **How will the ACCESS Model be responsive to provider and patient experiences?**
  - CHI encourages CMMI to provide as much detail as possible about how it will track specific technologies employed for each participant to aid in the evaluation of the effectiveness of ACCESS Model services to ensure that effective technologies remain a part of Medicare payment models and those that are ineffective are identified and removed.
  - CHI appreciates CMMI's commitment to iterating as this 10-year model advances, and recommends that CMMI clarify that it will pursue quarterly stakeholder

feedback sessions during Year 1; conduct annual review and adjustment of OAP amounts based on actual costs and outcomes; engage in transparent sharing of model performance data and lessons learned; and indicate an openness to adding new clinical tracks based on evidence and demand.

We appreciate your consideration of our input at this critical time for the American healthcare system and the countless Americans who depend on it. We stand ready to assist you in any way that we can.

Sincerely,

Brian Scarpelli
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