ALLIANCE for CONNECTED CARE

October 9, 2026

Abe Sutton
Director of the Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: ACCESS Model and Alternative Opportunities

Dear Mr. Sutton,

Congratulations on the official launch of the ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) model and subsequent expansion to address additional chronic disease states. The Alliance is supportive of many of the ideas represented in the ACCESS Model, as we believe outcome-aligned payment is an important step toward removing barriers to technology-enabled care pathways. *However, we believe additional paths will be required to test, evaluate, and expand the technology-enabled care models needed to broadly transform care management services as outlined in the CY2027 Physician Fee Schedule RFI*.

The Alliance for Connected Care ("The Alliance") is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of connected care capabilities, including telemedicine, remote patient monitoring (RPM), and AI-enabled care. Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups that seek to better utilize opportunities enabled by virtual care.

The Alliance agrees that the ultimate solution for accelerating the adoption of highly efficient and cost-effective technology-enabled care is the creation of payment models that explicitly tie payment to outcomes. The ACCESS Model represents an important step in advancing this vision by moving away from volume-based payment structures that constrain innovation – and several of our members are participating. By rewarding outcomes rather than volume, ACCESS helps ensure that patients and providers are not forced to weigh outdated regulatory or payment barriers when determining the best modality for care.

We believe the model will be an exciting opportunity to test direct-to-consumer chronic disease interventions – and evaluate them based on demonstrated outcomes. As it stands, we are less optimistic about the prospects for this model as a means to empower a patient's existing medical care team to ensure that a patient who needs ongoing clinical support receives it. We look forward to early evaluations of this model – which should include meaningful data points for the future of AI-enabled care management interventions.

As clearly articulated in your design, the ACCESS Model (even with additional tracks) is a meaningful addition to – but not a replacement for – the care management services that Medicare covers today. The model and reimbursement structure were not designed to support practitioner-led care to higher acuity patients, such as seniors with multiple, complex comorbidities or disqualifying medical conditions. It will be limited in its ability to support patients that need meaningful hybrid in-person/virtual care treatments for their conditions. For example:

- The ACCESS model structure is meaningful for expanding access to low-cost chronic disease management but does not serve as a substitute for an active, real-time intervention from a clinician using Remote Physiologic Monitoring (RPM) to address a medication need or prevent a costly hospital readmission/mortality.
- The ACCESS model structure is meaningful for expanding access to low-cost musculoskeletal care for Medicare beneficiaries navigating nonsurgical and low-acuity treatment, but does not serve as a substitute for Remote Therapeutic Monitoring (RTM) in supporting post-surgical patients during a defined episode of care at the direction of their treating practitioner (preventing additional surgeries and advanced imaging).

In line with the CMS line of questioning about the future of the Care Management Code Family in the CY2027 Physician Fee Schedule RFI, we believe that CMMI should be testing additional technology-enabled care management model(s) that address needs currently unmet by ACCESS. We request the testing of a care delivery pathway that sits between existing fee-for-service care and the vision laid out in ACCESS. This model should -

- ✓ Align incentives and reduce inappropriate utilization through risk-based/outcome-based payments either related to specific measures or total cost of care (including ACO accountability).
- ✓ Support care delivery models that more closely resemble the practitioner-led care delivery pathways that exist today (in which general supervision by an ordering provider continues to exist in a meaningful way and there is no fee-for-service exclusion).
- ✓ Initially benchmark reimbursement to the costs incurred by practitioners offering existing care management services today (while still requiring these payments be at risk) and reevaluate costs over time as incentives and technology drive greater efficiency and outcomes.
- ✓ Continue to expand flexibility around the delivery of these services, in tandem with increasing provider risk/accountability – allowing greater automation and innovation to drive down costs and improve outcomes.

Taken together, these reforms would be significant transformation of care management services – and a meaningful step for CMS to take following its RFI. Additionally, accelerating the movement to outcomes-aligned payment is the right policy response to the utilization concerns outlined by CMS in CY2027 PFS and would be a better path forward for the future of these services than those currently proposed. Your leadership is needed to shape this path to value.

Thank you for your consideration of this request. We look forward to following up with more detailed recommendations on the above points. Please feel free to reach out to rikki.cheung@connectwithcare.org for additional information or context.

Sincerely,



Chris Adamec
Executive Director