



SETTING THE STAGE: CMS AND THE DIGITAL LANDSCAPE



NAACOS FALL 2026 CONFERENCE

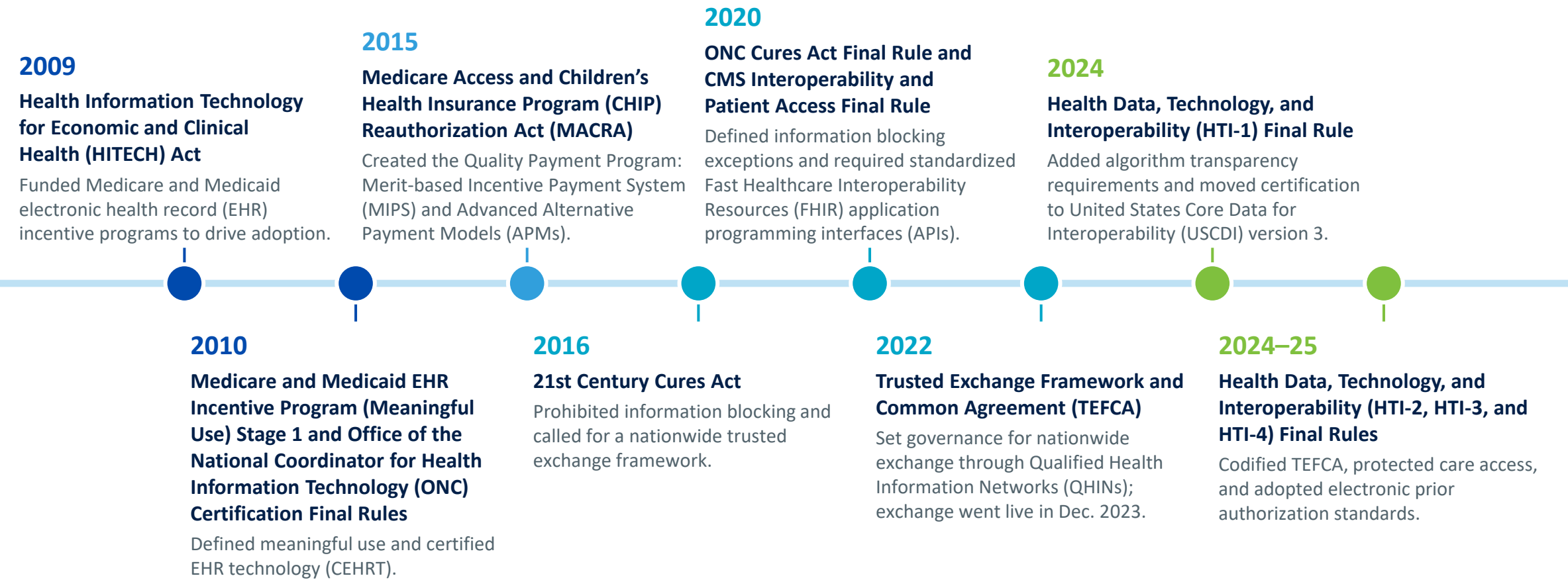
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Pre-Conference IT / ACCESS Session | October 14, 2026

"I don't know where I'm going, but I sure know where I've been."

- Eddie Van Halen

KEY LEGISLATION AND RULES

Key legislation and rules that have shaped Centers for Medicare & Medicaid Services (CMS) health information technology strategy



TECHNOLOGY REQUIREMENTS



What certified health IT is required deliver

Certification rules set the technology baseline that provider and payer requirements build on.

01 CERTIFY

ONC CERTIFICATION

Health IT must be certified to ASTP/ONC criteria; CEHRT is the baseline product providers are required to use.

CEHRT • certification criteria

02 CAPTURE

USCDI v3–v4

Certified systems must capture and share the USCDI data classes as structured, exportable data, not documents.

USCDI • structured data • export

03 OPEN

CURES ACT

Standardized FHIR APIs for single-patient and population access, with no special effort or information blocking.

FHIR • bulk data • patient access

04 EXCHANGE

HTI + TEFCA

HTI rules and TEFCA participation add trusted network exchange, identity, consent, and decision-support transparency.

TEFCA • HTI • identity

PROVIDER REQUIREMENTS



What clinicians, groups, and ACOs are accountable for

Provider obligations run through participation and payment programs — CEHRT use, quality reporting, and Promoting Interoperability performance – and finalized in the annual Physician Fee Schedule and other stand-alone rules.

●	CEHRT	CEHRT USE	Use certified technology and attest.
●	MIPS PI	PROMOTING INTEROPERABILITY	Report PI measures; scoring affects pay.
●	eCQMs	QUALITY REPORTING	Submit electronic quality measures.
●	INFO BLOCKING	DATA SHARING DUTIES	Do not impede access or use of EHI.
●	ACO / APM	PROGRAM PARTICIPATION	Medicare CQMs tie data to savings.

PROVIDER CHECKLIST

1

Use CEHRT in daily care

2

Submit eCQMs or Medicare CQMs

3

Meet PI measures and attest

4

Honor information blocking rules

5

Apply data in payment

What CMS-regulated payers must build and make accessible

CMS rules place API and data-sharing obligations directly on impacted payers. These are separate mandates — not consequences of the technology certification rules.

CMS RULES ON PAYERS

**CMS-9115-F
PATIENT
ACCESS**

2020: Patient Access
API, directories, payer-
to-payer

**CMS-0057-F
PRIOR AUTH**

2024: Provider Access
and prior auth APIs,
2026–27

**PROGRAM
RULES**

Conditions of
participation for MA,
Medicaid, CHIP

APIS AND DATA PAYERS MUST PROVIDE

**PATIENT AND
PROVIDER ACCESS**

Claims, encounters, clinical data, and prior
authorization status available via FHIR APIs

**PRIOR
AUTHORIZATION
TRANSPARENCY**

Automated requests and decisions, published
timelines, and denial reasons

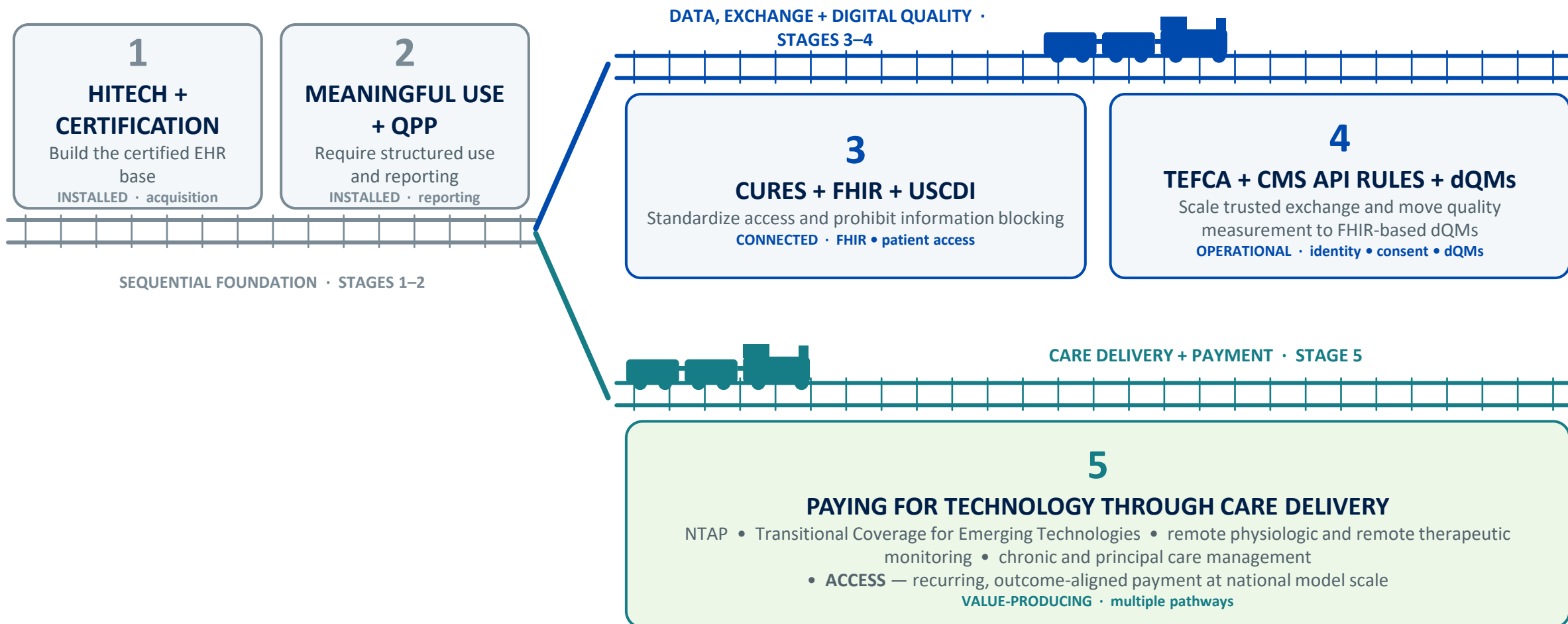
**DIRECTORIES
AND PAYER-TO-
PAYER**

Public provider directories and member data transfer
when patients change plans

INTEROPERABILITY WAS NEVER THE END GOAL

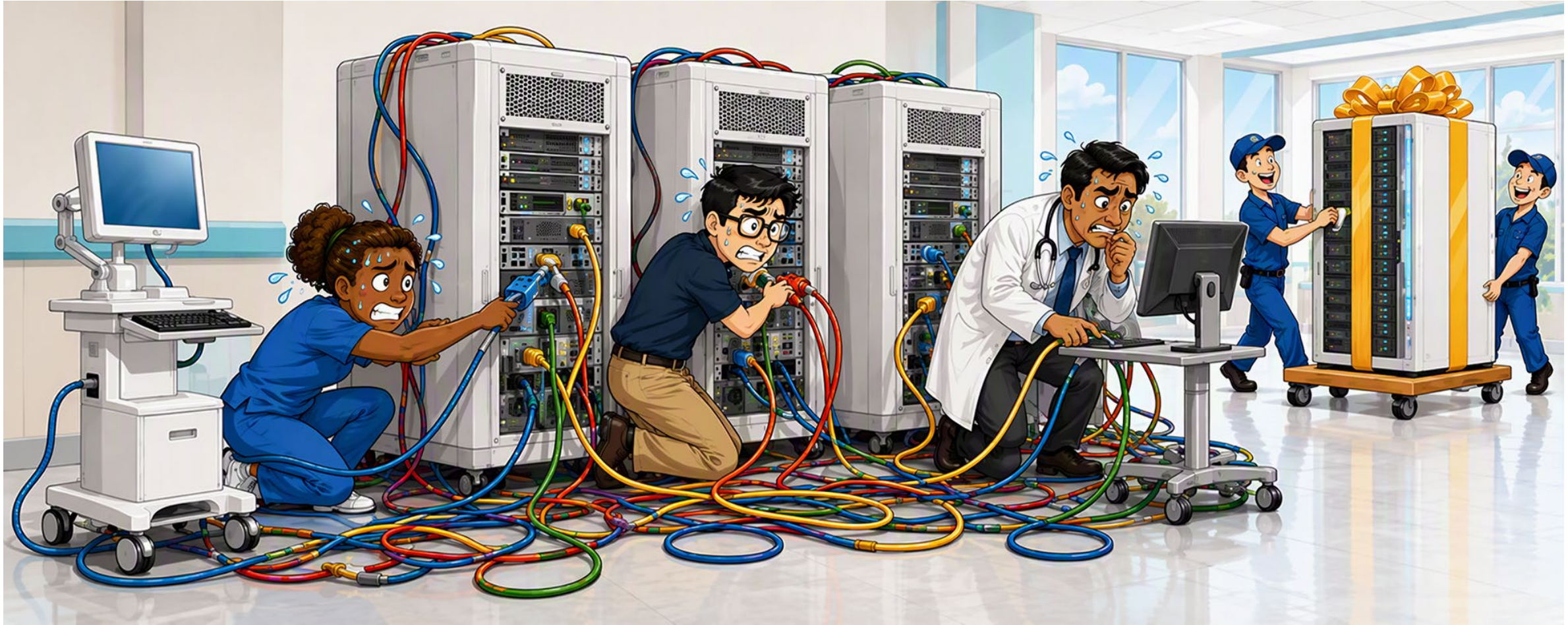
Stages 1–2 built the foundation; stages 3–4 now run on a parallel track alongside stage 5

The hard part is not installing technology — it is moving from installed to connected to operational to value-producing.



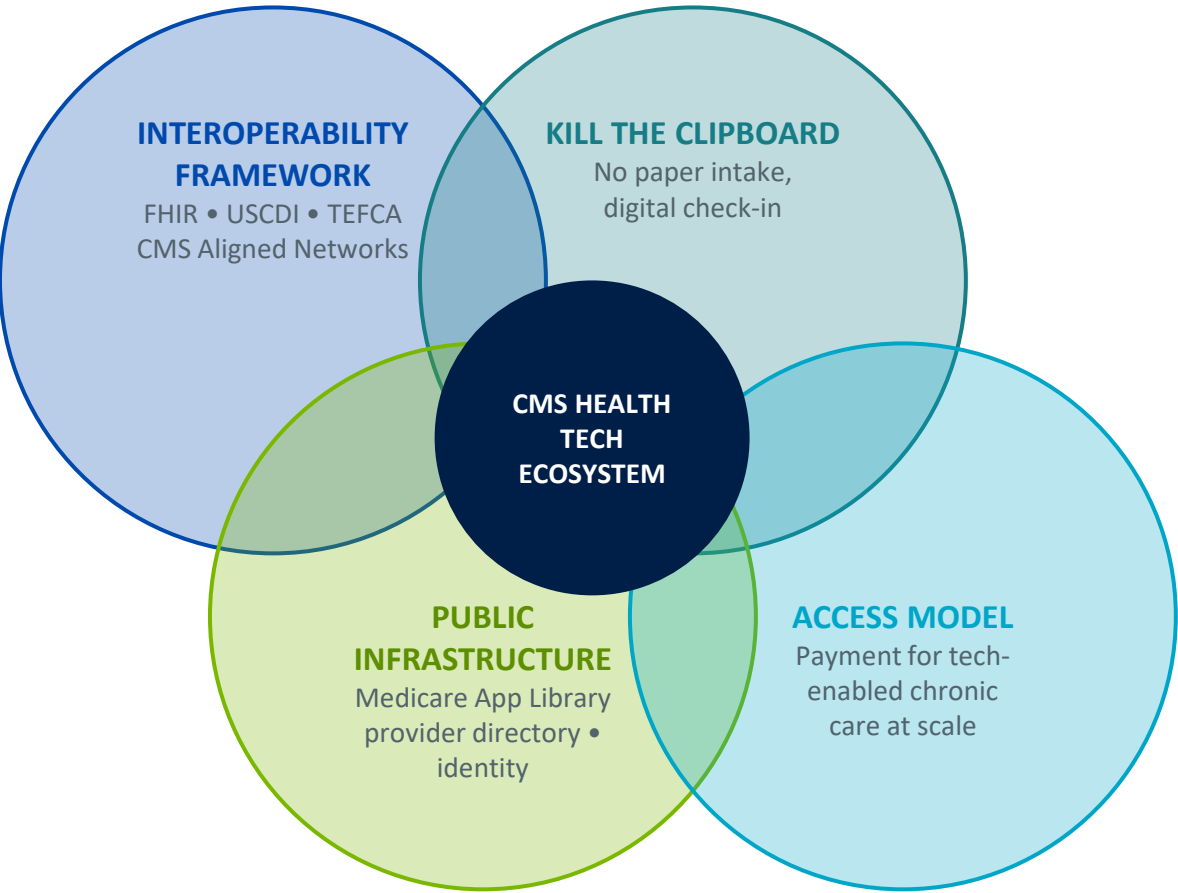
ON A LIGHTER NOTE

The elephant in the room



The CMS Health Tech Ecosystem is a living system, not a rulebook

Launched July 2025 with 60+ pledgees and now 700+ organizations, CMS calls it "a movement, not a mandate" — data exchange, patient-facing tools, and public infrastructure evolving together, with interoperability as one component.



WHAT CMS IS ACTUALLY BUILDING

CMS Interoperability Framework — voluntary criteria for real-time, consented FHIR exchange

CMS Aligned Networks — networks self-attest to the full criteria and answer patient, provider and payer requests

Kill the Clipboard — patients arrive with records, coverage and history already digital

CMS-built infrastructure — National Provider Directory, modern identity on Medicare.gov, Medicare App Library

WHO PLEDGED AND WHAT THEY OWE

PLEDGEES 700+ orgs — Google, Amazon, Epic, UnitedHealth, Humana, etc.

APP DEVELOPERS patient tools: navigation, chronic disease, conversational AI

PROVIDERS / EHRs accept digital intake; expose data at the point of care

ALIGNED NETWORKS clinical + claims data, identity, trust, FHIR exchange

CMS sets criteria, publishes early adopters, showcases delivery

ACCESS ORGANIZATION (PARTICIPANT)

- Organizations that are Medicare Part B—enrolled providers or suppliers (excluding durable medical equipment and laboratory suppliers) are eligible to participate.
- Each organization must have an active Taxpayer Identification Number (TIN), comply with applicable state licensure, HIPAA, and FDA requirements (or otherwise be subject to FDA enforcement discretion), and designate a physician Medical Director responsible for clinical and compliance oversight.
- Participants provide treatment to aligned beneficiaries.

PARTNER (ACO/PCP/REFERRING CLINICIAN)

- Primary care and referring clinicians are central partners in the ACCESS Model. They are not contracted ACCESS Participants.
- The model gives them new ways to support patients with chronic conditions while remaining actively involved in their ongoing management.
- PCPs and referring clinicians can refer patients to ACCESS participants, which they can identify via a CMS directory of participating organizations, conditions they treat, and their risk-adjusted outcomes.

HOW THE ACCESS MODEL WORKS



Who can participate, and on what terms

Participation is voluntary and application-based. Organizations that join take on defined requirements for enrollment, accountability, and outcome reporting across a growing set of clinical tracks.

ELIGIBILITY AND APPLICATION

- Medicare Part B—enrolled providers or suppliers apply voluntarily through the CMS ACCESS Participant Portal.
- Quarterly cohorts run through 2033 within the 10-year model.
- More than 160 organizations joined the first cohort in July 2026, most new to serving Medicare.

OUTCOMES AND TRANSPARENCY

- Outcome reporting is mandatory — blood pressure, lipids, weight, HbA1c, and validated patient-reported measures.
- CMS publishes a public directory of participants, including conditions treated and risk-adjusted clinical outcomes.

CLINICAL TRACKS

Live since July 5, 2026

- Enhanced chronic condition management
- Chronic condition management
- Chronic musculoskeletal pain
- Behavioral health

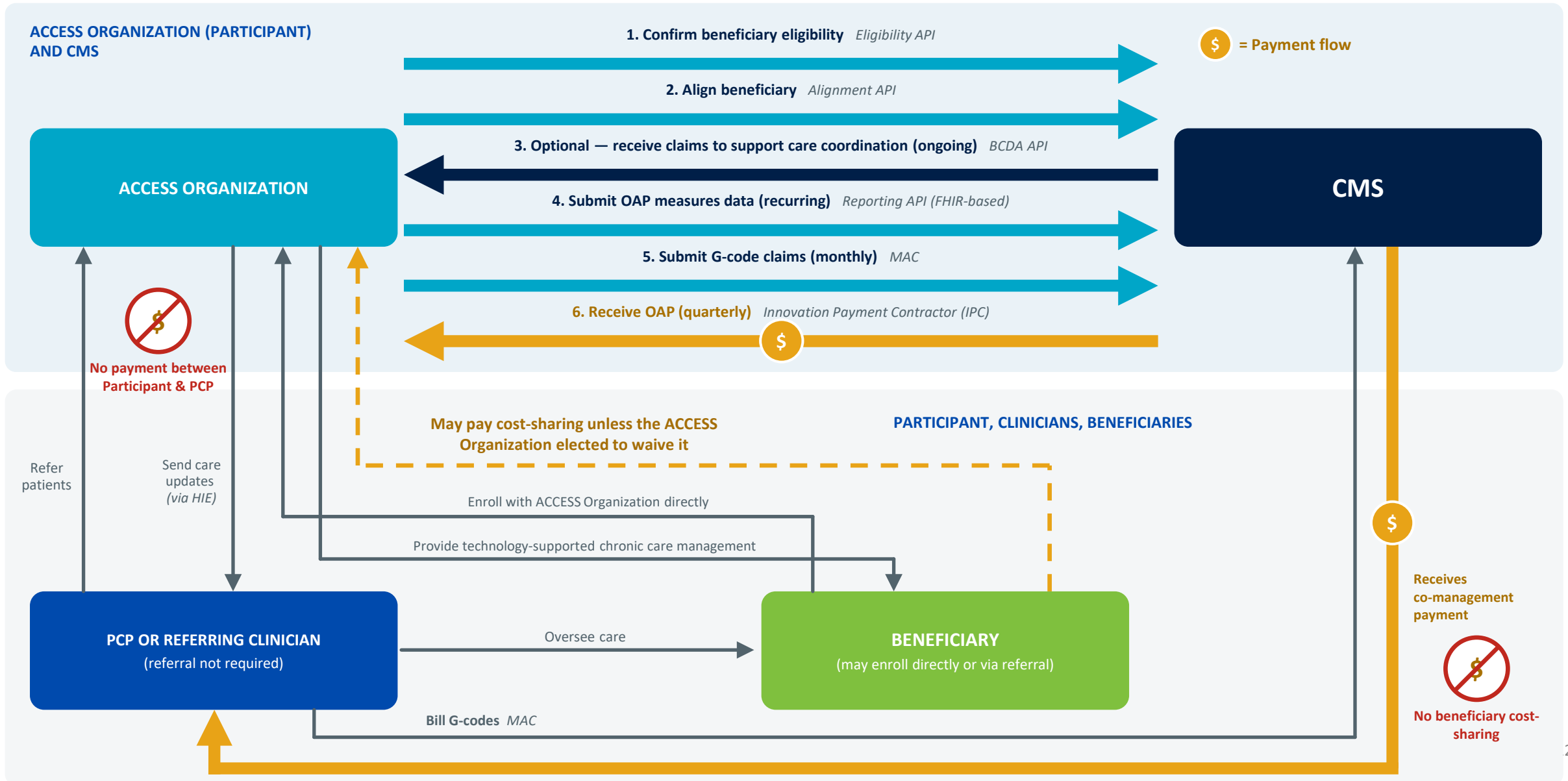
Adding April 1, 2027

- Heart failure
- Chronic obstructive pulmonary disease (COPD)
- Substance use disorder
- Tobacco cessation

*Plus, a follow-on period for chronic musculoskeletal pain.
Current participants and applicants do not need to reapply.*

THE ACCESS MODEL FLOW

How data, claims, and payment actually move



WHAT ACCESS CHANGES

The CMS hope: ACCESS Organizations (Participants) and ACOs/referring clinicians working together to improve clinical outcomes.

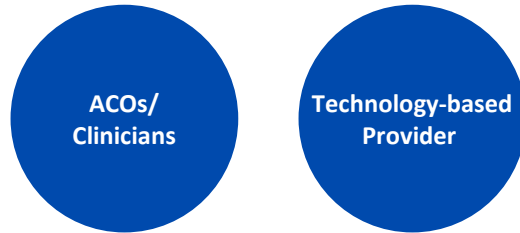


Outcome-based payment incentives could push them onto the same team or pull them further apart. Too soon to tell, but the risk is real.

TODAY — PARALLEL TRACKS OR OUTSOURCING

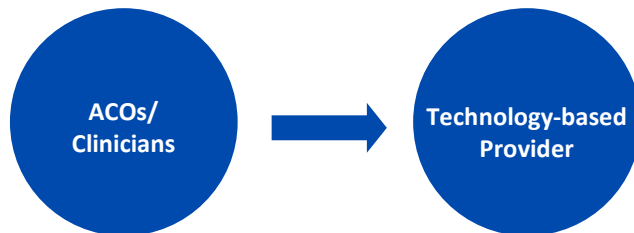
PARALLEL TRACKS

Each may work with the same patients independently; coordination is optional.



OR: OUTSOURCING

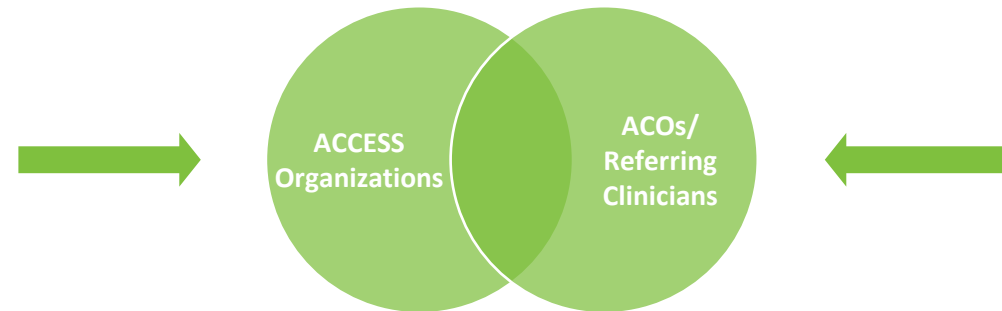
Some ACOs and practices hire technology-based providers themselves and pay them directly, keeping the patient relationship in one place.



UNDER ACCESS — PARTNERSHIP OR FURTHER FRAGMENTATION

THE HOPE: shared accountability

Ideally the OAP and co-management payment give both sides a stake in the same result.



THE RISK: deeper fragmentation

Paying ACCESS Organizations on outcomes could just as easily pull them further from the practice: duplicate care and outreach, patients unsure who is responsible, data that never reaches the PCP's EHR, and unresolved liability and billing overlap with CCM and RPM.



Buzz from the field

Most of this reads as launch-phase friction, not structural failure — but it is the friction that decides whether ACCESS Organizations participate and ACOs engage as partners.

ENROLLMENT BURDEN	Multi-step sequencing, short measurement windows, lab lookback, and technical issues.	Allow eligibility checks earlier
CONTROL GROUP COST	Onboarding is completed before assignment is known; the evaluation basis is unclear.	Clarify assignment and evaluation
SELECTION INCENTIVES	Pass/fail scoring with limited risk adjustment favors less complex patients.	Add graduated or partial credit
PROVIDER ROLE + LIABILITY	Providers assume they are the participant; liability for reviewing ACCESS Organization data is unsettled.	Educate PCPs and ACOs
BILLING OVERLAP	Whether care management and remote monitoring remain billable once enrolled is unclear.	Issue billing guidance

Acronyms used in this session

Federal health IT and value-based care terms referenced throughout the deck.

ACCESS — CMS model for technology-supported chronic care

ACO — Accountable Care Organization

AI — Artificial Intelligence

API — Application Programming Interface

APM — Alternative Payment Model

ASTP — Assistant Secretary for Technology Policy

BCDA — Beneficiary Claims Data API

CCM — Chronic Care Management

CEHRT — Certified Electronic Health Record Technology

CHIP — Children's Health Insurance Program

CMS — Centers for Medicare & Medicaid Services

CMS-0057-F — Interoperability and Prior Authorization final rule

CMS-9115-F — Interoperability and Patient Access final rule

COPD — Chronic Obstructive Pulmonary Disease

CQM — Clinical Quality Measure

dQM — Digital Quality Measure

eCQM — Electronic Clinical Quality Measure

EHI — Electronic Health Information

EHR — Electronic Health Record

FHIR — Fast Healthcare Interoperability Resources

HIE — Health Information Exchange

HITECH — Health IT for Economic and Clinical Health Act

HTI — Health Data, Technology, and Interoperability rules

IPC — Innovation Payment Contractor

IT — Information Technology

MA — Medicare Advantage

MAC — Medicare Administrative Contractor

MACRA — Medicare Access and CHIP Reauthorization Act

MIPS — Merit-based Incentive Payment System

NAACOS — National Association of ACOs

NTAP — New Technology Add-on Payment

OAP — Outcome-Aligned Payment

ONC — Office of the National Coordinator for Health IT

PCP — Primary Care Provider

PI — Promoting Interoperability

QHIN — Qualified Health Information Network

QPP — Quality Payment Program

RPM — Remote Patient Monitoring

TEFCA — Trusted Exchange Framework and Common Agreement

USCDI — United States Core Data for Interoperability

REFERENCE



Links to rules, programs, and model referenced in this session

Public CMS, ASTP/ONC, and TEFCA source pages for the rules, programs, and model covered today.

RULES AND LEGISLATION

ONC/ASTP Health IT Certification Program

<https://www.healthit.gov/topic/certification-ehrs/certification-health-it>

21st Century Cures Act / Information Blocking

<https://www.healthit.gov/topic/information-blocking>

HTI Rules (Health Data, Technology, and Interoperability)

<https://www.healthit.gov/topic/laws-regulation-and-policy/health-data-technology-interoperability-certification-program-updates-algorithm>

USCDI (v3-v4)

<https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi>

TEFCA / Recognized Coordinating Entity

<https://rce.sequoiaproject.org/>

CMS-9115-F Interoperability and Patient Access

<https://www.cms.gov/priorities/key-initiatives/burden-reduction/policies-and-regulations/cms-interoperability-and-patient-access-final-rule-cms-9115-f>

CMS-0057-F Interoperability and Prior Authorization

<https://www.cms.gov/priorities/key-initiatives/burden-reduction/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>

MIPS Promoting Interoperability

<https://qpp.cms.gov/mips/promoting-interoperability>

Medicare Physician Fee Schedule

<https://www.cms.gov/medicare/payment/fee-schedules/physician>

CMS HEALTH TECH ECOSYSTEM

Health Technology Ecosystem overview

<https://www.cms.gov/initiatives/health-technology-ecosystem/overview>

CMS Interoperability Framework and Aligned Networks

<https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/federal-interoperability>

Medicare digital tools and app ecosystem

<https://www.medicare.gov/>

CMS Innovation Center models

<https://www.cms.gov/priorities/innovation/models>

ACCESS MODEL

ACCESS Model home page

<https://www.cms.gov/priorities/innovation/innovation-models/access-model>

Beneficiary Claims Data API (BCDA)

<https://bcda.cms.gov/>

Quality Payment Program resource library

<https://qpp.cms.gov/resources/resource-library>

CMS Innovation Center overview

<https://www.cms.gov/priorities/innovation/about>

Thank You

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