Weekly Checkup

ACCESS for One – ACCESS for All

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The Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation's (CMMI) Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model is one of the more ambitious payment experiments the Innovation Center has launched in some time. Beginning July 5, 2026, and running for 10 years, ACCESS tests an "Outcome-Aligned Payment" structure in fee-for-service (FFS) Medicare for technology-supported chronic disease care. The basic premise is straightforward. FFS Medicare – as designed – is poorly matched to incorporate outcomes-based practices that are more easily achieved with the proliferation of digital, asynchronous, and device-enabled care. CMS wants to attempt to pay for trackable, measurable health improvement rather than solely a fixed list of FFS billable activities. **The model is not simply an expansion of telehealth, nor is it a generic endorsement of digital health. It is an effort to create a new Medicare payment lane for organizations that can show measurable improvement in chronic disease management.**

How will this work? There are some unknowns, but participating organizations will enroll in Medicare Part B as providers or suppliers, comply with traditional program rules, and report outcomes that CMS intends to publish in risk-adjusted form. This enrollment ensures accountability in clinical quality and patient support. Primary care providers are central to the model because the overarching Medicare benefits don't change. Care is still coordinated at the physician level, and physicians can refer patients into ACCESS, receive regular electronic updates, and bill a separate co-management payment for documented review and coordination activities. In the more innovative aspect of this, physicians are not limited to traditional documentation methods and can leverage technology-assisted tracking (such as wearables).This design choice suggests CMS appreciates that technology-supported care will be much more durable if it complements existing care relationships rather than attempting to replace them.

ACCESS initially focuses on four high-prevalence clinical areas: early cardio-kidney-metabolic conditions (eCKM), cardio-kidney-metabolic (CKM) disease, chronic musculoskeletal pain, and behavioral health. CMS says participating organizations will receive recurring payments tied to whether a sufficient share of their aligned beneficiaries meet condition-specific outcome targets, and those targets are built around guideline-informed measures such as blood pressure, lipids, hemoglobin A1c, pain, function, and behavioral health symptom scores. In theory, this gives Medicare a way to pay for modern chronic disease care while ensuring evidence shows the intervention had positive clinical impact.

The recently announced list of accepted applicants makes the model even more interesting. CMS highlighted more than 150 organizations to participate in the launch of ACCESS, while stressing that inclusion on the list does not guarantee final participation because Medicare enrollment, participation agreements, and final CMS approval still must be completed. Even so, the applicant slate offers a useful glimpse into what types of organizations believe ACCESS matches their capabilities and revenue model. Given the conditional publication of the list, it is best read as an early map of the market CMS is trying to create.

A chief takeaway of an initial review is the strong pull of cardio-kidney-metabolic care. That is not surprising. The eCKM and CKM tracks cover conditions such as hypertension, obesity, prediabetes, diabetes, chronic kidney disease, and atherosclerotic cardiovascular disease – exactly the kinds of conditions where device-enabled monitoring, medication management, lifestyle coaching, and longitudinal data collection are already relatively mature. These are also tracks where outcomes are easiest to define and verify. Blood pressure, weight, hemoglobin A1c, and kidney-related data are not perfect proxies for long-term health, but they are concrete, clinically legible, and more straightforward to standardize than many other chronic care outcomes. That makes ACCESS especially attractive to organizations built around remote monitoring, digital coaching, chronic disease management, and virtual specialty support.

A second bucket includes broader care-management platforms and provider-backed organizations that span multiple tracks rather than concentrating on a single condition. These applicants seem to view ACCESS less as a niche digital-health opportunity and more as a reimbursement framework for scaled longitudinal care. This suggests the model may evolve beyond a home for app-based chronic care vendors. It may also become a vehicle for multiservice medical groups, hybrid provider-technology organizations, and community-oriented clinical entities that want to combine digital infrastructure with more traditional clinical oversight. In that sense, ACCESS may wind up testing a broader

proposition than CMS explicitly says on paper: whether Medicare can support an entire layer of organizations that sit somewhere between physician practice, care coordination, remote monitoring, and virtual specialty management.

The behavioral health and musculoskeletal tracks appear somewhat different. Those categories are likely to attract organizations centered on therapy, psychiatric support, coaching, pain management, rehabilitation, or function-oriented care. They may also prove harder for CMS to evaluate rigorously. In these tracks, payment depends on patient-reported outcome measures and measures of pain intensity, interference, and function. That is entirely defensible, and probably necessary. But it is also more subjective than relying on blood pressure cuffs or laboratory values. If ACCESS succeeds in behavioral health and musculoskeletal care, it will be because CMS has shown that outcome-based payment can work even where improvement is real but inherently less tidy to quantify. If those tracks struggle, it will likely expose how difficult it is to standardize "value" across very different forms of chronic care.

ACCESS is an attempt to build a durable FFS Medicare payment architecture for technology-supported chronic care across a wide range of organizational types. The breadth of participation is what makes the model promising, but it is also what makes it risky. **The more organizations and care methods ACCESS tries to accommodate, the more important it will be for CMMI to prove that it is paying for measurable clinical improvement rather than simply creating a new reimbursement stream around modernized care navigation.** That is the central question hanging over the model now – and the newly announced participant mix only sharpens it.