The CMS ACCESS Model Advancing Chronic Care through Value-Based Innovation

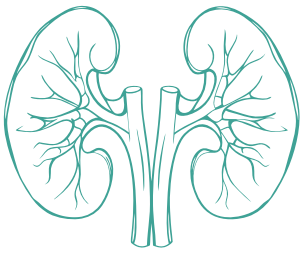
An Analysis by C. Robinson, February 2026

Overview

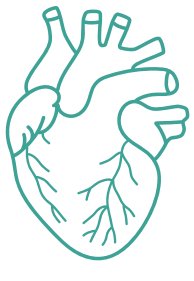
The CMS ACCESS Model is a voluntary Medicare initiative designed to modernize chronic care reimbursement by shifting payment away from individual services and toward demonstrated health outcomes for technology-enabled, longitudinal care. It enables participating organizations to deliver care flexibly across virtual, in-person, and asynchronous modalities while being held accountable for measurable clinical improvement and coordinated care with primary and specialty clinicians.

By embedding outcome-based payments, structured co-management, and public reporting of performance, ACCESS creates a standardized pathway for chronic care organizations to prove value, reduce fragmented care, and align incentives across providers and payers. While the model introduces meaningful operational and financial risk tied to outcomes and care coordination, it offers a credible, CMS-backed platform for organizations that can consistently deliver results and leverage those outcomes to accelerate broader value-based contracting strategies.

Initial Clinical Tracks

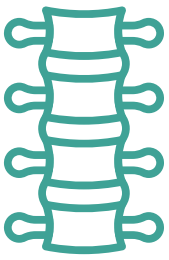


Early Cardio-Kidney-Metabolic (*eCKM*)



Cardio-Kidney-Metabolic (*CKM*)

Behavioral Health (BH)



Musculoskeletal (*MSK*)

Over the course of the **10-year model** (July 2026–June 2036):

- Participants can receive up to **50%** of the annual OAP during the **12-month care period**
- The **remaining 50% is withheld** pending reconciliation
- CMS reconciles performance semi-annually and **publishes public risk-adjusted outcomes**
- Payments can be **reduced** via a Clinical Outcome Adjustment **if outcome achievement falls below thresholds**, and a Substitute Spend Adjustment **if duplicative services increase beyond thresholds**

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Executive Summary

The CMS Innovation Center's ***ACCESS* Model** is a national, voluntary, 10-year Medicare fee-for-service (FFS) model that introduces **Outcome-Aligned Payments (OAPs)** for technology-supported chronic condition management. *ACCESS* is designed to address a core Medicare payment gap: traditional FFS reimburses individual billable activities, while many technology-enabled chronic care interventions are continuous, longitudinal, and not well captured by existing codes.

From a value-based care contracting lens, *ACCESS* is notable for three main reasons:

1. **It makes outcomes the unit of payment** instead of **encounters**, using recurring payments with explicit performance-based reconciliation.
2. **It creates a standardized Medicare pathway** for tech-enabled chronic care organizations to contract around outcomes and publish risk-adjusted performance, to potentially reshape how provider groups, health systems, and digital health vendors structure downstream commercial and Medicare Advantage agreements.
3. **It formalizes co-management and care coordination mechanics** (e.g., structured updates to primary care/referring clinicians and a specific co-management payment), which can reduce friction in VBC partnerships if implemented well.

Bottom line: *ACCESS* is best viewed as a CMS-sponsored "outcomes contracting primitive" for chronic care. Organizations that can consistently deliver measurable clinical improvement, coordinate tightly with local providers, and manage substitution/double-spend risk should strongly consider applying, especially those seeking to translate Medicare credibility into broader value-based contracting leverage.

1. Model Overview

1.1 Purpose and theory of change

CMS positions *ACCESS* to expand beneficiary access to technology-supported care by shifting reimbursement away from activity-based billing and toward **measurable health outcomes**—with flexibility to deliver care in-person, virtually, asynchronously, or through other technology-enabled methods.

1.2 Timeline and participation

- **Duration:** 10 years (beginning **July 5, 2026,** and continuing through **June 30, 2036**).
- **Applications:** CMS indicates portal-based submission with defined cohort start dates and describes rolling entry windows in technical materials.

- **Voluntary, nationwide** model test under CMS Innovation Center authority.

**CMS web materials describe first-cohort deadlines and subsequent cohort start dates. Prospective applicants should rely on the CMS ACCESS page and RFA as the controlling sources for current deadlines and cohort logic.*

1.3 Who the model serves

- **Population:** Original Medicare (FFS) beneficiaries with qualifying chronic conditions; this **includes** dual eligibles and **excludes** Medicare Advantage.
- **Access mechanism:** beneficiaries can **enroll directly** with an *ACCESS* participant or be referred. Enrollment does not restrict access to other covered Medicare services.
- **Evaluation design:** a subset of attempted enrollees may be randomly assigned to a control group for evaluation purposes.

1.4 Initial clinical tracks (conditions)

CMS states **four** initial tracks:

- **Early Cardio-Kidney-Metabolic (eCKM):** hypertension, dyslipidemia, obesity/central adiposity markers, prediabetes
- **Cardio-Kidney-Metabolic (CKM):** diabetes, chronic kidney disease, or ASCVD
- **Musculoskeletal (MSK):** chronic musculoskeletal pain
- **Behavioral Health (BH):** depression or anxiety

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2. Detailed operating model

This section translates CMS design into an “operating model” view; useful for leaders evaluating readiness and VBC contracting implications.

2.1 Parties and roles

A) ACCESS Participants (the “risk-bearing” delivery entities)

- Defined at the organizational level by a **single Medicare Part B–enrolled TIN** eligible to bill under the Physician Fee Schedule, with certain exclusions, such as DMEPOS and lab suppliers.
- It can be provider organizations, suppliers, or technology-enabled care organizations that meet enrollment/eligibility requirements and accept the participation agreement obligations.

B) Beneficiaries (patients)

- Choose to align prospectively by enrolling; and can enroll in multiple tracks (in the same or different organizations).

C) Referring clinicians / PCPs (care team integrators)

- Expected recipients of structured updates and care plans.

- May bill a **co-management payment** for documented review of updates and coordination actions.

D) CMS (payer, evaluator, publisher)

- Pays OAPs, reconciles performance adjustments semi-annually, and publishes risk-adjusted outcomes to promote transparency and selection.

2.2 Enrollment, alignment, and attribution mechanics

Prospective alignment via beneficiary enrollment

- Beneficiaries voluntarily enroll with the participant (either directly or via referral), aligning prospectively for the relevant track.
- Importantly for VBC contracting, this is closer to a "membership" mechanic than classic FFS utilization mechanics, which can simplify outcome-contracting logic but increase operational requirements around onboarding and informed consent-like workflows.

Control group assignment

- CMS may randomly assign a portion of attempted enrollments to a control group for impact evaluation.
- Operationally, participants must be ready to explain this to referral sources and patients without creating reputational harm.

2.3 Care delivery expectations (what participants must operationalize)

CMS expects integrated technology-supported care that may include clinician consultations, lifestyle/behavioral support, therapy/counseling, medication management, diagnostics, and FDA-authorized (or enforcement discretion) devices/software.

Care modality flexibility

- In-person, virtual, asynchronous, and other tech-enabled methods, as clinically appropriate.

Care coordination requirements

- Participants must electronically share care plans and updates at defined moments (initiation, completion, and milestones) and integrate with a **Health Information Exchange (HIE) or similar trusted network** to enable secure access by referring clinicians.

Continuation period concept

- Most tracks include an optional continuation period with a reduced payment rate; CMS notes MSK differs (focused on resolving chronic pain during the initial care period, without the optional follow-on period).

2.4 Payment model mechanics (OAPs): How money flows

ACCESS replaces traditional activity-based reimbursement for the covered service approach with **fixed Outcome-Aligned Payments** for managing a beneficiary's qualifying condition over a 12-month period, with full payment **contingent** on outcomes.

Core payment architecture

- OAPs are recurring and tied to track-specific outcome measures (targets relative to baseline).
- CMS pays **up to 50% of the total annual OAP amount** during the 12-month care period and **withholds the remaining 50%** pending reconciliation after the care period.

Performance-based adjustments (downside only, as written in the RFA)
CMS describes two main reconciliation adjustment concepts and applies only the **larger reduction** in a reconciliation period to avoid compounding penalties:

1. **Clinical Outcome Adjustment**

- Based on an Outcome Achievement Rate compared to an Outcome Achievement Threshold (first-year threshold described as **50%**).
- Capped at a **50% reduction** of the full OAP amount.

2. **Substitute Spend Adjustment**

- Designed to reduce duplicative Medicare spending by discouraging new initiations of services considered substitutes for the same condition managed under *ACCESS*.
- Uses a Substitute Spend Rate relative to a threshold (first-year threshold described as **90%**), with proportional reductions and a **25% cap** on the reduction.

Semi-annual reconciliation

- CMS reconciles on a semi-annual basis and nets reductions against withheld amounts, with the ability to offset future payments or use Medicare recoupment processes if needed.

Co-management payment

- Referring/co-managing clinicians may bill a new co-management service paid at approximately **$30 per service**, *subject to geographic/payment adjustments*.

2.5 Measurement, reporting, and transparency

Outcome measures

- The RFA indicates track-specific outcome measures used to assess performance under the OAP methodology, including **clinical measures** and **patient-reported measures**.

Public reporting

- CMS intends to publish risk-adjusted outcomes in a **public directory** to support transparency and inform patient and clinician choice; effectively creating a "reputation market" for outcomes.

Data access

- CMS describes providing claims data access via the *Beneficiary Claims Data API* to support substitute spend management and coordination.

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3. Pros, cons, and key strategic considerations (VBC lens)

3.1 Pros

1) A standardized Medicare outcomes-contracting pathway
ACCESS operationalizes outcomes-aligned chronic care payment inside Original Medicare, providing a credible template that can be reused in commercial/VBC contracting conversations.

2) Better unit economics for "continuous care" models
Organizations that deliver high-touch virtual-first care, such as cardiometabolic, musculoskeletal, or behavioral health, often struggle to match their cost structure to discrete CPT reimbursement. A recurring payment model can better align revenue with longitudinal care delivery.

3) Built-in co-management mechanism
The co-management payment plus structured update requirements can **reduce the "PCP friction"** that derails many digital health partnerships, especially in risk arrangements where changes in medication and problem-list updates matter.

4) Market signal and branding
CMS involvement plus public reporting may create **durable credibility** for high-performing organizations and strengthen contracting leverage with health systems and payers.

3.2 Cons

1) Outcomes accountability is operationally difficult
If you cannot reliably move outcomes across diverse populations (and document baseline/endline cleanly), the withheld amount and reconciliation reductions can substantially impair margins.

2) Substitute spend dynamics can undermine performance economics
Participants may be penalized if beneficiaries initiate "substitute" services elsewhere. This creates a dependency on referral discipline, patient engagement, and local care pattern management- which is even more difficult in fragmented markets.

3) Coordination overhead is non-trivial
HIE integration, structured communications at milestones, and documentation standards all add to the implementation cost, as well as partner-management complexity.

4) Evaluation design can create conversion friction
Control group assignment may create confusion for referring providers and patients; organizations need careful scripting, workflow design, and experience management.

5) Policy and model drift risk over a 10-year period
Thresholds, track scope, and operational rules can all evolve. Long-lived models create opportunities but also uncertainty for investment cases.

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4. Value proposition by stakeholder

4.1 For beneficiaries

- Access to more continuous, tech-enabled support beyond episodic visits.
- Potential for improved outcomes (blood pressure, glycemic control, pain, anxiety/depression) through guided programs.

4.2 For primary care and specialty referrers

- A formalized partner for longitudinal condition management, plus possible compensation for co-management activities.
- Potentially reduced clinical burden if the *ACCESS* participant manages monitoring, education, adherence, and escalation pathways.

4.3 For *ACCESS* participants (provider groups, tech-enabled care organizations)

- Predictable, recurring revenue tied to outcomes rather than visits.
- A CMS-endorsed platform for proving outcomes and then translating those results into broader value-based contracts.

4.4 For Medicare (and indirectly, other payers)

- CMS explicitly expects reductions in avoidable utilization and expenditures through improved outcomes and the prevention of avoidable events.
- Substitute spend adjustment is designed to prevent duplicate spending and "double pay" for overlapping services.

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5. Potential financial implications

Important: CMS materials describe the **mechanics** (*withholds*, *thresholds*, *reconciliation*) but applicants should build Pro Formas using the most current CMS-published payment rates and track-specific parameters available during the application window.

5.1 Revenue timing and cash flow

- **Up to 50% of annual OAP is paid during the care period**, with **50% withheld** until reconciliation.
  Implication: even high-performing participants need working capital discipline; lower-performing participants face real claw back/withhold risk.

5.2 Performance risk

- Clinical outcome adjustment can reduce payment proportionally and is capped at a 50% reduction.
- Substitute spending adjustment can reduce payment proportionally and is capped at 25%.
  Implication: One's unit economics depend not just on clinical efficacy, but also on one's ability to prevent duplicative care patterns.

5.3 Cost structure shifts

Participants should expect increased costs in:

- Outcomes measurement operations (baseline/endline capture, QA, audits)
- Interoperability and HIE connectivity
- Provider partnership management (referral relationships, workflow integration, co-management communications)

In exchange, successful participants can **reduce** costs by:

- Scaling asynchronous and digital modalities where clinically appropriate
- Avoiding unnecessary in-person utilization through earlier detection/intervention

5.4 Implications for VBC contracting outside Original Medicare

If an organization demonstrates strong *ACCESS* outcomes (and appears favorably in CMS reporting), it may:

- Strengthen negotiating position for commercial value-based contracts (e.g., outcomes guarantee, shared savings arrangements, PMPMs tied to clinical targets).
- Provide evidence to health systems/ACOs that partnering with the organization can improve performance on chronic quality metrics and reduce avoidable utilization, aligning incentives across contracts.

5.5 "Second order" implications for health systems and ACO-like entities

Even if a health system does not directly apply as an *ACCESS* participant, it may still benefit by:

- Using *ACCESS* partners to improve chronic disease outcomes that drive total cost of care under other risk arrangements.
- Leveraging the co-management payment as a modest offset for coordination work.

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6. Recommendation: who should apply (and why!) — value-based contracting focus

6.1 Best-fit applicant profiles

1) Tech-enabled chronic care organizations with proven outcomes
Organizations that already show measurable improvement in:

- cardiometabolic control (BP, A1c),
- MSK functional/pain outcomes, or
- Behavioral health symptom improvement will be best positioned to retain withheld payments and avoid reconciliation reductions.

2) Provider groups / integrated delivery organizations seeking a scalable VBC "engine"
Groups that want a standardized Medicare mechanism to scale longitudinal programs beyond episodic billing (especially those already operating under shared savings or downside risk contracts) may find *ACCESS* strategically synergistic.

3) Organizations with strong referral-channel control and care coordination maturity
Because substitute spend depends on avoiding duplicative services, the model favors organizations that can:

- integrate tightly into local referral networks,
- provide high-trust clinical updates, and
- keep beneficiaries engaged and aligned to a coherent care plan.

4) Organizations with "contracting ambition"
If your strategic goal is to use Medicare credibility to unlock broader value-based deals, *ACCESS* is a compelling signaling mechanism; CMS participation + published outcomes can be powerful in payer/provider negotiations.

5) The *ACCESS* Model is ideally suited for:

1. **Digital-First Provider Groups:** Entities already using technology to manage chronic populations (e.g., virtual clinics).
2. **Specialty Practices (Cardiology, Orthopedics, Nephrology):** Practices focused on high-cost chronic conditions looking to stabilize revenue.
3. **Innovative Health Systems:** Systems with mature population health infrastructures that want to "monetize" their technological investments.

6.2 Who should be cautious (or avoid applying initially)

1) Organizations without reliable outcome measurement infrastructure
If baseline/endline data capture is inconsistent, your clinical performance may be undercounted and your economics impaired.

2) Organizations that cannot manage "substitute spend" risk
If you operate in highly fragmented markets without strong provider relationships, you may be penalized for duplicate initiations outside your control.

3) Organizations without sufficient capital runway
With 50% withheld until reconciliation, *ACCESS* can stress cash flow, especially during ramp and early cohort learning curves.

6.3 Practical "why apply" framing for value-based care contracting.

For organizations that are a fit, *ACCESS* can be positioned as:

- **A Medicare-backed outcomes contract** that validates an organization's clinical model
- **A standardized payment chassis** for longitudinal tech-enabled care
- **A negotiation accelerant** for commercial VBC deals (outcome guarantees, PMPM arrangements, shared savings), leveraging CMS transparency and measured performance.

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7) Conclusion

Organizations should apply because the *ACCESS* Model represents the **purest form of clinical value-based care** currently offered by CMS. Unlike TCOC models such as ACO REACH, which can be influenced by "coding intensity" or factors outside a clinician's control, like an expensive surgery, *ACCESS* rewards **clinical efficacy**.

By participating, organizations can build the "digital muscle" required for the future of healthcare while securing a predictable, outcome-based revenue stream that is insulated from the traditional FFS "treadmill."

ACCESS is an important CMS experiment: it converts technology-supported chronic care from "hard-to-reimburse services" into a **repeatable outcomes-based payment approach** inside Original Medicare. For value-based care leaders, the model's biggest strategic value may be less about the specific first-year rates and more on what it normalizes: **outcomes as currency**, standardized co-management, and a transparent performance market.

Organizations that can deliver measurable improvement, coordinate effectively, and manage duplicative-service risk should strongly consider applying- not only for Medicare FFS revenue, but for the broader VBC contracting halo effect that CMS-endorsed outcomes performance can provide.

8. Sources

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APPENDIX: CMS ACCESS
Implementation Roadmap (2026 – 2027)

This roadmap outlines the critical path for organizations applying for the **July 1, 2026,** launch.

Phase 1: Strategic Readiness (Q1 2026)

- **Track Selection:** Determine which of the four clinical tracks (eCKM, CKM, MSK, or Behavioral Health) align with your current patient volume and clinical expertise.
- **Gap Analysis:** Evaluate existing technology capabilities against CMS requirements (telehealth, remote monitoring, and asynchronous coaching).
- **Application Submission:** Complete the Request for Application (RFA) by **April 1, 2026,** deadline.

Phase 2: Operational Build (Q2 2026)

- **Tech Integration:** Establish API-based data feeds to your regional Health Information Exchange (HIE) to meet coordination requirements.
- **Workflow Design:** Standardize the "Baseline Measurement" process. Ensure clinical staff are trained to capture the specific metrics (e.g., blood pressure, PHQ-9, or functional pain scores) required to trigger Outcome-Aligned Payments (OAPs).
- **Clinical Director Appointment:** Formally designate a Medicare-enrolled physician to oversee quality and model compliance.

Phase 3: Launch & Enrollment (Q3 2026)

- **Beneficiary Onboarding:** Identify eligible Original Medicare beneficiaries. Launch "Direct-to-Patient" education campaigns or partner with primary care offices for referrals.
- **The "30-Day Setup":** Ensure all enrolled patients receive their monitoring devices or app credentials within the first 30 days of alignment to initiate the base payment.

Phase 4: Performance & Optimization (Q4 2026 & Beyond)

- **Outcome Tracking:** Monitor patient progress against clinical targets (e.g., the 10-mmHg reduction for hypertension).
- **Co-Management Billing:** Begin issuing electronic updates to referring PCPs to enable them to bill the **$30 co-management code**, strengthening your referral network.

Key Financial Formula for Strategy Meetings

For your internal financial planning, remember that the total revenue per patient in the *ACCESS* Model (R_{total}) is calculated as the sum of the base payment and the outcome-contingent portion:

$$R_{total} = P_{base} + (P_{outcome} \times S_{success})$$

Where $S_{success}$ is your organization's success rate in meeting clinical benchmarks.