

ACCESS: CMMI’s tech-enabled chronic care model

What is the ACCESS model?

The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model is a voluntary, national, 10-year CMMI model that tests outcome-aligned payments (OAPs) for technology-enabled chronic care in Original Medicare. Rather than paying for discrete services or visit volume, CMS pays participating organizations based on measurable improvements in condition-specific outcomes over defined care periods.

ACCESS is organized around four clinical tracks: early cardio-kidney-metabolic (eCKM), cardio-kidney-metabolic (CKM), musculoskeletal (MSK), and behavioral health (BH). Within each track, participants are responsible for managing all qualifying conditions a beneficiary has, supporting integrated, longitudinal care.

Expected ACCESS participants

- Medicare Part B-enrolled organizations that deliver technology-enabled chronic care
- Organizations that manage beneficiaries with high-burden chronic conditions
- Participants focused on conditions affecting more than two-thirds of people with Medicare, including high blood pressure, diabetes, chronic musculoskeletal pain, and depression

What is new about ACCESS?

ACCESS relies on a different payment and accountability structure from both traditional fee-for-service Medicare and total cost of care models. Instead of rewarding volume or broad spending reduction, ACCESS centers payment on whether organizations achieve measurable improvement or sustained control for specific chronic conditions.

Key design features include:

- **Outcome aligned payments by condition:** CMS ties payment directly to clinical and patient reported outcomes for each track. Organizations earn full payment only when beneficiaries demonstrate improvement or control relative to baseline, shifting financial risk and reward to performance rather than activity.
- **Explicit support for technology-enabled care:** ACCESS allows organizations to deploy virtual care, remote monitoring, digital therapeutics, and asynchronous care models without tying payment to specific services, codes, or visit types.
- **Voluntary beneficiary enrollment:** Beneficiaries actively choose to enroll with an ACCESS participant, which strengthens patient engagement and distinguishes the model from claims-based attribution used in ACOs.
- **Track-based accountability:** CMS evaluates performance within defined clinical tracks rather than across total cost of care, allowing participants to focus resources on conditions where technology enabled care can drive measurable improvement.

How does payment work under ACCESS?

ACCESS uses fixed, recurring outcome-aligned payments tied to 12-month care periods, with rates that vary by clinical track and phase of care. CMS pays approximately \$180 to \$420 per beneficiary during an initial period focused on onboarding and early improvement, then \$90 to \$210 for a follow-on period of continued management. CMS adds a \$15 supplement for rural eCKM and CKM beneficiaries during the initial period to cover higher device distribution costs.

CMS issues payments monthly and withholds a portion until the end of the care period, when CMS reconciles payment based on achievement of outcome targets and avoidance of duplicative substitute services. As part of the model's care coordination requirements, primary care providers and referring clinicians may also bill an approximately \$30 co-management payment for documented review of ACCESS care updates and coordination activities.

How are outcomes measured under ACCESS?

Each ACCESS track uses a focused set of outcome measures to determine whether beneficiaries experience meaningful improvement or sustained control of their conditions over time. CMS evaluates performance based on change from a beneficiary's starting point and assesses results at the overall ACCESS participant level rather than for each assigned beneficiary.

Track	Qualifying condition	Outcome-aligned measures
eCKM	Hypertension, or two or more of the following conditions: dyslipidemia, obesity or overweight with a marker of central obesity, prediabetes	Control or minimum improvement in blood pressure, lipids, weight, and hemoglobin A1c (HbA1c)
CKM	One or more of the following conditions: diabetes mellitus, chronic kidney disease, atherosclerotic cardiovascular disease	Control or minimum improvement in blood pressure, lipids, weight, and hemoglobin A1c (HbA1c); submission of estimated glomerular filtration rate (eGFR) and urine albumin-creatinine ratio (UACR) data
MSK	Chronic musculoskeletal pain	Minimum improvement in pain intensity, pain interference, and overall function, assessed using validated patient-reported outcome measures
BH	Depression or anxiety	Control or minimum improvement in depression and anxiety symptoms, measured using standard patient questionnaires (PHQ-9 for depression and GAD-7 for anxiety). Participants may optionally submit a functional assessment (WHODAS 2.0) to describe overall daily functioning.

Hands-on support to realize your full potential

Optum consulting works side by side with organizations participating in ACCESS to support performance under outcome-aligned payment, helping assess model fit and build the strategy and analytics needed to succeed.

For additional assistance, get in touch at advisory.com/optum-support



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