Wakely
An HMA Company

Wakely.com

WHITE PAPER

ACCESS Model Implications for Care Management Vendors

Ben Cruz, ASA, MAAA

Olivia Lang

Nick Cartossa, ASA, MAAA

January 2026

INTRODUCTION AND BACKGROUND

Historically, Medicare has facilitated payments for services primarily supporting in-person care. These payments are tied to a specific set of Medicare-reimbursable procedures, which have provided limited coverage for remote patient monitoring, care coordination, and longitudinal management activities. As a result, providers have faced structural disincentives to adopt technology-enabled care models, creating barriers to continuous monitoring and proactive engagement for patients living with chronic conditions.

On December 1, 2025, the Centers for Medicare & Medicaid Services (CMS) announced the creation of the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model. ACCESS is designed to expand access to technology-supported solutions that enable providers to improve outcomes for patients with chronic conditions. The model is scheduled to begin July 1, 2026, with applications no later than April 1, 2026. This paper outlines the ACCESS model, conditions for vendor participation, and the implications—both opportunities and challenges—for care management vendors operating in or seeking entry into Traditional Medicare. Unless otherwise noted, descriptions of the model are based on CMS Innovation Center materials and public statements from CMS leadership.

ACCESS MODEL OVERVIEW

The ACCESS model introduces Outcome-Aligned Payments (OAPs), a payment structure that links Medicare reimbursement to measurable improvements in clinical outcomes for defined chronic conditions rather than payments tied to the volume of services delivered.[1] This approach gives participating providers and technology-enabled organizations flexibility to deliver care through virtual monitoring, digital interventions, behavioral health support, and community-based services, while maintaining accountability for patient improvement.

Rather than reimbursing specific procedures or technologies, ACCESS establishes performance targets for grouped chronic conditions and allows participating organizations to determine how best to achieve those outcomes. Monthly OAPs are intended to fund longitudinal, continuous care models that extend beyond episodic visits, consistent with CMS's objective of rewarding outcomes.

[1] Centers for Medicare & Medicaid Services. Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model Overview. December 2025. Available at: https://www.cms.gov/priorities/innovation/innovation-models/access.

ACCESS is structured as a voluntary, national 10-year demonstration with defined beneficiary populations, clinical tracks, and performance metrics. The model focuses on high-cost, high-prevalence chronic conditions and incorporates ongoing data collection, reporting, and transparency. CMS has indicated that performance results will be publicly reported and that participation standards may increase over time based on observed results. By aligning payment with outcomes and enabling technology-supported care, ACCESS is designed to reduce barriers to innovation, broaden access to supportive services, and provide CMS with evidence on whether this program should become a permanent component of Medicare.

CONDITIONS FOR VENDOR PARTICIPATION

CMS is seeking vendors that provide a variety of technology-enabled services for participation in ACCESS. CMS provides a number of examples of types of services that would be included under the program; however, they note that the list is somewhat limited exhaustive. Examples include:

- Clinician consultations
- Lifestyle support services such as nutrition counseling, exercise support, and smoking cessation interventions
- Remote monitoring via connected medical devices
- Therapy and behavioral health counseling
- Patient education and care coordination
- Medication prescription and management
- Ordering and interpretation of laboratory and diagnostic tests
- Connected device deployment and monitoring
- Deployment and oversight of Food and Drug Administration (FDA)-cleared, authorized, or approved software devices

In addition to having applicable technology-enabled services under ACCESS, vendors seeking to participate must meet both administrative and clinical requirements as described below.

ADMINISTRATIVE REQUIREMENTS

Participating organizations must meet the following criteria:

- Be a Medicare Part B–enrolled provider or supplier (excluding durable medical equipment [DME] and laboratory suppliers)
- Maintain an active Taxpayer Identification Number (TIN)
- Comply with applicable state licensure requirements
- Adhere to Health Insurance Portability and Accountability Act (HIPAA) and FDA requirements (or FDA enforcement discretion, as applicable)
- Designate a physician Clinical Director responsible for clinical and compliance oversight[2]

CLINICAL EXPECTATIONS

For the introduction of the ACCESS model, CMS is focusing on four clinical tracks:

- Early cardio-kidney-metabolic conditions (eCKM) such as hypertension (high blood pressure), dyslipidemia (high or abnormal lipids, including cholesterol), obesity or overweight with marker of central obesity, and prediabetes
- Cardio-kidney-metabolic conditions (CKM) such as diabetes, chronic kidney disease (3a or 3b), and atherosclerotic cardiovascular disease, including heart disease
- Musculoskeletal conditions (MSK) such as chronic musculoskeletal pain
- Behavioral health conditions (BH), including depression and anxiety

[2] Centers for Medicare & Medicaid Services. ACCESS Model Frequently Asked Questions. December 2025. Available at: https://www.cms.gov/priorities/innovation/access-technical-frequently-asked-questions.

Table 1 details the prevalence rate of each of the conditions mentioned above in Traditional Medicare.

Table 1. Prevalence of Clinical Conditions and Among Medicare Enrollees

Clinical Tracks	Prevalence	Sub-Conditions	Sub-Condition Prevalence	Estimated Medicare Enrollees
Early cardio-kidney-metabolic conditions (eCKM)	**81.7%**	*Hypertension*	**63.9%**	22,400,000
		Dyslipidemia	**58.8%**	20,600,000
		Obesity	**18.9%**	6,600,000
		Prediabetes	**10.0%**	3,500,000
Cardio-kidney-metabolic conditions (CKM)	**46.3%**	*Diabetes*	**26.9%**	9,400,000
		CKD Stages 3a and 3b	**10.6%**	3,700,000
		Atherosclerotic Cardiovascular Disease	**25.1%**	8,800,000
Musculoskeletal conditions (MSK)	**41.2%**	*Musculoskeletal conditions (MSK)*	**41.2%**	14,400,000
Behavioral health conditions (BH)	**18.7%**	*Depression*	**11.3%**	3,900,000
		Anxiety	**12.5%**	4,400,000

Source: Centers for Medicare & Medicaid Services. Limited Data Set (LDS) Files. Updated July 22, 2025.

Participating organizations are expected to provide integrated care capable of managing all qualifying conditions within a given clinical track.

OPPORTUNITIES AND IMPLICATIONS FOR CARE MANAGEMENT

ACCESS presents a meaningful opportunity for care management vendors in that it creates a new pathway to participate in Traditional Medicare that aligns payment with outcomes rather than discrete services. The model reduces reliance on visit-based billing and formally recognizes technology-enabled care organizations as partners in delivering chronic care services, **finally allowing vendors to co-manage patients with physicians**.

Although ACCESS expands opportunity, it also reshapes the competitive and operational landscape for vendors. The model's strategic opportunities, along with its implications, challenges, and risks, are explored in detail below.

STRATEGIC OPPORTUNITIES

Flexibility in care design and cost sharing: Vendors may bundle remote monitoring devices, digital platforms, coaching, medication support, and community services without requiring separate reimbursement for each component. ACCESS also allows participating organizations to waive beneficiary cost sharing at their discretion. CMS has suggested that market dynamics will determine whether cost sharing is reduced or eliminated, creating a potential competitive advantage for organizations able to operate at sufficient scale to absorb these costs.

Access to Traditional Medicare at scale: ACCESS creates a national, standardized mechanism for vendors to participate in Traditional Medicare, covering a substantial share of beneficiaries across multiple chronic conditions.

Performance-based differentiation: Public reporting of results creates an opportunity for high-performing vendors to differentiate themselves based on clinical outcomes, potentially driving physician referrals and long-term partnerships.

IMPLICATIONS, CHALLENGES, AND RISKS

Outcome-based revenue risk: Payments are contingent on demonstrating measurable improvement. Vendors that fail to achieve sufficient outcomes across a large enough population risk reduced payment or removal from the model. This could be aggregated if vendors choose to bundle multiple services under one reimbursement program with CMS.

Physician-led integration requirements: Vendors must operate within physician-led governance structures and ensure that data generated through their platforms are shared with to clinicians and support care decisions. In addition to the ongoing administrative burden associated with this situation, many vendors may be unable currently to operationalize this process, which would delay their participation in the program.

Data, interoperability, and reporting burden: ACCESS requires robust data infrastructure, interoperability, and analytics to support outcome measurement, audits, and CMS reporting. These requirements may raise barriers for smaller or less mature vendors.

Competitive pressure, scalability, and reputational risk: Because CMS intends to compare and publish organizational performance results, underperformance carries both reputational and financial risk. Vendors that enter the model before achieving operational readiness may face challenges not only in meeting payment thresholds, but also in maintaining credibility with referring physicians and partners.

Regulatory and program uncertainty: As a long-term Innovation Center demonstration, ACCESS is expected to evolve. Changes to metrics or thresholds over time introduce uncertainty that vendors must manage operationally and financially.

Bundled reimbursement risk: Bundled reimbursement rates can be subject to funding risks if rates are not set adequately. It will be imperative that those taking risk from this payment method ensure that rates are set appropriately.

VENDOR READINESS AND MARKET TIMING CONSIDERATIONS

Given the structure of ACCESS, participation may be most appropriate for vendors that have already demonstrated outcome improvement in treating relevant chronic conditions. Organizations considering participation might benefit from preparatory steps such as validating care pathways, ensuring interoperability with physician electronic health record (EHR) systems, stress-testing financial models under partial payment scenarios, and piloting outcome measurement prior to entering the model at scale.

CONCLUSION AND STRATEGIC OUTLOOK

ACCESS represents a deliberate shift by CMS toward outcome-based chronic care management in Traditional Medicare. For care management vendors, the model offers a significant opportunity to expand beyond episodic and supplemental roles into core partners in chronic disease management. At the same time, ACCESS introduces meaningful performance accountability, competitive transparency, and operational requirements that will reshape the vendor landscape.

Vendors best positioned to succeed under ACCESS will be clinically integrated, outcome-driven, and operationally scalable, with the ability to manage longitudinal risk across complex populations. For organizations prepared to enter the model with operational readiness and proven capabilities, ACCESS may represent a durable pathway to embed technology-enabled care as a foundational component of Medicare's chronic care strategy.

SOURCES

1. CMS Innovation Center, Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model Overview, December 2025.
2. CMS Innovation Center, ACCESS Model Frequently Asked Questions, December 2025.
3. American Medical Association, Moving Medicine Podcast: ACCESS—What This New Payment Model Means for Physicians and Patients, interview with Abe Sutton, December 2025.

ABOUT THE AUTHORS

Ben Cruz, ASA, MAAA
Consulting Actuary I
ben.cruz@wakely.com

Olivia Lang
Senior Actuarial Analyst
olivia.lang@wakely.com

Nick Cartossa, ASA, MAAA
Consulting Actuary II
nick.cartossa@wakely.com

ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier health care actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the health care industry, collaborating with payers, providers, and government agencies.