

CMS Expands ACCESS Model to Four New Conditions

On September 15, 2026, the Centers for Medicare & Medicaid Services (CMS) announced that it will add four clinical tracks to the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, covering heart failure, chronic obstructive pulmonary disease (COPD), substance use disorders, and tobacco cessation. CMS will also extend payment for chronic musculoskeletal (MSK) pain beyond the current 12-month care period.¹ The additions come approximately 10 weeks after the model began operating and enlarge a payment experiment that makes half of participant revenue contingent on documented clinical improvement. This Health Capital Topics article reviews the expansion and the outcome-aligned payment mechanics that determine what participating organizations are ultimately paid.

The ACCESS Model

CMS announced ACCESS in December 2025 as one of six payment models the CMS Innovation Center unveiled between December 2025 and January 2026, a group that also included the MAHA ELEVATE, BALANCE, GLOBE, GUARD, and LEAD Models.² Of the models announced in that period, only the Transforming Episode Accountability Model (TEAM) and the Ambulatory Specialty Model (ASM) employ episodic bundled structures; the remainder rely on outcome-aligned payments, cooperative agreements, or drug pricing frameworks.³ The voluntary ACCESS Model operates nationwide, in all states, U.S. territories, and the District of Columbia, over a 10-year performance period running from July 5, 2026 through June 30, 2036.⁴ Rather than paying fee-for-service rates tied to discrete activities, it tests whether an alternative payment methodology – outcome-aligned payments (OAPs) – can reduce expenditures for technology-enabled chronic care while preserving or enhancing quality.⁵

Participants must be Medicare Part B-enrolled organizational entities identifiable by a single taxpayer identification number (TIN) and eligible to bill under the Medicare Physician Fee Schedule, excluding durable medical equipment and laboratory suppliers.⁶ Each must designate a Medicare-enrolled physician as Medical Director.⁷ CMS reported 160 participating organizations at launch and has since noted that the roster has exceeded that figure.⁸ Notably, most participating organizations have not previously served Medicare beneficiaries.⁹

At launch, ACCESS comprised four clinical tracks: early cardio-kidney-metabolic (eCKM), cardio-kidney-metabolic (CKM), MSK, and behavioral health (BH).¹⁰ Qualifying conditions are hypertension, dyslipidemia, obesity, and prediabetes for the eCKM track; diabetes, chronic kidney disease stages 3a and 3b, and atherosclerotic cardiovascular disease for the CKM track; chronic musculoskeletal pain lasting over three months for the MSK track; and depression and anxiety for the BH track.¹¹ A beneficiary may align to more than one track at a time, but may not enroll in both the eCKM and CKM tracks.¹²

The New Condition Tracks

CMS describes the heart failure track as supporting continuous monitoring directed at measurable gains in function, symptom management, and quality of life, the COPD track as offering targeted support to maintain or improve lung function, ease symptoms, and sustain day-to-day activities, and the tobacco cessation track as assisting beneficiaries with quitting.¹³ The substance use disorder track will cover opioid, alcohol, and other substance use disorders, including integrated support for co-occurring depression and anxiety, which CMS ties to the Trump Administration's Great American Recovery initiative.¹⁴ The new tracks take effect April 1, 2027, and CMS has stated that current participants and applicants will not need to reapply to participate in them.¹⁵

With the additions, CMS estimates that three out of four Medicare beneficiaries qualify for at least one ACCESS track.¹⁶ The agency also plans to publish a reference specification for a maternal cardio-kidney metabolic track, including hypertensive disorders of pregnancy, as a voluntary standard that other payors, including Medicaid plans, may adopt.¹⁷

Outcome-Aligned Payment Mechanics

ACCESS pays a fixed annual allowed amount per aligned beneficiary for each 12-month care period, set at two tiers. The initial period rate reflects the higher resource demands of onboarding a beneficiary and achieving initial clinical improvement, while the lower follow-on period rate reflects continued management of beneficiaries already established in care or well controlled at baseline.¹⁸ For the initial period, the annual allowed amount is \$360 for the eCKM track, \$420 for the CKM track, and \$180 for each of the MSK and BH tracks.¹⁹ Those figures are maximums per beneficiary and encompass both the 80% Medicare program payment

and the 20% beneficiary coinsurance, although participants may adopt a uniform policy waiving collection of that coinsurance.²⁰ For the follow-on period, the amounts fall to \$180 for the eCKM track, \$210 for the CKM track, and \$90 for the BH track.²¹ The MSK track has no follow-on period at all, so payment for chronic musculoskeletal pain currently ends when the initial 12-month care period does.²² The September 2026 expansion adds one, limited to certain specified conditions, though the payment schedule now in effect through December 31, 2027 still lists no follow-on amount for that track.²³

Regarding the mechanics behind those amounts, CMS issues monthly payments equal to one-twelfth of the Medicare portion of the annual allowed amount, but the sum of those monthly payments may not exceed 50% of that portion; the remaining 50% is withheld and reconciled only after the 12-month care period concludes, through a Clinical Outcome Adjustment and a Substitute Spend Adjustment.²⁴ The Clinical Outcome Adjustment turns on an Outcome Attainment Threshold, which CMS has set at 50% for all participants, including first-year participants, during the effective period running from July 5, 2026 through December 31, 2027.²⁵ A participant earns full payment only if at least half of its aligned beneficiaries complete their care period and meet every required outcome measure target.²⁶ Attainment is assessed on an all-or-nothing basis at the beneficiary level; partial target attainment does not constitute success.²⁷ The Substitute Spend Adjustment separately reduces payment where aligned beneficiaries receive defined substitute services from other Medicare providers above a threshold CMS has set at 90% for the same period.²⁸

Each required measure carries two possible targets: an absolute control target and a minimum improvement target measured from the beneficiary's own baseline, and the measure is met if either is achieved.²⁹ CMS characterizes the improvement target as a clinically meaningful change rather than the beneficiary's ultimate clinical goal, and states that anchoring targets to each starting point reduces the incentive to avoid beneficiaries who begin far from control.³⁰ The MSK track is the exception, setting no control targets at all, a design CMS says is meant to incentivize minimum improvement rather than maintenance of existing symptom levels.³¹

Payment Adequacy

The rates have drawn criticism as too low to sustain technology-supported care. Several scaled digital health companies, among them Hinge Health, Omada Health, and Sword Health, did not participate in the first cohort, and the research firm Capstone has flagged a risk of negative profit margins for participants. Other participants defend the calibration, arguing that rates set at this level compel delivery models built on software rather than headcount.³² CMS, for its part, characterizes the structure as rewarding measurable improvements in patient health outcomes rather than volume of services.³³

Cross-Payor Alignment

Although ACCESS itself reaches only Original Medicare beneficiaries, CMS has built it for use well beyond Traditional Medicare. In February 2026, the agency announced that major health payors covering over 165 million Americans across Medicare Advantage, Medicaid, and private coverage had pledged to offer payment arrangements aligned with the model's core principles by January 1, 2028, among them Centene, Cigna, CVS Health, Humana, and UnitedHealthcare.³⁴ To support that alignment, CMS is making available a sample provider agreement and payment adjustment code, track-specific G-codes usable by any payor, and a reporting interface built on Fast Healthcare Interoperability Resources standards through which payors can rely on outcome measures CMS already collects.³⁵ Eighteen clinical and patient societies have separately expressed support for the model.³⁶

Conclusion

The expansion doubles the number of clinical tracks in ACCESS and pushes the model into disease states where outcome measurement is considerably harder than a blood pressure reading or a lipid panel. Substance use disorder and heart failure do not yield endpoints a connected device captures cleanly, yet the withhold structure makes participants in those tracks carry that difficulty as revenue risk. Whether outcome-aligned payment travels into conditions whose endpoints resist device capture, and whether rates calibrated for the current tracks will support participation in the new ones, are open questions as the model approaches its second performance year.

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- 7 *Ibid.*
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- 9 *Ibid.*
- 10 Health Capital Topics, Vol. 19, Issue 1 (January 2026); “Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model: Model Payment Amounts and Performance Targets” Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, p. 3.
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- 12 *Ibid.*
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- 15 “ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model” Centers for Medicare & Medicaid Services.
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- 26 *Ibid.*
- 27 *Ibid.*, p. 5.
- 28 *Ibid.*, p. 4-5.
- 29 *Ibid.*, p. 5-6.
- 30 *Ibid.*
- 31 *Ibid.*, p. 13-14.
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