CLIENT ALERTS & INSIGHTS

CMS Announces New ACCESS Model, Advancing a National Outcomes-Based Framework for Chronic Care, Health Equity and Community Integration

DECEMBER 3, 2025

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Key Takeaways:

- CMS is developing the ACCESS Model, a new national program that will pay Medicare Part B-enrolled organizations based on chronic-condition outcomes, care coordination and social-needs integration, with direct beneficiary enrollment for the first time.
- ACCESS represents a major shift in Medicare participation. Organizations that manage chronic disease or address HRSNs could see new reimbursement pathways but they will also face increased expectations around data exchange, equity reporting and outcomes accountability.
- With an RFI expected in 2026, organizations should begin assessing infrastructure readiness now-especially data-sharing capabilities, CEHRT alignment, HRSN workflows and potential partnerships to position for early participation when the model launches.

The Centers for Medicare & Medicaid Services ("CMS"), through the CMS Innovation Center ("CMMI"), has announced the ACCESS Model-Advancing Clinical Care, Equity and System Sustainability, a national demonstration model designed to create an outcomes-based payment pathway for chronic-condition management, care coordination and health-related social needs ("HRSN") integration. Unlike prior Innovation Center demonstrations, the ACCESS Model establishes a structure in which a wide range of Medicare Part B-enrolled organizations-including physician practices, digital chronic-care platforms, home-based providers and community-supported care organizations-may receive Medicare payments tied directly to clinical and equity-related outcomes. CMS has also taken the unprecedented step of allowing direct beneficiary enrollment, removing historical dependence on ACO alignment or claims-based attribution.

While the ACCESS Model remains in a pre-rulemaking phase, with a Request for Information ("RFI") expected in 2026, the model represents CMS' continued movement toward expanding Medicare participation pathways for organizations capable of managing chronic disease, addressing social needs and integrating digital or community-delivered interventions.

Model Overview and Policy Rationale

CMS describes the ACCESS Model as part of a broader transformation effort aimed at addressing persistent gaps in Medicare's chronic-care infrastructure. The ACCESS Model is designed to streamline these workflows by offering a unified, outcomes-based payment approach that holds organizations accountable for improving chronic-condition outcomes, reducing avoidable utilization and addressing social determinants of health.

The policy rationale is driven by four core themes:

1. the substantial cost and morbidity burden associated with diabetes, hypertension, COPD, CHF, obesity, frailty and behavioral health conditions;
2. persistent gaps in care coordination across primary care, specialty care and community-based partners;
3. the limited ability of fee-for-service payment to support proactive engagement, digital integration and home-based care strategies; and
4. CMS' goal of establishing a scalable national model that can operate in parallel with MSSP ACOs and Medicare Advantage programs without requiring participation in either.

The ACCESS Model thus functions as a national care-redesign structure, anchored in chronic disease improvement and social-needs integration rather than in financial-risk contracts.

Timeline and Model Development

CMS has not yet finalized dates for Access Model implementation. The agency expects to issue an RFI in 2026, followed by technical guidance and model specifications. Based on the cadence of prior Innovation Center demonstrations, earliest performance periods would likely begin in 2027 or 2028, allowing organizations time to align infrastructure, data-sharing mechanisms and contracting arrangements. CMS intends for the Access Model to operate at scale, with no geographic limitations announced to date. The agency also indicates that the Access Model may be coordinated with Medicaid programs, especially for dual-eligible beneficiaries, suggesting a broader multi-payer design could emerge in later phases.

Participation Pathways and Organizational Eligibility

A central feature of ACCESS is its broad eligibility standard. Any Medicare Part B-enrolled organization may apply to participate, subject to compliance with model requirements. CMS anticipates participation from primary care practices, multispecialty groups, home- and community-based providers, as well as technology-enabled chronic-care management companies.

Every ACCESS Organization must designate a physician Clinical Director responsible for clinical governance and oversight of care-management standards. Unlike MSSP ACOs or ACO REACH entities, ACCESS Organizations are not required to assume downside financial risk. CMS intends the model to function as an outcomes-based structure rather than a risk-bearing total cost-of-care arrangement.

This creates one of the most accessible Innovation Center participation pathways for digital and hybrid chronic-care companies, many of which historically operated only through subcontracting relationships with ACOs, MA plans or health systems.

Beneficiary Alignment and Direct Enrollment

One of the most significant departures from prior Innovation Center models is direct beneficiary enrollment. CMS indicates that beneficiaries may: (i) enroll directly with an ACCESS Organization; or (ii) enroll after a referral from a primary care practitioner or other qualified practitioner. This mechanism allows organizations to engage Medicare beneficiaries without relying on claims-based attribution or ACO assignment. Beneficiaries may self-select into ACCESS based on chronic conditions, social-needs profiles or interest in care-management services, bringing a consumer-driven dimension unprecedented in CMMI models. Condition-based eligibility will be further defined in the forthcoming RFI, with an expected initial focus on high-burden chronic diseases.

Payment Methodology and Outcomes-Based Compensation

CMS describes the ACCESS Model as an outcomes-based payment framework. Payments will depend on achieving measurable improvements in chronic-condition outcomes, patient engagement and HRSN resolution. CMS has not finalized the payment methodology but indicates the model will include performance-based payments tied to clinical outcomes and may incorporate prospective support for care coordination, digital tools, HRSN screening, navigation and related services. ACCESS is intended to align reimbursement with longitudinal outcomes rather than discrete fee-for-service activities.

Performance Measurement, Health Equity Requirements and Reporting

The ACCESS measurement structure will center on chronic-condition outcomes, patient-engagement metrics, functional-status improvement and resolution of identified social needs. CMS highlights several required capabilities, including:

- HRSN screening using CMS-approved tools;
- tracking and documenting closed-loop referrals to community-based organizations;
- stratification of outcomes across demographic and equity categories; and
- standardized reporting on engagement and clinical progress.

Participants must exchange data with CMS, practitioners and community partners using CEHRT or comparable technology.

Data Sharing, Interoperability and Technology Requirements

The Access Model will require participants to maintain substantial data-exchange capacity. CMS references expectations related to CEHRT utilization, bidirectional data exchange with primary care practitioners and ACOs, and timely reporting of chronic-disease metrics, HRSN screenings and engagement measures.

Future rulemaking may require FHIR-based APIs or TEFCA-aligned exchange standards. CMS indicates that the Access Model will also include standardized formats for reporting HRSN activity and outcome improvement.

Relationship with MSSP ACOs, ACO REACH and Other Medicare Models

The Access Model is intentionally designed to operate alongside, not in place of, MSSP ACOs and other Innovation Center models. Whereas ACOs rely on alignment, benchmarking and shared savings methodologies, the Access Model is focused on outcomes and social-needs resolution for enrolled beneficiaries. ACO participation is “preferred” but not required.

For organizations participating in both models, CMS notes that alignment, data exchange, clinical responsibilities and patient-management expectations must be coordinated. The Access Model thus introduces a dual-pathway structure in which ACOs retain population-level accountability while ACCESS Organizations manage condition-specific or patient-selected engagement cohorts.

Fraud and Abuse Considerations

As a CMS-sponsored model under the Innovation Center’s Section 1115A authority, the Access Model is expected to qualify for the CMS-Sponsored Model Safe Harbor under the Anti-Kickback Statute, offering protection for care-management payments, digital engagement supports, community-partnership payments and patient incentives that meet model requirements.

However, the Access Model does not displace the physician self-referral law (Stark Law). Organizations expecting to share Access Model-derived payments with Clinical Directors or participating practitioners will likely need to rely on value-based enterprise (VBE) structures and value-based arrangements (VBAs) under the Stark value-based exceptions. Contracting frameworks will therefore resemble those used in ACO REACH and other Innovation Center demonstrations, albeit without the financial risk elements.

Key Considerations for Stakeholders

The ACCESS Model has meaningful implications for a broad spectrum of healthcare stakeholders.

Primary Care Practices	New Medicare revenue to support chronic-care management, patient engagement and HRSN workflows; opportunity to partner with ACCESS organizations without entering financial risk arrangements.
Health Systems	Ability to integrate digital chronic-care programs, home-based care, navigation teams and community-health initiatives into a reimbursable Medicare framework; alignment needed with existing MSSP or MA strategies.
ACOs (MSSP / Reach)	Potential enhancement of chronic-condition management infrastructure through ACCESS partners; need to reconcile attribution, data exchange, quality reporting and patient-engagement responsibilities across models.

Tech-Enabled Chronic-Care Platforms	First national CMS opportunity for direct beneficiary enrollment and outcomes-based payments; reduced dependence on ACOs and health systems as intermediaries; potential for scalable Medicare participation.
Community-Based Organizations (CBOs)	New reimbursable pathways for delivering social-needs interventions, care navigation and community partnerships; expanding role alongside clinicians in chronic-care workflows.
Investors / Digital Health Capital	Material Expansion of the Medicare addressable market for digital chronic-care companies, HRSN platforms, home-based care and virtual-first models; reduced regulatory barriers for Medicare revenue participation.

Key CMS Resources

For clients who wish to review CMS's primary materials, the most relevant publicly available resources on the ACCESS Model are:

CMS Innovation Center - ACCESS Model Page
ACCESS Model - Technical Frequently Asked Questions

Final Takeaway

The ACCESS Model reflects CMS' continued movement toward expanding direct, outcomes-based participation opportunities for chronic-care providers, digital-health organizations and community partners. By combining direct enrollment, broad organizational eligibility, outcomes-based payment and mandatory health equity integration, the ACCESS Model may redefine national chronic-care infrastructure and create new pathways for Medicare participation outside of ACOs or risk-bearing arrangements, representing a continuation of the Innovation Center's progression from care-management pilots and ACO models toward broader, more flexible structures capable of integrating digital health, social-needs interventions and community-based services at scale.

The Benesch Healthcare team is monitoring Access Model developments closely and assisting organizations in assessing readiness, evaluating partnership structures, preparing governance frameworks and aligning operational infrastructure as CMS moves toward issuance of the RFI and formal model guidance.