

ACCESS Model: The Digital Health Payment Experiment That Might Actually Matter

JAN 23, 2026 • PAID



Share

Abstract

CMS launched the ACCESS Model in December 2025, creating a new payment pathway for technology-enabled chronic disease management tied to clinical outcomes rather than billing codes. The model offers recurring condition-specific payments based on risk-adjusted improvements in validated measures like blood pressure control, A1c reduction, and depression response. Payment levels appear modest compared to existing RPM and CCM codes, with roughly \$100 per beneficiary annually plus co-management fees around \$30 per primary care review. This structure favors automated, lower-touch interventions over labor-intensive care models. The opportunity exists primarily for companies that can deliver scalable digital solutions achieving measurable clinical improvements while maintaining unit economics under constrained reimbursement. Implementation barriers include upfront infrastructure costs that may exclude smaller practices and safety-net providers, risk of selective enrollment gaming, and unclear coordination mechanisms with traditional delivery systems. Success depends on whether payment levels support meaningful chronic care transformation versus incentivizing documentation optimization. For investors and entrepreneurs, ACCESS represents a potential wedge into Medicare chronic disease management if approached with realistic expectations about margins, target populations, and care model design constraints.

Table of Contents

Why ACCESS Actually Matters This Time

The Payment Math That Changes Everything

Who Wins Under This Structure

The Infrastructure Problem Nobody Wants to Talk About

Gaming Mechanics and Why They Matter

What This Means for Product Development

The Equity Issue That Could Kill the Model

Investment Thesis and Reality Check

Why ACCESS Actually Matters This Time

CMS has been running payment experiments through CMMI for over a decade and the track record is pretty brutal. The Congressional Budget Office concludes CMMI increased federal spending by more than five billion dollars in its first decade instead of generating savings. Most models showed modest or transient effects because organizations optimized documentation and patient selection rather than actually redesigning care delivery. So when CMS announces another demonstration project, the appropriate response is usually skepticism mixed with mild curiosity about whether anyone makes money before the model gets shut down.

ACCESS is different in one specific way that matters for digital health companies. Instead of bolting outcome requirements onto existing fee-for-service billing or creating complex attribution schemes within ACO frameworks, ACCESS creates a standalone reimbursement pathway explicitly designed for technology-enabled longitudinal care. The model pays recurring condition-specific amounts tied to measurable clinical improvements in hypertension, diabetes, chronic pain, and behavioral health conditions. This is not another pilot program asking whether digital tools can theoretically improve outcomes. This is CMS saying they will pay for digital chronic disease management if it demonstrably works.

The timing reflects two converging realities. Medicare beneficiaries increasingly require continuous management for multiple chronic conditions, but fee-for-service mechanisms remain poorly suited for technology-enabled care that does not fit into discrete 15-minute encounters. Existing codes for remote patient monitoring and chronic care management have been narrowly defined and administratively complex, limiting utility for sustained engagement. Digital health companies have spent years trying to wedge their products into billing codes designed for completely different care models, leading to tortured compliance interpretations and perpetual uncertainty about reimbursement sustainability.

ACCESS attempts to solve this by creating payments explicitly intended for digital tools, remote monitoring, app-based interventions, and virtual care teams. The structure aligns payment with sustained clinical improvement rather than specific activities or time thresholds. This is the payment model digital health has been asking for since companies started pitching remote monitoring solutions a decade ago.

The Payment Math That Changes Everything

The economics determine everything else about this model. CMS outlined outcomes-aligned payments whose total depends on the proportion of patients achieving guideline-informed targets. Organizations receive approximately \$30 for each documented primary care review, a one-time \$10 onboarding payment, and a cap around \$100 per beneficiary per year. These figures matter because they define what business models are viable.

Compare this to existing reimbursement pathways. National average RPM payments include roughly \$48 monthly for treatment management and \$43 to \$47 monthly for device supply and transmission. That works out to around \$546 to \$570 annually for the monitoring components. CCM pays approximately \$60 monthly for 20 minutes of care management with an additional \$45 for each extra 20-minute increment, reaching \$720 annually at baseline. ACCESS payments are substantially lower than either established pathway.

This gap has immediate implications for care model design. A company building hypertension management service needs to cover costs for patient onboarding, ongoing monitoring, care team time, technology platform, clinical oversight, and administrative overhead while generating enough margin to be worth building. At \$100 annually per patient, the unit economics only work if labor costs are minimized through automation and asynchronous engagement. Synchronous video visits, intensive care coordination, or relationship-based coaching models become difficult to sustain without supplementary revenue.

The structure incentivizes specific technical architectures. Automated alerts, standardized protocols, and passive monitoring become more economically viable than personalized care planning. Companies that can identify clinical deterioration through algorithms and route only high-risk patients to human clinicians will have better margins than those requiring regular touchpoints. The payment level effectively selects for lower-touch interventions regardless of what might produce better clinical outcomes.

This creates interesting dynamics around patient selection and enrollment. The system ties payment to proportion of patients achieving clinical targets, so organizations have clear incentives to enroll individuals most likely to improve. Someone with uncontrolled hypertension taking no medications represents both higher potential measured improvement and higher likelihood of requiring intensive intervention to achieve it. The optimal patient from a financial perspective probably falls somewhere in the middle, sick enough to show meaningful improvement but not so complex that achieving guideline targets becomes difficult. Companies will need to think carefully about target populations and enrollment criteria because the business model only works if enough patients hit clinical thresholds.

Who Wins Under This Structure

Large integrated health systems with existing digital infrastructure enter ACCES with substantial advantages. Organizations that already operate remote monitoring hubs, employ care coordinators, and maintain behavioral health integration can

ACCESS payments onto existing capabilities. The incremental cost of adding chronic disease management workflows to established infrastructure is much lower than building from scratch. These systems can absorb upfront investment in workflow redesign and new tool integration more readily than smaller practices.

This infrastructure advantage matters enormously for participation feasibility. Independent primary care practices, federally qualified health centers, and rural providers face a different calculus. Even if ACCESS payments could eventually support ongoing care delivery, many organizations lack capital to build the baseline data analytics, staffing, and technology integration required to participate. The program includes payment adjustments for rural beneficiaries, but this primarily helps offset recurring operating expenses rather than initial fixed costs. Smaller practices may find ACCESS theoretically beneficial but practically inaccessible without external support for capacity building.

Digital health companies face their own segmentation. Vendors capable of delivering automated services at scale find ACCESS economics favorable. A company that uses connected devices, algorithmic risk stratification, and asynchronous messaging to manage diabetes can potentially operate profitably at \$100 per patient annually if patient volumes are sufficient. Firms relying on synchronous clinician time or intensive human coaching struggle under the same payment level. This shapes not only which companies participate but also the intervention characteristics that succeed.

The model particularly favors companies that already have distribution channels within the delivery system. A digital health vendor with existing relationships at large health systems can position ACCESS as an additional revenue stream for clients rather than trying to create entirely new commercial relationships. Companies without established distribution face the challenge of convincing organizations to adopt new technology specifically for a CMS demonstration with uncertain longevity. Given that many digital health companies have died waiting for provider adoption to reach critical mass, this distribution advantage is not trivial.

There is also a regulatory arbitrage opportunity around the technology definition. ACCESS explicitly allows for digital tools, remote monitoring, and app-based

interventions without rigidly defining what these must include. Companies can potentially package various technical capabilities as chronic disease management services as long as they produce measurable clinical improvements. This flexibility creates room for experimentation with intervention design, though it also opens questions about what level of clinical rigor is required.

The Infrastructure Problem Nobody Wants to Talk About

The upfront costs of ACCESS participation create a selection effect that undermines the model's broader policy goals. CMS wants to improve chronic disease management across Medicare, which requires reaching diverse populations including those served by under-resourced providers. But the organizations most able to participate are precisely those that least need additional chronic care funding because they already possess sophisticated digital infrastructure.

Consider what participation actually requires. Organizations need data systems capable of tracking patients across care settings, identifying eligible beneficiaries, monitoring clinical measures, and documenting improvement. They need staff trained to use new digital tools and workflows redesigned to incorporate remote monitoring data. They need compliance processes ensuring appropriate enrollment and coordination with primary care providers. They need analytics to assess which patients are progressing toward clinical targets and which need intervention escalation. All of this requires upfront investment before any ACCESS payments materialize.

For a large integrated delivery system, these capabilities often already exist in some form. The challenge is adaptation rather than creation. For a small independent practice or a safety-net clinic, these requirements represent fundamental infrastructure that does not currently exist. Even if such organizations wanted to participate, they lack the capital to make necessary investments and cannot afford the risk that ACCESS payments will not materialize as expected or that the model gets discontinued before achieving return on investment.

This dynamic has played out repeatedly in CMMI models. Demonstrations consistently show participation clustering among well-resourced organizations v struggling to engage smaller practices and safety-net providers despite policy rh about broad adoption. ACCESS includes rural payment adjustments but provide mechanism for supporting the upfront infrastructure costs that determine whetl participation is feasible. Without complementary funding for capacity building, ACCESS will likely concentrate among organizations that already have digital he capabilities.

From an investor perspective, this creates opportunity and constraint. Companies selling into large health systems find receptive customers with budgets and infrastructure to deploy new tools. Companies trying to serve smaller practices f market where potential customers want the product but lack resources to imple: it. This market segmentation has been a persistent challenge in digital health, ar ACCESS does not fundamentally change the underlying dynamics.

Gaming Mechanics and Why They Matt

Tying payment to clinical outcome improvement creates obvious gaming vectors will shape how the model actually functions in practice. Organizations have stro incentives to enroll patients most likely to achieve measured improvement while avoiding those with complex medical or social barriers. Risk adjustment is supp to account for this, but risk adjustment models consistently struggle to capture full complexity of patient populations.

The most straightforward gaming approach is selective enrollment. Screen poter participants for factors predicting success and decline those with barriers to improvement. Someone with uncontrolled hypertension who owns a smartphone demonstrates medication adherence, and has stable housing is much more likely achieve blood pressure targets than someone with similar clinical measures but unstable living situation and intermittent healthcare engagement. Both patients benefit from chronic disease management, but only one generates reliable ACCE payments. Rational economic actors will optimize enrollment accordingly.

Another vector is measurement gaming. Clinical improvement is assessed through validated measures like blood pressure control and A1c reduction, but these measures depend heavily on measurement circumstances. Organizations can potentially improve measured performance through strategic testing timing, patient preparation, or selective measurement of patients most likely to show good results. This is not necessarily fraud, but it represents optimization of measured outcomes rather than actual clinical improvement.

The coordination requirement with primary care creates additional complexity. ACCESS specifies co-management payments for documented primary care review, but the model does not clearly define how care coordination should work when patients receive chronic disease management from entities separate from their usual source of care. This could lead to fragmentation where patients have multiple parties involved in their care without clear accountability. Alternatively, it could lead to documentation of coordination that occurs nominally but not substantively.

These gaming vectors matter because they determine whether ACCESS actually improves chronic disease management or just creates new documentation and payment selection optimization. If organizations focus energy on enrollment screening and measurement strategy rather than care delivery innovation, the model fails to achieve policy goals even if it technically demonstrates measured improvement.

Distinguishing real clinical progress from administrative relabeling will be essential for evaluation.

For companies building ACCESS-focused products, understanding these dynamics is crucial for product-market fit. Solutions that help organizations identify and enroll optimal patients will find ready customers even if they do nothing to improve care delivery. Tools that genuinely improve clinical outcomes but do not optimize measured performance may struggle commercially. This creates a tension between building what healthcare systems will buy versus what actually helps patients.

What This Means for Product Development

The payment structure and gaming dynamics translate into specific product requirements for companies targeting ACCESS. First, solutions need capability patient identification and enrollment optimization. Health systems need tools to screen Medicare beneficiaries for ACCESS eligibility, assess likelihood of clinical improvement, and streamline enrollment workflows. This is fundamentally a data analytics problem requiring integration with electronic health records, claims data, and potentially external data sources.

Second, products need automated longitudinal monitoring with intelligent escalation. At \$100 annually per patient, sustained human touch is not economically viable. Solutions must use connected devices, patient-reported data, or other passive monitoring to track clinical measures with minimal labor cost. When deterioration occurs or intervention is needed, algorithmic risk stratification routes patients to appropriate care team members. The key is maintaining clinical quality while minimizing expensive synchronous engagement.

Third, products need robust documentation and reporting for coordination with primary care. ACCESS requires documented primary care review for co-management payments, which means systems must generate summaries of patient status, clinical changes, and recommended actions in formats that busy primary care physicians can quickly review. This is harder than it sounds because primary care practices vary enormously in their EHR systems, workflows, and preferences for receiving information.

Fourth, products need measurement and outcome tracking demonstrating clinical improvement. Organizations participating in ACCESS need proof that enrolled patients are achieving guideline-informed targets at rates justifying continued participation. This requires longitudinal data collection, comparison to baseline measures, and reporting that aligns with CMS requirements. Companies that make it easy for health systems to demonstrate success will have stickier products than those requiring manual outcome assessment.

Fifth, products need flexibility around chronic condition focus. ACCESS covers hypertension, diabetes, chronic pain, and behavioral health, but organizations must

want to prioritize specific conditions based on patient population characteristics and internal capabilities. Solutions that can address multiple conditions or easily address different clinical focuses will have broader market applicability than single-condition tools.

From a technical architecture perspective, this favors platforms over point solutions. A company offering comprehensive chronic disease management across multiple conditions with integrated monitoring, care coordination, and reporting has advantages over one addressing only diabetes or only hypertension. The platform approach also creates better unit economics because development costs amortize across larger patient populations and health system customers can consolidate vendors rather than managing multiple relationships.

The measurement focus also creates opportunity for companies with clinical validation. ACCESS ties payment to validated clinical measures, which means organizations need confidence that deployed tools actually improve outcomes. Digital health companies with published clinical trial data or real-world evidence demonstrating impact have credibility advantages over those making claims without supporting evidence. In a market where many digital health solutions have failed to show meaningful outcomes, validated effectiveness becomes a differentiator.

The Equity Issue That Could Kill the Model

ACCESS could inadvertently widen healthcare disparities if implementation follows predictable patterns. Organizations have incentives to enroll digitally engaged patients with fewer barriers to improvement, which means beneficiaries with limited digital literacy, unstable housing, or complex social needs may be systematically excluded. Technology-enabled chronic disease management sounds egalitarian until you consider who actually gets enrolled.

The digital literacy barrier is substantial. ACCESS assumes patients can engage with apps, respond to messages, use connected devices, and navigate digital interfaces. Many Medicare beneficiaries struggle with these technologies, particularly older

adults with cognitive decline or those who have never regularly used smartphones or computers. Solutions requiring significant digital engagement will naturally select for patients already comfortable with technology, leaving behind those who might benefit most from additional support.

The coordination challenge with traditional delivery systems creates another equity concern. Patients who already have strong primary care relationships and good care continuity may benefit from ACCESS as an enhancement to existing management. Patients with fragmented care, multiple providers, or weak connection to the healthcare system may find ACCESS creates additional complexity rather than improvement. The model assumes care coordination will work smoothly, but coordinating between digital health vendors and busy primary care practices is notoriously difficult.

Social determinants of health matter enormously for chronic disease management but are difficult to capture in risk adjustment models. Someone struggling with food insecurity faces different barriers to diabetes control than someone with stable nutrition regardless of clinical complexity. Housing instability affects hypertension management independent of medication adherence. These factors influence both baseline clinical measures and ability to improve, but risk adjustment models consistently underweight social factors relative to clinical ones.

For companies building in this space, the equity issue creates both risk and opportunity. Risk because if ACCESS demonstrably increases disparities, the model could face political backlash and early termination. Opportunity because solutions that effectively serve high-need populations while maintaining viable economics differentiate themselves in a market where most digital health tools skew toward already-engaged patients.

Realistically though, the equity challenge is hard to solve under ACCESS payment levels. Serving complex patients with multiple barriers requires more intensive intervention, which means higher costs that the payment structure does not adequately support. Unless CMS substantially increases payments for high-risk populations or creates supplementary funding for infrastructure serving safety-net

patients, ACCESS will likely concentrate among relatively healthy, digitally engaged beneficiaries. This is probably politically acceptable in the short term but creates long-term questions about whether the model actually improves chronic disease management for populations driving Medicare costs.

Investment Thesis and Reality Check

For investors evaluating companies targeting ACCESS, several factors determine whether the opportunity is real. First is addressable market size. Medicare covers approximately 65 million beneficiaries, with substantial proportions managing chronic conditions. Hypertension alone affects more than half of Medicare beneficiaries. Diabetes prevalence exceeds 25 percent. The potential patient population is enormous if ACCESS achieves meaningful adoption.

Second is payment sustainability. CMS demonstrations have a history of early termination or significant modification after initial evaluation periods. ACCESS launched December 2025, which means serious evaluation data will not exist until 2026 or 2027. Companies building specifically for ACCESS face regulatory risk if the model ends or changes dramatically before they achieve scale. This is not a hypothetical concern given CMMI's track record. Investors need to assess whether portfolio companies have viable business models independent of ACCESS or whether they are making binary bets on demonstration continuity.

Third is competition and market saturation. ACCESS creates clear reimbursement pathway for digital chronic disease management, which means every digital health company with relevant capabilities will pursue this market. Competition will intensify quickly as companies recognize the opportunity. First movers have advantages in establishing health system relationships and proving outcomes, but the window for differentiation is probably measured in months rather than years. Investors should evaluate whether portfolio companies have defensible advantages beyond being first to market.

Fourth is unit economics and path to profitability. At \$100 per patient annually, margins are thin unless patient volumes are substantial and costs are tightly

controlled. Companies need realistic models showing how they reach profitability given payment constraints. Many digital health companies have historically struggled with unit economics, and ACCESS does not fundamentally change the challenging math of selling into healthcare. Investors should be skeptical of projections showing easy profitability without clear explanation of how costs stay low enough to generate meaningful margins.

Fifth is clinical evidence and validation. As noted earlier, organizations participating in ACCESS need confidence that deployed tools actually improve outcomes. Companies with published studies or real-world data demonstrating clinical impact have credibility advantages. Investors should evaluate strength of clinical evidence and whether it is sufficient to convince risk-averse health systems to adopt new technologies.

The realistic opportunity here is probably more modest than initial enthusiasm suggests. ACCESS creates a new reimbursement pathway, which is genuinely valuable for companies that have struggled to monetize digital chronic disease management. But payment levels are constrained, competition will be intense, regulatory sustainability is uncertain, and implementation barriers are substantial. This is a sure bet on explosive growth.

The companies most likely to succeed are those with existing distribution into large health systems, validated clinical outcomes, technical capabilities supporting automated monitoring with intelligent escalation, and business models that work if ACCESS payments disappoint. These are fundamentally execution-focused businesses rather than technology moonshots. The returns will probably be solid but not spectacular, with exit multiples in line with other healthcare services companies rather than pure software businesses.

For entrepreneurs considering building in this space, ACCESS creates a wedge into Medicare chronic disease management that has not previously existed. This is valuable. But the pathway to success requires clear thinking about target population, realistic assessment of unit economics, and honest evaluation of competitive positioning. The companies that win will be those that deeply understand health

delivery system needs, build products that genuinely improve clinical outcomes working within payment constraints, and execute relentlessly on sales and implementation. This is hard, operational work rather than visionary technology development.

The broader question is whether ACCESS represents meaningful payment reform or just another demonstration with constrained impact. CMS is attempting to modify chronic care reimbursement and expand access to digital tools, which are worthy goals. But the model includes all the design flaws that have limited previous CM demonstrations including modest payment levels, high infrastructure barriers, geographic vectors, and unclear equity impact. Whether ACCESS succeeds depends on implementation details that are still being worked out and evaluation results that will not be available for years.

For investors and entrepreneurs, the appropriate posture is probably cautious engagement. ACCESS creates real opportunity for companies with the right capabilities and positioning. It is not a paradigm shift requiring wholesale portfolio reorientation. The winners will be those that execute well on a difficult opportunity rather than those betting everything on regulatory transformation. That is a reasonable foundation for investment thesis but not an exciting one, which is probably the most honest assessment possible given available information.



3 Likes

← Previous

Next

Discussion about this post

Comments

Restacks



Write a comment...