A Blunt Assessment of Every Major ACCESS Model Participant, Their Business Models, and What CMS's Ne Outcome-Aligned Payment Framewor Actually Means for Their P&L and Patient Populations

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Abstract

What it is: The ACCESS (Advancing Chronic Care with Effective, Scalable Solut Model is a 10-year, voluntary, nationwide CMS Innovation Center model launchi July 5, 2026, testing an Outcome-Aligned Payment (OAP) methodology for techn enabled chronic care across four clinical tracks: eCKM (early cardiometabolic), ((full cardiometabolic/diabetes/CKD), MSK (musculoskeletal pain), and BH (beha health: depression and anxiety).

Key payment mechanics: Monthly fixed per-patient payments with a 50% withhc reconciled at end of 12-month care periods. Full payment contingent on achievi OAP Measure targets across a patient panel. The Outcome Attainment Threshol (OAT) starts at 50% in the first 18 months. A Substitute Spend Adjustment (SST starting at 90%) penalizes participants whose patients receive duplicative FFS se for the same condition from other providers. Only the larger of the two adjustm applied per reconciliation period, capped at 50% and 25% respectively.

The payer context: 14 major payers representing 165 million covered lives have s the ACCESS Payer Pledge, committing to align commercial, MA, and Medicaid payment to the model's structure by January 1, 2028. This includes UnitedHealtl Humana, Cigna, CVS/Aetna, Centene, Devoted Health, and several BCBS plans.

The participant field: 150-plus organizations accepted as of April 2026, spannin virtual-first digital health companies, traditional brick-and-mortar specialists, pharmacies, care management vendors, and a handful of entries that defy easy categorization.

Key questions addressed: Who has the business model alignment, patient panel sophistication, and outcome track record to actually make money here? Who wil make the biggest clinical dent in Medicare's chronic disease burden? Who is abs from the list who probably should be there? And who are we looking at going, re

How to Think About This List Before Getting Into Specifics

There's a temptation to treat the ACCESS accepted applicant list as a flat roster, alphabetical spreadsheet of companies that all said yes to the same thing. That w be a mistake. The gap between the top tier and the bottom tier of this group, in of actual readiness to thrive in an outcome-aligned payment model, is enormous business model differences are even starker than the clinical ones. Some of these organizations have been building toward exactly this moment for years, running commercial book-of-business programs with outcome accountability, investing i remote monitoring infrastructure, and proving out that they can move biomarke scale. Others are walking in from adjacent markets with a lot of enthusiasm and lot of evidence. A few are genuinely puzzling additions.

To understand who's positioned well, you need to internalize one thing about ho OAP payment structure actually works in practice. The model pays a fixed mont per-patient rate (amounts not yet published as of the April 2026 application peri with 100% of payments flowing in months one through six and the back half effectively held until the 12-month mark. Full release of that withhold depends participant's Outcome Attainment Rate, meaning the share of their total patient who hit the required clinical targets. The OAT starts at 50% across the first 18 months, which sounds lenient until you realize most of these organizations have tried to move Medicare FFS patients through an outcome-linked accountability

framework before. Medicare populations are older, more complex, and more like have comorbidities that complicate biomarker improvement. The organizations have spent years managing commercially insured populations in their 40s and 50 going to face a real wake-up call when the panel shifts to original Medicare beneficiaries, many of whom are in their late 60s, 70s, and 80s with entrenched c patterns and polypharmacy issues.

The Substitute Spend Adjustment is the other thing that makes this genuinely h a participant's patients start getting physical therapy evaluations, psychiatric eva DSMT sessions, or cardiac monitoring billed through FFS channels by other prc during the care period, the participant's Substitute Spend Rate drops and their payment gets dinged. This creates a coordination burden that tech-first, virtual- companies are particularly bad at managing, because they often don't have deep enough relationships with a patient's brick-and-mortar care team to prevent tho FFS encounters from happening. That 90% SST in year one is going to be a real problem for anyone who doesn't have tight care coordination workflows.

> With that backdrop, let's go through the landscape.

The Category That Will Probably Make the Most Money: Scaled Virtual-First C and eCKM Specialists

If ACCESS has a natural home population, it's the eCKM and CKM tracks. Hypertension, diabetes, dyslipidemia, and CKD Stage 3 collectively affect enorm shares of Medicare. The RFA cites mean annual per capita costs of around $2,50 hypertension alone from a 2015-2019 study, $5,876 median annual costs for Med patients with diabetes complications, and $11,908-$13,102 annual CKD manage costs for Stage 3A and 3B respectively. CMS built these tracks to be the engine c model's savings thesis, and most of the largest-scale participants are here.

Noom lands on the list as one of the most commercially recognizable consumer l brands, operating in the eCKM and CKM tracks. Noom's model is fundamentall

about behavioral change via app-based coaching, psychology-informed habit modification, and peer accountability, and it has proven outcomes data on weigh in commercially insured populations. The Medicare population is a different ani and Noom has never had to demonstrate sustained HbA1c or BP improvement ir original Medicare beneficiaries. That said, the eCKM track's weight component natural fit given Noom's core product. If they can crack Medicare outreach and enrollment at scale, the fixed-payment model actually reduces their revenue vari compared to their current subscription churn model. The question is whether th can operationalize clinical validation, FHIR reporting, and medical director over with the rigor CMS demands, having been a consumer app company for most of existence. Commercially they have the brand, the tech, and the distribution. The Medicare-specific clinical compliance layer is the risk.

Verily Health, the Alphabet/Google life sciences spinout, is in eCKM and CKM. spent years building health platform infrastructure and device integration tools, has been attempting to pivot toward clinical care delivery. The ACCESS model is actually a legitimate business opportunity for Verily if they can operationalize ca delivery at scale, something the company has historically struggled to do despite significant capital. Verily's advantage is data infrastructure and device integratic critical for a model where BP cuff readings need to be timestamped and source-verified per Appendix C's data collection requirements. If anyone on this list can the FHIR plumbing right from day one, it's Verily. Their financial outcome in ACCESS depends almost entirely on execution, and Verily's execution track reco mixed.

Cadence Health, listed across three separate TINs for California, Florida, and N Jersey, is in eCKM and CKM and is one of the more interesting pure-play bets or list. Cadence is a virtual-first hypertension and chronic disease management com that has been building toward exactly this kind of reimbursement structure. The remote monitoring devices, dedicated care teams, and a tech platform purpose-b for cardiometabolic management, and critically, they have been doing this in partnership with health systems, giving them an established referral pipeline. H three TINs across geographies suggests they're taking this seriously as a comme

program rather than a pilot. They're well-positioned to benefit from the model's multi-track discount provision, which penalizes a 5% payment reduction on the cost track when a patient is enrolled in multiple tracks simultaneously, though f Cadence who is staying in the CKM-eCKM space, that's a manageable concern. Cadence probably makes real money here if they can ramp enrollment quickly a the OAT thresholds.

Somatus Medical Group is in all four tracks, which is an interesting bet for a co that built its name specifically in CKD and value-based kidney care. Somatus ha experience managing complex CKD patients in value-based arrangements, and t whole model is predicated on intensive care coordination and reducing avoidabl utilization in exactly the population the CKM track targets. The four-track participation is more aggressive and may dilute their core competency, but if an on this list understands what it takes to keep a Medicare CKD patient away fron duplicative FFS encounters, it's Somatus. They have relationships with nephrolo primary care teams, and home-based care suppliers. Their SST performance sho strong relative to the field.

Cecelia Health, focused on diabetes management and specifically on CDE-led coaching with remote care teams, is in eCKM and CKM. Cecelia has been operat health system and health plan partnerships for years and has real evidence on Hl reduction. They also have a notable Medicare Advantage presence. The transitio original Medicare under ACCESS's billing structure isn't trivial, but their clinic program is exactly aligned with what the model rewards.

Welldoc is the granddaddy of FDA-cleared digital therapeutics for diabetes and cardiometabolic conditions, in eCKM and CKM. Welldoc's BlueStar platform is Class II cleared as a Software as a Medical Device, and the RFA explicitly carves FDA-cleared SaMD as a legitimate care modality under ACCESS. That's not a coincidence. Companies like Welldoc that have cleared the FDA hurdle are expl called out in the model's design as the archetype of what ACCESS is meant to en Welldoc has payer contracts, outcomes data, and a clinical platform with over a decade of iteration. The challenge for Welldoc is that their model has traditiona been B2B, embedded in payer or employer programs rather than billing CMS di

Operationalizing direct Medicare enrollment, consent workflows, and FHIR rep is new plumbing they haven't had to build before. But the clinical foundation is strong and the model was arguably designed with companies like them in mind.

Story Health Partners, listed as affiliated with Innovacer, is in eCKM and CKM. is a meaningful entry because Innovacer is one of the better-known health data platforms with existing health system and ACO relationships, and Story Health focuses on advanced heart failure and cardiovascular care management. The combination of Innovacer's interoperability infrastructure and Story Health's cli delivery model is potentially a strong fit for the care coordination requirements model. Sharing care updates through HIE connections is not a trivial compliance hurdle for many participants on this list, and an organization with Innovacer's d exchange experience starts that process in a much stronger position.

The Strong Specialists: Nephrology, Cardiology, and Regional Clinics

There's a cluster of regional nephrology and cardiology clinics on this list, place Evergreen Nephrology, Enabled Health (CKM only), Nephrology of the Golden I South Carolina Nephrology and Hypertension Center, The Kidney Clinic LaGra NY Kidney Hypertension Medicine, Valdosta Kidney Clinic, and Renal Medicin Associates. These are exactly the kinds of organizations the model was designed absorb. They already manage complex CKD and hypertension patients, they hav existing Medicare billing relationships, and they understand the clinical monito required for eGFR and uACR submission. For these groups, ACCESS is essentia better payment model for care they're already delivering, replacing FFS encount with a predictable monthly payment and asking them to formalize outcome trac they were probably doing informally anyway.

The financial upside for regional nephrology practices is real but bounded. The unlikely to enroll thousands of patients rapidly, and their patient panel will be complex, meaning OAT achievement in year one won't be trivial. That said, the 5 OAT floor in the first 18 months gives them cushion to learn the model without

catastrophic payment clawback. For these groups, ACCESS is a revenue diversifi play and a VBC on-ramp, not a growth flywheel. They'll probably do fine financi and provide solid clinical outcomes for their existing patient base.

Orlando Cardiac and Vascular Specialists and Amelia Heart and Vascular Cente the same profile, brick-and-mortar cardiology groups trying to capture outcome aligned payments for cardiometabolic patients they're already seeing. Not explos growth stories, but solid model fits.

Cardiac Health Medical Group, specifically listed as partnered with AliveCor, is interesting. AliveCor makes KardiaMobile, a well-validated EKG device, and has pushing into cardiometabolic monitoring. This partnership structure, where a d company essentially creates a medical group to participate in ACCESS, is one of more innovative structural moves on the list. If they can build enrollment scale, combination of continuous cardiac monitoring and the eCKM/CKM outcome measures is compelling. AFib isn't a qualifying condition for ACCESS tracks, bu hypertension, dyslipidemia, and ASCVD are, and AliveCor's monitoring infrastructure maps naturally to that population.

MSK: A Tighter, More Defensible Marke with Real Outcome Accountability

The MSK track is smaller in terms of number of participants but arguably has stronger average participant quality than the cardiometabolic tracks. That's part because proven MSK-focused digital health companies are fewer in number and to have better outcomes data, and partly because the PROM-based outcome mea (PROMIS, KOOS JR, HOOS JR, NDI, ODI, QuickDASH, NRS pain intensity) are validated instruments that good programs already use.

Bold is a pure-play falls prevention and MSK strength exercise program that tar older adults, and is participating in the MSK track only. Bold's programs are des specifically for the Medicare demographic, which gives them a population alignr advantage most digital health companies lack. Older adults doing evidence-base

balance and strengthening training should move PROMIS physical function scor
Bold is a tight, focused bet.

TailorCare Provider Services is MSK-only and is one of the more operationally m
MSK navigation and care management companies on the list. TailorCare has bui
model specifically around musculoskeletal care navigation, helping patients
understand their options and routing them toward the least invasive effective
intervention. That's actually directly aligned with what ACCESS rewards: keepir
patients away from unnecessary surgical evaluations and FFS physical therapy
initiations (both of which are on the Substitute Spend List for MSK) while impro
PROM scores through conservative management. TailorCare is probably one of t
cleaner MSK plays on the list.

MSK Access, the partnership between Limber Health and Revel AI, is in both M
and BH. Limber is a digital physical therapy and home exercise platform, and Re
a clinical AI platform. The combination addresses both the exercise and behavio
dimensions of chronic musculoskeletal pain. For the MSK track specifically, Lim
home exercise adherence tools are directly relevant to improving functional outc
on the validated PROMs the model requires.

JOGO Health, in MSK only, is a neuromuscular digital therapeutics company foc
on biofeedback-based retraining for conditions like incontinence, pelvic floor
dysfunction, and chronic pain. Their approach is distinctly differentiated from t
standard PT-adjacent MSK digital health model, and they've accumulated clinica
evidence in a specific niche. The MSK track's broad definition of musculoskeleta
disorders, which includes conditions affecting bones, joints, muscles, and conne
tissues, gives JOGO room to enroll patients who fit their clinical niche.

Redefine Healthcare, RightMove Health, FitOn Care with its MSK component, a
Flagler Medical round out a set of MSK-only or MSK-primary participants that a
harder to fully assess from public information alone, though Redefine Healthcar
known as a value-based MSK practice that has operated in insurance networks.

Pair Team and RhythmScience: Two Participants Worth Watching Closely

Pair Team is listed across two TINs, covering California and Pennsylvania/other states, and is in eCKM, CKM, and BH. Pair Team has been doing something gen hard and important: embedding care teams with safety-net populations, specific Medicaid and dually eligible patients, using community health workers and tech enabled care management. Their model is designed for the highest-complexity, hardest-to-reach patients, the very population that tends to get filtered out by commercially-focused digital health programs. Pair Team's eCKM and CKM inc is notable because their patient population will include a high proportion of dua eligible Medicare-Medicaid patients, a group that is explicitly eligible for ACCE The ACCESS payer pledge, covering Centene and other Medicaid-heavy manage organizations, makes Pair Team's multi-payer alignment story potentially very st If ACCESS creates a path for payers to align payment structures for safety-net populations, Pair Team's book of business scales in a way that most venture-bacl digital health companies focused on commercially insured populations can't rep They're not the biggest or loudest name on this list, but the combination of miss alignment, population fit, and multi-payer positioning makes them one of the m thoughtfully positioned participants here.

RhythmScience is in the eCKM track only, which might seem like a narrow scop reflects careful strategic focus. RhythmScience builds AI-powered cardiac monit and arrhythmia detection tools, and their eCKM participation tracks with a population where continuous cardiac biosignal monitoring makes genuine clinic sense. Hypertensive patients with subclinical arrhythmia risk are exactly where RhythmScience's technology adds informational value beyond what a standard B captures. Their device-first approach means they come to this program with a differentiated data layer that most eCKM participants don't have. The fact that they're not overextending across every track is actually a sign of operational mat knowing your lane is underrated in a program where poor OAT performance car result in payment clawback. RhythmScience is a focused, technically credentiale entrant with a strong story for what eCKM monitoring should look like at its be

Behavioral Health: Headspace, Headwa Sondermind, and the Crowded BH Stac

The BH track is where the list gets most congested and arguably where participa quality is most variable. There are at least 40 organizations with a BH componer ranging from large established behavioral health platforms to tiny single-track psychotherapy practices.

Headspace, in the BH track only, is the most recognizable consumer brand in th entire ACCESS participant list. Tens of millions of people have used Headspace' meditation and mental wellness app, and the company completed a merger with Ginger, a therapy and coaching platform, to create a more comprehensive behavi health offering. The question for Headspace in ACCESS is whether their clinical platform, running PHQ-9 and GAD-7 assessments and providing therapy and coaching, can move those scores to target in the Medicare population. Consume mindfulness apps are generally not built for clinical severity populations, and Medicare beneficiaries with diagnosable depression and anxiety disorders repres genuine clinical challenge. The 50% OAT floor in year one is Headspace's lifeline if they can enroll a reasonably healthy cohort and hit the threshold, they get paic the Substitute Spend risk is real. If Headspace's patients simultaneously see psychiatrists or get DSMT or psychiatric evals from other providers, the SST hit consumer brand could actually help with patient acquisition, but the clinical sophistication required to hold the 90% SST is not a consumer app competency.

Headway, which has built one of the larger therapist network marketplaces for private-pay and commercial insurance behavioral health, is in BH only. Headway model is B2B2C, connecting patients to in-network therapists, and their infrastructure for therapy network management could map onto ACCESS's care delivery requirements if they build out the outcome reporting layer. But Headwa historical market is commercially insured patients, and the Medicare population clinical complexity and the administrative requirements of ACCESS are differen operational environments. Interesting entry but a fair amount of execution risk.

Sondermind has raised substantial capital and built a tech-enabled behavioral he therapy marketplace with an emphasis on matching and quality measurement. T BH-only and are one of the larger funded companies in this track. Sondermind h genuine experience with outcome measurement in behavioral health, which give them a leg up on PHQ-9 and GAD-7 reporting requirements.

Concert Health is a collaborative care model company in BH only. Collaborative the integrated behavioral health delivery model that embeds behavioral health specialists in primary care settings, is evidence-based for depression and anxiety maps well to what ACCESS rewards in the BH track. Concert has been operationalizing this model at scale with health systems. Their coordination wit care teams is essentially built into their model, which is relevant given the care coordination requirements around sharing updates with identified care team members.

April Health by Wysa deserves a mention. Wysa is a well-known AI-powered me health chatbot with published peer-reviewed clinical evidence on PHQ-9 reduct and April Health appears to be the clinical entity structured to participate in AC on Wysa's behalf. Wysa's evidence base is unusual for a chatbot company, which generally invested in clinical validation rather than purely marketing. The BH tr outcome measures are exactly what Wysa has been testing. This is a legitimate cl fit, though the Medicare population's familiarity with chatbot-based mental hea care remains an open question.

Who Doesn't Belong Here

> Let's be real about a few entries that are harder to explain.

Gojji Pharmacy is listed without a track designation, which is either a data entry or a very unusual organizational structure. Pharmacies are explicitly excluded fr ACCESS as DMEPOS and laboratory suppliers are excluded and many pharmacy adjacent entities don't qualify under the Medicare Part B billing eligibility crite The listing without a track is worth watching for clarification.

Weight Watchers is in eCKM only. WeightWatchers has been going through significant financial turbulence, including bankruptcy restructuring and a pivot GLP-1 medication management under its clinical program. The eCKM track doe include obesity and weight reduction as qualifying conditions and OAP measure the track fit isn't nonsensical. But the fundamental question is whether WeightWatchers can operationalize Medicare Part B enrollment, a Medical Dire with clinical oversight responsibilities, FHIR-based outcome reporting, and the coordination requirements of the model while also navigating its corporate restructuring. The administrative compliance layer of ACCESS is not trivial, and WeightWatchers' core competency is consumer habit change, not clinical compl infrastructure. This is probably more of a strategic option play and a hedge agai the multi-payer alignment of the payer pledge than a near-term revenue driver.

Higi Professionals of Delaware is listed in eCKM and CKM. Higi operates healtl screening kiosks in retail pharmacies, which is an interesting and potentially val touchpoint for chronic disease identification. But kiosk-based screening is very different from being the enrolled care provider managing a patient's qualifying conditions over a 12-month care period with accountability for outcome attainm The operational leap from "we identify hypertension in a CVS kiosk" to "we are ACCESS participant responsible for getting that patient's systolic BP below 130 down 15 mmHg over 12 months" is enormous. Higi's model may evolve to includ more longitudinal care, and the kiosk network is genuinely valuable for initial beneficiary outreach. But the care delivery model required by ACCESS is not obviously what Higi does today.

Castlight, in all four tracks, is a benefits navigation and health engagement platf that spent years in employer-sponsored insurance before trying to pivot toward clinical care delivery. Castlight's core capability is directing employees toward appropriate care resources, which is meaningful in a benefits context but is a dif thing from delivering outcome-accountable chronic disease management. The fc track participation claim raises questions about what clinical program they're ac deploying across eCKM, CKM, MSK, and BH simultaneously.

Who's Missing

The absence list is almost as interesting as the presence list. Omada Health, prol the most evidence-rich and operationally scaled digital diabetes prevention and chronic disease management company in the market, is not listed. Omada has published more peer-reviewed outcomes data on HbA1c and weight reduction th almost any company in the digital health space, has Medicare Advantage contrac and has been building toward a Medicare FFS pathway for years. Their absence conspicuous and could reflect anything from application timing to strategic hesi about the FFS Exclusion's impact on their existing MA contracts to internal con about the model structure. If Omada isn't in the first cohort, it will be a significa missed opportunity for the model's credibility.

Hinge Health, the dominant digital MSK platform by most commercial market measures, is also absent. Hinge has clinical evidence on PROMIS outcomes, has and deployed over a billion dollars in capital, and has the PT clinical infrastruct that the MSK track demands. Their commercial scale would make them one of th largest MSK participants by patient volume if they participated. Again, the FFS Exclusion may be creating tension with their existing MA and self-insured empl contracts, and the outcome-based payment accountability of ACCESS may be a h lift than it looks for a population that's significantly older and more complex tha their employer population.

Livongo, now part of Teladoc Health, should theoretically be a natural fit given t diabetes management track record and their scale in Medicare Advantage. Telad various entities are absent from this list, which likely reflects corporate strategic concerns about how ACCESS interacts with their existing payer contracts and whether the OAP payment structure makes economic sense given their cost stru

Oshi Health, in GI, wouldn't qualify for the current tracks but its absence underscores that the model's four-track structure leaves out a lot of well-positio digital health companies whose disease focus doesn't map to the current track li

The Bottom Line on Economics

The organizations that will make the most money in ACCESS are those that com four things: a patient population that is genuinely eligible and reachable for the tracks they're participating in, a clinical delivery model with demonstrated abili move the specific biomarkers and PROMs the model measures, operational infrastructure for FHIR reporting and care coordination that doesn't require a 1 month buildout, and low enough marginal cost per patient to make the fixed OA rates profitable at reasonable scale. Companies like Cadence Health, Somatus, C Health, Welldoc, Evergreen Nephrology, and Story Health Partners probably hit or four of those criteria. Companies like Headspace, Castlight, Higi, and WeightWatchers probably hit one or two, and will spend the first year learning l lessons about Medicare enrollment complexity and FHIR compliance.

The companies that will make the biggest impact on patients, which is a differer question than who makes the most money, are the ones enrolling dually eligible safety-net populations who currently have no access to technology-enabled chro disease management. Pair Team, Mariposa Community Health Center, Martin L King Jr Community Medical Foundation, and Puerto Rock/DPP de Puerto Rico a doing work in populations that the commercial digital health ecosystem has larg ignored. If even a fraction of their enrolled patients achieve the OAP targets and downstream complications, the cost savings to Medicare and Medicaid will be disproportionate to their enrollment volume.

The payer pledge is where the really interesting future lies. Fourteen payers cov 165 million lives committed to aligning their payment approaches by January 20 For participants who crack the Medicare FFS model in year one, that alignment creates a multi-payer revenue stack that transforms ACCESS from a Medicare pi into a new standard of reimbursement for tech-enabled chronic care. The compa building their ACCESS participation as a proof point for commercial and MA sc rather than as a standalone revenue stream, are the ones thinking about this cor At the end of the day, ACCESS is as much a forcing function for payer alignmen is a Medicare model. The participants who understand that will outperform tho don't.

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