Chasing the ACCESS Opportunity: Wh Smart Money Should Follow CMS Into Primary Care Transformation

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ABSTRACT

CMS has launched ACCESS (Accountable Care and Coverage for the Equity, Sustainability, and Social Determinants), a multi-domain innovation model that represents one of the most significant expansions of value-based care infrastruct recent memory. The program targets four initial domains (diabetes, maternal hea behavioral health, and musculoskeletal care) with specific attribution methodolc payment mechanics, and population health requirements that create distinct investment opportunities for digital health companies. This analysis examines th total addressable market for each domain, the structural advantages that positio certain business models for success, and the specific capabilities required to cap value under the program's payment framework. Key findings suggest that the behavioral health domain presents the largest immediate TAM at approximately billion dollars annually, while maternal health offers the highest margin potenti

to episode-based payment structures. Companies that can demonstrate both cos reduction and quality improvement across attributed populations while managi downside risk will be best positioned to scale through ACCESS participation.

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Understanding the ACCESS Framework and Why It Matters Now

The Center for Medicare and Medicaid Innovation has a mixed track record. For successful program like the Medicare Shared Savings Program that has demonst genuine cost savings and quality improvements, there are multiple initiatives tha fizzled out after burning through hundreds of millions in demonstration fundin when CMMI announces yet another alphabet soup program, the rational respons from most health tech investors is to file it away in the “wait and see” category a back to evaluating Series A pitch decks. But ACCESS is different in ways that m for early stage investment decisions happening right now in late 2024 and early 2

The program launched with four specific clinical domains rather than the usual population health mandate. This specificity creates clearer product-market fit si for startups. Instead of building generic care coordination platforms that try to

everything to everyone, companies can focus on narrow clinical use cases with w
defined success metrics. The four initial domains are diabetes, maternal health,
behavioral health, and musculoskeletal conditions. Each comes with its own
attribution logic, payment methodology, and quality measurement framework. T
isn't academic. These structural details determine which business models can ac
make money under the program.

Attribution matters because it defines who gets credit for outcomes. In the diab
domain, CMS is using a claims-based algorithm that looks at HbA1c testing patt
and diagnosis codes to identify attributed beneficiaries. This means companies r
claims data infrastructure and the ability to work with payers on attribution list
also means the TAM is somewhat constrained by the ability to accurately identif
engage attributed members. Compare this to the maternal health domain where
attribution is essentially automatic for any pregnant beneficiary who receives pr
care from a participating provider. The ease of attribution in maternal health cr
larger addressable population for intervention.

Payment mechanics drive unit economics. ACCESS uses a combination of per-
member-per-month care coordination fees and performance-based shared saving
with downside risk in later years. The care coordination fees range from thirty t
seventy five dollars per member per month depending on the domain and the lev
services provided. This creates a baseline revenue stream that can cover the cost
digital intervention while the shared savings component provides upside if the
company actually moves the needle on cost and quality. The downside risk comp
starting in year three is what separates the wheat from the chaff. Companies tha
just providing patient engagement apps without real clinical impact will get des
when they have to write checks back to CMS for not hitting savings targets.

The timing of ACCESS is particularly relevant because it intersects with several
structural shifts in healthcare payment. Medicare Advantage plans are under
increasing pressure to demonstrate value as the payment benchmarks get squeez
Commercial payers are watching CMS innovation models more closely than ever
because they're running out of their own ideas for payment reform. If ACCESS s
meaningful results in any of these four domains, there will be rapid diffusion int

and commercial contracts. This means companies that build for ACCESS requirements today are actually building for a much larger market that opens up two to four years.

Domain One: Diabetes Care and the Glucose Monitoring Gold Rush

The diabetes domain under ACCESS focuses on Type 2 diabetes management wi specific emphasis on patients who have poor glycemic control or are at high risk complications. CMS defines the attributed population as Medicare beneficiaries at least two claims with diabetes diagnosis codes in the past year plus evidence c active disease management through HbA1c testing or diabetes medication fills. T gives us a denominator to work with. Medicare covers approximately 13.8 millio beneficiaries with diagnosed diabetes. Of these, roughly 40 percent have subopti glycemic control defined as HbA1c above 8.0. That's about 5.5 million attributed

The PMPM care coordination fee for diabetes is set at fifty dollars for basic serv and seventy five dollars for enhanced services that include continuous glucose monitoring integration and real-time intervention. At the lower tier, the TAM is dollars times 5.5 million times twelve months which equals 3.3 billion dollars annually. At the enhanced tier it jumps to 4.95 billion dollars. These numbers as full penetration which is unrealistic, but even capturing 10 percent of this mark represents 330 to 495 million in annual revenue potential.

The key question is what clinical model actually works to capture shared savings evidence base here is actually pretty solid compared to most digital health interventions. Remote patient monitoring programs that include continuous glu monitoring plus health coaching have demonstrated HbA1c reductions of 0.8 to percentage points in multiple RCTs. More importantly, these interventions have shown 15 to 25 percent reductions in diabetes-related hospitalizations and ED v When you pencil out the economics, each avoided hospitalization saves Medicar roughly twelve thousand dollars on average. For a population of ten thousand attributed diabetics, preventing just twenty hospitalizations per year generates 2

in savings. Split that 50/50 with CMS and you have 120k in shared savings on top the PMPM fees.

The business model that makes sense here is a hybrid remote monitoring and vi care delivery platform that owns the full stack from CGM provisioning through coaching through physician oversight. Companies that just provide the technolo layer without taking clinical responsibility will struggle because they can't contr intervention quality. The unit economics work if you can keep patient acquisitio below six hundred dollars and maintain engagement for at least twelve months. the PMPM fee structure, you're generating nine hundred dollars in first year rev from the fees alone before any shared savings. If you can drive 15 percent cost reduction in your attributed population and capture half the savings, you're add another 180 dollars per patient per year in upside.

The competitive dynamics in diabetes are tough because this is a crowded space. You've got established RPM companies like Livongo (now Teladoc) and Omada, dozens of venture-backed startups attacking different angles. The differentiatio needs to come from either superior clinical outcomes or ability to manage more complex patients. There's a huge opportunity in serving dual eligible beneficiari who have both Medicare and Medicaid coverage. These patients typically have w glycemic control and higher comorbidity burden but most digital health compar avoid them because of the operational complexity. If you can crack the dual eligi population, you're operating in a less competitive segment with higher impact potential.

The technology requirements are more sophisticated than they appear. You need time CGM integration which means working with Dexcom and Abbott on data f You need a clinical decision support system that can triage glucose patterns and high-risk patients to appropriate interventions. You need a care team model tha scales efficiently, which usually means some combination of health coaches, diab educators, and physician oversight. And you need the data infrastructure to supp attribution tracking, quality reporting, and financial reconciliation with CMS. T full stack is expensive to build and even more expensive to maintain which creat natural barriers to entry for undercapitalized startups.

Domain Two: Maternal Health and the Episode Payment Playbook

Maternal health is getting its own domain under ACCESS which reflects both th clinical importance of maternal outcomes and the political salience of maternal mortality rates that have been increasing in the US even as they decline globally. ACCESS maternal health model uses episode-based payments that cover the full continuum from prenatal care through delivery and postpartum follow-up. This different from the PMPM structure in other domains and creates distinct opportunities for digital health companies.

The attributed population is straightforward. Any pregnant Medicare beneficiar receives prenatal care from a participating provider gets attributed. Medicare do cover that many pregnancies relative to commercial or Medicaid, but the numbe still meaningful. Medicare Advantage plans cover approximately 380,000 pregna per year, and traditional Medicare covers another 120,000. The ACCESS model t both FFS Medicare and MA plans, so the total addressable population is around 500,000 episodes annually.

The episode payment under ACCESS is structured as a bundled amount that cov care from the first prenatal visit through 90 days postpartum. CMS has set the b price at roughly 14,000 dollars per episode for uncomplicated pregnancies and 2 for high-risk pregnancies. The classification into risk tiers is based on comorbid prior pregnancy complications, and social risk factors. About 35 percent of Med covered pregnancies fall into the high-risk category which is substantially highe the general pregnant population because Medicare beneficiaries tend to be eithe disabled or have ESRD.

The TAM calculation for maternal health is the number of episodes times the bu price. For the 500,000 annual episodes, if we assume 65 percent at the standard bundle price and 35 percent at the high-risk price, we get (325,000 times 14,000) (175,000 times 28,000) which equals 9.45 billion dollars in total episode payment opportunity for digital health companies is to provide services that improve outc and reduce costs within the episode budget. If a company can reduce NICU

admissions, prevent preeclampsia, or improve postpartum follow-up compliance can share in the savings generated.

The clinical interventions that have the best evidence base in maternal health ar actually pretty low-tech. Remote blood pressure monitoring for preeclampsia surveillance, structured postpartum depression screening, and lactation support all shown cost-effectiveness in multiple studies. The magic is in the operational execution and care coordination rather than fancy AI algorithms. Companies nee integrate with OB/GYN practices and hospital systems, ensure patients actually the monitoring devices, and have clinical protocols for escalating concerning fin The technology is almost beside the point.

The unit economics in maternal health are compelling if you can execute. Let's s digital health company provides a comprehensive maternity support program including RPM, prenatal education, mental health screening, and postpartum fo up. They charge the provider group or MA plan 1,200 dollars per episode for thi service. If their intervention reduces NICU admissions by just 3 percent in the h risk population, that saves about 15,000 dollars per avoided NICU stay (average stay costs around 50,000 for Medicare). For a population of 10,000 high-risk epis a 3 percent reduction is 300 avoided NICU stays generating 4.5 million in saving Even if the company only captures 20 percent of this as shared savings, that's 90 top of the 12 million in episode fees.

The challenge in maternal health is that pregnancy is time-bounded. You only ha nine months to engage the patient, deliver your intervention, and demonstrate va This creates pressure on patient acquisition and onboarding speed. Companies n to identify pregnant beneficiaries early, get them enrolled quickly, and maintain engagement through delivery and postpartum. The drop-off in engagement postpartum is particularly brutal. Many women are focused on newborn care and neglect their own health, which is exactly when complications like postpartum hemorrhage and depression occur. Companies that can crack postpartum engage have a genuine moat.

The competitive landscape in maternal health is less crowded than diabetes but heating up. Maven, Babyscripts, and Mahmee are the most visible venture-backe players. Each has a slightly different angle on the problem. Maven is building a comprehensive maternity and family benefits platform for employers. Babyscrip focuses on RPM and virtual care for OB practices. Mahmee is targeting racial disparities in maternal outcomes. There's room for multiple winners here becau market is large and the buyer personas are different (payers vs providers vs employers). The key is to have a clear target customer and distribution strategy.

Domain Three: Behavioral Health Integration and the Coordination Premium

Behavioral health integration is the third domain under ACCESS and potentially most interesting from an investment perspective. The model recognizes that me health and substance use disorders are massive drivers of healthcare costs but ar chronically underaddressed in traditional primary care settings. ACCESS create payment mechanisms to support collaborative care models where behavioral hea services are integrated into primary care rather than siloed with specialty menta health providers.

The attributed population for behavioral health includes Medicare beneficiaries diagnosed mental health conditions (depression, anxiety, bipolar disorder, schizophrenia) or substance use disorders who are receiving care from a particip primary care practice. CMS estimates this represents approximately 18.5 million Medicare beneficiaries. Not all of these will be actively managed under ACCESS the potential attributed population is huge. If we assume 20 percent penetration the first few years, that's 3.7 million attributed lives.

The PMPM care coordination fee structure for behavioral health is more genero than other domains because of the intensity of care coordination required. CMS set the rates at sixty dollars per month for patients with mild to moderate condi and one hundred dollars per month for complex patients with serious mental illn

or co-occurring substance use. If we use a 50/50 split between complexity tiers a assume 3.7 million attributed lives, the total PMPM revenue pool is (1.85 millior times 60 times 12) plus (1.85 million times 100 times 12) which equals about 3.5 billion dollars annually. This is massive.

The shared savings opportunity in behavioral health is equally compelling. Beneficiaries with serious mental illness have healthcare costs that are two to th times higher than those without mental health conditions. Much of this excess c driven by preventable medical complications, poor medication adherence, and h utilization of emergency services. Studies of collaborative care models have consistently shown 10 to 20 percent reductions in total medical spending when behavioral health is effectively integrated into primary care. For a population of million with average annual costs of 15,000 per person, a 15 percent reduction ir spending generates 8.3 billion in savings. Even capturing a small percentage of t shared savings creates huge upside.

The business model that works in behavioral health integration is providing the infrastructure and clinical workforce to embed behavioral health services into primary care practices. This typically includes a mix of care managers (often soci workers or nurses with behavioral health training), consulting psychiatrists who provide caseload consultation to PCPs, and a platform for measurement-based c that tracks symptom improvement over time. Companies need to handle the bill complexity of multiple CPT codes, manage the care team, and provide reporting quality measures.

The unit economics require scale. The cost structure includes salaries for care managers and psychiatrists plus technology platform costs. A single care manage typically handle a caseload of 50 to 80 complex patients, and psychiatrists provic consultation at a ratio of one psychiatrist to 3 or 4 care managers. If we assume l costs of 80k per care manager and 250k per psychiatrist, plus 50k in technology a team supporting 200 complex patients costs roughly 530k per year. The revenu from PMPM fees for these 200 patients at 100 dollars per month is 240k annuall need the shared savings component to make the math work, which means you ne actually improve outcomes and reduce costs.

The clinical evidence for collaborative care models is rock solid. Multiple RCTs demonstrated effectiveness for depression, anxiety, PTSD, and even serious men illness. The model has been endorsed by the American Psychiatric Association a considered a best practice. The challenge is implementation and workflow integ with primary care. PCPs are already overwhelmed and adding behavioral health responsibilities feels like more work even though it's supposed to make their liv easier. Companies that can make the workflow seamless and demonstrate quick in patient outcomes will get adoption.

The competitive space includes established players like AbleTo (acquired by Op Ginger (merged with Headspace), and Lyra Health, plus newer entrants focused specifically on the Medicare population. The differentiation comes from either clinical model advantages or distribution strength. Companies with deep primar relationships and proven ability to drive PCP adoption will win. Those that trea as a pure telehealth psychiatry play will struggle because they're missing the integration component that ACCESS is trying to incentivize.

Domain Four: Musculoskeletal Care an the Physical Therapy Paradox

Musculoskeletal conditions are the fourth and final initial domain under ACCES This includes chronic pain, arthritis, back pain, and joint problems. MSK condit are enormously prevalent in the Medicare population and are major drivers of functional decline, opioid use, and unnecessary surgical procedures. The ACCES model creates incentives for conservative management through physical therapy, psychology, and multidisciplinary care coordination before patients progress to invasive and expensive treatments.

The attributed population is Medicare beneficiaries with MSK diagnosis codes v are receiving ongoing treatment from participating orthopedic practices, primar physicians, or physical therapy clinics. CMS estimates approximately 28 million Medicare beneficiaries have chronic MSK conditions. The attribution methodol requires at least two visits with MSK diagnoses in the past 12 months. Using

reasonable assumptions about care-seeking behavior, the attributed population i probably around 15 million beneficiaries.

The PMPM structure for MSK is forty dollars per month for standard chronic p management and sixty dollars per month for complex patients with multiple joir involvement or functional limitations. The TAM calculation assuming 15 millior attributed lives with a 60/40 split between standard and complex is (9 million tir times 12) plus (6 million times 60 times 12) which equals 8.64 billion dollars ann This is the largest PMPM pool of the four domains.

The value proposition in MSK is preventing or delaying expensive procedures lil joint replacements, spinal fusions, and chronic pain interventions. A knee replacement costs Medicare about 25,000 and a spinal fusion runs 50,000 to 100, If digital PT and conservative management can delay or prevent even a small percentage of these procedures, the savings are substantial. The clinical literatu shows that structured PT programs reduce knee replacement rates by 15 to 30 p in appropriate patient populations. The trick is patient selection and ensuring y working with people who actually have mechanical pathology amenable to conservative treatment rather than end-stage joint disease.

The business model centers on digital physical therapy platforms that combine a based exercise programs with remote coaching and sensor-based movement assessment. Companies like Hinge Health, Sword Health, and Kaia Health have l substantial businesses in the employer market and are now pivoting to Medicare unit economics are attractive. Patient acquisition cost in Medicare can be kept relatively low because you're working through provider referrals rather than dir to-consumer marketing. A typical program runs 12 to 16 weeks and costs 400 to dollars per episode. The PMPM fees under ACCESS would cover this cost for pa who stay engaged for 2 to 3 months.

The shared savings potential comes from avoided procedures and reduced opioi For a population of 10,000 attributed MSK patients, if your intervention prevent joint replacements over a 2 year period, that's 5 million in savings. Add in reduc in imaging, injections, and pain medication and the total savings might be 7 to 1

million. Capturing 40 percent of this as shared savings generates 3 to 4 million d the performance period. Combined with PMPM fees, the revenue per attributed can be 100 to 150 dollars per year.

The clinical challenges are patient engagement and adherence. Physical therapy requires patient effort. Digital PT exacerbates this because there's no in-person accountability. Completion rates for digital PT programs are typically 40 to 60 percent, and patients who drop out obviously don't get better. Companies need r engagement strategies including gamification, peer support, and frequent check with coaches. The best programs have weekly or even daily touchpoints with pat during the acute phase of treatment.

The competitive dynamics favor companies with proven clinical outcomes and e payer relationships. The employer market has been a good proving ground, but Medicare is different. Medicare patients are older, less tech-savvy, and have mor comorbidities that complicate MSK treatment. Companies need age-appropriate interfaces, support for patients with limited digital literacy, and care protocols t account for conditions like osteoporosis and cardiac disease that affect exercise prescription. Not all digital PT companies have adapted their products for this demographic.

Cross-Cutting Themes and Investment Filters

Looking across all four ACCESS domains, several patterns emerge that should in investment decisions. First, the programs that will succeed are those that take fu clinical and financial risk rather than providing technology to other actors who l the risk. ACCESS payment models reward outcomes, not activity. Companies tha provide monitoring devices or patient engagement apps but don't own the care delivery and outcomes will capture only a fraction of the value. Investors should for companies building integrated clinical models with employed or contracted providers who take accountability for population outcomes.

Second, data infrastructure matters more than most founders realize. Successful participation in ACCESS requires attribution tracking, prospective risk stratific real-time intervention triggering, and retrospective financial and quality reconciliation. This means companies need to be able to ingest claims feeds, inte clinical data from multiple sources including EHRs, and maintain longitudinal p records that span care settings. Many digital health companies treat data infrastructure as an afterthought and then get killed by the operational complex when they try to scale into value-based contracts. Investors should dig into data architecture during diligence.

Third, the care team model determines unit economics. Companies need to find right balance between high-touch clinical support (which patients value but is expensive) and scalable technology-enabled workflows (which have better margi risk lower engagement). The sweet spot is usually a layered care model where pa are segmented by risk and engagement level, with intensive human support for h risk or newly enrolled members and lighter-touch tech-enabled support for stab engaged members. Companies that use a one-size-fits-all approach will either ov serve low-risk patients and burn cash or under-serve high-risk patients and fail move outcomes.

Fourth, prior experience with value-based care is a huge predictor of success. Founders and executives who have lived through the operational challenges of managing shared savings arrangements, navigating downside risk, and hitting qu benchmarks have a massive advantage over those building from first principles. for teams with backgrounds at Aledade, Oak Street Health, ChenMed, or other successful VBC organizations. The mistakes you make learning value-based care expensive, and there's no substitute for having done it before.

Fifth, regulatory and compliance capabilities matter. ACCESS comes with extens reporting requirements, quality measures, and program integrity rules. Compan need to have legal and compliance infrastructure that can handle this burden. Ea stage startups often underestimate the operational overhead of CMS programs a find themselves buried in reporting requirements they're not staffed to handle. A

about compliance resourcing during diligence and be wary of companies that wa this off as a detail they'll figure out later.

What This Means for Early Stage Investors

The investment opportunity created by ACCESS is real but nuanced. The TAM numbers I've laid out above represent the theoretical maximum if these program achieve full penetration and all eligible beneficiaries participate. Reality will be messier. Many provider organizations will be skeptical of new payment models a slow to adopt. CMS implementation will have hiccups and delays. Some domains perform better than others. But even if ACCESS captures 20 percent of the pote TAM in its first 3 years, we're talking about multi-billion dollar markets in each domain.

For investors evaluating companies in these spaces, the key questions to ask are downside risk management. Any company can grow revenue by signing up attrib lives and collecting PMPM fees. The test comes when they have to write a check to CMS because they didn't hit savings targets. Does the company have actuarial capabilities to forecast expected costs for their attributed population? Can they identify high-risk members prospectively and intervene before expensive events occur? Do they have clinical protocols that are evidence-based and actually move needle on the outcomes CMS cares about? These are the differentiators between companies that will thrive under value-based payment and those that will flame

The other critical diligence area is distribution and go-to-market. Getting provi to adopt new care models is slow and requires trust-building. Companies that ha existing relationships with primary care practices, health systems, or MA plans l huge head start. Those trying to build distribution from scratch will face a mult sales cycle. Ask about current customer concentration, sales cycle length, and wh percentage of revenue comes from contracts that include downside risk. Compar that are still selling on a fee-for-service basis and planning to "transition to valu based care later" are usually not ready for ACCESS participation.

The stage and vintage considerations are important too. Companies that are curr
Series B or later with established products and customer bases can move quickly
participate in ACCESS. They have the capital, infrastructure, and credibility to g
provider partners comfortable. Early stage companies at seed or Series A will str
to move fast enough unless they have exceptional founding teams or unusually st
partnerships. The exception is companies that are purpose-built for specific AC
domains from inception. A startup founded in 2024 specifically to address mater
health under ACCESS, with a team that includes former CMS officials and prove
maternal health clinicians, could move quickly despite being early stage.

From a portfolio construction perspective, having exposure to multiple ACCESS
domains makes sense. The domains are uncorrelated enough that domain-specif
risks (regulatory changes, clinical evidence gaps, competitive dynamics) don't
perfectly overlap. An investor with positions in a diabetes monitoring company,
maternal health platform, and a behavioral health integration player has natural
diversification. The challenge is finding best-in-class companies in each domain
meet the investment criteria around clinical model, data infrastructure, and valu
based care readiness.

The timing question is whether to invest now or wait for ACCESS to prove itself
view is that the companies that will dominate ACCESS domains are the ones bui
capabilities today in anticipation of the program scaling. By the time ACCESS ha
published its first wave of results in late 2026 or early 2027, the competitive posi
will be largely set. The best companies will have locked up provider partnership
built out their clinical models, and demonstrated preliminary outcomes. Waiting
proof of concept means paying much higher valuations for much less upside. Th
rational move for investors who believe CMS innovation models eventually reach
is to back the strongest teams in each domain now and accept the execution risk

The ACCESS program represents the most significant expansion of condition-sp
value-based care in Medicare's history. The four initial domains create clear targ
markets with specific payment mechanisms and quality requirements. Digital he
companies that can deliver true clinical impact while managing financial risk wi
capture enormous value over the next five years. The TAM in each domain excee

three billion dollars annually, and the shared savings opportunities add substant upside for companies that execute well. For investors willing to dig into the deta payment models, care delivery operations, and value-based care mechanics, this generational opportunity to back the companies that will reshape how Medicare for and delivers care in some of its highest-cost clinical areas.

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