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Healthcare Alert

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CMS announces new value based payment model for technology-enabled care

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The ACCESS Model is designed to expand tech-enabled care for Medicare beneficiaries with certain chronic conditions, aligning payments with outcomes for better patient health.



What's the impact?

- A Medicare model targeting conditions like hypertension, diabetes, chronic pain, and depression with scalable, tech-supported solutions.
- Providers, tech firms, and health systems gain new reimbursement pathways; application opens soon with the first performance period starting July 1, 2026.

CMS has announced the [ACCESS](#) (Advancing Chronic Care with Effective, Scalable Solutions) Model, a new, voluntary value-based payment model in Original Medicare (a/k/a fee-for-service Medicare) designed to expand access to technology-supported care for chronic conditions. The model will run for 10 years and will test an outcome-aligned payment approach that prioritizes results over activities.

Who is affected

Organizations that serve Original Medicare beneficiaries with certain chronic conditions—including physician groups, digital health and remote care companies, chronic care management vendors, health systems, and specialty practices—particularly those focused on high blood pressure, diabetes, chronic musculoskeletal pain, and depression. Examples of digital technologies that impact care under the model include: telehealth software, wearable devices that monitor sleep, heart rate and blood sugar, coach applications that assist in lifestyle changes through consultations, therapy, patient education, and other FDA authorized devices and software.

Why this matters

Today, Medicare payment barriers limit access to technology-supported chronic care because some tech-tools and supports are not Medicare reimbursable. ACCESS aims to remove those barriers by aligning payment with outcomes, enabling healthcare providers and suppliers to deploy scalable, technology-enabled services that complement traditional care and support prevention, health promotion, and co-management of patients. Patients with these chronic conditions may gain access to innovative, tech-enabled care options; providers may gain new reimbursement pathways and care partners; and tech companies may have a direct route to Medicare payment.

Key dates

The first performance period starts July 1, 2026, and the model will run through June 30, 2036. Applications will be available soon and accepted on a rolling basis. Applications submitted after March 20, 2026, will be considered for a January 1, 2027, start.

Types of chronic conditions involved

Initially, ACCESS will focus on the following common chronic conditions:

- / **Early Cardio-Kidney-Metabolic (eCKM):** Hypertension (high blood pressure), dyslipidemia (abnormal or elevated lipids, including cholesterol), obesity or overweight with marker of central obesity, and prediabetes
- / **Cardio-Kidney-Metabolic (CKM):** Diabetes, chronic kidney disease, or atherosclerotic cardiovascular disease
- / **Musculoskeletal (MSK):** Chronic musculoskeletal pain
- / **Behavioral Health (BH):** Depression or anxiety

Each condition includes specific measures and outcome targets to be met (e.g., control or improvement in blood pressure or weight).

Conditions of participation

Participating providers and organizations must be enrolled in Medicare Part B (as providers or suppliers), designate a physician Clinical Director, and meet all applicable federal and state requirements, including licensure, HIPAA, and FDA requirements, as applicable. Each participating organization may participate in multiple tracks (conditions) and is responsible for collecting baseline measures for each patient they serve, which will be used to track improvement and outcomes that shall be tied to payment. Participants must share patient information including care plans and outcomes data electronically through a Health Information Exchange (HIE) or similar means with primary care providers (PCPs) and referring providers. PCPs and referring clinicians will be eligible to receive Medicare reimbursement for a co-management payment (up to \$100/year/beneficiary) to incent collaboration and coordination. While Original Medicare fee-for-service payments will continue to be tied to specific activities or device uses, additional recurring payments (Outcome-Aligned Payments (OAPs)) will be made to reward management of a patient's qualifying condition based on meeting achieved health outcomes.

Beneficiary access

Novel for this type of program, Medicare beneficiaries may sign up with a participating organization or upon a referral from another provider. CMS will create and maintain a directory of ACCESS participating organizations, including the chronic conditions each treat and each organization's clinical outcomes.

Safe harbors

As most models under the CMS Innovation Center provide for waiving of certain regulatory requirements, ACCESS will fall within the CMS-sponsored model patient incentive safe harbor to the Federal Anti-Kickback Statute if participating organizations intend to waive beneficiary cost-sharing for OAPs to incent beneficiary engagement; provided, however, this determination is made upon applying to ACCESS and the policy is applied to all participating patients uniformly. Note, no patient cost-sharing obligations shall be applied to co-management payments made to PCPs and referring providers.

Note, too, that while ACCESS is applicable to Original Medicare, CMS is promoting its adoption across payers, including by providing information and resources to help with model contracting and performance. CMS has indicated that Medicare Advantage Organizations "do not need a waiver to implement such arrangements and have flexibility to structure payments under existing program requirements." Importantly, too, CMS has noted that all OAPs for patient care will be

considered medical expenses for purposes of calculating payor medical loss ratios and thus, not considered administrative expenses of the payor.

Nixon Peabody is tracking this program and can assist with organizations looking to participate, including with Medicare enrollment, HIPAA, FDA's regulation of digital health technologies, and other regulatory compliance questions and concerns.

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