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CMMI New Model Overview

February 2026

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ACCESS – At a Glance

Program Timeline

ACCESS is a 10-year Medicare initiative starting July 2026 focused on chronic care management

The 4/1 application deadline is followed by an 10/1 deadline for a 1/1/2027 start date, quarterly thereafter

Payment Model

ACCESS provides an outcomes-based payment stream for tech-forward, high-automation solutions

Modest fees are split between baseline and outcomes

Referring clinicians bill FFS normally + a $30 quarterly coordination payment per patient per track

Target Population

The program targets Original Medicare beneficiaries with eligible chronic conditions (roughly two-thirds of Part B beneficiaries)

Program Goals

ACCESS aims to encourage innovative care, long-term engagement, and improved clinical outcomes

The focus is on flexibility, not micromanaging

It is compatible with FFS and other VBP models, though frictions may arise

ACCESS - How it Works

- Patients sign up directly with an ACCESS organization; community physicians can refer, ingest data and coordinate care plans for quarterly payments
- ACCESS has 4 clinical tracks, up to 3 of which can generate monthly outcomes-aligned payments (OAPs) for a given patient:

Early Cardio-Kidney-Metabolic (eCKM)]	**Cardio-Kidney-Metabolic (CKM)**	**Musculoskeletal (MSK):**	**Behavioral Health (BH):**
Hypertension, obesity dyslipidemia, or prediabetes	Diabetes, chronic kidney disease, or atherosclerotic cardiovascular disease	Chronic musculoskeletal pain	Depression or anxiety

- eCKM and CKM are mutually exclusive

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ACCESS - Payments

- ACCESS Participants can only bill for Outcomes Aligned Payments (OAPs)
- Payments are higher in the first 12-month period

Early Cardio-Kidney-Metabolic (eCKM)]	Cardio-Kidney-Metabolic (CKM)	Musculoskeletal (MSK):	Behavioral Health (BH):
$360 initial $180 follow-on	$420 initial $210 follow-on	$180 initial No follow on	$180 initial $90 follow on

- A small (5%) discount may apply to MSK and BH tracks if coupled with eCKM or CKM
- The full OAP amount is received if at least half the patients served by the ACCESS participant meet clinical progress or control objectives
- Community clinicians can continue to bill most CCM and RPM codes, but a subset of codes are deemed duplicative and could lower OAPs

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ACCESS - Considerations

- The model will reward those solutions that are both “scalable” through automation and effective at shifting outcomes or selecting risk
- It is not a shared-savings or total-cost-of-care model, however:
  - “Substitute” claims can reduce OAPs
  - OAPs and downstream services triggered by ACCESS participants can impact shared savings for ACOs that share beneficiaries (labs, physician visits, etc.)
- Participants need to weigh B2B and B2C marketing strategies
- Positives for referring clinicians:
  - Strategic opportunities for providers to offer a perceived value-add and deepen the patient-provider relationship
  - Potential for additional shared savings without additional effort
  - A small new revenue stream
- Negatives for referring clinicians:
  - Risk of losing primacy in the patient relationship, and even the relationship itself
  - ACCESS Participants might not be aligned with other VBP commitments or care approach
  - For those not already participating in HIE, it may bring system implementation costs

LEAD – At a Glance

- Continues the highest-risk ACO design after REACH ends in December 2026, and extends for 10 years
- Continues REACH 100% global risk and 50% professional risk tracks, with capitated payments
- Introduces an add-on payment for rural providers and FQHCs to support infrastructure to become an ACO (not reconciled)
- Includes innovations to encourage all ACOs to enroll high needs populations
  - Risk and benchmark adjustments are calculated separately for high needs populations
  - Minimum aligned beneficiary threshold is lowered if patients have access to 24/7 care and >40% of aligned beneficiaries are “high needs” (aged, disabled, ESRD, etc.)

LEAD - Continued

- Offers new MA-like benefit flexibilities:
  - Allow incentives for healthy living, including meals and exercise
  - Part B cost-sharing reduction
  - Part D premium buydown
- Includes CMS Administered Risk Arrangements (CARA)
  - CMS will provide a framework to support episode-based risk arrangements (EBRAs) with preferred specialists to incentivize quality and cost outcomes
  - EBRAs will include sharing episode data, providing common contracting frameworks, allowing for configurable episode design and payments
- CMS will promote collaborations with Medicaid for an integrated approach to duals (two states to be announced in 2026)

LEAD - Considerations

- Details on LEAD are limited, with more information expected in the RFA issued in "early spring" 2026
- Removes the REACH 2%-4% discount from the benchmark and does not rebase ACOs with high savings, but expect a lower trend factor
- Risk corridors are expected to reflect REACH (+/- 10% for 100% risk) and an automatic discount on the benchmark is expected, making LEAD appealing primarily for organizations experienced with managing risk and population health
  - The size and duration of add-on payments, and any risk reductions for small ACOs and first-time ACOs have not yet been announced
  - The caps in retrospective trend adjustments have not been finalized

AHEAD

- The most radical CMMI model yet. States that participate must commit to engage Medicare, Medicaid and commercial insurance in a global budget model
- Six states in the initial rollout
  - Maryland started in 2026
  - Vermont, Connecticut, Hawaii, Rhode Island and New York begin in 2028
  - Up to four additional states begin in 2028 or 2029
- The model consists of three components
  - Hospital Global Budgets
  - Primary Care AHEAD
  - Geo AHEAD
- Incorporation of new CMMI priorities: evidence-based prevention, patient empowerment, choice and competition
  - CMMI may propose that states implement two new Choice and Competition initiatives
    - Options: Site neutrality in Medicaid, telehealth expansion, prescription drug price transparency, greater provider mobility

GEO AHEAD

- The model will run for 8 years, to December 31, 2035
  - All AHEAD states, including Maryland, start in 2028
- The goal is to align 100% of eligible Original Medicare beneficiaries to risk-taking systems of care, called “Geo Entities”
  - For regions participating in AHEAD, any beneficiary not already participating in an ACO or other qualifying accountable care model will be assigned to a Geo Entity
  - On average, 40-50% of Original Medicare beneficiaries would be assigned
  - Geo Entities are responsible for the total cost of care (TCOC)
  - Shared savings are also conditional on scores in eight quality measures
- Geo entities can be comprised of (and led by) physician groups, health systems, health plans, digital health companies and other risk bearing entities

GEO AHEAD

- Geo Entities will bid on up to two 4-year contract periods based on data supplied by CMS
  - Data includes historical data and TCOC benchmarks for the eligible population
- CMS will evaluate bids based on the magnitude of their proposed discounts vs the benchmark, and their capacity to effectively manage care and realign providers to pursue population outcomes
  - At least two Geo Entities must be selected in each AHEAD state (at least three in states with over 200,000 eligible beneficiaries) or the program will not proceed
  - Geo Entities can also choose to bid on substate regions selected by CMS; those that do must be controlled by providers that practice in the region
- Geo Entities can bid on an entire state or a region within a state

GEO AHEAD Considerations

- Similar to an ACO, Geo Entities can engage providers in two ways: as full participants receiving capitation and whose claims contribute to the benchmark, or as affiliates aligned with a Geo Entity that receive FFS payments and quality bonuses or shared savings/losses
- Statewide Geo Entities will need strong outreach and care management capabilities at the scale of a health plan to be able to have an impact, or partner with organizations that do
  - For health plans, it creates an opportunity to serve an untapped market, but one that might be resistant to managed care
- Provider-based Geo Entities whose regions fit well with their service areas have new incentives to establish relationships with other local providers
  - Provider-based Geo Entities whose regions go well beyond their service area take on a type of risk they have never before attempted to manage, similar to a health plan

MAHA ELEVATE

- Focus on healthy lifestyle, whole person
- Model begins September 2026. A second cohort will start in January 2027
- Only 30 proposals will be accepted nationwide, each of which will receive $3 million over 3 years.
- Successful applicants are expected to be, or partner with, organizations that have a history providing integrative or whole-person approaches to health improvement services that:
  - Are not currently covered by original Medicare
  - Have a demonstrated empirical basis for improving health outcomes
  - Include nutrition or physical activity (other interventions related to sleep, stress reduction, etc. may also be incorporated)

MAHA ELEVATE Considerations

- ELEVATE participants could also bill FFS Medicare if properly licensed, etc.
- Unclear if funding could be used to build a platform used for other payers
- In addition to nutrition or physical activity, other interventions related to sleep, stress reduction, etc. may also be incorporated
- At least three approved proposals will relate to dementia therapy

Stepping Back: Model Interactions

- ACCESS, LEAD and Geo AHEAD redesign incentives to improve health outcomes, but in overlapping and potentially conflicting ways
- ACCESS's independent funding stream and rewards for participants based on clinical outcomes, not TCOC, creates multiple potential conflicts:
  - ownership of the patient-provider relationship, preferred site of care, contradictory communications
- LEAD and Geo AHEAD do not have overlapping beneficiaries, though LEAD ACOs compete to reduce the Geo AHEAD pool and could engage in risk-skimming
- LEAD and the global budget portion of AHEAD are TCOC models that have different savings "sweet spots": 3-5% for AHEAD and up to 10% for LEAD
  - LEAD ACOs are expected to keep 100% of savings to 10% below the benchmark, and future benchmarks are not reduced by present savings
  - AHEAD global budget entities keep 100% of savings, but future budgets are ratcheted-down if savings are too high (exact threshold TBD, but expected to be <5% of benchmark)

Stepping Back: Comparing Value-Based Models

Total Cost of Care	Condition-Specific	Alternative Approaches
MSSP Basic ACO	TEAM	MAHA ELEVATE
MSSP Enhanced ACO	ASM	
REACH ACO	ACCESS	
LEAD ACO		
AHEAD		
Geo AHEAD		

Moving Forward: Timelines

Model	Deadline	Model Start	Application Cadence
MSSP ACO	Usually June	2012	Annual
REACH ACO	Closed	2023	Program Ending
LEAD ACO	Expected June*	January 2027	Expected Annual
AHEAD	July 2026 (2 states)	January 2026/2028	N/A
Geo AHEAD	N/A*	By January 2028	N/A
ASM	None (25% Selected)	January 2027	N/A
ACCESS	April 2026	July 2026	Bi-Annual/Quarterly
MAHA ELEVATE	N/A*	September 2026	Two cohorts

*Application has not yet been released. LEAD application is expected in March.

Moving Forward: Next Steps

- CMMI looking for models (and other federal funding, e.g., Rural Health Transformation) to complement each other
- ACCESS timeline is fastest
- Massive preparation and clinical transformation required
- Not all models are right for all organizations
- Sachs Policy Group has experience helping organizations understand applicability of the models, whether they are right fit, the operational changed needed to implement the models, and how to put complementary models together

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