ACCESS: How Incentives Will Shape Outcomes in CMS's New Tech-Enabled Chronic Care Model

CMS's Stated Goals for ACCESS

1. **Expand access** to tech-enabled chronic care services.
2. **Create a national payment pathway** for digital health in Original Medicare.
3. **Align payment with outcomes**, not activities or visit volume.
4. **Increase patient choice** and allow more flexible, home-centered care.
5. **Improve condition-specific intermediate outcomes** (BP, A1c, PHQ-9, pain, weight).
6. **Strengthen coordination** between ACCESS orgs and primary care.
7. **Catalyze a commercial market** for chronic condition digital care vendors.
8. **Generate real-world evidence** to support FDA evaluation and regulatory modernization.

What I Like About ACCESS

Real Payment Lane for Digital Care

Payment Tied to Clinical Outcomes

Baseline-Relative Outcome Measurement

Modality-Neutral Care Delivery

Direct Patient Choice

Give Patients More Ongoing, Tech-Enabled Support

Patient Incentives & Copay Waivers

Acknowledgement of Team-Based Care

Long Time Horizon (10 Years)

My Core Concern: Incentives Determine Behavior

> **"Show me the incentive and I'll show you the outcome." — Charlie Munger**

ACCESS's incentive structure will naturally lead to:

- Cherry-picking easier, tech-ready patients
- Lemon-dropping non-engaged or complex patients
- Gaming metrics rather than improving whole-person care
- Fragmentation across multiple condition-specific vendors
- Offloading coordination responsibilities to PCPs

Problem: Voluntary Enrollment → Cherry-Picking

Predictable behavior:

- Target "movable" patients: younger seniors, higher socioeconomic stability, higher digital literacy
- Offer enrollment incentives (gift cards, waived copays, free devices)
- Optimize marketing to attract healthier, easier-to-improve beneficiaries

Patient A:

65, new HTN, smartphone, Peloton, stable housing → likely to enroll

Patient B:

78, HF/CKD/DM/COPD, unstable housing, limited English → unlikely to enroll, high dropout risk

Problem: Fragmentation & Burden on Primary Care

Required vendor-to-PCP updates include:

- Medication change recommendations
- Remote monitoring alerts
- Care plan updates at initiation, milestones, completion
- Symptom score summaries (PHQ-9, pain scales, PROMIS)
- Engagement summaries and device adherence messages

PCP responsibilities:

- Review each update
- Adjust care plans or meds
- Document actions
- Integrate conflicting recommendations across multiple ACCESS vendors

All for $80–$100 per patient per year.

ACCESS optimizes a *slice*. PCPs are accountable for the *entire patient*.

Problem: Total Cost of Care (TCOC) Not Measured

Although CMMI must aim to improve quality or reduce spending, ACCESS:

Measures condition-specific outcomes, not whole-person trajectory

Does **not** hold vendors accountable for hospitalization, ED visits, or polypharmacy

Allows model "success" even if broader Medicare spending rises

Evaluates quality at the condition level, allowing cost-shifted harms to be ignored

Now add in machine learning to find the most profitable patients

This is not a bad thing, but just an honest thing.

It's not **bad** to keep healthy patients healthy. But let's just acknowledge that this is what this program will mostly do.