PATIENTS & PRACTICE

New CMS Models: What Family Physicians Need to Know

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Family physicians approach Centers for Medicare & Medicaid Services (CMS) value-based models with understandable caution: the promises are big, while the day-to-day reality can be added administrative burden with only modest upside. Even so, CMS's newest Innovation Center models — ACCESS, ACO LEAD, and MAHA ELEVATE — may meaningfully reshape the care team, chronic disease supports, and care coordination for Medicare beneficiaries. Knowing the basics now can help practices protect continuity, set expectations with partners, and leverage these new opportunities to benefit their patients.

Quick Summaries of the New Models

ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) is a voluntary Original Medicare model that tests Outcome-Aligned Payments (OAPs) for technology-supported chronic condition management. ACCESS starts with four tracks: early cardio-kidney-metabolic (eCKM), cardio-kidney-metabolic (CKM), musculoskeletal (MSK) chronic pain, and behavioral health (BH) (depression/anxiety).

Participating organizations receive recurring prepayments for enrolled patients and an annual quality payment tied to whether patients meet measurable health outcomes such as A1c and blood pressure targets. This payment model indicates a significant shift for Medicare towards paying for clinical outcomes rather than a fee-for-service model. The model's first performance period begins July 5, 2026; to be considered for that start date, applications must be submitted by April 1, 2026.

ACO LEAD (Long-term Enhanced ACO Design) is a new 10-year Medicare ACO model running Jan. 1, 2027 to Dec. 31, 2036. The model provides targeted support for rural, smaller, and independent practices, through lower beneficiary alignment minimums, flexible prospective payments, rural infrastructure payments, and improved benchmarking methodology. A significant new component of this ACO model is CARA (CMS Administered Risk Arrangements), which allow ACOs to create episode-based risk arrangements with specialists to align primary care and specialty incentives and address "specialty leakage." New beneficiary benefits to encourage patient engagement in preventive care also feature prominently in this model. Over the long term, ACO LEAD will create formal Medicaid-Medicare coordination frameworks to enable ACOs and practices to manage dual-eligible patients more effectively. ACOs can apply beginning in March 2026.

MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) funds organizations that can deploy evidence-based prevention programs (including nutrition and physical activity interventions) and aims to build evidence for approaches not currently covered by Original Medicare. CMS plans to release a Notice of Funding Opportunity (NOFO) in early 2026, with a model launch of Sept. 1, 2026.

Why ACCESS Matters Most to Family Physicians Right Now

ACCESS is the most immediate "practice-level" disruptor because it creates a pathway for external entities to provide continuous, technology-enabled chronic care and because it pays based on outcomes. If implemented well, it could help more Medicare patients achieve meaningful improvements in blood pressure, glycemic control, pain/function, or depression/anxiety — especially those who need support between visits.

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At the same time, it's reasonable for primary care clinicians to be wary: many "innovation" models have promised alignment but delivered extra workflow and unclear accountability. ACCESS raises a different concern: continuity risk. CMS notes that beneficiaries may enroll "on their own or upon referral," meaning chronic care support could occur outside the primary care practice unless collaboration is strong.

CMS has built in mechanisms meant to keep primary care connected. The model anticipates sharing updates with referring clinicians and includes a separate co-management payment for primary care/referring clinicians who review updates and coordinate care. CMS includes no beneficiary cost-sharing for that co-management payment. Whether these safeguards work will depend on partner behavior and real-world interoperability.

CCNC's Recommendation: Protect Continuity with Primary Care

If your patients are considering ACCESS — or you are asked to refer — choose partners that strengthen (not compete with) the primary care relationship:

- Define roles in writing: who adjusts medications, orders labs, manages adverse effects, and escalates care
- Demand usable information flow: timely updates that fit your EHR workflow and arrive *before* major changes, not after
- Require warm handoffs for material changes: direct clinician-to-clinician communication for medication starts/titrations or significant symptom changes
- Use co-management intentionally: build a simple internal process to review updates, document actions, and close the loop with the patient

ACCESS can improve outcomes, but only if it functions as an adjunct to primary care, preserving trust and continuity for patients.

Selected References

1. Centers for Medicare & Medicaid Services. ACCESS Model webpage (updated Dec. 30, 2025).

2. Centers for Medicare & Medicaid Services. ACCESS Technical Frequently Asked Questions (updated Dec. 18, 2025).

3. Centers for Medicare & Medicaid Services. LEAD Model webpage (updated Dec. 18, 2025).

4. Centers for Medicare & Medicaid Services. MAHA ELEVATE Model webpage (updated Dec. 11, 2025).