PETERSON CENTER ON HEALTHCARE

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CMS'S ACCESS MODEL IN CONTEXT

Outcome-Based Payment for Health Technologies

About the Peterson Center on Healthcare

The Peterson Center on Healthcare is a non-profit organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. The organization works to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the organization collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships and research.

EXECUTIVE SUMMARY

The CMS Innovation Center's 10-year ACCESS model marks an important milestone: the entry of Traditional Medicare as a major purchaser of clinical outcomes for chronic disease management, demonstrating broad recognition that payment should be based on results rather than services delivered.[1] Outcome-based payment models are particularly well suited for chronic disease management, where outcomes can be clearly defined, measured, and tied to payment.

In this report, the Peterson Center on Healthcare synthesizes findings from the work of the Peterson Health Technology Institute (PHTI) to examine how rigorous evaluations of health technologies laid the groundwork for broader outcome-based payment models, such as ACCESS.

Since 2023, PHTI has evaluated more than 60 health technologies to determine whether meaningful clinical improvement and net savings are achieved in practice.[2] These assessments equip employers and health plans with clear, evidence-based insights into what solutions work, for whom they are effective, whether they deliver value, and how purchasers can hold solution vendors accountable for results.[3]

PHTI's approach begins by focusing on conditions that are major drivers of disease burden and healthcare spending. For each condition, PHTI identifies clinically meaningful outcome measures—such as HbA1c reduction for diabetes or systolic blood pressure control for hypertension—alongside evidence of potential net savings.

Defining standardized measures creates a common framework for the market. Rather than allowing each vendor to define success differently, purchasers can align around a consistent set of clinically meaningful outcomes. This gives employers, health plans, providers, and patients clear benchmarks for evaluating products while giving vendors well-defined targets for evidence generation, product development, and performance improvement.

As stronger comparative evidence accumulates, purchasers gain greater confidence in identifying which solutions deliver value. With better evidence about performance, adoption of health technologies increases.

Once clinical outcome measures are selected and performance targets are set, outcome-based contracting becomes far more feasible. This market evolution is already influencing contracting strategies. In 2025, 75% of commercial health plans and 61% of health systems had a performance-based contract in place that tied payment to outcomes for health technologies.[4]

Earlier this year, PHTI released customizable contracting toolkits to help more purchasers—especially employers, who lag behind health plans in adopting outcome-based contracts—operationalize performance-based agreements for health technologies.[5] These resources simplify implementation of outcome-based contracts by outlining all the key design decisions purchasers need to make, such as which patients to engage and what performance measures to tie to payment.

There is now growing confidence across both the private and public sectors that certain technologies can deliver measurable improvements in health outcomes, reduce costs, and merit broader adoption at scale.

The emergence of the ACCESS model signals even more definitively that the market is moving toward accountable, outcomes-focused payment for health technologies.[6] ACCESS's initial clinical tracks—behavioral health; musculoskeletal care; and cardio-kidney-metabolic conditions including diabetes, chronic kidney disease, and hypertension—and associated outcome measures closely align with PHTI assessments. This underscores growing market convergence around standardized measures.

As outcome-based payment models are increasingly adopted, the market for health technologies will continue to evolve, including by producing more technologies that drive better clinical outcomes. PHTI's assessments have helped to lay the foundation for broader outcome-based payment models for health technologies; CMS's ACCESS signals the readiness of the nation's largest purchaser—Medicare—to do so at national scale.

KEY TAKEAWAYS

1 Meaningful outcome measures and evidence generation are foundational to developing accountable payment models for health technologies.

2 Momentum for outcome-based payment is accelerating across both the private and public sectors—with CMS's ACCESS model representing the clearest signal yet that health technologies are increasingly expected to demonstrate measurable improvements in clinical outcomes and lower costs.

3 The market is converging around standardized outcome measures, reflected in the strong alignment between the clinical focus areas and outcome measures used in the ACCESS model and PHTI assessments.

4 As outcome-based payment models for health technologies scale, they will continue to reshape the market.

SETTING MEANINGFUL OUTCOME MEASURES

Assessments form the basis of outcome-based payments

Standardized, meaningful outcome measures can create a common language across vendors, purchasers, providers, and policymakers. They make scaling accountable outcome-based payment models possible. PHTI focuses on assessments of health technologies because of their potential to deliver improved clinical outcomes at a market level while costing less than traditional services.

PHTI evaluates health technologies across two dimensions: clinical effectiveness and economic impact. PHTI chooses assessment areas on the basis of disease burden, level of healthcare spending, investment and market growth, and a strong evidence base to inform clinical and economic impact assessments. PHTI's assessment areas span the treatment and management of conditions, including:

- Type 2 Diabetes[7]
- Hypertension[8]
- Musculoskeletal (MSK) Care[9]
- Depression and Anxiety[10]
- Opioid Use Disorder[11]
- Gastrointestinal Conditions[12]
- Chronic Kidney Disease[13]
- Maternity Care[14]

Each assessment identifies core outcomes that matter to patients, providers, and purchasers. Assessments prioritize outcome measures that are clinically meaningful, measurable, standardized, and capable of demonstrating real improvements in a patient's health status.

Too often, when paying for health technologies, purchasers default to engagement process metrics such as billable events, app downloads, session/visit counts, or program enrollment rates. These measures are easier to track but do not capture evidence of clinical improvement or meaningful outcome achievement.

Well-designed outcome measures and targets:

- **Reflect material improvements in health status or disease control**—for example, focusing on improvements in systolic blood pressure control for hypertension or HbA1c reduction for diabetes (a blood test that shows average blood glucose level over a 2–3-month period) instead of rewarding whether systolic blood pressure or HbA1c was merely recorded.
- **Are widely recognized within clinical guidelines, quality measurement programs, or value-based care frameworks**—for example, leveraging the PHQ-9 and GAD-7 (two widely used, clinically validated tools to measure symptom severity for depression and anxiety).
- **Are consistently measurable across studies and patient populations to enable apples-to-apples comparisons between solutions.**
- **Are realistic and achievable within an appropriate timeframe for evaluating the clinical effectiveness of health technology interventions.**

Developing a common set of meaningful outcomes helps consolidate purchaser demand around consistent measures. Over time, this creates shared industry benchmarks that enable employers, health plans, health systems, providers, and patients to evaluate solutions using consistent, standardized definitions of success.

DEMAND FOR OUTCOME-BASED PAYMENT ARRANGEMENTS IS GROWING

Performance-based contracts tie some or all vendor payments to achievement of prespecified outcome measures and targets, such as improvement in disease control or reduced utilization.

Purchasers are increasingly seeking performance-based contracts that tie payment to outcomes—a trend captured in PHTI's annual purchaser survey.[15] Three-quarters of health plans and 61% of health systems surveyed use at least one performance-based contract for health technologies. Of the purchasers not using performance-based contracts, almost two-thirds were interested in adopting them in the future.[16]

While purchasers acknowledge the importance of innovation and are eager to partner and scale solutions, they also face pressure to demonstrate evidence of clinical effectiveness and return on investment. In response, more vendors are evolving their sales models and a growing number of companies (such as Virta, Sword, and Meru Health) now publicly assert that 100% of their fees are at risk or that they guarantee multiple returns on investment.[17–19]

As purchasers place greater emphasis on measurable outcomes, vendors are also increasingly investing in higher-quality evidence generation to demonstrate clinical and economic impact. In turn, as the evidence base matures, purchasers are gaining greater confidence in identifying which solutions deliver value.

To help facilitate increased performance-based contract adoption, PHTI developed a playbook and customizable performance-based contracting toolkits for health technologies.[20] While most health plans and health systems use at least one performance-based contract for health technologies, only 14% of employers do so. Performance-based contracts can be burdensome to execute and manage for employer benefits teams who have limited capacity to negotiate contract terms and monitor performance. As a result, they can default to contracts that pay on the basis of per member per month enrollment fees or patient engagement rates—which do not drive clinical improvements or cost savings. The contracting toolkits help level the negotiating playing field by identifying validated, clinically credible, feasible measures with transparent data sources and calculation methods.

As these technologies proliferate, it is increasingly important to scale outcome-based payment arrangements that ensure they are delivering value to patients and the healthcare system.

Measuring clinical outcomes across health technology solutions

Even among tools designed to manage the same condition, performance varies widely. Success appears to depend less on the condition being treated and more on how the intervention is structured, targeted, and delivered. Across every condition evaluated by PHTI to date, there are solutions that have demonstrated clinically meaningful improvements in patient outcomes relative to usual care.[a]

For example:

- **In mental health, self-guided virtual solutions for depression and anxiety can meaningfully improve outcomes for people with mild to moderate symptoms—especially those who are not already receiving psychotherapy.** Evidence suggests that prescription digital therapeutics can also improve depression and anxiety symptoms when paired with usual care. Here, continuous access to evidence-based behavioral interventions and more frequent patient engagement between traditional clinical encounters appear to be key drivers of impact.[21]
- **For the treatment of common musculoskeletal conditions, patients who use physical therapist–guided virtual solutions experience comparable improvements in pain and function as those who receive in-person physical therapy.** Physical therapy solutions augmented by remote therapeutic monitoring deliver superior pain and function results to usual care. This is likely in part because users of virtual solutions tend to have better adherence and complete more frequent exercise sessions.[22]
- **For hypertension management, a critically important driver of blood pressure control is rapid clinical feedback loops.** Solutions that pair remote blood pressure monitoring with dedicated virtual care teams capable of adjusting medications enable patients to achieve blood pressure control much faster than usual in-person care. These models focused on medication management reduce systolic blood pressure by an average of 7.1mm Hg in 3–6 months, compared with a year for usual care.[23]
- **For diabetes, effectiveness is closely tied to patient selection and timing.** While remote monitoring does not generally produce clinically meaningful results, it can be effective when targeting patients with the highest starting HbA1c levels and those who are at critical transition points in their care plan (e.g., patients newly starting insulin). Solutions focused on nutritional ketosis deliver clinically meaningful reductions in HbA1c sufficient to achieve remission of diabetes in some patients.[24]
- **For the treatment of opioid use disorder (OUD), digital wraparound solutions increased treatment retention by an average of 13 additional days over six months compared with usual care.** The modest gains appear to result from reduced barriers to ongoing engagement in treatment through easier access to care, continuous support between visits, and more convenient access to medications for OUD—especially buprenorphine.[25]
- **For gastrointestinal care treating inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS), the strongest clinical evidence supports clinician-led solutions that integrate gastroenterologists and clinical teams directly into care delivery.** These solutions combine physician oversight with support services, such as nutrition counseling and behavioral health, and show clinically meaningful improvements in symptom severity and quality of life for patients with IBS and/or IBD when compared with usual care.[26]

[a] Usual care is defined as the standard, nondigital clinical care that patients would ordinarily receive for the treatment of a particular condition. The exact definition varies by condition and serves as a comparator group for each assessment. For example, for hypertension, usual care was defined as standard hypertension management through existing primary care and specialty care, without digital interventions.

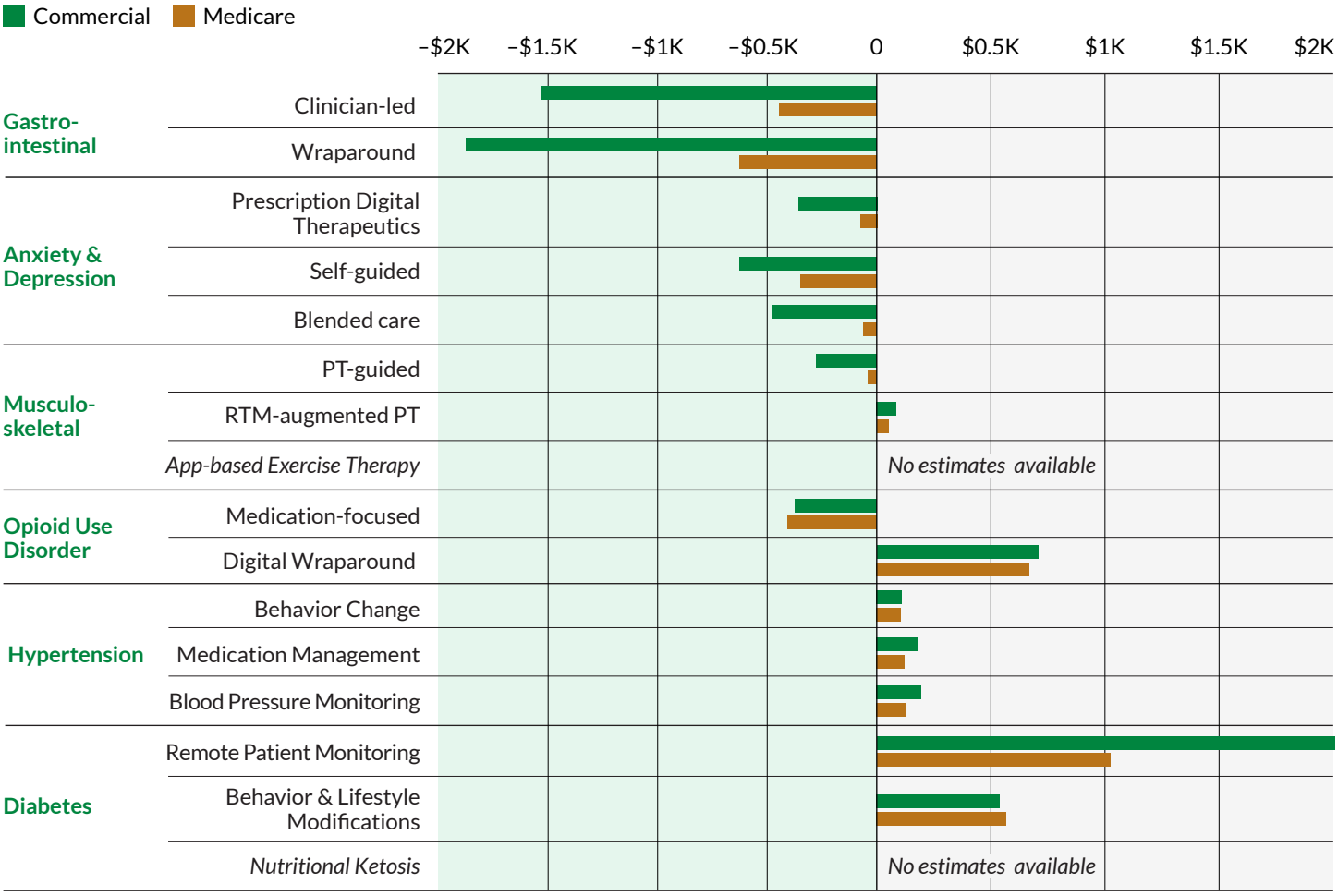
Measuring economic outcomes across health technology solutions

PHTI evaluates the economic impact of health technologies by estimating the net impact on overall healthcare spending by payer type—commercial, Medicare, and Medicaid. Spending estimates include both the cost of the solution and any resulting changes in healthcare utilization.

Estimated net savings vary widely by condition and solution type **(see Exhibit 1)**. For example, remote patient monitoring for diabetes is estimated to increase commercial spending by $2,002 per user per year, while wraparound services for IBS and IBD management are estimated to reduce spending by $1,889 per user per year. Among the solutions evaluated to date, solutions for gastrointestinal care show the strongest evidence of net savings. Based on vendor-reported pricing of $825, Medicare could see annual net savings of $629 per beneficiary after fully covering the cost of wraparound solutions. These savings are driven by reductions in avoidable utilization, such as unnecessary emergency department visits and hospitalizations.

Exhibit 1

ESTIMATED PER USER BUDGET IMPACT OF HEALTH TECHNOLOGIES BY MARKET



Color indicates the market: bright green (commercial) and ochre (Medicare). The left side indicates per user per year savings, while the right side indicates added costs. Net spending for diabetes, musculoskeletal, and hypertension tools were estimated as 2- or 3-year projections and are represented here as calculated annual spending. Savings opportunities are represented on a per user basis to more accurately reflect impact of the solution. Source: Budget Impact Models from PHTI Assessments. See full assessment reports, including estimated budget impacts for all solutions in Medicaid, at phti.org for details and methodology.

SCALING OUTCOME-BASED PAYMENTS FOR HEALTH TECHNOLOGIES

CMS Innovation Center ACCESS model and FDA TEMPO pilot

ACCESS and TEMPO are among the clearest signals of growing public-sector confidence and market readiness to scale outcome-based payments for health technologies.

Beginning July 5, 2026, CMS's Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model will test clinical outcome–aligned payments for technology-supported chronic care in Traditional Medicare.[27] The model represents a meaningful shift for Traditional Medicare beneficiaries who have historically had limited access to health technologies because Medicare does not directly reimburse them. As a voluntary 10-year model, ACCESS creates a pathway for high-value health technologies to reach millions of older adults for the first time.

At launch, ACCESS will focus on the most common chronic conditions that affect more than two-thirds of Medicare beneficiaries and drive significant spending:

- **Early cardio-kidney-metabolic conditions** such as hypertension, dyslipidemia, obesity, and prediabetes
- **Cardio-kidney-metabolic conditions** such as diabetes; chronic kidney disease; and atherosclerotic cardiovascular disease, including heart disease
- **Musculoskeletal conditions** such as chronic musculoskeletal pain
- **Behavioral health conditions** of depression and anxiety

The conditions and clinical outcome measures of the ACCESS model closely align with those from PHTI's assessments (**see Exhibit 2**) and commercial market adoption. This reflects a shared focus on high-cost conditions that drive a disproportionate share of healthcare spending, where technology solutions exist to intervene, and growing consensus on what outcome measures matter most. It also reflects where there is mature-enough evidence to support a sophisticated outcome-based payment model.

ACCESS is further enabled by the FDA's Technology-Enabled Meaningful Patient Outcomes (TEMPO) for Digital Health Devices Pilot.[28] TEMPO is designed to promote patient access to promising technologies that may not fit neatly within existing FDA regulatory pathways, while still maintaining appropriate safeguards for patient safety and real-world performance monitoring.

This is particularly important for emerging technologies such as generative AI-enabled tools, many of which currently lack a clear pathway to FDA authorization despite rapid growth in clinical interest and deployment. Under the TEMPO pilot, manufacturers may request that FDA exercise enforcement discretion for certain regulatory requirements when technologies are deployed within the ACCESS model and are intended to improve meaningful patient outcomes. FDA will monitor real-world performance, including issues such as model drift and safety concerns.

Together, ACCESS and TEMPO demonstrate a broader shift in federal policy toward linking evidence generation, real-world performance monitoring, and payment innovation. CMS is testing whether technologies can improve outcomes and lower costs at scale, while the FDA is exploring more flexible oversight mechanisms for technologies for which performance may evolve continuously after deployment. This coordinated approach could help create a more-durable pathway for high-value technologies—including AI-enabled tools—to reach Medicare beneficiaries while remaining accountable for patient outcomes and safety.

Under the ACCESS model's Outcome-Aligned Payment (OAP) structure, a majority of payment is tied to whether participating organizations avoid duplicative services and achieve specified clinical outcomes, such as a one-percentage-point reduction in HbA1c for diabetes or a five-point reduction in PHQ-9 for depression. Payment levels vary across the four ACCESS clinical tracks, with more clinically intensive tracks generally receiving higher payment rates. For example, the model sets an initial annual payment of $420 per patient per year for the management of cardio-kidney-metabolic conditions, compared with $180 per patient for depression or anxiety management.

Exhibit 2

CLINICAL OUTCOME MEASURES—PHTI AND ACCESS MODEL COMPARED[29, 30]

ACCESS Track	PHTI-Assessed Condition	PHTI Performance-Based Contract Recommended Performance Measures	ACCESS Outcome-Aligned Payment Measures[b]
Early cardio-kidney-metabolic Conditions (eCKM)	Hypertension	• Blood pressure control for patients with hypertension (HEDIS measure BPC-E) • *Alternative:* Absolute change in systolic blood pressure • *Optional:* Medication adherence	• Systolic blood pressure reduction or control • Weight reduction or control (BMI) • HbA1c control (for pre-diabetes patients only) • Low-Density Lipoprotein Cholesterol (LDL-C) Control (for dyslipidemia patients only)
Cardio-kidney-metabolic Conditions (CKM)	Diabetes & Chronic Kidney Disease	• Laboratory reported HbA1c • *Optional:* Weight loss percent	• Systolic blood pressure reduction or control • HbA1c reduction or control (for diabetes patients only) • Weight reduction or control (BMI) • Low-density Lipoprotein Cholesterol (LDL-C) Control (for dyslipidemia and Atherosclerotic Cardiovascular Disease (ASCVD) patients only) • eGFR and uACR measurement (for CKD and diabetes patients only)[c]
Musculoskeletal Conditions (MSK)	Musculoskeletal	• Minimum clinically important difference (MCID) attainment on pain/function with an industry validated scale (e.g., NPRS, VAS, PROMIS-PI, KOOS-PS, ODI, PROMIS-PF, QuickDASH, HFAQ, LCAT)	• Improvement in physical function and pain interference (one measure selected according to site of pain—PROMIS-PF/PROMIS-PI, ODI, NDI, QuickDASH, KOOS JR, HOOS JR) • Pain Intensity control (NRS or PROMIS NRS)
Behavioral Health (BH)	Depression & Anxiety	• Patient Health Questionnaire-9 (PHQ-9) • Generalized Anxiety Disorder scale (GAD-7)	• Depression reduction or control (PHQ-9) • Anxiety reduction or control (GAD-7)

[b] The full list of OAP measures is available here. [c] Submission-only measures, no performance targets set. Included as the only CKD-specific measures in the model; other submission-only measures for the ACCESS model are excluded from this table.

Future considerations as outcome-based payments scale

As outcome-based payment models for health technologies spread, they will increasingly reshape the market. Most directly, health technology solutions will improve and generate better clinical outcomes as payment is increasingly tied to performance. Over time, scaling these models will also likely influence how vendors design, price, and deploy solutions.

Outcome-based payment models will generate substantial real-world data, showing how health technologies perform across diverse patient populations and clinical settings. These data will strengthen the evidence base for technology-enabled care, providing greater insights into which interventions produce the strongest outcomes, which patient populations are most likely to benefit, and at what cost. Continuous evidence generation will allow vendors and purchasers to identify what is and is not working faster.

Because of its scale and duration, the ACCESS model is expected to generate much of this new evidence base. Making the most of these data will require rapid feedback loops and the ability to respond to the evidence—including using it to phase out lower-performing solutions and promote higher-performing ones.

As the ACCESS model expands, it could also establish new payment expectations. Commercial health plans, employers, and other purchasers will likely look to the ACCESS rates as an important reference point when negotiating their own contracts with health technology vendors. Because payment is tied to measurable outcomes at relatively modest reimbursement rates, ACCESS payments could exert downward pressure on pricing across the industry.

With lower reimbursement expected for these tools, developers will face strong incentives to develop scalable solutions that can deliver clinical improvement at the lowest-possible marginal cost. This dynamic may accelerate investment in highly automated and AI-enabled tools capable of supporting large patient populations at a lower operating cost. While this trend could improve scalability and affordability, it may also disadvantage provider-led or service-intensive models that rely on clinicians or care teams—even in cases where those approaches produce meaningful clinical improvement or lower overall costs. Purchasers and policymakers will need to ensure that outcome-based payment rewards demonstrated value rather than the lowest delivery cost, so that effective care models are not crowded out by the most easily automated ones.

CONCLUSION

Without clearly defined metrics and confidence that outcomes can be measured in real-world settings, it is difficult to operationalize an outcome-based payment model predictably and at scale. PHTI's work to synthesize the evidence base has helped create an industry foundation for purchasers and technology developers to utilize in implementing outcome-based payment models such as ACCESS. The next test is whether purchasers can build the rapid feedback loops needed to act on the evidence these models generate—scaling the solutions that demonstrably work and retiring those that do not.

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