CMSA™
Case Management Society of America

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model:

The Role of Case Management

Position Paper

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Foreword

Healthcare is at a pivotal moment in the evolution of chronic disease management. As the complexity and prevalence of chronic conditions continue to rise, healthcare systems must move beyond fragmented, episodic care toward models that are proactive, coordinated, technology-enabled, and grounded in whole-person care. The Centers for Medicare & Medicaid Services (CMS) Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model represents an important step in this transformation.

The ACCESS Model recognizes that improving outcomes for Medicare beneficiaries requires more than clinical intervention alone. Success depends on interdisciplinary collaboration, patient engagement, integration of behavioral and social care, equitable access to technology, and coordinated care delivery across the continuum. Professional case managers are uniquely positioned to operationalize these goals.

For decades, case managers have served as the connective infrastructure of healthcare delivery—bridging gaps between providers, settings, services, patients, families, and communities. Their expertise in care coordination, advocacy, transitions of care, behavioral health integration, and addressing social drivers of health aligns directly with the core principles of the ACCESS Model.

This position paper from the Case Management Society of America (CMSA) highlights the essential role of professional case management in advancing scalable, patient-centered chronic care delivery. It demonstrates how case managers translate technology-enabled innovation into meaningful patient engagement, improved outcomes, enhanced equity, and more effective resource utilization.

Importantly, this paper reinforces a critical reality: technology alone does not improve healthcare outcomes—people do. Digital tools, predictive analytics, remote monitoring, and artificial intelligence may support care delivery, but it is the professional judgment, advocacy, compassion, and coordination expertise of healthcare professionals that transform these tools into better patient experiences and outcomes.

As healthcare continues shifting toward value-based and outcomes-focused care, professional case management will remain indispensable to achieving sustainable, equitable, and person-centered healthcare transformation.

This position paper offers not only a roadmap for ACCESS implementation, but also a vision for the future of coordinated chronic care delivery.

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Executive Summary

The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model is an evidence-based framework developed to address the complex needs and rising costs of chronic disease management for Medicare beneficiaries (CMS, 2026). The fiscal and clinical burden of chronic conditions are significant for the U.S. and abroad. These conditions (e.g., arthritis; cancers; cardiovascular, cerebrovascular, and pulmonary conditions; diabetes; renal diseases) account for over 60% of mortality and estimated cost expected to reach $47 Trillion by 2030 (Anderson & Durstein, 2019; Hacker, 2024). Barriers to care pose major impediments for vulnerable populations. These include a rural-urban divide obstructing availability and access to specialists, and a digital divide courtesy of techquity and other social drivers of health (Chen, 2025; Schwarz et al., 2022).

Studies demonstrate how proactive, coordinated care models driven by case management reduce mortality and cost. The ACCESS model tests an outcomes-aligned payment approach that leverages digital technology and other innovations designed to enhance patient-centric interventions. Interdisciplinary team collaboration and professional case management drive the model's efficiency and effectiveness.

Core Model Principles and Alignment with Professional Case Management

The ACCESS Model integrates evidence-based components validated in numerous clinical trials and population health studies. Risk stratification tools, such as predictive analytics and standardized assessment instruments, have been shown to effectively identify patients at highest risk for adverse outcomes (Itchhaporia, 2021; Oddy et al., 2024). Individualized care planning, developed and refined through patient and provider engagement, is associated with improved disease control and patient satisfaction. Interdisciplinary case management teams are proven to reduce fragmentation and improve continuity of care (Kongker et al., 2025; Moreo et al., 2017). Inclusion of telemedicine and remote monitoring are supported by systematic reviews that demonstrate reductions in healthcare utilization, including emergency department use, hospitalizations, and primary care use (Ezeamii et al., 2024; Vudathaneni et al., 2024). Continuous quality improvement processes equally ensure that interventions remain aligned with current evidence and clinical guidelines.

Case management is a well-established strategy for high-value chronic care delivery. Randomized controlled trials and meta-analyses indicate how case management lowers readmissions, enhances medication adherence, and improves quality of life for people with chronic conditions. The ACCESS Model provides opportunities for case managers to coordinate care transitions, minimize duplication of services, and facilitate timely interventions that yield better patient experiences and fewer adverse events. Skilled interventions drive patient-centric psychoeducation, which enhances self-management, treatment adherence, and systematically addresses critical social drivers of health that can obstruct access to care (Magnan, 2021).

Introduction

Chronic disease remains one of the most significant drivers of morbidity, mortality, and healthcare expenditure among Medicare beneficiaries. Conditions such as hypertension, diabetes, chronic kidney disease (CKD), depression, and chronic pain are highly prevalent within this population and frequently coexist, compounding clinical complexity and increasing risk for avoidable emergency department visits, hospitalizations, and functional decline. Effective management of these conditions requires sustained engagement, interdisciplinary coordination, early identification of risk, and attention to social and behavioral determinants of health. Yet care delivery for many Medicare beneficiaries remains fragmented, episodic, and reactive, despite the major advances in clinical knowledge and digital health innovation,

The Centers for Medicare & Medicaid Services (CMS), through its Innovation Center, is assessing a new 10-year payment and care delivery model designed to support scalable digital care and whole-person chronic disease management. The ACCESS Model seeks to integrate technology-enabled monitoring, coordinated interdisciplinary workflows, and equity-focused performance accountability into a structured, longitudinal framework. The alignment of reimbursement with measurable improvements in clinical outcomes, patient experience, and cost performance fuels the objective of CMS to advance a sustainable model that leverages digital infrastructure while addressing disparities in access to, and engagement in care delivery.

The Case Management Society of America (CMSA) has long advocated for coordinated, person-centered, and equitable approaches to chronic disease management. For decades, the association has emphasized the essential role of professional case managers in integrating medical, behavioral, and social care across the continuum. The main elements within ACCESS are whole-person care, proactive coordination, technology-enabled communication, and equity-driven measurement. These critical domains align with the CMSA Standards of Practice and professional advocacy of the workforce toward sound population health. CMSA affirms that professional case management is indispensable to translating digital innovation into meaningful, measurable improvements in the health and well-being of Medicare beneficiaries. It is critical intel for CMS to be aware of as the ACCESS model's effectiveness is formally evaluated for longer-term utilization.

Overview of the Access Model

Expand Access to Technology-Supported Care

The expansion of technology-supportive services through the ACCESS Model will create newer and broader opportunities to increase accountability for actions that support patient self-management, eliminate geographic barriers, and extend the reach of healthcare services. These critical actions will improve performance and utilization outcomes, quality of care and patient experiences and health outcomes. Healthcare supported through emerging and existing digital technologies will also be positively impacted, as it is further integrated within the Medicare mainstream.

Improve Chronic Disease Outcomes

Pre-emptive attention to chronic disease is among the main goals of ACCESS. Proactive versus reaction attention to key health treatment needs contributes to unnecessary healthcare utilization such as in emergency stays, hospitalizations, and readmissions. Practical attention to blood pressure (BP) control, hypertension, hemoglobin A1-c levels, and glycemic control for individuals with diabetes. Depression severity improvement should be measured by validated screening tools such as the PHQ-9. Heeding gold standard measures for pain intensity and functional improvement scores for chronic pain populations become vital to prevention and wellness, as do markers of chronic kidney disease progression such as changes in glomerular filtration. This innovation also leverages advancement of long-term care management through incorporation of effective and scalable solutions, improved patient education, self-care, acceptance, and adherence.

Increase Flexibility in Care Delivery

The ACCESS Model encourages and fosters a versatile care environment that can adapt to both the patient and provider's needs. The continued work with tele-health advances use of mobile health units in rural and underserved areas. Integration of digital technology, and the creation of and continued collaboration of partnerships with community resources at all levels of care sets a quality infrastructure for robust healthcare delivery. Greater access to care will foster prevention and achievement of successful outcomes, leading to increased utilization and performance improvement. This will also aid in improved patient experience and satisfaction scores as well as that of their caregiver.

Advance Health Equity and Beneficiary Empowerment

Through surveys and focus groups the ACCESS Model will help to identify gaps and other issues in healthcare services. This will help foster training, education, and support for diverse populations as well as to include enhanced cultural inclusion and policies that address systemic barriers in healthcare. Equity and patient empowerment will then be increased by addressing the digital divide. By having access to their health data, patient self-advocacy can be achieved. It also helps to support transparency in healthcare that has been identified and noted.

Align with National Healthcare Priorities

The use of digital technologies can not only transform the way care is delivered but also assist clients in better interacting with their providers, in monitoring physiological parameters, and in receiving coaching to support changes in habits and lifestyle (CMS, 2026). This strategy is expected to improve physical and behavioral health. Technologies such as telehealth, wearable devices, and coaching applications can be valuable to all communities, especially those with limited access to care (CMS, 2026). The four tracks prioritized by the ACCESS Model are early cardio-kidney-metabolic conditions, existing cardio-kidney-metabolic conditions, musculoskeletal conditions, and behavioral health conditions by promoting prevention and adherence to reduce worsening health (CMS, 2026). The model provides reimbursement to providers and organizations approved to participate for referring clients to engage with these technologies. For clients in rural areas, CMS will implement a monthly fixed adjustment payment to offset the increased costs of delivering technology-based care, ensuring equitable participation and access (CMS, 2026). The distribution of connected devices will come at a higher cost. Providers will receive regular electronic updates from the organizations providing the technology (CMS, 2026). Each of the tracks targeted by the model includes a specific set of measures and outcome targets, based on clinical guidelines and/or Client-Reported Outcome Measures (CMS, 2026).

CMS, along with the Department of Health and Human Services (HHS), developed a framework to address health disparities (HHS, 2022). The ACCESS Model supports the framework, and healthcare organizations, professionals, providers, health plans, tribal nations, and quality improvement partners will reap the benefits. Promoting and supporting the use of digital technologies to prevent and improve chronic conditions can better meet the needs of all communities, but most especially underserved communities and minorities. Even though 85% of American households have internet access, many in rural areas still lack broadband (Jongebloed, 2024). In June 2023, Congress passed the Broadband Equity, Access, and Deployment (BEAD) Program (NTIA, 2025). This $42.45 billion federal grant program aims to connect every American to high-speed internet by funding partnerships to build infrastructure (NTIA, 2025). As states begin implementing improvements in internet access in rural areas, participation in the ACCESS model is expected to increase.

The ACCESS Model targets providers in the ambulatory setting, especially primary care providers, but also includes other healthcare sectors such as health plans and quality improvement programs (CMS, 2026). Case managers can play an integral role in recommending and encouraging clients to participate in the programs included in the model.

Healthcare quality programs such as the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA) are likely to support the model. Still, NCQA is the only quality organization to have published its support for measurement. NCQA sets standards for health plans, providers, and medical groups that use measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to drive transparency, accountability, and client outcomes (NCQA, 2026). NCQA is partnering with CMS to provide the quality measures needed to track the model's success (NCQA, 2025).

Implications for Care Delivery

Several design features of ACCESS directly reshape how care for individuals with chronic conditions is delivered daily specifically, improving access to technology-supported care options. While improving the health and well-being of a population has been about managing risk, the American health care system has been primarily focused on those at the highest risk rather than engaging lower-risk populations to help them stay healthy and prevent worsening health (Kolinski, 2026). The model provides a proactive approach to care that allows for it to be delivered in person, virtually, asynchronously, or through other technology-enabled methods.

Technology-Supported Care Expansion

Care delivery under ACCESS is expected to scale technology-enabled approaches as routine longitudinal supports, including remote physiologic monitoring (RPM), digital therapeutics (DTx) and virtual or asynchronous interactions that extend care between traditional encounters (CMS, 2026a). In practical workflow terms, this means patient-generated data must be paired with defined review cadence, clear thresholds for escalation, and timely outreach or clinical action to prevent avoidable deterioration (CMS, 2026a; CMS, 2024). Virtual behavioral interventions similarly become operationally “real” only when teams have a reliable mechanism to identify symptom worsening, intensify support, and coordinate changes with the broader clinical team (CMS, 2026a).

Because care may occur across modalities (in-person, virtual, asynchronous), the care plan must function as a shared, living artifact rather than a static document. The ACCESS model’s requirement for ongoing electronic updates makes shared-care platforms (or platform-like workflows) central to engagement, education, and continuity (CMS, 2026a, 2026b). For care delivery, the implication is that patient education and self-management supports should be structured and trackable (e.g., goals, adherence supports, symptom check-ins, teaching points, action plans), with version control that allows all parties to align around the current plan (CMS, 2024).

ACCESS also introduces a specific co-management pathway: PCPs/referring clinicians may bill when they document review of the ACCESS care update and document coordination actions in the EHR (CMS, 2026b). This directly changes care delivery by legitimizing asynchronous clinical oversight and coordination as billable, accountable work—thereby strengthening shared responsibility between technology-enabled care entities and traditional clinical teams. (CMS, 2026b). Operationally, this raises the bar for the quality and usability of updates, requiring that care updates must be clinically actionable, not merely informational, to support efficient review, appropriate changes, and closed-loop documentation (CMS, 2026b).

Enhanced Interdisciplinary Collaboration

Because ACCESS requires regular electronic updates to primary/referring clinicians, collaboration becomes a designed workflow rather than an ad hoc courtesy (CMS, 2026a, 2026b). In care delivery terms, this elevates the need to synchronize documentation and care plans across disciplines and care team roles – primary care, specialists, behavioral health, pharmacy, and community organizations, especially where medication management, behavioral health treatment plans, and community-based supports must align with clinical targets and patient preferences (CMS, 2024). To be functional, synchronization across shared health informational technology systems must include (a) clear role clarity (who owns which decisions), (b) standardized handoff points (when updates are pushed/pulled), and (c) escalation pathways that specify when specialist or PCP input is required (CMS, 2026b).

Enhanced collaboration under ACCESS is underwritten by interoperable information flow. The technical expectations described by CMS, including use of CMS application programming interfaces (APIs) and secure mechanisms for exchange, imply greater reliance on interoperable pathways so that care updates and plan changes can be accessed and acted upon by all providers (CMS, 2026a, 2026b). This has a concrete care delivery consequence: teams must design workflows that assume distributed care delivery while maintaining a single, coherent clinical narrative—minimizing duplication, preventing conflicting recommendations, and ensuring that the plan visible to each discipline reflects the most current decisions (CMS, 2026b).

Shifting From Activity-Based to Outcome-Based Care

When payment and accountability are tied to improvement on track-specific outcomes, the operational center of gravity shifts from “how many touches occurred” to “what changed for the patient” (CMS, 2026a; CMS, 2024). In the context of effective care delivery, this means workflows must be built around outcome-producing sequences, which are already cornerstones of case management practice (2024): assessment, goal setting, intervention selection, monitoring, and escalation/adjustment rather than a generic cadence of outreach. This alignment is especially vital in technology-supported care, as it prevents alert fatigue and ensures that monitoring signals reliably triggers appropriate action such as education, coaching, medication optimization, referral, or urgent escalation (CMS, 2026b).

Additionally, ACCESS’s care update expectations and co-management billing pathway make documentation a frontline care delivery tool, not a retrospective record (CMS, 2026b). Consistent documentation should connect:

1. What was observed (symptoms, vitals, patient-reported outcomes),
2. What was decided (clinical reasoning, shared decision-making),
3. What was done (interventions, referrals, medication changes), and
4. What happens next (timelines, responsibilities, escalation criteria)

(CMS, 2024).

Progress tracking and analytics then allow teams to identify non-response early, adjust intensity, and differentiate “engagement issues” from “clinical optimization issues.” These actions are essential when care is delivered through multiple modalities and handoffs (CMS, 2024; CMS, 2026a).

Equity and Access Considerations

Technology-enabled care can either reduce barriers through convenience and reach, or compound inequities related to connectivity, device, language, disability access, and digital literacy gaps. ACCESS's care-delivery expectations therefore imply that equity-ready implementation must include multi-modal engagement options and practical supports for onboarding, troubleshooting, and sustained use for all beneficiaries (CMS, 2026a). Operationally, this translates into designing alternative pathways when the "ideal" tech workflow fails (e.g., telephone-based coaching, simplified workflows, caregiver-enabled engagement, in-person bridge touchpoints) so that access to technology does not become a gatekeeper to clinical support (CMS, 2024).

ACCESS explicitly recognizes rural access challenges and incorporates a rural adjustment for qualifying tracks, reflecting a care delivery intent to extend technology-supported care where local options are limited (CMS, 2026a). In practice, rural implementation often requires added attention to connectivity constraints, device logistics, and availability of in-person escalation routes. This validates the importance of hybrid models (virtual-first with reliable local escalation) and community partnerships as critical to achieve comparable outcomes (CMS, 2024).

As care becomes more distributed and asynchronous, professional case management standards and ethics become even more essential guardrails for safe, person-centered, and accountable care delivery. The CMSA Standards of Practice for Case Management emphasize a collaborative process that includes assessment, planning, facilitation, care coordination, evaluation, and advocacy; these functions map directly onto technology-supported chronic care workflows and shared-plan coordination (CMSA, 2022). The Commission's (2026) Code of Professional Conduct similarly reinforces expectations for professional, interdisciplinary practice and includes enforceable standards relevant to technology-enabled care contexts (e.g., confidentiality, professional responsibility, and safeguards that protect the public interest) (Together, these standards support an ACCESS-aligned care delivery approach in which patient engagement is intentional, coordination is explicit, escalation is reliable, and documentation is sufficiently rigorous to ensure continuity, accountability, and ethical practice across digital and traditional settings (CMS, 2026b; CMSA, 2022; The Commission, 2026).

The Critical Role of Case Management in the ACCESS Model

Case managers have a pivotal role in coordination of longitudinal care. They develop relationships with patients to help them guide their complex, chronic, or psychosocial needs through the entire continuum of care. As a result, case management bridges the gaps between providers, settings (e.g., hospital to home), and services ensuring that care is not just episodic, but rather integrated over time to improve outcomes and reduce costs.

Case managers provide care throughout the healthcare continuum. They are employed in various settings including hospitals, primary care, specialty care, ACOs, HMOs, integrated care teams, and healthcare insurance. They serve as the central coordinators of longitudinal care, who ensure continuity for patients across the care continuum.

Case managers identify their patients in various settings through predictive modeling, data mining, provider referrals, and re-admission data (e.g., inpatient hospitalizations or emergency visits). Their positioning across the transitions of care mandates access to electronic health records (EHR) for patients to make determinations for timely and appropriate care, and without duplication.

Research has shown that when case managers are involved in longitudinal care, they have a significant impact on care quality and costs. Patient satisfaction and improved quality of life are other benchmarks of case management involvement. Utilization of healthcare services is often decreased when case managers are involved due reduction in service duplication and ensuring care plans are implemented and followed. Programs often report reduction of hospital admissions resulting in significant cost savings.

The electronic health record (EHR) platform serves as a foundational infrastructure for telehealth and virtual care by enabling real-time visibility of patient information for providers and care teams regardless of geographic location. The product is equally central to technology-enhanced case management. This centralized system stores patient information, medical history, and care plans which allow real-time updates accessible by the care team across the continuum. This real-time access facilitates seamless communication between providers and insurers which prevents gaps or duplication in care. The EHR patient portal is an essential tool for the team for communication and care coordination.

Remote patient monitoring systems and wearable technologies can be integrated into the EHR to track patient progress, allowing care teams to identify concerning trends and intervene earlier in the course of disease management. Predictive analytics further strengthens this capability by enabling case managers to identify individuals at increased risk for healthcare utilization, including emergency department visits and hospitalizations. Through analysis of clinical data and utilization patterns, predictive models can identify high-risk populations—such as patients with diabetes, congestive heart failure, or chronic obstructive pulmonary disease—allowing case managers to initiate targeted interventions and proactive care planning to prevent complications and reduce avoidable utilization.

Artificial intelligence (AI) and machine learning tools are also increasingly being incorporated into healthcare workflows to support administrative efficiency, analyze complex datasets, and assist in identifying potential care risks. While these technologies offer significant opportunities to enhance care coordination and decision support, they must be applied thoughtfully and supplemented by professional clinical judgment. The nuanced assessment, critical thinking, and contextual understanding provided by professional case managers remain essential to interpreting algorithm-generated insights and ensuring that technology-supported care remains patient-centered, clinically appropriate, and ethically grounded.

Regulatory compliance and data security are fundamental requirements for all digital platforms used in healthcare. Health information systems, data storage infrastructures, and communication technologies must adhere to established regulatory standards and employ secure, encrypted protocols to protect patient privacy, maintain data integrity, and ensure the safe exchange of health information across care teams.

Addressing Social Drivers of Health (SDOH)

Case managers address the root causes of health disparities as well as coordinate resources. Addressing the social drivers of health is fundamental to the case manager's role in advancing equitable, patient-centered care. Evaluating access to technology and connectivity has become increasingly critical as healthcare delivery expands through telehealth and digital platforms. Case managers must assess whether patients have reliable internet service, appropriate devices, digital literacy skills, and privacy for virtual visits. Without this evaluation, vulnerable populations may be excluded from essential services.

Mitigating barriers related to affordability, health literacy, or caregiver availability requires skilled problem-solving and interdisciplinary coordination. Case managers assess financial constraints, insurance coverage, medication costs, eligibility for assistance programs, and connect patients with assistance programs when needed. In addition, case managers assess health literacy to tailor education in clear, culturally sensitive language, empowering patients to make informed decisions and practice self-management. When caregiver availability is limited, case managers coordinate supportive services such as home health, respite care, or community-based support to reduce risk, enhance stability, and prevent avoidable hospitalizations.

Case managers serve as a bridge between healthcare systems and community-based resources. By maintaining knowledge of local transportation services, food programs, housing assistance, disease-specific support groups, and nonprofit organizations, case managers facilitate meaningful connections that extend care beyond clinical settings.

Behavioral health issues frequently coexist with chronic medical conditions and significantly influence adherence, recovery, and overall outcomes. Case managers conduct comprehensive, holistic evaluations that encompass medical, psychosocial, behavioral, cultural, and environmental determinants of health. This assessment includes systematic screening for depression, anxiety, and substance use utilizing evidence-based validated tools such as PHQ-9, GAD-7, and other SBIRT. By leveraging HIT-enabled screening tools, clinical insight, and risk stratification, case managers address behavioral health needs as integral components of whole-person care.

Digital tracking tools and symptom monitoring platforms enable continuous evaluation of adherence to psychotherapy appointments and medication regimens. Automated reminders for repeat screening at defined intervals support evidence-based care. When symptom escalation is detected, timely modification of the plan of care reduces crisis escalation and preventable acute care utilization.

Case managers synthesize assessment data with social drivers of health, caregiver capacity, and medical complexity to determine level of risk and urgency. Patient engagement, avoidance of adverse outcomes or disease progression, and enhancing adherence to the plan of care are priorities. Using HIT, case managers can analyze trends to identify high-risk cohorts, disparities in health care, gaps in service access as well as identify areas of potential over or under utilization of health care resources. This data-driven approach strengthens quality improvement initiatives and aligns with value-based care metrics. Evaluation of adherence trends and symptom stabilization contributes to improved functioning, reduced relapse, and enhanced quality of life. HIT-enabled dashboards allow case managers to trend symptom scores over time, track response to therapy or pharmacologic treatment, and identify early signs of relapse or deterioration. Addressing these psychosocial and behavioral health realities for patients provide case managers further opportunities to enhance outcomes.

Alignment With CMSA Standard of Practice H – Health Information Technology

CMSA Standard of Practice H affirms that health information technology (HIT) is not ancillary to case management practice, but is now foundational to effective communication, coordination, clinical decision-making, and the achievement of measurable outcomes (CMSA, 2022). The ACCESS Model advances and operationalizes this standard by embedding digital infrastructure, interoperable data exchange, and technology-enabled care coordination as core mechanisms of whole-person, equity-focused care delivery.

Within ACCESS, professional case managers are positioned not simply as end users of technology, but as clinical, operational, and ethical leaders responsible for ensuring that HIT meaningfully supports patient needs, interdisciplinary collaboration, and system accountability. This alignment reinforces the professional expectation that case managers actively shape how technology is selected, implemented, and used, ensuring that digital tools enhance care coordination rather than contribute to fragmentation, inequity, or administrative burden.

Rather than functioning as parallel documentation systems, HIT tools under ACCESS are intentionally incorporated into care planning processes to support shared decision-making, real-time updates, and longitudinal accountability. Through this integration, technology becomes a facilitator of individualized, coordinated care rather than a disconnected administrative function.

Ensuring Accurate, Timely, and Reliable Health Information Exchange

The ACCESS Model depends on seamless, bi-directional health information exchange to support longitudinal accountability and coordination across the continuum of care. Case managers play a vital role in facilitating real-time communication among providers through interoperable EHRs, shared care platforms, and secure digital portals that span acute, post-acute, ambulatory, behavioral health, and community-based settings.

Case managers ensure that critical information, including care plans, medication changes, diagnostic results, discharge instructions, and social service referrals, is accurate, current, and accessible to all members of the care team. They also identify and mitigate gaps in information flow that contribute to duplication, delays, or adverse events (Yeung et al, 2023). This function directly operationalizes Standard H's emphasis on reducing information silos, improving continuity, and preventing fragmentation of care.

Patient and Caregiver Training, Digital Literacy, and Technology Adoption

CMSA Standard H also recognizes that technology must be accessible, understandable, and usable to achieve its intended impact. Within ACCESS, case managers assess patient and caregiver digital literacy, access to devices, broadband availability, and comfort with technology as part of routine care coordination. These assessments inform individualized education and support strategies related to telehealth visits, patient portals, remote monitoring devices, mobile health applications, and digital therapeutics.

Case managers tailor education to patient capacity, language preferences, cultural context, cognitive considerations, and disability accommodations. They provide hands-on guidance, reinforce learning over time, and troubleshoot barriers to sustained engagement. Through this role, case managers ensure that technology enhances patient understanding, adherence, and self-management rather than exacerbating confusion, disengagement, or disparities.

Outcome Measurement, Performance Monitoring, and Data-Informed Practice

The ACCESS Model explicitly links reimbursement and accountability to quality, equity, and cost outcomes, making data-informed practice a core expectation. These are integral elements of outcomes measurement and amplify importance of Standard O (Outcomes) (CMSA, 2022, 2024) Case managers leverage HIT dashboards, analytics tools, and reporting systems to monitor required ACCESS metrics. These provide opportunities for case management to identify trends, recognize early indicators of risk or care breakdown, and focus on continuous quality improvement.

This consistent monitoring enables case managers to prioritize interventions, escalate concerns, and coordinate timely responses with interdisciplinary partners. Data is translated into actionable insights that inform care planning, resource allocation, and performance improvement initiatives. In this way, When Standard H's emphasis on technology-enabled decision support is fully integrated with Standard O, case managers are able to bridge data analytics and total quality management with clinical judgment and coordination expertise.

Promoting Equity Through HIT Access and Advocacy

Equity is a central pillar of the ACCESS Model, making the identification and mitigation of digital disparities a core responsibility of professional case management. Case managers assess barriers related to broadband access, device availability, affordability, language access, health literacy, and disability accommodations. They connect patients and caregivers to community resources, subsidy programs, and technical assistance that support meaningful engagement with digital care tools (Rodriguez et al, 2022).

Beyond individual interventions, case managers advocate for system-level solutions that promote digital inclusion, such as expanded broadband infrastructure, accessible platform design, and policies that reduce cost-related barriers (Saeed & Masters, 2021). This advocacy role aligns directly with Standard H's expectation that case managers promote ethical, equitable, and patient-centered use of technology.

Ethical Stewardship and Responsible Use of Technology

Consistent with CMSA Standards and professional codes, case managers under ACCESS serve as ethical stewards of health information technology. They support responsible data use, safeguard patient privacy, promote transparency in technology-driven decision-making, and ensure that digital tools complement rather than replace clinical judgment and human connection.

This stewardship role is increasingly critical as advanced analytics, automation, and artificial intelligence are incorporated into care coordination workflows. Case managers provide oversight to ensure that technology is applied ethically, equitably, and in alignment with patient values and professional standards.

Workforce: Essential Competencies

Successful implementation of the CMS Innovation Center's ACCESS Model depends on a prepared, supported, and appropriately structured workforce, including case management professionals. ACCESS introduces new expectations related to technology-enabled care, equity-focused practice, and data-driven accountability that extend beyond traditional healthcare functions. Organizations participating in ACCESS must therefore invest in workforce development, competency alignment, and organizational infrastructure to ensure that healthcare professionals are equipped to lead and sustain this model.

Core competencies include the following:

Behavioral Health Support and Integration

ACCESS emphasizes whole-person care, requiring case managers to competently identify, support, and coordinate behavioral health needs alongside medical and social care. healthcare professionals must recognize common behavioral health conditions, understand referral pathways, and support engagement with both digital and in-person behavioral health interventions (Fink-Samnick, 2026).

Data Interpretation and Outcome Reporting

ACCESS links care coordination activities directly to quality, equity, and cost outcomes. Healthcare professionals must be competent in interpreting dashboards, analytics reports, and performance metrics tied to ACCESS requirements. This includes recognizing trends, identifying gaps, and translating data into actionable care coordination strategies. Competency in outcome reporting supports transparency, continuous improvement, and organizational accountability while reinforcing the measurable value of case management practice.

Digital Health Literacy

Healthcare professionals must demonstrate proficiency in using and navigating digital health tools, including electronic health records, care coordination platforms, patient portals, remote patient monitoring technologies, telehealth systems, and digital therapeutics. Digital health literacy extends beyond basic use to include understanding data flow, interoperability limitations, workflow integration, and patient usability considerations (Kelly et al, 2025). Under ACCESS, healthcare providers are expected to confidently engage with technology as a routine component of care coordination rather than as an adjunct or optional tool.

Interdisciplinary Communication via HIT Platforms

Effective ACCESS implementation relies on seamless interdisciplinary communication supported by HIT platforms. Healthcare professionals must be skilled in using shared digital tools to communicate care plans, escalate concerns, document coordination activities, and align interdisciplinary teams. This competency includes understanding role-based access, documentation standards, and communication etiquette within digital environments to promote clarity, accountability, and collaboration.

Knowledge of Equity Frameworks and Barrier Mitigation

Equity is foundational to ACCESS, requiring healthcare professionals to understand and apply health equity frameworks in daily practice. Competency includes recognizing structural and social barriers to care, identifying digital and non-digital disparities, and implementing mitigation strategies through advocacy, resource connection, and workflow design (Chen, 2025). Healthcare professionals must integrate equity considerations into assessments, care planning, and technology use to ensure that ACCESS advances health equity goals, rather than undermines them.

Motivational Interviewing in Virtual and Technology-Enabled Contexts

As ACCESS expands the use of telephonic, virtual, and asynchronous engagement, healthcare professionals must adapt motivational interviewing and patient engagement techniques to digital environments. This includes building rapport remotely, assessing readiness for change through virtual interactions, and sustaining engagement when face-to-face contact is limited. Effective virtual motivational interviewing supports adherence, activation, and self-management across diverse patient populations (Papus et al, 2022).

ACCESS Workforce Competency Grid

Core Competency	Description	Key Skills / Applications	Relevance to ACCESS Model
Behavioral Health Support and Integration	Identification and coordination of behavioral health needs within whole-person care models.	• Recognizing behavioral health conditions • Coordinating referrals • Supporting digital and in-person interventions • Integrating behavioral health into care plans	Supports ACCESS emphasis on whole-person care and integrated service delivery
Data Interpretation and Outcome Reporting	Ability to interpret dashboards, analytics, and performance metrics linked to quality, equity, and cost outcomes.	• Trend analysis • Gap identification • Translating data into action • Outcome reporting and documentation	Directly aligns care coordination activities with measurable outcomes, reinforcing accountability and value of case management
Digital Health Literacy	Proficiency in navigating and utilizing digital health tools, including EHRs, care coordination platforms, telehealth, and remote monitoring technologies.	• Use of EHRs and care platforms • Understanding interoperability and data flow • Workflow integration • Patient usability assessment	Positions technology as a core component of care coordination rather than optional; supports scalable, tech-enabled care delivery
Interdisciplinary Communication via HIT Platforms	Effective communication and coordination across teams using digital platforms.	• Shared care plan communication • Documentation standards • Escalation workflows • Role-based access understanding	Enables seamless interdisciplinary collaboration and real-time coordination across the continuum

Core Competency	Description	Key Skills / Applications	Relevance to ACCESS Model
Knowledge of Equity Frameworks and Barrier Mitigation	Application of health equity principles to identify and address barriers to care.	• Identifying structural and social barriers • Addressing digital divide issues • Resource connection and advocacy • Integrating equity into care planning	Ensures ACCESS advances equitable care delivery and mitigates disparities rather than exacerbating them
Motivational Interviewing in Virtual Contexts	Adaptation of motivational interviewing techniques to telehealth and digital environments.	• Building rapport remotely • Virtual readiness assessment • Sustaining engagement without in-person contact • Supporting self-management	Enhances patient engagement and adherence in technology-enabled care models

Workforce Development and Training Implications

Organizations implementing ACCESS must align onboarding, education, and ongoing professional development with these expanded competency expectations. This includes structured training in digital tools, data literacy, virtual engagement techniques, equity-informed practice, and interdisciplinary collaboration (Endalamaw et al, 2024). Ongoing coaching and competency validation are essential to maintaining workforce readiness as technology and model requirements evolve.

Organizational Structure and Support Considerations

To support ACCESS-focused healthcare practice, organizations must ensure appropriate staffing models, role clarity, and workload alignment. Healthcare professionals require protected time for technology-supported coordination, data review, and interdisciplinary collaboration. Leadership support, access to informatics expertise, and integration of best practices into strategic planning are critical organizational enablers of success.

Organizational Considerations and Competencies to Support Effective ACCESS Implementation

Effective implementation of the ACCESS model requires aligned organizational structures, infrastructure, and leadership commitment to equip case managers for practice at the level the model demands while intentionally reinforcing defined professional competencies. The following organizational considerations are essential to support effective case management practice:

Infrastructure and Health Information Technology

Because ACCESS embeds technology into routine care coordination, organizations must invest in reliable, interoperable systems. Case managers cannot demonstrate digital fluency or support technology-enabled engagement if platforms are fragmented or poorly integrated.

Shared digital platforms must support accurate documentation, role-based access, secure communication, and real-time data exchange across disciplines. Robust interoperability among health providers, community-based organizations, and remote monitoring systems is essential to ensure seamless coordination and continuity across care domains.

Leadership Alignment and Strategic Integration

Successful ACCESS implementation requires visible leadership support and strategic integration of case management within organizational planning. When leadership alignment is strong, organizational culture reinforces professional competency development and equitable, technology-enabled care delivery.

Leadership engagement, informatics collaboration, and cross-department alignment are essential to sustaining model success. Case managers should participate in governance discussions related to digital transformation, equity initiatives, and care redesign to ensure frontline insight informs system-level strategy.

When leadership recognizes case management as a strategic asset rather than solely an operational function, organizational alignment strengthens. This alignment reinforces professional competencies and ensures that technology-enabled care remains patient-centered and equitable.

Quality Improvement and Accountability Structures

The ACCESS model links care coordination activities to measurable quality, cost, and equity outcomes. To meet these expectations, organizations must align quality improvement processes and accountability structures with case management practice to systematically identify disparities, close care gaps, and strengthen outcomes.

Accountability structures should include clearly defined performance metrics, stratified reporting dashboards, routine performance reviews, and documented follow-up processes when gaps are identified. Quality initiatives should monitor digital engagement rates, telehealth utilization, behavioral health referral completion, SDOH barrier resolution, and clinical outcome measures across demographic groups to ensure equity remains visible and actionable.

Structured feedback loops between leadership and frontline case managers are equally essential. Routine data review meetings, performance scorecards, and shared improvement plans promote adaptive change while reinforcing the measurable value of professional case management within the ACCESS framework.

Staffing Models and Role Clarity

ACCESS expands expectations across digital engagement, behavioral health coordination, interdisciplinary communication, and data accountability. Staffing models must reflect this broadened scope of practice.

Organizations should allocate defined and safeguarded time within workload expectations for data review, interdisciplinary collaboration, digital engagement, care planning, patient education, and follow-up activities. These responsibilities cannot be treated as add-ons to existing caseload expectations.

Clear role delineation across medical, behavioral, and social care teams reduces duplication of effort and minimizes fragmentation by ensuring that responsibilities are well-defined and coordinated.

System-Level Integration of Equity and SDOH Assessment

Health equity requires systematic identification of structural and social barriers that affect access, engagement, and outcomes. Under the ACCESS model, where equity is an explicit performance expectation, organizations must ensure these barriers are identified and addressed consistently.

Barriers to technology-enabled care are often rooted in social determinants and digital literacy challenges. Organizations must therefore embed validated SDOH and digital literacy assessments into standard workflows and care planning processes to reduce disparities.

Integrating validated screening tools into electronic platforms supports a structured approach to advancing equitable care by enabling early and systematic identification of barriers. This alignment enables organizations to meet ACCESS equity and outcomes accountability requirements.

Workforce Development and Competency Alignment

The expanded competencies required under ACCESS, digital health literacy, data interpretation, virtual engagement, behavioral health integration, interdisciplinary collaboration, and equity-informed practice necessitate structured and continuous workforce development.

Sustaining competency requires intentional and ongoing investment in workforce development. Professional development initiatives should extend beyond initial training to include digital health literacy, data fluency, equity-informed care, virtual engagement strategies, and competent technology use. As digital tools and performance expectations continue to evolve, competency validation should occur continuously through coaching, peer learning, and performance feedback mechanisms.

Organizational Considerations to Support ACCESS Implementation

Domain	Description	Key Organizational Actions	Impact on Case Management Practice
Infrastructure and Health Information Technology	ACCESS embeds technology into routine care coordination, requiring reliable, interoperable systems.	• Invest in interoperable HIT platforms • Ensure real-time data exchange across settings • Support secure communication and role-based access • Integrate community and remote monitoring systems	Enables digital fluency, seamless coordination, and continuity of care across the continuum
Leadership Alignment and Strategic Integration	Leadership engagement is essential for sustainable implementation and cultural alignment.	• Integrate case management into strategic planning • Engage leadership in digital transformation and equity initiatives • Include case managers in governance and redesign efforts • Partner with informatics and cross-functional teams	Positions case management as a strategic asset and strengthens system-wide alignment

Domain	Description	Key Organizational Actions	Impact on Case Management Practice
Quality Improvement and Accountability Structures	ACCESS links care coordination to measurable quality, cost, and equity outcomes.	• Develop performance dashboards and stratified reporting • Monitor key metrics (engagement, referrals, SDOH resolution) • Conduct routine performance reviews • Establish structured follow-up processes • Create feedback loops among leadership and frontline staff	Drives continuous improvement, accountability, and measurable demonstration of value
Staffing Models & Role Clarity	Expanded scope of practice necessitates intentional workload design and role delineation.	• Allocate protected time for coordination, data review, and patient engagement • Align staffing models with expanded responsibilities • Clearly define interdisciplinary roles • Avoid adding responsibilities to existing caseloads without adjustment	Reduces fragmentation, improves efficiency, and supports high-quality care coordination
System-Level Integration of Equity and SDOH Assessment	Equity requires systematic identification and mitigation of structural and social barriers.	• Embed SDOH and digital literacy assessments into workflows • Utilize validated screening tools within EHRs • Standardize barrier identification and intervention processes • Align care planning with equity goals	Promotes equitable access, reduces disparities, and supports ACCESS performance expectations
Workforce Development and Competency Alignment	Expanded competencies require structured and continuous professional development.	• Provide ongoing training in digital literacy, data interpretation, and virtual engagement • Incorporate equity-informed care education • Establish coaching, peer learning, and feedback loops • Implement continuous competency validation	Ensures workforce readiness and sustained competency in evolving care models

Challenges and Solutions

Implementation of the ACCESS model introduces both opportunity and complexity. As care becomes more technology-enabled and data-driven, organizations must anticipate potential challenges to workforce sustainability and patient engagement and implement strategies to mitigate them.

Variation in patient digital literacy and access remains a significant challenge. Without structured assessment and support, technology-enabled care may inadvertently exclude individuals with limited connectivity, device access, or confidence using digital tools. Embedding digital literacy and social determinant assessments into routine workflows helps ensure inclusive participation.

Workforce adaptation presents another challenge. Expanded expectations for data interpretation, virtual engagement, behavioral health integration, and equity-informed practice require ongoing professional development and realistic workload alignment. When responsibilities increase without corresponding structural support, quality and equity goals are difficult to sustain.

Technology fragmentation and interoperability limitations may further strain coordination efforts. Implementation of clear documentation standards, streamlined digital workflows, and collaboration across clinical and informatics teams help reduce inefficiencies and prevent duplication.

Finally, increased reliance on performance metrics can create data fatigue. Data must remain actionable and directly connected to patient-centered care planning. Structured feedback loops between leadership and frontline case managers ensure that performance monitoring strengthens practice rather than overwhelms it.

Anticipating these challenges and addressing them proactively allows organizations to operationalize ACCESS in a way that is sustainable, equitable, and aligned with professional case management standards of practice.

Policy and Practice Recommendations

The successful implementation of the ACCESS Model requires coordinated action from healthcare organizations, professional case managers, and policymakers. CMSA affirms that the advancement of technology-enabled, equity-focused care must be supported by intentional policy alignment, workforce investment, and infrastructure development. The following recommendations outline strategic actions necessary to ensure that ACCESS achieves its intended impact while reinforcing the central role of professional case management.

Recommendations for Policymakers and CMS

Policymakers and CMS should prioritize national efforts to support HIT standardization and interoperability across care settings, including acute, ambulatory, behavioral health, and community-based systems. Standardization reduces fragmentation, enhances continuity, and ensures that digital infrastructure meaningfully supports coordinated care.

Federal and state initiatives should continue to fund and expand digital equity programs that address broadband access, device affordability, accessibility accommodations, and technology literacy for Medicare beneficiaries. Digital access is a prerequisite for effective participation in ACCESS and must be treated as a structural determinant of health.

Evaluation frameworks for ACCESS and future CMS Innovation Center models should explicitly incorporate case management–specific metrics that recognize the coordinating and integrative functions of professional case managers. Measurement domains should reflect care planning, barrier mitigation, engagement support, and interdisciplinary coordination to accurately capture case management contributions.

Finally, future payment models should align reimbursement structures with the essential role of case management in digital, equity-focused care delivery. Sustainable funding mechanisms that recognize proactive coordination, technology integration, and population health management will ensure that ACCESS and similar models achieve lasting transformation.

Evaluation and Measurement Considerations

The ACCESS Model requires a comprehensive and multidimensional evaluation framework that links care coordination activities to measurable improvements in clinical outcomes, utilization patterns, patient experience, health equity, and overall value. Evaluation within ACCESS must extend beyond traditional cost and utilization indicators to incorporate whole-person, technology-enabled, and equity-driven measures.

Clinical outcome measures aligned with ACCESS priorities are essential indicators of success. These measures reflect the ACCESS emphasis on early identification, proactive intervention, and continuous monitoring supported by coordinated care and digital tools.

Utilization measures remain important indicators of cost impact and system performance within ACCESS. These utilization metrics must be interpreted in conjunction with clinical outcomes to demonstrate the integrated impact of technology-enabled and equity-focused care delivery.

Patient experience and engagement are equally critical domains of evaluation. Metrics such as patient activation levels, self-management, telehealth attendance, portal utilization, and adherence to remote monitoring protocols help determine whether care coordination efforts are truly engaging patients in their own health management.

ACCESS relies heavily on digital infrastructure, evaluation and must also include HIT-related process measures that assess both adoption and effectiveness. These process measures help determine whether technology is being integrated equitably and effectively into care coordination workflows.

Equity considerations must be embedded across all measurement domains. Outcome, utilization, experience, and process measures should be stratified by race, ethnicity, language, disability status, geography, and digital access variables to assess whether improvements are distributed equitably.

Evaluation under ACCESS must be multidimensional, integrating clinical outcomes, utilization patterns, patient engagement, digital process measures, and case manager–specific contributions. A comprehensive evaluation framework demonstrates accountability, validates the measurable value of care coordination, and reinforces the essential need in advancing coordinated, technology-enabled, and equitable healthcare delivery.

ACCESS Evaluation & Measurement Considerations Grid

Measurement Domain	Focus of Evaluation	Key Measures / Indicators	Interpretation Within ACCESS
Care Coordination Value (Case Management Contribution)	Impact of care coordination on outcomes and system performance	• Care plan completion • Interdisciplinary collaboration • Barrier resolution • Timeliness of coordination • Avoided utilization	Demonstrates accountability and validates the measurable value of case management within ACCESS
Clinical Outcomes	Patient health status and effectiveness of coordinated care interventions	• Disease control measures (e.g., A1c, BP) • Readmissions • Complications • Functional status	Reflects early identification, proactive intervention, and continuous monitoring supported by coordinated, technology-enabled care
Digital Health (HIT) Process Measures	Adoption and effectiveness of technology in care coordination workflows	• Telehealth utilization rates • Remote monitoring use • Data exchange and interoperability • Workflow integration • Documentation completeness	Assesses whether digital tools are effectively and equitably embedded into care delivery processes
Equity & Disparities (Cross-Cutting)	Distribution of outcomes and access across populations	• Stratified outcomes by race, ethnicity, language • Disability and geographic variation • Digital access disparities • SDOH-related barriers	Ensures equitable distribution of improvements and identifies gaps requiring targeted intervention

Measurement Domain	Focus of Evaluation	Key Measures / Indicators	Interpretation Within ACCESS
Patient Experience & Engagement	Patient activation, participation, and satisfaction in care	• Patient activation levels • Self-management behaviors • Telehealth attendance • Portal utilization • Remote monitoring adherence	Indicates whether patients are meaningfully engaged in managing their health through coordinated and digital care strategies
Utilization Patterns	Healthcare resource use and system efficiency	• ED visits • Hospitalizations • Length of stay (LOS) • Avoidable utilization	Must be interpreted alongside clinical outcomes to demonstrate true value and impact of care coordination

Conclusion

Chronic disease remains a major cause of morbidity, mortality, and healthcare costs, necessitating a fundamental shift in care delivery. Fragmented, episodic approaches are inadequate for the complex, longitudinal needs of Medicare beneficiaries with multiple chronic conditions. The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model offers a structured framework that prioritizes proactive intervention, interdisciplinary coordination, technology-enabled care, and accountability for outcomes. As healthcare systems continue to shift toward value-based and equity-focused models, ACCESS provides a scalable pathway to improve individual and population health outcomes, while addressing inefficiencies.

Professional case management is integral to success of the ACCESS Model. Case managers integrate medical, behavioral, and social care, facilitate interdisciplinary communication, and ensure patient-centered care. Their ability to synthesize clinical information, data, and patient-reported outcomes into actionable care plans is crucial for measurable improvements in quality, cost, and patient experience. Case management is not simply a support function, but a foundational component of effective chronic care delivery.

Technology enhances ACCESS by expanding care reach and timeliness through remote monitoring, predictive analytics, and virtual engagement. However, intentional implementation and oversight are crucial. Technology complements rather than replaces the clinical judgment, critical thinking, and relational engagement endemic to case management practice. Case managers bridge digital innovation and patient care, ensuring technology is clinically appropriate, ethically grounded, and aligned with patient goals.

Equity is central to ACCESS's success. While technology can reduce barriers, it also exacerbates disparities if digital literacy, connectivity, language, and socioeconomic factors are not thoughtfully considered. Case managers identify and address these barriers, advocate for patients, and connect individuals to resources for equitable participation in care. Advancing digital equity is a clinical and structural priority within ACCESS and future care delivery models.

Successful implementation of ACCESS depends on workforce readiness and organizational alignment. Healthcare professionals must develop competencies in digital health, data interpretation, interdisciplinary collaboration, behavioral health integration, and equity-informed practice. Organizations must support these competencies through targeted training, appropriate staffing, leadership engagement, and investment in interoperable technology infrastructure. The promises of ACCESS will be in jeopardy without these further actions to leverage workforce sustainability and model effectiveness.

Successful population health mandates comprehensive evaluation frameworks that capture the full value of care coordination.[52] Traditional metrics focused on utilization or cost are insufficient to reflect case management's multidimensional impact.[53] This evaluation must include clinical outcomes, patient experience, engagement, equity, and technology-enabled process measures. There must also be recognition of case management's distinct contributions to this charge. Data must be actionable, transparent, and linked to continuous quality improvement.

As policymakers and healthcare leaders implement ACCESS and similar value-based models, they must also ensure reimbursement structures, regulatory frameworks, and national initiatives embed case management. There must be an equal commitment to invest in digital infrastructure, expand equitable access to technology, and include case management-specific metrics in evaluation design. Professional case managers must be key decision-makers in model design, implementation, and policy development.

The ACCESS Model envisions a coordinated, patient-centered, and equitable healthcare system; one that is proactive, continuous, and driven by outcomes. This vision will be realized by intentionally integrating professional case management as the mechanism for translating innovations into practice. Otherwise, healthcare systems will be unable to achieve the meaningful, measurable, and sustainable improvements in outcomes, experience, and equity that they strive to attain.

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