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ARTICLE

OPERATIONALIZING THE ACCESS MODEL: MANAGING THE 50% RECONCILIATION RISK

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EXECUTIVE SUMMARY: THE TRANSITION TO REAL-RISK CHRONIC CARE

The launch of the Centers for Medicare & Medicaid Services (CMS) **Advancing Chronic Care with Effective, Scalable Solutions (ACCESS)** model in July 2026 introduces a fundamental shift in the financial risk profile of outpatient chronic care. While previous Value-Based Care (VBC) initiatives often functioned as "upside-only" or marginal shared-savings programs, ACCESS utilizes a aggressive **Outcome-Aligned Payment (OAP)** structure where 50% of the total revenue is withheld pending clinical performance reconciliation. For Physician Management Organizations (PMOs) and Management Service Organizations (MSOs), the success of the model depends on the ability to operationalize real-time clinical oversight. Managing the 50% reconciliation risk requires moving beyond retrospective claims analysis toward a proactive "ground truth" data strategy that ensures every patient remains on the path toward their specific outcome target.

THE OAP ARCHITECTURE: UPFRONT CAPITAL VS. PERFORMANCE WITHHOLDS

The financial mechanics of the ACCESS model are designed to provide the upfront liquidity necessary for technology adoption while maintaining strict accountability for results.

The Two-Tiered Payment Structure

- **Prospective Payments:** CMS provides a portion of the OAP prospectively each quarter. This upfront capital is intended to fund the "tech-stack"— remote monitoring devices, digital therapeutics, and specialized care coordinators—required to manage patients between traditional encounters.

- **The 50% Performance Withhold:** Half of the total OAP is held in escrow by CMS. This revenue is only released during the reconciliation period if the participant demonstrates that their patient panel has met or exceeded a predefined clinical threshold.

For a practice managing high-acuity Cardio-Kidney-Metabolic (CKM) or Musculoskeletal (MSK) populations, this 50% withhold represents the difference between significant operating margins and a catastrophic loss of revenue.

DECIPHERING THE THRESHOLD: OAT VS. OAR

The release of the withheld funds is governed by a binary performance standard: the Outcome Attainment Threshold (OAT).

- **Outcome Attainment Rate (OAR):** This is the percentage of a participant's aligned beneficiaries who complete the care period and meet all required clinical targets relative to their unique baseline.
- **The Performance Mandate:** For the 2026 performance year, CMS has set the OAT at 50%.
- **The "All-or-Nothing" Gradient:** To earn the full OAP, a participant's OAR must be equal to or higher than the 50% OAT. If the OAR falls below this threshold, the organization risks losing the entire 50% withhold, creating a "cliff" effect that does not exist in traditional shared-savings models.

THE "SUBSTITUTE SPEND" ADJUSTMENT: THE HIDDEN REVENUE LEAK

Beyond clinical outcomes, ACCESS participants are held accountable for "Substitute Spend"— the volume of services a patient receives from *other* Medicare providers for the same condition during the ACCESS care period.

- **The Leakage Penalty:** If a high percentage of a participant's patients seek "substitute" services elsewhere — such as unnecessary ER visits for hypertension or uncoordinated physical therapy for MSK pain — CMS applies a downward adjustment to the OAP.
- **The Coordination Mandate:** This adjustment serves as a financial penalty for care fragmentation. Success requires the participant to be the "primary" owner of the patient's condition, ensuring that all interventions are coordinated within their engineered pathway.

OPERATIONAL READINESS: DATA INTEGRITY AS A FINANCIAL CONTROL

Managing a 50% revenue risk is impossible using legacy EHR systems designed for billing rather than real-time clinical guidance. Operationalizing ACCESS requires three specific "financial controls" embedded in the clinical workflow:

Veracity-Driven Baselines

Reconciliation starts with the baseline. Under the Veracity Mandate, participants must collect high-fidelity baseline measures—such as 24-hour ambulatory blood pressure or validated functional scores—that are audit-ready. An inaccurate baseline (too high or too low) can make an outcome target mathematically impossible to hit, ensuring a reconciliation failure before the care period even begins.

Real-Time Variance Detection

In a 12-month care period, an organization cannot wait for retrospective reports to see who is "failing."

- **The Clinical Control Loop:** Technology must flag "variance"— patients whose biomarkers or functional scores are trending away from the target.

- **Automated Remediation:** Once variance is detected, the system must trigger a remedial action (e.g., medication adjustment, telehealth consult, or behavioral intervention) within days, not months.

Interoperable Defense

ACCESS participants are required to share electronic updates with primary care and referring providers via FHIR®-based APIs or Health Information Exchanges (HIEs).
This interoperability is not just a compliance checkbox; it is a defensive measure. By proving that care is being coordinated, the participant protects themselves against the "Substitute Spend" adjustment.

THE CEO/CFO PERSPECTIVE: RISK MITIGATION STRATEGIES

Executive leadership must treat the 50% withhold as a core business risk, rather than a clinical metric.

- **Risk-Adjusted Enrollment:** Use predictive analytics to identify beneficiaries whose starting points offer the highest probability of clinical improvement. While ACCESS is inclusive, managing the OAT requires a strategic understanding of panel composition.
- **Clinical Director Accountability:** The model requires a designated physician Clinical Director responsible for care quality and compliance. This role should be incentivized based on the OAR performance, aligning clinical leadership with the 50% reconciliation goal.
- **Capital Reserves for Withholds:** Organizations should maintain financial reserves to tolerate the initial cash-flow impact of the withholds, especially in Year 1 as clinical protocols are refined.
- **Leverage Co-Management Payments:** To minimize "Substitute Spend," participants should actively encourage PCPs to bill the new ~$30 co-management code for reviewing ACCESS updates. This incentivizes the PCP to keep care within the participant's ecosystem.

CONCLUSION

The 2026 ACCESS model represents the final transition of the medical practice from a "service-for-fee" business to a "performance-for-outcome" enterprise. While the 50% reconciliation risk is substantial, it is manageable for organizations that replace administrative proxies with proven medical accuracy. By operationalizing real-time variance detection and rigorous baseline integrity, healthcare executives can secure their revenue, reduce "Substitute Spend" leakage, and thrive in an environment where clinical results are the only currency that matters.

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