Access, OAPs, and the Illusion of Easy Money: A Strategic Guide for Health Tech Investors and Operators

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Abstract

This essay examines the CMS Advancing Chronic Care with Effective, Scalable Solutions model and its Outcome Aligned Payment rates through an investor and operator lens.

Key points:

1. Breakdown of annual allowed amounts across eCKM ($360/$180), CKM ($420/ MSK ($180), and BH ($180/$90) tracks and the implications of the 50% withhold structure.

2. Analysis of Clinical Outcome Adjustment and Substitute Spend Adjustment mechanics and their capital intensity implications.

3. Detailed review of measure validity windows, baseline requirements, and FHI based reporting infrastructure demands.

4. Strategic positioning guidance for founders and investors considering particip enablement, or infrastructure plays around the model.

5. Discussion of multi-payer alignment and how technical requirements reshape product architecture and underwriting risk.

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The Payment Is Small, the Risk Is Not

The headline numbers look modest enough to dismiss. Three hundred sixty doll early cardio kidney metabolic in the initial period. Four hundred twenty for full cardio kidney metabolic. One hundred eighty for musculoskeletal. One hundred eighty for behavioral health with a follow on at ninety. Those are annual allowed amounts per beneficiary, inclusive of Medicare and coinsurance. At first glance t feels like rounding error against total cost of care in any of these populations.

That reaction is precisely where the trap sit

These payments are not fee for service add ons. They are recurring payments tie explicitly to outcome attainment and subject to both a clinical outcome adjustm

and a substitute spend adjustment. Monthly disbursement equals one twelfth of Medicare portion, but only half of the annual Medicare payment is released prospectively. The other half is withheld and reconciled after the twelve month c period. That single detail changes the entire underwriting logic.

In other words, ACCESS is a small capitation with a delayed earn out. The real n is not in the three hundred sixty dollars. It is in whether an organization can consistently clear the fifty percent outcome attainment threshold while avoiding substitute spend leakage that drags down the reconciled amount. Capital allocat need to stop thinking about this as a new revenue line. It is a risk bearing micro contract with embedded data and compliance obligations that most operators ar ready for.

Table 1: Annual Payment Allowed Amounts by Track

Clinical Track	Initial Period	Follow-On Period
Early Cardio-Kidney-Metabolic (eCKM)	$360	$180
Cardio-Kidney-Metabolic (CKM)	$420	$210
Musculoskeletal (MSK)	$180	N/A - No Follow-On Period
Behavioral Health (BH)	$180	$90

Understanding the Outcome Aligned Payment Mechanics

Outcome Aligned Payments are structured around initial and follow on periods. Initial reflects higher resource intensity. Follow on is lower, recognizing that bas control may already be achieved. For eCKM the drop is from three hundred sixty one hundred eighty. For CKM it is four hundred twenty to two hundred ten. Behavioral health halves from one hundred eighty to ninety. Musculoskeletal has follow on period at all.

This tiering alone creates a non trivial intake triage problem. Participants qualif initial period payment when it is the first time treating the beneficiary in that tr within two years and at least one required measure is not at target. That languag forces careful intake screening. A beneficiary already at control for all required

measures is economically unattractive in the initial period. Conversely, someone from control carries outcome risk but unlocks higher initial payment. Good luck designing care team incentives around that tension without accidentally enginee adverse selection into your panel.

Monthly payment cadence has improved versus the original quarterly concept fr version one of the request for applications. That helps working capital meaningf But the fifty percent withhold remains the real capital constraint. A growth stag operator enrolling ten thousand CKM beneficiaries in the initial period effective front loads only about one hundred sixty eight dollars per member per year in Medicare cash flow, with the rest contingent on year end reconciliation. Scale th fifty thousand members and the withhold receivable becomes a material balance item with clinical performance covenants attached. Investors modeling this need treat the reconciled fifty percent as a receivable, not as guaranteed revenue.

Clinical Outcome Adjustment and the Fifty Percent Threshold

The outcome attainment threshold is set at fifty percent for the effective period, meaning at least half of aligned beneficiaries must complete the care period and all required measure targets to earn full payment. Partial attainment does not cc Miss one required measure and the beneficiary is non attainment for the full car period. No partial credit, no rounding up.

In eCKM and CKM, required measures include blood pressure, weight and BMI condition specific HbA1c or LDL components depending on diagnosis. Blood pressure must be below one hundred thirty systolic or show a fifteen millimeter reduction. HbA1c control thresholds differ for prediabetes versus diabetes. For prediabetes in eCKM the control target is below six point five percent. For diabe CKM it is below seven point five with a one point minimum improvement thresh LDL targets vary and tighten considerably for atherosclerotic cardiovascular dis where the bar drops to below seventy milligrams per deciliter versus the standar hundred.

Consider the combinatorics on a high complexity patient. A CKM beneficiary wi diabetes, dyslipidemia, and ASCVD must simultaneously hit blood pressure con reduction, weight criteria, HbA1c below seven point five or a one point reductio LDL below seventy or a thirty milligram reduction. Failure on any single require measure negates attainment for that beneficiary for the full care period. At a fift percent OAT an organization can tolerate some misses across the population, bu law of large numbers will punish sloppy care coordination, especially in the high acuity segments.

For investors the question becomes actuarial before it becomes clinical. What is baseline distribution of these measures in the enrolled population and what is th historical conversion rate under similar interventions? If starting systolic blood pressure median sits at one hundred fifty eight with a standard deviation of fifte fifteen millimeter drop is achievable with guideline directed therapy at meaning scale. If baseline HbA1c clusters around eight point eight, a one point drop is plausible with GLP-1 adoption or basic intensification. But if a large share of incoming patients already have LDL below eighty five, control targets may alrea met and minimum improvement is not applicable. The nuance matters enormou when building a pro forma that holds water.

Substitute Spend and the Shadow P an L

The substitute spend adjustment is the more subtle lever and the one most oper will underestimate in year one. Payments get reduced when aligned beneficiaries receive defined substitute services from other Medicare providers above a ninety percent threshold during the care period. The service list varies by track. For behavioral health the updated code list includes psychiatric diagnostic evaluatio remote therapeutic monitoring device setup, and initial psychiatric collaborative management. The intent is obvious. CMS does not want to pay an OAP to an AC participant while also paying full freight to external providers delivering functio equivalent services for the same diagnosis.

From an operator perspective this creates a shadow profit and loss tied entirely t leakage. If a beneficiary drifts to an outside psychiatric diagnostic evaluation coc under the principal ACCESS diagnosis, that spend counts toward the substitute calculation and may reduce the OAP at reconciliation. The ninety percent thresh provides some buffer but high volume participants with loose referral networks find this adjustment painful when the year end math lands.

Modeling substitute spend exposure requires granular claims analytics that mos delivery startups simply do not have at launch. It is not enough to deliver outcor One must manage referral pathways, patient engagement, and network design tc reduce outside utilization for substitute service categories. That is a non trivial operating requirement. It pushes participants structurally toward vertically inte or tightly networked care models. A loosely affiliated independent practice association attempting ACCESS participation will have almost no ability to man leakage and will consistently be surprised at reconciliation time.

The compliance dimension compounds this. Marketing and outreach are permit but must comply with the anti kickback statute and the physician self referral la Participants who attempt to manage leakage through financial arrangements wit referral sources will have a bad time. The operational solution is engagement an network design, not financial incentives.

Measure Engineering and Data Plumbi

The measure validity windows read like an informatics exam designed to punish people who skim footnotes. Blood pressure valid up to fifteen days from collecti submission. Weight and BMI also fifteen days. HbA1c up to one year for benefic with diabetes or prediabetes and two years for all others. LDL similar with a one two year split depending on dyslipidemia diagnosis. Estimated glomerular filtrat rate and urine albumin to creatinine ratio required for diabetes and CKD beneficiaries at baseline, each with one year validity. All patient reported outcon measures require collection within fifteen days of submission.

Baseline measures must be submitted within sixty days of alignment via a FHIR API, the specifications for which CMS indicates will be released before model la Miss that window and the beneficiary is unaligned, meaning the ACCESS partici cannot provide services under the model. Quarterly reporting windows sit seven one hundred ten days after the prior submission, a forty day target window that sounds generous until a care team is managing thousands of patients across mul chronic conditions simultaneously. End of period measures are due within four hundred twenty five days from alignment, with early success reporting permitte to ninety days before day three sixty five for eCKM and CKM, or up to one hund eighty days early for behavioral health and musculoskeletal.

Early success reporting deserves specific attention. If a participant submits final measures before day three sixty five, they can continue submitting monthly ACC claims for the remainder of the twelve months provided they continue deliverin active care. Worsening of measures after early success does not negate earlier attainment. CMS will use those values for monitoring but not for payment adjustment. That creates an asymmetric payoff structure. There is real value in h targets early when clinically appropriate, locking in attainment while maintainir billing for the remainder of the care period.

For investors the data plumbing is where the genuine venture scale opportunity participant needs near real time data ingestion, validation, and submission pipel Automated reminders tied to validity window expiration. Structured lab data flo from health information exchanges, since external sources are explicitly permitt most clinical measures provided collection date and methodology standards are PROMIS CAT instrument administration, which requires HealthMeasures elect administration permission for digital platform integration. All of it auditable, b CMS will be monitoring and publicly reporting risk adjusted outcomes. The pic shovels business is more interesting than the clinical delivery business here.

Track Level Economics: eCKM and CKM

Cardio kidney metabolic tracks represent the largest potential volume given population prevalence. Hypertension, diabetes, dyslipidemia, and chronic kidney disease describe a massive share of the Medicare beneficiary pool. Yet the OAP amounts are modest relative to total cost of care in these populations. Four hundred twenty dollars annual allowed for CKM initial period equates to roughly thirty five dollars per member per month gross before the withhold. With fifty percent withheld pending reconciliation, cash in hand is about seventeen dollars per member per month from the Medicare portion before any coinsurance collection. That is a thin number to build a standalone business on.

To justify participation an operator must either leverage existing infrastructure at near zero marginal cost or operate at scale sufficient to amortize compliance and reporting overhead across a large enough panel. Remote monitoring devices are permitted and useful for blood pressure and weight tracking, but they are billed separately and not bundled into the OAP. CMS provides a fifteen dollar fixed rural supplement for eCKM and CKM initial period beneficiaries to offset connected device distribution costs. That payment barely covers shipping a blood pressure cuff, which gives a useful signal about how thin the overall margin architecture is intended to be.

The clinical targets are not revolutionary. Blood pressure below one hundred thirty, LDL below one hundred or seventy depending on ASCVD status. HbA1c below seven point five. Weight reduction of five percent or BMI below thirty. These are standard guideline directed targets that any nephrology or endocrinology practice pursuing quality improvement is already chasing. The model is not paying for novel protocols. It is paying for documented improvement tied to specific attribution and reporting structures.

The stacking question is where the economics start to make sense. If the same beneficiary cohort sits under a Medicare Advantage value based care arrangement, the OAP becomes additive incremental revenue with substantial overlap in care management activities. The monitoring, lab ordering, medication titration, and patient engagement already happening under the MA contract generate much of the data needed for ACCESS reporting. That stacking logic is where the unit economics

work. As a standalone revenue line in traditional fee for service, it probably does pencil without very low marginal cost infrastructure already in place.

Track Level Economics: Behavioral Hea

Behavioral health at one hundred eighty dollars initial and ninety follow on is ev thinner than the metabolic tracks, but the measure design is somewhat more tra for a digital model. PHQ nine and GAD seven thresholds are administratively si to collect and score. A five point reduction in PHQ nine for beneficiaries with a baseline score of ten or higher. A four point reduction in GAD seven for anxiety beneficiaries with a baseline of ten or above. Patient global impression of chang required at end of period as a submission only measure, meaning the act of subn itself constitutes attainment. Optional WHODAS 2.0 twelve item for functional assessment, flagged as potentially informing a future OAP measure.

The eligibility constraint is worth internalizing carefully. Beneficiaries scoring b ten on both PHQ nine and GAD seven at baseline are not eligible for the initial on the basis of those conditions alone. They can qualify for the follow on period directly if referred by a provider with a documented history of depression in the eighteen months. That means the mildly symptomatic population, which is gene the easiest to engage digitally, is not available for initial period payments. The h acuity patients who unlock the higher payment tier are harder to engage, more l to disengage before completing the care period, and more likely to seek outside services that count toward the substitute spend adjustment.

Since beneficiaries lost to follow up remain in the denominator for outcome attainment, churn directly threatens the fifty percent threshold. A digital behavi health startup may be tempted to position around this track. The math suggests caution. If cost to acquire and engage a Medicare beneficiary exceeds the annual allowed amount, the model collapses immediately. The only defensible strategy i embed within existing primary care or integrated delivery systems where patient acquisition cost is effectively zero and incremental cost to administer and score nine and GAD seven is marginal.

Track Level Economics: Musculoskeleta

Musculoskeletal offers one hundred eighty dollars annual with no follow on peri
Required measures are PROM heavy across anatomical site specific instruments.
PROMIS physical function and pain interference with two point T score improv
thresholds applicable to any or multiple sites of pain. Or site specific instrumen
lower back using the Oswestry Disability Index with an eight point reduction ta
on a one hundred point scale. Neck using the Neck Disability Index with eight p
on a fifty point scale. Shoulder, arm, and hand using the QuickDASH with a ten
reduction on one hundred points. Knee and hip using KOOS JR and HOOS JR
respectively with ten point increases on their converted interval scales. Numeric
rating scale additionally required for all MSK beneficiaries, with an allowable cc
target of no more than a two point increase, meaning pain cannot meaningfully
worsen.

The absence of control targets and exclusive focus on minimum improvement re
the episodic orientation of MSK care. The model's design here is explicitly abou
functional restoration within a single twelve month period rather than long term
maintenance. An eight point ODI reduction over twelve months is achievable wi
conservative therapy including physical therapy, exercise programming, and coa
But the payment is small relative to even a modest therapy cost structure.

This track may suit digital MSK platforms that already operate at low marginal c
through asynchronous coaching and remote exercise prescription. The OAP bec
incremental revenue tied to documented PROM improvement in an existing mer
base. The quarterly reporting and validity windows add overhead, and PROMIS
administration requires licensing and technical integration through HealthMeas
But if the infrastructure already exists for a self insured employer book of busin
Medicare adaptation may be mostly a billing and API exercise.

Operational Friction: Reporting Windo
and API Reality

Baseline reporting within sixty days or the beneficiary is unaligned. Quarterly submissions within a narrow forty day window. End of period by four hundred t five days. These are not suggestions. They are hard gating criteria for payment a continued billing eligibility.

In practice this means a participant must build or buy a robust population regis with automated outreach, validity window tracking, and data validation logic ru continuously across the enrolled panel. For blood pressure and weight the fiftee validity window implies either in clinic measurement or reliable connected devi integration with verified data provenance. Self reported values are generally not permitted except for weight and patient reported outcome measures. That const eliminates the idea of casual patient entered data as a compliance pathway witho verification infrastructure behind it.

The FHIR API specifications are forthcoming before launch, which is worth not for anyone doing build versus buy planning right now. The reporting architectu designed for bidirectional data flow, with CMS also intending to deliver data ba payers under the multi payer alignment framework. That creates an interesting infrastructure dependency. Whoever controls the FHIR reporting layer for a participant gains visibility into population level outcomes data that has downstr value well beyond the ACCESS model itself.

From a venture perspective, companies that underestimate this plumbing will bu cash at the intersection of clinical operations and regulatory compliance in a wa is particularly hard to recover from. The regulatory overhead is closer to a mana care organization than a lightweight digital health app. CMS will publicly repor adjusted outcomes for ACCESS participants. Reputational risk compounds finar risk in a public directory context. Getting the data infrastructure wrong is not ju compliance problem. It is a market positioning problem.

Multi Track Discount and Portfolio Strategy

When a beneficiary aligns to multiple tracks with the same participant, CMS ap five percent discount to the lowest cost track during overlap months. For three t with the same participant during any overlapping period, the discount applies t two lowest cost tracks. The multi track discount does not apply to beneficiary coinsurance responsibility and does not apply when a beneficiary is aligned to different tracks with different participants.

This creates an interesting portfolio strategy question for integrated platforms. vertically integrated operator covering CKM and MSK simultaneously may see marginal revenue erosion of five percent on the MSK portion for overlapping pa However, operational synergies in care coordination, data infrastructure, and pa engagement almost certainly exceed five percent. The real calculus is whether managing multiple tracks increases outcome risk through clinical complexity on same panel rather than whether the discount erodes revenue materially.

A focused single track specialist might avoid the discount entirely but forfeits c sell opportunity and loses the operational leverage that comes from managing re conditions together. For investors the portfolio strategy question is whether to b single vertical point solutions optimized for one track or integrated platforms spanning multiple. The five percent discount is not the deciding factor. The integration burden, compliance overhead, and outcome risk management across multiple condition categories is the deciding factor.

The multi payer alignment framework adds a layer to this calculus. CMS is maki available standardized G codes usable by any payer, a FHIR based reporting API payers can instruct providers to use for their own payment determinations, and provider agreement templates with payment adjustment code calculations. That means the infrastructure built for ACCESS compliance may have direct commer extensibility into Medicare Advantage, Medicaid, and commercial payer contrac align on the same measure framework. That extensibility changes the return on investment calculation for the infrastructure investment considerably.

Who Should Play and Who Should Run

Participants with existing Medicare populations, embedded care teams, and rob data infrastructure should consider playing. The incremental revenue while mod can support quality improvement investments, generate valuable population leve outcomes data, and position the organization favorably for future value based co expansions with CMS and commercial payers aligned to the ACCESS framework

Startups built solely around ACCESS revenue should run. The allowed amounts too small to support standalone patient acquisition and care delivery. The fifty p withhold strains early stage cash flow in ways that can be existential. Substitute and outcome thresholds add volatility to the revenue line that is hard to model i seed or series A context. This is not easy money and it is not the right primary re model for a growth stage company with a long cash runway requirement.

Infrastructure plays are a different story entirely. FHIR reporting layers, PROM administration tooling, analytics engines modeling outcome attainment probabil the individual patient level in real time, leakage detection systems for substitute spend, population registry platforms with validity window automation. These ar scalable across participants and potentially across payers given the explicit mult payer alignment design. That is where venture scale lives in this model. Not in running a thin margin CKM clinic but in selling the compliance and analytics infrastructure that allows participants to run their clinic without drowning in reporting overhead.

The economics of the enablement play are structurally better. A software platfor charging participants a per member per month fee for ACCESS compliance tool that is small relative to the OAP revenue it enables, while operating at software g margins, is a far more interesting investment than a care delivery organization operating on seventeen dollars per member per month in prospective cash flow v year end outcome risk attached.

Closing Thoughts on Positioning Inside the Innovation Program

Innovation programs often get misread as grant like revenue. ACCESS is not tha a tightly specified micro risk contract with small payments, heavy data requirem and meaningful clinical accountability. The outcome targets are clinically sensib evidence based. The reporting requirements are exacting and operationally demanding. The economics reward scale and integration, not scrappy standalone with a new billing code attached.

For health tech investors and entrepreneurs the strategic posture should be clea eyed. Participate if there is already control of the patient population and the ma cost of compliance is genuinely low. Build tooling that makes compliance trivial others and price it at a fraction of the OAP value it enables. Avoid building a bu whose only revenue line is three hundred sixty dollars a year contingent on hitti blood pressure target on fifty percent of a Medicare panel.

There is real opportunity here, but it sits in the boring parts. Data validation. A orchestration. Claims leakage analytics. Population level outcome forecasting. V window management at scale. The glamour of clinical innovation is mostly abse The grind of operational excellence is entirely front and center. In Medicare valu based models, that is almost always where the durable value eventually hides.

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