Can ACOs Survive the Complicated New Landscape in Medicare Risk?

written by Theresa Hush | July 25, 2019

What a difference a year makes. In Spring 2018, many Accountable Care Organizations (ACOs) pondered a walkout over Medicare plans that included downside risk in ACO financials. Nonetheless, CMS finalized its plans to make provider risk a reality for all ACOs in its Pathways to Success overhaul of the Medicare Shared Savings Program (MSSP).

ACOs' lukewarm reception to the goal of compelled savings, however, was not forgotten. Fast forward to April 2019, when CMS announced five Primary Care Models to propel physician groups to adopt risk-based reimbursement directly—including capitation. Those models are now under fast-paced implementation, with application deadlines approaching.

CMS is determined to impose cost caps and hold providers at risk. We are not surprised. Long before Department of Health and Human Services Secretary Alex Azar revealed this week that it had plans to boost Medicare Advantage (MA) plans, we predicted that CMS would deploy a multi-prong strategy, including direct contracting with physician groups and expansion of Medicare Advantage. Why? Providers were moving too slow with risk-based models, avoiding participation in ACOs, or choosing the lowest risk path in ACOs as well as other risk initiatives,

like Bundled Payments for Care Improvement (BPCI). In addition, ACOs had limited success at achieving savings and an aversion to risk.

More careful with words this year, ACO representatives are writing letters to CMS supporting the Primary Care Models and making helpful suggestions for mitigating the overlap. Yet behind the scenes they seem puzzled. Why is there a frenzy to create overlapping models, all of which put providers at risk?

Risk Models Overlap by Design

Let's put one issue to rest. CMS did not underestimate the competition between the models of ACOs and primary care for winning provider participation in their communities. The agency also did not forget to address overlap of features that may cause ACOs problems in recruitment of physicians who may be more interested in dealing with Medicare risk independently through a Primary Care Model, or confusion in the market among providers and patients.

The overlap benefits CMS. How? First, the message to providers shows the absolute certainty of risk-based reimbursement and the death of Fee-for-Service. That clear message speeds up the transition and lowers resistance. Second, the overlaps force an election among providers to choose their best options for risk, without CMS having to mandate a program. There is no doubt that a period of competition will effectively demonstrate how providers prefer to participate in risk, and which model will be most successful financially for Medicare. As someone who also tried many big changes in health care via government, I have to acknowledge that the strategy is brilliantly conceived to meet the administration's goals.

CMS has also carefully paired its financial initiatives with policy goals. The Medicare Advantage boost is not only a payment hike, but a "strategy to tackle maternal mortality rates, social determinants of health and rural healthcare access." Primary care models "will reduce administrative burdens and empower primary care providers to spend more time caring for patients." Whether the policy goals can be achieved by payment models alone can be debated. But the message seems to be working.

Will Downside Risk Kill the ACO Golden Goose—and Why Does it Matter?

ACOs were conceived as the solution to Value-Based Health Care. But they proved hard and expensive to establish, and more difficult, still, to succeed. Small physician-run ACOs have achieved better savings, yet have a higher drop-out rate, a clear demonstration of the conflicting organizational and financial issues involved in risk, especially for lower income

organizations.

Despite the success of small physician-run ACOs, however, ACOs are so varied in structure, participation, and goals that there is no sure model of success. Some larger organizations have achieved savings. And it is possible that larger ACOs with a genuine interest in care redesign and coordination simply require more time to change cost trends, align providers effectively, and better collect and use data and technology required to improve patient care. A premature push to risk may lead some ACOs that could be successful to fold the tent rather than risk financial failure.

CMS actions put higher emphasis on capping costs through risk than on a long-term fostering of the ACO concept. Perhaps the desire to move quickly away from Fee-for-Service outweighs the perceived benefit of an ACO model of care delivery. Or, that the ACO program is too complicated and too varied to prove manageable. Government may see no advantage in fostering better efficiencies through provider-led delivery systems, and may see Medicare as health care insurance. Whether the design of health care delivery is established by payers or providers may be unimportant to decision-makers.

For now, there is a small group of 41 Next Generation ACOs that form the core of providers that are willing to accept downside risk. If that number dwindles, or if MSSP ACOs fail to mature into successful risk-bearing organizations, CMS patience will certainly diminish. No doubt the realization of an uncertain future has compelled ACOs to request that Next Generation ACOs be deemed a permanent model—a request to which CMS has not yet responded.

ACO Model Survival Depends on Being Equal to or Better than Medicare Advantage

Considering that ACOs and other models compete for the same providers and patients, ACOs have a very difficult road ahead to define their advantages to either group.

Direct Contracting and Next Generation ACO offer similar perks to providers, including extra benefits and services for patients who align with providers. The payment and savings reconciliation under each model are substantially different, with partial or global capitation in Direct Contracting and a more complicated All-Inclusive per beneficiary rate for Next Gen ACOs. However, these are technicalities and the manner in which revenues return (or not) to ACOs and Direct Contracting groups will not affect immediate sustainability.

In some geographic areas, ACOs and Direct Contracting or Primary Care First groups cannot co-exist. Low physician supply of primary care or specialty physicians will affect the ability of ACOs

to achieve effective physician coverage in such communities. In larger urban areas, we can expect a patchwork quilt of ACOs and DC practices. It may indeed be difficult for ACOs to recruit premier physician groups who could remain successfully independent under capitation.

But the key threat to ACO survival does not come from Direct Contracting or Primary Care First. While these models could impair ACO ability to form solid provider networks, such situations will most likely be rare.

What matters more is whether ACOs can achieve same or better results than Medicare Advantage plans. MA is the real competitor to ACOs. Concerns over selection bias that favor MA seem to have disappeared, and CMS is clearly pushing for expansion of MA. To call MA the privatization of Medicare would not be an overstatement, and it is a strategy that could appeal strongly to an anti-regulatory, fiscally conservative government.

The Strongest Strategy for ACOs to Compete: More Risk!

ACOs have tread cautiously toward adopting risk, but financial risk must be a "sink or swim" proposition. Without alignment of payment systems that encourage efficiency over volume, ACOs and their provider groups have trouble unraveling the incentives for productivity, admissions, and referrals of their physicians. Those incentives kill success under risk.

An ACO's best advantage is that its network and infrastructure can serve multiple purposes for a variety of payers. Then clinicians can be consistently focused on interventions and efficiencies for all patients, not just Medicare patients.

ACOs should build their capacities to negotiate commercial health plan contracts for risk-based reimbursement, if they aren't doing so already. They will require identified claims data to understand their per-member/per-month costs for covered patients as part of these negotiations, and to segment risk by patients and create interventions. Without claims data, ACOs are blind to the leakage from their systems and preventable costs. Participation agreements with physicians and hospitals should be flexible enough to permit narrow networks within the ACO for particular contracts, if warranted.

Financial risk can enable the development of pathways toward positive results, as well as predictable cost and outcomes to patients and payers. ACOs must be the engine of change rather than the administrative contracting entity.

Energy Is the Antidote to Noise and Distraction

The imperative for would-be and existing ACOs is to overcome a paralysis that can arise from noise and distraction. Until (and unless) CMS allays ACO concerns by managing the overlap of various risk models, coexisting risk arrangements—Primary Care Models, Medicare Advantage, ACOs—will be the norm. So, too, will be the permanency of ACOs, in general, and the Next Generation ACO. Uncertainty is the rule.

Many ACOs have been working to achieve goals, but most still lack the tools to predict risk and stem costs. The inability to better organize their networks through negotiated arrangements with physicians and hospitals is an issue that they need to overcome. Data, for many ACOs, is limited to CMS claims and does not include the risk factors necessary to help guide patient care plans. ACOs must raise the resources to fulfill these gaps.

ACOs have the possibility of fulfilling their promise, but they must seize the day.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: NRKbeta