

Beyond Payment Models: The ACO as a Hub for Patient Health

written by Theresa Hush | June 26, 2026



In our last four articles, we have focused on payment models and infrastructure to establish how ACOs can be central to Value-Based Care, even under specialty models. Now it's time to shift our focus back to what the payment models set out to do: improve patient health and rationalize costs.

We cannot lift up patient health and lower costs through independent payment models, each focused separately on cohorts of practitioners or patients. They are a means to an end.

Some entity must serve as the hub to organize the pieces into an integrated care system to effect better results for patients, and to link together patients, providers, services, and the outside world. CMS envisioned the ACO fulfilling functions in the specialty payment models and outlined its future vision for ACOs in LEAD. But what if ACOs become the hub, not only for managing patients in various payment models, but for health delivery across the spectrum?

The ACO Was Always About the Patient—Not the Payment Model

The ACO was always designed to be the hub of coordinated, accountable care for a defined population—responsible not just for what happens inside a hospital or a specialist's office, but for the health and total cost of care for each patient. That original vision is now more achievable—and more financially urgent—than ever before. We have spent years defining their mission, working out systems of accountability

and measurement of costs and quality. We have followed that with aggregation of data, initiatives, more payment models, and tweaks to those models. Peel back all the structure and here's what we get: the patients, their health, and how we influence daily choices that quietly determine whether they thrive or deteriorate

The Gap Between Visits Is Where Health Is Won or Lost

The average high-risk Medicare patient—the one with Type 2 diabetes, hypertension, and early-stage chronic kidney disease—sees their primary care physician four to six times a year. That leaves roughly 359 days when no one from the care team is actively present in that patient's health decisions. This is where chronic disease accelerates. Not in the exam room, but in the grocery store, the drive-through, the decision to skip a walk because the day got away from them.

Consider the CABG patient—the one with uncontrolled hypertension and a hemoglobin A1C of 8.2, heading into open-heart surgery with a comorbidity burden that will drive complications, slow recovery, and inflate episode costs. The clinical team will manage the surgery brilliantly. But who managed the A1C for the two years before the surgical referral? Who had the conversation about weight, about processed food, about the metabolic cascade that connects poor glycemic control to the cardiovascular disease that led to that OR table? In our system of health care today, the honest answer is no one, or no

one consistently.

The ACO that closes that gap—not just with care management check-in calls, but with structured, sustained engagement between visits—will see improvements in its outcomes and shared savings. The ACO that does not will keep managing the consequences of preventable deterioration, one expensive episode at a time.

A New Service Architecture: What the ACO Hub Can Offer Beyond Payment Model Basics

The good news is that the tools exist. The evidence base is strong. And the ACO—with its longitudinal patient relationships, population-level data, and financial alignment with outcomes—is the right organizer for all of it. Not everything will be viable for all ACOs; physician-based ACOs or those in rural areas may focus on one or two. Here is what an expanded ACO service architecture looks like:

1. Health Literacy as a Clinical Strategy

Many patients with Type 2 diabetes do not know that poorly controlled blood sugar is simultaneously damaging their kidneys, their eyes, and their cardiovascular system. The urgency of daily behavior change remains abstract and easy to defer. We know from psychological research that patients build

their behaviors not based on facts. Despite that, we also know that health literacy interventions work not by presenting facts in isolation, but by giving patients a coherent personal story that is connected with their own daily choices. It is correlated with improved patient risk and lower obesity, and with increasing positive changes in patients with metabolic disease. ACOs that invest in patient education as a clinical strategy, delivered through education, technology and digital micro-content, and group sessions organized around shared risk profiles, will see it in their outcomes.

2. Dedicated Obesity Prevention and Management Programs.

Obesity is a clinical condition with complex origins that sits at the root of an enormous share of ACO cost. ACO dedicated programs, such as group-based weight management cohorts, help patients make behavioral changes to lower risk. Simple, practical guidance matters: how to read a food label, how to take small steps like swapping processed foods for higher-density nutrient alternatives, how to find ten minutes of movement in a day that feels already full. These are not clinical interventions in the traditional sense, but they extend the ACO reach and brands it as a health partner.

3. Patient Technology for Care

The ACO can build the organizational capability to sponsor and use digital tools as part of a structured between-visit engagement strategy. This can include fitness trackers, continuous glucose monitors, home blood pressure monitors, apps with diet or sleep tracking, and mindfulness apps—all being promoted among employers, private insurers, and practices.

ACOs can identify the right tools for specific patient populations, delegate training care managers to support digital onboarding, and integrate the data these tools generate back into the ACO's central data hub so that the glucose trend from a patient's CGM informs the care manager's outreach, and the blood pressure readings from the home cuff update the care team's risk stratification in real time. Motivated patients respond to these powerful between-visit links. Moreover, many such technology measures have shown meaningful improvements in glucose control, weight, adherence to diets, hypertension, and other intermediate outcomes.

For ACOs, remote patient monitoring with simple technology can also reduce hospital readmissions. A [prospective study](#) of remote patient monitoring within an ACO following patients' hospitalization for congestive heart failure and COPD demonstrated the potential to reduce post-hospitalization mortality, hospital admissions, and emergency care visits. An intervention that simultaneously improves patient outcomes and lowers total cost of care creates the defining combination in Value-Based Care performance.

4. Health Coaching for Lifestyle Changes

Health coaching is a structured, evidence-based discipline focused on the behavioral changes that [clinical care alone cannot produce](#). For patients with prediabetes, coaching-supported programs like the CDC-recognized [Diabetes Prevention Program](#) have demonstrated that weight loss as modest as 5 to 7 percent of body weight can delay or prevent the progression to Type 2 diabetes, reduce blood pressure, and improve lipid profiles. Similarly, a [randomized controlled trial](#) demonstrated direct effects on A1C for patients with diabetes, influencing a

key ACO quality measure. For patients already managing chronic metabolic disease, trained coaches using motivational interviewing techniques can transform a routine check-in call into a genuine conversation about what gets in the way of patient compliance with treatment plans, and gently guide the patient back to their goals. Health coaching can be an independent program or combined with patient technology or specific programs.

5. Pre-Surgical Preparation: ERAS and the ACO's Unique Role

Enhanced Recovery After Surgery protocols are evidence-based clinical pathways designed to optimize patients before surgery, reduce complications, and accelerate recovery. The ACO, with visibility into a patient's longitudinal primary care record, is uniquely positioned to begin that preparation long before the surgical date. The ACO knows the A1C is elevated. It knows the patient smokes. It knows the blood pressure has been trending upward for six months. That is a pre-surgical optimization roadmap—and the ACO has both the data and the patient relationship to act on it. Doing so improves surgical outcomes, reduces complications, and directly lowers TEAM episode costs. By tying into the ACO prior to a surgical episode, the primary care physician can pre-treat conditions and prepare the patient for surgery to avoid problems after the fact.

Why the ACO Is the Right Organizer for All of This

No other entity in the healthcare ecosystem has the combination of population-level data, longitudinal patient relationships, primary care infrastructure, and financial alignment with outcomes that the ACO has. This includes ACOs in all its forms, physician-, hospital- and health system-based ACOs. Especially if the ACO also contracts value-based contracts with private health plans, it is an essential connector between payment and value for its community. A health system without an ACO often has a vision to fulfill these patient-focused functions, but the financial alignment with Value-Based Care and risk may be lacking, and hospital ownership may change the incentives for the system. The ACO sees the whole person over time—and is the only participant whose financial incentives are aligned with keeping that person well.

This is not a new role for ACOs to invent from scratch. It is the natural extension of what many high-performing ACOs are already doing. The difference between high-performing and average ACOs in MSSP is not primarily in their claims analytics; it is in their investment in the human infrastructure of care—the care managers, the educators, the coaches, and the community health workers who extend the clinical team's reach into patients' daily lives. The payment model evolution that we've describe in this series makes that investment more financially justified with each passing year. An ACO managing TEAM episodes has a direct financial interest in whether its highest-risk surgical patients are metabolically optimized before their procedures. An ACO in LEAD has a decade-

long horizon to recoup the investment in patients whose disease progression it measurably slows or reverses.

This Is What Value-Based Care Was Always Supposed to Be

Our series began with the payment model landscape, moved to the analytics challenge. We have addressed the technology imperative. And now we arrive here: the human question at the center of the whole enterprise. What does the ACO owe its patients beyond patient care coordination and quality reporting?

The answer is significant. The ACO that takes it seriously—building the between-visit engagement that genuinely changes patient trajectories along with the infrastructure to identify cost drivers and improve quality—will be the organization that justifies the original promise of Value-Based Care to the patients who most need it to work. And it will be the organization that thrives financially as CMS continues building a payment system designed to reward exactly that.

At Roji Health Intelligence, we believe that better data, better analytics, and better patient engagement infrastructure work together and that ACOs and health systems should not have to choose between them. If your organization is ready to evaluate where it stands against the future of Value-Based Care, [we'd welcome that conversation.](#)

Founded 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.

Image: Jim Gade