With Competing Payment Models on Hold, What's the Future for ACOs?

written by Theresa Hush | March 19, 2021



When CMS first announced new primary care payment models in

April 2019, ACOs understood that their future might be threatened by competition for both physicians and patients. If medical groups could independently contract with Medicare under these models, they would have the advantage of greater control over their physician network, referral arrangements, and clinical decisions.

The Value-Based primary care models of Direct Contracting (DC) and Primary Care First (PCF) were presented as a strategy to fortify primary care and independent practitioners. By combining prospective payment, quality monitoring, and incentive pools for lowering admissions and total costs, providers could potentially reap the benefits of risk without the go-between health plan or an ACO. But these models also served a key goal for CMS to move providers away from Fee-for-Service reimbursements.

Now CMS is walking back some of the previous administration's decisions and reviewing these payment models—as we predicted. While this is a "normal" reset to evaluate prior programs within a larger programmatic context, there's good reason to expect that the Geographic DC Model will not see the light of day. It's unlikely that the PCF model for highest risk individuals will come to fruition, either. What that means for the ACO MSSP (Medical Shared Savings Program) model—given a recent delay in the applications schedule—is sparking new speculation. Here's what's at stake:

With New Health Care Imperatives, What Models Make Sense for the Future?

The fragmentation and fragility of our health care system has never been clearer than this past year, along with our system's

strengths. The difficulty of implementing a public health response through private health care systems and entities, and the uneven capabilities of different communities, evidence the urgent need to reassess goals to achieve real Value for the health care system. Those goals are at least partly engineered through federal policies. And with a stated intent of creating a public option for health care coverage, they will certainly get a diligent review.

The stream of changes and new models announced under the prior administration had a common theme: move toward risk-based reimbursement for providers. These shifts were also often disruptive. Rather than building on prior initiatives and revising them, the new models demonstrated a change in course. This was especially true not only of changing reimbursement models, but also of whole systems of care.

ACOs, along with Direct Contracting, Primary Care First, and Specialty Care Models—plus Medicare Advantage—now all overlap in a complicated and sometimes competitive approach to providing and financing health care. To see how this works (or, rather, doesn't) let's examine the announcements to bench Geographic DC and the PCF High Risk models while review is underway.

Who Leads Health Care in Communities?

Some CMS primary care models challenged the structure of health care leadership in communities, as well as who can take responsibility for the most vulnerable patients. That was definitely on display with Geographic DC as well as PCF High Risk.

In most large and mid-sized urban areas of the country, local competition between providers is strong, even fierce. Physician and patient loyalties matter, and both large and small systems have become more vertical with hospital-owned physician practices. The opposite is true of rural health care, where there may be only one hospital and few physicians, and patients must travel far to access either.

The Geographic DC model depends on carving up territories for Medicare patients. Urban health systems have struggled for decades to breach the boundaries of these territories, in order to create larger referral networks for patients. They set up outposts for primary or specialty care in communities already occupied by competitive systems. But rural networks are largely so cash poor that it would be next to impossible for them to take a shot at this program.

Even if we assume that the Geographic DC model could work in urban areas, who could lead a successful system for patient care that involves competitors? Providers have invested in their own physical plants, networks, and technology arsenals. They conduct competitive research and other functions. Gaining a voluntary cache of patients under risk-based payment is not enough of an incentive for them to exert effort over a larger territory. They already have all the patients they can handle, in many cases. Risk upsets their current incentive and revenue structure for just one segment of their patient population. Why bother?

Those most likely to try and organize geographic contracting regions are health plans and equity-backed groups with the capital and entrepreneurship to do so. Health plans have the

history of behind-the-scenes partnerships with ACOs, and some primary care-based equity groups have growth plans tied to population risk payment. But neither arrangement may be compatible with the current agenda focused on repairing health care fragmentation and health inequities. Without that compatibility, the prospect of spending political capital on Geographic Direct Contracting seems unlikely.

What Role Should the Public Health Care System Play in Value-Based Care?

The PCF High Needs, Seriously Ill model goes straight to the community system of public hospitals, clinics, federally qualified health centers, and private providers. These often overlap geographically. The model creates potential opportunities for collaboration among entities, and some individual organizations might be interested.

Even if providers see an opportunity, however, there are two reasons why a commitment to a large-scale program for a PCF population with special needs is unlikely. First, the payment model is capitated Risk, with success hard to achieve. For politically rooted public systems, it is doubly hard. Second, there will be political concerns about whether the model promotes a separate and unequal system of care.

Both obstacles will winnow the field of providers willing to participate to a small number. It may be small enough that the truly interested providers—and CMS—might decide to accomplish such a program through a single demonstration program and waiver, rather than a formal process as outlined. This would make it less expensive and less problematic, but not less complicated in an integrated Value-Based Care effort. In the

end, a small-scale experiment that cannot be replicated may not be worth the effort. Instead, there may well be a desire to create models that can foster the best solution for people with high needs, wherever they live and access health care.

How Do ACOs Fit into the Future Landscape?

One of the more obvious lessons of ACOs in recent years is that the category is not homogenous. Large and small, new and experienced, successful and not, risk-averse or pro-risk, independent providers or cohesive network, hospital or physician-based—it's hard to characterize a model so individually configured. In addition, ACO results are driven by non-generic factors, activities they have pursued, the connection with ACO participating physicians, and the particular patient population. In short, the future of ACOs is unlikely to be defined by simple criteria, and certainly not only by total cost savings.

The last few years have focused on ACO savings and payment models, with a movement toward standardizing quality requirements across all providers while reducing the number of quality measures. But there has been little activity in pushing the agenda of outcomes improvement, of illness risk reduction, and activities that will generate large long-term cost reduction. The Diabetes Prevention effort, which stands apart, has no place in any of the new payment models. As the new administration focuses on health disparities, risk factors and activities to improve results will probably emerge as more important.

These activities depend on data and clinical improvement strategies. ACOs consisting of independent or disparate

provider groups may have a much harder time leveraging these tools. Many lack the infrastructure and provider source system data to examine costs and clinical outcomes on a detailed basis. While there will still be easily achieved savings from care coordination and reducing costs of specialty and post-acute services, the pot of gold is found by engaging providers and patients in care and clinical decision-making.

The future for ACOs will hinge on how fast they can mature from invisible administrative entities into systems with the most improved outcomes and costs. If they can provide the central hub for data and tools to help participating physicians and patients improve, ACOs will grow into permanent, essential care models. Their alternative is to remain payment models with a future that awaits all payment models: eventual replacement with a newer design.

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Image: Dan DeAlmeida