Tipping Point Test for ACOs: Consent to Financial Risk

written by Theresa Hush | May 24, 2018

Last week the conversation about financial risk for providers in ACOs took on a decidedly different and more contentious tone. After months of CMS reports of ACO growth and success, while retreating on MIPS quality reporting requirements as concessions to "provider burden," CMS signaled that they were finished waiting for providers to accept financial risk under Value-Based Health Care.

With a third of Medicare patients served by an ACO and an even higher number of patients receiving health care via private sector ACOs, the industry seems on track to adopt ACOs as the preferred model of health care contracting and reimbursement. All that tipping point talk, however, cannot mask a countervailing trend: while providers have been willing to set up and participate in ACOs, they have not been moving quickly to accept financial risk. This is even more the case for Medicare ACOs than private ACOs, which tend to have some down-side risk.

Indeed, according to some accounts, a majority of providers have declared that if Medicare insists they accept more risk, they will simply withdraw from the program, if not Medicare altogether.

For Payers, Value-Based Health Care Has Always Meant Financial Risk

From its inception, Value-Based Health Care (VBHC) has focused on the cost of health care relative to patient outcomes. The consistent message to providers from employers, private health plans,and government: stem rising costs.

Yet, payers were also eager to deflect criticism from consumer and patient groups about outright reductions in health care. Recalling backlash over HMOs and restricted access to care by patients, private health plans as well as Medicare took a different approach. The "value" in VBHC was couched as efforts to evaluate quality and outcomes, as if the problem only involved getting more benefit for the current payout.

That kinder and gentler message persuaded providers to get on board with Value-Based Health Care. After all, who could really criticize the idea that providers should suffer if they could not meet an acceptable quality standard? Plus, the idea that they could "be" insurance companies was of great appeal to providers eager to eliminate the middleman.

Despite the emphasis on quality incentives and penalties, however, both Medicare and private plans took repeated aim at Fee-for-Service (FFS) reimbursement. ACO agreements with Medicare as well as most private health plan ACOs have spending targets that are clearly designed to transition to limits. Additionally, even under FFS, providers were scored and penalized by Medicare for higher cost than peers, first through the Value-Based Payment Modifier and then under MIPS. MACRA legislation and rules were forthright, stating that Alternative Payment Models that incorporated financial risk were the intended goal for Medicare.

So why the surprise and pushback from providers? Were they simply deluded by the voluntary nature of PQRS and MIPS regulatory programs into believing that FFS could continue as is? How could ACO providers not anticipate the direction of the model toward risk?

For Providers, Value-Based Health Care Has Meant Market Share

Prior years of managed care negotiations with payers have driven home a message to providers: You are at peril if you are not important to the other side of the negotiating table. Consolidation of health care organizations, which spiraled upward in response to proposals for ACOs and coordination of care, were sparked by perceived need to build leverage through market share and patients.

For an organization to be an ACO, it must leverage enough resources to provide all the services needed by patients. Providers have interpreted that as requiring ACO participants to offer as many clinical services as possible. Ironically, however, providers' attempts to stem leakage from the system have only increased their costs because that larger infrastructure is more expensive. Recently it has become clear that intense consolidation of provider organizations has raised costs and decreased market competition.

Consolidation has been further encouraged by the push to adopt EMRs and medical technology, as well as the need to support infrastructure for measuring and reporting quality under VBHC. Fee-for-Service reimbursement fuels this merger and acquisition frenzy, in turn generating a backlash against the lack of marketplace competition and furthering criticisms of FFS.

But those who continue on the consolidation path are not realistically evaluating heightened concerns about health care costs and affordability Nor are they appreciating health care consumerism's growing momentum, driven by unaffordable coverage and rising costs of care.

Outrage over the high cost of health care and lack of equivalent improvement in health outcomes is increasing, not going away. And as Medicare threatens other solutions—contracting with providers, for example, or forcing the issue on financial risk—providers will have a difficult public relations problem, at the very least. They cannot afford simply to oppose all solutions to controlling costs.

Nor can providers realistically turn down the opportunity to create their own systems of care under financial controls in a risk-based ACO. The solution is to carefully build the ACO to prosper in a risk environment, rather than trying to fashion an ACO out of the current tools built for Fee-for-Service. Here's our approach for a successful transition to risk.

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.

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