Identifying and Addressing Barriers to Accountable Care Adoption

Introduction

There is a longstanding recognition that underlying the U.S. health care system's high costs, variable quality and fragmented care delivery relies on a fee-for-service payment system that fails to incentivize care coordination and management, quality, or efficiency. For decades, there has been bipartisan support for developing innovative payment models that promote accountability for cost, quality, and outcomes. Accountable care offers significant strengths as compared to a fragmented fee-for-service delivery system. Benefits include improving care coordination, creating efficiencies, eliminating burdensome requirements, and saving money.

As a result, a growing share of health care providers are participating in accountable care models – payment models that hold providers accountable for health outcomes and cost. Across both political parties, policy leaders have articulated goals of moving 100 percent of Medicare payments and most Medicaid payments to accountable care on a more rapid timetable. Recent data demonstrates substantial progress against this goal, with an increasing share of revenue across lines of business in accountable care relationships. In addition, accountable care experience has shown that providers can save money and improve health outcomes in efficient delivery models.

Despite impressive progress, more can be done to alleviate barriers and accelerate the transformation to accountable care. In December 2024, the Accountable for Health Institute and West Health Policy Center convened a roundtable of experts to discuss the accountable care landscape, including barriers to adoption and suggested next steps to continue momentum in building an accountable health care system that achieves better outcomes, improves care experiences, increases access, and lowers costs. Participants encouraged modernizing accountable care policy to keep pace with the movement and identified implementation challenges that should be addressed to accelerate adoption.

Framing the Discussion: Current Progress toward Accountable Care Goals

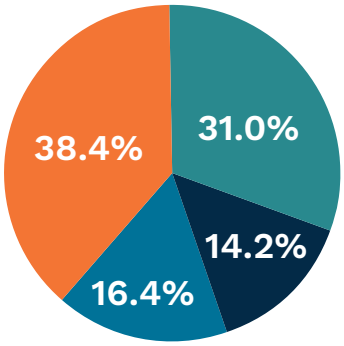
Background – Measuring Progress towards Accountable Care Goals

To understand the barriers to accountable care adoption, it is helpful to begin with an understanding of the extent to which there is participation in accountable care today. The Health Care Payment Learning & Action Network (HCP-LAN) developed a framework to categorize payment types across lines of business (traditional Medicare, Medicare Advantage, Medicaid, and Commercial). The LAN developed four categories for measuring progress of alternative payment model (APM) adoption. The categories describe payments to clinicians based on increasing levels of financial accountability, from no link to quality or value (Category 1) to population-based or capitated payments (Category 4). The HCP-LAN uses a measurement effort to determine the percentage of payments in each of the four categories (see pie graph on following page).

A successful transition to accountable care would show an increase in the portion of revenue in categories with two-sided risk (where the provider shares in savings and in any potential losses) and a decreasing portion of

Payment in All Lines of Business (LOB)

CY 2023 Data Year



92.7% of the market represented in the survey

Based on 73 health plans, 4 states, and Traditional Medicare

CATEGORY 1

Fee for Service
No Link to Quality & Value

38.4%

CATEGORY 2

Fee for Service
Link to Quality & Value

16.4%

CATEGORY 3

APMS Built On Fee-For-Service Architecture

3A
Upside Rewards

16.7%

3B
Upside Rewards & Downside Risk

14.3%

CATEGORY 4

Population-Based Payment

4A
Condition-Specific Population-Based Payment

3.7%

4B
Comprehensive Population-Based Payment

6.4%

4C
Integrated Finance & Delivery Systems

4.2%

28.5% **APMs with Downside Risk (Categories 3B, 4A, 4B, & 4C)**

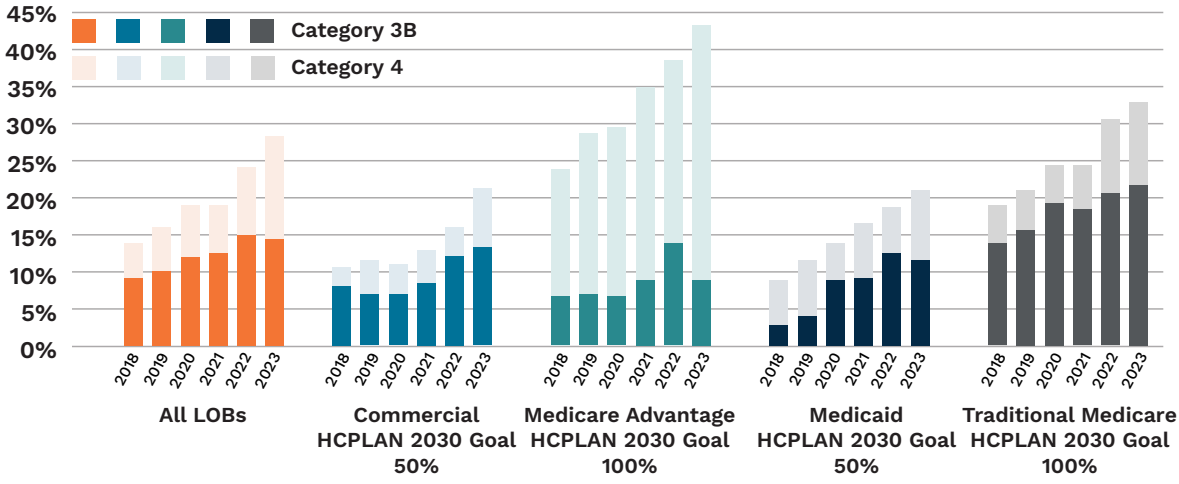
revenue in categories that are either pure fee-for-service with no link to quality or cost or pay-for-performance categories, where providers may be rewarded or penalized for their performance on quality metrics. The most recent HCP-LAN measurement report shows that the percentage of all health care payments that remain in fee-for-service with no link to quality or value (Category 1) has declined from 62% in 2015 to 38% in 2023, a dramatic decrease in fee-for-service with no accountable care model. Across all lines of business, in 2023, 28.5% of payments were in categories with two-sided risk. LAN data also shows an increase in spending categories in accountable care models with two-sided financial accountability, categories 3B and 4, since 2018.

Progress in the Adoption of Downside Risk APM Spending by LOB since 2018

Spending in Categories 3B-4 by Year and LOB

The bar graph below illustrates progress in the adoption of downside risk APM spending (Categories 3B-4) by LOB since 2018

Data provided by HCPLAN Summit



Specifically in traditional Medicare for purposes of this discussion and paper, participation in accountable care models has also continued to grow. In January 2025, **CMS announced participation by**:

- 476 MSSP ACOs representing 655,725 providers and organizations providing care to over 11.2 million people.
- 103 REACH ACOs with 161,765 health care providers providing care to 2.5 million people.
- 24 Primary Care Flex ACOs serving 349,000 people.

Taken together, along with other primary care, episode and condition-specific accountable care models, as of January 2025, 53.4 percent of people with traditional Medicare are in an accountable care relationship with a provider, a 4.3 percent increase from January 2024. This figure includes Medicare accountable care organizations and other Innovation Center models. However, still nearly half of the traditional Medicare population remains outside of accountable care models.

This transition to accountable care is important for several reasons. Accountable care has been demonstrated to improve access to care, including creating more timely access to care, easier access to appointments, improved care coordination, fewer emergency department visits and lower cost of care.

This experience in and growth of accountable care models has created a substantial body of evidence for effective accountable care delivery. Stakeholders, including policymakers are currently identifying barriers and opportunities to accelerate the transformation for those remaining in fee-for-service and to continue to drive improvement of existing accountable care models to ensure that care delivery meets the needs of patients, providers, and policymakers.

Barriers to Adoption of Effective Accountable Care

In this convening, stakeholders identified several key barriers to the adoption of effective accountable care:

- Weakened incentives to drive transformation;
- Regulatory barriers to beneficiary engagement;
- Lack of stability and predictability in the accountable care environment.

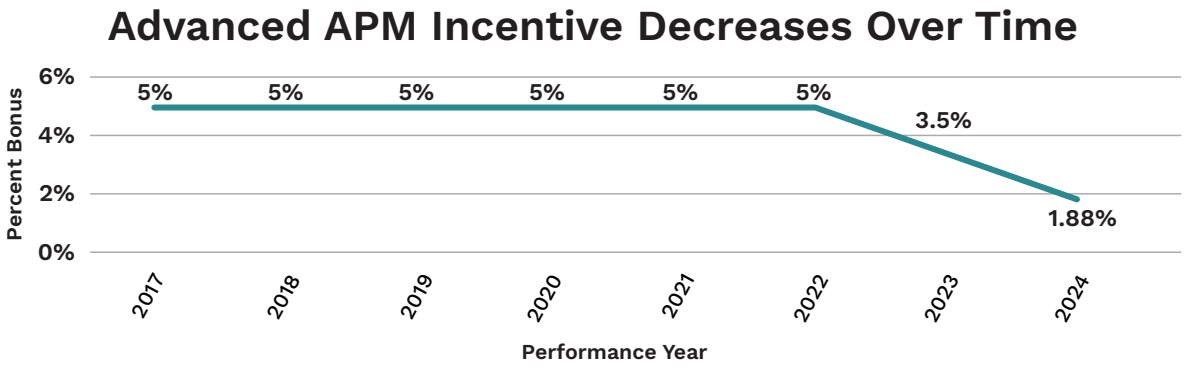
Weakened Incentives to Drive Transformation

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included important incentives to accelerate the adoption of and participation in accountable care. Through MACRA, Congress laid out two clear paths: the Merit-Based Incentive Payment System (MIPS) and Advanced APMs. MIPS was intended to create a pay-for-performance system in traditional Medicare, rewarding higher quality and lower cost care, and penalizing lower quality and higher costs. MIPS was comprised of four weighted categories of measurement with increasing financial reward and penalties over time. Importantly, MIPS was structured as a budget neutral program, meaning that money taken from penalized low performers would be used to pay bonuses to high performers. Over time, MIPS has evolved to a complex web of performance measurement, often with a small return on investment for participating clinicians. Bonuses have tended to be small and the reporting burden has been significant.

Simultaneously, MACRA designed two main incentives intended to encourage clinician participation in advanced APMs – an incentive payment or bonus for participating in advanced APMs and a MIPS

exemption for clinicians participating in advanced APMs. In recent years, both of these incentives have been dampened over time.

Under the original law, MACRA included a 5 percent bonus for clinicians participating in advanced APMs. This incentive is paid directly to the clinician and was intended to serve as a strong financial incentive for participation. However, the original 5 percent bonus expired and while Congress has stepped in to extend the bonus, it has done so at a reduced percentage each year, most recently reduced to 1.88 percent.[1]



In addition to the reduced amount of the incentive, structural issues with the bonus payments have emerged since MACRA's passage. For example, there is currently a two-year lag between when a clinician performs in an advanced APM and when they receive their bonus payment. For example, a clinician could participate in an ACO in 2023 and receive their bonus payment in 2025. The two-year lag decreases the saliency of the incentive.

One reason for the lag is that the advanced APM bonus is calculated as a percentage of claims billed for covered professional services, introducing another flaw in the structure of the incentive. The advanced APM bonus is directly linked to volume of services provided while APM participants are trying to move away from volume. This creates competing incentives – while the models intend to move away from volume-based approaches, the bonus rewards greater volume of services. In the early days of MACRA, most of the models that qualified were based on a fee-for-service chassis; today many models are moving to Category 4 payments, including capitation and population-based payments that do not rely as heavily on fee-for-service. Tying the bonus to the fee-for-service infrastructure no longer aligns to the overall movement to accountable care.

SUMMARY POINTS

Weaknesses of Advanced APM Incentive Structure

- ➜ Amount of the incentive is decreasing over time while incentives in fee-for-service remain stable
- ➜ Two-year lag between performance in an advanced APM and incentive payment
- ➜ Incentive is linked to volume

In addition to the weakened impact of the APM bonus, CMS has increasingly overlaid MIPS requirements on advanced APM participants. This decreases the value proposition of APMs, which are intended to promise lower burden and increased flexibility in exchange for accountability.

[1] As of January 2025, the APM bonus has expired – leaving APM participants with no incentive payment for the 2025 performance year/2027 payment year. There is hope that Congress will act to extend the bonus in the 119th Congress.

MIPS Reporting Burden on APM Participants

MIPS clinicians report four performance categories: (1) quality; (2) cost; (3) improvement activities; and (4) promoting interoperability (PI). Under MACRA, APM participants are generally excluded from MIPS reporting – creating an incentive to move away from fee-for-service. Despite this, CMS recently finalized a policy requiring all eligible clinicians in MSSP ACOs to report MIPS PI data, including APM participants that were previously exempt. This requirement extends beyond Medicare patients – applying to all patients and all payers – and runs counter to MACRA's intent of lowering burden for APM participants in exchange for accountability, and dampens the attractiveness of APMs.

Taken together, these policy developments show that the incentives to move to accountable care could be significantly strengthened as stakeholders seek to move remaining clinicians and beneficiaries to accountable care.

Regulatory Barriers to Beneficiary Engagement in Accountable Care

Participants also discussed regulatory barriers to beneficiary engagement in accountable care. In most cases, beneficiaries are aligned to ACOs based on where the beneficiary receives the plurality of their primary care services. This is in stark contrast to Medicare Advantage, for example, where beneficiaries affirmatively enroll. As a result, many beneficiaries may not know that they are receiving their care from an ACO.

Recent research shows the strength of accountable care for beneficiaries. The **American Heart Association** recently conducted research to understand patient, family caregiver and health care team member experiences with ACOs. The study found that patients and their caregivers overwhelmingly reported that ACOs provide better care compared to fee-for-service. The study pointed to increased time for patients with their providers, and a more holistic approach to physical, mental and health-related social needs as key elements of the improved experience.

Despite these and other findings that support accountable care participation for beneficiaries, stringent CMS rules govern marketing and communication around ACO participation. Stakeholders commented that these restrictions impede efforts to educate beneficiaries on the role of APMs in providing more coordinated, patient-centered care. For example, MSSP ACOs must use CMS template language for communications whenever available. This one-size-fits-all approach limits educational and engagement potential to certain populations and specific audiences. ACOs **often report** confusion in disentangling beneficiary notification requirements which contributes to administrative burden, beneficiary uncertainty and operational complexity.

Participants also pointed to barriers around the ability to address cost sharing for ACO beneficiaries and the desire for additional flexibility to provide additional benefits for ACO patients. Participants agreed that more flexibility and less regulation would improve patient experience and affordability. While some Innovation Center models offer waivers, the flexibilities are inconsistent and often come out of the provider's bottom line. By comparison, Medicare Advantage plans have substantial resources through rebate dollars to offer cost sharing support and other additional benefits to improve beneficiary care experiences.

Lack of Stability and Predictability in the Accountable Care Environment

Participants also pointed to a lack of stability and predictability in the accountable care environment as a barrier to accountable care adoption. Specifically, two sets of factors – those specific to accountable care models and those impacting the broader payment environment for organizations participating in accountable care.

Model-specific predictability to some degree stems from the design of Innovation Center models. Specifically, many current models were designed to exist for 5-years and are slated to expire at the end of 2026. With the political transition in Washington, DC, and limited evaluation of these models, it can be difficult to predict the next steps in model testing. This unpredictability serves as a barrier to expanding model adoption and encouraging additional clinician participation.

A lack of financial stability within the models also serves as a barrier to ongoing participation. Mid-stream financial model changes and retrospective adjustments have created provider abrasion and led to some participants exiting accountable care models overall. This lack of stability was cited as a barrier to ongoing participation and to attracting new clinicians to participate.

In addition, the overall health care policy environment affects accountable care participants. For example, recent changes to risk adjustment in Medicare Advantage, drug pricing, and overall physician fee schedule structural and financial considerations all reverberate through the accountable care environment – as many providers take risk in both the traditional Medicare and Medicare Advantage populations, and most accountable care models continue to be tied to the fee schedule. Stakeholders in our convening described the pace of recent changes to the overall health care policy environment as impacting accountable care adoption, calling for greater stability, transparency and predictability across the board to help spark more participation in accountable care.

Addressing Barriers to APM Adoption

Clear, Strong Incentives for APM Participation

Evidence supports accountable care as a mechanism of delivering high quality, lower cost care to populations. Incentives to transform health care delivery to effective accountable care should be clear and strong. This means addressing the structural inequities and barriers in current APM incentive programs. Specifically, incentives should be closer in time to performance, divorced from their reliance on volume, and set for a specific period of time, rather than piecemeal extensions. In a reformed payment system, incentives for accountable care should clearly be more attractive than MIPS incentives.

CMS should also re-establish firm distinctions between MIPS performance requirements and advanced APM requirements, reversing the recent blending across pathways. Specifically, Advanced APMs should not be subject to MIPS requirements so that APM participants in two-sided risk models feel a meaningful decrease in reporting requirements while gaining flexibilities in care delivery.

Reducing Regulatory Burdens to Beneficiary Participation

CMS should provide accountable care entities with the financial resources and flexibility to deliver enhanced benefits aligned to MA benefits, for traditional Medicare beneficiaries.. This will also support providers in providing robust care delivery across Medicare patients, whether they are covered by Medicare Advantage or fee-for-service.

CMS should also permit APM participants to better communicate the value of accountable care to patients and make it easier for Medicare beneficiaries to opt-in to accountable care models, such as ACOs, in their markets. Patients in ACOs and their caregivers **overwhelmingly report** better care compared to traditional fee-for-service when interviewed about their experience. This is due to strong primary care relationships, patient engagement, care coordination and a team-based approach that includes care managers, social workers and other professionals.

Stable, Predictable Participation Options

The CMS Innovation Center should consider ways to improve stability and predictability for participants in its models. This may include removing retrospective adjustments that can be disruptive and providing

greater notice, transparency, and feedback opportunities around model changes to ensure that stakeholders have sufficient time to digest changes and engage with the agency around unintended consequences of mid-stream model changes.

CMS should articulate clear, timely transitions when models are slated to end, whether that incorporates a model extension or a follow-on model or other transition. CMS must also ensure that organizations participating in APMs have clear glidepaths and sufficient time to move from one model to the next, including contracting their provider network and communicating to their beneficiary populations. This is especially important given forecasting needs and investments to develop and refine programs.

Conclusion

Effective accountable care has a demonstrated track record of improved health outcomes and improved cost savings performance as compared to traditional fee-for-service reimbursement. While significant progress has been made in increasing participation in accountable care models, policy can continue to evolve to support the evolution and adoption of these models in the future.

Appendix – List of Attendees

- Katie Boyer, Director of Policy & Government Affairs, agilon health
- Caroline Carlson Delgross, Vice President of Medicare ACO Performance, One Medical
- Sean Cavanaugh, Chief Policy Officer, Aledade
- Chris Crowley, Director, Strategy & Senior Health Systems Engineer, West Health Institute
- Lisa Dombro, President, Ilumed
- Mary Gens, Senior Research Associate, West Health
- Jeet Guram, Associate Partner, McKinsey & Company
- Mark Japinga, Associate Director, Health Policy, West Health
- Ron Kuerbitz, Chief Executive Officer, lIumed
- Mark McClellan, Director, Duke-Margolis Center for Health Policy
- Mara McDermott, Chief Executive Officer, Accountable for Health
- Kristen McGovern, Partner, Sirona Strategies
- Farzad Mostashari, Co-Founder and CEO, Aledade
- Elyse Pegler, Executive Director, VBC Center of Excellence, Aetna/CVS Health
- Jack Rowe, Senior Medical Director, agilon health
- Will Robinson, Senior Vice President of Accountable Care, HarmonyCares
- Matthew Rubin, Amazon Health Services
- Robert Saunders, Senior Research Director of Health Care Transformation, Duke-Margolis Center for Health Policy
- William Scanlon, West Health
- Dana Strauss, Senior Director of Government Affairs, CVS Health
- Sarah Sugar, Senior Director, Sirona Strategies
- Namrata Kaur Uberoi, Director of Health Policy, West Health