Perhaps the most dramatic recent development in value-based care is the announcement by HHS Secretary Alex Azar that the Center for Medicare and Medicaid Innovation is launching “new, bold” models for value-based payment.

In late 2018, the Centers for Medicare and Medicaid Services (CMS) released its Pathways to Success rule, overhauling its largest ACO program, the Medicare Shared Savings Program (MSSP). The new rule’s driving ACOs to move to risk. For many ACOs, savings programs (e.g., the Medicare Shared Savings Program) and pushes ACOs into two-sided risk models.

Without real accountability, we’re just offering bonuses on top of payments that may be too high already. That’s why we have now proposed to simplify the ACO system into two tracks, requiring them to take on real risk.” Mr. Azar said. Azar has also said that the administration would “revise” mandatory models that it had previously scrapped in cardiac care and said the time had come for “exploring new and improved episode-based models in other areas, including radiation oncology.”

The changes in risk contracts have been in concert with the actions of Toms Price, MD, the previous HHS secretary who canceled and scaled back major mandatory bundled payment programs. And more often than not the private sector follows Medicare and Medicaid’s directions in payment reform.

Accountable care organizations (ACOs) have become a major payment and delivery reform tool once they were introduced as a key component of the Affordable Care Act. Currently, there are more than 1,000 ACOs covering about 35 million lives across all payers—numbers that have steadily increased over time. The ACO model continues to evolve, but it seems to be here to stay.

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