New ACO Playbook: Three Ultimate ACO Strategies to Keep Physician Practices Onboard

written by Theresa Hush | August 19, 2021



ACOs have zealously protected their favored status under Medicare Value-Based payment models, ensuring enough time for organizations to feel comfortable with financial risk and make investments in infrastructure. But if your own ACO is losing physicians to new equity-financed networks or to hospitals consolidating practices, more time does not help you. Primary care physicians are being picked off by your competition, and their patients go with them.

Private equity firms and venture capital-funded groups have gained significant ground in acquiring physician practices, with mergers and acquisitions hitting record highs in 2019 and 2020, and accelerating in 2021. Equity firms and health insurers now own almost one-third of physician practices, and 70 percent of physicians are employed by hospital systems and corporate entities including private equity firms and insurance companies.

Consolidation of practices through hospital and private company acquisitions is decreasing the number of small practices and increasing larger practices and networks, conferring market power and better negotiating leverage for new owners with payers and employers. It is also driving increased costs in the industry. The Biden administration recently announced intentions to enforce anti-trust laws to avoid the cost escalation associated with monopolistic providers while Fee-for-Service still dominates.

How Does Physician Acquisition and Competition Affect ACOs?

Depending on your seat at the ACO table, consolidation can hurt your competitive position, unless you are the purchaser. Practice consolidation and ACO penetration are related, with consolidation fueling growth of market share through larger physician groups.

If yours is an independent, physician-led ACO, your pool of participating physicians is shrinking. You face the potential of being edged out of your local market by consolidated groups with more marketing, attractive benefits for physicians, and consumer-friendly options for patients. Equity-backed and venture-backed medical groups often develop their own ACOs to take on risk and/or to participate in Medicare Advantage.

If your hospital-based ACO seems secure in a broad primary care physician base, keep in mind two important realities. First, as value-based payment models take hold, it will affect the economics of your operations, making hospital expenses a greater liability and stagnating physician compensation. Second, once most independent groups are picked off, well-

capitalized networks have only one source for recruiting physicians—you.

Why Are Physicians Choosing Acquisition and Employment with Equity and Venture Capital-Backed Practices?

Physicians are not pawns in the acquisition process. They are voting with their feet, influenced by benefits that private equity and venture-capital funded organizations are offering. As relatively new acquirers that are more active than other categories, private equity and venture capital-backed practices provide an excellent perspective that has been attractive to established groups desiring to maintain clinical independence. Some health system and hospital-led ACOs have also provided these benefits, especially the first two:

- Financial stability and growth. Access to financial administration and payer contracts (including risk-based reimbursement) through venture capital-backed MSOs provides an avenue for revenue stabilization and growth. Practices which suffered financially during the pandemic may be particularly focused on gaining more access to new patients, supported by investments in telecommunications.
- Data, analytics, and technology. Most private companies have a strong technology orientation, coupled with a desire to share results data with physicians that has been less common in hospital-based practices and unavailable when practices are small and self-funded.
- Support. Investment in extenders, as well as support staff, frees physicians to perform clinical functions.
- Autonomy in clinical decision-making. Equity and venture

capital-based acquisitions are perceived to offer physicians more autonomy than hospital-based practices.

Three Broad Jump-Start Strategies for Your ACO to Keep Physicians

To stem the erosion of your physician base, your ACO will need to ensure physicians that you will provide security for fundamentals of their finances, administrative efficiencies, and data to weather the effects of value-based reimbursement. These three essential strategies will help them to move onto more solid ground:

1. Implement data technology for providing physicians with the feedback and resources they need.

There are two basic options: you can use a vendor to collect and process data from practices' existing clinical and transactional systems or purchase a common system for everyone to use. The former is faster and cheaper than adopting a common system, which is often a multi-year planning and implementation process. As your capacity for analytics grows, however, you may eventually want to consider a common system so that you can integrate changes faster between various technologies.

Collecting data is just one part of this strategy. Just on the data front, you will want analytics that dive into costs and outcomes, the ability to examine total cost of care and condition-specific costs and outcomes together through episodes, and population health technology that can implement both patient outreach and physician collaboration projects. To get a handle on your downstream specialty costs and evaluate

your referrals, you will also need treatment and procedure episodes that give you comparable cost and outcome data.

Your investments should also extend to other technologies—a common telehealth system, wearable device reporting (e.g. continuous glucose monitoring), and patient-reported outcomes.

Here's why time is not on your side: the competition already has these tools, which take time to implement. You should start now. Too many ACOs are currently dependent solely on claims data and have been caught short by trying to avoid the need (and by resistance from practices) to change their practice technologies.

Delay has already made it impossible to meet new ACO Performance Pathways (APP) reporting. Waiting will only cause you to fall further behind in helping physician practices cope with the growing demands of interoperability, transparency, data, and demands for better and more equitable health care.

2. Involve physicians in data and change.

Physicians universally report that cost data is not shared with them, and they don't know how to address costs with patients. That has to change. Physicians need to be fully aware of how episode costs are calculated and be involved in creating optimal clinical pathways for improvement. They, more than administrative staff, are aware of what their patients need to change their own risks, and these physicians must be more involved in crafting solutions for their patients. Administrators who process complaints from physicians about their workload too often misinterpret the message from physicians. They aren't asking to be removed from patient care,

they are asking for either the time to do what they need, or someone to catch the ball and carry through the whole intervention.

Your programs to help physicians are best if they are physician-directed and formulated, and implemented by trusted staff. To begin this process, involve physicians in comparative analytics of their own patients and all referred services through patient episodes that are clinically defined—only possible once the data supports both claims and providers' own data.

3. Advance toward value-based reimbursement with linked rewards for physicians.

If you and your practices are still rewarding only volume of services and have not yet established a mechanism to reward value, you can't fully realize the potential of your steps toward change. It doesn't matter whether your reimbursement is still on Fee-for-Service or not; you can still construct a pool of money to align with your cost goals. Unless physician compensation is financially aligned with your goals, it will be more difficult to get attention from practices and physicians.

To do this, you obviously need to create the necessary pool of money. If you have or purchase an MSO to manage ACO claims, you can take percentages of revenues out of claims before paying providers. Otherwise, you will need to require up-front annual investments from physicians, which is much harder and may not be sufficient. As your ACO proceeds down the basic tracks of ACO Pathways, you will need a risk structure, in any case, to accommodate the ACO when value-based reimbursement becomes the norm, to protect yourself from overruns. PHOs and IPAs have

performed this function for years, but some ACOs have not.

ACOs were conceptualized as the leaders of a movement to Value-Based Care. But they are losing ground as the movement pushes forward, and risk-takers and entrepreneurs see the possibilities.

The idea that providers themselves can still be on the forefront of controlling costs is a compelling vision. But to realize that vision, you need the tools for success. Our New ACO Playbook addresses various areas of strengths and weaknesses of ACOs for competitive models, but clinicians represent the focus of these strategies, because their actions determine patient outcomes and costs. Without physician volume and leadership, your ACO cannot survive. And your physicians need much more support to stay afloat.

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: Ricky Kharawala