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Primary Care Physician-Owned, Operated ACOs Drive Collaboration, Competition

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A physician-owned-and-operated accountable care organization (ACO) puts physicians back in the driver's seat, enabling them to manage the overall healthcare of their patients. Participating physicians work closely with other healthcare providers to ensure the right care is provided without duplication of unnecessary services. The model allows these doctors to stay independent, practice medicine like they have always wanted to and benefit financially by keeping people healthy.

Physician-owned-and-operated ACOs provide private practice physicians an opportunity to drive healthcare quality and financial outcomes. The focus of this type of ACO is to ensure physicians are involved in the operations of an ACO versus simply acting as participants in an organization. It allows for increased autonomy for physicians, which will motivate them to provide quality and cost-effective care because they have vested interest in financial outcomes.

An ACO need not be captive to one single health system, such as a hospital, to be successful. In fact, hospitals have attempted to build a fence around care delivery and retain most of the services within the hospital, ultimately resulting in higher healthcare costs. An independent, private physician-owned-and-operated ACO can collaborate with multiple health systems serving a geographic footprint of a physician group's provider base. Due to the fact that this type of ACO is not aligned or controlled by any particular hospital system, physicians have the power to admit patients to a hospital or facility of their choice and the one most suitable for their patients. This should create a more competitive healthcare marketplace and provide accountability among healthcare providers.

In addition, this type of ACO could enter into collaborative agreements with provider/suppliers in a post-acute care network, such as skilled nursing facilities, home health agencies and palliative and hospice care providers. These agreements would ensure a comprehensive, competitive environment among providers that could promote increased productivity in healthcare and focus on coordinated care protocols to achieve the triple aim.

An ownership interest in an ACO would give physicians a voice and skin in the game. As part of their initial offering and capital structure, new ACOs should invite independent, private practice physicians, who have established a positive record of performance and have experience in achieving the delivery of cost-effective, quality healthcare, as potential shareholders or owners.

Another alternative is establishing a primary care physician (PCP)-owned ACO coupled with a specialist network. A PCP's relationship with a patient is more comprehensive and personal in comparison to that of a specialist. The goal would be to provide a holistic approach to social, mental and physical care to satisfy all the needs of a patient. PCPs focus on the delivery of all-inclusive care of a patient in comparison to specialty physicians who focus on a specific type of care. PCPs could take the lead with specialists to provide expertise managing more complicated issues. This would be the ultimate model.

In order for an ACO's structure to be effective, all providers involved in the treatment of care must work together. Coordination of care is a key component in ensuring effectiveness of this model of care.

As the healthcare system gears up for a value-based philosophy, physicians have been obligated to comply with quality improvement measurements within their practices. ACOs are at the forefront of the shift to value-based reimbursement. Networks of independent physicians who band together to deliver coordinated care to patients that result in positive health outcomes for patients are being rewarded under a value-based, payment structure.

A physician-owned ACO would allow independent, private practice physicians to take the lead on delivering better care at a lower cost. This can be accomplished by increasing preventive care visits and transitional care services, which should result in a decrease in emergency department visits, hospital utilization and hospital readmission rates, while also empowering providers to succeed in the new value-based, healthcare market.

Besides awarding private physicians ownership, a successful ACO should be governed by an independent, private practice physician board and community members. Board membership should be based on extensive leadership experience, past experience in achieving cost-effective quality, healthcare outcomes and successful participation in quality improvement programs. Each board member should serve one year unless re-elected by the members/owners at an annual meeting. All participating physicians (providers and suppliers) should be encouraged to seek nomination and election to the board and participate in various ACO committees.

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In addition to the participation of physicians, an ACO should encourage participation of the community including, but not limited to, two community members appointed to seats on an ACO board. The goal of an ACO should be to encourage active participation in the governance by all participating physicians to ensure equal representation. This active participation by physicians would differentiate a physician-owned-and-operated ACO from all other ACOs.

Participating physicians have the opportunity to earn shared savings based on lowering costs and meeting performance standards on quality of care. By being an ACO owner, a physician has an opportunity to reap even more savings by not having to share them with a third party, such as a hospital. This could be an attraction for PCPs to join a fully physician-owned-and-operated ACO, when the window opens each year by the Centers for Medicare & Medicaid Services (CMS).

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