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Navigating the Transition to Accountable Care in 2025

Executive Summary

As of January 2025, 53.4% of people with Traditional Medicare are in an accountable care relationship with a provider, representing more than 14.8 million beneficiaries. This marks a significant 4.3 percentage point increase from January 2024—the largest annual increase since CMS began tracking accountable care relationships.[1]

The Medicare Shared Savings Program (MSSP) achieved historic results in 2023, yielding more than $2.1 billion in net savings while distributing $3.1 billion in shared savings payments to participating ACOs—the highest figures since the program's inception.[2] Yet despite these promising results, independent physician practices face mounting challenges in successfully participating in value-based care arrangements.

This white paper provides physician organizations with a comprehensive framework for supporting member practices through the complex transition to accountable care, offering practical strategies for overcoming common obstacles and maximizing success in value-based contracts.

The Current Landscape

Growth and Participation

The landscape of accountable care organizations has expanded significantly:

Medicare Shared Savings Program (2025):

- 476 participating ACOs
- 655,725 health care providers and organizations
- More than 11.2 million Medicare beneficiaries (3.7% increase from 2024)
- 228 applications approved for 2025 (the most in program history), including 55 new ACOs[3]

ACO REACH Model (2025):

- 103 participating ACOs
- 161,765 health care providers and organizations
- Approximately 2.5 million Medicare beneficiaries
- Generated $1.643 billion in gross savings in 2023, with net savings of $694.6 million to CMS[4]

Primary Care Innovation: The new ACO Primary Care Flex Model launched on January 1, 2025, includes 24 ACOs serving 349,000 Medicare beneficiaries, testing innovative payment structures for primary care within the Shared Savings Program.[5]

The Independent Practice Crisis

Despite the financial promise of value-based care, independent physician practices are struggling:

- **Nearly 80% of physicians** are now affiliated with hospitals, health systems, or corporate entities as of 2023, up from 74% in 2022[6]
- **Declining reimbursements:** CMS finalized a 2.83% reduction to the physician fee schedule conversion factor for 2025, marking the **fifth consecutive year of reductions**[7]

- **Infrastructure gaps:** Independent practices often lack the technology infrastructure, population health management expertise, and post-acute care relationships needed for value-based contracts[8]

According to a Black Book Q2 2025 survey, **70% of independent practice administrators worry that even strategic partnerships will not be enough to preserve independence** under current value-based care pressures.[9]

Core Challenges Facing Member Practices

1. Technology and Data Infrastructure

The Challenge: Value-based care requires sophisticated electronic health records (EHR), data analytics platforms, and population health management tools that many independent practices cannot afford or manage alone.

The Impact:

- Inability to identify high-risk patients proactively
- Limited capacity for quality measure reporting
- Difficulty tracking care coordination across settings
- Inadequate benchmarking against performance targets

2. Financial Risk and Benchmarking

The Challenge: ACO benchmark methodologies can penalize high-performing practices, while downside risk models expose smaller practices to significant financial jeopardy.

The Impact:

- Fear of shared savings "ratcheting" effects
- Insufficient capital reserves to absorb losses
- Difficulty projecting financial performance
- Reluctance to accept two-sided risk arrangements

3. Care Coordination Complexity

The Challenge: Managing care across the continuum—from primary care through specialist referrals to post-acute services—requires infrastructure and relationships that small practices typically lack.

The Impact:

- Preventable readmissions and emergency department utilization
- Poor performance on care coordination quality measures
- Missed opportunities for care gap closure
- Fragmented patient experience

4. Quality Reporting and Improvement

The Challenge: Meeting quality measure requirements while maintaining productivity is increasingly difficult amid administrative burdens and staffing shortages.

The Impact:

- Time diverted from patient care to documentation
- Incomplete capture of quality activities
- Difficulty achieving quality benchmarks
- Reduced shared savings or penalties under quality gates

5. Regulatory Complexity and Change

The Challenge: CMS regularly updates ACO rules, quality measures, and reporting requirements, creating a moving target for practices already stretched thin.

The Impact:

- Compliance risks and potential penalties
- Difficulty planning long-term strategy
- Resource drain on administrative staff
- Missed opportunities due to lack of awareness

How Physician Organizations Can Support Member Practices

1. Centralized Technology and Data Analytics

Strategy: Create a shared technology infrastructure that provides all member practices with enterprise-level capabilities at a fraction of individual cost.

Key Elements:

- **Population health management platform** with risk stratification algorithms
- **Real-time dashboards** showing ACO performance, quality metrics, and care gaps
- **EHR integration services** that aggregate data across disparate systems
- **Predictive analytics** to identify high-risk patients and intervention opportunities
- **Quality measure tracking** with automated reporting to CMS

Expected Outcomes:

- 40-60% reduction in per-practice technology costs
- Improved identification of care gaps and opportunities
- Enhanced quality measure performance
- Better shared savings distribution

2. Care Coordination Infrastructure

Strategy: Build centralized care coordination services that extend the reach of each member practice.

Key Elements:

- **Care coordination team** (RNs, care managers, social workers) shared across practices
- **Transitional care management** programs for hospital discharges
- **High-risk patient programs** with intensive outreach and engagement
- **Specialist and post-acute care networks** with preferred partnerships

- **Community resource connections** for social determinants of health

Expected Outcomes:

- 15-25% reduction in hospital readmissions
- 10-20% reduction in emergency department utilization
- Improved performance on care coordination quality measures
- Enhanced patient satisfaction scores

3. Revenue Cycle and Coding Optimization

Strategy: Provide expert revenue cycle management services that maximize reimbursement and optimize risk adjustment.

Key Elements:

- **Hierarchical Condition Category (HCC) coding** programs
- **Clinical documentation integrity** education and auditing
- **RAF score optimization** initiatives
- **Quality payment program (QPP) expertise** for MIPS and APM pathways
- **Denial management** services

Expected Outcomes:

- 8-15% improvement in risk-adjusted revenue
- Better capture of chronic condition diagnoses
- Improved quality performance and payment adjustments
- Reduced claim denials and faster payment cycles

4. Financial Risk Management

Strategy: Create shared risk arrangements or risk corridors that protect individual practices while maintaining accountability.

Key Elements:

- **Pooled risk reserves** to absorb variations in small practice performance

- **Stop-loss protections** for catastrophic cases
- **Performance-based distribution models** that reward quality and efficiency
- **Financial forecasting tools** with regular performance updates
- **Benchmark management strategies** to prevent ratcheting effects

Expected Outcomes:

- Reduced financial volatility for individual practices
- Increased willingness to accept downside risk contracts
- Better alignment between effort and financial rewards
- Sustainable long-term participation in value-based care

5. Quality Improvement Support

Strategy: Implement physician organization-wide quality improvement programs with shared best practices and collaborative learning.

Key Elements:

- **Quality improvement advisors** embedded with practice teams
- **Best practice sharing** through regular collaborative meetings
- **Provider performance feedback** with peer benchmarking
- **Evidence-based clinical protocols** adapted for practice workflows
- **Patient engagement campaigns** for preventive care and screenings

Expected Outcomes:

- Consistent improvement on all-domain quality scores
- Achievement of quality benchmarks across member practices
- Reduced variation in care delivery
- Enhanced provider engagement and satisfaction

6. Regulatory Compliance and Advocacy

Strategy: Centralize regulatory monitoring, compliance support, and advocacy efforts at the physician organization level.

Key Elements:

- **Regulatory monitoring service** tracking CMS policy changes
- **Compliance auditing and support** for quality reporting requirements
- **CMS program expertise** (MSSP, ACO REACH, Primary Care Flex)
- **Advocacy representation** with CMS and Congressional stakeholders
- **Educational webinars and resources** on regulatory updates

Expected Outcomes:

- 100% compliance with ACO reporting requirements
- Reduced administrative burden on practice staff
- Better anticipation of regulatory changes
- Stronger collective voice in policy development

Implementation Framework

Phase 1: Assessment and Planning (Months 1-3)

1. **Conduct comprehensive assessment** of current ACO participation and readiness
2. **Identify technology gaps** across member practices
3. **Analyze financial performance** and benchmark methodologies
4. **Survey provider attitudes** toward value-based care
5. **Develop 3-year strategic roadmap** for ACO support services

Phase 2: Infrastructure Development (Months 4-9)

1. **Select and implement** population health management platform

2. **Establish care coordination team** and protocols
3. **Launch revenue cycle optimization** programs
4. **Create financial risk management** policies and reserves
5. **Deploy quality improvement** advisors to practices

Phase 3: Practice Enablement (Months 10-18)

1. **Provide comprehensive training** to practice teams
2. **Integrate technology systems** with practice EHRs
3. **Launch care coordination services** for high-risk patients
4. **Implement HCC coding and documentation** improvement programs
5. **Establish regular performance reporting** and feedback cycles

Phase 4: Optimization and Scale (Months 19-36)

1. **Analyze performance data** and identify improvement opportunities
2. **Expand successful programs** to additional practices
3. **Negotiate enhanced value-based contracts** with payers
4. **Share best practices** across the physician organization
5. **Continuously refine** based on outcomes and member feedback

Key Success Metrics

Financial Performance Indicators

- **Gross savings per beneficiary** (target: top quartile of MSSP performance)
- **Shared savings earned** as percentage of available shared savings
- **Quality payment program bonuses** earned by member practices
- **Revenue cycle metrics:** days in A/R, claim denial rate, RAF score accuracy

Quality and Clinical Outcomes

- **All-domain quality score** in MSSP (target: 95+ points)
- **Hospital readmission rate** (target: 15% below benchmark)
- **Emergency department utilization** (target: 20% below benchmark)
- **Care gap closure rate** for chronic conditions (target: 85%+)
- **Patient satisfaction scores** (target: 90th percentile)

Operational Efficiency Indicators

- **Percentage of member practices** actively engaged in ACO programs
- **Provider satisfaction scores** with PO support services
- **Technology adoption rate** across practices
- **Care coordination touches** per high-risk beneficiary
- **Quality measure reporting compliance** (target: 100%)

ACO & Value-Based Care Support Checklist for Physician Organizations

- [ ] **Technology Assessment:** Evaluate current technology infrastructure across all member practices and identify gaps in population health management, EHR integration, and data analytics capabilities

- [ ] **Financial Risk Analysis:** Review ACO benchmark methodologies, historical performance, and financial risk exposure for member practices

- [ ] **Care Coordination Audit:** Assess current care coordination capabilities, transitional care management programs, and post-acute care relationships

- [ ] **Quality Performance Review:** Analyze quality measure performance across all domains and identify improvement opportunities

- [ ] **Regulatory Compliance Check:** Ensure all member practices are compliant with current ACO reporting requirements and CMS program rules

- [ ] **Platform Selection:** Select and implement an enterprise-grade population health management platform with robust analytics and reporting

- [ ] **Care Team Development:** Hire and train care coordinators, case managers, and quality improvement specialists

- [ ] **Provider Education:** Launch comprehensive training programs on HCC coding, clinical documentation, and value-based care principles

- [ ] **Network Development:** Establish preferred relationships with high-quality specialists, hospitals, and post-acute care providers
- [ ] **Performance Reporting:** Create real-time dashboards that show ACO performance, quality metrics, and financial projections
- [ ] **Risk Management Framework:** Develop financial risk reserves, stop-loss protections, and performance-based distribution models
- [ ] **Best Practice Protocols:** Implement evidence-based clinical protocols for chronic disease management and preventive care
- [ ] **Patient Engagement Strategy:** Launch patient-facing programs for care gap closure, preventive screenings, and chronic care management
- [ ] **Benchmarking and Feedback:** Provide regular performance feedback to practices with peer comparisons and improvement recommendations
- [ ] **Advocacy and Representation:** Engage in policy advocacy with CMS and payers on behalf of independent practices

Conclusion

The transition to value-based care represents both the greatest challenge and the greatest opportunity for independent physician practices in a generation. While the financial and operational pressures are real, the evidence from 2025 demonstrates that properly supported practices can thrive in accountable care arrangements.

Physician organizations play a critical role in this transition by providing the infrastructure, expertise, and scale that individual practices cannot achieve alone. By centralizing technology, care coordination, financial management, and quality improvement services, physician organizations enable their member practices to compete with large health systems while maintaining clinical autonomy and governance independence.

The path forward requires strategic investment, thoughtful implementation, and unwavering commitment to practice independence. But the rewards—both financial and clinical—are substantial and sustainable.

Joyn Health partners with physician organizations to build comprehensive ACO support capabilities that drive superior performance while preserving practice independence. Our proven frameworks, technology solutions, and expert teams have helped numerous physician organizations and their member practices achieve top-quartile results in Medicare Shared Savings and commercial value-based contracts.

This white paper is provided by Joyn Health as an educational resource for physician organizations and their member practices. The information contained herein is for informational purposes only and does not constitute legal, financial, or medical advice. Physician organizations should consult with appropriate professionals before making strategic decisions about ACO participation and value-based care arrangements.

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