Private Sector Accountable Care Organization Development: A Qualitative Study

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ABSTRACT

OBJECTIVES: To explore accountable care organizations (ACOs) as they develop in the private sector, including their motivation for development, perspectives from consumers regarding these emerging ACOs, and the critical success factors associated with ACO development.

STUDY DESIGN: Comprehensive organizational case studies of 4 full-risk private sector ACOs that included in-person interviews with providers and administrators and focus groups with local consumers.

METHODS: Sixty-eight key informant interviews conducted during site visits, supplemented by document collection and telephone interviews, and 5 focus groups were held with 52 consumers associated with the study ACOs.

RESULTS: We found 3 main motivators for private sector ACO development: 1) opportunity to improve quality and efficiency, 2) potential to improve population health, and 3) belief that payment reform is inevitable. With respect to consumer perspectives, consumers were unaware they received care from an ACO. From the perspectives of ACO stakeholders, these ACOs noted that they prefer to focus on patients' relationships with providers and typically do not emphasize the ACO name or entity. Critical success factors for private sector ACO development included provider engagement, strategic buy-in, prior experience managing risk, IT infrastructure, and leadership, all meant to shift the culture to a focus on value instead of volume.

CONCLUSIONS: These organizations perceived that pursuing an accountable care strategy allowed them to respond to policy changes anticipated to impact the way healthcare is delivered and reimbursed. Increased understanding of factors that have been important for more mature private sector ACOs may help other healthcare organizations as they strive to enhance value and advance in their ACO journeys.

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The introduction of the accountable care organization (ACO) as a form of healthcare delivery and payment system reform supported by the Affordable Care Act is hoped to improve quality of care and reduce healthcare costs by aligning the incentives of physicians, hospitals, and other clinicians and healthcare organizations.[1-4] Coined in 2006 by Fisher et al,[5] the ACO label has been defined as "groups of providers who are willing and able to take responsibility for improving the overall health status, care efficiency, and healthcare experience for a defined population."[6]

Although early adopters of the ACO model commonly operated under the CMS Medicare Shared Savings Program (MSSP) or the Pioneer ACO Program,[7,8] recent market entrants have included ACOs in the private market.[8] These private sector ACOs have goals similar to those of the MSSP and Pioneer models in that the contracts with payers include both cost and quality targets; however, they have more flexibility with respect to contract terms relative to Medicare ACOs.[9] For example, private sector ACOs are able to develop multiple contracts with multiple payers to extend coverage across broader, commercially insured populations and those including children. In addition, private sector ACOs can have very different quality reporting requirements and financial relationships with, and incentives for, providers—within the boundaries of antitrust considerations—relative to Medicare ACOs.[9-14]

Early reports have suggested that provider groups decide to become ACOs for a variety of reasons, including the desire to save money and improve care,[15-19] and due to a sense of inevitability about the direction of health reform.[16,20,21] However, few studies to date have focused on private sector ACOs[9,22]—particularly those that bear downside risk—and none have asked both ACO stakeholders and consumers affiliated with these organizations about their perspectives. Because private sector ACOs are not bound by the federal regulations and reporting requirements of Medicare ACOs, they have the potential to develop quickly and for different reasons and in different environments than Medicare ACOs. We undertook this study to improve our understanding of ACO development and

TAKEAWAY POINTS

Improving the understanding of factors that have been important for more mature accountable care organizations (ACOs) can help organizations that are developing and continuing to evolve as ACOs. Our study is among the first to explore private sector ACO development, and we found the following:

- An adequate information technology infrastructure enabling timely access to meaningful data was essential for ACOs to manage and monitor quality and outcomes.
- Consumers generally lacked knowledge of ACOs and were unaware they were part of an ACO.
- Physician engagement and strong organizational leadership to shift culture from a volume focus to a value focus were crucial to ACO development.

implementation in the private sector, which is one of the most rapidly growing sectors of the ACO market.[23] Our research objective was to explore the rationale for private sector ACO development, the perspectives consumers had about these emerging ACOs, and the critical success factors interviewees associated with private sector ACO development.

METHODS

Study Design

We conducted 4 comprehensive case studies of private sector ACOs that assumed full risk from different geographic regions of the United States. Unlike most studies that focus only on the perspectives of ACO providers and leaders, we also focused on the consumer perspective. We elected to use a multiple case study design[24] because of the exploratory nature of our study and our desire to learn from multiple stakeholders to improve our understanding of a relatively new organizational form.[25]

Site Selection

We selected ACOs for study that both operated in the private sector and assumed financial risk for substantial portions of the populations they served. Organizations had to self-identify as an ACO and, consistent with common definitions of ACOs,[13,26,27] they had to involve groups or networks of providers that assume responsibility for the cost and quality of care for defined populations, including some level of downside financial risk. We also maximized the variability of our sample to include ACOs that differed along several important dimensions, including structure (ie, physician-owned vs physician-hospital organizations), size, geography, and population (ie, pediatric vs general). Summary information about our 4 ACOs is included in **Table 1**.

Data Collection

We collected data through site visits during the spring and summer of 2013. Across the 4 sites, we held a total of 68 in-person or telephone key informant interviews. In addition, we held 5 focus groups comprising 52 consumers (**Table 2**). Our data collection process included a concomitant assessment of interview and focus group transcripts and discussion of preliminary findings to permit probing for new concepts and to ensure that we reached saturation in data collection consistent with standards for rigorous qualitative research.[28]

Site visits and key informant interviews. During 2- to 3-day visits, we conducted semi-structured interviews with ACO stakeholders from 4 main areas: 1) organizational leaders (eg, chief executive officer [CEO], chief operations officer, chief marketing officer); 2)

TABLE 1. Characteristics of Study ACOs

Site	ACO Structure	ACO Payment Arrangements	ACO Patient Population	Governance and Structure
New West	Physician-owned	Full risk for physician (professional) services	15,000 (Medicare Advantage)	Primary care group practice 64 PCPs, 16 midlevels, 1 cardiologist (80% shareholders) 11-member elected board
Advocate	Physician and health system organization	Global capitation and shared savings	435,000 (commercial); 105,000 (Medicare Advantage)	1 "Super PHO" and 10 hospitals/PHOs, 250+ sites of care 5500 MDs on staff, 2 MD groups (1100 employed, 3000 independent), 1500 network MDs Over 100 MDs hold governance positions, including PHO boards
Partners for Kids	Pediatric hospital-based (wholly owned subsidiary)	Global capitation	300,000 (Medicaid)	Children's hospital 750+ MDs (primary care, pediatrics, specialists) 16 representatives from hospital, employed and independent MDs who participate in a PHO
Children's Mercy Pediatric Care Network	Pediatric health system–based	Global capitation	110,000 (Medicaid)	Sole member corp of children's health system 400+ employed specialists 200+ network primary care providers

ACO indicates accountable care organization; MD, physician; PCP, primary care physician; PHO, physician-hospital organization.

administrators and staff members who could provide insight about the ACO decision making and development process (eg, informants from business development, strategic planning, finance, contracting, marketing, external affairs, information systems, quality and performance improvement); 3) administrators, staff members, and clinicians involved in ACO operations (eg, ACO administrator, contracts manager, practice manager, medical director); and 4) physicians affiliated with the ACO.

Interview guides and interview process. To ensure consistency in our data collection, we used 2 standard interview guides: 1 tailored for providers and 1 for administrators and staff. The interview guides consisted of multiple-question domains, including: 1) History and Context; 2) ACO Implementation; 3) Consumer Involvement; and 4) Critical Success Factors. These interview guides were tested in a pilot study of a different ACO to improve question clarity and refine the guides prior to our study site visits. Most interviews were conducted in person and lasted 30 to 60 minutes. All interviews were recorded and transcribed verbatim.

Focus groups. Each focus group was conducted using a standard guide that included open-ended questions exploring consumers' perspectives about ACOs and their own healthcare. A study investigator moderated each of the focus groups, with an additional investigator present as a co-moderator. One focus group was conducted at 3 of the ACO sites and 2 were conducted at the fourth site to capture consumer perspectives from both the urban and rural markets this ACO served. Each focus group comprised 7 to 16 participants who lived in the ACO market and interacted with the ACO as patients or parents of patients of ACO providers. Sessions lasted 90 minutes and participants were given a $50 gift card as a token of appreciation for their time. All sessions were recorded and transcribed verbatim.

Document collection and review. For each participating ACO, we also requested key documents related to ACO development. Examples of these documents included the ACO strategic plan, communication vehicles, ACO progress reports, board presentations, and annual reports.

Data Analysis

Our analytic approach included using both inductive and deductive methods to analyze the 1158 pages of transcripts from our interviews and focus groups in an iterative process. After each site visit, the research team first compiled a "Site Visit Summary" that included summary impressions. This initial analysis was helpful for conceptualizing findings and themes and provided insight into more focused inquiry.[29]

Our second analytic step involved coding the interview transcripts to break this qualitative data into smaller, meaningful segments for analysis.[29] We developed an initial set of codes based on our interview guides and emergent themes from the site visit summaries; we then summarized these codes in a "coding dictionary" that included detailed definitions to ensure consistent application of the codes.[29] This preliminary coding dictionary was further refined as themes and patterns emerged in the data. Three members of the research team then coded the data and, throughout the coding process, conducted cross-checks of the coded data to ensure that codes were consistently applied.[28] Data were coded and managed using a qualitative software program, Atlas.ti (Scientific Software Development GmbH; Berlin, Germany).

TABLE 2. Study Participants, by Site

Site	Key Informants	Focus Group Participants
New West	12	13
Advocate	17	9
Partners for Kids	22	7
Children's Mercy Pediatric Care Network	17	23 (2 groups)
Total	68	52

The third step of analysis we conducted for this paper involved examining the codes of "motivations" and "critical success factors" to inform our understanding of private sector ACO development. We used an inductive approach to identify themes and patterns in the coded data, first focusing on patterns within cases (ie, study sites) and then evaluating whether these were replicated across cases, paying particular attention to any differences in the contrasting cases (eg, in pediatric ACOs vs others).[25] At each stage of this coding and analysis process, we also sought and considered disconfirming evidence[25,28,29] to ensure the robustness of our findings.

RESULTS

Motivation for ACO Development

When asked about their motivation for developing a private sector ACO, interviewees across the study sites noted 3 reasons, explained here and with supporting evidence presented in **Table 3**. The first was to lower costs while improving care quality. As one ACO executive summarized, "We came together with a fundamental mission of improving cost of care and improving quality of care." Second was to improve coordination of care and population health management. This motivation was acknowledged even in the face of understanding that all incentives were not aligned. As one interviewee explained, "You can't see either the hospital or the health plan or the physician group or whoever the players are as adversaries, even though your incentives might not always be completely aligned. You've got to find a way, a common ground to do what's right for the patient." The third common motivator had to do with a sense of inevitability given the direction of health reform. One interviewee reflected, "I think if you polled hospital CEOs, 90% of them are going to say, 'We are on the path to an accountable care

TABLE 3. Motivation for Developing a Private Sector ACO

Motivator	Representative Verbatim Comment
Reduce Costs While Improving Quality of Care	"We needed to organize in a way that we could provide this cost-effective, quality care, and yet benefit on an economic way. You know, by helping to control cost, and if there's cost savings, that we share in them, reasonably. I look for partnerships where we can mutually benefit. How can everybody benefit? The patient? The physicians? You know, how can everybody benefit from this sort of thing?"
	"Essentially it was driven around the recognition that ... we needed to find a new way to manage patient care. Cost escalations, the burden faced by employers, the patients in terms of the shifting of the costs. We needed to find a new way to manage the care while also improving quality. So, the ACO concept enables us to do that."
	"We were looking for a way to advance quality and improve the efficiency of healthcare, and hopefully lower the overall total cost of care in the marketplace."
Improving Population Health Management	"And as far as-I truly believe that a lot of this is the right thing to do. I think we are providing better care. You can see how we're able to cut some of the unnecessary waste out of the system. I don't think we're there yet; there's a long ways to go. And then-I haven't mentioned the patient experience. I think our patients really see how hard we're trying to improve their experience and promoting quality, and they comment on us. They can see that we're trying really hard to improve their care."
	"I think it's probably at the current time the only evidence-based system that's going to allow us to deliver coordinated and comprehensive care. It's a system that's been developed, proven to work and so I think in order for us to improve healthcare delivery has to start at the primary care level."
Responding to Anticipated Policy Changes	"Health reform is a chance, really, for provider organizations to take a different level of responsibility in the overall care that's provided to the patients, right?"
	"And I think that's kind of what we saw was primarily with exchanges coming into play, and then the uninsured moving into-having the ability to get insurance and get coverage and actually seek care without having to worry about how they're going to pay for it. ... So I think we saw that coming and we said what can we do within that change in context."
	"And then of course you had all the debates of at the federal level, at the state level of global budgets and capitation in general and sort of these factors from top just pushing down more pressure on the provider to figure out a different care delivery model but also a different payment model and so what we decided was that was the right time."

ACO indicates accountable care organization.

organization.' ...there is now a general belief and acceptance in that this is the right thing to do in that whether you're an insurance company, a provider, a hospital, you are moving in this direction." Although individual interviewees at the sites noted other reasons, such as the desire to consolidate market power so that the organization could "leverage the best payments" or to be "a market leader" in this new model of care, these comments did not reflect the collective sentiment across interviewees and institutions.

Consumers' Perspectives about ACO Development

Across the focus groups, none of the consumer participants was familiar with the terms "accountable care organization" or "ACO," nor were any individuals aware they were part of an ACO. This became apparent during each session when no participants provided answers to the questions, "Prior to coming here [to this focus group session], did you know what an Accountable Care Organization was?" and "Did you know that [this organization] was an ACO?" As a result, participants' answers to open-ended questions instead reflected their experience with their own physicians or a named hospital and not the ACO entity. Consumers' lack of familiarity with the ACO model had been predicted by our sites' key informants, who consistently indicated that their ACO outreach efforts purposely did not include branding the ACO to consumers, nor promoting the ACO as something new and different.

Critical Success Factors for Private Sector ACO Development

When asked what interviewees believed to be critical success factors for development and implementation of an ACO model in the private sector, responses could be classified into 5 main categories: 1) physician involvement, 2) strategic buy-in to the ACO vision, 3) information technology (IT) infrastructure and data, 4) experience and understanding, and 5) leadership. These factors are explained below, with additional supporting evidence provided in **Table 4**.

1. Physician involvement. Provider buy-in and engagement were mentioned often and across all 4 sites, and were perceived to be the key factors limiting whether the ACO model could be implemented. As one senior executive explained, "The providers actually have to buy into it...Because if they don't, you can provide reports and have meetings and do everything that you want to, but if the providers haven't actually bought into it, it's an uphill battle." Engagement and involvement of physicians in ACO governance were also important, with one interviewee summarizing this factor as "absolutely bringing physicians to every point in the table."

2. Strategic buy-in to the ACO vision. Strategic vision and buy-in at the organizational level (ie, moving beyond provider-level buy-in) involved commitment from and across the organization rather than only individuals (providers) engaging with the ACO concept. One senior executive reflected, "I think you really need that strategic

TABLE 4. Critical Success Factors for Private Sector ACO Development

Success Factor	Representative Comment
Physician Involvement and Engagement	"Without our support and from our physicians and their buy-in, you can get people to contract with you—they don't necessarily have to be an active participant in what's going on. Our physicians are so active and so responsive—they're amazing. We have a great group of people we work with. Buy-in from everybody."
	"The governance structure that we've built so that it is physician governed. That seems silly to say that, but it's critical because it doesn't always exist. With an attitude, if [the ACO] does well, I know I will do well. So they come to meetings less focusing on themselves and what the group can do for them, but 'if the group does well, I do well, so what can I do for the group?' And achieving that is not a simple task."
	"Physician champions. … They really carry the message out there in the docs' lounge to the other independents, and then physicians are complaining about '[organization's] making me do this, [organization's] making me do that' they can kind of bring the value proposition to the physician."
Strategic Vision and Buy-in	"I just think the biggest is buy-in. You have to get people to believe it. You have to have payers who are willing to do it and/or it has to be forced on the payers by the government."
	"So I think, in an accountable care world, I think, truly, to be successful, it's about partnership at every level around this vision. And so vision is critical, then. And the vision is one that everybody has to buy into culturally and operationally. And then I think you can get onto the meaningful work of, you know, providing the best outcomes, but there's a lot of trust that has to develop in order to do that."
	"This model is the most radical shift on that model because essentially it says 'It doesn't really matter who sees the patient. It doesn't really matter if the patient is seen. It doesn't matter wherever the patient is; the most efficient and effective healthcare should get to them. Whether that's in their home, that's in their iPhone, that's from a nurse practitioner, it's fine.'"
IT Infrastructure and Data	"[T]o have the infrastructure in place to be able to share the outcomes data with your physicians on an ongoing basis to see how they're doing. You can have physicians who are bought into it and are engaged in it, but they need to know how they're doing, and they want to know they're doing, right? So I think that would be a second critical success factor."
	"You've got to have adequate data from your health plans so that you can figure out what you need to figure out."
	"A good data infrastructure. I think time and time again we've seen that really anybody in healthcare wants to do better if the data can be provided to them that they really believe in and that's provided on a regular basis."
Experience and Understanding	"I don't think [we would have been successful without our experience managing risk]. I mean, I think we could be in the game, but I don't know if we could have achieved our medical home status that we have as quickly. I don't know if we'd have the key staff in place to be as successful as we are. I think we could still be in it, I just don't know if we were as set up for success like I think we are."
	"What we find is that with the experience that we've had previously, we're sort of anticipating what's coming down the road. And I think that's positioning as well, as we move forward. Otherwise, you're spending a lot of time scrambling."
	"Back when we were preparing for capitation in the late '90s, I was involved with, actually our CEO was working with clinical pathways to try to make ourselves a little bit leaner and standardize our care, so that was all setting the stage for delivering the best care possible in an efficient manner."
Leadership	"Well, I think [our CEO] had a lot to do with it. You know, she's got an actuarial background, and so she understands the reality that physicians are wonderful caregivers, but they're not great businesspeople, necessarily. And so she has led them, very gently but very directly, down a road where her expertise has affected—positively affected the financial outcome of the organization."
	"I think it's probably our leadership. I think our president, who's a practicing doctor, understood it and our CEO understood it, because she came from the health plan. Just the fact they understood that to begin with and they embraced it set us up for long-term success, I think."
	"I guess you have to have a strong administrative leadership. You're in this for the long run, your system…has to support this. Because there are winners and there are losers in this. If we reduce admissions to help unnecessary admissions to reduce costs, that's definitely affecting/impacting the whole system."

ACO indicates accountable care organization; CEO, chief executive officer; IT, information technology.

buy-in … the fact that the healthcare system needs to take some responsibility to figuring out how to provide more effective, affordable, and efficient care that still meets the needs of the patients." Interviewees at other sites made similar comments about the importance of buy-in to help ensure support for required investments and the effort required to support cultural changes for the organization.

3. IT infrastructure and data. IT was commonly recognized as critical. As summarized by one executive, "Well, an IT infrastructure is key. You can't control what you can't measure. You need to define your quality and utilization parameters. … You've got to build the structure right. You've got to have adequate data from your health plans so that you can figure out what you need to figure

out." Beyond infrastructure, interviewees also recognized the need for the data that the systems supported. As one ACO director noted, "You can have physicians who are bought into it and are engaged in it, but they need to know how they're doing, and they want to know how they're doing, right?"

4. Experience and understanding. At all 4 sites, interviewees explicitly noted that past experience with risk was contributing to their successful implementation of the ACO model. One director commented, "What we find is that with the experience that we've had previously, we're sort of anticipating what's coming down the road. And I think that's positioning as well, as we move forward. Otherwise, you're spending a lot of time scrambling." This understanding was also valued at another site, as an interviewee explained, "We felt that we could take risk for a population that we knew very well and that we could manage the health of that population within the fiscal constraints."

5. Leadership. Comments emphasizing leadership as a success factor reflected the importance of the leadership function overall, as well as the need for leadership of the cultural changes required to implement the ACO model. One manager commented, "The cultural shift is pretty huge to move from fee-for-service. And that whole mindset and getting people to really be able to embrace that." Leadership was noted to be especially important as the ACO model evolved. As one executive explained, "And even when everybody's on board it's tough, because there are winners and losers, and people's roles are going to change, how they're perceived to perform, their incentives will change. It's a tough cultural change even when everybody's on board. So if there's any hesitation by an important part of the organization, it's going to be tough."

DISCUSSION

The ACO concept has spread beyond the Medicare ACO initiatives, as provider and payer organizations in the Medicaid and private markets are developing ACOs to serve these populations. Lacking clearly defined models for private sector ACOs, however, payers and providers in these spaces are left to develop their own models. Furthermore, because most research to date has focused on ACOs developed in the MSSP and Pioneer ACO programs, there is little information about how and why ACOs are developing to serve other populations. In this paper, we have begun addressing this gap by providing early insights from the development and implementation of 4 ACOs serving privately insured and Medicaid populations.

Although private markets and populations may vary from those served by the MSSP and Pioneer programs, our findings suggest that many of the motivators for developing private sector ACOs are similar. The need to control the rising costs of care while simultaneously improving the quality of care, the need to develop capabilities to manage population health, and a sense of the inevitability of healthcare reform were the primary motivations for ACO development espoused by our interviewees. In a sense, providers want to "do the right thing," and they perceive the ACO model as providing an opportunity to do that. This mix of motivators suggests both push and pull forces at work. The sites we studied are moving away from legacy approaches to healthcare financing and delivery, including fee-for-service and fragmented, siloed care, which they feel are no longer sustainable nor desirable. At the same time, these organizations are moving toward new contractual and organizational arrangements that they perceive both as inevitable and as allowing them to improve the health of populations.[27,30] In short, healthcare reform efforts to better align incentives with quality and population health goals for traditional Medicare populations appear to be affecting transformations more broadly.

Our findings that consumers lacked knowledge of ACOs and were unaware that they were part of an ACO are notable, especially given growing emphasis on the engagement of patients in their own care.[31-33] Providers and payers involved in developing ACOs are investing considerable time, money, and effort to transform the healthcare system, and yet the parties with arguably the greatest stake in that transformation are neither informed of nor empowered to shape these efforts. Given the linkage between patient behaviors and many health outcomes, we expect there are numerous opportunities to involve consumers in ways that will improve the abilities of ACOs to accomplish their goals. For example, there may be opportunities to provide incentives, including financial ones, to engage patients or to provide physicians training in patient engagement.[34] Other opportunities may be to include patient representatives in governance, as required in the MSSP and Pioneer ACO programs, but not required in any private sector ACO model of which we are aware.

Implications for Management and Policy

Our findings suggest the importance of having strong leadership and physician engagement as part of ACO development, thus highlighting the importance of physician engagement reported in prior studies.[22] Moving beyond physician engagement, however, all of the ACOs in our study had physicians in formal leadership positions and 3 of the ACOs had strong physician representation on their governing boards. The ACOs in our study included employed and community physicians in various aspects of decision making, ranging from compensation and incentive committees to quality improvement initiatives. Our findings about the importance of physician leadership are consistent with a recent national survey of public and private ACOs, which found that more than half of all ACOs are physician-led and that physicians make up the majority of governing boards in over 75% of the ACOs surveyed.[23] Strong physician leadership could also help facilitate high levels of communication across providers, thereby improving patient care.[35]

These findings also underscore the need for adequate IT infrastructure for ACO development. Policies, such as Meaningful Use,

helped motivate providers to implement electronic health records, which is a necessary first step. However, ACOs need the ability to access timely and meaningful data to monitor and improve outcomes and efficiency. The ACOs we studied are making significant capital investments in data and reporting capabilities; meanwhile, the ACOs that are unable to make the necessary capital investments in IT infrastructure will likely lag in terms of development. The Medicare Advance Payment Model attempts to address this capital need for smaller or rural Medicare ACOs; however, there do not appear to be similar arrangements in the private sector ACO markets.[36] Rather, private sector ACOs either rely on capital infusions from physician groups or health system partners or turn to the credit markets. The limited options for capital support may hinder private sector ACO development, particularly for newer and smaller private sector ACOs.

The ACOs in this study had all been in risk arrangements well ahead of the emergence of the term "ACO" and had considerable experience (and success) in managing risk. Thus, they were able to reorganize relatively quickly as ACOs and had the confidence that they could take on the associated risk and responsibility successfully. New ACOs may face more challenges ramping up and may need to enter the private sector ACO market with lower-risk arrangements, such as shared savings, as they work to gain experience with contracts and population health management.

Limitations

One important limitation of this study was the small number of organizations involved. Given the time and energy constraints of qualitative studies, there are significant barriers to large-scale studies. Future work can include the development of surveys based on this research to explore and validate our findings in large samples. However, the ACOs included in our study are relatively mature, and their experience and perspectives provide important insights for newer ACOs that are considering entering the private market and assuming downside risk. Another possible limitation is that the ACOs in our study are likely to have experienced substantial changes from the time of our initial visits, given the rapid development of the ACO market.

Future Work

The private sector ACO market is developing rapidly. Recent estimates suggest that approximately half of the 600 ACOs identified in the United States are private sector ACOs.[37] Given this rapid growth, future research should include larger-scale studies to explore the structural and financial arrangements in private sector ACOs that facilitate their development. Future studies should also focus on the performance and sustainability of the ACO model in this market. To date, approximately one-third of the ACOs participating in the Medicare Pioneer ACO program have withdrawn[38]; however, far less is known about exits within the private sector.

CONCLUSIONS

This study is among the first to explore the development of ACOs in the private sector. We found that these ACOs developed under the belief that payment reform is inevitable and that they perceived that becoming an ACO would allow them to respond to anticipated policy changes that will impact the way healthcare is delivered and reimbursed. These ACOs were also motivated by the opportunity to increase quality of care and efficiency and to improve population health. Moreover, each organization's prior experience with successfully managing risk was identified as a factor that prepared these ACOs to enter downside risk arrangements with confidence. Although private sector ACOs are still evolving, improving our understanding of the factors that have been important for more mature ACOs can help facilitate the development of less mature organizations that are beginning or evolving their ACO journeys. ■

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