Accountable Care Organizations Are Increasingly Led by Physician Groups Rather Than Hospital Systems

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ABSTRACT

Because hospitals and health systems sponsored the majority of new accountable care organizations (ACOs) from 2010 to 2015, they influenced priorities and strategies of the policies designed to drive ACO adoption. In recent years, however, the majority of new ACOs have been sponsored by physician groups. This shift means that policies need to be developed with the characteristic strengths and weaknesses of physician-led ACOs in mind. Using data from the Leavitt Partners ACO database, we analyzed the types of providers becoming ACOs over time to look at their numbers and market potential. Because the market potential for further growth of physician group–led ACOs is much stronger than for hospital- or health system–led ACOs, policy makers need to create programs and policies that facilitate physician-led ACOs' success by helping them develop the capacity to take on risk, finance investments in high-value healthcare, and partner with other organizations to provide the full spectrum of care.

Am J Manag Care. 2020;26(5):225-228. doi: 10.37765/ajmc.2020.43154

From 2010 to 2015, hospitals or health systems sponsored the majority of new accountable care organizations (ACOs). This allowed them to influence the priorities and strategies of policy makers as they created regulations and polices designed to drive these organizations. However, in recent years, the ACO market has seen a shift in leadership as physician group organizations have begun to lead the majority of new ACOs (**Figure 1**). This trend, and the significantly higher market potential for physician groups, suggest that they will continue to lead a significant number of new ACOs. With this change, policy makers and practitioners must consider the unique needs and opportunities of physician groups in the transition to value-based care.

Background

ACOs consist of healthcare providers that accept responsibility for the cost and quality outcomes of a defined population. The defining characteristic of an ACO is the contract that establishes the provider group as being financially accountable for value. However, the type of care delivery changes that can be implemented to achieve ACO goals is determined by an ACO's organizational structure.

In response to the policy environment, many early ACOs were large organizations that included hospitals, had prior experience with risk-based contracts, and had access to capital to invest in new technologies and start-up costs.[1] For example, of the 10 participants in the Physician Group Practice Demonstration—the precursor to the Medicare Shared Savings Program (MSSP)—8 were hospital affiliated, 8 had experience with performance-based payment arrangements,[1] and 8 had prior access to, or funding for, electronic health records (EHRs) and other information technology (IT) systems to track data. Because many early ACOs were hospital affiliated, policies, payment models, and care delivery models originally focused on building competencies for similar organizations. However, these policies and strategies may need to be reconsidered as the model moves forward.

Presently, ACOs range from large integrated delivery systems to hospitals with partner practices to multispecialty physician groups to small primary care physician groups.[2,3] To understand changes in care delivery, it is important to understand the organizations

TAKEAWAY POINTS

New accountable care organizations (ACOs) are increasingly led by physician groups rather than hospital systems.

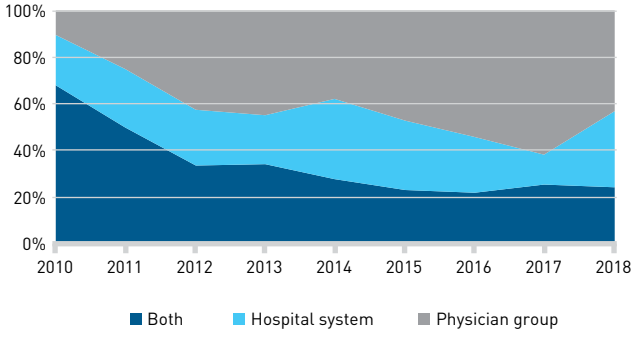
- In 2018, physician group–led ACOs represented approximately 45% of all ACOs, hospital-led ACOs accounted for approximately 25%, and joint-led ACOs represented 30%.
- There is greater market potential for new physician-led ACOs than for those led by hospital systems, so physician-led ACOs will likely be the dominant type of ACO in the future.
- Because hospitals and health systems sponsored many early ACOs, policies, payment models, and care delivery models initially focused on building competencies for these groups. However, these policies and strategies may need to be reconsidered as the model moves forward.

participating, their characteristics and capabilities, and new participants attracted to these models. Our study reveals that physician groups—rather than hospitals or health systems—are becoming the dominant type of ACO and represent the largest potential type of organization to join the model. We use a simplified provider type to separate ACOs into 3 categories: hospital-led ACOs, physician group–led ACOs, and ACOs that are led by both a hospital and physician group. ACOs with hospitals are generally well financed, include an established health IT (HIT) infrastructure, and either have implemented or are experimenting with sophisticated data analytics systems.[4,5] In contrast, average physician group ACOs tend to have less sophisticated HIT capabilities and data analytic tools[6] and tend to be smaller, averaging a patient population of 20,000 lives, whereas ACOs with hospitals average 44,000 lives. ACOs across and within these groups have varying needs, competencies, and capabilities.

DATA AND METHODS

Data on ACO provider types were obtained from the Leavitt Partners ACO database, which tracks organizations that are participating in accountable care payment arrangements and includes information on organizational structure.[7] Hospital affiliation or ownership by an ACO in the database has been previously validated through surveys.[4]

FIGURE 1. ACO Provider Type by Start Year



ACO indicates accountable care organization.

Determination of whether the ACO is physician, hospital, or jointly led is based on qualitative assessment of the broader organization, not just the providers participating in an ACO contract. For example, a health system consisting of hospitals and physicians may participate in the MSSP but may only list primary care physician practices on the official participant list. Because no hospitals are officially listed as participants, some evaluators would consider this "physician led," but we consider this to be jointly led because the health system, including the hospitals, established and directs the ACO. Physician-led ACOs, then, should be viewed as organizations that are involved in ACOs that do not involve hospitals directly in the payment arrangement or in the broader organization. The data include all ACOs in the database with information on their provider type, which represented 1221 of 1334 ACOs as of the end of 2018. For this paper, we track only the year of their first contract and include organizations that subsequently dropped out of all ACO programs in the aggregate estimates. Estimates of total market size are derived from Torch Insight,[8] a commercial healthcare data aggregator.

RESULTS

Figure 1 provides an overview of the types of providers that are becoming ACOs over time. The figure should be interpreted as the percentage of ACOs that fall into each category for each year. In 2010, 22% of ACOs were led by physician groups only, 63% of new ACOs were led by both a hospital system and a provider group, and 16% were led by hospital systems only; 79% of all ACOs in 2010 included a hospital in the ACO's structure.

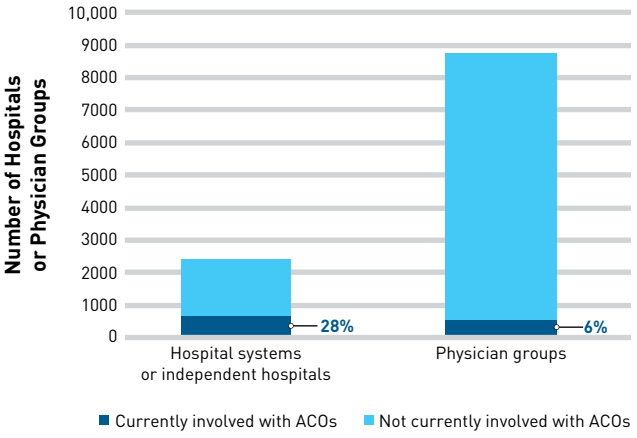
By 2016, the market changed, and 55% of new ACOs did not have a hospital participant. This continued into 2017, when 62% of all ACOs were physician group–led ACOs, although in 2018, only 45% were. The broader trend has been for the proportion of both hospital-led ACOs and joint hospital and physician group–led ACOs to decline.

In the aggregate in 2018, physician group–only ACOs represented approximately 45% of all ACOs, whereas hospital-led ACOs accounted for approximately 25% and joint-led ACOs represented 30%. This indicates that although physician-led ACOs represent the majority of new entrants, they are a minority of total ACOs, but they may become the dominant type of ACO in the country within the next few years if the trend of new entrants continues. A figure representing overall ACOs is available in the **eAppendix** (available at **ajmc.com**).

Estimating the market potential for ACOs is challenging, but we performed back-of-the-envelope calculations to get a sense for ACOs' market penetration and potential. We first estimated that health systems or independent hospitals that included short-term acute care hospitals could potentially form an ACO and that physician groups with at least 15 providers could potentially form an ACO (based on the minimum number of physicians for the smallest

ACOs). Ongoing consolidation could decrease this total market potential when larger groups or health systems combine, or it could increase this number as smaller physician groups merge to become large enough to enter into an accountable care contract. Also, some physician groups are owned by hospital systems, which may decrease the market potential for potential physician-led ACOs that do not include a hospital.[9] We estimate that as of December 2018, 28% of existing health systems or independent hospitals were participating in an ACO of the more than 1700 hospitals or systems that could potentially form an ACO. In comparison, only 6% of the more than 8200 physician groups that are large enough to ultimately form an ACO have done so. **Figure 2** depicts the market potential.

FIGURE 2. Market Potential for ACOs



ACO indicates accountable care organization.

DISCUSSION

Although 45% of ACOs now comprise physician groups without a hospital partnership, the market potential for further growth of physician group–led ACOs is much stronger than for hospital- or health system–led ACOs. Our market potential estimates are admittedly rough and should be viewed as only directionally correct, but they suggest that there is more room for physician-led ACOs to develop than for ACOs that include hospitals. The sheer number of physician groups suggests that the dominant type of provider moving forward that has the potential to bear risk will not be hospital based. Additionally, the Medicare Access and CHIP Reauthorization Act, which is targeted to physicians, may further the adoption of ACO models by physician groups so that they can avoid the Merit-based Incentive Payment System and potentially receive the additional 5% boost from participating in an advanced alternative payment model.[10]

Implications

Although well-capitalized health systems[4] with control over much of the care spectrum were early adopters of the ACO model, physician groups are increasingly becoming the predominant provider type involved in accountable care. As physician groups tend to have less experience managing risk, less access to capital, lower overhead, and less-integrated EHRs,[6] policy makers need to understand how increased numbers of physician group–led ACOs will necessitate changes in policy initiatives.

Advantages

Physician-led ACOs have done better at achieving savings and improving quality scores despite less access to capital, less experience managing risk, and less sophisticated HIT systems.[11] MSSP results have consistently shown that smaller, physician-led ACOs are more likely to earn shared savings than hospital-led or integrated hospital and physician group–led ACOs.[11] From a business perspective, physicians are able to focus on eliminating costly hospital admissions without suffering a drop in inpatient revenue.[4] ACOs with hospitals may struggle with decreasing inpatient admissions, which can cause issues with maintaining capital-intensive inpatient facilities.

Disadvantages

Although physician group ACOs tend to achieve better savings results, lack of capital is a major barrier to market entry and the building of competencies for success. Physician group ACOs often lack the capital to invest in sophisticated HIT systems, data analytics, and other technology capabilities.[12] Without technology, care coordination and management are significant challenges, although some can be met with key management partners.[13]

Financial risk may be another concern as more physician groups enter the ACO market. With little capital or experience in managing care and costs across populations, smaller physician group organizations may not be capable of adequately managing risk. Provider groups in the 1990s attempted to assume full capitation risk and eventually suffered massive financial losses.[14] Policy makers should be wary of pushing too much risk onto physician-led ACOs too quickly and consider initiatives that promote risk management among smaller organizations. The Advanced Payment Model demonstration program and ACO Investment Model did furnish capital to physician-led ACOs, but these programs have been closed to new entrants, and restarting a similar model could be considered.[15] The recent Pathways to Success program does limit the amount of risk that smaller organizations must bear through a "low-revenue" option, and it is apparent that CMS is seriously considering the differences between ACOs with and without hospitals.[16,17] Despite this focus, recent ACO dropouts have disproportionately been physician led, suggesting the need for policies that support physician group success under accountable care models.[3,18]

Recommendations

As physician-led ACOs are increasingly forming and have significant market potential, it will be important to create programs and policies that facilitate their success. Much work has been done in identifying the skills necessary to successfully manage a patient

population,[19-22] such as modernizing technology and accelerating real-world evidence to learn from successful organizations,[19] but more is needed, including learning how to finance necessary investments for smaller groups. Policy makers should encourage the development of tools to evaluate physician-led ACOs and continue to assess how vendors and ACO enablers or management partners can help these organizations succeed.[14] CMS is focusing on reducing the length of time that providers can be in an upside-only ACO arrangement while giving additional time to "low-revenue" providers—a measure they believe is a proxy for physician-led ACOs and rural hospitals.[17] But even with a delay before 2-sided risk is required, there is a continued need to quickly help organizations develop the competencies to succeed. This can be encouraged with additional investment in peer learning communities, sharing examples of successful organizations, and policies that favor the use of ACO enablers (organizations that work with many ACOs to help them be successful and share in the financial success).[23]

Additionally, policies should encourage and facilitate physician-led ACOs to partner with other organizations. By definition, physician-only ACOs will not provide the whole spectrum of necessary medical care. Mechanisms need to be created to help physician groups work effectively with hospitals, postacute care providers, pharmacies and pharmacists, mental and behavioral healthcare providers, and others.[24,25] Policy makers can identify barriers, such as antikickback and Stark laws, that inhibit partnerships across organizations but do not result in consolidation and resulting price increases—in late 2019, HHS did propose changes[26] to these laws, which, if adopted, may encourage these partnerships.

CONCLUSIONS

Physician groups are becoming the dominant type of new entrant into the ACO space and have been the most successful in achieving savings to date. It is uncertain whether this trend will continue, given the Trump administration's push to move ACOs to take on risk earlier, which may hinder the participation of smaller physician group ACOs. Policy makers, vendors, and developers of payment programs must recognize that physician-led ACOs have unique needs and opportunities to address care for patients, and they should create policies that focus on identifying the skill sets necessary for physician-led ACOs to manage the full spectrum of care while concurrently eliminating barriers to partner with other providers and break down care silos. ■

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Source of Funding: None.

Author Disclosures: Dr Muhlestein is employed by Leavitt Partners, which provides consulting services around accountable care organizations (ACOs) and sells ACO-related data. Ms Tu was a contracted employee at Leavitt Partners. Dr Colla reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (DM, CHC); acquisition of data (DM); analysis and interpretation of data (DM, TT, CHC); drafting of the manuscript (DM, TT); critical revision of the manuscript for important intellectual content (DM, TT, CHC); statistical analysis (DM); administrative, technical, or logistic support (DM); and supervision (DM).

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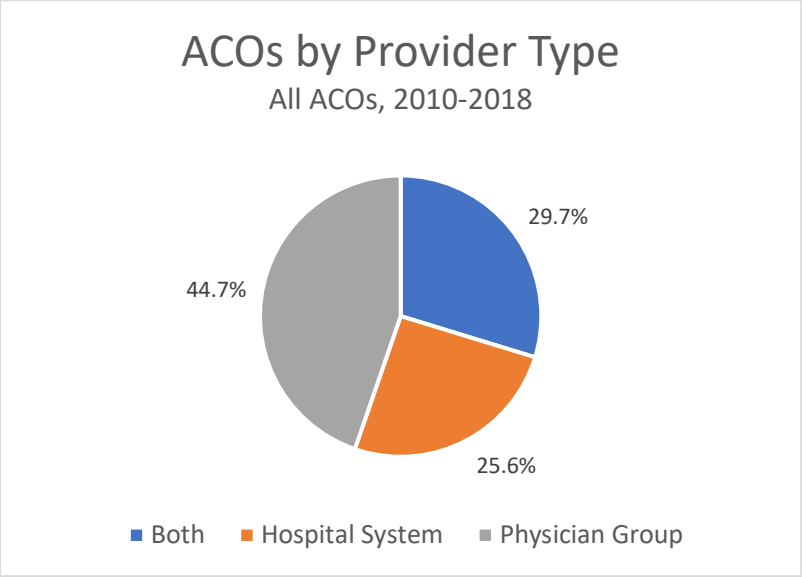
eAppendix. ACOs by Provider Type



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