

Coordination Without Consolidation? Options for ACOs

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Accountable care organizations (ACOs) have been a large part of the transition away from fee-for-service payments, with the number of ACOs rapidly growing over the past decade. However, there has been a plateau in the number of ACOs since 2018, with ACO exits outweighing entrants for the past 2 years.¹ From our analysis of Medicare Shared Savings Program data,² we have found that one key category of ACOs has become less likely to join or remain an ACO: physician group-led ACOs. These lower entrance and survival rates are a problem for the ACO movement given the positive shared savings and quality results that many physician group-led ACOs have been able to achieve.³

In this issue of *The American Journal of Accountable Care*[®], Streat et al examined a cohort of Aledade's physician-led ACOs to understand their evolution, including the specific care changes made by these ACOs, their specific utilization pattern changes compared with others, and overall quality and cost over time.⁴ The authors, part of Aledade themselves, used a difference-in-differences approach to compare the ACO cohort with their region, largely drawing on Medicare claims. In short, the analysis found that, compared with their region, the ACO cohort made multiple care changes: They expanded the number of attributed members receiving annual wellness visits, significantly increased the number of patients receiving transitional care visits, and overall provided a greater number of primary care visits. The authors report that these care delivery changes were associated with reductions in emergency department usage, inpatient visits, and skilled nursing facility utilization, especially in comparison with their region. Overall, Streat et al find that all 5 ACOs achieved shared savings by their fifth year, and the cohort's adjusted costs were 13% lower than those of their region compared with a 2015 baseline.

These findings add to the growing literature showing that multiple types of ACOs can be successful, whether they are confederations of smaller, independent primary care practices or larger, integrated systems. This is an important point given concerns about consolidation.^{5,6} Further, the article underscores that ACOs can be an important tool in supporting independent primary care. Independent primary care practices have been struggling during the past 2 years, with their revenue dropping dramatically during the early days of the COVID-19 public health emergency. Many practices instituted furloughs, merged with or sold to a larger system, or simply closed their doors. Our research found that clinicians who were part of an alternative payment model were more likely to weather the storm because they had more financial flexibility and had built up organizational competencies that had allowed them to quickly pivot their care workflows to the care needed during COVID-19 (eg, more telehealth, greater attention to social drivers of health, and more coordination with testing and public health).⁷

Given these policy benefits, we must ask what we can learn about successful physician group-led ACOs and how payers can help these practices succeed. From this article and our own research, we will highlight 4 points to support physician group-led ACOs, as well as other types of ACOs, in improving the health of their attributed population.

First, this article and our prior work find that value-based payment models take time to succeed. Streat et al found that results were not seen in the first and second years. It was not until the third year that consistent results were observed for the 5 physician-led ACOs. This 3-year timeline is consistent with our own findings, as we found that the risk of ACO exit drops substantially after the first 3 years.⁸ The policy implication is that

the current Pathways to Success program allows 1 to 3 years before moving to downside risk, with the longer time period for ACOs with low-revenue status (as a surrogate for physician group-led ACOs). It will be important to continue to monitor whether physician group-led ACOs are appropriately classified as low revenue and how they are progressing through that risk sequence. Further, this research and our own were conducted outside a public health emergency, and the transition to risk may be more challenging when organizations are juggling other priorities. As a result, the Medicare Shared Savings Program has proposed pausing automatic advancement along its glide path of increasing levels of risk for performance year 2022.⁹

Second, any discussion of physician group-led ACOs must include access to start-up capital, which is a major barrier to entry for many new ACOs. ACOs can need substantial up-front capital for data infrastructure, hiring and developing staff members, and population health interventions.¹⁰ Smaller, physician group-led ACOs may have less access to capital than larger, more integrated organizations. The issue of access to capital can be addressed via 2 strategies, either through new models that directly support ACOs (eg, the ACO Investment Model¹¹ or CHART model) or through a clear, predictable program for outside capital such as private sector partnerships (eg, Adelaide, Agilon, Caravan).

The third takeaway is the challenge that administrative costs present, potentially causing physician group-led practices to reject participation in an alternative payment model. Streat et al highlighted that physician group-led ACOs often have fewer resources and staff to help with administrative tasks. One strategy for reducing the administrative overhead of ACOs and other alternative payment models is by aligning quality measures across payers, which will focus attention on the measures that matter most. In addition, there are opportunities to align other model components across alternative payment models and across payers (eg, benchmarking, attribution). Efforts to reduce administrative overhead can make it easier for all types of ACOs to join and remain in the model as well as reduce clinician stress and burnout.

Finally, Streat et al recommend that the ACO model should help reduce health disparities. This is an important time to examine how ACOs can improve equity, given that the COVID-19 pandemic revealed and exacerbated health disparities¹² and that CMS has emphasized the importance of equity for all agency programs.¹³ ACOs, and value-based payment broadly, have the ability to improve equity given their financial flexibility, which allows care delivery organizations to devote resources to social drivers of health and to examine their data to identify the services and needs among different populations of attributed patients.^{14,15} One approach to further advance health equity in ACOs would

be to integrate equity-focused quality measures, such as measures that capture important processes (eg, social needs screening) or by stratifying existing quality measures by sociodemographic factors (eg, race, ethnicity, language). Payers could also empower ACOs with greater flexibility and technical support to address social drivers of health, such as food insecurity, transportation, and housing.

In summary, this article presents a useful case example of successful physician group-led ACOs that were able to improve care quality while reducing costs. The work is timely, as ACOs are one way to continue to support independent primary care practices that have struggled throughout the public health emergency and to help them reduce the disparities that have been made more visible throughout the pandemic. The article demonstrates the importance of ensuring that ACO programs can continue to support multiple types of ACOs, such as through more aligned measures and payment model components, better access to capital, and a glide path toward risk. Streat et al remind us that improving quality and shared savings are possible and point toward a future in which we are able to align incentives of care, cost, and quality.

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