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Valuation of Accountable Care Organizations: Competitive Environment

As of the first quarter of 2022, 1,010 accountable care organizations (ACOs), comprising 1,760 private and public ACO contracts that covered 32 million beneficiaries, operated across the U.S.[1] The majority of these ACOs were physician-led (41%), rather than hospital-led (26%) or jointly-led (27%) ACOs.[2] While the number of ACOs have steadily increased over the past several years, ACO growth has slowed, and even slightly decreased, in the past couple of years;[3] this may be explained by shifts in federal government programs that are pushing all ACOs to take on downside risk at a faster pace.

Arguably the greatest resource of ACOs is primary care physicians (PCPs), who play a large role in these organizations as the so-called quarterbacks of coordinated patient care. Therefore, the supply of ACOs is partly driven by the supply of PCPs. Between 2017 and 2021, the supply of PCPs[4] generally increased, both overall and as a function of people per physician.[5] Despite primary care continuing to be one of the most popular medical specialties, the number of PCPs is expected to decrease in coming years, with more PCPs moving toward retirement.[6] Predictions from the Association of American Medical Colleges (AAMC) expect a shortage of over 14,000 to 49,000 PCPs by 2030.[7] In addition to workforce attrition, another critical factor in the supply of available physicians is the generation of new entrants into the physician workforce, which is currently not sufficient to make up for the retirement trends.[8] However, the ACO model does not solely require physicians for patient treatment; on the contrary, the participation of advanced practice clinicians (APCs) such as nurse practitioners is instrumental, and many Medicare beneficiaries already use nurse practitioners and physician assistants as their primary care providers.[9] Therefore, ACOs' use of non-physician providers may put the industry at a competitive advantage as PCP shortages become more acute.

ACO participants can vary greatly depending on the ACO. In addition to PCPs, most ACOs include hospitals, specialists, and post-acute providers; some also include pharmacies.[10] ACOs generally do not focus on one specialty because the organization is responsible for *all* beneficiary expenditures, leading many ACOs to integrate a variety of parties.[11] Physician-led ACOs are typically large specialty provider groups and a hospital, while hospitals employ the physicians in hospital-led ACOs.[12] In some ACOs, private insurers play a significant role, although payors are not in charge of medical care.[13]

Due to the variety of participants in a given ACO, the demand for ACO services correlates to the healthcare service industry overall. The variation in services offered allows ACOs to shift services to other less-costly areas of the ACO. For example, an ACO may find emergency room physicians to be relatively costly and move services to skilled nursing facilities (SNFs) or shift patients away from PCPs or specialists by utilizing telehealth. Consequently, ACOs are uniquely positioned to rewrite the traditional rules of supply and demand in healthcare services because the conventional analysis of physician demand cannot be utilized.

Overall, the demand for healthcare services is expected to rise, due in large part to the aging American population.[14] Medicare beneficiaries are projected to become the most significant core users of healthcare services in the U.S. by 2030.[15] While not all Americans may have insurance, many Americans will have increased spending power due to being employed.[16] Demand drivers for ACOs in particular include the U.S. healthcare delivery system's shift from *volume*-based to *value*-based reimbursement (VBR), which, as discussed in the previous installment in this series, requires providers to work together to reduce cost and increase quality. However, generating savings necessarily depends on the reimbursement paid to the ACO, which will be discussed in the next installment.

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