ACO’s in 2015
EXECUTIVE SUMMARY

Forty-one preliminary Accountable Care Organizations (ACOs) existed at the end of 2010, but the ACO really began its journey with the dawn of the Affordable Care Act (ACA) in 2011 and Medicare’s Pioneer ACO and Shared Savings Program in 2012. Although value-based care means many things (bundled payments, partial capitation, medical homes, etc.), the ACO is at the forefront of these new delivery systems.

In the last few years, private carriers, State Medicaid programs, physician organizations, hospitals, non-profit community organizations and practice management companies began testing the ACO waters.

The pay-off verdict is not in, but with over 600 ACO organizations currently operating in the U.S., many providers are going forward with a leap of faith that it will be one of the ways to reach the ACA’s three-pronged goal of improving quality outcomes and patient experience/care, all at a lower cost to the American health care system.

In 2015, ACO models still represent a minority of care in the U.S. and it will be up to those who took the challenge and set up their ACO models to encourage, teach and assist others in following them. Even the largest health care organizations in ACOs say it is not easy to balance providing better care at a lower cost while maintaining enough income to keep their organizations profitable. In 2014, we saw some organizations rise to the top and some drop out of their contracts, due to the expense of setting up the new entity and taking on the “risk” portion of their ACO contracts.

ACOs must be able to increase and retain their patient base, since loss of patients means loss of
revenue which can directly affect cost-savings from new efficiencies. ACOs must also have the capital
to invest in technology for coordinating patient care along with analytics that shows when they are on
target, and when corrective actions are required.

With all that to do, ACO organizations continued to grow in 2014 with projections for more growth in 2015.
This whitepaper summarizes what has taken place with ACOs in 2014 and where they are headed in 2015.

BACKGROUND

The growth of ACOs was impressive from their start in 2012 through January 2013. However, 2013
slowed with only 35 new ACO organizations in the first 9 months. At the same time, the Medicare Pioneer
ACO Program lost some of its members in the summer of 2013.

The creation of ACOs picked up early in 2014, when the Centers for Medicare and Medicaid
Services announced 123 new Medicare Shared Savings Program (MSSP) Accountable Care
Organizations (ACOs). Some of these organizations were already known to be ACOs, including those
that transferred from the Pioneer ACO program, but many were new to accountable care, bringing the
total number of public and private ACOs to 626.

Leavitt Partners, through its Center for Accountable Care Intelligence, estimated that the number of
ACOs had grown from a few dozen at the end of 2010 to nearly 500 at the end of September 2013 and
was actively tracking 626 ACOs across the US in May 2014. Of these 626 ACOs, 329 have government
contracts, 210 have commercial contracts and 74 have both government and commercial contracts.
The remaining 13 ACOs have not made specific announcements about the nature of their contracts or
are in the process of finalizing contracts that are not yet active.

The 626 ACOs cover over 20.5 million lives with the majority in commercial accountable care contracts,
followed by the Medicare Shared Savings Program (MSSP), the Pioneer ACO program and finally Medicaid
programs. The growth in ACO-covered lives continues to be concentrated in high-density populations and
states with Medicaid ACO legislation.¹

In the summer and fall of 2014, Medicare lost four more Pioneer ACO’s but continued to seek and
take applications for new ACO organizations to join the initiative. As a result, 89 new ACO’s joined the
MSSP on January 1, 2015. The proposed rule on December 2, 2014 is evidence that CMS is adjusting
their original structure regulations to encourage new entities to participate and to provide incentives
to retain their current participating ACOs.

Commercial carrier and Medicaid ACOs continued to spring up across the country in 2014. Physician-led
organizations continue to be the most common, followed by hospital-based, insurers and others.

Where Medicare is tip-toeing lightly with risk-models, commercial carriers are looking for physicians
to take on more risk. But physician groups need to be more aggressive in modeling out their financial
future in the areas of risk strategy, contract structure and incentives.²

ACO UPDATES

Physician-Led ACOs

Although more than half of the ACOs in the United States are physician-led, many physicians, 60% from the latest study published in March 2014, have not joined an ACO and do not plan on doing so in the near future. In most cases these are physicians who do not have the resources to manage the costs of setting up and running an ACO. This generally includes instituting electronic health records, care coordinators, formal quality improvement initiatives and caring for chronically ill patients.

Most of the physicians involved in ACOs are in larger practices that receive patients from a physician owned IPA and/or PHO, and those with greater patient-centered medical home management processes.

Some are physician-owned and others are joint ventures with capital partners or other integrated systems. Generally, but not always, they include primary care as well as specialists-owned systems.

The physician-led ACO hopes to prosper by keeping its patients out of the hospital and ER and by reducing readmissions. Mechanism to do so include managing care in the office and outpatient settings and using patient-centered medical homes to coordinate care among specialists.

Charlie Baker, the former Secretary of health and Human Services in Massachusetts and now Governor of the state, recently noted “that nearly every shared-risk model in Medicare Advantage is with physician groups and not hospitals...because insurers know that’s how to save money.”

Physician-led ACOs also promote and enhance competition in markets as they shift patients to higher-value and lower-cost hospitals.

Although, most physician-led ACOs are large practices, they tend to be smaller than hospital ACOs, serving on average about half the number of patients.

At a time when physicians are asked or required to participate in programs which affect their revenue by changing how they practice (e.g. PQRS, Value-based Modifier Program, conversion to EHR systems and potentially, ICD-10), joining or starting an ACO is another monetary risk, especially for smaller groups.

The Medicare Shared Savings Program certainly offers ways for physician-led groups to participate in an ACO with upside potential and little to no financial risk in the first years. Commercial carriers entice practices by offering technical assistance, relieving many of the start-up burdens. The challenge, no matter what type of ACO, is to remain successful once the start-up period is over and monetary risk becomes a factor.

Those interested in physician practices who are making the ACO-type model work for them will be interested in the following articles.


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THE MEDICARE ACO PROGRAMS

CMS promotes the ACO model for its potential to increase the value of health care services rendered to patients across providers, specialties and sites of care. Now finishing its third year, Medicare’s ACO programs (Pioneer and Medicare Shared Savings) have so far produced inconsistent results. Some policy experts and ACO executives have blamed this on how Medicare calculates ACO savings. Several ACOs have dropped out of the Pioneer ACO program and many participants of that program and the MSSP have concerns about the risk they will incur by staying in the programs. The results of a survey in October 2014 by the National Association of ACOs shows that many ACOs are unhappy with the MSSP! In fact, 2 of 3 MSSP ACOs are highly or somewhat unlikely to remain in the program.

In September 2014, CMS announced that ACOs saved Medicare $817 million through 2013. Dozens of participants shared $445 million of that amount, but three-quarters of ACOs saw nothing after failing to do sufficiently well against the financial benchmarks.

With the release of the financial results of the Pioneer ACOs in October 2014, first year results showed health care spending slowing by as much as 7% for some ACOs and increasing as much as 5% for others. The second year saw decreases up to 5.4% and increases up to 5.6%.

Eleven Pioneer ACOs earned bonuses in the program’s second year, with savings that ranged from $1.2 million to $13 million. Six generated losses and will be required to repay Medicare.

The quality-of-care ratings for the Pioneer ACOs were better than their financial outcomes. In their second year (2013), the Pioneer program improved performance in all 3 dimensions (higher quality, better patient experience, and lower Medicare spending). Their mean overall quality score was 84% in 2013, compared with 70.8% in 2012.

However, in this third year, when risk became higher for the Pioneer ACOs, four more ACOs left the program (Sharp HealthCare in San Diego, Franciscan Alliance in Indianapolis, Genesys PHO in Flint, MI and Renaissance Health Network in Wayne, PA) leaving 19 organizations from the original 32.

The new departures may suggest that even large, sophisticated health systems may be unwilling to take losses as policymakers test new payment and delivery models. In order to keep health care organizations participating in the Medicare ACO initiatives and to encourage new participants, CMS has restructured some of their original regulations and requirements and will offer new incentives.

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5 Evans, Melanie, “Medicare’s Pioneer program down to 19 ACOs after three more exit,” Modern Healthcare, September 25, 2014.
CMS Offers More Tools

In 2014, amidst concerns from participants, the Pioneer program evolved to grant more tools to help ACOs improve care and accountability. These included a waiver of the 3-day hospitalization rule before a beneficiary becomes eligible for skilled nursing facility services, offering shared learning activities, and enlarging staffing. CMS also created the Innovation Pod where ACOs can track their costs for care management and calculate a return on their investments.

Two ACOs have opted to have a portion of their fee-for-service reimbursement converted to a monthly population-based payment, which offers them revenue flexibility to reallocate resources for care management. More organizations are expected to opt for this payment method in the future.

Curbing Seniors from Seeking Care Outside the ACO

With the release of the mixed Medicare ACO results, one of the measures CMS is considering to improve revenues is curbing seniors from seeking care outside their ACO. Currently, seniors may see the doctor they wish, which is often outside the ACO’s territory. Going outside the ACO for care can undermine the ACO’s efforts to manage quality and costs and weakens incentives for ACOs to make investments in services or programs that won’t deliver immediate returns.

In 2015, the CMS Innovation Center will test whether seniors will elect to enroll in an ACO and if they do, will evaluate whether seniors are likely to stay within the ACO’s provider network. Managed care plans under Medicare Advantage can keep seniors enrolled as they offer variations on deductibles and other financial incentives to keep them in their provider’s network. ACOs do not have these tools and must be innovative in ways to keep their seniors within their ACO walls.

The Innovation Center has chosen 5 Pioneer ACOs to participate in this initiative. These ACOs will solicit patients to enroll with them. Critics of this idea say seniors become attached to their physicians, do not understand the concept of ACOs and if they have cognitive impairment or limitation, they would be less likely to enroll and stay in the ACO.

But, CMS is hoping that signing up with an ACO may make seniors more conscious of the quality-of-care benefits of ACOs along with the ACOs’ attempts to manage their care, particularly those with chronic disease conditions.

ACO Investment Model

On October 15, 2014, CMS announced their new ACO initiative called the ACO Investment Model. The new ACO Investment Model is a pre-paid shared savings that builds on experience with the Advance Payment Model. It encourages new ACOs to form in rural areas and to better coordinate care to rural and underserved areas by providing up to $114 million in upfront investments to up to 75 ACOs across the country.

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7 Evans, Melanie, “Pioneer ACOs can Recruit Seniors under new CMS Test,” ModernHealthcare, November 11, 2014.
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Through the CMS Innovation Center, this initiative will provide up front investments in infrastructure and redesigned care processes to help eligible ACOs continue to provide higher quality care. It is hoped this will increase the number of beneficiaries, regardless of geographic location. CMS will recover these payments through an offset to an ACO’s earned shared savings.

Eligibility is targeted to ACOs who joined the Shared Savings Program in 2012, 2013, 2014, and to new ACOs joining the Shared Savings Program in 2016.

**The New Proposed Rule**

With the fourth year coming soon, those Track 1 ACOs who joined in 2012 are at the end of the Medicare Shared Savings Program (MSSP) contract. To be able to continue in the program next year, they will have to share in risk as well as savings. But with Pioneer ACOs dropping out and some MSSP participants thinking of dropping out in 2015, CMS had to come up with more incentives to keep their participants as well as obtain new ones.

One of the major incentives for current participants would be to offer Track 1 (shared savings, not losses) ACOs an additional three years in operation before they must switch to Track 2 (shared savings and losses). The carrot to not contract for the additional three years is that those entities would keep 50 percent of the Medicare savings, where entities in the three year extension would only keep 40 percent of their Medicare savings. Another incentive is to create a Track 3 for those organizations who want to keep 75 percent of the money saved Medicare in trade for taking on more risk.

CMS is also looking for commenters to suggest ways to determine whether an ACO has truly saved money. This is in response to those critics who say CMS is going about calculating savings in the wrong way and possibly because the OIG has placed the Pioneer ACO Model on its work for list for 2015 with the intention to conduct a risk assessment of internal controls over administration of the model.

See our article from the December 2014 edition of the *Washington News* for more information on this proposed rule. The public has until February 6, 2015 to comment on the rule.

**Quality Measures**

Although CMS proposed (in the 2015 Proposed Medicare Physician Fee Schedule) to increase the number of quality measures ACOs are responsible for reporting, the final rule, kept the same 33 measures as 2014. However, 8 measures that CMS believed to be similar to existing measures or measures that did not align with updated clinical guidelines were deleted [6] or replaced with another measure [2] and six new measures were added for 2015. In the final rule, CMS said “although the number of measures in the measure set remains at 33, we are reducing the number of measures reported through the CMS web interface by 5 to reduce burden.” They also reduced the number of patients ACOs are required to report on for each measure.

The complete listing of measures for 2015 can be found in Table 81 of the *2015 Medicare Physician Fee Schedule*, page 370.
CMS continues to move forward, adding 89 new organizations in 2015 and by tweaking regulations and incentives to encourage exiting ACOs to extend their contracts later this year.

COMMERCIAL ACOs

Even with the slow growth of ACOs between providers and commercial carriers in 2013, many commercial carriers planned on increasing their number of provider groups to enter into value-based contracts saying their future remains in accountable care, whether it’s ACOs, bundled payments or global risk in 2014. Other carriers intend to enable provider groups to switch from a fee-for-volume to a value-based fee structure by providing groups with technology, care management programs and consulting support.

Finding cost and quality results of commercial carriers and comparing them to the Medicare ACOs is not an easy task as most information on commercial carriers is published through their carrier’s press releases. Plus commercial carriers design their own quality metrics although many are similar to Medicare’s. Commercial carriers also engage in contracts that are very specific to each provider entity and even then, financial requirements and quality metrics are not always consistent with each contract.

However, from the information released in 2014, it appears commercial carriers, primarily the largest ones, are still forging ahead with new ACO and other value-based contracts, indicating that their ACO partnerships are moving in the right direction. Becker’s Hospital Review published seven new ACO partnerships with commercial carriers that either started as of the fall 2014 or will start January 1, 2015. {Humana Health [3], Cigna [1], Medicare Shared Savings [1], United Healthcare [1] (see below), Anthem BCBS [1] }.

Some quality and cost success has come from one of the longest running ACO-type entities hosted by Massachusetts BCBS, called the Alternative Quality Contract. It started in 2009 before the ACA. The AQC is a global payment model hybridized with substantial performance incentives, plus design features intended to lower the cost of care over time. 85 percent of BCBSMA’s HMO physicians participate in the program.

In an independent study by Harvard Medical School released in the New England Journal of Medicine in October 2014, researchers concluded that compared with similar populations in eight other Northeastern states, the ACQ enrollees had lower spending growth and greater quality improvements after four years.

Quality scores for these enrollees increased to 12 points above the national average during the course of the contract with improvements in preventive care for healthy children and adults and in management of serious chronic illness.

In the initial year of the project, savings were approximately 6 percent and by year four, the AQC groups saved 10 percent compared to the control groups. The most savings were found in the “outpatient setting as providers increasingly used lower cost settings and by reducing utilization, including discretionary procedures, imaging and testing.”

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Here is what three of the larger commercial insurance carriers accomplished in 2014 and project to accomplish in 2015.

**AETNA**

Aetna’s strategy has been to concentrate on investments in support tools for ACOs. Aetna has made a $1.5 billion investment in clinical support tools for accountable care by acquiring companies like Medicity, Active Health and others in order to drive clinical and financial information to be interpreted in a way that can influence the outcome at the point of care.9

Aetna offers several collaboration models including full accountable ACOs for both commercial and Medicare and participates in the Medicare Shared Savings and Pioneer ACO Models. Plus other value-based programs such as bundled payment pilots, patient-centered primary care initiatives and value-based health plans.

Aetna boasts on their website that their ACO programs have resulted in:

- 45% reduction in hospital admissions
- 50% fewer patient hospital days
- $600 savings per patient

Their most recent partnership is with four networks in Washington State where they introduced their Aetna Whole HealthSM plan. This new health plan will give members access to coordinated care in three counties built around four distinct networks. All four networks include Seattle Children’s Hospital. This product will be available for self-insured customers starting on January 1, 2015 and for fully insured customers in early 2015. This is Aetna’s fourteenth ACO collaboration in 2014.

**CIGNA**

As of October 2014, Cigna was engaged in 106 Collaborative Accountable Care (CAC) initiatives in 27 states. These programs provide services to more than 1.1 million Cigna customers. 41,000 physicians participate in these CACs, about evenly split between primary care and specialists.

For their arrangements that have been operational for at least two years, 73% have met their targets for improving quality, 73% for controlling medical cost and 55% for both quality and medical costs. On average, these arrangements have demonstrated three percent better than average total medical cost and two percent better than market average quality.

**UNITEDHEALTHCARE**

Nationwide, more than $36 billion of UnitedHealthcare’s annual physician and hospital reimbursements are tied to accountable care programs, centers of excellence and performance-based programs. That

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9 Miller, Julie, “Data Will Drive ACOs in the Real World,” Managed Healthcare Executive, February 1, 2014
number is expected to grow to $65 billion by 2018.

Their latest collaboration was with Commonwealth Primary Care in Arizona this past November. This latest collaboration increases UHC’s ACO coverage to 1.6 million people in Arizona with a provider network of 78 hospitals and more than 14,000 physicians statewide. The Commonwealth Primary Care ACO is the first physician-led ACO UHC has contracted with in Arizona.

Commonwealth’s care providers will be eligible for payment incentives based on specific quality metrics and evidence-based guidelines, such as hospital readmission rates, disease management and prevention, patient safety and care delivery, and total cost savings and patient satisfaction.

MEDICAID ACOS

With increasing Medicaid spending, especially in Medicaid expansion states, the state programs are looking for ways to cut costs, and participating in ACO-type programs is one of them. Currently, nineteen states are in the process of implementing ACO type plans, all very different from each other. (AL, AR, CA, CO, HI, IA, IL, LA, ME, MA, MN, NC, NJ, OR, TX, UT, VT, WA).

The National Academy for State Health Policy’s website publishes the criteria for participation, governance, measurement and evaluation, payment, project scope and support for infrastructure for each of the states participating or attempting to participate in some type of ACO entity.

The Medicaid ACO structures vary by state and include those that:

- Employ regional organizations that receive capitated payments to care for patients with quality incentives phased in.
- Modify existing managed care plans into ACO contracts.
- Move certain Medicaid plans into a per member per month bonus, shared savings or other new model.
- Pay physicians based on the ability of physicians to lower historical spending targets.

The Medicaid programs are contracting with networks of doctors, clinics and hospitals that agree to provide more integrated care of beneficiaries while reining in costs. In most versions, participating providers are eligible to receive shared-savings payments if the ACO meets quality benchmarks.

Despite generally low Medicaid reimbursement rates—60% of Medicare rates on average—interest among hospitals and providers is high. That’s not only because of the potential to earn bonus payments, but also because hospitals hope their efforts will reduce unnecessary ER visits.

One of the most well-known Medicaid ACO venture is in New Jersey.

In August 2011, Governor Christie signed into law NJ P.L. 2011, Chapter 114 requiring New Jersey’s Department of Medicaid and Human Services (DMAHS) to establish a three year Medicaid ACO demonstration project. The demonstration project was designed to give the New Jersey Medicaid program an opportunity to:
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- explore innovative system re-design;
- test the ACO as an alternative to managed care;
- evaluate how care management and care coordination could be delivered to high risk, high cost utilizers;
- stretch the role of Medicaid beyond just medical services but to integrate social services, and;
- test payment reform models including pay for performance metrics and incentives.

Applications for the program were due on July 7, 2014 for providers to join the three-year Medicaid ACO demonstration project. The applicants must assume responsibility for coordinating the care of residents within specific geographic areas and are required to be a nonprofit organization serving a minimum of 5,000 Medicaid beneficiaries within a designated region.

The applicants must also include all of the acute-care hospitals in their area, as well as 75% of the primary-care providers and four behavioral health providers. Two community residents must serve on the organization’s board.10

Eight different alliances/ACOs are listed on the NJ Medicaid website as submitting applications to join the program. As of November 2014, New Jersey was still reviewing the applications.

HOSPITAL-BASED ACOS

Despite 2013’s slower than expected ACO growth rate, hospital participation in accountable care organizations (ACOs) was projected to double in 2014, according to Premier, Inc.’s fall 2013 Economic Outlook C-suite survey.

Similar results were obtained by another survey conducted by Purdue Healthcare Advisors (PHA) where nearly half of hospital executives (46 percent) said they intend to use an ACO-like model in their systems even though only 20 percent currently do so.

Reasons for not participating ranged from not enough evidence of ACO success, their hospital was too small to benefit from an ACO, lack of financial compensation to cover the costs of creating an ACO, unrealistic benchmarks, overwhelming staff transition and those already under pressure to reduce their costs.

Larger hospitals are more likely to move faster than smaller ones and rural and standalone hospitals are least likely to participate in an ACO.

To accommodate the move towards ACOs hospitals are:
- investing in infrastructure to manage population health, such as investing in advanced HIT and providing lifestyle and wellness coaching,
- setting up partnerships with large employers, other local providers and health departments,
- contracting with public and private payors.

Twelve hospital/health-system-led ACOs, from Becker’s “100 ACOs to know in 2014”, joined either the

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Medicare or a commercial ACO program in 2014.\(^{11}\)

Unlike physician-led ACOs who, to save money, must keep patients out of the hospital by taking better care of them upfront, hospital-led ACOs must focus on better management of patients once they are admitted to the hospital to reap the ACO savings. This is a concern for hospitals as they traditionally make their money with full beds.

Some large hospital systems are buying or have bought up physician practices with the goal of becoming ACOs that directly employ the majority of their providers. But more and more, we are seeing partnerships between hospitals and physician groups in the form of joint ventures or physician-hospital organizations. It is thought that because hospitals usually have access to capital, they are better able to finance the initial investment necessary to achieve the quality benchmarks, like creating the electronic record system in order to track patients.\(^{12}\)

However, the other side says that physicians want clinical autonomy and an assurance from hospitals that economics are not driving decisions on how to care for patients. Physicians have performed better than hospitals in the MSSP and it is thought that hospitals can improve their results by delegating the clinical arm of their operations to a physician-led, risk-bearing group.

Physician groups will want to use hospitals with high-quality, high-value facilities where the care is focused and efficient with outcomes that are in line with a network that is trying to manage value.\(^{13}\) Hospitals can benefit from improving quality and satisfaction scores enabling them to avoid readmission penalties.

Experts say that the next wave of accountable care, or ACO 2.0, will require tighter bonds among hospitals, physician groups and post-acute providers.\(^{14}\)

ACOs and Health Insurance Exchanges

Experts believe ACOs will play a major role in health insurance exchanges although no one knows what form[s] of ACO will be established. Many are leaning towards full risk-bearing entities with their own insurance products made up of narrow networks.

This will be something to watch in 2015.

\(^{11}\) Gamble, Molly, “100 Accountable Care Organizations to Know/2014,” Becker’s Hospital Review, August 13, 2014.


WHAT DOES IT ALL MEAN?

As we can see, ACOs continued to grow in 2014 with momentum into 2015. However, as indicated by the Pioneer ACO and CMS’ attempts to incentivize their MSSP programs, balancing quality care and economic success remains a challenge. The preliminary reports on quality measures, patient health outcomes and costs show mixed results and none are overwhelmingly convincing that ACOs will be health care’s savior.

CMS’ proposed extension of their Track 1 program could entice smaller practices to join the ACO movement. Along with physician-led, insurers and hospitals, expect to see more ACOs from entities like Walgreens, community care organizations and other healthcare entities. Although many organizations and physicians are still wading in the water, there are those who are pushing forward in an effort to change the standard way to deliver and pay for health care.

Some predict that 2015 will bring the second phase of ACOs or ACO 2.0, as they like to call it. Where ACO 1.0 focused on integrated primary care networks, ACO 2.0 will introduce more specialists into the networks, as well as post-acute providers covered in bundled payment programs. More attention to care coordination and risk management will be needed as phase two ACOs rely more on value-based and risk-based reimbursement.  

The movement to ACOs is projected to continue to gain momentum in 2015. Not all ACOs are set up the same; many are still experimenting with successful strategies while others are having a hard time making it work. But there are successful ACOs and they need to be the leaders in expanding the program to smaller practices and hospitals. They need to share what they have learned, including how-to:

- Reduce costs
- Assess quality care,
- Provide for proper staffing
- Expand Health IT infrastructure
- Produce data of utilization patterns and resource

Given this momentum, it is critical for physicians, especially mid-size and larger groups, to become involved, if that effort isn’t already well underway. This imperative is especially important for specialists who run the risk of being viewed a “cost center” unless they actively describe how they can contribute to better outcomes and lower costs. Based on your local environment, becoming involved may mean as little as participating in planning discussions. Or it may mean evaluating the financial benefits and risks of participating in one (or more for specialists) of your local ACOs.

It will be interesting to follow the trends in ACO numbers to see whether the biggest ACOs continue to expand, or whether a large number of smaller ACOs continue to crop up.

Like other healthcare reform entities, such as Insurance Marketplaces, it is still too early to tell how Accountable Care Organizations will evolve. But the pressure to offer better care at lower prices isn’t going away: it is only increasing. It seems likely that ACO’s will be part of the solution.

Resources:
Becker’s Hospital Review – [ACO Manifesto: 75 Things to Know about Accountable Care Organizations – 2014 Edition](#)