The Rise and Future of Accountable Care Organizations in the United States

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Abstract
The Patient Protection and Affordable Care Act ("ACA") was signed into law in early 2010, causing an immediate stir to the health care landscape. The idea of improving access to health insurance, as well as reforming private insurance markets, were two of the most important outcomes associated with the ACA. However, the ACA was somewhat ineffective in recognizing the need to reform the delivery system itself. Although no prescriptive approach was mandated, a foundation was set for creating provider-led organizations which could reduce health care spending while improving quality outcomes.

Recognized before passage of the Affordable Care Act, Accountable Care Organizations (ACOs) emerged in the late 2000s and early 2010s as a delivery model that links provider reimbursements to quality improvements and lower costs of care. In an effort to stimulate growth of ACOs, the ACA established a mechanism for healthcare providers to care for Medicare patients under an ACO payment arrangement. An initial set of participation guidelines and evaluation criteria are contained in the Act.

This paper will focus on the initial implementation of ACOs, the theories associated with this delivery model, and the necessary clinical integration needed to align systems. Once there is an understanding of how the organization should work, we will look at early case studies to determine if there is evidence to believe ACOs are working. The goal of this paper is to determine whether or not Accountable Care Organizations are proving to drive down costs in health care spending.
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Introduction to Accountable Care Organizations

On March 30, 2010, the Patient Protection and Affordable Care Act was signed into law. This piece of legislation, known as the Affordable Care Act ("ACA"), opened the eyes of Americans to distinct segments of healthcare reform that would remain in the spotlight for many years to come. One of these segments, private insurance reform, was introduced to tackle the issue of restricting coverage based on preexisting conditions and lifetime limits for subscribers. As a result, insurers and the insured will now become familiar with terms such as individual mandate and community rating. The second important issue addressed in the ACA was improving access to health insurance through health insurance exchanges. This exchange system will help create a more structured and competitive market for Americans to purchase health insurance.

According to the Kaiser Foundation Report, health expenditures in the United States rose to nearly $2.7 trillion in 2010. This number is nearly ten times the amount spent on healthcare in 1980. These statistics illustrate an important area of reform that was not recognized in the ACA. In an effort to keep post-ACA budgets stable after uncertain insurance reform, healthcare providers’ attention has now been drawn to addressing delivery system reform. Although no explicit approach was mandated by the ACA, a foundation was set for creating provider-led organizations that could reduce health care spending while improving quality outcomes.

Established in the late 2000s and early 2010s, Accountable Care Organizations (ACOs) were recognized as a delivery model that linked provider reimbursements to quality improvements and lower costs of care. The Centers for Medicare and Medicaid...
Services (CMS) defines an accountable care organization (ACO) as, “an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries enrolled in the traditional fee-for-service program who are assigned to it” (31). In broader terms, this model will change the method of delivery of health services and the way in which it is then paid for. The overarching goal of an ACO is to deliver seamless, high quality care for Medicare recipients while lowering costs to both patient and provider. An initial set of participation guidelines and evaluation criteria are contained under the Medicare Savings Program of the ACA.

Accountable care organizations are governed by three core principles issued by the CMS. Those three include (Reference 2):

1. Provider led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.

2. Payments linked to quality improvements that affect costs

3. Reliable and progressively advanced performance measurement to support improvement and to provide confidence that savings are achieved through better care

The CMS has the authority to provide incentives for organizations achieving key benchmarks in quality care. These incentives are administered through the Medicare Shared Savings program. The program will reward ACOs that achieve slower growth in Medicare healthcare cost while meeting quality performance standards. These rewards take the form of payment incentives that can accrue or be distributed to the organization, providers, patients, or shareholders depending on the organization type (2). The CMS has
identified five areas of quality standards. Within each key area are 6-10 specific measures that are to be monitored closely in order to benefit from potential savings. As a result, there is an increased awareness of what physicians and health administrators should be monitoring in order to keep their patients healthy and happy. A further discussion of these quality measures will be found in the next section of the paper.

Although the 2010 law provides for the establishment of the Medicare ACOs (mentioned above), private insurers can also set up ACOs on their own. Interest in commercial ACOs surfaced from regulation and privacy hurdles of the Medicare model. This private, or commercial, arrangement of an ACO is much less defined and regulated at this point. There has not been a precedent set on the distribution of profits as a result of cost saving and improved quality of care initiatives. It will be up to the leaders at each insurer and healthcare provider to negotiate how this is done in each case. However, it is clear that these organizations are catching onto the potential benefits of the ACO concept. There are also many providers organized under the Shared Savings Program that are beginning to create separate partnerships with commercial insurers in addition to their arrangements with the CMS. Providers under the Medicare ACO programs are also interested in merging into the private sector as well. The success and challenges of these two “worlds” of ACO alignment will be important to the future of delivery reform as a whole.

It is becoming clear that the establishment of ACOs as a part of the ACA has afforded a great deal of potential change to the health care delivery system. However, it is unclear to what extent the system will be changed. With the help of the CMS, many ACOs have been established across the nation at an increasing rate since 2010. Before looking into the
successes and shortcomings of these early ACOs, it is important to understand the theories and strategies that the CMS believes should lead to increased savings and an overall culture change within health organizations. Gaining an understanding of the CMS recognition, payment models, quality measures, and ACO prototypes will allow for a smoother transition into the role of clinical integration. After a thorough discussion of the significance of seamless integration between systems, we can then begin to look into early results of ACOs in the United States. A collection of case studies will be analyzed in hopes of detecting patterns or trends in organization structure and processes that are leading to successful cost saving and patient satisfaction.

From these findings, we hope to draw conclusions on the impact ACOs have had in their first several years of existence. In doing so, we hope to answer the following question: Are Accountable Care Organizations proving to drive down costs in health care spending?
Section I: Theories and Models Associated with Accountable Care Organizations

The process of dissecting the drafts, statues, and regulations of the Shared Savings Program and individualized private ACO models can be somewhat overwhelming for both providers and insurers. The guidelines and regulations that have been established through the CMS are intended for the national Medicare Shared Savings ACO program. Providers wishing to coordinate ACO care through commercial insurers must use these CMS toolkits as major building blocks to form an operationally and financially sound ACO. The following section will outline how the mechanism prescribed in the ACA was intended to work. This section will discuss the coordination and cooperation among providers, financial incentives and payment models, and conclude with the patient’s role in accountability of care.

In a recent report issued by the CMS, medical care for Medicare beneficiaries with multiple chronic conditions accounts for over 90% of fee-for-service expenditures (24). As the number of chronic conditions per patient rises, the total costs associated with that patient skyrocket. It would not be uncommon for these patients to receive care from a number of providers and specialists. The health community is beginning to recognize that the failure to coordinate care among these providers can lead to negative health outcomes and increased health expenditure. The CMS believes that, in theory, coordination and communication will be beneficial for both patients and providers. As a result, the Medicare Shared Savings Program model was created to help facilitate this coordination among providers. Commercially organized and Medicare sponsored ACOs alike review this program as a means to structure their organization.
Under the Medicare Savings Program, an ACO will agree to provide care to a minimum of 5,000 Medicare beneficiaries over a span of 36 months. The concept relies on comprehensive care in a primary care model as a means to reduce costs and improve the overall quality of healthcare (3). In an effort to support the transparency of quality care and provider statistic tracking, outcome reporting is very important. Specific examples of outcome reporting measures include post-operation infection, nerve injury, hospital readmission, and pain. The CMS notes that the ACO may not participate in other shared savings programs during this period (1). Beneficiaries may visit any provider of their choosing, regardless of their participation in an ACO. After one year, beneficiaries are assigned to the enrolled ACO that provided the bulk of the patient’s primary care.

The ACA designates four provider group categories that could potentially fall into ACO coverage. The original four include integrated health systems, multispecialty provider groups, physician-hospital organizations, and independent provider associations (2). As more commercial payers and organizations integrate into this system, we may see this list expand. These providers will continue to be paid under current Medicare payment plans. Their performance will be measured against benchmarks set for each ACO to determine whether they have earned shared savings or will be responsible for the losses. This portion of the agreement becomes their financial incentive. However, in the Shared Savings model, the CMS sets a shared savings minimum- the amount the organization must exceed in order to receive this financial incentive. The CMS minimum savings rate is set at 2% (3).

Each ACO must choose a payment model for sharing savings accumulated throughout the year. The CMS had originally proposed two payment models based on projected savings within the first year of operation. In the first, one-sided model, the ACO
shares any savings above 2%. However, the organization is not liable for losses. The second model is *two-sided*, meaning the ACO assumes the potential risk of both losses and savings. They are not forced to recognize the 2% minimum savings rate. After the 36-month trial period, a new arrangement can be made based on trends in the previous years’ savings schedule (13). This *two-sided* model is a key feature of the CMS Pioneer program discussed later in the paper.

Among the most important pieces to the accountable care movement as a whole are the quality and performance measures. Mentioned earlier in the paper, there are five key areas of quality established to improve patient care and reduce readmission rate. These five areas are as follows:

- **Patient and caregiver experience** (Ex: timely care, provider communication, access to specialists)
- **Care coordination** (Ex: medication reconciliation, readmissions)
- **Patient safety** (Ex: screening for fall risk)
- **Preventive healthcare** (Ex: influenza immunization, weight screening, mammography screening)
- **At risk populations- elderly and chronically ill** (Ex: blood pressure control, drug therapy for lowering LDL-Cholesterol, composite scoring for diabetes)

(Reference 2)

In total, there are 33 quality measures within these five broad categories. The CMS issued a table outlining the “Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings”. The following items can be found in this table: the ACO measure number; its domain of care; its measure steward and National Quality Forum number (if available); and method of data submission, among others. The
measures are reported through CMS claims, Group Practice Reporting Option (GPRO) Web Interface, and patient experience of care surveys.

The scoring of these measures changes from year to year during the 36-month initiation period. Scores for all 33 measures must be reported for each of the first three years in order to remain eligible for savings. However, payment for performance does not kick-in until the second and third year of the program. Pay for performance applies to 25 measures in year two and 32 measures in year three. The performance benchmarks are released at the beginning of the second year. This process allows the newly formed ACOs some leeway in starting-up their coordination and alignment programs. Minimum levels are set at the national 30 percentile and performance at or above 90 percent will earn the maximum points for the specific measure (25).

The improvement of these quality measures and the means to attain improvements rely on the provider's ability to understand what should be measured and for whom. Providers must recognize populations of interests and the outcomes associated with these groups and look to shift costs accordingly, if possible (4). Subgroups of the provider population that may face greater risks based on socioeconomic factors or age must be tracked closely in order to predict potential performance scores.

According to an article published in American Medical News, there are 25-31 million Americans participating in ACOs. This number is divided into three categories of patient. The breakdown can be found below:

- 2.4 million are Medicare patients
- 15 million are non-Medicare patients receiving care within medical practice that is part of a Medicare ACO
• 8-14 million are commercially insured patients in a non-Medicare ACO

(Reference 5)

However these numbers line up in the upcoming years, it is essential to identify the importance of the patient to the future of ACOs. Patients must feel invested in the management of their healthcare. The organization as a whole must motivate patients to “buy-in”. However, before this can happen, the physicians themselves must also see the importance of their patient’s satisfaction with their care and the organization as a whole. The necessity of seamless clinical integration and physician leadership will be the tackled in the next section of the paper.

To test these practices, the CMS will continue to funnel organizations through the Center for Medicare and Medicaid Innovation program and patiently wait for positive results or data. Early results of these programs, as well as private payer models, will be discussed later in the paper. As is true for most governmental programs, the Shared Savings model is not perfect. There will most likely be a number of kinks and hurdles in the future of many ACOs. However, the foundation for reduced spending and improved quality measures is now ready for trial.
Section II: Clinical Integration

Clinical integration is now a familiar concept among medical professions as a means to facilitate the coordination of care across the healthcare spectrum. True clinical integration can only be achieved through a culture change within the provider organizations as a whole. The goal of clinical integration is to create an environment of safe, efficient, and patient-focused care with ready access to patient-specific data and population level quality data. Becker's Healthcare Hospital Review designed a model for evaluating clinical integration initiatives in late 2012. Their four-part platform highlights the following “pillars” to achieving effective clinical integration- collaborative leadership, aligned incentives, clinical programs, and technology infrastructure (29). These platforms are essential to accomplishing quality care improvements within the ACO model. The most important role in this integration process will be that of the physician. However, leading physicians into this ACO model will not be an easy task.

Physicians are inquisitive by nature, prone to questioning new practices and theories in an attempt to retrieve proven facts and evidence. Therefore, it is not unreasonable to expect many providers to be skeptical of changes made to compensation and patient care under the ACO model. Business leaders in healthcare must be able to reassure physicians that the groundwork has been set for this change, patients will want this kind of care, and that incentives will align to provide them benefits as well. Once these practitioners commit to the ACO arrangement, we can begin to fine tune the operations of these practices and incorporate the key components of clinical integration.
Leadership within physician groups will need to be able to collaborate with administrators to develop strategies to evaluate contracts and legal arrangements under federal requirements. Strategies incorporating both risk and value-based contracts must be in order prior to achieving shared savings (29). ACOs must also undergo cultural changes in order to prioritize outcome-based reimbursement. This cultural change will be driven from within by the physicians and nursing staff that interact with patients daily.

Effective clinical integration requires a high level of coordination among both hospital administrators and physicians. Both of these parties must actively lead staff and patients in an effort to achieve results. To achieve positive patient satisfaction scores, as well as performance quality measures, each member of an ACO team must take notice of specific details of the patient care process. From the front desk receptionist to the billing manager, each step in the care management course is equally as important. With that being said, it is becoming clear that physicians will be the stakeholder held accountable for the overall success of the organizational model.

Payment and incentive structures will vary greatly between ACOs in the first several years of existence. Many organizations will establish pay-for-performance programs to incentivize physicians to follow up with care management procedures and quality indicators on an individual level. Other ACOs may invest savings back into the organization in order to rebuild or improve the current infrastructure as needed. Alternatively, some organizations might create a hybrid of these two models, incorporating both group and individual incentives. The alignment of incentives must be communicated effectively to the organization in order to achieve significant results. The education and training process must be well designed and easily accessible.
The final piece to this integration process is the technological infrastructure established to improve the connection between physicians and their patients. The investment strategy needed to provide this infrastructure is essential to the functionality of the ACO. Two important features of such a system include a health information exchange and a clinical data repository.

The ability to track patient care across all healthcare setting is crucial to providing quality care. A health information exchange connects ambulatory electronic medical records, hospital records, pharmacy data, and lab results (29). This exchange will connect data sets and records that would otherwise be somewhat time-consuming to obtain. This system will be extremely helpful to providers across the ACO, including the nursing and pharmacy staff.

The second technological feature needed for ACO success is a repository designed to identify trends in claims data and performance measurements. This integrated data repository (IDR) merges medical data from clinical practices with both administrative and public health data from the organization. This collection will lead to increased ability to research and identify the needs of the specific ACO. An effective IDR should prioritize standardization and seamless data collection. The CMS has set the following goal for incorporating this data system into their ACO model; “transition from stove-piped, disparate set of databases to highly integrated data environment for the enterprise” (30).

Physicians must actively participate in the evaluation of their own quality data to achieve effective clinical integration. Although practice administrators will determine what information is provided to physicians and what they are expected to do with it, physicians are encouraged to “log-in” to the information system on a regular basis to review the data.
that has been collected for the given period. At a minimum, this process serves to keep the goals of the ACO arrangement in the back of their mind.

Once an ACO is able to incorporate these key integration components into their strategic plan, they can focus their attention on communicating with the patients themselves. This effort will help engage patients in their care through technological advancements. The next section of this paper will examine specific ACOs and their ability to align these integration components, as well as the key features of this delivery model, in their practices’ around the country.
Section III: Case Studies

Among the many concerns surrounding the effectiveness of ACOs, the lack of data and concrete evidence supporting the success of this model remains at the top of the list. Key stakeholders are anxiously awaiting the release of tangible evidence backing the implementation of performance measures tied to shared savings in an effort to reduce healthcare costs. This data will allow providers to review the benefits associated with accountable care models and make informed decisions concerning the future of their delivery system. Commercial insurers will also learn a great deal from this information. Published statistics will allow private insurance companies like Blue Cross Blue Shield to tailor and modify their own respective ACO agreements as needed.

Although the healthcare community does not have as much data as they would prefer in the early months of 2013, both CMS and private organizations are providing encouraging statements and preliminary outcomes. Many of the pioneer Medicare ACO programs are nearing the end of trial periods and are beginning to condense years’ worth of data. Participating hospitals are slowly beginning to report trends in particular datasets. A number of commercially insured ACOs have released brief statements noting early successes and trends in data. This section will dissect information and assertions reported from Advocate Health Care in Chicago, Cigna’s Collaborative Accountable Care Initiative, the Medicare Shared Savings Program, and the Medicare Pioneer program.

This section will conclude with a discussion of the CMS Physician Group Practice Demonstration. This initiative tested specific payment arrangements and the ability to help groups of physicians provide Medicare fee-for-service beneficiaries with high quality,
coordinated care (18). In doing so, connections will be made between the triumph of this CMS demonstration and the potential success of another CMS Innovation platform; the Physician Group Practice Transition Demonstration.

The most conclusive results indicating the potential value of ACOs can be drawn from the largest hospital system in Illinois, Advocate Health Care. Advocate has partnered with Blue Cross Blue Shield of Illinois (BCBSI) to provide accountable care for over 370,000 subscribers. This contract became effective on January 1, 2011. Under this arrangement, AdvocateCare is the largest commercial ACO currently in operation. AdvocateCare Vice President Lois Elia announced that in its first six months of operation, the collaboration with BCBSI resulted in hospital admission per member dropping 10.6 percent (19). During the same period, there was a 5.4 percent decline in emergency department visits, as well as a 2 percent decrease in readmission rates for chronic conditions (20).

Most importantly, AdvocateCare’s medical cost trend was 6.1 percent below market. Elia speculates that this shows reductions were, “likely due to prevention of ambulatory-sensitive conditions through better care management, physician access and the like” (21).

It is important to note that AdvocateCare hired 70 “care managers” to manage high-risk cases and encourage patients’ active involvement in their care (17). These managers were hired during the preparation stage of the program. The Executive Vice President and Chief Medical Officer of Advocate Health Care said that, “Our keen focus on care coordination, prevention, early detection and education is ensuring our patients receive the right care, at the right time and the right place” (17).

Although no specific financial data was provided by the organization, providers around the nation are taking note of the advances made by Advocate Health Care. Advocate
has fully embraced the ACO model and has recently expanded a physician group practice into the Medicare Shared Savings Program.

In 2008, Cigna launched their Collaborative Accountable Care Initiative aimed at providing financial incentives to physician groups and integrated delivery systems. This is another example of private insurers experimenting with the accountable care model. The program has expanded to include 42 physician practices (23). In a report highlighting interim quality and cost results, favorable trends in total medical costs and quality were revealed. The report highlighted three geographically and structurally unique practices in New Hampshire, Texas, and Arizona.

The report indicated that the total medical costs for the Arizona practice was $27.04 per patient per month more favorable than cost in the comparison group. New Hampshire achieved modest performance improvements in per patient per month costs, down $1.78. The Texas practice improved in the same category with a $6.56 decrease in per patient per month costs (23). It is important to note that all three practices were superior to their compassion group peers in all quality performance measures.

The Cigna model shared a feature similar to the AdvocateCare model mentioned earlier. The Collaborative Accountable Care Initiative featured care coordinator positions at each practice, similar to AdvocateCare’s “care managers”. This position is valuable to both Cigna and AdvocateCare because it allows the providers to follow up with patients that are not managing their conditions correctly in order to reduce potential readmissions. Cigna also provided consultant to help each practice define and implement plans to address care quality measurements (23).
The financial data reported in this *Health Affairs* feature provides what the healthcare community hopes to be the first of many positive indications that ACOs have the ability to reduce medical costs. The preliminary results of these two privately insured ACOs have proved to show somewhat convincing results indicating the success of a new delivery model. We now move to the Medicare side of the equation in an attempt to uncover similar results.

Unfortunately, the availability of data from the Medicare Shared Savings Program in the early stages of 2013 is quite sparse. The program is currently in its second year of operation and has added 106 new ACOs in the 2013 cycle. The number of accepted organizations has increased at a consistent rate since its inception in April 2012. The number of MSSP ACOs is now up to 215 in total, with an additional 35 participating in a separate CMS Innovations demonstration called the Advance Payment program.

In an article published in the January 2013 Issue of *Atlantic Information Services Health Report*, healthcare consultant Clif Gaus states that, “there likely won’t be evidence of cost savings from ACOs within the Medicare program for 2013…. the target should be large costs savings several years from now, in 2016 or 2017” (26). Gaus, among others, indicate that there is more to the story than just financial success. The Senior Vice President at Avalere Health, Erik Johnson, notes that we may see results for both the MSSP and Medicare Pioneer model by the end of 2013 (26). Regardless of the release date, it is clear that providers can learn a great deal about the preliminary organizational and operational challenges newly formed ACOs face.

In late 2012, the Medicare & Medicaid Research Review published an article detailing the “Statistical Uncertainty in the Medicare Shared Savings Program”. The
thirteen-page document outlines what the CMS believes to be shortcomings in the original design of the MSSP model. It is encouraging to see this branch of the Department of HHS take responsibility for projected issues in the program and making these proposed solutions known to providers, payers, and patients. The CMS recognizes that in the short term, they will need to reconsider these uncertainties in their financial, administrative, and care management planning. In the long run, the CMS and the participating ACOs must refine payment formulas to ensure the program is working as efficiently as possible (15).

The Medicare Pioneer ACO program is another CMS Innovation project that is consistent with, but separate from, the MSSP. The ongoing demonstration began on January 1, 2012 with 32 participating ACOs. The payment models have higher levels of shared savings and risk than proposed in the MSSP. In the third year of the program, participating ACOs that show specific levels of savings over the first two years of the program are eligible to move a large portion of their payments to a population-based model (27).

Results from a Michigan-based Pioneer ACO, Genesys PHO, have emerged with positive projections. Genesys PHO provides care for 18,000 patients under the ACO agreement. Genesys PHO uses information provided to it by the CMS to establish performance targets while supplementing and validating this information with its own utilization data (22). This is collected through its own internal referral and hospital information system. Based on this collection, Genesys PHO projects about 8 percent shared savings in addition to the 2 percent that the CMS will retain under the Pioneer ACO contract (22). The organization also plans to continue reducing the cost of care through increased waste reduction and engagement of high-risk and noncompliant patients.
Long before the ACA laid the groundwork for ACOs in the United States, the CMS began a demonstration program that created incentives for physician groups to coordinate the overall care delivered to Medicare patients. This program, called the Physician Group Practice (PGP) Demonstration, began in 2005 and ended in 2010. The healthcare delivery model utilized in this demonstration is commonly referred to as the patient-centered medical home. It has now been extended through an entirely new entity in 2010. Results of the original PGP program showed a total of $16.7 million in savings for improving quality and efficiency of care during the second performance year among all ten participants (14). Each of the case studies examined earlier in this section, including AdvocateCare, Cigna Collaborative Accountable Care Initiative, and MSSP, used key elements outlined in the PGP demonstration. The slightly modified Physician Group Practice Transition Demonstration was rolled out on January 1, 2011 and remained active until December 31, 2012.

The CMS is using this extension of the PGP demonstration to investigate whether specific payment arrangements can help physician groups to provide Medicare fee-for-service patients with coordinated care with a focus on quality and performance measures (18). Key areas that were modified from the original PGP model were beneficiary assignment, nation benchmarks, percentage of shared savings, and risk adjustment. Six organizations participated in the PGP Transition Demonstration; three of which are now participating in the Pioneer ACO model. Although the program was completed at the end of 2012, financial data has not yet been released through the CMS in 2013.
Conclusion

Although there is not an overwhelming amount of evidence supporting positive financial outcomes of ACOs in their third year of existence, there is certainly reason to believe they will be an integral part of our delivery system moving forward. The statistics and statements that have already been provided by industry leaders are encouraging and relevant to the specific goals of ACOs and delivery reform as a whole. Most importantly, it is promising to see private insurers already buying-in to the ACO model, even without a vast amount of cost-saving data in circulation. Nationally recognized leaders in the health insurance market sponsor both of the privately insured ACOs outlined in Section III of this paper. However, this should not be much of a surprise to the healthcare community.

The Medicare and Medicaid programs were established in 1965 under the Johnson administration. Throughout the 48-year history of these programs, a majority of the nationally recognized healthcare practices that are still in place today were established by the CMS. From the diagnosis-related group reimbursement model to prescription drug relief, Medicare policy has a profound effect on the future of health care as a whole. Policy initiated by Medicare has historically cascaded down to the private sector fairly rapidly. There is no reason to believe that the Medicare Shared Savings Program and ACO arrangement will be a departure from this trend.

In 2012, the Kaiser Foundation reported 49,435,610 total Medicare beneficiaries in the United States (32). As of January 2013, 2.4 million of these beneficiaries have already been enrolled in a Medicare ACO, with an additional 15 million non-Medicare patients enrolled in a Medicare-sponsored ACO. We can see that a large portion of the population is
Currently being funneled through the Medicare ACO system as directed by the CMS, with millions more coming through individualized ACO with private insurers. With the understanding the Medicare policy typically has a great deal of sway within the healthcare community, as well as the preliminary statistics provided by industry leaders, we can conclude that the future of ACO is very bright.

Although I am unable to prove my original question of whether ACOs are proving to drive down costs in healthcare spending, I can conclude that their ability to impose change in the delivery of care is extremely visible to the healthcare community. With the full support of the CMS and commercial insurance companies, the recent movement to incorporate highly coordinated care and quality performance measures in an effort to reduce the cost of care will maintain its grip in the current healthcare climate.
References:


