

Accountable care organizations (ACOs) are rapidly growing in popularity as a new health care delivery model for health systems and provider groups. This article explores the possibility of employers contracting directly with an ACO.

eACOs— The Next Generation of Health Plans



by | **Eric M. Parmenter, CEBS**

The Accountable Care Act (ACA) is transforming the way hospitals and health systems deliver care by shifting how providers get paid from volume to value-based care. It is also influencing the way large employers are thinking about delivering health benefits to employees over the next several years. Regardless of political efforts to modify the health care reform law passed in 2010 and largely upheld by the U.S. Supreme Court in July, the die has been cast with respect to health care delivery in the years to come.

In the short run, over half of the hospitals and health systems, as surveyed by SullivanCotter and HighRoads, expect a decrease in revenue and are being asked to consolidate and operate in a leaner environment.¹ In addition, employers are

ramping up their focus on employee health plans and looking for ways to reduce costs and improve employee health in order to comply with the new law.

ACA is estimated to cut \$155 billion in Medicare payments to hospitals and increase the burden on hospitals and health systems to:

- Modernize infrastructure
- Install electronic medical records
- Attract and retain good talent
- Integrate across clinical functions, acquiring physician practices and other facilities
- Increase patient flow with insurance coverage to reduce bad debt
- Implement pay for performance requiring new skills,

better measurement and tighter management.²

As hospitals and health systems strive to do more with less and rethink their role in an evolving health care marketplace, many are looking to accountable care organization (ACO) models. ACOs are viewed as a solution to more cost-effective management of care. It is hoped they will improve clinical outcomes, soften the impact of decreasing fee-for-service reimbursement and shift the axis of power away from large insurance companies to the health system, the provider of care.

One bold view, espoused by Ezekiel Emanuel and Jeffery Liebman of the *New York Times*, suggests that “By 2020, the American health insurance industry will be extinct. Insurance companies will be replaced by accountable care organizations—groups of doctors, hospitals and other health care providers that come together to provide the full range of medical care for patients.”³ Regardless of whether health insurance companies are ultimately replaced by ACOs, there is little doubt that ACOs are emerging as a viable new form of health care delivery.

This article describes ACOs at a high level, discusses the critical success factors for ACOs and explores a unique opportunity for employers to form partnerships directly with health systems through ACO-like models for employer-sponsored health plans.

ACO Basics

The hallmark of an ACO is the provider taking on risk. Elliott Fisher, director of the Dartmouth College Center for Population Health, coined the term *accountable care organization* in 2006.⁴ ACOs have been compared to the elusive unicorn: “Everyone seems to know what it looks like, but no one has actually seen one.”⁵ While some view an ACO as a recycled idea from the managed care era of the 1980s—like an HMO in disguise—its flexible structure and approach to compensating providers makes it a new form of health care delivery. The massive ACA gave a booster shot to the new form of delivery; however, ACOs don’t depend on health care reform legislation to grow and thrive. Hospitals, physician practices and other entities can form ACOs, which can compensate providers through fee-for-

service, capitation, “shared savings”⁶ or a mix of methodologies.

The primary target population of ACOs initially is Medicare beneficiaries. As the model succeeds, it is expected to be adopted more broadly in a variety of settings, including Medicaid, commercial group health plans and insurance exchanges. The ACO model, at its highest level, is a business model that:

- Attempts to change provider incentives
- Rewards quality patient care in an efficient, cost-effective manner
- Reduces overutilization of health care resources
- Improves patient handoffs and transitioning between providers.

The new models essentially shift performance and financial risk from purchasers and payers to providers. What characterizes an ACO more than anything else are doctors who are accountable for the results that come from working collaboratively with other health care providers across the care continuum to manage the patterns of how patients use health care services, striving to reduce the total cost of care.⁷ Figure 1 illustrates the spectrum of financial risk that providers are taking on under ACO models.⁸

The Centers for Medicare and Medicaid Services (CMS) has a three-part aim, with four domains, for ACOs:

1. Better care for individuals
 - Patient/caregiver experience
 - Care coordination
 - Preventive health/patient safety
2. Better health for populations
 - At-risk population
3. Lower growth in expenditures.

This three-pronged approach will require meeting quality standards in four domains—the subcategories to

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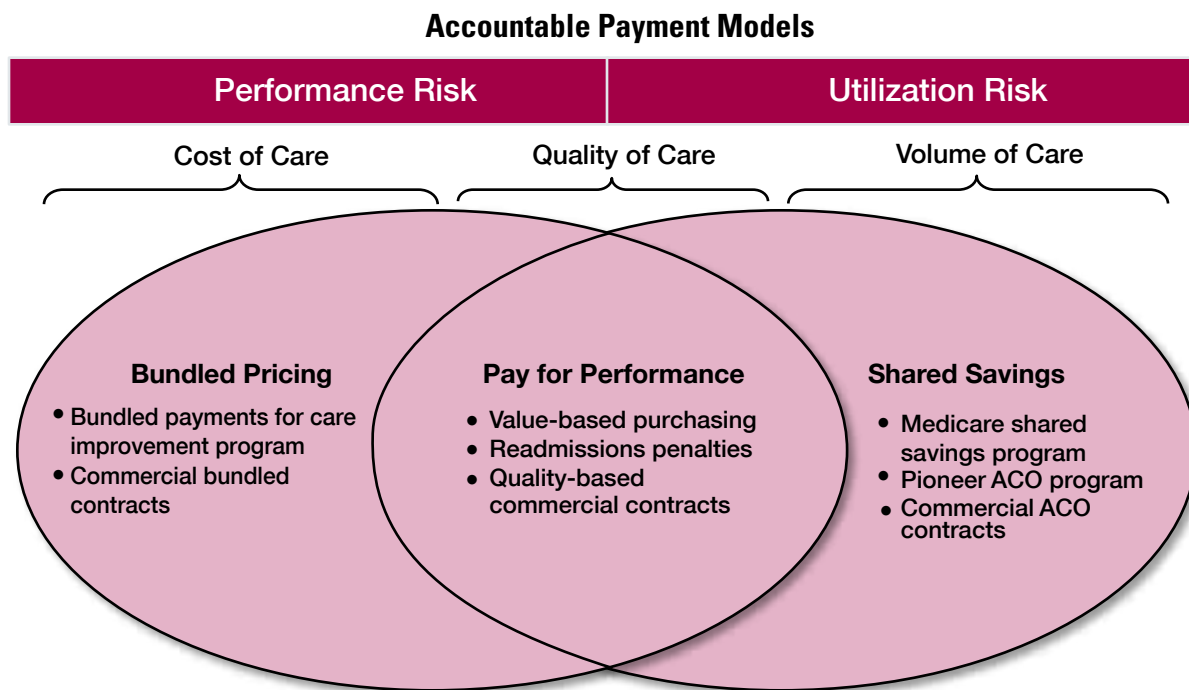
The New Health Care Reform Law: What Employers Need to Know—A Q&A Guide, Third Edition

by James R. Napoli and Paul M. Hamburger. Thompson Publishing Group, Inc. 2012.

For more details, visit www.ifebp.org/books.asp?8928.

FIGURE 1

Payers Shifting Financial Risk Onto Providers



Source: Health Care Advisory Board.

the three-part aim—by utilizing 33 quality and performance standards (the author calls this model the *3-4-33 framework*).⁹

Under the final ACO regulations, released on October 20, 2011, in the formal CMS ACO model, ACOs can and will take many different forms and encompass various provider groups that commit to participate in the Shared Savings Program for three years. It is beyond the scope of this article to describe in detail the requirements of the final ACO regulations, and the details of shared savings, as extensive resources exist in the public domain.

A number of health systems and medical clinics have adopted an ACO-like structure. It seems that every month an announcement is made of another organizational merger or change in structure for clinics or health systems to become an ACO or ACO-like entity. Several health systems are at various stages of ACO development. Some have applied to CMS to become formal ACOs beginning in 2012 while others are assembling all the necessary components to later become an ACO. The table lists 59 organizations that are at various stages of ACO development. The organizations in bold-faced type

have joined the Pioneer ACO initiative as sponsored by the Department of Health and Human Services (HHS).¹⁰

Under the Pioneer ACO initiative, 32 leading health care organizations from across the country will participate with HHS, through the CMS Innovation Center, on an accelerated path to forming ACOs. These organizations already have some level of ACO experience, and a significant portion of their revenue is tied to the delivery of value-based care.

In addition to the Pioneer organizations, 27 organizations were selected by CMS on April 1, 2012 as the first participants in the Medicare Shared Savings Program that will provide care to nearly 375,000 beneficiaries in 18 states and include more than 10,000 physicians, ten hospitals and 13 physician-driven organizations in both urban and rural areas.¹¹

Paying ACO Providers

There are many reasons why physicians and health systems form ACOs. ACOs present an opportunity for growth and expansion into new markets and for offering additional products and services.

TABLE

Organizations at Various Stages of ACO Development*ORGANIZATION***Atrius Health**

Advocate Health Care

Agnesian HealthCare

Allina Hospitals & Clinics

Atlantic Health System

Banner Health Network**Bellin-Thedacare Healthcare Partners****Beth Israel Deaconess Physician Organization**

Blue Shield of California

Bronx Accountable Healthcare Network (BAHN)**Brown & Toland Physicians**

Castle Health Group

Catholic Medical Partners

Cigna Medical Group

Dartmouth-Hitchcock Medical Center**Eastern Maine Healthcare System****Fairview Health Systems****Franciscan Alliance**

Geisinger Clinic

Genesys PHO

Gonzaga Medical Group

Healthcare Partners Medical Group**Healthcare Partners of Nevada****Heritage California ACO**

Holston Medical Group

Integrated Solutions Health Network

Intermountain Health

JSA Medical Group, a division of HealthCare Partners

Medical Clinic of North Texas

MedStar Health

Memorial Hermann

*REGION***Eastern and central Massachusetts**

Illinois

Wisconsin

Minnesota and western Wisconsin

New Jersey

Phoenix, Arizona metro area**Northeast Wisconsin****Eastern Massachusetts**

California

New York City (the Bronx) and lower Westchester County, New York**San Francisco Bay area, California**

Hawaii

New York

Arizona

New Hampshire**Central, eastern and northern Maine****Minneapolis, Minnesota metro area****Indianapolis and central Indiana**

Pennsylvania

Southeastern Michigan

Texas

Los Angeles and Orange Counties, California**Clark and Nye Counties, Nevada****Southern, central and coastal California**

Tennessee

Tennessee

Utah

Orlando, Tampa Bay and surrounding South Florida

Texas

Texas

Maryland

Providers that join ACOs will be compensated primarily in two ways: traditional fee-for-service (FFS) reimbursement under Medicare Parts A and B, as they are currently, and a bonus for managing patient costs against a historical benchmark projected forward. This bonus will derive from any savings that are generated against the benchmark and will be distributed between CMS and the ACO. The shared savings model contains two tracks:

- **Track One:** Providers will receive up to 50% of the shared savings with no downside risk.

- **Track Two:** Providers will receive up to 60% of the shared savings but with downside risk all three years.

The maximum bonus will be limited to 10% of the CMS benchmark costs per beneficiary, per year under Track One and 15% under Track Two.¹² It is unlikely that ACOs will hit the maximum bonuses, but the targets become a compelling motivator.

Slicing up the shared savings pie will be one of the significant challenges with ACOs, but enormous potential exists. For most ACOs, some of the bonus dollars will first be used to offset the investments in infrastructure needed for success.

TABLE

Organizations at Various Stages of ACO Development (cont.)

Mercy Medical Group	Missouri
Michigan Pioneer ACO	Southeastern Michigan
Monarch Healthcare	Orange County, California
Montefiore Medical Center	New York
Mount Auburn Cambridge Independent Practice Association (MACIPA)	Eastern Massachusetts
New West Physicians	Colorado
North Texas ACO	Tarrant, Johnson and Parker Counties in North Texas
Norton Healthcare	Kentucky
OSF Healthcare System	Central Illinois
Palmetto Health Quality Collaborative	South Carolina
Park Nicollet Health Services	Minneapolis, Minnesota metro area
Partners Healthcare	Eastern Massachusetts
Pendulum Health	Illinois
Physician Health Partners	Denver, Colorado metro area
Piedmont Physicians Group	Georgia
Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico
Primecare Medical Network	Southern California (San Bernardino and Riverside Counties)
ProHealth	Connecticut
Renaissance Medical Management Company	Southeastern Pennsylvania
Seton Health Alliance	Central Texas (11-county area including Austin)
Sharp Healthcare System	San Diego County
Southeast Michigan Accountable Care	Michigan
Southeast Texas Accountable Care Organization	Texas
Steward Health Care System	Eastern Massachusetts
TriHealth, Inc.	Northwest central Iowa
University of Michigan	Southeastern Michigan
University of Pittsburgh Medical Center	Pittsburgh, Pennsylvania

Note: Organizations in bold-faced type have joined the Pioneer ACO initiative sponsored by the Department of Health and Human Services (HHS).

Source: Author's compilation and the U.S. Department of Health and Human Services, "Affordable Care Act helps 32 health systems improve care for patients, saving up to \$1.1 billion," December 19, 2011.

Critical Success Factors for ACOs

ACOs are a transformational endeavor to create a business model that focuses on complex case management, particularly for patients with chronic disease and multiple comorbidities. The goal is to keep these patients, who are often repeat visitors to the emergency department, outside of the perimeter of the acute care hospital in lower cost community settings.

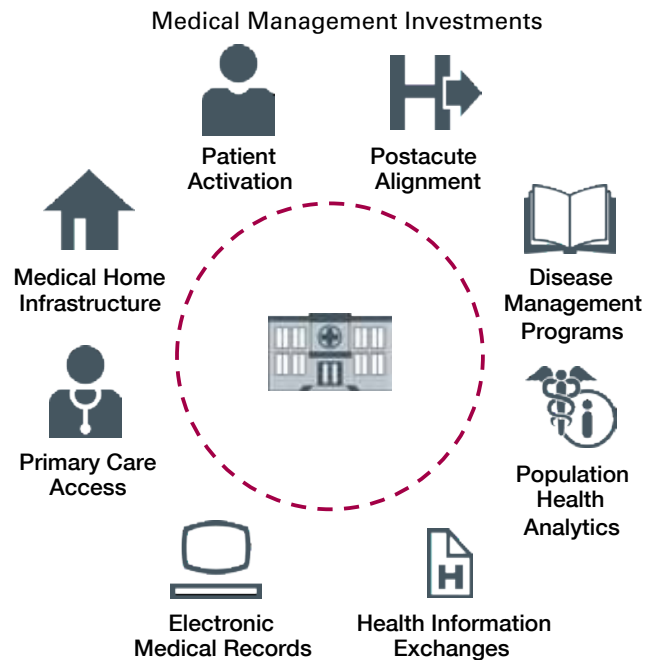
If this goal is achieved, delivery of care is transformed from a physician-centric approach to a patient-centered focus. As shown in Figure 2, successful ACOs essentially must construct a "medical perimeter" around the acute care

environment, working to provide as much care as possible within its lower cost, lower acuity settings. The ideal perimeter serves as a high-functioning ambulatory care network—a system of resources and processes designed to improve chronic disease management, prevent unnecessary inpatient utilization, reduce readmissions, identify opportunities for preventive intervention and coordinate care across the continuum, from physician office to postacute provider.¹³

This strategy creates patient-centered medical homes (PCMHs) that are built on primary care physician (PCP) access. Electronic medical records provide the analytics needed to

FIGURE 2

The Medical Perimeter



Source: Health Care Advisory Board interviews and analysis.

help the PCP reduce patient utilization through coordinating care. Patients are engaged in managing their own health and coached so that they comply with their treatment programs. This model shifts the focus from reactive intervention to proactive prevention and management. ACOs are intended to reorient the delivery system to expand access for patients in a PCMH environment. Because medical and mental conditions

are comorbid in over 50% of patients, mental and behavioral health coordination are essential.¹⁴

Physician incentives must be aligned, particularly for the growing number of employed doctors, which suggests that incentives will be different for PCPs than for specialists. Many health systems are feeling a capacity crunch, and the ACO structure lets hospitals focus on sicker patients by successfully moving those who are less acutely ill to the perimeter around the acute care facility.

The ACO Opportunity for Employer-Sponsored Health Plans

With the advent of ACOs, an opportunity exists for hospitals and health systems to partner with employers in their communities to develop an ACO-like structure that leverages the providers and clinical resources of the health system to provide care directly to employers. That cuts out the large insurance carrier as an intermediary. This employee ACO, or eACO, mirrors that of a true ACO but is part of an employee benefit plan offering and not subject to CMS rules and regulations. It does, however, remain governed by the Employee Retirement Income Security Act of 1974 and other regulations for self-funded plans and state regulations for fully insured plans.

In converting the employer's traditional PPO or HMO plans to an eACO provided directly by the health system, all of the fundamental building blocks described above would need to be established, with seven additional adjustments:

1. Formation of a direct partnership with the health system to build the eACO within a robust culture of health that focuses on the well-being and productivity of employees and offers decision-support structures such as health risk assessments and biometric screenings and a broad spectrum of health improvement programs
2. An optimized health and prescription benefit design promoted through meaningful financial incentives
3. Utilization of a narrow network of health system facilities, PCPs and other specialists and providers that deliver coordinated care, with a wraparound rental network to plug gaps
4. The proper balance between clinical resources that are part of the health system and outside partnerships to optimize care for employees and their families
5. Development of a provider compensation model that would be funded in part out of the employee health plan

<< bio




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budget, containing elements of shared savings as envisioned under the more formal Medicare ACO model

6. Marketing and promotion of the program within the employee population to grow membership and engagement (an activity that is limited under the formal Medicare ACO model). The eACO could be offered as an option in addition to traditional PPO or HMO plans, assuming a sufficiently large population, or as a full-replacement plan.
7. Incentives to participants to engage with their PCPs and comply with treatment plans and healthy lifestyle behaviors.

Conclusion

According to the 2012 Deloitte Survey of U.S. Employers: Opinions About the U.S. Health Care System and Plans for Employee Health Benefits, employers believe that direct contracting with provider organizations will be a viable cost-containment strategy.¹⁵ Furthermore, according to the same survey, CEOs and CFOs are more inclined to think that direct contracting is favorable compared to HR and benefits staff.¹⁶ Finally, not only are ACOs a viable alternative for employer-sponsored health plans but employers believe that health insurance exchanges are a viable channel for employer benefit strategies.¹⁷ ACOs can be packaged inside of individual and small-group products and sold on exchanges. A significant opportunity exists for employers to cut out a layer of the health care cost spectrum by contracting directly with health systems through eACOs. 

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Endnotes

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takeaways >>

- Many hope ACOs will improve clinical outcomes, soften the impact of decreasing fee-for-service reimbursement and shift power from insurance companies to the health system.
- In an ACO, doctors are accountable for the results of working collaboratively with other health care providers to manage how patients use health care services, striving to reduce total costs.
- Successful ACOs try to manage care so that chronically ill people receive most of their care in lower cost, lower acuity settings.
- ACOs present an opportunity for growth and expansion into new markets and for offering additional products and services.
- Providers in ACOs are paid through traditional fee-for-service reimbursement under Medicare Parts A and B and a bonus for managing patient costs against a historical benchmark. This bonus is from savings resulting from better care management.
- An employee ACO is part of an employee benefit plan offering and not subject to CMS rules and regulations. It is governed by ERISA and other regulations for self-funded plans and state regulations for fully insured plans.

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