The ABCs of ACOs – Accountable Care Organizations

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The Patient Protection and Affordable Care Act, (ACA) escalated the interest and growth of Accountable Care Organizations, (ACOs). Based on the final rules and regulations issued by the Centers for Medicare and Medicaid Services, (CMS), there are very specific rules for the Medicare population, such as specific start dates, 33 quality measures, risk arrangements and marketing requirements. In Eastern Massachusetts, over 150,000 Medicare recipients are covered by five ACOs involved in the Pioneer ACO Model, (Per CMS: “The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings.”). Specifically, the five are, Atrius Health Services, Beth Israel Deaconess Physician Organization (BIDPO), Mount Auburn Cambridge Independent Practice Association (MACIPA), Partners Healthcare and Steward Health Care System.

In the commercial market, ACOs are much more flexible and frankly, confusing. As the saying goes, “If you have seen one ACO, you have seen one ACO!”

So, what is a commercial ACO?

Broadly, an ACO is a provider led network of doctors and hospitals that share financial and medical responsibility for providing patient care. The goal is to improve outcomes, while limiting unnecessary spending, by offering coordinated/seamless care for each member directed by a primary care physician. ACOs look to provide population care with a strong emphasis on prevention, keeping healthy people healthy and managing members with chronic diseases, while treating the sick with coordinated care. ACOs typically will partner with an Insurance Carrier or other Third Party Payer for administration and benchmarking support.

The types of financial payment arrangements vary greatly from providers sharing a portion of the savings, to bearing some of the risk, to global payments, and to capitation arrangements.

Why are ACOs being considered in the Commercial Market?

Fee for service arrangements have not provided the proper incentives for providers to limit cost. To the contrary, by reimbursing each procedure, test and service, the medical community is incented to provide more services, whether or not these services actually improve patient care.
In an ACO, doctors and hospitals must meet specific quality benchmarks that require them to provide coordinated care, in order to limit unnecessary costs; they do this by focusing on prevention and management of patients with chronic conditions. If the ACO meets their specific quality of care benchmarks at a lower cost, then providers are rewarded.

**What are the potential downsides of ACOs?**

The biggest potential downside of ACOs is more consolidation among healthcare providers, which may result in providers with marketplace superiority and little competition, potentially leading to higher prices. Another issue is that payment reform and practice reform are very difficult and expensive. So, it will take time to implement, hence the lack of commercial ACOs in the marketplace currently.

At this time, true commercial ACOs are in limited supply locally and nationally. Sullivan Benefits actively monitors the marketplace for efficient health care models, including ACOs, and is well versed on current market offerings that maximize patient care, while minimizing plan costs. Please contact us to learn more.