Organizational Issues

Accountable Care Organizations: The Missing Link to Engagement in Health and Health Care?

Accountable care organizations (ACOs) aim to transform health care delivery and provider payment in a way that improves patient access, engagement and quality of care. If successful, ACOs may help the U.S. health care system finally evolve from a “diagnose, treat and reimburse mostly acute, episodic health care” approach to one that encourages and compensates health care providers that work with their patients throughout a full continuum of care to prevent and manage chronic conditions. What are the implications for ACOs from a workforce health perspective? ACOs were built on a framework for delivering evidence-based health care interventions to engage patients in managing and improving their health. But to what extent do ACOs or employers actually follow such a framework and how can these interventions be integrated with workplace health improvement and wellness efforts? The authors explore the mechanisms for impacting workforce health and provide a checklist to assist employers with evaluating ACOs and assessing feasibility of potential ACO integration with workplace health improvement programs.

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Accountable care organizations (ACOs) are becoming a formidable presence in the health care landscape. Fueled primarily by the Patient Protection and Affordable Care Act’s (ACA’s) progressive reimbursement packages, hospitals, physician groups and health plans have placed ACOs in the center of their efforts to transform health care delivery and provider compensation.

For employers that sponsor workplace health programs, there is a great deal riding on the success of these efforts: The ACO model, along with the health exchange, is the foundational framework for the potential transformation of the U.S. health care system. While the objective of the health exchange is to improve access to health care financing or coverage, the ACO aims to transform health care delivery and
provider payment in a way that improves patient access, engagement and quality of care.

Is the system finally evolving from a “diagnose, treat and reimburse mostly acute, episodic health care” approach to one that encourages and compensates health care providers that work with their patients throughout a full continuum of care to prevent and manage chronic conditions? The three key considerations for both employers and ACO providers are:

1. **Why and how was the ACO model developed, and what are the key objectives of an ACO?**
2. **What are the mechanisms and interventions within the health care delivery framework that can better engage patients in their health and health care?**
3. **How can ACOs be integrated with employer-sponsored or workplace health programs to improve population health and workforce productivity?**

As a product of this review, the authors present the reader with a simple checklist employers can use to:

- Inventory and map their present wellness program’s use of evidence-based methods to engage employees in their health and health care.
- Assess one or several ACOs’ use of the same evidence-based methods to improve health status.
- Evaluate the feasibility of ACO integration with existing workplace health improvement efforts.

**Why and How Was the ACO Model Developed?**

The question “Why do we need ACOs?” is perhaps trivial at this point. We know that the present system for health care financing and payment doesn’t reward health care providers for engaging patients in preventive health and managing chronic health conditions. We also know that Americans, on average, have health risks and conditions that are not well-managed and adversely impact quality of life, health and job productivity. Finally, we know all too well that health care costs are excessively high in comparison with other goods, services and economic indicators. As our nation has developed and endorsed the ACO model as the means for transforming the way...
health care is delivered, it’s important to understand how it was developed.

Dr. Elliott Fisher coined the term accountable care organization during a Medicare Payment Advisory Commission meeting in 2006 and described the concept in his subsequent 2007 Health Affairs article, “Creating Accountable Care Organizations: The Extended Hospital Medical Staff.” But to understand how Fisher got to that point, why the ACO innovation has diffused so rapidly and, specifically, how both provider and patient engagement can be improved through the ACO model, we need to look further back to the development of the first prepaid health plans, through the evolution of staff model clinics, independent practice associations (IPA), health maintenance organization (HMO) models and the various versions of integrated delivery systems (IDS). Figure 1 summarizes the plan developments and major efforts and events leading up to today’s ACOs. We will briefly discuss the rationale for each provider framework or health plan model specific to how it may impact provider and patient engagement in health and health care.

These various evolving models were developed to promote professional, science-based health care as an alternative to home remedies or no care at all. From prepaid plans (give people access to a clinic when needed, for a monthly fee) to HMOs (control patient access to care, limit utilization to necessary treatment and manage health and health care costs), innovation in health care delivery and financing was deliberate yet abundant. While changes in health policy have been driven by legislation, the markets and practices have been driven primarily by employers in their efforts to provide affordable health care to their workforce members. For a time, managed care seemed to offer the solution. However, the economics (and countless 11 o’clock news stories of health care rationing) ultimately caught up with the HMOs, and the rest is history.

Meanwhile, with more sophisticated data management, along with increasing rates of obesity and chronic disease, we soon learned that more of the potentially excessive costs were not necessarily from routine health care utilization. Rather, the increasing burden of chronic conditions and obesity were primary cost drivers. While managed care organizations (MCOs) and employers responded primarily through cost shifting (to employees), innovative clinicians, researchers and entrepreneurs focused on the determinants, or sources, of these conditions and better ways to identify and assist individuals with the management of their diseases. This led to the development of disease management and wellness efforts, which now are ubiquitous in employer-sponsored or worksite health plans.

While wellness products and services were developed and sold to employers as the way to improve population health, Ed Wagner and colleagues, with the support of the Robert Wood Johnson Foundation, quietly developed, piloted and published their efforts with the chronic care model (CCM). The patient-centered medical home (PCMH), which is now integrated with the CCM, was also developed and piloted during this period. These new models established an ideal framework for providing an evidence-based, patient-centered care experience throughout a full continuum of chronic care management. The underlying theory of these new models is that if physicians and physician groups could team up to deliver evidence-based chronic care management, and get compensated for these efforts, patient experiences and health outcomes would improve measurably. The rationale from a practice perspective is simple: By collaborating with the patient and focusing on quality and excellence in care coordination, patients will be better engaged with their health. By combining the CCM and PCMH models, an ideal patient experience, for which an integrated care team could deliver evidence-based care throughout the full continuum of a chronic condition, would involve patient autonomy and care team support for mastery of self-management and connection with community resources.

Considering the process mechanisms of the provider, the care team would collaborate with real-time access to all relevant patient health status and treatment plans, with evidence-based decision support and payment structures that reward the practice for delivering efficient care that produces the most efficacious outcomes. Through these models, the ideal system-of-care approach could be realized while mutually benefiting patients, providers, health systems and organizational stakeholders such as employers, community and government.

While this model is patient-centered from the provider’s perspective, in many
ways it is provider-centered from the health system and payer’s perspectives. Thus, health care providers that adopt such evidence-based practices may now take back much of the control that was held by the MCO or payers for the past 30 years. While the CCM provides the mechanisms for the PCMH, the PCMH is the foundation for provider practice transformation to the ACO. In relation to an ACO, the PCMH is at the individual practice level, whereby the ACO is often described as the medical home neighborhood, as it is comprised of numerous practices.

**What Are the Key Objectives of an ACO?**

The initial elements described by Fisher focused on accountable care, performance measurement and payment reform. Major elements of his design emphasized the importance of integrated delivery systems that could:

- Support comprehensive performance measurement
- Effectively manage the full continuum of patient care
- Participate in shared savings approaches to payment reform.

Through these efforts, the Institute for Healthcare Improvement (2007) developed the Triple Aim for populations—a collaborative effort to reach certain goals in community health: Simultaneously improve the health of the population, enhance the experience and outcomes of the patient and reduce per capita cost of care for the benefit of communities.

The Centers for Medicare and Medicaid Services (CMS) established the Medicare Shared Savings Program (MSSP) with a set of 33 performance measures to rate or assess ACOs. These measures are grouped into specific domains, including:

- **Patient/caregiver experience** (qualitative impact)
- **Care coordination/patient safety** (process measures)
- **Preventive health** (care delivery)
- **At-risk population** (biometric outcomes for diabetes, hypertension, ischemic vascular disease, heart disease and coronary artery disease).

While these performance measures are good indicators that essential health care services are being delivered, they are almost exclusively outcome measures of biometric indicators or process measures for specific care.

While this is a positive and progressive step forward, and it does promote accountability in delivering care, there is a missing element that is equally as important when considering the nature of health risks, chronic health conditions and human behavior. There is an absence of measures to assess the specific delivery methods to promote health engagement—that is, what interventions were delivered to engage patients in self-management, and what measures were taken to connect patients with the community resources that will help them to sustain or continue to improve their health status?

If Medicare’s performance measures continue as the primary targets for ACO performance, ACOs will continue to build their practices on meeting the

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**FIGURE 2**

**The Chronic Care Model**

Source: Adapted from the MacColl Institute’s Chronic Care Model, ACP-ASIM Journals and Books.
outcome objectives, while the processes through which they achieve outcomes will vary considerably across ACOs.

Several organizations offer accreditation services for ACOs, including URAC and National Committee for Quality Assurance (NCQA). The criteria for evaluation are more robust than the MSSP measures, yet most of the focus is on clinical systems, performance measures, provider infrastructure and patient satisfaction. While some elements address self-management support (SMS) and community-based programming, these are limited primarily to surface-level assessment and do little to facilitate assessment of the actual mechanisms that promote and facilitate patient engagement in health improvement efforts.

What Are the Mechanisms and Interventions That Can Better Engage Patients in Their Health and Health Care?

Effective management of the full continuum of patient care needs to be supported by effective methods for engaging patients in their health and health care. To understand how and why an ACO can do this, we must look specifically at the CCM and PCMH, which provide the framework for provider integration and care delivery. The CCM framework comprises six primary elements: health system, SMS, community resources and policies, delivery system design, decision support and clinical information systems. The model later integrated with the PCMH by emphasizing the importance of patient safety (in the health system), cultural competency (in delivery system design), care coordination (in the health system and clinical information systems), community policies (in community resources) and care management (in delivery system design). Figure 2 displays each of the primary elements in relation to the model.

The table provides a brief summary of the key points for each of the primary elements of the CCM.

### Table

<table>
<thead>
<tr>
<th>CCM Element</th>
<th>Key Points</th>
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<tbody>
<tr>
<td>Health system</td>
<td>Create a culture, organization and mechanisms that promote safe, high-quality care.</td>
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<tr>
<td>Delivery system design</td>
<td>Assure the delivery of effective, efficient clinical care and self-management support.</td>
</tr>
<tr>
<td>Decision support</td>
<td>Promote clinical care that is consistent with scientific evidence and patient preferences.</td>
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<tr>
<td>Clinical information systems</td>
<td>Organize patient and population data to facilitate efficient and effective care.</td>
</tr>
<tr>
<td>Self-management support</td>
<td>Empower and prepare patients to manage their health and health care.</td>
</tr>
<tr>
<td>Community resources and policies</td>
<td>Mobilize community resources to meet needs of patients.</td>
</tr>
<tr>
<td>Care coordination</td>
<td>All providers working with a particular patient share important clinical information, have clear, shared expectations about their roles, and work together to keep patients and their families informed and to ensure that effective referrals and transitions take place.</td>
</tr>
</tbody>
</table>

Source: Adapted from the MacColl Institute’s descriptions of the CCM elements at www.improvingchroniccare.org.

How Can ACOs Be Integrated With Employer-Sponsored or Workplace Health Programs to Improve Population Health and Workforce Productivity?

What are the implications for ACOs from a workforce health perspective? Employers and workplace health had a major role in the development of the original prepaid and managed care models. As the diffusion of ACOs expands, it is likely that employers will have major input as to how ACOs are used to improve health in the workplace. Many employer organizations have contracted either directly or indirectly (through their health plan) with an ACO. However, the focus of attention on the ACO impact to these programs is once again primarily on the outcome measures, rather than the process through which patient engagement can be improved.
The narrow, high-performing network of integrated physician groups and/or hospitals report delivering better care at a lower cost—primarily reducing cost via supply-side economies, but also taking cost out of the system through better coordinated care efforts. These usually are key considerations for employers in evaluating provider networks.

Based on the evidence and the current markets, this outcome-centered approach is sound in respect to traditional network considerations; yet, as the ACO is far more than a network, this approach misses opportunities for employers to assess a given ACO’s potential for impacting employees’ health engagement. More specifically, the two components of the CCM that are most relevant to improving engagement in health improvement efforts, SMS and community resources, which can be essential elements of an ACO, are likely the two least integrated CCM elements in ACOs. Why? There are a number of reasons, but primarily because there is little connection to the MSSP performance measures. If the employer has already developed efforts in these areas (via wellness, health promotion and disease management programs), then this is certainly an opportunity for integration—or at least some alignment in order to coordinate health improvement efforts. A major problem with our health care system is fragmentation, yet with the development of ACOs, much of this fragmentation can be eliminated with respect to primary care delivery.

However, when an employer is operating disease management programs, employee health coaching and other health improvement elements that are not a part of the ACO operations, or are not coordinated with the ACO, fragmentation persists at the expense of the employer, the employee and the ACO.

To explore the specific mechanisms and the need for an integrated, patient-centered approach to health improvement, we will explore SMS at a clinical level. Wagner (creator of the CCM) and colleagues developed 12 evidence-based principles for delivering SMS in primary practice (Battersby et al., 2010):

1. **Brief targeted assessment.** The practitioner must have specific knowledge of the patient’s health status and lifestyle activities in order to assess the patient’s needs, risks and appropriateness for further intervention.

2. **Evidence-based information to guide shared decision making.** Providing tailored feedback and targeting the patient’s unique needs is more effective in motivating action toward skill building than simply providing general health education.

3. **Use of nonjudgmental approach.** While a clinician’s advice may have strong credibility, this is not sufficient to empower a patient to engage in health efforts. Being told what to do without a feeling of empathy does not enhance motivation or build self-efficacy. And when such advice appears judgmental, it can actually do more harm than good. A nonjudgmental, collaborative approach with questions and reflections from the provider will go a lot further than providing advice or giving directions.

4. **Collaborative priority and goal setting.** When the patient has a say in developing a care plan (rather than the provider writing it up) in a collaborative way with the clinician, the patient is likely to take greater ownership and accountability to adhere to the plan.

5. **Collaborative problem solving.** The clinician guides the patient through various problem-solving scenarios specific to health improvement efforts. This helps the patient build skill, competence and self-efficacy toward handling troubling situations that may otherwise lead to a relapse to previous behaviors and health status after initial success has been achieved.

6. **SMS by diverse providers.** The evidence clearly demonstrates that physicians should not deliver all the interventions. The care team may and should include nonphysician clinicians, such as nurses, counselors and dietitians. Additionally, with sufficient training, lay health educators can be effective interventionists, with the main qualifying criteria having already made similar changes themselves.

7. **Self-management interventions delivered by diverse formats.** There is evidence for the effectiveness of several delivery settings (individual, group, in-person, telephonic, web-based, written self-help materials), with face-to-face interventions outperforming telephonic and self-help. There is also evidence supporting individuality—in that each patient has unique needs and preferences and, while one patient...
may respond well to one modality, another may not do well at all. This is why patients should have the opportunity to participate in several modalities and settings, so they may explore and stay with what works best for their needs.

8. **Patient self-efficacy.** Patient self-efficacy is the result of achieving task mastery. Through skill building, a patient develops greater confidence toward performing certain tasks even in difficult situations. Interventions that aim toward this objective will be most effective.

9. **Active followup.** Simply put, when the patient has a planned followup schedule, there is greater likelihood of achieving goals. Such patient program planning throughout the continuum of care is essential to help patients stay committed to their care plan beyond the initial care phase.

10. **Guideline-based case management for selected patients.** Case management is a care element that easily can go off track. Yet when an integrated care team is involved in an ongoing, patient-centered (and tailored), team-based effort to assist the patient with unique care needs, greater adherence to the care plan can be achieved and the effort yields better outcomes.

11. **Linkage to evidence-based community programs.** Community-based programs that are supported by evidence can be critical in helping certain patients bridge the gap between their care team and their own self-determination. In many ways, the employer is the “community” in its employees’ lives. The care team should look for opportunities in the community as well as those programs available through a given patient’s employer.

12. **Multifaceted interventions.** Similar to Principle 7, providers should seek multiple means for intervention delivery. However, beyond simply having different modalities or settings, the interventions should be structured to include a variety of means for clinician (or lay educator) contact and intervention.

While the evidence clearly demonstrates that these principles would guide providers toward having greater impact on their patients’ health, to what extent do ACOs actually follow such a framework?

There usually are some of these efforts in the medical practice, some in a hospital setting and some at the worksite. However, is an integrative process for delivering care by following these or similar principles on the priority list for ACOs? And if the ACO isn’t doing this, can the employer?

While workplace wellness and disease management programs vary considerably across employers and populations, some employers have developed internal programs that have effectively integrated the principles above. One employer, a large health care system in Texas, recently piloted a program that used all of these principles (Halterman and Balezentis, 2015). In brief, the program incorporated key elements, as follows:

- Highly structured sequence of interventions throughout the initial program phase, along with a series of predetermined checkpoints and milestone targets throughout the one-year program to promote continued engagement
- Behavioral-health, clinical team-based care with staffing and collaboration, consultation and referral through individual and group sessions to incorporate all elements of the CCM and to integrate with the hospital system’s ACO
- On-site/worksite-based, face-to-face interventions, with an emphasis on assessment of health risks with direct feedback and action planning
- Group counseling, with a peer support promotion structure, including peer-led groups, peer sponsor and accountability partner assignments as well as champion credentialing to recognize achievements and promote growth and sustainability
- Licensed, experienced behavioral health counselors delivering care and engaging participants in exploring core issues that contribute to their health status while working with each person’s unique situation
- Extensive training and credentialing in health coaching as well as regular intervention-specific team-based training in therapy methods for all team members.

This program was actually developed in collaboration with the organization’s ACO and is now being integrated with ACO programming for employer organizations.
Conclusion

In answering the question "Are ACOs the missing link to employee engagement in health and health care?" the emphasis needs to be on the importance of an integrated approach within an ACO network—one that leverages the full CCM and PCMH models. An employer would need to specifically identify both its own health engagement efforts and those of a given ACO. This can be done by following these three steps:

1. Inventory and map the present wellness program’s use of evidence-based methods to engage employees in their health and health care.
2. Assess one or several ACOs’ use of the same evidence-based methods to improve health status.
3. Evaluate the feasibility of ACO integration with existing workplace health improvement efforts.

The checklist in the appendix can be used to assist an employer with this process. While a deeper exploration of capabilities, resources and functional capacity should also be conducted, the checklist should help to identify key elements for feasibility and initial assessment of both the employer’s organizational readiness and ACO capabilities for employee health engagement.

Endnote

1. URAC, "an independent, nonprofit organization, is a well-known leader in promoting healthcare quality through its accreditation, education, and measurement programs" (www.urac.org/about-urac/about-urac/). The National Committee for Quality Assurance (NCQA) is "a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality” (www.ncqa.org/AboutNCQA.aspx).

References


Halterman, Steven L. and Melinda S. Balezentis. Workspan, April 2015, Volume 58, No. 04.


### EMPLOYER CHECKLIST FOR ACO CONTRACTING AND WORKFORCE HEALTH ENGAGEMENT FEASIBILITY AND ASSESSMENT

#### Part I: ACO Assessment

**ACO Framework—Organization**

1. Did the ACO operate as an “ACO-like” organization prior to 2012? □
2. Did the ACO participate in the Medicare Shared Savings Program (MSSP)? □
3. Was a payment made by Medicare for 2013? □
4. Did the ACO participate in a Shared Savings Program with a commercial payer? □
5. Was a payment made by the payer for the most recent distribution period? □
6. Can the ACO provide health care services at or near the employer’s worksites? □
7. Does the ACO presently provide on-site health care services for other employers? □
8. Can the ACO contract with other payers/third-party administrators (if the employer changes its payer/third-party administrator)? □
9. Does the ACO presently contract with other payers/third-party administrators? □
10. Is the ACO willing to integrate services with the employer’s employee assistance program and other health engagement programming (both internal and external)? □

**ACO Framework—Accreditation**

1. Does the ACO participate in credentialing beyond CMS’s MSSP? □
2. Is the ACO accredited by NCQA? (If yes, request report card.) □
3. Is the ACO accredited by URAC? (If yes, request results.) □
4. Are provider practices within the ACO certified PCMHs through NCQA? □
5. Is the ACO accredited by any other agencies or organizations? (If yes, request reports.) □

**ACO Framework—Chronic Care Model/Patient-Centered Medical Home**

1. Does the ACO specifically use the CCM in its framework? □
2. Does the ACO incorporate all elements of the CCM in its operations? □
3. Are there specific processes for triaging patients for delivering structured SMS interventions? □
4. Is there a specific process for integrating SMS interventions with primary care? □
5. Does the ACO collaborate with community organizations for continued support of patient engagement in health-improving activities? □
6. Does the ACO collaborate with community-based health organizations to provide on- or near-site programming? □
7. Does the ACO integrate care delivery with behavioral health providers? □
EMPLOYER CHECKLIST FOR ACO CONTRACTING AND WORKFORCE HEALTH ENGAGEMENT FEASIBILITY AND ASSESSMENT

ACO Framework—Access
1. Does the ACO’s service area reach all desired workplace locations? ☐
2. Does the ACO’s service area reach the desired number of employees’ residences? ☐
3. Does the ACO have partnerships with the desired hospitals within the service area? ☐
4. Do practices offer extended office hours that facilitate employee provider appointments outside of the employer’s standard business hours? ☐

ACO Framework—Structured Health Engagement Process
1. Does the ACO employ licensed behavioral health counselors or certified health coaches to deliver health engagement interventions? ☐
2. Does the ACO deliver a motivational enhancement intervention along with the completion of a health risk assessment? (Assessment of health risks with feedback.) ☐
3. Does the ACO conduct risk stratification and triage to assign patients to the most appropriate level of care for chronic condition management or general health improvement? ☐
4. Does the ACO conduct a counseling or coaching session to assist the patient to assess for level of motivation, activation, engagement and goal-setting readiness? ☐
5. Does the ACO conduct a counseling or coaching session toward developing a specific treatment plan for health improvement/engagement? ☐
6. Does the ACO conduct a counseling or coaching session as a followup to the treatment plan development? ☐
7. Does the ACO offer ongoing counseling or coaching sessions for patients with chronic conditions? ☐

Part II: Internal Employer Assessment
Health Engagement Strategy and Milieu—Check each of the items that apply.
1. Does the organization have a documented strategy for workforce health engagement or is it willing to develop a workforce health engagement strategy? ☐
2. Have recent change leadership/management efforts been successful? ☐
3. Is leadership willing to take an active role in the development and support of internal health engagement efforts? ☐
4. Does the organization presently offer employee wellness programs? ☐
5. Is the current financial situation one in which the employer may establish a multiyear budget for internal health engagement resources? ☐
6. Is the organization willing to focus on longer term (3-5+ years) financial performance objectives, rather than seeking a hard return on investment in Years 1 and 2? ☐
7. Does the organization aim for high employee retention rates for the workforce on average? ☐
8. Has the organization developed or is it willing to develop “built environment” efforts, such as on- or near-site fitness access (walking/running trails, gym), access to healthy foods and vending? ☐
EMPLOYER CHECKLIST FOR ACO CONTRACTING AND WORKFORCE HEALTH ENGAGEMENT FEASIBILITY AND ASSESSMENT

9. Has the organization developed or is it willing to develop on- or near-site health clinics, pharmacies and health counseling offices?

10. Is the organization willing to align health engagement with other workforce connectivity and talent management initiatives and strategies?

Strategy Outcome—Check one of the following.

A. If most or all of the items above are checked, it may be feasible to develop internal health engagement efforts that can be integrated with an ACO.

B. If only a few of the items above are checked, internal health engagement efforts are not likely feasible, and the employer should focus primarily on external efforts with an ACO.

C. If none of the items above is checked, ACO and other health engagement efforts are not likely feasible for the organization. It may be prudent for the organization to consider the public exchange for employee health care coverage.

If A is checked above, continue to the internal inventory below.

Part III: Internal Employer Inventory of Evidence-Based Health Engagement Structure

1. Does the organization employ or contract with licensed behavioral health counselors or certified health coaches to deliver health engagement interventions?

2. Does the organization or its business associate deliver a motivational enhancement intervention along with the completion of a health risk assessment? (Assessment of health risks with feedback.)

3. Does the organization or its business associate conduct risk stratification and triage to assign patients to the most appropriate level of care for chronic condition management or general health improvement?

4. Does the organization or its business associate conduct a counseling or coaching session with the patient to assess for level of motivation, activation, engagement and goal-setting readiness?

5. Does the organization or its business associate conduct a counseling or coaching session toward developing a specific treatment plan for health improvement/engagement?

6. Does the organization or its business associate conduct a counseling or coaching session as a followup to the treatment plan development?

7. Does the organization or its business associate offer ongoing counseling or coaching sessions for patients with chronic conditions?

Evidence-Based Structure—Check one of the following.

A. If most or all of the items above are checked, the organization should continue these efforts with a focus on integrating with the ACO.

B. If none or only a few of the items above are checked, the organization should evaluate feasibility of the ACO performing these functions exclusively.

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