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Estudo de caso sobre mudanças no modelo de assistência médica e pagamento: a experiência da ACO Unihosp Medhealth em Goiás, Brasil

Case Study on Changes in the Healthcare and Payment Model: The Experience of ACO Unihosp Medhealth in Goiás, Brazil

Estudio de caso sobre los cambios en el modelo de atención médica y de pago: La experiencia de la ACO Unihosp Medhealth en Goiás, Brasil

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Abstract
The objective of this paper is to narrate a case study about integration of healthcare by means of an Accountable Care Organization (ACO), developed in the state of Goias, Central Brazil. The method used was a case study focusing on a partnership formed between seven hospitals and three diagnostic imaging clinics with the purpose of integrating primary, secondary, and tertiary levels of care. The coordination of the health system is made through a hospital unit in the primary level. The proposition brings innovation in the sense that the focus changes

from volume of medical procedures to the patient health wellbeing. The current healthcare context in which this case was created presents strong challenges to managers and executives in the healthcare sector: combination of overuse of the healthcare system with increasing medical costs. The results showed improvement in a set of health indicators when comparing the ACO initiative with the figures from the National Supplementary Health Agency (ANS), such as consultations per patient per year (5.5 for ANS versus 3.7 for ACO), number of patient examinations per year (23.4 for ANS versus 8.39 for ACO), X-ray examinations per patient per year (0.6 for ANS versus 0.1 for ACO), and non-surgical hospitalizations per patient per year (0.072 for ANS versus 0.008 for ACO). This study can contribute to healthcare by presenting a proposal aimed at addressing one of the major current challenges in the field: excessive use of the healthcare system on one hand and high medical costs on the other.
Keywords: Accountable Care Organization; Patient Well-Being; Healthcare; Level of Healthcare.

Resumo

O objetivo deste artigo é narrar um estudo de caso sobre integração de cuidados de saúde por meio de uma Organização de Cuidados Responsáveis (ACO), desenvolvida no estado de Goiás, Brasil Central. O método utilizado foi um estudo de caso focado em uma parceria formada entre sete hospitais e três clínicas de diagnóstico por imagem com o objetivo de integrar os níveis de atenção primária, secundária e terciária. A coordenação do sistema de saúde é feita por meio de uma unidade hospitalar no nível primário. A proposta traz inovação no sentido de que o foco muda do volume de procedimentos médicos para o bem-estar da saúde do paciente. O contexto atual da saúde em que este caso foi criado apresenta fortes desafios para gestores e executivos do setor de saúde: combinação de uso excessivo do sistema de saúde com aumento de custos médicos. Os resultados mostraram melhora em um conjunto de indicadores de saúde ao comparar a iniciativa ACO com os números da Agência Nacional de Saúde Suplementar (ANS), como consultas por paciente por ano (5,5 para ANS versus 3,7 para ACO), número de exames de pacientes por ano (23,4 para ANS versus 8,39 para ACO), exames de raios X por paciente por ano (0,6 para ANS versus 0,1 para ACO) e internação hospitalar não cirúrgica de paciente por ano (0,072 para ANS versus 0,008 para ACO). Este estudo pode contribuir para a área da saúde ao apresentar uma proposta que visa

abordar um dos principais desafios atuais do setor: o uso excessivo do sistema de saúde, por um lado, e os altos custos médicos, por outro.
Palavras-chave: Organização de Atenção Responsável; Bem-Estar do Paciente; Assistência à Saúde; Nível de Atenção à Saúde.

Resumen

El objetivo de este artículo es describir un estudio de caso sobre la integración de la atención médica a través de una Organización de Atención Responsable (OAR), desarrollada en el estado de Goiás, en el centro de Brasil. El método empleado fue un estudio de caso centrado en una alianza entre siete hospitales y tres clínicas de diagnóstico por imágenes, con el fin de integrar los niveles de atención primaria, secundaria y terciaria. La coordinación del sistema de salud se lleva a cabo a través de una unidad hospitalaria de atención primaria. La propuesta es innovadora, ya que el enfoque se desplaza del volumen de procedimientos médicos al bienestar de la salud del paciente. El contexto sanitario actual en el que se desarrolló este caso presenta importantes desafíos para los gerentes y directivos del sector: una combinación de uso excesivo del sistema de salud con el aumento de los costos médicos. Los resultados mostraron una mejora en diversos indicadores de salud al comparar la iniciativa de la Organización de Atención Responsable (ACO, por sus siglas en inglés) con las cifras de la Agencia Nacional de Salud Complementaria (ANS, por sus siglas en inglés), tales como las consultas por paciente al año (5,5 para la ANS frente a 3,7 para la ACO), el número de exploraciones médicas por paciente al año (23,4 para la ANS frente a 8,39 para la ACO), las radiografías por paciente al año (0,6 para la ANS frente a 0,1 para la ACO) y las hospitalizaciones no quirúrgicas por paciente al año (0,072 para la ANS frente a 0,008 para la ACO). Este estudio puede contribuir al ámbito sanitario al presentar una propuesta que busca abordar uno de los principales desafíos actuales del sector: la sobrecarga del sistema sanitario y los elevados costes médicos.
Palabras clave: Organización de Atención Responsable; Bienestar del paciente; Atención sanitaria; Nivel de atención sanitaria.

Introduction

The Association of High Complexity Private Hospitals of the State of Goiás (AHPACEG), which represents the largest and most representative private health institutions

in the State of Goiás, through its business unit UNIHOSP, in partnership with the private health plan Medhealth, decided to develop an Accountable Care Organization (ACO) - aiming to integrate primary, secondary and tertiary care levels, through the coordination of access and navigation to the health system through primary care. The innovation in relation to the ACO proposal is that through it, the healthcare sector stops working in a logic that is based on transaction volume, t The focus of the research problem is the dilemma between rising healthcare costs and excessive utilization by users, in a context where there is a lack of coordination between stakeholders such as health insurance plans and healthcare providers (hospitals and clinics).hat is, paying based on quantity multiplied by the price, something that is economically unsustainable. and starts focusing on a model aimed at the effectiveness of patient health, in a profitable way.

According to the National Supplementary Health Agency (ANS), the private Brazilian healthcare market has 670 health plans but is concentrated in nine companies nationally accounting for 40% of the 52 million users in the country. Specifically, the state of Goiás, which is the focus of this study, is assisted by a total of 38 players nonetheless dominated by three large private health plans. The combination of market concentration and high costs is bringing a considerable risk of unsustainability, stemming from the excessive use of healthcare services on the one hand, and high medical costs on the other. This reality could lead to the closure of healthcare institutions, with a consequent reduction in the quality and safety of regional healthcare services, which motivated the creation of the ACO (Accountable Care Organization) as a way to balance the challenges facing the healthcare system.

Accountable Care Organizations (ACOs) are networks of healthcare providers that assume joint responsibility for costs and quality of care for a defined population and are reimbursed (partially) through shared savings/value-based agreements, rather than fee-for-service. (ALJELBAN et al., 2023; HSU et al., 2024; KAUFMAN et al., 2019; McWILLIAMS et al., 2015). International and US evidence shows that ACOs can reduce the use of hospitalizations and emergency care and improve some prevention and chronic care metrics; cost reduction and effects on clinical outcomes are heterogeneous across programs, depending on design, maturity, patient profile, and data/IT capabilities. (BAO; BARDHAN, 2024; BARNES et al., 2014; KAUFMAN et al., 2019). In Brazil, interest and small pilot projects/adaptations of the ACO concept have emerged (mainly in the private/health plan sector), but large-scale implementation is still limited and faces structural, regulatory, and information system challenges.

Considering the context exposed above, the overall objective of this paper is to describe a case study on the integration of healthcare through an Accountable Care Organization (ACO), developed in the state of Goiás, in the Central-West region of Brazil. The specific objectives are as follows: describe the healthcare management context in which the ACO has developed; explain the partnership design; present the integration of health protocols; narrate the pillars for the Quadruple Aim of the Institute for Healthcare Improvement; and report the remuneration model.

The Challenge

Healthcare institutions are in search of improving results by focusing on centered care and patient needs and, at the same time, they need to reduce costs (WIERSEMA et al., 2023) to continue serving private healthcare providers, which are reporting losses and/or unprecedented increases in claims, with the growing aging population and an unfavorable epidemiology. Given this context, it is essential to find new forms of care and prioritize the optimization of care in the right place, at the right time, at the right cost, with the improvement of the patient experience and the population health, without forgetting the satisfaction of the healthcare provider. Healthcare institutions in Goiás suffer from the same reality, with a market concentration higher than the national average, which highlights the urgency of finding a solution, a challenge faced by ACO.

ACO Unihosp Medhealth addressed problems related to the coordination (BAO; BARDHAN, 2024) of healthcare, fragmentation of the healthcare network, and lack of communication between providers. In other words, currently the care pathway is fragmented, for example, a patient who, due to a symptom of chest pain, goes to an emergency room, where they are seen by the on-call doctor, undergo tests for a diagnosis and receive a treatment recommendation. After this initial visit to the emergency room, the patient spontaneously seeks out a cardiologist, who does not have access to the tests and diagnosis that were previously made during the initial visit, a process that is repeated with every access to a healthcare institution or professional. Coordination between levels of care can be defined as the articulation between the various health services and actions related to a given intervention so that, regardless of where they are provided, they are synchronized and aimed at achieving a common objective.

Therefore, in order to effectively guarantee health care, it is essential to establish integrated networks, the construction of which necessarily recognizes the interdependence and, often, conflicts between actors in the system, that is, patients, health plans, health providers, suppliers and government, in situations of shared power. There is a management challenge since none of these entities has all the resources, which is the situation in this ACO, nor the health institutions involved are part of the same economic group (McWILLIAM et al., 2015) or under a single management. By analogy, we can consider the arrangement of the Massachusetts Medicare ACOs, MassHealth, although there is no similar arrangement in Brazil. The Unihosp ACO model overcame management barriers from the moment it integrated the network and care management among the patient, health plan, service providers, and suppliers.

Method

To achieve the objectives of this study, a case study method was used, which, according to Yin (2015), is a relevant method when there is a need to describe a social phenomenon in depth. This author also argues that it is a suitable method in situations where it is necessary to explain how or why a social phenomenon works. The social problem addressed here is a partnership between ten healthcare institutions in the state of Goiás (Brazil), including seven hospitals and three imaging clinics, which was formed with the objective of developing a new model of healthcare delivery, an Accountable Care Organization (ACO).

To operationalize the case study, conducted between September and November 2024, evidence was collected through interviews with experts and access to partnership documents. Eight people were interviewed, holding the following positions in the participating institutions: Chief Medical Officer, Chief Executive Officer, Chief Operations Officer, Medical Coordinator of the Primary Care Clinic, Family Nurse, Patient Care Coordinator, Technology Coordinator and Marketing Coordinator. In addition to the eight interviews mentioned, the following documents were accessed: Service and Assistance Indicators Report, Financial Report, Service and Assistance Protocols, Strategic Planning, Navigation Map, Referral and Counter-Referral Reports, Risk Stratification System, NPS Assessment Report and Marketing and Communication Manual. The case study protocol included the

following topics to be addressed throughout the research, in relation to the study of the partnership: (1) the challenge: describing the healthcare management context that stimulated the proposal envisioned in the ACO; (2) the partnership design: who the participants would be and what functions were planned for each; (3) integration of health protocols: throughout the patient's care journey with the reference health services in the metropolitan region of Goiânia, capital of the state of Goiás; (4) addressing the four pillars of the Quadruple Aim of the Institute for Healthcare Improvement (IHI), which are: 4.1 - Improving the patient experience; 4.2 - Improving population health; 4.3 - Reducing the per capita cost of healthcare; and 4.4 - Improving the experience of healthcare professionals; and (5) change in the remuneration model: from "fee-for-service" to capitation via revenue sharing.

The Execution

The previous 12 months of meetings with the ACO network were held to develop the new healthcare and remuneration model. The model review meetings were time-consuming and required significant collaboration from the ACO network executives. It turned out to be an incredible opportunity for key team members to come together and discuss specificities, incentives that were not aligned with the current reality of the private healthcare system, transparency, and improvements to the new model. This was a gradual process that required 12 months of a multidisciplinary healthcare and non-healthcare team to be ready for the start of operations, which occurred in June 2023. During this initial period, the main barrier was cultural, since service providers were accustomed to the volume-based model, better known as fee-for-service, meaning the more they produced, the more they would receive. The change in the remuneration model was essential to overcome this barrier. Therefore, we changed the care and remuneration models together; otherwise, it wouldn't have worked.

The implementation of the ACO represented a disruptive change in the way health plan patients, health providers, private health plans companies and health service providers interact (CHERNEW et al., 2023). The model has been in operation for 24 months and was already managing 310 patients, with an average age of 33 years old, 82% female and 18% male. This figure was obtained through the sale of medical assistance products to companies, with their agreement and acceptance of the proposed healthcare model with integrated care at all levels and coordinated access through primary care.

The ACO - Accountable Care Organization developed by Unihosp in conjunction with Medhealth is a group of previously selected hospitals, clinics and doctors who presented satisfactory indicators of outcome, quality, safety and cost. For example, hospital infection rate, prevention of adverse events, patient satisfaction, mortality, morbidity, emergency room return rate, readmission rate, effectiveness, engagement, waiting time, among others. These players were willing to work together, even though they were from different health institutions, with the objective of providing better care to patients, improving the health of this assisted population and reducing costs (Porter, 2010) through an integrated care model and remuneration with revenue sharing, which was called expanded capitation (Porter; Kaplan, 2014).

The ACO is responsible for coordinating care through the Primary Care Clinic, which plays a central role in coordinating care across the entire specialized care network, following protocols based on scientific evidence in patient management and prevention (Barnes et al., 2014) for 100% of users, with an active recruitment strategy for all patients. For example, the Basic Healthcare Protocols for Women's Health, developed and adopted by the Ministry of Health.

Connected by the Primary Care Clinic through processes and protocols with the tier 2 and tier 3 levels, with referral and counter-referral methods, a ACO Network was created consisting of seven hospitals, totaling 430 beds: Hospital Santa Bárbara, Hospital do Coração de Goiás, Hospital de Acidentados, Hospital da Criança, Hospital de Neurologia Santa Mônica, Hospital Ver, Maternidade Ela - and three image diagnostic clinics: CRD Imaging Diagnosis Clinic, CDI Premium Imaging Diagnosis Clinic, and São Marcelo Imaging Diagnosis Clinic, all located in the metropolitan region of Goiania. Patient referrals are limited to this select group of healthcare providers that are connected to the Primary Care Clinic, which implements care plans to provide necessary care to patients in conjunction with the family physician. In 16 months, the health services maintained the following figures: operator's claims ratio at 69%, NPS at 98, medical remuneration average at 28.84%, above the Fee for Service Table used as reference by plan operators in the State, concluding that there was improvement in all four pillars of the Institute for Healthcare Improvement's (IHI) Quadruple Aim, since: 1- There was an improvement in the patient care experience, which was reflected in an NPS of 98; 2 – There was an improvement in the health of the population; 3 – There was an improvement in reducing the per capita cost of healthcare while maintaining

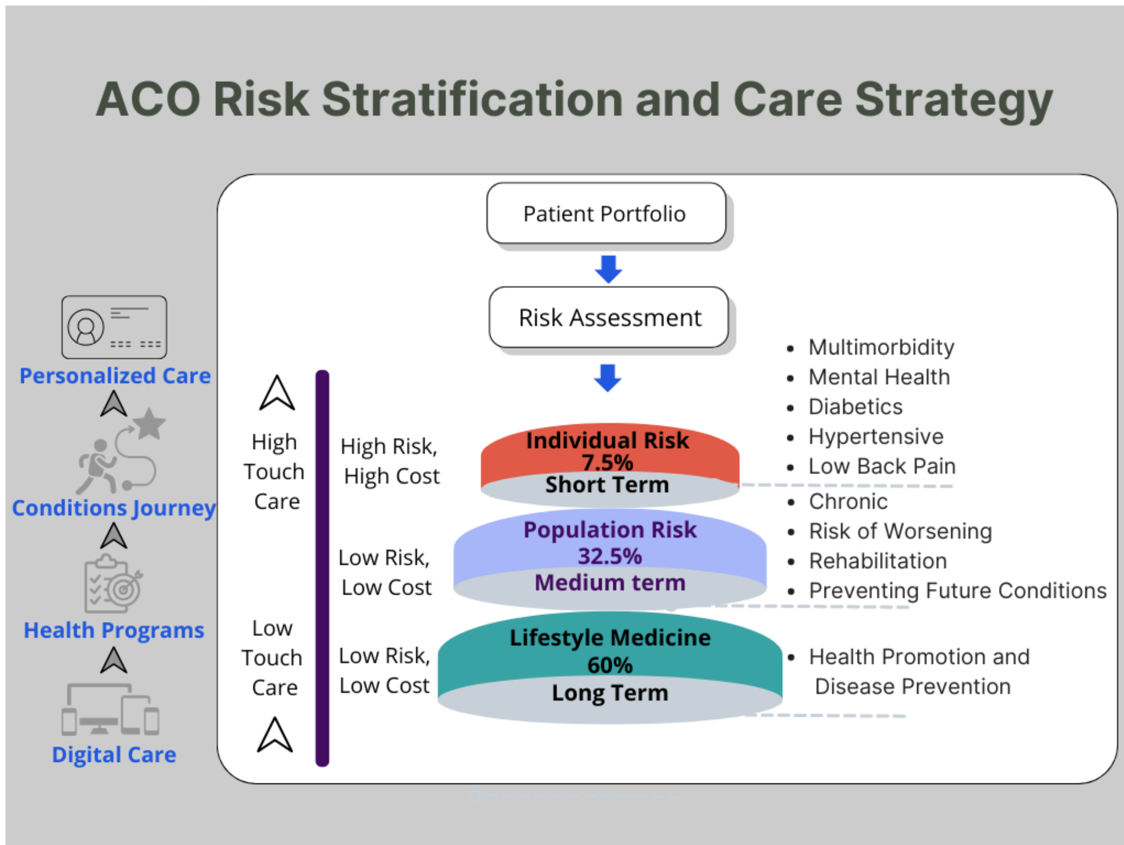
the claims ratio at 69%; and 4 – There was an improvement in the experience of healthcare professionals with compensation 28.84% above the market.

With the ACO network chosen, the Primary Care Clinic and the healthcare management team available and integrated, all incoming patients were approached by telephone to engage in the 360º health management model, with the objective of improving the well-being of patients, through a set of integrated health actions that aimed to increase the individual's quality of life, according to their lifestyle, work or study, in addition to the specific health needs of each one.

The telephone approach is carried out by the family nurse who will be responsible for the entire care and treatment journey of each patient, creating a personal connection from the beginning, since the same family nurse who made the initial telephone contact is the same one who will attend to them at the Primary Care Clinic on all occasions. From the first telephone contact, health information, demographic and social data are collected, which will be used for initial guidance and for scheduling the appointment with the multidisciplinary team coordinated by the family doctor. The first telephone contact is proactive and aims to reach out to the patient and raise their awareness regarding their health care. This approach changes the concept that the population seeks health care only when they are already sick, to a health care system that actively seeks out the beneficiary to prevent diseases. In this way, the satisfaction and engagement with this approach is 80%, based on Unihosp's experience.

During the telephone contact, 100% of the entrants were introduced to the multidisciplinary team coordinated by the family doctor, and questions related to their health were asked with the aim of mapping, classifying and stratifying (GULUR et al., 2024) in order to define the lines and strategies of care and monitoring (Figure 1). This is done through electronic health record software, which collects patient clinical data and organizes it according to defined and validated criteria to classify them into risk categories, such as low, medium, high, and very high. In this way, multidisciplinary healthcare teams, coordinated by family medicine, can prioritize care, plan targeted interventions, and monitor the progression of each patient's risk.

Figure 1 – Prescription of Care and Risk Stratification in ACO



Source: Authors (2025)

Using the detailed stratification tool shown in Figure 1 above, each patient is interviewed by the family nurse, and through software that cross-references and integrates data into a single medical record, with advanced information technology to establish preventive measures for identifying ailments such as heart disease, diabetes, breast and prostate cancer. After detecting potential risk signs in the interviewed members, the ACO examines their results and advises each patient on follow-up procedures to better prevent the development of these diseases.

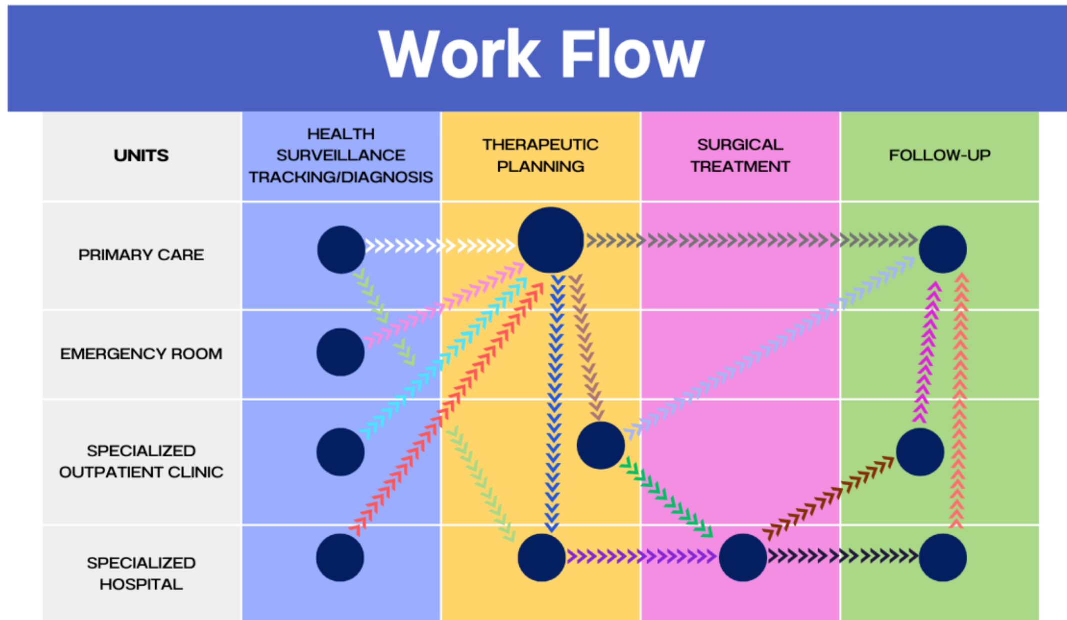
The stratification, for example, actively identified hypertensive members who were carefully monitored and now have a reduced risk of developing heart disease. At the same time, overweight members were encouraged to exercise. In addition, diabetic members were diagnosed through the initial approach. From this structured data, the ACO was able to engage members in smoking cessation and weight loss programs, for example, by creating and encouraging new clinical and behavioral approaches to complex risk behaviors. The multidisciplinary team is instructed to invite their patients to participate in group activities which, in some cases, have achieved very high levels of success.

This involves effective coordination of care, via the Primary Care Clinic to other levels of the health system, focusing on measures linked to integration, with the effective guarantee of comprehensive health care. The main strategies identified were: creation and strengthening of the primary care clinic structure with the role of coordinator and access navigator with a multidisciplinary family health team, organization of flows, electronic medical records and the provision of regional specialized services in the ACO network (Figure 2).

For example, we describe the journey of a member who was contacted by phone for the first time, having been stratified and identified as a patient at high risk of hypertension. Considering their family history, weight, and lifestyle, this member was given priority for a consultation with their family doctor, who requested complementary laboratory and cardiological tests and concluded that a referral to a cardiologist within the ACO network was necessary for a more in-depth evaluation of an identified arrhythmia. The patient was seen by the cardiologist, who performed further tests and ruled out any pathology, discharging the patient from cardiology care and referring them back to the family doctor, with all tests performed included in the discharge report.

Following the management of their health, the patient was referred to a nutritionist, a psychologist, and other healthcare professionals, generating a sequence and management of care through the coordinated and guided navigation of each member within the ACO network. Regarding the implementation of the care and management flow, the entire multidisciplinary team of the Primary Care Clinic and the specialist physicians in secondary care were introduced to the solution and trained to navigate with patients following defined processes. These steps resulted in a positive outcome for the patient, as they truly benefited from integrated care, with acceptance from all participants in the process. It is worth noting that, although the stakeholders initially showed resistance, when presented with the final result, they were convinced of the validity of the new model.

Figure 2 – Work Flow Steps

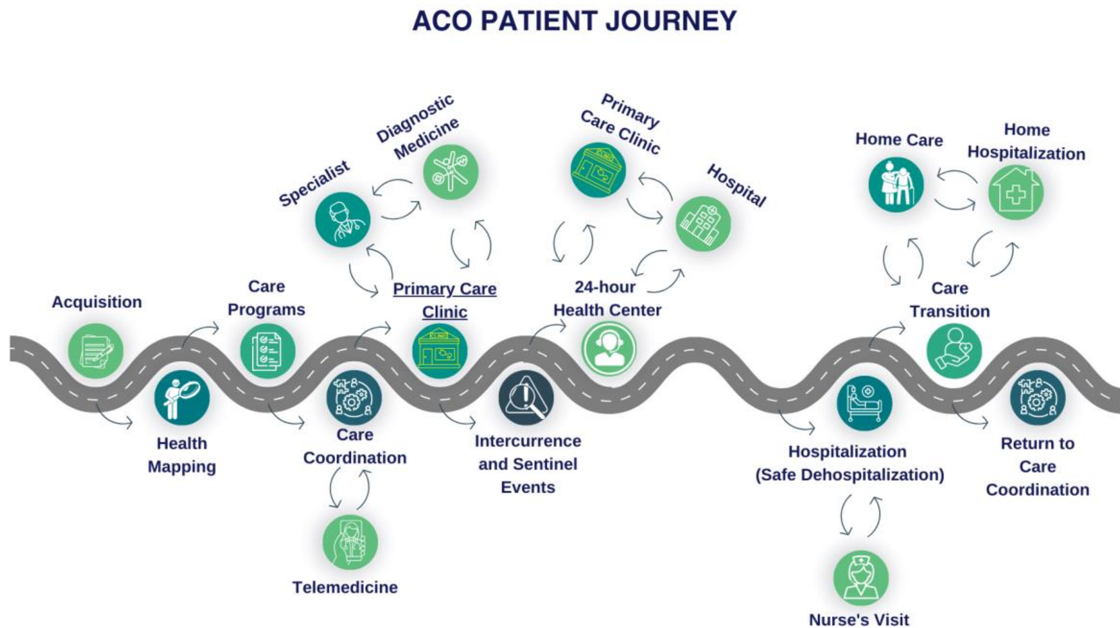


Source: Authors (2025)

The care workflow is a navigation map for the patient between levels of healthcare and their respective units. For example, following the navigation map of a patient who began their journey in the Emergency Room with a specific complaint and had their treatment completed in that unit. Subsequently, they proceed to an active approach by the multidisciplinary team of the Primary Care Clinic for a post-emergency room follow-up consultation, with a report and examinations that were performed in that care unit. From the family doctor's consultation, the patient can navigate to secondary care with a specialist physician for further evaluation. This consultation may generate a referral for a surgical procedure and their subsequent return to Primary Care; that is, the patient's navigation map clearly demonstrates the leading role of Primary Care in the management and coordination of access to and care of health services.

In addition to regulating access, the Primary Care Clinic monitors the progress of treatment at the secondary and tertiary levels and approaches patients for follow-up after specialized care, allowing the family health team to monitor the user's journey. This monitoring occurs through alerts generated by the electronic medical record and the ACO network's service system, which mandatorily signals that the member/patient is being treated at a specific unit, allowing the access coordination team to approach the patient proactively or sequentially, sharing health records. (Figure 3).

Figure 3 – ACO Patient Journey



Source: Authors (2025)

The ACO Patient Journey Map is the path that members follow according to their health condition and stratification, but it also demonstrates that even without a health demand, or rather, a disease, all new members go through health mapping. In this mapping, members are stratified by risk levels, and may progress to a care program. This program can progress to care coordination, which guides the patient through secondary and tertiary care, in person or via telemedicine, but always returning to care coordination.

The coordination led to the implementation of revenue sharing, which was essential for the complete implementation of the healthcare model with a new remuneration model, which encouraged the transformation, that is, remuneration based on management of patient health and experience and not on usage volume. This provided financial recognition (Aljelban et al., 2024) to healthcare institutions, which became participants in the medical cost management process and assumed responsibility for supervising and managing treatment costs in their healthcare institutions. The ACO network was also responsible for meeting quality, outcome and efficiency standards, which further protect patients (Hsu et al., 2024).

As previously mentioned, the ingrained fee-for-service culture within healthcare institutions was a barrier that required education on the new care and payment model, which

was complex due to the innovative nature of the proposal, considered disruptive. There was a financial incentive from the moment each healthcare institution would receive monthly payments based on the ACO's revenue and not on the member's utilization of the system. In addition, other strategic incentives were offered to the network that guaranteed the mitigation of any risk, as well as the maintenance of a minimum profit margin based on referenced local market rates.

Through actuarial and epidemiological calculations, supported by a software, each patient's revenue was distributed, considering variables to the provider's vocation and specialty in the ACO network, where on average partners received 28.84% remuneration above the Fee For Service reference used in the healthcare market (Table 1). Due to intellectual property concerns, it was not possible to detail and describe the internal variables and methodology used by ACO.

Table 1 – Receipt Margin Above Market Table

Provider	Receipt Margin Above Market Table
Clinic A	27,69%
Clinic B	11,89%
Clinic C	14,52%
Clinic D	8,20%
Clinic E	15,17%
Hospital A	12,14%
Hospital B	127,13%
Hospital C	111,03%
Hospital D	13,32%
Hospital E	86,53%
Hospital F	26,56%
Hospital H	12,00%

Source: Authors (2025)

Table 1 is a snapshot of a specific moment in time, showing variations in results, as well as variations by the specialty of each institution in the ACO network. This reflects variables such as risk, reserves, characteristics of current members, and may accumulate higher or lower results than others, depending on the moment evaluated. For example, consider the following services: an imaging diagnostic clinic that performs highly complex exams and a clinical analysis laboratory; or a hospital specializing in neurology and neurosurgery and another hospital specializing in ophthalmology. From the point of view of the characteristics of the members served, we may momentarily have a demographic of

female members of childbearing age, which will generate a greater demand for deliveries, increasing its cost in relation to revenue, which may be restored in the following month, as there may be no deliveries in the next month. Similarly, due to the intellectual property of the ACO, it was not possible to detail and disclose strategic business information in this Case Study.

Results and Discussion

Not all patients were willing or able to change providers, since the current culture of free choice of doctors and services from a list requires efforts to change the culture of these patients. However, the model is mandatory, causing members/patients who are unwilling to maintain the new healthcare model, which results in monthly savings in medical expenses, to request exclusion from the ACO. These efforts include marketing (Quinan; Costa Filho, 2021), through awareness campaigns, visits with lectures by family doctors at the patients' companies, with the participation of 80% of the companies' employees presentation of the model and its resolution indicators to society, spread through the press office campaigns to encourage exemption from copayment by the patient when using the primary care clinic and everything that is forwarded through it. Additionally, the offer of a concierge is a facilitator and navigator in the ACO network, such as scheduling and releasing priority lines of care in the network. These concierges have been trained for this role, offering members privileges and benefits within the ACO network, including exclusive scheduling, exclusive waiting areas, home collection of laboratory tests, among others.

Another obstacle was the market's acceptance of the new private health plan model by the members/patients who, despite seeking to save money on their health insurance costs, found it difficult to overcome the cultural barrier of the patient. This difficulty persists to this day, since the reference is the free choice of doctors and health services for patients to access. The market understands that the new model being offered takes away the freedom of choice of patients, who seek services according to their needs. However, this rationale might lead to a long patient journey, since a headache symptom, for instance, does not necessarily mean the need to go to the Neurologist and have a MRI (magnetic resonance imaging), since this symptom can be an ocular, digestive, emotional, hormonal, orthopedic, or a nutritional. And all this complexity can lead to higher costs for the healthcare system, while the changes

promoted by the ACO's care and payment model have resulted in a reduction in waste, as shown in Table 2.

The lack of trust between all parties is an obstacle and a hindrance from the point of view of service providers (LI et al., 2021). The change in the care model through the adoption of integrated and targeted evidence-based protocols is still a barrier to overcome but which has been showing a weakening of resistance over time, with the delivery of the outcome, with the pillars of the IHI's quadruple AIM framework, and with the disclosure of results and indicators. The current system operates through an archaic remuneration model focused on transaction volume known as “fee for service”, which interferes with the new proposed care model provided, resulting in inadequate care journey and problems of service continuity, compromising the outcomes and raising the costs (MECHANIC et al., 2024). This was demonstrated in Table 2.

In the case study of ACO UNIHOSP, the evolution from distrust to trust occurred due to a negative perspective on the future and the economic and financial sustainability of the institutions in the face of the results of the private healthcare market. This was combined with the offer of financial recognition to participating institutions through revenue sharing and the joint development of protocols and indicators, without losing focus on patient-centered care and the delivery of appropriate care, at the right time, place, and cost. This service was delivered with a high NPS (Net Promoter Score), demonstrating that the proposed model is viable, thus gaining the trust of the network and generating interest from new entrants.

To date, the results achieved have been the increase in the healthcare provider satisfaction with simultaneous reduction of operational costs. In the first sixteen months of operation, it was possible:

- to maintain an average medical cost of 69%;

- to obtain a Net Promoter Score of 98, and;

- and to get an average remuneration to providers of 28,91% above the market, based on the “fee for service” payment model.

The comparative metrics used proved to be relevant. According to the ANS (2023a) Situation Room, the last average loss ratio of Health Plans in Brazil was 84.3%, and of the largest Health Plan in Goiás it was 93.9%, while the loss ratio of the ACO was 69%. When analyzing the healthcare utilization indicators according to the ANS (2023b), it was

demonstrated below some comparative indicators of the ACO with the private health market in Brazil (Table 2).

Table 2 – Comparison of ANS and ACO Indicators

	ANS	ACO
Consultation Patient/Year	5,5	3,7
ER Consultation Patient/Year	1,3	0,1
Exams Patient/Year	23,4	8,39
X-ray Paciente/Year	0,6	0,1
Non-surgical hospital admission Patient/Year	0,072	0,008

Source: Authors (2025)

The table of indicators from ANS and ACO reflects the results of the managed and coordinated model, which advocates prevention and the adoption of evidence-based care protocols and the integration of care levels with the primary care system playing a leading role, as used by ACO. The differences between the market indicators and those of ACO are striking due to their discrepancy, but this is a true reflection of the waste that the private healthcare system currently experiences. It is important to note that there is no practice of under-treatment, that is, the healthcare institution, to the detriment of the outcome, does not fail to indicate care, treatment, examinations, or surgery, since the integrated indicators are managed by the National Agency for Supplementary Health – ANS. From the specific point of view of the hospital admission indicator, it also reflects the epidemiological characteristics of the ACO members/patients, since they did not require highly complex procedures related to hospitalizations.

Regarding the Patient Experience of Care, the ACO achieved an NPS of 98, while the last available information for the other health plans was a maximum of 70 (SENA, 2022). In addition to the comparative metrics, medical remuneration average at 28.84%, above the Fee for Service Table used as reference by plan operators in the State.

Concluding Remarks

Considering the results presented, although positive, they are preliminary, given the relatively short operating time of the ACO. Some important conclusions are suggested below:

a) The creation of an integrated (CHIMA et al., 2024) network for the ACO improved relations between the healthcare provider (KAUFMAN et al., 2019) and the private health plan operator (Medhealth), with shared management and better remuneration compared to other payers, on average 28.84% above the Fee For Service table of the two largest private health plan in the State of Goiás, and improved the care journey of patients;

b) Adherence to the ACO network encouraged the improvement of protocols based on clinical evidence, quality standards and participation in improvement processes in exchange for references and referrals; even with these improvements, the challenge of ensuring continued adherence of professionals to the protocols remains, as mentioned earlier;

c) The biggest challenge is still changing the culture of patients on how to navigate and access the health system; overcoming this challenge involves acculturation through information, the improvement of ACO tools to get closer to the member/patient and their family every day, with the power of persuasion through the appropriate journey, as well as the sharing of experiences from other users of the model currently implemented by the ACO;

d) From the perspective of the ACO network, the change in the care and remuneration model (QUINAN; BALESTRIN, 2023) is disruptive since it generates the prospect of sustainability for the entire healthcare system, restoring patient confidence and satisfaction, and dismantling distrust, as there cannot be a healthy and thriving market without the development of new disruptive solutions. Resources for healthcare are scarce, and there are no prospects for increased costs, as the paying sources are mostly exhausted; therefore, change is necessary.

Limitations

Despite the still small number of patients in the ACO, where any bias or characteristic tends to influence the results more intensively, evaluating the data from the year 2023, where it is possible to identify specific trends or patterns, albeit preliminary, however, for broader conclusions, a larger sample would be recommended. Given that this is a pioneering case study, it is expected that in the future other cases will be analyzed and the results compared in order to evaluate the potential of the new healthcare model described here.

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