AMA
AMERICAN MEDICAL ASSOCIATION

Accountable care organizations
Model checklist

Physicians should be cognizant of key questions to ask and have answered when negotiating an agreement to participate in an accountable care organization (ACO), as many such entities have matured and developed sophisticated arrangements over time. This checklist identifies top issues to consider early in the due diligence and negotiation process and can serve as a guide to the terms of the agreement. The American Medical Association has also developed the "Accountable care organizations: Snapshot" that covers topline issues to consider when partnering with an ACO, as well as the in-depth "Accountable care organizations: How to perform due diligence and evaluate contractual agreements" to use when vetting contract language and structure.

Due diligence in evaluating ACO opportunities

☐ **Evaluating the health of the ACO**
When evaluating ACO opportunities, physicians should carefully review available information related to the financial health of the ACO, including past savings and losses results. In the case of Medicare Shared Savings Program (MSSP) ACOs, information about shared savings and losses is available through the Centers for Medicare & Medicaid Services (CMS) "public use file." Physicians can look for such information for non-Medicare ACOs on publicly available websites or upon request of the ACO. Physicians should also seek to understand how the ACO is financed and the costs associated with participation, how the entity gauges quality performance and metrics, the composition of the ACO and its relationship(s) with payers when performing due diligence.

☐ **Physician satisfaction and governance**
Every ACO must have a chief medical officer. However, opportunities for other participating physicians to be involved in the governance of an ACO can vary significantly. Some ACOs may require a majority of the board to be licensed physicians, while others may have more limited opportunities for physician involvement in governance. Often, physicians have opportunities to serve on committees. Physicians should consider their individual preferences related to ACO governance and whether an ACO governance model fits those preferences. For example, some physicians may prefer that there be more physician representation on the board, while others may be satisfied with having a medical director advise the board on clinical matters.

☐ **Contracting authority with payers**
Physicians should understand the manager's role related to contracting with payers. Some ACO agreements may give the ACO authority to contract with payers on behalf of participants, while others may allow participants to retain this responsibility. ACOs may also reserve the right to negotiate payer contracts later. In any case, physicians need to know what authority the ACO has related to payer contracts and any exit rights that participants may have if they do not wish to grant the ACO such authority.

Transitioning to risk

☐ **ACO's strategy to move to downside risk**
Physicians should understand whether and how an ACO plans to move or has already moved to accepting downside risk and the protections it has in place against excessive payments due to shared losses. Physicians should be aware of potential obligations the ACO may impose on Participants (for MSSP ACOs, defined as an entity identified by a Medicare-enrolled tax identification number through which one or more ACO providers/suppliers bill Medicare; for non-Medicare ACOs, defined by the ACO) when taking on risk, such as requiring physicians to contribute to repayment mechanisms and/or deducting fees and expenses from shared savings earned by the ACO. Although important to all participating physicians, this may be particularly relevant for non-owner physician employees of a practice and for physicians who are still repaying educational loans.

☐ **Responsible parties for shared losses**
Two-sided MSSP ACOs are responsible for paying penalties if they experience losses, but also have the opportunity to qualify for bonus payments if there are savings. ACOs will handle this potential liability for shared losses differently. Some may delegate responsibility for such losses to all participants, while others may delegate this responsibility to major participants or a portion of the losses to the ACO legal entity itself. Physicians should be mindful of the implications of such decisions as they may be liable for losses depending on the circumstance.

☐ **Establishment of a repayment mechanism**
An MSSP ACO must establish a repayment mechanism to assure CMS that it is able to repay losses incurred by the ACO. Non-Medicare ACOs may establish their own rules in this area. Similar to contractual considerations related to shared losses, physicians should pay careful attention to contractual language related to repayment mechanisms and the entit(ies) responsible for initially funding the mechanism and replenishing the mechanism (see "Accountable care organizations: How to perform due diligence and evaluate contractual arrangements," section 2.b). ACOs may require participants and their employed physicians to contribute funds to the mechanism.

☐ **Expenses deducted from shared savings**
If the ACO delegates its management or certain key services to an outside manager or vendor, physicians should be mindful of the fee structure for these services. The manager may charge a flat fee for its services or a percentage that is based on the gross revenue of all participants. An ACO may also deduct a portion of the participants' revenue and/or shared savings prior to distribution to fund management fees. In all cases, physicians should understand their financial responsibility related to management fees when evaluating the costs and benefits of participation.

Emerging organizational and participation models

☐ **Emerging models**
Physicians should evaluate a variety of established and emerging ACO models available in their community (such as "supergroup" models and models focused on a tightly defined patient population) and understand how participation in these models may affect their individual practice. In the supergroup model, specialty practices collaborate to manage a defined set of services. Physicians should also consider the value of aligning with a "brand" when determining whether to participate in ACOs established by "brand name" organizations. While such brands may have value in the health care marketplace, they may restrict practice independence as a condition of participation.

☐ **Referrals**
An ACO may establish requirements for physician referral of patients to specific providers. Federal law generally does not allow an ACO or a participant to require patients only to receive care from providers within the ACO's network, but often, ACO Participant agreements contain provisions requiring physicians to refer within the ACO preferentially. Provider referral requirements should be compliant with the Stark Law, however, non-Medicare ACOs may have greater flexibility. Physicians should, however, ensure that there is contractual language in an agreement with an ACO allowing a physician to refer to other, out-of-network providers based on independent medical judgment, patient preference and/or insurance requirements (see "Accountable care organizations: How to perform due diligence and evaluate contractual arrangements," section 3.b).

☐ **Clinical judgment**
While many ACOs establish standardized protocols or practice guidelines for participants, it is important that decisions related to the individual practice of medicine and clinical judgment remain with the physician rendering services. Physicians may wish to include contractual provisions in an agreement with an ACO to ensure that certain functions related to their individual practice remain under physician control, including selection of staff, supervision, and operation of facilities (see "Accountable care organizations: How to perform due diligence and evaluate contractual arrangements," section 3.c). Such provisions ensure that physicians retain their independence in their direct practice of medicine and the preferred level of control over day-to-day operations of their medical practices.

☐ **Evaluation of brand and management entities**
Physicians should know the identity and business practices of the entity responsible for managing the ACO and the implications of its management approach on physician practice. Some ACOs are entirely managed by physicians, while others engage an outside manager or a major participant (designated by an ACO as such based on a variety of factors which may include clinical expertise, patient volume, key personnel, number of attributed beneficiaries or revenue). In such cases, physicians must relinquish a degree of independence related to administrative and operational management of clinical integration activities related to their practice. Non-physician management may be useful, because such entities can have more expertise in managing a patient population. However, physicians should ensure specific activities—such as implementation of evidence-based medicine and quality improvement—remain within their purview.

Data access

☐ **Data collection and reporting**
Physicians must know and understand the data that an ACO provides to its participants. These data should enable physicians to provide better care and care coordination and may, in turn, lead to greater shared savings. Physicians should ask questions and have a working knowledge of the frequency, contents and quality of such data, and ensure that the ACO processes the data in ways that make it useful for improving care. Physicians should also inquire as to whether ACOs will report on their behalf to meet federal or commercial payer reporting requirements.

☐ **Data sharing and analytics**
Physicians should have a clear understanding of the data available to ACO participants, as these data can be used to improve the care that they provide to patients. Physicians should be careful when negotiating with ACOs to ensure they gain the maximum value from data sharing and ensure that the ACO efficiently shares data with participants by utilizing an appropriate platform for data aggregation and analytics.

Financial incentives and intangibles

☐ **Shared savings distribution**
Physicians should carefully review an ACO's methodology for distributing shared savings. Distribution may depend on a host of factors in addition to the number of attributed beneficiaries, including quality, committee participation (such as those related to quality, finances, network development and technology) and resource use. Additionally, physicians should be aware of any potential deductions to shared savings that an ACO might make, including those related to management fees and other costs associated with services for which participants may be responsible.

☐ **Other benefits and associated costs**
Physicians should understand the potential financial incentives/penalties and intangible benefits/risks that may result from ACO participation. Physicians should not only understand how an ACO plans to distribute shared savings, but also how the ACO provides financial or in-kind benefits to participants, such as care coordination staff, administrative assistance, and other resources and infrastructure to a physician's practice. Physicians should understand all obligations or costs tied to such benefits when evaluating opportunities to join an ACO.

☐ **Care coordination costs**
While ACOs may present opportunities related to access to care coordination infrastructure, physicians seeking to participate in an ACO should be aware of the support and cost associated with care coordination and the parties responsible for bearing those costs. Participants may be required to provide capital to contribute to the cost of operating the ACO or may have such costs deducted from distributions of shared savings. Such costs may be evenly distributed amongst all participants or concentrated with major participants with access to a greater amount of capital. Physicians should understand that while ACOs may lead to financial rewards related to successes because of care coordination, the amount of such rewards will be offset by the initial operating expenses.

☐ **Changes to electronic health records and cost of clinical documentation software**
Participation in an ACO can also require physicians to make changes in their electronic health record platforms and other data sharing mechanisms, such as participation in clinical registries or health information exchanges. These changes may present significant opportunities related to population health management. Physicians should understand the costs and administrative burden related to making such changes when evaluating opportunities for ACO participation.

Other considerations

☐ **Federal and/or vendor obligations**
Physicians should also understand what activities the ACO performs on their behalf in contracts with the federal government or vendors. Federal law requires MSSP ACOs to provide participants with a copy of its participation agreement with CMS. Having access to these agreements is important for physicians to understand the legal obligations of the ACO and the downstream impact of those obligations on participants. Physicians should ask to review the ACO's payer and important vendor agreements in their negotiations with an ACO to best understand the delegated responsibility provided to the ACO, including the ACO's duties regarding data reporting, payer negotiation, compliance and distribution of shared savings.

☐ **Exclusivity**
ACOs are often confronted with the challenge of managing the costs and outcomes of care delivered to patients who receive services from providers outside of the ACO. Such cases can undermine the Participant's management of patient care and may lead to unnecessary clinical interventions. ACOs often require physician practices to agree to become exclusive to a single ACO. Physicians should understand the implications of this exclusivity and when such requirements should be subject to negotiation.