



Accountable Care Organizations:
How to Perform Due Diligence and
Evaluate Contractual Agreements



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Introduction

Over the past decade, Accountable Care Organizations (“ACOs”) have matured significantly. They are now often sophisticated networks that can involve multiple legal entities, relationships with a variety of governmental and non-governmental payers, unique skills in managing primary care or clinical specialties, and/or a more defined focus on specific patient populations and markets. Physicians face unique challenges in evaluating opportunities to participate in sophisticated ACOs or similar arrangements in their market.

For purposes of Medicare ACOs, an ACO “Participant” is an entity identified by a Medicare-enrolled billing tax identification number through which one or more ACO providers/suppliers bill Medicare. Non-Medicare ACOs may define an ACO “Participant” in other ways, including an individual physician or a physician practice. ACOs may also determine that certain Participants (however defined) may carry more important strategic considerations than others for reasons such as the Participant’s clinical expertise, patient volume, key personnel, number of attributed beneficiaries, or revenue. For purposes of clarity, this document refers to these strategically important individuals or entities as “major Participants.”

At certain times, this document also refers to distinctions between “physician-led” and “hospital-led” ACOs. A “physician-led” ACO is an ACO that is exclusively or primarily composed of physician Participants, while a “hospital-led” ACO often includes one or more hospital Participants in significant roles. Note that this terminology is similar to, but slightly different from, the concept of “low-revenue” and “high-revenue” ACOs under the “Pathways to Success” Medicare ACO rule published by the Centers for Medicare and Medicaid Services (“CMS”). Under this rule, CMS categorized ACOs into “high-revenue” and “low-revenue” ACOs, with low-revenue ACOs afforded more favorable treatment, including the option to wait longer to transition to downside risk. CMS observed that low-revenue ACOs are more likely to be physician-led, which has created some confusion around the application of these rules. In fact, a physician-led ACO may be either low-revenue or high-revenue, depending on the amount of Medicare reimbursement its Participants receive. For example,

an ACO composed of several multi-specialty physician practices that own surgical centers, infusion suites, and other ancillary services might qualify as a “high-revenue ACO.” As a result, references to physician-led ACOs elsewhere in this document should not be treated synonymously with “low-revenue” status.

This document is intended to supplement the AMA’s extensive background materials on value-based payment opportunities such as ACOs by providing specific guidance to strategically evaluate opportunities and negotiate important contract terms. The AMA has also produced a [Model Checklist](#) and [Snapshot](#) addressing topline issues to consider when partnering with an ACO.

Evaluating ACO Opportunities

Physicians can evaluate the ACO opportunities open to them by asking questions, consulting legal counsel, and querying public information in a due diligence process. Physicians should understand that ACOs need physicians to succeed and ensure that any arrangement strikes an appropriate balance between ACO benefits (like opportunities for shared savings and reporting capabilities) clinical autonomy, and care quality.

1. Evaluating the Health of the ACO:

When an arrangement unwinds, physicians are faced with the task of obtaining payment for their services independent of their former employer/counterparty.

a. Transparency on Past Savings or Losses

Shared savings and losses are the core economic relationship available to ACOs. Physicians should carefully evaluate the transparency of past savings and losses when considering entering any ACO arrangement. Information about MSSP ACO shared savings and losses is available through the CMS “public use file” (“PUF”) data (see example of the PUF for 2017, [here](#)). Private ACOs may use their own savings and losses methodology; physicians should understand how savings/losses will be calculated and the ACO’s record of performance under these rules. Physicians can also access this information on an ACO’s public website.

b. Finances of the ACO and Participants

Physicians should do their best to understand ACO system finances, who contributes operating funds, and whether the physician will ever be required to contribute operating funds. Physicians may request information about the financial performance of the ACO (including financial or income statements) as well as information about the major Participants. Physicians can also consult public information sources such as Securities and Exchange Commission filings for publicly-traded entities (see [EDGAR](#)) or information about non-profit financials maintained by the Internal Revenue Service.

c. Quality Performance and Metrics

Physicians should understand the ACO's quality metrics, how quality performance affects shared savings and losses calculation, and how the ACO has performed under quality measures in the past. The MSSP ACO quality measures are available [here](#), information for each MSSP ACO's performance is available through the [PUF](#), and the national averages are available [here](#). ACO public websites also contain information related to quality metrics. Physicians should note that private ACOs may apply their own quality measures. Physicians should understand these measures and verify they are endorsed by qualified organizations like specialty societies, [CMS](#), or the National Quality Forum [here](#).

d. Composition and Stability of Participants

Physicians should seek to learn about the other Participants in the ACO. The most recent list of each MSSP ACO's Participants is available [here](#). Private ACOs should also provide prospective participants with this data. Physicians should understand whether the ACO is physician-led or includes hospital Participants, and whether there have been any recent significant departures.

e. Physician Satisfaction and Governance

Physicians should understand the morale of ACO physicians by, for example, speaking to the ACO's medical director and representatives of any physician practice Participants. Physicians should pay particular attention to ACO

requirements related to practice changes and evaluate whether these changes have been implemented in a manner that retains physician trust and independence.

Physicians should also understand their personal role and the role of other physicians in governance, management, and decision-making. ACOs typically have a Chief Medical Officer, but opportunities for other participating physicians to be involved in the governance of the ACO can vary significantly from one ACO to another.

Some ACOs require that one or more physicians must serve on the ACO Board or act as the general or specialty medical director for the ACO. In some cases, like the MSSP, an ACO's operating agreement will place specific requirements on the composition of an ACO's governing board, like requiring that a majority of the Board be comprised of representatives of Participants in the ACO, including licensed physicians. Even within these requirements, however, physicians should understand and evaluate whether physicians in independent practice have an effective position in the ACO's governance, or whether physicians with a large administrative (non-active practice) focus are involved.

When evaluating an arrangement with an ACO, physicians should be aware of the actual and potential roles for physicians in ACO governance and management, and the implications of these governance rights. Some physicians may prefer that there be ample physician representation on the Board to ensure that those actually caring for patients are represented, while others may be satisfied with simply having a medical director advising the Board on concerns related to quality of care that may require specialized knowledge, as required by federal regulations.

Even if they do not have significant representation on the ACO's Board, physicians may serve on ACO committees. These committees address matters such as quality, finances, network development, and

technology. The operating agreement, bylaws, or Participant Agreement (agreement between the ACO and Participant setting out the terms of participation) may include language identifying such opportunities.

Sample “Operating Agreement” Language

Board of Managers

The Board of Managers will be comprised of X Managers, unless otherwise determined by the Member from time to time. The “Member Managers” shall be selected by the hospital Member. All other Managers shall be representatives selected by and from the Participants from a slate of nominees identified by Participants and approved by the Managers (“Participant Managers”). In establishing the slate of nominees, the Managers shall endeavor to provide for a representative slate of nominees from Participant organizations, with consideration to practice specialty and organizational affiliation (i.e., independent practice, hospital-affiliated etc.). A majority of the Managers shall be licensed physicians, and among such physician Managers a majority shall be primary care physicians. The “Beneficiary Manager”, if any, shall be selected and approved by majority vote of the Member Managers and the Participant Managers.

Medical Director

Clinical management and oversight shall be managed by a medical director who is appointed by the Board of Managers, and who shall serve at the pleasure of the Board of Managers (the “Medical Director”). The medical director shall be a physician who is physically present on a regular basis at a clinic, office or other location of the ACO, Participant or provider/supplier, and who is a board-certified physician licensed to practice medicine in a State in which the ACO operates.

Committee Participation

Participating Providers shall have rights to meaningful involvement in the governance, direction, and operation of ACO. Among other governance rights, such Participating Providers shall be eligible to serve on the committees of ACO and provide input into ACO policies and practices. The majority of the membership of committees of the ACO focusing on network composition, patient care and quality shall be comprised of physicians engaged in active practice through a Participant practice within the ACO.

f. Cost of Clinical Documentation Software and Access

Physicians should understand any investments in software or information technology the ACO will require, in particular those related to clinical documentation software. If the ACO mandates use of a given system, physicians should understand whether the ACO or another Participant will fund physician’s access to that system. If the practice is already well-established with a competing system, physicians should evaluate whether the practice can use an interface to access the ACO’s preferred platform.

g. ACO’s Relationships with Payers

ACOs may market their network and population health capabilities to multiple payers, including commercial payers, in addition to governmental payers such as Medicare and Medicaid. ACO arrangements with payers may include agreements for shared savings, pay-for-performance, and pay-for-quality. Physicians should obtain a list of the payers with which the ACO contracts prior to beginning a relationship. Physicians’ agreements with the ACO should specify the ACO’s contracting authority. The ACO’s authority may be limited to ACO Agreements or “Clinical Integration Agreements” with payers involving shared savings or other quality-based compensation. Alternatively, the ACO may have broader authority to negotiate traditional fee-for-service “Payer Agreements” with third party payers. In some cases, the physician’s agreement with the ACO will allow it to negotiate fee-for-service reimbursement only in some cases (e.g., only after the ACO’s governing board has provided notices and a defined opportunity for each Participant to terminate the Payer Agreement). Alternatively, physicians may agree to participate in any arrangements negotiated by the ACO, whether for quality-based or fee-for-service based compensation.

Physicians should weigh potential methods of delegating contracting authority against their preferences for control over the payer contracting process. Some physicians may be satisfied with completely delegating control to the ACO, while others may want more oversight rights and supervision over the process.

Sample “Participant Agreement” Language

ACO shall have the authority on behalf of Participant to enter into ACO Agreements, Payer Agreements, and other agreements with Payers for the provision of Covered Services by Participant (and Participant’s ACO Providers/Suppliers and Advanced Practice Clinicians, as applicable), to Covered Persons, subject to the terms of this Agreement. Participant hereby appoints ACO as Participant’s agent and attorney-in-fact, and ACO agrees to act as such agent and attorney-in-fact, to enter into ACO Agreements, Payer Agreements, and other agreements with Payers for the provision of Covered Services to Covered Persons, subject to the terms of this Agreement. Participant shall in all respects comply and cooperate with ACO to fulfill the requirements applicable to ACO and ACO Participants as set forth in the Payer Agreements.

Some ACOs do not initially negotiate fee-for-service reimbursement under payer contracts on behalf of Participants but may reserve the right to do so at a later time. In such cases, Participants should be aware of these rights as well as the ability to exit such arrangements if they do not wish to provide the ACO with the authority to enter into payer contracts on their behalf.

Sample “Participant Agreement” Language

ACO will not initially negotiate fees with any Payers, and will limit its negotiations of ACO Agreements to those involving shared savings and similar arrangements. However, during the Term, ACO may determine, by Board of Managers Approval, to negotiate Payer Agreements involving fee arrangements and/or at risk arrangements on behalf of Participants. Prior to commencing negotiations of Payer Agreements on Participant’s behalf, ACO will provide Participant with ninety (90) days prior written notice in accordance with ACO Policies, and Participant may terminate this Agreement by written notice to ACO within ninety (90) days after receipt of such notice. If Participant does not elect to terminate this Agreement, any Payer Agreement negotiated by ACO will supersede any individual Payer Agreements Participant has previously entered into with the designated Payer for the same product.

Another common model that physicians may adopt is a “messenger model,” in which the ACO communicates commercial payer opportunities that the Participant can review and choose whether or not to accept. Alternatively, the ACO may only be responsible for negotiating Payer Agreements for certain specialties. Physicians should explore other contracting opportunities and understand how the ACO may or may not negotiate on their behalf. Such opportunities are often highly negotiated in the course of contracting.

h. Size and Sophistication of the ACO

ACOs can vary from purely regional collaboratives operated by local physicians to nationwide models with professional outside management. Physicians should understand the size and sophistication of the ACO and any manager. Large ACOs may have more experience managing risk and may be able to manage costs more effectively by consolidating back office and supply chain functions. Because large ACOs treat more patients, they may find it easier to predict and control costs without the risk of sudden changes due to patient outliers. However, physician-led ACOs have had the most success in earning shared savings and may provide practices with more control over the process.

i. The ACO’s Participation History and Lifecycle

Physicians should understand where the ACO is in its lifecycle to evaluate its major strategic decisions and the timing of key steps. ACOs may begin contracting with Participants before they submit any application to the MSSP or other payers.

When assessing this kind of early stage ACO, physicians should determine the major responsible parties, the kinds of infrastructure investments to be made (by both the physician/practice and ACO), the ACO’s timeline for applying to the program, and the ACO’s desire to add additional Participants. Physicians should also understand whether they are responsible for a significant share of the ACO’s attributed beneficiaries, as this may play a significant role in future negotiations.

For a mature ACO with several years of operations under the MSSP or a private ACO arrangement, the physician should evaluate aspects of its performance history. This may include its record of shared savings/losses, its success in implementing practice modifications, any recent or planned changes in Participants, and its desired timeline for moving to downside risk. The physician should also understand how long the ACO has left under its existing ACO Agreements and whether it anticipates renewing or moving to another model.

j. ACO's Use of Waivers of Fraud & Abuse Laws

ACOs have the unique ability to waive the application of certain fraud and abuse laws (including the Stark Law, Anti-Kickback Statute, and Civil Monetary Penalty Law) to relationships that are reasonably related to the goals of the Medicare program. However, the waivers may be subject to changes in Administration policy or judicial interpretation. Their reach also may end when the ACO or relevant Participants leave Medicare ACOs. Physicians should understand when they are operating under a waiver of the fraud and abuse laws and the potential implications if the waivers are no longer available. If a physician intends a relationship to potentially last beyond the term of the ACO, the physician should be sure his or her practice has the ability to restructure the relationship to bring it into compliance with applicable law, even if the waivers no longer apply. Physicians should also confirm that the ACO has undertaken all formal and logistical steps necessary to effectuate any waiver, including obtaining governing body approval.

ACOs may also take advantage of other waivers, such as the Skilled Nursing Facility ("SNF") 3-Day Rule Waiver, allowing coverage of certain SNF services that are not preceded by a qualifying 3-day inpatient hospital stay. Physicians should also understand how other types of waivers might impact their practice when considering ACO arrangements.

2. Transitioning to Risk:

a. ACO's Strategy to Move to Downside Risk

One of the most significant recent changes for ACOs, particularly MSSP ACOs, is an increased focus on moving to downside risk. Under the Pathways to Success Rule, new MSSP ACOs must commit to taking on risk within five years or less (depending on the revenue of the ACO). Non-Medicare ACOs may vary in their approach to taking on downside risk. Therefore, physicians should understand the ACO's strategy to transition to risk. Physicians should ask questions about the timeline to move to risk, the process to decide to move to risk or take on more risk, physician involvement in these decisions, Participants' right to leave the ACO if the level of risk becomes too high, and whether the ACO is investing in strategies to reduce the likelihood of shared losses (such as improving care, managing care to prevent the need for hospital admissions, and rethinking approaches to rehabilitation and post-acute care).

b. How will the ACO Protect Itself Against Potential Shared Losses and What is the Physician's Role?

ACOs adopt different strategies to protect against excessive payments due to shared losses. Until recently, nearly 90% of ACOs participated in the "upside only" track of the MSSP, in which the ACO could earn shared savings bonuses without being held responsible for any losses. Under a new set of federal rules governing the MSSP, all ACOs must transition to "two-sided" models within at least three years after entering the MSSP (new high-revenue ACOs must transition within two years, while new low-revenue ACOs may participate under an upside-only model for up to three years; these periods may be shorter for ACOs with experience in downside risk). The MSSP ACO rules require ACOs participating in downside risk to supply a "repayment mechanism" equal to the lower of either: a) 1% of the ACO's benchmark or b) 2% of the combined Medicare Part A and B fee-for-service revenue of all of the ACO's Participants. The MSSP will only allow the repayment mechanism to be in the form of an escrow account, surety bond, or letter of credit. In addition, ACOs may enter into reinsurance

arrangements to protect themselves against repayment obligations (or repayment mechanism for a private ACO Agreement). Each of these options has pros and cons. For example, an escrow account requires a large amount of up-front capital, a letter of credit may involve variable fees based on a bank's determination of the ACO's creditworthiness, a surety bond may need frequent renewals to cover the full ACO participation period, and reinsurance requires premium payments that may cut into shared savings. Physicians should understand any fees or other terms associated with the ACO's repayment mechanism.

Sample "Participant Agreement" Language

Participant understands and agrees that beginning on the Effective Date and for the first one year period of ACO's participation in an ACO Agreement with each Payer that requires ACO to assume downside risk, Participant's responsibility for financial losses incurred by the ACO will be capped at \$[x] per Participant provider/supplier (i.e., if 6 physicians in Participant group, 6 x \$[x] or \$(6 x [x])). For each subsequent year of the ACO Agreement with such Payer, the amount of financial losses per Participant provider/supplier may be modified by action of the ACO Board no less than sixty (60) days prior to the ACO Agreement renewal date, and in the absence of any such modification, the per provider/supplier amount shall remain unchanged. Participant agrees to pay and fulfill such financial obligation in full on demand.

The repayment mechanism required as part of the MSSP application process is one way ACOs prepare for potential shared losses. The ACO must be able to demonstrate to CMS that the repayment mechanism is adequate on an annual basis. The amount held in the repayment mechanism depends on the specific type of ACO and when the agreement period began.

Physicians should pay careful attention to contractual language related to repayment mechanisms, especially the entit(ies) responsible for initially funding the mechanism and replenishing the mechanism. The ACO legal entity is ultimately responsible for paying any shared losses to CMS, so it must be the liable

party for the repayment mechanism. Although the ACO is the liable party, it may require Participants (and their employed physicians) to contribute funds to the repayment mechanism, given that CMS has suggested it may expect to see at least some meaningful contribution made by Participants to repaying shared losses. With that in mind, physicians should fully understand their obligations to bear any risk under an ACO agreement. For example, physicians should be cautious of contractual language requiring them to share in a large percentage (or even 100%) of shared losses earned by the ACO, or requirements to hold the ACO legal entity harmless from shared losses. Physicians should also be careful about their obligation to replenish the repayment mechanism if the ACO earns shared losses. For example, a contract that requires equal contributions from each ACO Participant may not be fair when the ACO includes many small practices and one large health system.

ACOs engaged in commercial and certain other "at risk" arrangements may be impacted by state insurance laws that impose requirements related to insurance licensure, financial reserves and other details that may limit the ability of the ACO to accept financial risk. Physicians should understand the near and long-term plans of an ACO related to potential at-risk arrangements, including the potential implications such arrangements may have for their practices.

Sample "Participant Agreement" Language

ACO shall provide written notice to Participant prior to entering into a shared-loss model under the MSSP.

- a. Participant must demonstrate its ability to repay shared losses to ACO in an amount equal to 1% of Participant's pro rata share of the ACO's total benchmark expenses, which is estimated by CMS at the time of application or participation agreement renewal, by placing funds in escrow, obtaining a surety bond, establishing a line of credit, or establishing a combination of such repayment mechanisms, that will ensure Participant's ability to repay ACO by January 1 of each year. Participant's

pro rata share is defined as the percentage of Beneficiaries preliminarily attributed to Participant as compared to the total number of Beneficiaries preliminarily attributed to all Participants.

- b. Participant must demonstrate the adequacy of this repayment mechanism prior to the start of each period in which it takes risk, and upon request from ACO. The repayment mechanism must be in effect throughout the Term of this Agreement and for a sufficient period after the expiration or termination of the Agreement to permit CMS to calculate the amount of shared losses owed and the ACO to collect such losses from Participant.
- c. After the repayment mechanism has been used to pay any portion of shared losses owed to ACO under this Agreement, Participant must replenish the amount of funds available through the repayment mechanism within ninety (90) days.

c. What Kinds of Expenses will be Deducted from any Shared Savings Earned?

ACOs often deduct management fees and operating expenses from any shared savings earned before distributing any remaining funds to Participants. Physicians should be aware of these obligations because they may reduce the economic benefit of the ACO. In particular, physicians should be aware of all expenses that may be removed from shared savings and whether there are any ongoing expenses that might be applied to future years of shared savings. MSSP ACOs are not required to offset any earned shared losses against future shared savings, but some choose to do so. If there are significant ongoing expenses required for participation in an ACO (for example, startup costs carried over multiple years), it may not be economically viable for a physician to participate in that ACO.

If the ACO delegates its management or certain key services to an outside manager or vendor, physicians should be aware of fee structures for these ACO management services. While the services provided by the manager or vendor may be essential, these fees can significantly reduce the physician's potential opportunity

to participate in shared savings by increasing the ACO's operating costs. Management fees can take different models. A manager may charge the ACO fees for management services that are related to the gross revenue of all of the Participants, and the ACO could then pass these fees on to Participants through a periodic flat fee. Alternatively, the manager may set fees based on the number of beneficiaries attributed to the ACO, the expenses incurred by the manager, or another model. As a common alternative to an up-front or periodic fee structure, the ACO may deduct a portion of any shared savings earned by the ACO prior to distribution to the Participants.

Sample "Participant Agreement" Language

Sample Deduction Arrangement

Distribution of Savings Available. The ACO will, at all times, maintain a reserve of X% of the Funds available. Operating costs of the ACO will be paid before any further distribution of Funds.

3. Emerging Organizational and Participation models:

ACO models are evolving quickly into similar or related organizational styles. Physicians should understand the structure of these emerging models and evaluate the business impact of participation in these models.

a. Emerging Models

Physicians should understand the variety of different models operating in their region and specialty, like "supergroup" models and ACOs focused on a tightly defined patient population. Many of these models build on the traditional ACO model by adding focus. For example, in the "supergroup" model, specialty practices collaborate to manage a defined set of services. A "supergroup" may jointly contract with payers, including private payers or certain CMS bundled payment models, and may also make joint investments in needed information technology, data analysis, and personnel necessary to accomplish these goals. Alternatively, ACOs may develop various additional structures, including large multi-state and regional ACOs or ACOs focused on a tightly defined patient population.

b. Impact on Growth and Clinical Operations

Physicians should evaluate whether participation in an alternate ACO model will expand or limit their opportunity for growth. In some ways, participation in a focused ACO model may be attractive for a specialty practice because performance metrics will be tailored to that specialty. This may allow greater opportunity for specialties that are not represented in traditional ACOs (which have more of a primary care focus). However, this approach may also cause the practice to become highly integrated in a network that may serve a limited patient population. Conversely, a traditional ACO may offer fewer opportunities for specialists, but may allow them to work collaboratively to serve a broader set of patients. This may help specialists hedge against future changes in reimbursement. Physicians should also evaluate any implications of these models for their clinical workflow and operation, such as any required referrals within the network or mandatory changes to the practice.

Physicians should be aware that an ACO may establish expectations and in some instances, requirements for their referral of patients to other providers. Federal law generally does not allow an MSSP ACO or a Participant to require that patients only receive care from providers within the ACO's network. However, Participants have some ability to require employed physicians to preferentially refer to specific providers that have relationships with the ACO (or meet criteria established by the ACO), so long as the participant does not restrict physicians' ability to refer based on patient preference, the physician's independent medical judgment, and/or insurance requirements. Contractual language reflecting this notion allows physicians to exercise their independence to refer a patient to a provider that will provide the best care, as well as protect patient choices and preferences. In addition, some private ACO Agreements (e.g., certain narrow network, capitation, or other arrangements) may require in-network referrals as part of the benefit plan.

Sample "Participant Agreement" Language

Participant understands and agrees that ACO's population health focused mission involves the provision of medically necessary care in a manner intended to improve the quality and reduce the cost of health care services received by ACO's attributed patients and beneficiaries. Therefore, Participant and Participant's provider/suppliers will be expected to consider and take into account information, practice guidelines and other variables in connection with patient care, while exercising independent medical judgment. To the extent feasible and appropriate to patient care, Participant will be encouraged to consider and use the services of other provider/suppliers within the ACO network in connection with patient care to promote ACO's care coordination, access to data and other goals.

Participant is prohibited from (a) conditioning the participation of any individual or entity performing activities for ACO on referrals of federal health care program beneficiaries who are not assigned to ACO, (b) requiring that MSSP-covered patients be referred only to other Participants or to any other Provider/Supplier (except that Participant may require referrals by Participant's Provider/Suppliers operating within the scope of their contractual arrangement to Participant's organization, so long as the employees and Provider/Suppliers remain free to make referrals without restrictions or limitation if: (i) the beneficiary expresses a preference for a different Provider/Supplier, practitioner, or supplier; (ii) CMS determines the choice of Provider/Supplier, practitioner or supplier; or the (iii) referral is not in the beneficiary's best medical interests in the judgment of the referring party).

c. 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, clinical judgment, and operation of the physician's practice remain with the physician rendering services. Participant agreements should optimally contain provisions reserving control over the provision of professional services to physicians, and physicians should be free to exercise their independent professional judgment over patient care. Physicians also may seek to include other actions related to

the operation of a practice in such provisions, like the selection of staff, supervision, or the operation of facilities and equipment, depending on the level of independence the physicians would like to retain after joining an ACO.

Sample “Participant Agreement” Language

Participant and each physician affiliated with Participant shall be free to exercise independent professional judgment in the delivery of patient care. In addition, the operation and maintenance of the offices, facilities, and equipment of Participant, and the provision of all Covered Services provided by Participant, shall be solely and exclusively under the control and supervision of Participant. ACO shall have no right, authority, or control over the selection of the staff, the supervision of the personnel, the operation of the practice, or the provision of any of Participant’s services.

d. Evaluate the Brand and Management Entities

Physicians should carefully assess the value of aligning with a brand as part of any emerging ACO-type model. Hospital or large group brands can have clear commercial value because of reputations with patients or payers. However, physicians should understand that arrangements involving the use of a brand often come with significant restrictions that may limit the practice’s ability to market the affiliation or make certain statements about care. Larger entities may also demand changes to credentialing processes and other aspects of practice management as a condition of allowing the physician to use their brand. Further, if independent physicians are tied too closely to a larger brand, they may be impacted by negative information associated with the brand. As a result, physicians should carefully define their degree of affiliation with any larger brand.

When considering whether to participate in a particular ACO, physicians should also understand the identity of the entity or persons who will manage the ACO and the implications of their management objectives and approach. Management responsibilities may be delegated

to an outside, for-profit entity that specializes in the provision of management services or a major Participant that can access capital at a reasonable cost (like a hospital or a large practice).

Outside management or management by a major Participant may be attractive for physicians who are not interested in being closely involved in the operational details associated with the management of the ACO or those who are unwilling to invest significant funds to permit the ACO to hire its own management expertise to address operations. An ACO’s decision to “purchase” management expertise rather than creating it within the organization may impact the degree of independence and influence physicians have related to administrative and operational management of the ACO’s operations, and that can in-turn, have spill-over effects on the physician’s practice activities. Physicians may also have limited opportunity to influence or express disagreement related to the ACO’s strategic direction if responsibility for managing the ACO lies with an outside party.

Delegation of certain management activities to non-physician entities may be useful because these entities may have more expertise in particular areas that will be beneficial to the ACO (i.e., financial management, technology/data analytics etc.). Certain management activities, including those focusing on clinical care and population management, should still be subject to significant physician input, direction, and supervision. Because care coordination requires clinical knowledge, especially when it comes to implementation of evidence-based medicine and quality improvement, management agreements often will explicitly provide for physician supervision of such activities within an ACO.

Sample “Participant Agreement” Language

In collaboration with ACO’s primary care physicians and care management activities and programs, Manager will assist in the implementation of a coordinated care

management model to improve health outcomes and quality of life for ACO's attributed beneficiaries under the MSSP; to reduce hospitalizations and skilled nursing facility placements; to support enrollee's self-management, mobility and functional status, along with improving their understanding and satisfaction with their health status and health services; to support and utilize appropriate clinical management to achieve designated clinical outcomes; and to promote other objectives of the MSSP.

4. Data Access:

Physicians should understand the contents, frequency, and quality of data they will receive through the ACO.

a. Payer Data

At a minimum, the ACO should receive payer data regarding patients treated by the ACO. This may include information about a patient's treatment outside the ACO itself. Physicians should understand when this data will be available, what kinds of processing and/or summarization the ACO will do, and how frequently the ACO will distribute reports to ACO Participants.

In order to access patient data, CMS requires each Participant to offer the patient the opportunity to opt out of data sharing. The Participant Agreement will typically include language offering this and similar rights in connection with commercial or other ACO Agreements, and potentially impose contractual obligations on the Participant that Participants should understand. Further, CMS will require the Participant and ACO to enter into a separate mandatory "data use agreement" that regulates the parties' use of beneficiary-identifiable data. This agreement requires additional administrative, technical, and physical safeguards to protect the confidentiality of this patient data.

Sample "Participant Agreement" Language

Notification Regarding Access to Clinical Data.

If Participant provides Primary Care Services, before requesting claims data about a particular Covered Person, Participant must provide the Patient with written notice explaining that ACO may request such claims data and

that such Patient will have a meaningful opportunity to "opt-out" and decline having his/her claims data shared with ACO. Participant must also comply with any data use agreement entered into by ACO, the Program Regulations and other applicable law relative to beneficiary-identifiable data.

Although data provided by CMS and payers can be extremely useful, it has important limitations. Most importantly, CMS and other payers will only provide high-level data identifying specific patients once per month, and a more detailed report once per quarter. Given the time needed to process data from these sources, Participants may face significant delays in obtaining usable reports. While this data can be very useful, it usually comes long after the date of service provided to the beneficiary; by the time a physician learns of a health issue or service it may be too late to efficiently manage the associated costs.

To address this issue, many ACOs have developed internal data-sharing capabilities to track claims and services provided to patients within the ACO. When possible, physicians should look for opportunities for more efficient data sharing so that they are able to effectively manage a patient's health. At the very least, physicians must ensure that the ACO has an appropriate platform for Participants to submit data for the ACO to aggregate and analyze, and that the agreement commits to a timeframe for reporting data to the ACO. In some cases, this will be one of the services an outside manager will provide to the ACO.

In the context of ACOs participating in Medicare, MSSP rules give physicians the right to report data independently if it appears the ACO will be unable to report on their behalf; data reporting may be important for a number of reasons, including to earn bonuses or avoid penalties under the Quality Payment Program. Therefore, physicians should be careful about provisions that make it difficult for the practice to report data if the ACO fails to participate in the MSSP correctly. Examples include contractual provisions or policies that

centralize data collection in an Electronic Health Record (“EHR”) system outside the practice’s control, or requirements to use an unfamiliar data collection and reporting system without training or information technology integration support.

Sample “Participant Agreement” Language

During the Term, Participant must prepare and submit electronically in accordance with each applicable Payer Agreement and otherwise in a form and manner specified by ACO: (i) claims and Encounter Data for Covered Services rendered to Covered Persons along with information necessary to process and/or to verify such claims; (ii) all data and information, including quality and/or access data, required by ACO Policies or Payers. With respect to the MSSP, this provision shall survive the termination of this Agreement for any reason.

Participant understands that, after the ACO adopts health information technology and receives sufficient data from CMS and Participating Providers, the ACO will compile reports on the individual and collective performance of Participant and Participating Providers and provide Participant performance reports at least quarterly. In the event Participant identifies any incorrect information in the reports, it shall timely notify the ACO, which shall, upon verification, correct the inaccuracies.

b. Data Collection and Reporting

Payer data may not be delivered as sufficiently, frequently, or rapidly as necessary to truly support modifications to patient care. ACOs may use internal or third party data collection, analytics, and reporting tools to report on the activities of patients within the ACO network. While this kind of reporting is less detailed than the information that can be gleaned from the payer, it may allow more effective (and near real-time) management of patient care.

Physicians should be careful when negotiating with ACOs to ensure they gain the maximum value from this data sharing arrangement. CMS will provide the ACO with reports related to patient care across the ACO once per quarter. The ability to share such data has an important role not only for the ACO as a whole, but also

for Participants within the ACO and other physicians who work with the ACO. These reports can provide physicians a closer look into ways that patients utilize the healthcare system and paint an accurate picture of a patient’s health that a physician otherwise might not have been able to see (for example, the reports might indicate that a patient had been seeing a specialist unbeknownst to the patient’s primary care physician).

Either the Participant Agreement or the Management Agreement should clearly identify which party has the responsibility of collecting all data provided by CMS, commercial payers, and Participants, and who will perform necessary analysis of this data to achieve actionable results.

Sample “Participant Agreement” Language

Manager will provide a full set of data analytics and business intelligence tools including:

1. Providing access to claims data to support performance under value-based contracts and provide personnel and analytics expertise to make the data actionable.
2. Providing access to a population health management platform that combines functions of data analytics and care management. Such platform shall include the functionality of a database, disease registry, analytics, care management and ADT coordination platform across the ACO’s network. This platform shall support web-based, iOS and Android compatible tools, performance reporting no less often than monthly, a HIPAA-compliant secure messaging tool, and, a resource site for Participants.
3. Supplying analytics staff with experience in areas including statistical modeling, analysis and manipulation of payer data, analytic consulting, and healthcare platforms, who shall support data, reporting, and strategic analytic requests for Participants.

c. Regulatory Reporting

Physicians should understand whether an ACO will report on their behalf for purposes of federal or commercial payer reporting requirements. For example, MSSP ACOs assume many of the reporting obligations for clinicians under Merit-based Incentive Payment System, Alternative Payment Models and Advanced Alternative Payment Models under the Medicare Quality Payment Program. Physicians should also understand whether the ACO will provide sufficient notice to the practice if the ACO determines it is unable to report sufficient data, and the consequences for failing to report that data (such as a promise to hold the practice harmless from any such failure).

d. Methodologies

Physicians should determine whether the ACO has access to all of the information necessary to model and predict the likelihood and magnitude of shared savings or losses. For example, many payers use unique and proprietary risk adjustment methodologies. Physicians should evaluate whether the ACO has access to such methodologies and any other unique or proprietary information that the ACO needs to fully evaluate payer opportunities.

Physicians should consider the types of capabilities and resources related to data analysis that ACOs offer related to overall infrastructure development. Having the ability to not only access data shared across the ACO, but also understand what that data means is important for physicians' ability to manage care. Data analytics and other investments will help Participants understand their practice patterns and how they are performing against benchmarks so that they can modify their performance to achieve better outcomes.

Sample "Participant Agreement" Language

a) Manager shall provide to ACO access to Manager's hardware and software to operate the information systems necessary for the ACO's operations, including but not limited to systems for the operation of patient database and outcomes-oriented information management. Such

information systems will be owned, licensed and operated by Manager for use for ACO's purposes, and the cost of such systems shall be paid for by ACO as an element of Manager's fee. Manager shall use its best efforts to ensure that all of the information systems are compatible with Manager's existing and any future information systems. Manager will coordinate and arrange for maintenance of the information systems at ACO's sole expense. The information systems to be provided to ACO by Manager shall include:

i) *Clinical Integration Tools for all ACO Participants:*

- A. Clinical decision support based on Clinical Integration guidelines and measures with underlying clinical registry
- B. Communication across the network (Secure messaging and Referral Management)
- C. Point-of-care alerts
- D. Order entry
- E. Delivery of performance reports
- F. Results viewing

ii) *Population Management and Reporting:*

Data must be: comprehensive, accurate, timely

- A. Support correct patient attribution and accurate identification for Clinical Integration guidelines and measures
- B. Support physician and network measurement

5. Financial Incentives and Intangibles:

Physicians should understand the scope of the different financial incentives and intangible benefits they may receive through participation in the ACO.

a. Shared Savings Distribution

The opportunity to participate in distributions of shared savings and other ACO income generated from ACO Agreements is an expected source of revenue for the ACO and a positive incentive for physicians to participate in ACO arrangements. Physicians should understand how any shared savings earned by the ACO will be distributed among Participants. The agreement between the ACO and the Participants or ACO policies and procedures should explicitly specify how this will be accomplished. Note that ACOs have significant flexibility to design this savings methodology. As a result, physicians may be able to negotiate the terms of this distribution.

The distribution methodology can depend on a variety of factors, including quality, committee engagement (such as those related to quality, finances, network development, and technology), and resource use. These factors are frequently addressed in internal policies of the ACO rather than in contractual language. Methodologies can vary significantly and be complex, so a careful review of contractual provisions and/or associated policies setting forth shared savings distributions is warranted prior to entering into Participant Agreements.

Sample “Participant Agreement” Language

Sample Distribution Language

- a. Shared Savings.** For the ACO to share in savings, the savings amount must exceed a Minimum Savings Rate (“MSR”), which is based on a sliding scale according to the number of assigned beneficiaries. The ACO will share in savings from the first dollar once it achieves savings in excess of the applicable MSR.
- b. Distribution of Savings Available.** The ACO will, at all times, maintain a reserve of X% of the Funds available. Operating costs of the ACO including management fees, will be paid before any further distribution of Funds. Of the remaining Funds, Y% will be distributed to Participants and Z% will be distributed to management and ownership.
- c. Participant Distribution.** Participant shares will be allocated by agreed upon percentages based on the Participant’s Net Economic Impact (resource use); Committee participation; Quality Care reporting requirements; and incentive criteria to be determined by the ACO Governing Board. The precise distribution methodology will be reflected in ACO policies governing such matters and available to Participant upon request.

b. Other Benefits and Associated Costs

Physicians seeking to participate in an ACO should be aware of the planned and actual support for care coordination activities, along with the associated cost and parties responsible for bearing those costs. A common

focus of many ACOs is on care transitions and effective post-acute care. An ACO may offer care coordination personnel, administrative assistance with claims preparation, consulting regarding care management opportunities, transportation assistance to beneficiaries, reminder services to help beneficiaries maintain adherence with medication or diet regimes, and other benefits to assist the physician’s practice. Physicians are well equipped to understand and evaluate ACO plans and resources in connection with such matters, and they should evaluate and understand whether and how such care transition and coordination activities are likely to impact their practices and finances. Physicians should ask about these additional practice benefits and be sure they are recorded in applicable contracts.

Sample “Participant Agreement” Language

- a. Support.** ACO shall support and coordinate the activities of Participants in providing ACO Services to encourage joint accountability for improving the quality of care and reductions in spending growth. ACO provides administrative services, data analysis, data support, and operational and policy recommendations to Participants. ACO facilitates coordinated sharing of best practices and uniformity of policies and processes among payers and providers.
- b. ACO shall provide specific support as appropriate to the initiative involved as follows:**
 - 1. Collect claims and clinical data in the ACO central data repository. Provide data analysis, reporting, performance measurement, and point-of-care clinical data support.
 - 2. Assist Participants so that every patient involved in an ACO Program has a primary care provider who assumes responsibility for care, with access to a multi-disciplinary team to address each patient’s needs.
 - 3. Consistent with recognized national standards, develop and provide training in and support programs to incorporate evidence-based

best practice standards of care (i.e., common chronic diseases, such as diabetes; asthma; hypertension; congestive heart failure; heart attack; multiple chronic disease management; reduced hospital readmissions; care transition protocols; prevention of unnecessary Emergency Department visits; and development of prevention roadmaps). Guidelines and care delivery processes will cover diagnoses with significant potential to achieve quality and cost improvements, taking into account circumstances of individual patients.

4. Establish clinically valid and severity-adjusted performance metrics, monitor performance measures, and provide regular feedback, including periodic reports.
5. If requested by a payer, and pursuant to applicable law, be involved in contractual communications with public and private payers.
6. Provide tools and initiatives to facilitate care transitioning, including admission to and discharge from the inpatient setting.
7. Provide administrative services support, including financial accounting and administration, and operate in a prudent and fiscally sound manner.

Participant agrees to pay, in a timely manner, such credentialing fees, membership dues, administrative assessments, and other payments as may be reasonably imposed from time to time by ACO to reimburse, in part, ACO's administrative, marketing, and infrastructure costs.

ACOs require capital to support ACO operations and investments. As part of the overall capitalization strategy, an ACO may require participating physicians or their practices to pay initial and/or annual membership or participation fees. Such fees are typically defined on a per physician or other provider basis, with appropriate consideration of revenues in connection with the fee structure. Costs could also be deducted from the distribution of savings. Institutional providers including hospitals, post-acute providers, and others can also potentially support the

ACO's operating costs and operations through participation fees or similar means. For example, if a physician practice joins an ACO operated by a large hospital system, the hospital Participant may fund a significant portion of care coordination costs due to its financial position and access to capital. However, in that case, the physician may have less control over the ACO.

Sample "Participant Agreement" Language

Flat Fee Arrangement

During the term of this Agreement, Participant agrees to pay a monthly participation fee of (\$X) per month. (Any future fee adjustments must be mutually agreed to by the parties in writing.) Such participation fees will be used to fund the infrastructure of ACO and may include amounts necessary to cover network access fees or participation fees incurred by ACO as a result of participating in network initiatives or other networks. Failure to pay the required participation fees shall be grounds, in ACO's sole discretion, for termination of this Agreement. Any participation fees paid under this Section shall be non-refundable and will not be returned to Participant or Participant Providers following termination of this Agreement.

c. Intangible Costs/Benefits

Physicians should also evaluate any other strategic benefits or detriments associated with participation in the ACO. For example, engagement with an ACO may help the practice develop closer clinical ties to other ACO Participants, improve the practice's clinical reputation among patients and in the community, help the practice adopt needed technology improvements, and ultimately deepen the clinical relationship between physicians and their patients. ACOs may also allow the physician to make these improvements while retaining the independence of their practice entities. However, physicians should also evaluate the intangible costs of working with a given ACO, as it may make it more difficult to work closely with other providers in the region that are not part of the ACO. In addition, physicians should understand the precise scope of practice independence the physician may give up to enter the ACO.

d. Physician/Practice Obligations

Finally, physicians should understand any obligations the ACO will impose on the physicians and/or practice as a condition of participation. For example, the ACO may require the practice to contribute a certain amount (or percentage) of initial start-up costs, or may require the practice to assume a portion of shared losses. The ACO also may require periodic capital contributions from its Participants, including the physician practice, in order to fund ongoing operations. Physicians should also keep in mind that ACOs are paid fee-for-service, and if a practice needs to provide new services like after-hours access and care management, it must determine how to support the personnel providing these additional services. Physicians should understand whether they are required to report any data at the practice level (such as data about adoption of a Certified Electronic Health Record Technology) or demonstrate that they have adopted the ACO's practice management obligations. As such, physicians should understand contractual terms that condition ACO participation on potentially costly practice investments (such as hiring new personnel or making information technology investments). If the ACO is helping with these practice investments, the physician should understand the terms of this initial assistance, including whether it involves any debt (and the terms of such debt). This balance of benefits and obligations will inform the physician's overall determination of whether or not to participate in an ACO arrangement.

Participation in an ACO can also require physicians to make changes in their electronic health record ("EHR") platforms and other data sharing mechanisms. Because ACOs must aggregate a large amount of health information, it is important that they are able to access and use that information seamlessly. This, in turn, may require Participants to adopt new systems and participate in data sharing, such as participation in clinical registries or health information exchanges. While these changes present significant opportunities to enhance population health, physicians who are not interested in changing their EHR practices

or joining registries might consider other alternatives such as the development and use of interfaces between their existing EHR, practice management and other data systems, and those used by the ACO. Understanding the expectations and requirements related to data sharing, including the potential associated costs, will be important to evaluating ACO participation strategies.

Physicians should avoid contracts with unclear standards related to sharing data, like those with no specified timeframe or content, requirements to accept data as-is, and contracts with no (or limited) discussion of analytics or other data interpretation.

To the greatest degree possible, physicians should get written commitments about the kind, frequency, and specifications of the data and analytical information provided by the ACO. Importantly, the Medicare MSSP and Next Generation ACO programs provide significant fraud and abuse waivers that can be used to permit the ACO and/or certain third parties to fund some or all of the costs of technology and interfaces that are reasonably necessary and related to the ACO's operations.

Sample "Participant Agreement" Language

Participant agrees to adopt and implement an electronic health record and/or other systems, including participation in clinical registries or health information exchanges, as determined by the applicable ACO, to facilitate the use and exchange of PHI and other information in connection with patient care and successful performance under Clinical Integration Agreements.

Participant shall provide relevant data for and abide by performance measurement activities, including those which may impact Participant's qualification for case management, shared savings, or other value-based payments, pursuant to all applicable laws, regulations, and data use agreements. Data requirements and/or performance metrics will follow nationally recognized criteria where possible and ACO metric selection protocols, and be approved by relevant ACO committees. However, within this framework, specific data set requirements or particular performance measures may vary by payer.

6. Other Considerations

a. Understanding ACO obligations

It is important for physicians to understand what obligations the ACO has assumed and the activities that the ACO will perform, including those that may be performed on the physicians' behalf. This information is often included in ACO Agreements with payers (including the federal government) and other agreements with third party vendors or service providers.

Federal law requires that ACOs participating in the MSSP provide Participants a copy of its ACO Agreement with CMS, but the Participation Agreement between a Participating provider and the ACO does not currently have the same requirement. Physicians should request the right to review and understand key agreements. These types of agreements spell out important details of the ACO's obligations and operations, including methods of earning shared savings, data reporting obligations, and others that can impact participants in significant ways. Having access to information from these key agreements is important for physicians to understand the business terms and legal obligations of the ACO and the downstream impact of those obligations. As part of any negotiation, physicians should ask about the ACO's payer and important vendor agreements. Physicians may seek to review copies of those agreements or obtain information on their material terms.

Sample "Participant Agreement" Language

ACO shall provide a copy of its ACO participation agreement with CMS and other payers to all ACO Participants, ACO providers/suppliers, and other individuals and entities involved in ACO governance. ACO shall provide copies or information regarding the other ACO Agreements to ACO Participants upon request.

b. Exclusivity

ACOs are often confronted with the challenge of managing the costs and quality of care delivered to patients who receive services from providers outside the ACO. Because the ACO does not have a relationship with these providers, this "leakage" can undermine the ACO's ability to

understand each patient's record of services, avoid unnecessary or clinically unwarranted diagnostic tests or clinical interventions, or assist in handoffs between settings of care. Physicians should understand that while they may have control over managing the conditions that they treat, they may not be able to control what happens in a hospital following an admission for an unrelated episode. MSSP ACOs cannot restrict patients' ability to receive care from other providers (although commercial ACOs may have more capability to do so). However, ACOs often require physician practices to agree to become exclusive to a single ACO.

The MSSP ACO rules explicitly require that a participating physician practice must be exclusive to a single ACO if the practice provides primary care services that cause patients to be attributed to the ACO. The MSSP rules do not necessarily require other providers (such as specialty providers or hospitals) to be exclusive to a single ACO. However, an ACO is permitted to require exclusivity from these providers as well as through their contractual agreements. Relatedly, when entering into an arrangement with an ACO, physicians should keep their options in mind in the event that the arrangement is terminated. Physicians should understand contractual terms like non-compete provisions which may prevent them (or their practice) from joining other ACOs in the region, or non-solicitation provisions that may prevent them from continuing relationships with skilled professionals. Physicians should also understand the effect of termination on receiving any owed shared savings payments.

ACOs have considerably greater flexibility related to exclusivity issues in connection with commercial payer arrangements. In all instances, the establishment of exclusive participation strategies raises potential antitrust law issues that the ACO will need to consider in its payer contracting activities and strategies and in connection with the requirements and limits imposed on its participating practices.

Sample “Participant Agreement” Language

Under the MSSP, Participants that furnish primary care services are limited to participation in only one MSSP ACO (or similar Medicare initiative involving shared savings). Therefore, in the event Participant (a) participates as a Participant in an MSSP ACO and (b) also furnishes primary care services, Participant agrees that Participant will not participate in any other MSSP ACO, or similar Medicare initiative that involves shared savings payments, during the Term, unless specifically permitted by the respective Medicare initiative.

At the same time, physicians should understand that the MSSP only requires exclusivity in a limited number of cases – Participants providing primary care services under the MSSP. In other cases, these exclusivity requirements are purely contractual and, therefore, subject to negotiation.

Sample “Participant Agreement” Language

Except as otherwise expressly provided herein, this Agreement is non-exclusive and Participant and its Provider/Suppliers are free to contract directly or through another accountable care organization or clinically integrated network with any payer that has not contracted with ACO, unless otherwise prohibited under one or more ACO Agreements.

Exclusive payer contracting models offer both risks and opportunities. If an ACO is the exclusive vehicle for contracting with a payer, it may be able to negotiate more advantageous rates than each Participant would be able to negotiate independently. However, this strategy reduces the flexibility of the Participants in the market, and may raise antitrust compliance issues. The exact degree of risk and opportunity will depend on the degree of competition and the number of available commercial ACOs within the region.

Conclusion

ACOs present an exciting opportunity for physicians to expand the capabilities of their practices, deliver more clinically integrated care, and access added revenue. However, there is wide variation in the kinds of deals offered by different ACOs. Understanding contractual provisions and implications can help physicians understand how they can be involved in ACO governance, consequences of various management styles, and infrastructure investments and associated costs. Given the growth in these entities and regulatory changes forcing modifications to their networks, physicians may be in a strong position to negotiate with ACOs or management companies. Therefore, physicians would be well served to actively review their Participant Agreements with ACOs and understand how to negotiate such agreements in ways that reflect their preferences related to practice management and independence.

Author’s Note: The AMA previously covered basic background information on alternative payment models and pay-for-performance contracts [here](#). In addition, the AMA produced detailed information about the legal and regulatory background applicable to ACOs and similar arrangements [here](#). The AMA has also produced materials to help physicians evaluate opportunities involving hospital-based ACOs, available [here](#), and physician-only ACOs, available [here](#). Other AMA resources addressing ACOs can be found [here](#). Physicians may wish to review those resources in addition to this document to gain a basic understanding of the ACO model.