AMA
AMERICAN MEDICAL ASSOCIATION

Accountable care organizations

How to perform due diligence and evaluate contractual agreements

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Introduction

Accountable care organizations (ACOs) can be sophisticated networks involving multiple health care entities of varying specialties and sizes, as well as community-based organizations, and other types of organizations collectively working toward managing primary care or clinical specialties, sometimes with a more defined focus on specific patient populations or markets. Physicians face unique challenges in evaluating opportunities to participate in, or help lead, ACOs or similar arrangements in their markets.

Fundamentally, ACOs take accountability for the health care costs and the quality of care provided to patients treated by the ACO's members or "Participants." Participants are the basic building block of the ACO; as the physicians and health care organizations who deliver patient care, they are the source of the ACO's patient attribution and responsible for much of the ACO's overall performance. The term "Participant" is defined differently in different ACO programs. In Medicare Shared Savings Program (MSSP) ACOs, a "Participant is an entity (such as a hospital or physician practice) identified by a Medicare-enrolled tax identification number (TIN) through which one or more ACO providers/suppliers bill Medicare." Other Medicare programs and non-Medicare ACOs may define an ACO Participant differently. For example, in ACO REACH and many commercial ACOs, an *individual practitioner* is a Participant. Because the collective performance of the ACO's Participants drives the ACO's performance, ACOs are often highly strategic in selecting Participants. ACOs may evaluate potential Participants based on factors like the Participant's clinical expertise, patient volume, key personnel, number of attributed beneficiaries or revenue. **For purposes of clarity, this document refers to "Participants" using the Medicare Shared Savings Program definition unless explicitly stated otherwise.**

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.

This document is intended to supplement the American Medical Association's extensive background materials on value-based care arrangements such as ACOs by providing specific guidance to strategically evaluate opportunities and negotiate important contract terms. The AMA has also produced two other resources—"Accountable care organizations: Model checklist" and "Accountable care organizations: Snapshot"—that address topline issues to consider when partnering with an ACO.

ACO categories

ACO relationships have evolved into a wide variety of potential structures. Many payers incorporate ACOs in their products and portfolios including the Medicare program, other governmental managed care programs, commercial programs and employer-based programs. The rules and strategic objectives of each ACO arrangement can vary based on several factors including the identity of the payer, the kinds of Participants, and the clinical and strategic focus of the ACO.

Most ACO arrangements, including Medicare ACOs, continue to focus on managing "total cost of care." Under this approach, Participants are responsible for managing all facility and professional (and sometimes pharmacy) expenses for a defined patient population. However, the ACO model may also be used to manage cost and quality for other, more narrowly defined services or patient populations. For example, CMS has expressed interest in developing strategies to engage specialists in ACOs through strategies such as "shadow bundles" (or reporting on the costs of specific episodes within an overall ACO). Medicare has also developed a number of non-ACO value-based specialty models, with detailed rules regarding their interaction with the Medicare ACO programs. Finally, an individual ACO may focus on a particular sub-population even if it is operating under a larger "total cost of care model" (for example, primary care physicians may collaborate with orthopedists to develop an ACO that drives overall cost savings by focusing on improving quality and reducing costs associated with musculoskeletal care).

As ACO models (and other related value-based models) have proliferated, physicians have faced new challenges in addressing the advantages and disadvantages of various alternative payment arrangements. Some have explicit "overlap" requirements that, among other things, may cause a Participant to become ineligible for participation in other value-based payment arrangements. Even when Participants can be in multiple arrangements, there may be implications for calculation of shared savings for example.

ACO financial models also continue to evolve considerably. ACOs have traditionally earned shared savings, which are calculated based on the difference between the payer's expected (often called a "benchmark" or "baseline") and actual spending for specified patients, adjusted for the ACO's performance on quality measures. These are calculated based on the collective performance of all ACO Participants, although earned shared savings are not immediately paid to Participants. Instead, the ACO distributes shared savings to Participants based on a methodology negotiated among the parties, typically based on a combination of the number of patients seen, work performed for the ACO, compliance with ACO operational standards and quality of care.

Similarly, depending on the arrangement, ACOs may earn "shared losses" if the actual cost of their Participants' care exceeds the baseline. ACO arrangements involving shared losses typically have sophisticated risk management requirements, including a requirement for the ACO to maintain access to sufficient resources to address significant shared losses. ACO arrangements may also require Participants to pay for a portion of shared losses. The treatment of shared losses is highly variable among different ACO arrangements, so it is an important point of contractual evaluation and negotiation.

ACOs can use a variety of other financial tools as well. For example, ACOs may provide upfront payments, often described as "advance," "prepaid" or "infrastructure" payments. These are often structured as per-member per-month payments, but may also be one-time lump sum amounts. The ACO may or may not require repayment or offsetting of such upfront payments from Participants. ACOs may also provide additional resources including access to electronic health record (EHR) systems, personnel and data analytic services. As a more indirect benefit, ACOs may function as joint contracting entities (similar to an independent practice association, or IPA) leveraging improved quality and decreased cost to negotiate favorable payer contract terms. Finally, ACOs may help physicians and their care teams, implement interventions that go beyond traditional medical care, such as strategies to address social determinants of health, to help close access gaps and drive savings for better managing a patient's care. These interventions can vary broadly but in some cases they include providing patient transportation, care coordinators or patient navigators, or assistance accessing housing or nutrition services.

Finally, the very concept of an "ACO" has become harder to pin down. Although the term is closely associated with entities participating in Medicare payment models, various other kinds of entities also provide similar services. For example, clinically integrated networks (or CINs) often function similarly and these terms are sometimes used interchangeably. Many private "value-based enablement" entities now offer their services—i.e., by combining aspects of a traditional management services organization with capacities related to improved documentation, data analytics, patient engagement, management of risk, etc.—similar to what ACOs offer, which can make it more difficult to distinguish between the two.

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.

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 past savings and losses when considering entering any ACO arrangement. Information about MSSP ACOs, including membership, attribution, and shared savings and losses is available through the CMS data portal at data.cms.gov (additional information on ACO data is available here). Physicians can also access Medicare information on an ACO's public website. However, this public information is limited to the ACO-level so practices should also ask ACOs how these details, particularly any shared savings payments, are broken down at the practice-level. CMS and other payers typically do not dictate how an ACO distributes its shared savings payments with individual practices so ACOs may develop their own savings and losses methodology; physicians should understand on what metrics savings/losses will be calculated and distributed amongst practice participants under these rules, as well as how payments have been distributed to participating practices in the past.

b. Finances of the ACO and Participants

Physicians should do their best to understand ACO system finances, who contributes operating funds, and whether the practice 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 individual participating practices. 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, and how these metrics or other quality metrics developed by the ACO may factor into downstream shared savings payments that are distributed to individual

practices. Additionally, physicians should determine whether the ACO or practice factor clinician salaries to value-based performance metrics. MSSP programmatic guidance (including quality measures, attribution models, and similar information) is available here. ACO public websites also contain information related to quality metrics. ACO REACH and other CMS Innovation Center models also make much of their operational guidance public.

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.

d. Composition and stability of Participants

Physicians should seek to learn about the other Participants in the ACO. The list of each MSSP ACO's Participants is available here. The CMS Innovation Center also makes information about Participants in its ACO models public. 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.

Physicians should also understand their ability to enter and leave the ACO. Certain payer relationships may require ongoing engagement with the ACO that limits the physician's ability to participate in other opportunities. For example, the MSSP requires practices that are responsible for patient attribution to be exclusive to a single ACO.

e. Physician satisfaction and governance

Physicians should understand the sentiments of ACO physicians by, for example, speaking to the ACO's medical director and representatives of 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 ACO models 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, such as requiring a majority of the board be composed 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 ample physician representation on the board to ensure that the clinical and business interests of physicians are represented, while others may be satisfied with representation in the form of a medical director responsible for quality oversight (the minimum required for MSSP ACOs under 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.

Several states have implemented their own laws requiring prior disclosure and filing of information related to transactions between VC/PE-backed entities and health care entities. These laws generally require notice to state regulators anywhere from 30 to 180 days in advance. In some states, officials can also challenge or prevent some or all of a proposed transaction. These laws may significantly lengthen the timeframe between negotiation and implementation of a VC/PE-backed investment, and may create additional risk for a transaction to "die" before closing (for example, if economic conditions change or a regulator challenges the arrangement).

Sample language: Operating agreement

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, and whether the ACO (or another

party) will pay for the interface. Physicians should also understand any related technological expectations, including data sharing logistics and privacy concerns, and any required tools to facilitate telehealth, in-home care, patient-directed communication, documentation and care delivery. If there are transitional costs associated with migrating to these tools, the ACO may provide assistance, potentially including financial support, training and personnel.

g. ACO's relationships with payers

Individual ACOs may market their network and population health capabilities to and sign separate contracts with multiple payers, including governmental payers such as Medicare and Medicaid, managed care plans, commercial payers and employers. ACO arrangements with multiple payers are likely to vary and may include various financial terms including shared savings, pay-for-performance and pay-for-quality provisions that can be structured as bonuses or holdbacks, and per-member per-month care management fees. Physicians should obtain a list of all 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 shavings 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 language: Participation agreement

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 language: Fee negotiation with payers

ACO will not initially negotiate fees with any Payer, 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.

One very common negotiation strategy is a "messenger model," in which the ACO communicates various commercial payer opportunities, which the Participant can review and choose whether or not to accept. These may cover all professional services or, alternatively, may be limited to payer agreements for certain specialties. Messenger model arrangements sometimes give physicians the choice to participate in various different payment models, including ACO and non-ACO arrangements. Participants should seek to understand how the ACO may or may not negotiate on their behalf, keeping in mind that the terms presented by the ACO may be highly negotiated between the ACO and a payer beforehand.

h. Size and sophistication of the ACO

ACOs can vary from purely regional collaboratives operated by local physicians to models with professional outside management. Physicians should understand the size and sophistication of the ACO and managing entity. 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 fluctuations that can be more common with a smaller patient population. However, physician-led ACOs have had success in earning shared savings and may provide practices with more control over the process.

i. 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.

Finally, physicians should understand the term of the agreement and any opportunities to terminate or renegotiate the arrangement. Many arrangements match the ACO's commitment to the relevant payer (often five years), but Participants sometimes have the ability to terminate without cause or upon certain events. Also, some arrangements allow the parties to renegotiate certain terms like shared savings distribution methodologies after certain periods of time or upon certain events occurring. For example, an arrangement might have a five-year term but contemplate a right to renegotiate if the ACO as a whole earns shared savings above a certain threshold.

j. ACO's use of waivers of fraud and abuse laws

Health care fraud and abuse laws (including the Stark Law, Anti-Kickback Statue and Civil Monetary Penalty Law) may be implicated anytime a physician receives something of value from certain entities, including ACOs. The consequences of violating these laws can be significant, including large financial penalties, onerous reporting obligations, exclusion from the Medicare program or even imprisonment. MSSP ACOs have the unique ability to waive the application of certain fraud and abuse laws for 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.

These waivers generally are not available to other kinds of ACOs like commercial ACOs. These ACOs may protect arrangements under other rules, including longstanding exceptions or safe harbors under the fraud and abuse laws. Some of these exceptions or safe harbors cover specific relationships like personal service arrangements or donations of EHR technology, while others cover whole categories of payers (like the exceptions for managed care relationships). In 2020, the federal government finalized a set of exceptions and safe harbors specifically covering value-based arrangements and certain related care coordination and outcomes-based compensation relationships. These "value-based" provisions are powerful, but they require ACOs and Participants to engage in oversight and governance functions to make sure the arrangement drives better care or lower costs.

Physicians should understand when an arrangement may implicate the fraud and abuse laws and, if so, how the ACO intends to comply with these laws. If the ACO is using a waiver, physicians should understand their responsibilities under such a waiver. If a physician intends a relationship to potentially last beyond the term of the ACO, the physician should be sure their 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 "payment rule" 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. Payment rule waivers may differ between programs.

Transitioning to risk

a. ACO's strategy to move to downside risk

One of the most significant decisions for ACOs is whether and when to move to downside risk. Many ACO programs including MSSP require ACOs to eventually move to risk-based payment, but ACOs often have the option to transition to downside risk faster. Risk-based payment arrangements tend to provide the greatest "upside" opportunity when the downside risk is greater. "Full risk" or capitated models are increasingly popular population health strategies as a result.

Therefore, it is important that physicians understand the ACO's expectations around transitioning to risk. Physicians should ask questions about the timeline to move to risk, the ACO's expectations about physician contributions to "shared risk" penalties, 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 how 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. Previously, 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. In 2019, the federal government announced it would require all ACOs to transition to "two-sided" models. Since then, MSSP rules have shifted to allow newer ACOs to remain in "upside only" participation for a longer period of time, though all MSSP ACOs must eventually transition to downside risk. Depending on the participants, a new ACO may be able to participate in "upside only" models for up to seven years.

The MSSP ACO rules require ACOs participating in downside risk to supply a "repayment mechanism" in the form of an escrow account, surety bond or letter of credit. ACOs may enter into reinsurance arrangements to protect themselves against repayment obligations (or repayment mechanism for a private ACO Agreement).

Note that ACOs may turn to various outside advisors to help negotiate and establish these repayment mechanisms. For example, some value-based enablement companies will agree to absorb most (or all) of the risk in exchange for a larger share of any ultimate shared savings payments.

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 how any fees or other terms associated with the ACO's repayment mechanism may be passed down to their practice, as well as their individual responsibility for paying back any shared losses.

Sample language: Participant agreement repayment mechanism

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 MSSP-required repayment mechanism 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. Note that non-Medicare ACOs may be required to meet other "risk management" obligations under state law or under the terms of their commercial or employer-based contracts. These may include repayment mechanisms like those required by CMS or other mechanisms like reinsurance.

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, since 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 and how that risk balances with shared savings bonuses they would be eligible to receive. 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 language: Shared-loss model

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 be less 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 language: 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.

Emerging organizational and participation models

Physicians should understand the structure of common emerging organizational models and evaluate the business impact of participation in these types of arrangements.

For example, in what is commonly known as a "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. Supergroups exist on a continuum with management service organizations and value-based enablement entities. Under this model, an outside management company buys several practices in a single specialty, implements standardized business practices tailored to value-based care participation and uses this tightly integrated network to participate in traditional value-based functions.

Alternatively, ACOs may develop other kinds of structures, including large multi-state and regional ACOs or ACOs focused on a tightly defined patient population. For example, providers could create ACOs specifically focused on pediatric patients or behavioral health conditions.

a. Impact on growth and clinical operations

Physicians should evaluate whether participation in an alternate ACO model will expand or limit their opportunity for growth. For example, specialists may be drawn to participate in a focused ACO model that tracks performance metrics and bonus opportunities more relevant to their practice. 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 targeted interventions or technologies for specialists but may allow them an opportunity to work collaboratively across specialties to serve a broader set of patients. This diversification may also help specialists hedge against future reimbursement, coding or care delivery changes. Physicians should also evaluate any implications of these models for their clinical workflow and operation, such as any required referrals within the network, mandatory clinical practice changes, such as referencing clinical databases for standards of care, and any new data reporting requirements.

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 language: Provision of medically necessary care

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 business for 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).

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, 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 language: Independent professional judgment

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.

c. 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 certain restrictions or implications 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 strategically important Participant that can access capital at a reasonable cost (like a hospital or a large practice).

Outside management or management by a sophisticated 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 should explicitly provide for physician input into and supervision of such activities within an ACO.

Sample language: Management responsibilities

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.

Data access

Physicians should understand the contents, frequency and quality of data they will be expected to report and that they will in turn 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 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 typically only provide high-level data identifying specific patients periodically, such as once per month, and a more detailed report less frequently, such as 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.

Physicians should also understand their responsibilities and expected timeframes for reporting data to the ACO, and whether this data can be used to satisfy Medicare and other payer data reporting requirements. Physicians must ensure that the ACO has a compatible platform for Participants to submit data for the ACO to aggregate and analyze, and that the agreement specifies a timeframe for reporting data to the ACO, and a commitment that the data will be reported on behalf of the practice to CMS and other payers to satisfy data reporting requirements through 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 to 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 or report aggregate data correctly regardless of payer. Examples include contractual provisions or policies that centralize data collection in an 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 language: Collection and reporting of data

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 support modifications to patient care protocols. 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 for more effective (and near real-time) management of patient care. Physicians should understand what if any data they will have access to through their participation in the ACO, as well as any expectations for using this data (such as consulting with a registry).

Physicians should ensure they understand their own data reporting expectations and gain the maximum value in return from any data sharing arrangement. The ability to share such data has an important role not only for the ACO as a whole, but also for Participating practices 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 health care 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, as well as ensure data is reported to CMS or other payers to satisfy data reporting requirements.

Sample language: Provisions for data management and analytics

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 health care 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, and whether those predictive analytics will be shared with participating practices and physicians. 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 opportunities to participate in various payer risk arrangements.

Physicians should consider the types of capabilities and resources related to data analysis that ACOs offer. Having the ability to not only access data shared across the ACO, but the ability to work with the data and turn it into meaningful patterns and insights is important for physicians' ability to manage care and design innovative solutions or interventions to drive quality improvement. 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. ACO partners may also vary in their ability to perform advanced analytics like disaggregating data based on ethnicity or socioeconomic status to help design effective clinical and social determinant interventions for relevant sub-populations.

Sample language: Data hardware and software

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

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.

Sample language: Shared savings distribution

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 overall care for beneficiaries. ACOs may also provide tools to help practices screen for social risk factors and behavioral health risks, as well as strategies and personnel to address these risks.

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 language: ACO resources and support

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. Any fees should reflect fair market value and should be generally proportionate to the actual operating costs of the ACO. This is another reason why it is important for practices to obtain information about other ACO participants in order to inform these negotiations.

Sample 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 or exposure among patients and in the community through marketing for example, 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 generally paid based on a one-time retroactive shared savings payment, so if a practice needs to provide new services like after-hours access and care management, the parties 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 EHR Technology) or demonstrate that they have adopted the ACO's practice management obligations. Federal program regulations may also impose certain obligations on practices that participate in ACOs, such as beneficiary notification requirements. 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 EHR platforms and other data sharing mechanisms. Because ACOs must aggregate a large amount of heath 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.

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 language: Physician/practice obligations

Participant agrees to adopt and implement an EHR 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.

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.

Although Medicare ACO programs require ACOs to disclose their Participation Agreements to Participant entities, these entities are not necessarily required to disclose information to their employees or to the ACO itself. For example, a Participant entity is not required to share all of its shared savings with employed physicians. Note that different Medicare ACO programs establish different rules around disclosure.

Physicians may have rights to review material agreements under their practice governing documents; if so, they 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 language: ACO obligations

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, ACO contracts sometimes require Participants not to contract with other ACOs. 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 trade secret provisions, that may limit their ability to disclose certain information even within their own practices, 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 may have greater flexibility related to exclusivity issues in connection with commercial payer arrangements compared to the MSSP. 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 language: Single ACO exclusivity

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, exclusivity provisions only apply to certain subsets of physicians identified in the applicable program rules. These are typically physicians providing primary care services to ACO beneficiaries, which under the terms of the MSSP for example are only allowed to contract with one ACO. In other cases, these exclusivity requirements are purely contractual and, therefore, subject to negotiation.

Sample language: Non-exclusivity

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 a potentially promising 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 arrangements and benefits offered by different ACOs. Understanding contractual provisions and implications can help physicians understand how they can be involved in ACO governance, as well as consequences of various organizational structures and associated responsibility to share in costs and any earned shared savings or losses under the model. Practices should also have transparent information regarding their obligations to report data, change referral or care delivery practices and benefits they may be entitled to for participating in the ACO, including enhanced support for new technology, non-medical supports and enhanced care coordination. Given the growth in ACO entities and evolving regulator changes, physicians should evaluate this information, along with terms of their contracts with ACOs or management companies, on a regular basis.

Author's note
The AMA previously covered basic background information on alternative payment models and pay-for-performance contracts here. The AMA has also produced materials to help physicians evaluate opportunities involving hospital-based 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.