



Snapshot: Accountable Care Organizations

Accountable Care Organizations (“ACOs”) have matured over the past several years. Participation in such entities, therefore, can pose complex and novel questions for physicians. Physicians interested in ACO arrangements must conduct due diligence to evaluate the opportunities available to them. To this end, the AMA has developed resources to help physicians navigate this process and understand their rights and obligations by providing this Snapshot covering topline issues to consider when partnering with an ACO, a [Model Checklist](#) and a [Contractual Guide](#) on ACOs to further supplement the due diligence process.

Topline issues to consider are as follows:

Evaluating the Health of the ACO

- **ACO Finances, Quality Metrics, and Payer Relationships.** Physicians must evaluate the ACO’s record of savings and losses and pay particular attention to the transparency of past savings and losses results. Physicians should consider how the ACO measures quality metrics and how it has previously performed under those measures; current or planned investment in software or information technology by the ACO; the ACO’s relationships with payers; the size and sophistication of the ACO; how the ACO is being financed; and where the ACO is in its lifecycle (early-stage, maturing, established).
- **Physician Satisfaction and Governance.** Joining an ACO is an option for physicians who want to remain independent and want to become a part of a network of providers managing care quality and costs related to a specific patient population. Physicians should understand their potential roles in an ACO when evaluating such opportunities and be cognizant of physician workforce stability and job satisfaction in an ACO. Physicians not only have important roles related to clinical matters and care coordination, but also can influence ACO decision-making through participation in governance activities. Physicians should be aware of potential implications on their clinical practice, such as being encouraged to rely on other ACO Participants when referring a patient to another physician.

Transitioning to Risk

- **Timeline and Strategy for Managing Risk.** Physicians should understand whether and how an ACO plans to move or has already moved to accepting downside risk, as well as the strategy for protecting itself against excessive payments due to shared losses and the costs and terms of any escrow, letter of credit, or bond in place to be used as a repayment mechanism. Physicians should also know the kind and amount of expenses that will be deducted from any shared savings earned in the ACO.

- **Shared Losses/Repayment Mechanism.** Two-sided Medicare Shared Savings Program (“MSSP”) ACOs are responsible for paying penalties if they incur losses, just as they can qualify for bonus payments based on shared savings. Different ACOs handle this potential liability for shared losses differently. The ACO may retain responsibility for a portion of such losses or may delegate the responsibility to major Participants or to all Participants. Additionally, an MSSP ACO must establish a repayment mechanism to assure CMS that it can repay losses associated with an ACO. The ACO may require Participants to contribute a certain amount to fund any repayment for losses. Physicians should understand how an ACO plans to recoup shared losses and fund its repayment mechanism and the potential financial implications those decisions may have on Participants and their employed physicians.

Emerging Organizational and Participation Models

- **Emerging Models, Impact on Growth, and Clinical Judgment.** Physicians should evaluate opportunities to participate in emerging models that build on traditional ACO models by adding focus-like “supergroups” and ACOs concentrated on tightly defined patient populations. Physicians should understand how an alternate ACO model expands or limits opportunities for growth, and how an ACO establishes requirements for the referral of patients to other ACO providers. In all cases, physicians must retain authority over matters related to clinical judgment, and should carefully negotiate whether they retain authority over other activities, such as the selection of staff, supervision, or the operation of facilities and equipment, after joining an ACO.
- **Evaluating a Brand and Management Entities.** While some ACOs may be physician-run, at times another entity is responsible for ACO management activities. When evaluating opportunities to become a part of an ACO, physicians should be mindful of the management styles associated with various types of managers. Some entities, like an outside manager or a major Participant (as defined by the ACO itself based on a variety of factors including clinical expertise, patient volume, key personnel, number of attributed beneficiaries, or revenue), may leave physicians with less control over administrative and operational management of clinical integration activities related to their practice. Some managers may contract with payers on behalf of Participants, while others may leave that responsibility with each Participant. Physicians should also consider how management fees are paid, as well as ensure that they retain control and independence over decisions related to the individual practice of medicine and clinical judgment.

Data Access

- **Payer Data, Data Collection, and Reporting.** Physicians should understand the contents, frequency, and quality of data they will receive through the ACO. This data includes payer data for patients treated in the ACO. Physicians should also know whether an ACO will report on their behalf for purposes of federal or commercial payer reporting requirements. And, importantly, physicians should determine whether an ACO has access to all of the information necessary to model and predict the likelihood and magnitude of shared savings or losses.

Financial Incentives and Intangibles

- **Shared Savings Distribution.** Shared savings are the primary source of revenue for the ACO and are one of the main incentives for physicians to participate in such arrangements. Physicians should understand how an ACO distributes shared savings and whether the ACO will deduct fees related to services provided from a Participant’s distribution. Distribution methodologies can be complex and the amount distributed may depend on a host of factors, including quality, committee participation (such as those related to quality, finances, network development, and technology), resource use, and volume of services provided.

- **Other Benefits and Associated Costs.** Physicians should understand the scope of the different financial incentives and intangible benefits they may receive through participation in the ACO, including the shared savings distribution, other financial and in-kind benefits such as access to care coordination personnel, administrative assistance with claims, and the ability to develop closer clinical ties to other Participants and the community. At the same time, physicians need to be aware of their obligations to the ACO such as financial contribution to start-up costs or assuming a portion of the shared losses.
- **Intangible Costs/Benefits and Physician/Practice Obligations.** ACOs will typically provide some level of infrastructure support to Participants, often related to data collection and reporting. ACO infrastructure investments may also include administrative services, personnel for care coordination, and establishing uniform policies and procedures and best practices related to care coordination and quality. Physicians should be aware of the costs associated with such infrastructure investments and the parties responsible for such costs, including those related to clinical documentation software. Participants may be required to pay for some investments or the ACO may deduct costs from shared savings distributions. Alternatively, sometimes a major Participant will fund ACO infrastructure investments.