AMA
AMERICAN MEDICAL ASSOCIATION

Contracting with aggregator entities to advance value-based care arrangements

Guidance for physician practices

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Introduction

This document is intended to help physicians identify core business considerations associated with evaluating potential relationships with a value-based care "aggregator." Practices may consider using this document to develop an initial set of questions, which they can then pursue with the help of counsel or other advisors.

For physicians and practices, value-based care (VBC) arrangements present important opportunities for new revenue options while simultaneously promoting a greater focus on quality, high-value care. However, these arrangements can often be overly complex and may require investment in new, highly technical and specialized business functions. For example, arrangements may require practices to develop expertise in risk-based contracting, data analytics, network design and management, actuarial planning, information technology, and management of insurance risk. If a practice chooses to join an existing value-based care entity like an Accountable Care Organization (ACO), this may also require significant practice changes like implementation of a new electronic health record (EHR) or modification of referral patterns.

Many health care providers (including physician practices) have turned to specialized private entities to help address such issues rather than fully invest in requisite solutions themselves. These entities may go by different names and have different legal structures. For example, they may be referred to as "enablers," "facilitators," "contracting organizations," "value-based service organizations" or other similar names. For ease of reference, we refer to all such entities as "aggregators" in this document. Their structures and business terms also vary substantially, from limited-scope service agreements to full-scale management arrangements, and from simple fee-based structures to arrangements involving complex reconciliation and risk-shifting structures. The sheer diversity of this sector creates challenges for physicians who are interested in value-based care. Although many physicians and practices are curious about working with aggregators, it can be challenging to evaluate the different available arrangements and make informed business decisions for a practice.

Aggregators can be useful partners, but these are complex business arrangements that can have significant implications for physician practice finances, flexibility, autonomy and relationships with outside partners. This document is intended to introduce common business issues that arise in value-based care arrangements and help physicians identify key questions to evaluate these opportunities. Some of these key questions include:

- *What are your goals in pursuing value-based care arrangements?*

  Some examples include financial benefits, moving away from fee-for-service reimbursement, changing practice style, independence, and alignment with the goals of payers or clinical partners.

- *Are you interested in assistance participating in a specific value-based arrangement, or are you looking for a partner to build a platform to negotiate arrangements with multiple payers?*

- *What is the scope of business functions that you would like the aggregator to provide?*

  For example, discrete and limited advisory services vs. full-scale practice management services; analytics to inform practice contracting vs. full delegation of payer contracting functions.

- *How can you best leverage your practice's prior experiences, including working with vendors, participating in value-based care arrangements and navigating changes to practice infrastructure?*

- *What documents and information should you review to understand and evaluate the business terms of value-based care arrangements?*

This document is intended to provide high-level strategic guidance that may apply across many types of value-based care arrangements. In practice, programmatic rules and payer requirements often layer additional complexity onto this basic arrangement. For example, payers may implement different rules around attribution, payment adjustments and handling ongoing payments. Arrangement components can also be changed through manuals, regulations or guidance documents. Payers, especially governmental payers, may also impose nuanced requirements related to legal structure, governance and patient representation, all of which are also subject to change.

Key VBC terms and structures

Value-based care arrangements take many forms and use many defined terms; the precise language used to describe similar concepts can vary between arrangements or payers. In this document, we apply the following general framework for value-based care concepts and terminology.

In general, value-based care arrangements usually involve an agreement (which we refer to as a **participation agreement**) between a payer and an entity (which we refer to here as a **population health entity**), under which the payer will compare the performance of certain **participating providers** (who may be entities or individuals, depending on the value-based care arrangement) in a **performance year** against a historical baseline or benchmark. Some value-based care arrangements are **voluntary** (participants opt-in, typically through an application process), while others are **mandatory** (for example, Medicare or a dominant payer may require all providers in a region to participate). Patients are **attributed** to the participating provider under certain **attribution rules** (e.g., a payer may require accountability for all covered enrollees in a region; attribution could be based on patients voluntarily opting-in; or attribution could be determined retrospectively based on actual services provided by participating providers).

Arrangements also differ on the type of care targeted – some arrangements target the **total cost of care**, while others target specific **clinical episodes**. If the participating provider(s) successfully meet programmatic goals (usually a mix of decreased expenses and improved or sustained quality), they will be eligible for a **population health bonus payment** (the exact name of this payment varies across arrangements, common terms include "shared savings," "bundled payment," "holdback," "withhold" or "population health payment"). Certain arrangements also provide ongoing fully or partially **capitated payments** (sometimes called "advance payments," "support payments" or "infrastructure payments"), often structured on a per-member basis (such as a per-member per-month (**PMPM**) methodology). Providers also may be eligible to continue billing traditional **fee-for-service** claims. Under some arrangements, if the participating providers fall short of their benchmark performance (for example, if their care is more expensive than predicted or if they fail to maintain quality), they may be required to make a **downside risk payment** back to the payer (such as "shared losses" in the context of ACOs). At some point after the performance year, the payer conducts a **reconciliation**, in which it compares the participating providers' performance against the baseline, applies certain **payment adjustments** (such as risk adjustments, geographic adjustments and sometimes deduction of ongoing payments) and determines whether a population health bonus or downside risk payment is due. Payment is generally made (or due) at some time after that reconciliation, often several months into the year following the performance year.

Evaluating the business goals of aggregators

After assessing their own strategic goals, physicians should consider the strategic goals and business purpose of potential aggregator partners by considering the following questions:

a. What value-based care arrangement(s) is the aggregator targeting?

Aggregators' business models are directly related to the value-based care arrangements in which they participate. Aggregators vary in their emphasis on different payment arrangements. Some are highly tailored to specific value-based care concepts (such as the Medicare Shared Savings Program (MSSP) and similar models). Others offer a "platform" approach that could potentially facilitate participation in different kinds of value-based care arrangements. These aggregators tend to focus on practice modifications and the creation of a high-quality provider network that could demonstrate high performance under a variety of arrangements. Alternatively, some aggregators focus on controlling the total cost of care, while others have expertise with one or more clinical episodes (for example, certain aggregators focus solely on orthopedic care, or even specific procedures like joint replacement). Finally, some are focused on governmental payers while others attempt to leverage a consistent arrangement across payer types. Practices should ensure they understand the strategic goals of their aggregator partner and that these goals align with the practice's goals.

b. What is the legal structure of the aggregator's relationship with its network of providers?

Given the diversity of value-based care arrangements, it is perhaps no surprise that aggregators operate under a variety of legal and business structures. An aggregator's legal structure and business model can have important implications for any participating providers, like physician practices.

Aggregator business models are heavily influenced by the value-based care arrangements in which they participate. Certain models, like the MSSP, impose detailed, mandatory legal requirements, including the establishment of an ACO that usually must be a legal entity distinct from any provider. ACOs must also comply with numerous regulations related to their governance and operations. Other arrangements may require or permit the formation of a "convener" entity responsible for managing a clinical episode. Still, other arrangements require one health care provider (typically a hospital) to take overall responsibility for a full clinical episode (for example, the Medicare TEAM model requires hospitals to take responsibility for a 100-day episode following certain surgical procedures). Each of these arrangements influences the legal structures of aggregators. In light of this complexity, aggregators often adopt two overall arrangements: ownership vs. contractual arrangements.

Ownership arrangement

In an ownership arrangement, the aggregator directly owns and operates the population health entity (for example, the ACO legal entity or convener). The participating providers are party to a participation agreement with the population health entity, which is typically structured to parallel regulatory requirements. The aggregator often provides all or most of the day-to-day operations of the population health entity, pursuant to a services agreement with either the population health entity or the participating providers.

Under this structure, the aggregator generally has more control over the population health entity, potentially including explicit "reserved powers," giving the aggregator sole authority or veto power over important business decisions. Although programmatic rules often require some representation of participating providers in the governance of the population health entity, some national population health entities are very large, which may limit any individual participating provider's voice in operating the population health entity. As the owner (typically the sole owner) of the population health entity, the aggregator will also have first access to any population health bonus payments, may deduct its fees directly from any such payments and may be eligible to receive profit distributions. Conversely, in these arrangements, the aggregator often takes full or partial responsibility for paying any downside risk payment (unless payer requirements mandate a different risk-sharing arrangement; for more, see the AMA Voluntary Best Practices for VBC Payment Arrangements Playbook). Liabilities related to operating the population health entity typically stay with the entity and are not transferred to participating providers.

Contractual arrangement

In a contractual relationship (sometimes called a management or services relationship), the aggregator does not own the population health entity. Sometimes, this is because no population health entity is necessary. For example, as mentioned above, the TEAM model places hospitals directly at risk for all services in a post-surgical period, with no need to set up an ACO, convener or similar entity.

In these arrangements, the aggregator tends to provide a comprehensive services agreement either to the entity at risk or to all participating providers. Alternatively, the aggregator may manage all the day-to-day services of a population health entity (such as an ACO). Finally, the aggregator may enter into more limited services agreements with each participating provider, under which it performs a specific set of services in exchange for a fixed fee (for example, data analytics, performance reporting or compliance with regulatory requirements).

The terms of these arrangements can vary greatly depending on the parties' goals. Still, in general, these arrangements usually involve a payment from the payer to a population health entity at least partly owned or controlled by the participating providers. The entity or the participating providers then pay the aggregator a fee that may include various elements, such as an ongoing periodic (monthly or annual) fixed fee, a capitated fee and a portion of any population health bonus payment earned. The agreement may specify how any population health bonus payment or downside risk payment will be divided among the aggregator and participating providers, or it may establish a process (such as a committee structure) to divide up any such payment obligation.

As a variation on the contractual arrangement, an aggregator relationship may involve management of all day-to-day back-office functions of each of the participating providers (that

is, the physician practices). This structure operates similarly to a managed services organization (MSO), under which the aggregator acts as a manager and receives management fees from the practice. The AMA has published other resources on private equity-backed arrangements, which are frequently structured as MSO arrangements. Under these arrangements, the manager typically purchases all the physician practice's nonclinical assets (often including real estate, furniture, equipment, technology, supplies, intellectual property and, in some states, medical records), employs its nonclinical personnel, and takes responsibility for most of its nonclinical functions. The manager may also set up a wholly owned ACO or convener entity and select the physician and non-physician members of its Board. This structure differs from a typical MSO relationship because, in this case, the practice becomes a participating provider as part of a network operating under a value-based care arrangement. As a result, these arrangements are often called value-based management service organizations (VB-MSOs). This arrangement allows the VB-MSO to roll out consistent practice management and population health management policies across a large network of managed participating providers. Among other things, because this structure allows the VB-MSO to negotiate directly on behalf of its network, it presents an attractive partner for payers.

Perhaps the most integrated aggregator arrangement is a single practice that directly employs other physicians to facilitate participation in value-based care. Under that arrangement, the practice entity purchases other practices, and the physicians become directly employed by the aggregator itself. The aggregator essentially combines the direct practice of medicine with functions provided by a VB-MSO. Although this arrangement is highly integrated, it has downsides. For example, it is difficult for non-physicians to invest in a physician practice entity (and sometimes prohibited under state law), which may then limit capital investments. It is also often difficult to operate a single, national practice entity due to differing state laws. Finally, physicians may have limited influence over the governance and operations of this kind of aggregator, depending on the structure of the ownership agreement.

Key consideration

It may be tempting to view the legal structure of the population health entity as a formality, since the short-term, practical outcome is the same: the aggregator takes responsibility for operating most population health functions. However, the structure has important implications, especially in the event of a dispute. Practices should understand key business terms of the arrangement, including the owner of any population health entity, any unique reserved powers held by the aggregator, the conditions of applicable financial and/or loan agreements, how funds flow from the payer to the participating providers, and their rights in the event of a dispute.

c. What business functions will the aggregator provide?

Aggregators may provide various business functions. As mentioned above, some aggregators provide full "day-to-day" management services, while others provide a more targeted set of services. The agreement between the aggregator and the applicable entity (either the population health entity or the participating provider) will spell out the services to be provided. These are often detailed in a "scope of work" attached to the contract.

Key consideration

The list of potential services is voluminous, but some examples include:

- Preparing an application for governmental value-based care programs and creating legal entities and contracts that comply with program requirements;
- Implementation of standardized tools and processes, including an interoperable electronic health record platform and information technology tools to report performance data to payers;
- Data analysis to ingest data from payers, providers, and other partners (for example, hospital participants in the value-based care arrangement), identify savings opportunities and provide ongoing outcomes feedback to providers;
- Implementation of process improvements, including improvements in scheduling, patient follow-up and clinical documentation;
- Maintaining a knowledge base about applicable value-based program rules, including adjusting strategy to address changes in regulations, manuals and market conditions; and
- Helping participating providers integrate supportive functions into their workflow, including care coordinators, social workers, dietitians, transportation vendors and other services intended to address social determinants of health.

One special category of services involves direct negotiations with payers. Some aggregators may function in a manner similar to traditional joint negotiating entities like independent practice associations (IPAs) or physician-hospital organizations (PHOs). In that case, the aggregator may be required to meet legal requirements applicable to these entities. The participating provider agreement may also include additional language covering the participating provider's rights with respect to agreements negotiated by the aggregator, including any applicable rights to opt-out of any agreement. However, because value-based care arrangements often involve complex arrangements requiring collective management of a patient population, aggregators often require all participating providers to participate in substantially all payer agreements.

Key consideration

Aggregator agreements can have substantial implications for unwary providers. For example, rates negotiated as part of a comprehensive value-based arrangement may conflict with, or possibly even supersede, a practice's independent agreement with the same payer. For this reason, participating providers should ensure they understand an aggregator's ability to negotiate on their behalf, as well as their ability to review and understand the implications of any payer agreements.

d. What are some unique business goals of aggregators?

Given the diversity of structures for aggregator relationships, providers may wonder how these arrangements differ from other common health care structures. For example, aggregators often have the same basic legal structure as MSOs, IPAs, ACOs or large practice entities.

However, aggregators have certain unique concerns because their core strategy involves participation in value-based care arrangements that collectively evaluate the performance of multiple providers. Many aggregators explicitly intend to create sizeable networks that furnish care to many patients because larger patient populations are generally easier to actuarially model and are less vulnerable to the impact of unusual or outlier cases.

In addition, while many MSOs and similar organizations attempt to standardize processes, this effort has heightened urgency in value-based care arrangements. Standardization and interoperability are essential parts of aggregators' strategy because, in most arrangements, no population health bonus payment can be earned unless participating providers achieve certain standards (often, each participating provider must meet minimum standards, and all participating providers must collectively achieve certain average or median performance standards). Because of this, aggregators often insist that participating providers adopt consistent vendors, processes and tools to ensure a high degree of consistency. This also helps aggregators identify potential interventions to improve quality and reduce costs.

Physician business considerations in working with an aggregator

a. What are the advantages and disadvantages of working with an aggregator?

Given the wide diversity of possible aggregator relationships, physicians may find themselves struggling to compare different opportunities. The right choice for a physician's practice will depend on the practice's financial and operational goals, desire for autonomy, culture and experience with value-based care. Physicians should keep certain concepts in mind when assessing aggregator opportunities.

Overall goals

- *First, physician practices should carefully consider their overall goals by asking themselves the following questions: Why are we interested in value-based care?*

  For example, is our practice interested in innovation in care delivery, a modified practice style less reliant on fee-for-service payment, an improved contracting posture with payers and/or access to additional revenue opportunities through population health bonus payments?

- *Which value-based care opportunities are we interested in exploring?*

  Are we focused on a specific value-based care initiative (such as the MSSP or TEAM models), or are we looking for help building a platform to participate in multiple initiatives and possibly negotiate new initiatives?

- *What degree of operational control are we willing to delegate to the aggregator entity?*

  Do we need help performing a specific function (e.g., data analytics, actuarial analysis) or are we looking for a more comprehensive solution that performs many functions (possibly even all practice business functions)?

- *What kinds of infrastructure investments are we willing to accommodate in terms of new information technology (potentially including a new electronic health record), new personnel who need to be integrated into existing clinical workflows and modified documentation practices?*

  Who will be responsible for paying for and implementing any infrastructure investments?

- *Is our practice prepared to take on financial risk?*

  In other words, is the practice comfortable taking the chance that it may need to make a payment in exchange for the opportunity to earn a potentially significant population health bonus?

Value-based care experience

Practices should also assess their experience with value-based care. Practices differ in their familiarity with value-based care arrangements. Some have participated in full cycles of previous arrangements (whether voluntary or mandatory), others may have participated for a short period of time, while still others have not participated at all.

If your practice has previous experience with value-based care, consider questions like these:

- *Has your practice adopted resources like updated electronic health record systems, internal data reporting, care coordination staff and protocols, and mechanisms to report data to payers?*
- *Can existing or prior investments be leveraged to support a relationship with a new aggregator?*
- *If the aggregator requires a different infrastructure (such as a new electronic health record system), who pays for these investments?*
- *What worked and didn't work in your practice's prior experience?*

  Why did your practice decide to end its prior participation? Were there notable areas of strength or weakness? What were the effects on the overall business, including practice finances, efficient management of resources and physician morale?

Key consideration

Note that aggregators sometimes require modifications in these systems and processes; practices may be able to avoid certain expenses by working with aggregators who can adapt to their existing practice investments.

On the other hand, if your practice does not have experience with value-based care, it may require different kinds of services from the aggregator. In addition to the overall questions listed elsewhere in this agreement, practices should consider the following cultural issues:

- *Who is responsible for making any practice investments, such as new data systems or personnel?*
- *What kinds of flexibility do you have in picking your own practice infrastructure and maintaining any practice investments after the arrangement ends?*

  For example, if the arrangement terminates, will you need to implement an entirely new practice management system?
- *What kinds of ongoing communication and training will be necessary to incorporate value-based care principles into the practice culture?*

  Although an aggregator can help with this process, existing practice leadership should be integrally involved in these efforts to ensure any practice modifications are aligned with the practice's existing culture.
- *How will the practice's physicians respond to modifications in practice features that may include internal and external data reporting expectations, communication tools, financial incentives and other mechanisms to align the practice with the goals of value-based care?*

  Are certain changes higher priority than others? Would certain kinds of information sharing or processes (for example, a dedicated oversight committee) help make physicians comfortable with these changes?

Outside vendors

Practices should also assess their culture with respect to working with outside vendors, including:

- *How do physicians in our practice prefer to receive information regarding opportunities to improve the cost or quality of care?*

  For example, do they prefer receiving raw data they can interpret to guide their practices, or more precise guidance regarding potential opportunities to change clinical practices or improve care coordination?
- *How much does the practice value autonomy and independence?*

  Will physicians in the practice prefer an arm's-length vendor relationship with limited scope (for example, dashboard reporting and periodic consultation) or would they be comfortable delegating a significant share of practice business functions to a management company?
- *Are physicians in the practice comfortable with practicing as part of a network, which may be tightly managed?*

  Value-based care efforts often involve tight integration between physician practices and other entities (like hospitals or post-acute care providers). "Leakage" out of the network may impact the population health entity's ability to manage costs and earn performance-based bonus payments. Physicians may be required or encouraged to refer to providers who have adopted certain kinds of care protocols, information technology systems or other features. Practices should evaluate whether their physicians would be comfortable with that kind of network management.

- *What kinds of governance rights will physicians in the practice expect to have?*

  Some practices prefer to maintain a minimum level of involvement (simply submitting data and collecting any payments), while others may wish to be involved in governance by sitting on the population health entity's governing body, quality committees or similar entities. Note that some governmental models (such as ACOs) require participant representation on the governing body.

- *What is the relationship between the various specialties in the practice?*

  Value-based care relationships often create opportunities that benefit some specialties more than others. For example, total cost of care arrangements like ACOs generally base attribution on primary care services. This means the practice's performance is largely based on the number and efforts of primary care physicians. Episode-based arrangements may depend on specific specialties (for example, joint replacement arrangements are heavily dependent on orthopedic surgeons). The practice, therefore, must consider existing dynamics between physicians of different specialties and consider how the introduction of value-based care funds may impact those relationships.

- *Does the practice have significant business or referral relationships with other entities, such as hospitals?*

  If so, practices should consider whether the aggregator is supportive of those existing relationships. Aggregators sometimes ask participants to integrate with specific preferred providers – for example, they may be aligned or affiliated with one specific health system in a community. These aggregator relationships may conflict with existing business relationships, like call coverage, medical director or staffing agreements. Therefore, a practice's shift to the aggregator's preferred relationships may disrupt the practice's business relationships or patient care. If conflicting relationships exist, a practice may be able to negotiate a carve-out with the aggregator.

Economic terms of aggregator relationships

Finally, the practice should understand the economic terms of the deal with the aggregator by asking the following questions:

- *How does the aggregator get paid?*

  Aggregators use a variety of fee structures, including guaranteed monthly or annual fees, capitated per-member payments and a percentage of population health bonus payments. Depending on the structure, they may also collect profits from entities like ACOs, conveners (population health entities that receive or manage bundled payments) or management companies. Practices should clearly understand how the aggregator makes money. For example, is the practice required to make ongoing payments even if the aggregator is not successful under a value-based care arrangement? How much of any population health bonus payment will be paid to the practice vs. retained by the aggregator?

- *What is the flow of funds?*

  Practices should understand the full flow of funds from the payer to the practice, any intermediary entity (such as an ACO or convener) and the aggregator. This can be challenging in value-based care arrangements, which sometimes involve a mix of fee-for-service payments to providers, population health bonus payments to an ACO or convener, and potentially other payments like capitated payments to community partners or financial incentives for beneficiaries. It's essential for practices to understand the flow of funds for purposes of timing, ensuring accuracy and resolving disputes. In particular, practices should understand any "waterfall" structure, in which multiple entities successively draw payments from a single population health bonus payment in a specified order; entities atthe "bottom" of the waterfall (later in the order) may receive few or no funds after the entities "higher" in the waterfall have deducted their fees.

- *How are payments to the practice calculated?*

  Does the aggregator apply a compensation formula, or is there a discretionary component? Who makes the decision and/or applies the calculation? If a committee is responsible, does the practice have representation? Does the practice have the right to review the underlying data and methodology used? If the calculation is dependent on data or information from the payer or the government, does the practice have access?

- *What timing requirements apply to the process of calculating and disbursing any payments?*

  When will any reconciliation occur (often months after the end of a performance year)? How soon thereafter will the population health entity pay the practice? Is payment dependent on any other condition that could introduce delays (for example, ACO participation agreements often say they are not required to make any payment until the ACO population health entity receives shared savings payments from CMS)? If the practice disagrees with the population health entity's calculation, is it required to provide notice of its objection within a certain timeframe? Does the population health entity provide any advance payments or infrastructure investment payments during the performance year, and if so, are these payments deducted from any population health payments as part of the reconciliation?

- *What kinds of investments does the practice need to make?*

  For example, will the practice be required to buy new software, hire new personnel or incur other expenses to participate in the aggregator's strategy? Will the aggregator assume responsibility for some of these expenses? What happens if the practice fails to implement required changes – for example, termination from the aggregator, forfeiture of payments or obligation to repay?

- *How does the aggregator intend to manage any downside risk payments?*

  Does it have a plan to avoid downside risk payments (for example, by maintaining a large number of covered patients)? Does it manage risk through reinsurance, a surety bond or similar repayment mechanisms? If so, is the practice required to contribute to any ongoing costs of maintaining that mechanism? If the aggregator incurs a downside risk payment, will the practice be required to contribute to this payment?

- *How will relationships with the aggregator impact the practice's internal compensation plan?*

  For example, will there be new revenue opportunities that may be paid out as compensation? Are there restrictions on how any new population health revenue can be used? How will any compensation changes be developed and implemented (for example, determined by the CFO, implemented through a compensation committee, etc.)? Are compensation model changes within the aggregator's scope of services?

- *How will the practice be impacted by the actions of others in the aggregator's network?*

  Many value-based arrangements make payments based on the collective performance of multiple unrelated providers. For example, an ACO earns shared savings if the aggregate costs attributable to all its participants are below a benchmark (also based on all providers) and the ACO's participants collectively meet certain quality metrics. Therefore, the quality and composition of the aggregator's network are important considerations for any participating practice. Participants who do not control expenses or have poor quality scores can reduce or eliminate the aggregator's population health bonus payment. Aggregators have different strategies for managing their networks. Some seek to create large, geographically diverse networks because a large patient population is less likely to experience significant cost events that could require downside risk payments. Others maintain smaller networks to focus on certain geographic areas or clinical issues. Aggregators should be able to explain their criteria for joining and remaining in the network. Different aggregators also include their participants in this process in different ways. Some include participants in decisions about new participants, others allow participants to terminate upon the addition of a new participant, while others inform existing participants about any new participant but do not offer them an opportunity to terminate.

b. What documents should I review to understand the terms of my participation in the aggregator strategy?

Due to the diversity of potential aggregator arrangements, it is not possible to provide a full list of potentially relevant documents. However, common agreements include the following:

- *An agreement under which the participant agrees to participate in a network operated by the aggregator.*

  This is often called a "Network Agreement," "Participation Agreement" or a similar name.

- *An agreement detailing the responsibilities of the aggregator.*

  The parties to this agreement may vary. It may be established as an agreement between the aggregator and the practice, or between the aggregator and an entity like an ACO. In any case, this agreement should include a list of the identifiable services provided by the aggregator and include important contract terms including the term (length) of the arrangement, rules around termination, dispute resolution processes, ownership of any intellectual property, conditions for the practice's participation, payment due to the aggregator and potentially a description of the overall economic model. This agreement is often called something like a "Services Agreement" or "Management Agreement."

- *An agreement reflecting the terms of the applicable value-based care arrangement(s).*

  This may or may not be in place at the outset of the practice's agreement with the aggregator. This is an agreement between a payer and one or more of the aggregators, practices or other entities (such as an ACO or convener). This agreement should cover the payer's administration of the value-based care arrangement, including attribution rules, the method of calculating any population health payment(s), timelines for calculating and paying any population health payments, criteria for any downside risk payments (including any required risk management tools), data to be shared/reported by each party, term and termination rules and the location of manuals or other information outside the agreement that might affect its application. This agreement is often called something like "Accountable Care Organization Agreement," "Value-Based Participation Agreement," "Model Agreement" or a similar name.

- *The agreements should include a clear description of the overall financial agreement between the practice, the payer, the aggregator and any other relevant entities.*

  This should address the method of funds flow, the amount of distribution to the practice, any requirements for the practice to modify its compensation policies, whether any "waterfall" applies, whether any amounts will be deducted from the practice's population health payments (for example, for overhead costs, infrastructure payments or failing to earn payments in prior years), and the treatment of any earned payments if the agreement terminates. The financial terms may be included in a standalone agreement or included as an exhibit or attachment to another agreement between the aggregator and practice (or sometimes the practice and an ACO or other intermediary entity). Certain governmental programs require the terms to be set out in structured agreements that meet federal rules (for example, the TEAM model sets out requirements for "Sharing Agreements" for certain arrangements between hospitals and practices).

- *Operational agreements reflecting certain services provided or arranged by the aggregator.*

  For example, if the aggregator is helping to add new care coordination staff to the practice, it may provide form employment or personal service agreements that the practice can use. If it provides or requires the use of a particular software solution, that arrangement may have a separate license agreement.

Key consideration

Although operational agreements are often treated as "boilerplate," they are binding legal agreements that apply to the practice (and may not apply to the aggregator), so the practice should carefully review them and ensure it can comply with any terms.

- *Value-based care arrangements involve sharing a significant amount of personal data, including protected health information (PHI) regulated under HIPAA.*

  Practices should ensure that the proper agreements are in place covering this data. Business Associate Agreements (BAAs) may be attached to any or all of the agreements described above. In addition, the payer may require compliance with a Data Use Agreement (DUA). These agreements can impose obligations on the practice, including data retention, destruction of PHI, restrictions on use of any data provided (sometimes including restrictions on deidentification or creation of other materials using the data) and limitation of liability to other third parties.

c. Are there any regulatory considerations my practice should keep in mind when working with an aggregator?

As with other parts of the health care industry, relationships between practices and aggregators are subject to certain regulatory constraints. Practices should be particularly cognizant of these considerations, especially in cases where aggregators are primarily technology entities that may have limited health care industry experience. Physicians should involve their own legal counsel to ensure they are comfortable with the overall arrangement.

Examples include:

- *Physicians continue to be responsible for their own licenses to practice medicine, and practices remain responsible for complying with the ongoing obligations of payer credentialing requirements, which may limit clinicians' ability to delegate certain services to others.*

  Although aggregators generally can provide advisory and nonclinical services, they cannot engage in the practice of medicine unless they are, in fact, set up as physician practices. Physicians should be aware that they may continue to bear responsibility for actions undertaken while practicing medicine, including, for example, from the perspective of license, medical staff and professional liability requirements. Practices should ensure that any agreements with aggregators make this division of responsibility clear.

Key consideration

Although physicians are responsible for ongoing compliance with payer credentialing requirements, an aggregator may help the practice navigate the process of obtaining or renewing payer credentials and may develop policies, procedures and workflows to help keep the practice compliant with these requirements.

- *Depending on the structure of the aggregator relationship, it may be required to obtain its own set of state licenses.*

  For example, several states require IPA arrangements, ACOs or entities accepting downside risk to obtain special licensure and meet legal requirements. Governmental value-based models also often have their own set of regulatory requirements. The practice should evaluate whether the aggregator understands its obligations under state and federal law. Any agreement between the practice and aggregator should require the aggregator to promise it complies with applicable law, and make it clear who is responsible for ongoing compliance with applicable standards.

- *Any financial relationship involving a healthcare provider must be evaluated for compliance with federal and state fraud and abuse laws.*

  The Anti-Kickback Statute, Physician Self-Referral Law, Beneficiary Inducement Statute and similar state laws put constraints on relationships between physicians and other entities. Many of these laws limit the exchange of anything of value or require that any payments be at "fair market value," which may be difficult to assess given the difficulty of predicting the availability or size of any population health payment. Some governmental programs have established waivers of these laws, and there are certain exceptions and safe harbors available for value-based care arrangements, but these are complex.

Termination and unwinding of aggregator relationships

Finally, practices should understand their right and practical ability to end the relationship. Aggregator relationships tend to involve much more integration than typical vendor arrangements. Although it may be counterintuitive to enter a legal arrangement thinking about its possible failure, it is important to consider these issues at the beginning of the arrangement to make sure they are addressed in relevant agreements.

First, value-based care arrangements often involve longer timeframes than payer agreements or affiliations with other common partners like health systems. Many health care arrangements are structured on relatively short terms (one or two years), and it's not uncommon for either party to have the right to terminate the agreement without cause. However, many value-based care arrangements require participants to agree to longer terms of five years or more. Aggregator arrangements often limit a party's ability to terminate without cause and often set the effective date of termination to the end of a calendar year to align with value-based care model programmatic rules. Finally, the timing of payments can create challenges for termination, since any population health bonus payment is usually made several months after the end of a performance year. Aggregator arrangements often specify that, if a practice terminates its arrangement, it forfeits any outstanding population health bonus payments. These provisions can make it difficult for a practice to effectively terminate contracts with the aggregator.

Second, aggregator relationships generally involve significant changes to the practice's administration. Aggregators may provide new electronic health record systems, powerful data and analytic capabilities, exclusive software, leased employees and other elements of practice infrastructure that may be difficult or expensive to replace. Aggregators also often build a tight network of providers who have committed to sharing information and facilitating care management. As a result, unwinding aggregator relationships may have implications for a practice's ability to coordinate care with specialists, hospitals or other care partners who remain within the aggregator's network. There may be financial implications as well.

Key consideration

Upon termination of the agreement, aggregators may demand repayment for costs incurred on the practice's behalf, potentially including repayment of any infrastructure investment funds paid to the practice.

These challenges may also be affected by the type of aggregator relationship. Unwinding a VB-MSO arrangement raises some of the same challenges as unwinding other MSO arrangements. If the practice's physicians have joined a new practice entity, termination of the agreement may mean starting over without office space, equipment, personnel or payer agreements. If the aggregator functions as an IPA or other contracting entity, departure from the aggregator may mean termination of any payer agreements it negotiated. Conversely, a less intensive service vendor relationship may be easier to disentangle.

Conclusion

Aggregators play a growing role in the health care system's transition to value-based care. Many practices will have opportunities to evaluate potential relationships with different kinds of aggregators. However, aggregator relationships can be difficult to understand and evaluate in light of the wide variety of value-based arrangements, aggregator structures and possible legal and financial relationships. The right partner can help a practice maximize its success under value-based care arrangements, including by increasing payments, transforming care, prioritizing clinical and human resources more effectively, and aligning more closely with government and commercial payer initiatives. Still, there are many potential pitfalls in working with aggregators, often due to mismatches between practice and aggregator goals and values. Practices can ensure they are well-positioned for success by clearly articulating their value-based care goals, learning from their prior experiences with vendors, conducting due diligence to fully understand the aggregator's goals and capabilities, and keeping the considerations described in this document in mind as they review and negotiate agreements with aggregators.

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