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MMS Guide to Accountable Care Organizations: What Physicians Need to Know

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I. Physician's Guide to Accountable Care Organizations

An accountable care organization (ACO) is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.¹ The provider composition of an ACO can vary and may include:²

- Integrated delivery systems (including hospitals and health systems)
- Physician group practices/physician organizations
- Physician hospital organizations (PHOs)
- Independent practice associations (IPAs)
- Virtual physician organizations

Through an ACO, participating providers can enter into agreements with payers to be accountable for managing the care of a defined population of patients under which they are offered the opportunity to receive payment incentives for providing high-quality, coordinated care in a cost-effective manner.³ This is achieved through a clinically integrated network of providers (e.g., primary care physicians [PCPs], specialists, hospitalists, and other care clinicians⁴) who follow common clinical protocols and have aligned measures and incentives based on improved value. For the independent medical practice, participation in an ACO can offer the opportunity, in partnership with other providers, to develop capabilities in management of a population that the market is increasingly demanding of providers.

In the shift toward a value-based health care and reimbursement environment, ACOs can leverage various strategies and tactics to achieve their mission, including disease management programs, improved care coordination, the use of nonphysician providers such as nurse practitioners and other health professionals, and health care information technology (HIT).⁵

A. KEY ATTRIBUTES

The shift from a volume- to value-based reimbursement environment necessitates the creation of a culture of collaboration, innovation, and accountability. According to Elliott S. Fisher, MD, MPH⁶, who coined the term “accountable care organization,” there are three core attributes that must align to effectively support an ACO and its providers in improving care. These three attributes are organized care, payment reform, and performance measurement.⁷

- *Organized Care* — An ACO needs to be able to effectively manage and provide a continuum of care to the patients for which it is accountable. The ACO can provide a vehicle through which participating providers can work collectively to transition their care delivery model to one designed to enable greater accountability for the overall care of a patient and support more informed clinical decision making, while improving quality and lowering cost. This can be achieved by further aligning entities (such as hospitals and physicians) and providing coordinated care to ensure that the patient is receiving the right care at the right time in the proper setting.

¹D.R. Rittenhouse, S.M. Shortell, and E.S. Fisher, “Primary Care and Accountable Care — Two Essential Elements of Delivery-System Reform,” *The New England Journal of Medicine*, 361:2301–2303, 2009.

²S.M. Shortell, L.P. Casalino, and E.S. Fisher, “How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations,” *Health Affairs*, 29:7, July 2010.

³S.A. Berkowitz and E.D. Miller, “Accountable Care at Academic Medical Centers — Lessons from Johns Hopkins,” *The New England Journal of Medicine*, 364:e12, 2011.

⁴D.M. Berwick, “ACOs — Promise, Not Panacea,” *JAMA: The Journal of the American Medical Association*, 308:1038, 2012.

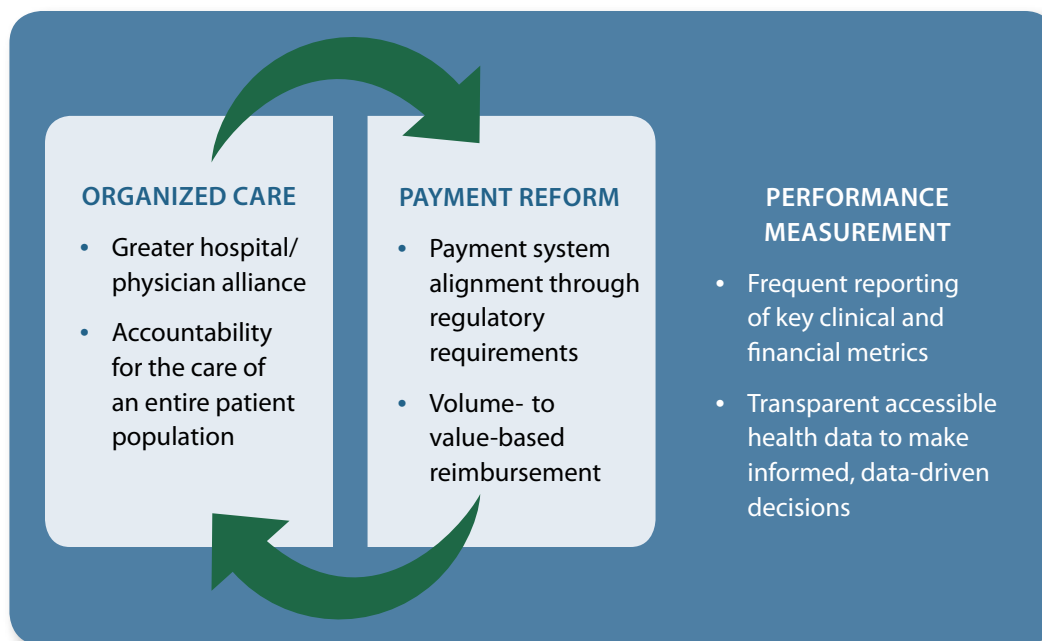
⁵L.R. Burns and M.V. Pauly, “Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s,” *Health Affairs*, 31:2407–2416, 2012.

⁶Dr. Fisher is the Director of the Center for Population Health at The Dartmouth Institute for Health Policy and Clinical Practice and Director of the Dartmouth Atlas of Health Care.

⁷“Perspective Roundtable: Creating Accountable Care Organizations,” *The New England Journal of Medicine*: <http://www.nejm.org/doi/full/10.1056/NEJMp1009040.pdf>.

- *Payment Reform* — It is important that payment reform accompany care delivery reform to provide a sustainable economic model that recognizes and rewards high-quality, cost-effective care. The prevailing fee-for-service (FFS) reimbursement model provides incentives for increased volume and does not effectively support or reward the development and ongoing operation of effective population health management.
- *Performance Measurement* — An ACO needs to be of sufficient size to support comprehensive performance measurement and have the analytic capabilities to be able to interpret data. An appropriate IT infrastructure is necessary for collecting, analyzing, and connecting clinical and financial data to demonstrate the impact on quality and efficiency.⁸

FIGURE 1.1 | Key Attributes of an ACO



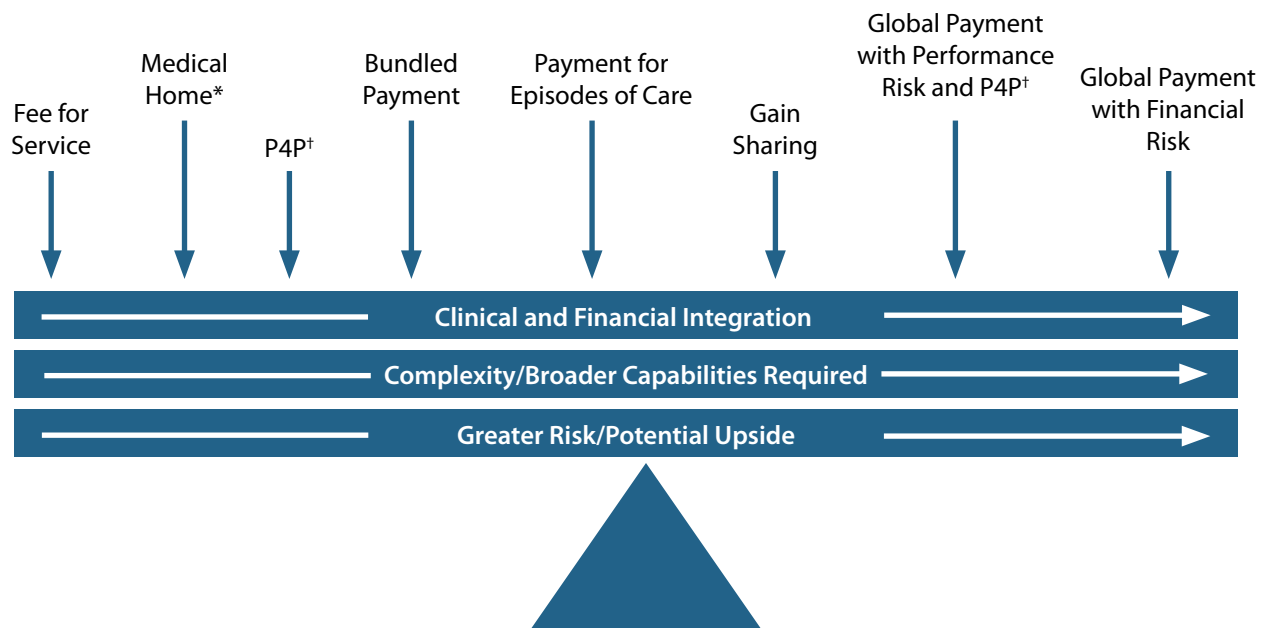
Implementation of each of these reform strategies must be carefully considered and should not be undertaken in isolation. For example, development of population health management capabilities without establishing new payment models with payers could leave organizations with higher costs and no mechanism through which savings associated with improved health and reduced cost for the population can be shared. Conversely, in order to successfully operate under value-based payment models, providers need to develop the capabilities for proactive management of the health of their patient population.

Ultimately, as the ACO evolves and accepts greater levels of financial accountability for management of the patient population, success will require an increasingly higher degree of financial and clinical delivery integration, as illustrated in Figure 1.2 (on the following page). While current payment systems are more transactional in nature, population health management payment methodologies, such as global or shared risk, require a more strategic partnership not only with payers but especially among ACO providers. Therefore, the pacing of clinical and financial integration activities is paramount as ACOs and other clinically integrated organizations attempt to create a meaningful prospect for achieving integration and appropriately managing utilization. Transitioning

⁸Ibid.

from a lower risk FFS model to a value-based payment model with increased risk share takes time, and the organization must adapt and progress through phases of integration before achieving a state of full risk acceptance.

FIGURE 1.2 | Financial and Clinical Integration of an ACO



*Medical homes that receive extra dollars for patient management.

†P4P = pay for performance

Source: Healthcare Financial Management Association, "Accountable Care: The Journey Begins," August 2010.

B. RANGE OF ACO CONTRACTS

Through the ACO, providers can participate in contracts with a range of payers for management of a patient population. These will include government-sponsored initiatives (e.g., the Medicare Pioneer ACO Model) which will be based on more explicitly defined business and regulatory requirements for participation and private and commercial payer arrangements the terms of which will be negotiated and can vary by ACO/payer. The subsections below describe and highlight some of the unique attributes of ACO agreements with public and private payers.

1. ACO Agreements with Medicare⁹

Perhaps the most highly publicized ACO agreements are those with Medicare. Medicare offers two ACO models, which include the Pioneer ACO Model and the Medicare Shared Savings Program (MSSP).

Under each of these models:

- The ACO is accountable for management of defined patient population.
- Patients are assigned to the ACO based on the physician who is identified as the primary care provider based on the patients claims data.
- Rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care.

⁹Accountable Care Organizations (ACOs), CMS overview, 2012: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco.

Selected Characteristics of the Pioneer ACO Model

- There are 32 ACOs participating the Pioneer ACO Model nationally, five of which are in Massachusetts.¹⁰
- The Pioneer ACO model was designed for organizations that are already experienced with coordinated care delivery models to test new and innovative payment models.
- Includes provisions for the ACO to accept shared-risk and higher potential for shared savings than the MSSP model. The level of risk and potential shared savings increases over time and as the ACO demonstrates its ability to reduce costs while meeting defined quality standards.
- Requires a minimum patient population of 15,000 (5,000 in rural communities).

Selected Characteristics of the MSSP Model

- There are 220 ACOs participating in the MSSP nationally, 13 of which are in Massachusetts.¹¹
- The MSSP Model includes two participation options referred to as Track 1 and Track 2:
 - Track 1 offers the potential for the ACO to earn a bonus payment if it is able to lower the growth in medical costs for its assigned patient population while meeting performance standards on quality.
 - Track 2 involves some shared-risk for the medical costs (i.e., if the costs are above the targeted level the ACO is liable for a portion of that difference) but also has the opportunity to share in a higher percentage of any savings.
 - Of the 220 ACOs participating in the MSSP, only 8 are in Track 2.
- Requires a minimum patient population of 5,000.

CMS also provides numerous resources to physicians seeking to understand the components of the various public programs through the Center for Medicare and Medicaid Innovation (CMMI) Accelerated Development Learning Session.¹²

2. Private Payer ACO Agreements

ACOs or other forms of clinically integrated provider networks can also participate in contracts with private payers to manage a defined patient population. Unlike with Medicare ACO models, the private payer contract terms are based on negotiated arrangements and can therefore differ by specific contract and payer.

In the Massachusetts market, as is the case nationally, there has been a renewed interest in risk-based contracting arrangements over the past several years. Based on the April 24, 2013, report on the “Examination of Health Care Cost Trends and Cost Drivers” published by the Massachusetts Attorney General’s office:¹³

- Risk contracts among Blue Cross Blue Shield of Massachusetts (BCBSMA), Harvard Pilgrim Health Care and Tufts Health Plan increased from approximately 19 in 2008 to 34 in 2012.
- BCBSMA has established global payment models with 17 provider organizations through its Alternative Quality Contract (AQC) contracts.
 - This includes the addition of six new contracts since 2010.
 - Nearly 400,000 members have a PCP who participates in the AQC contract.

¹⁰Map of Medicare ACOs in Massachusetts, Massachusetts Medical Society (MMS): www.massmed.org/ACOMap.

¹¹Ibid.

¹²https://acoregister.rti.org/index.cfm?fuseaction=dsp_home.

¹³www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf

In addition, Cigna and Baycare Health Partners, a Springfield, Mass., based PHO, recently announced that they have launched a “collaborative accountable care” (CAC) initiative, representing Cigna’s first ACO program in Massachusetts.

CAC is Cigna’s approach to accomplishing the same population health goals as ACOs. The program will include more than 17,000 individuals covered by a Cigna health plan who receive care from Baycare’s 413 primary care physicians.¹⁴

ACO contracts with private payers are gaining momentum throughout the country. In fact, by one report, the private sector is outpacing Medicare by a four-to-one margin in terms of ACO formation.¹⁵

While historically the majority of provider-sponsored ACOs were developed by hospital systems, over the past 2 years, physician groups are more commonly the sponsoring entities of ACOs. According to *Health Affairs*, the majority of ACOs in the United States (56%) are now sponsored by physician groups, surpassing those sponsored by hospital systems (36.5%).¹⁶

Unlike Medicare, private ACO contracts may offer a number of alternative payment arrangements such as sub-global budgets, case rates, bundled payments, and limited networks. They can also incorporate a hybrid approach to payment incentives, ranging from one-sided shared savings (e.g., upside savings only) within a FFS environment to an array of limited or substantial global budget arrangements with quality bonuses and two-sided risk (e.g., from partial to full-risk). Each contracting vehicle has unique considerations with varying levels of risk assumption.

C. OTHER ACO ACTIVITY IN MASSACHUSETTS

Chapter 224 of the Acts of 2012 included many provisions related to the development and expansion of ACOs and alternative payment methodologies in Massachusetts. More specifically, provisions of the law related to ACOs and adoption of alternative payment methodologies require:¹⁷

- The Commonwealth Health Insurance Connector Authority (Connector), the Group Insurance Commission (GIC), and the Office of Medicaid implement, to the maximum extent possible, alternative payment methodologies.
- The Executive Office of Health and Human Services (EOHHS) seek a federal waiver to allow Medicaid to participate in alternative payment methodologies.
- Private health plans, to the maximum extent possible, to reduce the use of fee-for-service payments.
- The Office of Medicaid to enroll its members in alternative payment contracts, with the goal of shifting 80 percent of its members, excluding those with other insurance such as Medicare or private insurance, into alternative payment contracts by July 1, 2015.
- The Office of Medicaid increase payment rates by two percent to providers that accept alternative payment methodologies from the Office of Medicaid or Medicaid managed care organizations.
- The establishment of a certification process for accountable care organizations. These ACOs would receive a contracting preference in state health programs.

¹⁴<http://newsroom.cigna.com/NewsReleases/baycare-health-partners-and-cigna-start-accountable-care-program-to-improve-health-and-lower-costs.htm>

¹⁵Jay Nawrocki, “The Number of ACOs Continue to Grow, but Mainly in the Private Sector,” June 22, 2012.

¹⁶<http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations>.

¹⁷Blue Cross Blue Shield of Massachusetts Foundation: *Summary of Chapter 224 of the Acts of 2012*; September 2012.

II. Key Considerations for Joining an ACO

Physicians should be thoughtful and thorough in their deliberation regarding ACO participation. While participation in an ACO may facilitate the transition into a value-based reimbursement environment, physicians must carefully contemplate the possible financial, operational, and strategic implications of the transition. As such, ACO participation should be considered through various perspectives, including:

- What should physicians consider before joining an ACO?
- What are the benefits and challenges of joining an ACO?
- How to choose the right ACO for you?
- How ready is my practice?

The following sections provide details around each of these perspectives as they relate to ACO participation.

A. WHAT SHOULD PHYSICIANS CONSIDER BEFORE JOINING AN ACO?

Deciding whether or not to join an ACO is a strategic decision that must be carefully considered relative to your unique circumstances. The table below identifies key questions to consider when determining whether or not to join an ACO.¹⁸

TABLE 2.1 | Determining Whether to Join an ACO

QUESTION	RELEVANCE
Do you currently belong to an IPA/PHO or other organization that meets your needs?	If you currently belong to an IPA/PHO or other organization that meets your needs, what, if anything, is it doing to meet the future challenges of operating in a value-based reimbursement environment? Has it required that/enabled you to adopt a common electronic medical record (EMR) system? Is your IPA democratically governed so that you are offered a forum to formally express your preferences? To what extent does IPA participation advance your clinical, business and personal goals?
What are the local provider dynamics within your community?	If hospitals are providing essential medical services to high-acuity patients only and not competing for outpatient services, then the market dynamics of your community may not be changing as rapidly as in other areas. If, on the other hand, hospitals are aggressively aligning with other physicians, your ability to compete against these larger entities may be impacted. Such competitive dynamics may be a driving factor for ACO participation.
What are the local payer dynamics?	If local payers are already looking to cut reimbursement and/or introduce new payment models then that movement may compel your practice to position for change. A key consideration is whether the practice has an effect on controlling medical spending while quality and then in return whether the practice should position to be paid for affecting that change.

¹⁸ "ACOs and other Options: A 'How-to' Manual for Physicians Navigating a Post-Health Reform World," 4th edition, AMA, Copyright 2010–2012.

TABLE 2.1 | Determining Whether to Join an ACO (continued)

QUESTION	RELEVANCE
Geographic Coverage	<ul style="list-style-type: none"> • What is the geographic coverage of your current patient base? • Does the ACO network of providers correspond to that coverage level?
Readiness for Value-Based Reimbursement	<ul style="list-style-type: none"> • What are the types of value-based reimbursement are you willing and able to accept? • Are you willing/prepared to accept a risk-based arrangement under which there is the potential for loss, but also a potential for greater gain?
Organizational Structures	<ul style="list-style-type: none"> • How much integration with the ACO network do you envision for your practice?
Provider Relationships	<ul style="list-style-type: none"> • Are the physicians and hospitals with which your practice currently has relationships participating in the ACO? • Are there services available that complement your specialty and will allow your practice to maintain a comprehensive referral network? • Are the physicians to whom your practice refers and/or from whom your practice receives referrals participating in the ACO? • How will the decision to participate or not participate in the ACO affect these provider relations?
What stage of your career are you in?	<ul style="list-style-type: none"> • If you are close to retiring, you may want to maintain your practice's status quo and transfer your patients to other physicians as your retirement date approaches. On the other hand, many physicians close to their retirement age may want to mentor other physicians and provide the experience and leadership to enable them to position their practices for the future health care landscape.
Do you have a niche practice?	<ul style="list-style-type: none"> • If you have a niche practice that is not dependent on payments from the types of systems that will most likely embrace the value-based payment reforms, there may be less impetus to undertake the changes associated with participation in an ACO. For example, if a large portion of your practice is elective cosmetic surgery or involves holistic techniques for which patients are typically willing or required to pay out of pocket, the status quo might be the right option.

B. WHAT ARE THE BENEFITS AND CHALLENGES OF JOINING AN ACO?

Deciding whether or not it would be prudent to join an ACO requires further consideration of the associated benefits and challenges related to the financial, operational, and strategic direction of the physician practice.

BENEFITS	CHALLENGES
<i>Physician Integration and Collaboration</i> — Physicians who participate in an ACO are part of an integrated community of providers who can share best practices and work together to provide patients with high-quality care.	<i>Loss of Autonomy</i> — Contracting organizations may institute policies in medical practice and the use of equipment/space. As a result, independent physicians may be wary of the loss of autonomy.
<i>Shared Savings</i> — Physicians who participate in ACOs and can meet specified criteria for quality and performance benchmarks may recognize the benefit of financial incentives.	<i>Shared Risk</i> — One recent ACO-like pilot demonstration resulted in substantial savings achieved by some participating institutions that were offset by a lack of savings at others. ¹⁹
<i>Strength in Numbers (i.e., Shared Responsibility)</i> — Unlike the solo practice setting, physicians who participate in ACOs share the responsibility and risk with other physicians in the system.	<i>Organizational Goals</i> — Keeping up with organizational policy changes and maintaining the most up-to-date information may present an additional administrative burden on physician practice staff.
<i>Access to Resources and Additional Support</i> — An added benefit to ACOs is the wide range of resources available to those within the organization (group purchasing and negotiating power as an example).	<i>Up-Front Costs</i> — Any group that is implementing an ACO may face substantial infrastructure costs to support improved and coordinated care. ²⁰
<i>Access to an Expanded Referral Network</i> — Physicians who participate in an ACO may have a broader range of access to different programs and services. Increased availability to specialists and other personnel in the form of an expanded referral network is a vital function of an ACO that can lead to improved quality outcomes.	<i>Control of Referrals</i> — Physicians are often encouraged to keep patients within the ACO network of providers who have agreed to be collectively accountable for the patient population. Participation in an ACO may pose challenges to existing relationships with any providers who elect not to participate in that network.
<i>Population-Based Health Efforts</i> — Through an ACO, providers can collectively invest in IT, care management and other resources to better support active management of a patient population. These programs may be too costly and resource-intensive to be offered by stand-alone providers.	<i>Information Overload and Data Reporting Requirements</i> — ACOs are dependent on multiple systems that often generate a significant amount of data. One challenge for providers is to learn to navigate and optimize multiple levels of the user interface, in addition to large amounts of information and data reporting requirements.

¹⁹Ibid.

²⁰"Accountable Care Organization 2012 Program Analysis: Quality Performance Standards, Narrative Measure Specifications, Final Report," prepared by RTI International, December 12, 2011. Accessed on August 6, 2012, at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf.

C. HOW TO CHOOSE THE RIGHT ACO?

Once a physician has determined that joining an ACO makes business and strategic sense for them and their practice, it is important to understand the organization's guiding principles and to ask the right questions. Prior to engaging in a contractual arrangement, physicians should understand how the ACO will help meet their business objectives. The objectives and expectations of both parties should be clearly defined ahead of time so that physicians know their role within the organization. Having these conversations in advance will best position physicians for success.

The table below outlines some of the key considerations that should be carefully evaluated before joining an ACO.

TABLE 2.2 | Choosing the Right ACO

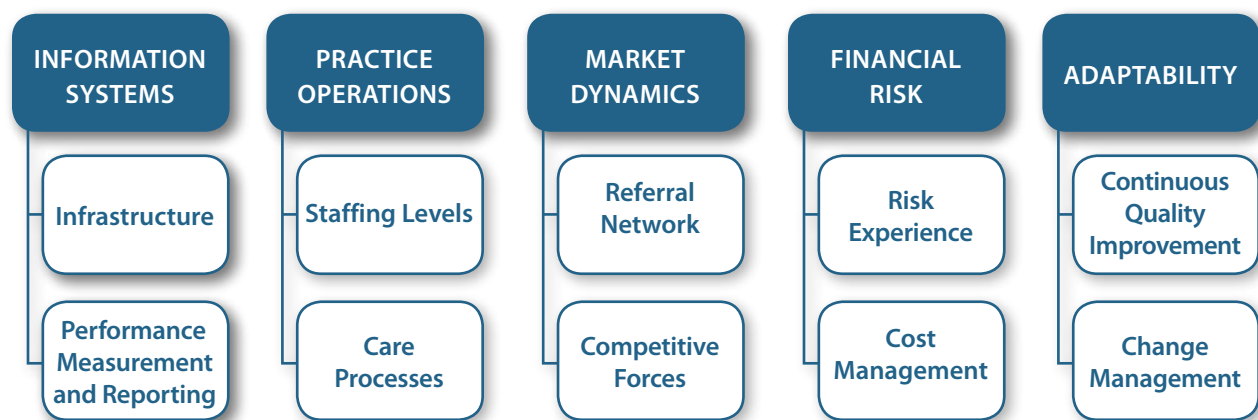
CONSIDERATION	DETAIL
Know your role and fit within the ACO	A physician's specialty area can have a significant impact on the role he/she plays within an ACO. While a PCP's main focus may be on the coordination of patient care, specialists can provide disease management support. A good working relationship between both is critical in order to avoid overlaps and gaps in care and to achieve the best outcomes for their patients. Specialist participation levels may vary by ACO depending on the local utilization rates of their respective services. Additionally, physicians may be asked to play a role within the leadership or governance structure of the ACO.
Understand your data	Physicians in an ACO need access to key data in order to make sound decisions on what approach their practice should take in providing quality patient care. Furthermore, in order to achieve cost savings, physicians need to be able to interpret data and identify opportunities for improvement based on clinical, financial, and utilization outcomes. Data analytics and data warehouses, as well as other tools, are an important aspect of an ACO, especially in risk-based contracting scenarios.
Know what value you bring to the ACO	Physicians should be aware of the value they bring to the ACO. For instance, participating in an ACO may mean that physicians need to become more conscious about their utilization patterns for diagnostic tests, procedures, prescriptions, etc., as well as determine the effectiveness of their practice patterns on clinical quality and efficiency. Having this knowledge base is key, as ACOs are about reducing unnecessary waste in the system.
Be willing to make clinical and operational transformation a priority	Physicians who want to join an ACO should be willing to further focus on continuous quality improvement through clinical collaboration and accountability. Clinically coordinated care is based on a collaborative approach for the development of clinical pathways/protocols and disease management programs, as well as the pursuit of clinical innovation. Additionally, most ACOs will assign accountability through the development of metrics and processes to monitor performance and compliance and reduce variation. In order to achieve clinically coordinated care delivery, operational changes at the practice level may be required to support the process.
Mission and values	Physicians should ensure that the mission and values of the ACO are aligned with their personal mission and values.

D. HOW READY IS MY PRACTICE?

Determining whether an ACO is a logical choice for your practice should also involve a thorough readiness assessment of your practice's ability to adapt to the necessary changes in a reasonable and timely manner as well as to understand whether there are deficiencies that can be alleviated through partnerships with select ACOs.

Approaching the decision from an informed position, in which you have done the research and understand your particular practice's current capabilities and potential deficiencies, will help in shaping important conversations and eliciting the information necessary to determine whether a particular ACO arrangement will be a good fit for your group, IPA, or individual practice's needs. A critical component of this process will be to assess your practice's readiness for value-based reimbursement in order to identify crucial gaps and prioritize strategic activities. Readiness can be assessed from the perspective of the five key domains shown in Figure 2.1.

FIGURE 2.1 | Five Key Areas for Practice Assessment



The subsections below further detail the factors to consider and approach for assessing your practice's readiness level. Taking the time to conduct an honest practice assessment is extremely important. Consider your level of readiness in the following five domains:

1. Information Systems

Robust information systems (e.g., EMR, secure messaging, patient portals, e-prescribing) are critical components of any clinical integration initiative to enable information exchange and data sharing. In order to meet clinical integration standards, ACOs will often require a system through which physicians can efficiently exchange information regarding patient and practice experience; utilization claims information can be gathered, analyzed, and communicated; and physician compliance and performance can be measured in accordance with physician-authored benchmarks and standards. Your organization's level of sophistication related to information systems should be contemplated based on two key functionalities: infrastructure (including information system integration) and performance measurement.

a. Infrastructure

Electronic data capture is essential for operating in a clinically integrated network, such as an ACO, therefore an operational electronic medical record is important. If a practice already has an EMR system in place, it will be important to understand whether that practice is currently fully reliant on electronic systems or somewhere in between. Physicians who wish to participate in an ACO should currently be able or willing to implement a system that will send and receive electronic transactions through an EMR, with the understanding that electronic data capture is an important aspect of an ACO model.²¹

²¹Accountable Care Organization (ACO) Principles, 2010 Interim Meeting of the AMA House of Delegates: www.ama-assn.org/ama1/pub/upload/mm/399/aco-principles.pdf.

While physicians should not be forced to switch EMR systems as a condition of ACO participation, the EMR system used should be certified and capable of performing the functions necessary to comply with state and federal regulations that support HIE and other such initiatives requiring the exchange of information among health care entities.²²

b. Performance Measurement and Reporting

It is also important to understand your practice's experience and comfort level with data reporting and analytics. Specifically, information sharing, transparent data reporting, data analysis, and trend identification and monitoring are core tenants of the ACO model. Therefore, an assessment should consider the practice's functional ability to support or transition operations for a comparable level of data optimization.

Many practices are simply not well positioned from a technology perspective to support the adoption of clinical IT, business intelligence, and Health Information Exchange (HIE) tools. They may not have an IT department at all, let alone one that is the appropriate size and composition to meet the requirements of an evolving environment where more emphasis is being placed on the adoption of sophisticated IT systems. Therefore, many ACOs may provide such services in order to help physician practices with the transition to clinical integration as well as to establish a new or stronger relationship with the practice. Figure 2.2 — Key Considerations for Assessing Information Systems (on the following page), details key questions that one should consider when assessing the group, IPA or practice information systems.

Thousands of measures have been developed or endorsed by a number of organizations, including the AMA-convened Physician Consortium for Performance Improvement (PCPI), National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), CMS, American Board of Medical Specialties (ABMS), and Ambulatory Care Quality Alliance (AQA). The performance measurement framework is generally structured around four areas:

- *Structural Measures* — Reflects the environment in which providers care for patients; more specifically, refers to whether or not a physician or other health care provider possesses EMR or e-prescribing capabilities.
- *Process Measures* — Evaluates the ways in which physicians interact with their patients, including the assessments, treatments (*aren't these more clinical in nature?), and procedures they provide.
- *Outcome Measures* — Describes changes in the patient's health status, including quality of life; examples of outcome measures include health literacy rates, infant mortality rates, and the percentage of the population with diabetes who demonstrate improvement in their health.
- *Cost Measures* — Reflects the cost of care provided to patients by providers in relation to the expected cost for similar cases across providers.

²²Ibid.

FIGURE 2.2 | Key Considerations for Assessing Information Systems

INFORMATION SYSTEMS ASSESSMENT	
Infrastructure	Performance Measurement
<ul style="list-style-type: none">• Is the practice currently on an EMR system?• Does the practice currently automatically share information with other entities electronically?• What level of EMR integration is currently in place (do you see labs, test, etc., performed at a hospital or other locations)?• Consider what electronic tools are currently in use.• Is the practice capable of handling any additional tools, including patient portals, data registries, and e-prescribing?	<ul style="list-style-type: none">• Does the practice currently have systems and processes in place to capture data?• How confident is the practice about the validity of existing data?• Does the practice currently use data to identify and monitor trends or support practice improvement initiatives.• If the practice is not currently reporting data, how easy would it be to initiate this process?• Does the practice require additional resources in order to successfully capture and report data?

2. Practice Operations

Evaluating your practice to understand your current patient panel size and associated patient needs is important. The ability to clearly articulate the type of patients you are caring for and truly understand the practice's current capabilities to assume responsibility for the full spectrum of care is key to understanding what interventions, in terms of care coordination, may be required in an ACO model.

FIGURE 2.3 | Key Considerations for Assessing Practice Operations

PRACTICE OPERATIONS ASSESSMENT
<ul style="list-style-type: none">• Does the practice have a solid understanding of the current patient mix?• How does the practice currently manage chronic care populations?• Does the practice currently use care managers or other nonphysician extenders to support the monitoring support of adherence to clinical treatment recommendations?• How does the practice currently handle patient handoffs and communication with referring physicians, local hospitals, local nursing homes, specialists, etc.?• What mechanisms, if any, does the practice currently employ to engage patients in their care?• What level of understanding and capability does the practice have in terms of coordinating care across all care settings?• Does the practice currently have a methodology to assign patients to a particular physician for reporting purposes?

3. Market Dynamics

Market dynamics may have a significant impact on determining whether ACO participation would be beneficial. Physicians must carefully assess their practice's position in the market and examine the impact of ACO participation on referral streams. There may be implications associated with choosing one ACO over another within a specific geographic area based on your specialty and existing relationships. While ACO participation may impact your referral stream, ACO participation may present an opportunity to address existing gaps in your referral

network. As such, having a comprehensive understanding of market dynamics, referral streams, and network composition will enable you to understand the implications of ACO participation and to best position the practice for success in a global budget or risk contract.

FIGURE 2.4 | Key Considerations for Assessing Market Dynamics

MARKET DYNAMICS

- Are there multiple ACOs in the local market? What level of geographic scope do these ACOs represent?
- Have local hospitals joined ACOs?
- Are you the primary referral resources involved in an ACO?
- Will your destination to join a particular ACO impact your current referral stream?
- Are there gaps in select services within your current provider network that are critical for the clinical management of your patient population?
- Have your competitors joined an ACO?

4. Financial Risk

It will be important to contemplate whether your practice can appropriately manage the performance risk associated with a population of patients. Practices must understand that under some payer contracts there could be financial risk associated with the practice's individual and/or the ACO's overall performance in managing costs and quality of care for a population with a given set of health conditions. This will depend on the structure of the reimbursement arrangement under the given contract and whether it includes financial risk for the practice based on individual or group performance. An additional consideration is the number of patients the practice has covered under a given health plan product. A relatively smaller number of patients will both limit the potential magnitude of any financial opportunity and increase the possibility of small number of high-cost patients skewing the financial performance of the practice in managing medical costs for its population. Further, the smaller the number of patients, the more likely it is that costs will vary significantly from year to year. Integration into an ACO model means thinking about practice financials differently (see *Section IV — Understanding the Financial Impact* for a detailed discussion on this subject). Providing care under a budget requires specific readiness considerations, such as those identified in Figure 2.5.

FIGURE 2.5 | Key Considerations for Assessing Financial Risk

FINANCIAL RISK ASSESSMENT

- Does the practice currently have any global budget or risk-based contracts? Prior experience, while not necessary, is helpful.
- Does the practice have experience with and a plan for allocation of any shared savings or incentives achieved through the model?
- Does the practice currently have a clearly articulated physician compensation model that is based on metrics, goals, and targets?
- Do physicians within the practice understand their individual cost-of-care metrics and how they compare to others within a defined peer group?
- Are there systems in place to monitor the practice's financial performance compared to a budget?
- What is the current level of financial strength of the practice? Is the practice strong enough financially to accept risk?
- What level of financial risk are you willing and able to manage?

5. Adaptability

Having an understanding of your practice's ability to modify existing policies, procedures, and processes in order to promote innovative care delivery in an ACO model is critical. The ability to implement and adapt to midcourse corrections is important, as most practices find themselves using the concept of continuous quality improvement to navigate the practice to a successful position in an ACO model. When thinking about how easily your practice adapts, consider the points identified in Figure 2.6.

FIGURE 2.6 | Key Considerations for Assessing Change Adaptability

CHANGE ADAPTABILITY

- How easy is it for you to implement process changes?
 - Does the staff adapt easily?
 - Do the physicians in the practice readily adjust when changes are necessary?
 - With the right education, communication, etc., do the patients adapt to practice process changes?
- Does the practice have experience in metric-based models and understand the need for continued tweaks to the process?
- Does your practice like trying new things?
- Is your practice innovative in terms of finding the creative solutions to common challenges?
- If your practice does not currently use managers or other nonphysician extenders, are you ready to consider the possibility of integrating these types of skill sets into your practice?
- Is the practice ready to consider the entire continuum of patient care as part of the overall responsibility for the patient?
- Does the practice currently maintain collaborative relationships with other stakeholders (including but not limited to hospitals, nursing homes, health clinics, and other community services)? If not, is this the practice willing to consider them as part of the extended team?

Reflecting on the five domains listed above, determine how ready your group, IPA, or practice is. Understanding current capabilities and potential deficiencies is essential for prioritizing the necessary level of financial investment and operational changes required in order to successfully engage in an ACO arrangement. Deficiencies should not be perceived as obstacles but rather as areas of focus that can help guide discussions with an ACO by highlighting key areas that could potentially be supported by the ACO's resources.

III. Legal Structures and Requirements of ACOs

ACOs can take any legal form permitted by applicable state law, but they are characterized by a care delivery and payment system that ties provider reimbursement to quality metrics and reductions in the total cost of care for a designated population of patients. While state and federal laws govern aspects of Medicare or state-certified ACOs, there are no laws or regulations that define what agreements with private entities may call the resulting delivery system an ACO.

The following existing entities may qualify to become ACOs, including integrated delivery systems:

- Hospitals, physicians, and other providers under common control
- Providers affiliated through clinical and/or financial integration or a contracting network
- Large PCP practices or multispecialty physician practices
- PHOs that are clinically and/or financially integrated
- Medical foundations
- Staff model health maintenance organizations (HMOs)
- Contracted groups of suppliers
- Joint ventures of two or more of the above-listed entities

Under federal guidelines, any group of providers, practitioners, and/or suppliers of items and services covered under Medicare Parts A and B that meet certain criteria may form a Medicare ACO. To qualify as a Medicare ACO, participating organizations must:

- Agree to be accountable for the quality and cost of care provided to Medicare FFS beneficiaries assigned to the ACO
- Agree to participate in the SSP for at least three years
- Establish a formal legal structure that has a shared governance that allows the ACO to distribute shared savings payments to participating providers and suppliers
- Include enough PCPs to care for the Medicare FFS population assigned to the ACO and have a minimum of 5,000 such Medicare beneficiaries assigned to it
- Have a leadership and management structure that includes clinical and administrative systems
- Define processes (such as through telehealth, remote patient monitoring, and/or other technologies) to promote evidence-based medicine and patient centeredness, report on quality and cost measures, and coordinate care
- Demonstrate that they meet patient-centeredness criteria such as the use of patient and caregiver assessments or individualized care plans

The recently passed Massachusetts health care cost containment legislation, Chapter 224, creates a process for ACOs to be certified, and charges the newly formed Health Policy Commission (HPC) with establishing minimum standards for certified ACOs. Chapter 224 requires that certified ACOs must:

- Be organized or registered as a separate legal entity from the ACO participants
- Have a governance structure that includes an administrative officer, a medical officer, and patient or consumer representation

- Receive reimbursements or compensation from alternative payment methodologies
- Have functional capabilities to coordinate financial payments among their providers
- Have significant implementation of interoperable health care IT for the purposes of care delivery coordination and population management
- Develop and file an internal appeals plan as required for risk-bearing provider organizations and obtain a risk certificate from the Division of Insurance
- Implement systems that allow ACO participants to report the pricing of services
- Engage patients in shared decision making

In addition, Chapter 224 gives the HPC broad ability to establish additional standards for ACOs. According to Chapter 224, the process of certification under Massachusetts law will be established by the HPC and be subject to renewal every two years; the HPC is yet to issue further guidance on the application and certification process.

A. LEGAL IMPLICATIONS OF ENGAGING IN AN ACO

As discussed above, ACOs may take many forms and are recognized as a legal entity under state law. The legal structure of ACOs is articulated in contracts between providers. Physician practice groups such as professional corporations (PCs) and limited liability companies (LLCs) may enter into agreements to become part of an ACO while maintaining their existing legal structure. As is the case in any contractual agreement, there is some risk exposure that accompanies joining an ACO. In order to minimize risk, it is important to examine and evaluate the other contracting parties and make certain that agreements contain the appropriately protective and legally compliant terms. Physician groups should ask some specific questions when contemplating ACO agreements.

- **Can the ACO bear the financial risks?**

A key feature of the ACO model is that the ACOs are risk-bearing entities due to their alternative payment structure. Chapter 224 requires that all risk-bearing entities, including all ACOs, register with the Division of Insurance. While this baseline oversight will provide some safeguard to be certain that ACOs are able to bear the risks of alternative payment structures, a key area of diligence when contemplating agreements to become part of an ACO is determining that the ACO is properly capitalized and has some experience with risk-based compensation models.

- **Does the ACO have the appropriate IT resources?**

ACOs will be required to measure and monitor the quality and cost of care in a timely and accurate manner. Chapter 224 requires that all certified ACOs maintain an interoperable EMR system. Before joining an ACO, prospective participants should consider if the IT system allows the ACO to clinically integrate, coordinate care, and control cost in a manner that works. If not or if it needs to improve in these areas, what actions will be taken to enhance the infrastructure? Chapter 224 has established opportunities for funding to support IT and EMR systems. Providers should inquire if the ACO intends to pursue these resources and how their practice or organization might benefit from accessing such funds.

When negotiating an agreement with an ACO, providers should seek terms that obligate the ACO to provide training on its EMRs and other software systems, as well as terms that require the ACO to provide ongoing technical support or update the existing IT infrastructure. Furthermore, if the physician practices have not implemented the EMR system used by the ACO, the agreement should clearly indicate who will pay for implementation of the system and how much time the practices have in order to get the system up and running.

- **What are the termination provisions of the agreement?**

Contracting parties should strive to negotiate reasonable termination provisions that are standard for most employment or leasing agreements, including the right to terminate for failure to make payments on a timely basis and the ability to terminate without cause on a reasonable notice (for example, within 60 days). More specifically, providers should carefully consider termination provisions of ACO agreements that contemplate losing ACO certification or termination of payer contracts. ACOs must report information on cost and quality. The requirements under Massachusetts law have not yet been determined by the HPC; under the federal ACO requirements, ACOs must agree to report to CMS on the quality, cost, and overall care of the beneficiaries assigned to the ACO. Should an ACO fail to meet these (or other) requirements, the ACO could lose its ACO certification. By definition, ACOs are flexible and diverse entities; protective contractual provisions that make sense for one provider/ACO may not make sense for another.

- **What will happen to my records in the event of termination of the agreement?**

Unless the physicians are becoming employees of the ACO, the medical records created for services provided during the term of the agreement would be the property of the physicians performing services (or of the hospitals at which the physicians performed services). Following termination of the agreement, the records would therefore remain the physicians' or the hospitals'. However, an agreement will likely include a provision granting the ACO access to records following the termination of the agreement. Such access should be allowed, though it should be limited to reasonable access for legitimate business purposes, which includes access required by government entities. If the physicians are providing services on behalf of the ACO (for example, under the ACO tax ID number [TIN] or NPI) as employees or contractors, the medical records will be the property of the ACO. As a result, the physicians should ensure that the agreement provides for reasonable access upon termination (a) or continued treatment of a patient following the receipt of a Medical Records Release form signed by the patient, (b) as a physician may need to satisfy audits conducted by any third-party payer, governmental agency, or quasi-governmental agencies, (c) because a physician or his/her professional liability insurance carrier may request medical records relative to litigation or threatened litigation involving the physician, or (d) for any other reasonable purpose allowed by law.

- **Will joining the ACO bind the group/physician to exclusive participation in one ACO?**

Under federal regulations regarding Medicare ACOs, every ACO participant with a tax identification number (TIN) that bills for primary care services must be exclusive to a single Medicare ACO. The regulations define "primary care services" broadly; therefore, specialists who bill for services such as office evaluation and management services may only participate in one ACO. Additionally, since the exclusivity provision applies to each TIN, if a physician group bills under a group TIN, which includes primary care physicians as well as specialists, specialists within the physician group that participates in an ACO will not be able to participate in any other ACO while billing under that TIN. For this reason, specialists may wish to furnish services under a separate entity that bills under a different TIN rather than the TIN associated with a group practice that provides primary care services. Specialists may contract with an ACO on an individual basis and bill using their individual Social Security number (SSN) in order to maintain the ability to work within more than one ACO. Physicians should note, however, that billing under multiple TINs and SSNs may cause administrative burdens or require written consent by payers to avoid breaching existing contractual obligations.

Aside from the regulatory exclusivity requirements, which apply only to Medicare ACOs, prospective ACO participants should review ACO agreements for exclusivity provisions, and are well-advised to negotiate to avoid any type of exclusivity arrangement. Additionally, participants can negotiate whether participation in an ACO will be for Medicare/Medicaid plans only, or whether the participant will participate in additional payer arrangements as well.

- **Does the agreement violate law or existing contractual obligations?**

As discussed further below, the contracts that govern an ACO must comply with current laws. Also, existing agreements for both parties may govern the ability to contract with additional providers or payers. Existing contracts should be reviewed for exclusivity and/or covenants not to compete, and some agreements may need to be amended to accommodate entering into agreements with an ACO.

- **What are the compensation terms in the agreement?**

The ACO will likely be negotiating global- or risk-based payment provisions with payers. However, how the ACO chooses to compensate participating providers is likely flexible under agreements with payers. The agreement between the ACO and providers should clearly detail the compensation provisions for participation with the ACO. Compensation may be on an FFS or a capitated basis. A physician may be eligible for bonuses based on certain quality targets or a portion of shared savings payments. However compensation is structured, the terms should be clearly outlined in the agreement. Providers should understand exactly how and for what services physicians will be getting paid prior to entering an agreement. Rates should be specified, quality measures should be outlined, and a process for payment should be included. Furthermore, to the extent that physicians will be receiving capitated rates on a per patient basis, the process for assigning patients should be clearly detailed. Similarly, if a physician is receiving payments for capitated services, or bundled payments intended to cover a diagnosis or procedure, what services are included should also be specified. For example, a physician should know if he/she will be responsible for the costs of lab tests, preoperative and postoperative visits, etc. Finally, a physician should determine whether or not there are specific services that need to be carved out and separately reimbursed because of their expense.

If the agreement states that providers will receive performance-based payments, in addition to ensuring that the measures for payment are clearly established, the agreement should also clearly identify what, if any, payments are going to be made up front to the physician or practice group. If performance will be measured on a quarterly basis, for example, will the physician or group receive monthly estimated payments, therefore allowing the physician or group to maintain cash flow in the interim? Furthermore, providers should ensure that the agreement specifies that the ACO will pay all earned but unpaid bonuses and other incentive payments in the event of termination.

The more detail that is included in the agreement up front, the less likely the arrangement will result in disputes and the better situated a provider will be to determine whether or not participation in the ACO makes sense for his/her practice.

- **What is the process for submission of claims and payment?**

The agreement should include a clear process for billing and payment. Physicians should have at least 60 days to submit claims or encounter data, if not longer, to ensure that claims will not be lost. Furthermore, the agreement should specify how long the ACO will have to process the claim (particularly for agreements with FFS payments). Massachusetts requires that managed care claims be paid within 45 days; this may be a good benchmark for claims to be paid by the ACO. However, the agreement should be specific; providers should not rely on time frames required by law, as not all ACOs will be subject to the applicable laws. Furthermore, the agreement should require that any denial of a claim should include an explanation so that providers can monitor and understand why payments are being denied. Additionally, providers should consider automatically requiring an ACO to pay interest upon the denial of a claim. This will provide incentive for the ACO to comply with the established timelines. An agreement should also include a process for appeals of denied claims. Regardless, the decision resulting from an ACO-operated appeals process should not be final and binding; providers should have the right to seek external dispute resolution, whether through the process outlined in the agreement or through the courts.

- **Does the agreement include a right to audit the ACO's records?**

To the extent payments are made based on any measure other than FFS, providers should have the right to audit the records of the ACO as they apply to the services provided, as well as any services the provider may be responsible for and other information that is relevant to how the payments are calculated. The agreement should allow for the right to audit on a reasonable basis and with access provided in a timely fashion as determined by the terms of the contract.

- **What covered lives will a physician be responsible for?**

To the extent that providers will be paid per member, or in any event in which covered lives must be assigned to a provider, the agreement should clearly identify the process for such allocation. One way to attribute covered lives is based on PCP identification. Alternatively, covered lives may be allocated randomly by the ACO or applicable payer. Before taking on risk for covered lives, providers should consider whether or not they will be able to have any control of the care provided to those patients. Furthermore, a physician should look for provisions addressing what will happen if a member is incorrectly allocated. Will payments be retroactively denied because a covered life was inappropriately attributed? If so, will there be a 30-, 60-, or 90-day cutoff date after which the ACO will be required to make payment? Alternatively, retroactive adjustments can be prohibited altogether. Similarly, for payments to be made on a per member per month (PMPM) basis, an agreement should specify whether or not a provider will be able to keep payment if a member becomes dis-enrolled in the middle of the month.

B. STARK LAW, ANTI-KICKBACK STATUTE, AND ANTITRUST ISSUES

The complexity of financial relationships between physicians and hospitals and among ACO providers, however the ACO is structured, presents a variety of legal issues under existing regulations, which include the Stark law, Anti-Kickback Statute (AKS), and antitrust laws.

1. Stark Law

Stark law prohibits physicians from having any financial relationship with an entity that furnishes Medicare-covered “designated health services” and from referring patients to that entity. It prohibits the entity from billing the Medicare program for any services performed as a result of such referrals. Stark-implicated financial relationships include both ownership interests and compensation arrangements. Therefore, both physician/hospital joint venture ACO ownership and hospital-employed physician ACOs will implicate Stark to the extent that designated health services are involved.

There are a number of important exceptions to Stark restrictions that will likely apply to ACOs. The risk-sharing exception provides that the referral prohibition is not triggered if a physician receives compensation pursuant to a risk-sharing arrangement. Since risk sharing is at the crux of the definition of an ACO, it is highly likely that the risk-bearing exception will apply. In the final rule regarding the risk-sharing exception, CMS indicated that the exception should be construed liberally to cover all risk-sharing compensation paid to physicians downstream from a managed care organization (such as an ACO). In addition, there are other exceptions that may apply to an ACO depending upon the structure of the underlying agreements, such as exceptions for personal service agreements, fair market value arrangements, and bona fide employment agreements.

2. Anti-Kickback Statute

AKS prohibits someone from “knowingly and willfully” giving (or offering to give) “remuneration” to another person if such payment is intended to “induce” referrals for the furnishing of health services or to induce the purchase, order, lease, or recommendation of items covered by Medicare. Notice that the AKS is an intent-based statute requiring the party to “knowingly and willfully” engage in the prohibited conduct. Without this requisite intent, there is no violation of AKS. Fortunately, CMS and the Office of Inspector General have made an exception for ACOs to distribute shared savings among ACO participants during the year in which the shared savings were earned.

3. Antitrust Issues

The Federal Trade Commission and the Antitrust Division of the Department of Justice recognize that in certain markets, ACOs could reduce competition and hurt consumers by raising prices and/or offering lower-quality care. When evaluating the likelihood of triggering scrutiny from antitrust agencies by joining a particular ACO, providers should consider the factors with which enforcement agencies are concerned, including if the ACO will improperly share competitively sensitive information or if the ACO will prevent or discourage payers from incentivizing patients to choose certain providers. Providers should also evaluate the extent to which contracting exclusively with ACO physicians, hospitals, ambulatory surgery centers, or other providers is done to prevent those providers from contracting with payers outside the ACO.

As each provider may not have the depth of understanding of each relationship and contract that governs an ACO, it is important to ascertain that the ACO has done an appropriate legal analysis and engaged competent legal counsel.

IV. Understanding the Financial Impact

Participation in an ACO presents the opportunity for independent provider organizations (e.g., independent practices or hospital systems) to participate in contracts that require, and offer potential for rewards associated with, cost-effective, coordinated, and high-quality care provided to a defined patient population. Through these arrangements, providers can develop the capabilities for population health management and position themselves for future stability and success as the market, particularly in Massachusetts, increasingly demands these capabilities. However, these arrangements are not without risks, and it is important for physicians to understand the structure of the financial arrangement in which they will participate, how their performance will be measured, and how the arrangement may evolve over time. This section provides an overview of financial arrangements within an ACO, as well as the implications and considerations for physician practices.

A. THE POPULATION MANAGEMENT RISK CONTINUUM

Through an ACO, provider organizations enter into contracts/agreements with payers under which they accept responsibility for managing the care and medical costs of a defined patient population and are offered the opportunity to share in the savings associated with improved health and lower cost of care. The financial structure under these agreements can vary by contract and patient population served. These can range from no-risk models with an opportunity to share in reductions in total medical costs for the population, to full-risk models where the ACO has increased financial opportunities but also faces the possibility of sharing in the deficit if medical costs exceed targeted levels. It is common for these contracts to call for an increase in the level of risk assumed by the ACO over time as the participating providers develop and demonstrate their ability to successfully manage the given population, as measured by medical costs, quality metrics, and patient experience metrics. Furthermore, many agreements, notably the Medicare ACO and BCBSMA AQC contracts, also link the magnitude of shared savings distribution to performance in meeting quality-based performance measures.

Although the structure and level of risk can take a wide variety of forms, Figure 4.1 describes the typical range of payment arrangements for population health management.

FIGURE 4.1 | The Population Management Payment/Reimbursement Continuum

	SHARED SAVINGS MODEL	SHARED-RISK MODEL	GLOBAL-RISK MODEL
Coverage Model	Operations continue under current insurance contracts coverage models (e.g., FFS reimbursement)	Payment is still pre-dominantly FFS but may include some alternative systems such as bundled payments	Provider groups receive a mix of FFS and prospective payments
Level of Provider Risk	The provider assumes no risk associated with the medical costs of the population	Provider groups are at risk for losses if spending exceeds projected benchmarks. However, the risk is shared with the payer, thereby mitigating the potential liability to the ACO	The ACO is liable for the medical costs in excess of the spending the target. The level of liability the provider assumes may be capped
Financial Incentives	Provider groups receive a relatively modest percentage of earned savings due to limited risk	Provider groups receive a higher percentage of any earned shared savings in line with increased risk	If groups are successful at meeting budget and performance targets, there are greater financial incentives
Infrastructure Requirements	This model requires a moderate health IT infrastructure and evolving care coordination capabilities	This model requires a moderate health IT infrastructure, care coordination capability, and demonstrated track record in managing care	This model is only appropriate for providers with a robust health IT infrastructure and demonstrated track record in finance and quality
Considerations	This is attractive to new entities, risk-averse providers, or entities with limited organizational capacity or experience with coordinating care across providers	This increases the incentive for providers to invest in care management capabilities and more effectively manage care and costs	Providers may be required and should consider obtaining reinsurance coverage to mitigate potential losses
Care Management Capabilities	Evolving	More advanced	Sophisticated

1. Transition along the Population Management Payment/Reimbursement Continuum

Broadly defined, there are three payment/reimbursement models most commonly employed to support population health management agreements between payers and ACOs. These include the shared savings model and two variations of risk sharing models. Each are described below and are represented in Figure 4.1 on the previous page.

The ACO presents a legal structure through which separate providers can collectively develop care management capabilities and participate in payment models for management of a defined population. The key components of each model are discussed below.

- The Patient Protection and Affordable Care Act identified the characteristics required of provider organizations that choose to be accountable for the quality, cost, and overall care for a designated group of Medicare beneficiaries.
- In many states, the Medicaid agencies are rolling out various ACO models.
- Some health systems are using the ACO model to align and integrate the delivery of care between the hospitals, physicians, and health plans.

2. Shared Savings Model

Under the Shared Savings Model, a budgeted/targeted medical cost is established for the population the ACO is accountable for managing and the ACO is offered the opportunity to share in some of the savings if the actual cost falls below the budget/target. The budgeted/targeted level is most commonly based on historical medical costs for the population, with adjustments applied to account for trends (i.e., increases) in medical costs and patient risk-scores based on diagnostic history. All providers continue to be reimbursed on FFS basis, with a measurement of performance in managing cost for the population at the end of each year (or other time period defined in the agreement). If the total cost of providing care for the defined population is lower than the budgeted/targeted level, the ACO shares in a percentage of this savings. The percentage that is shared is defined within the terms of each contract (prescribed for Medicare and negotiated for private payers). These arrangements will also typically include defined quality and patient experience measures. Contracts may require the providers to meet a minimum performance level to be eligible for shared savings payments, as well as the opportunity to receive higher payment levels as the performance levels increase. The financial opportunity under the shared savings model is less than other models since the ACO does not face the risk of sharing in the losses if cost targets are not met. This is the most common model for ACOs participating in the Medicare Shared Savings Model.

3. Shared-Risk Model

As with the Shared Savings Model, under the shared-risk model, the financial performance of the ACO is measured by comparing the actual total medical costs of caring for the managed patient population with a targeted/budgeted cost. Providers will generally continue to be reimbursed on a FFS basis, with a measurement of performance at the end of defined time periods. If the actual costs are below budget the ACO can share in the savings, and if they exceed budget the ACO can share in a portion of the deficit. The percentage of the savings shared by the ACO is higher under the Shared-Risk Model than under the Shared Savings Model. As with the Shared Savings Model, these arrangements will also typically include defined quality and patient experience measures.

Under the category of shared-risk models are a range of risk levels that vary from the ACO sharing in only a portion of the savings/deficit to assuming the majority of this risk. The higher the level of risk assumed by the ACO, the greater its opportunity for sharing in any medical cost savings. However, given the accompanying downside risk, it is important that the ACO only assume a level of risk commensurate with its ability to effectively manage the care of a population of patients. A higher level of risk requires more sophisticated capabilities to both manage the population and to measure and improve performance from both a financial and clinical perspective.

The significant barriers to shared risk models include:

- Current legal and regulatory standards make the formation of a qualified network a lengthy, complex, expensive, and risky undertaking.
- The challenges in creating effective clinical collaboration, including care delivery and performance metrics, are substantial. To be effective, provider organizations will require a degree of integration that few health care delivery systems currently achieve.
- The culture of many organizations is firmly entrenched in FFS, even if the stated strategy includes moving toward payments based on shared risk and population. As previously noted, there are significant functional differences between FFS and at-risk payment models. Right or wrong, culture trumps strategy, and unless the culture is changed, attempts to promote coordinated care will be stymied.

The Pioneer ACO Model (for at least years 1 and 2) and the BCBS AQC contract would be characterized as Shared-Risk Models.

4. Global-Risk Model

The Global-Risk Model is an extension of the Shared-Risk Model under which the ACO assumes a more significant portion of the risk associated with the performance in managing the medical costs for the population. The ACO would also have the opportunity to realize a higher percentage of the savings if actual costs fall below targeted/budgeted level, while meeting defined quality standards. Under this model, the ACO providers may also receive a reduction in their FFS reimbursement levels with a higher percentage of the contract dollars distributed as a bonus associated with performance in managing medical costs.

The Pioneer ACO Model offers this option beginning in year 3 of the contract for ACOs that have demonstrated an ability to successfully manage medical costs while meeting the defined quality measures.

B. DEFINING THE PATIENT POPULATION

Another important element of all risk-based contracts is defining the patients for whom the ACO will be responsible. The process of defining the population is typically referred to as patient attribution.

- Under HMO and other health plan products where patients **must** select a PCP, the patient population is simply defined by those patients who have a PCP participating in the ACO.
- Under the Medicare ACO models, patients are attributed to ACOs based on the physician (PCP) patients have seen for primary care services the majority of the time. However, under traditional Medicare and PPO plans, although patients may have a relationship with a PCP, they are not **required** to declare to the payer who they have selected and may even elect not to have such a relationship.
- Consequently, commercial health plan risk contracts are typically limited to only patients enrolled in HMO products, although many health plans are exploring attribution models for PPO plans that would assign patients to PCPs based on utilization history (e.g., the PCP who the patient has seen most frequently).

C. UNDERSTANDING ACO FUNDS FLOW

The funds flow model for an ACO includes both external funds flow arrangements (dollars paid from the payer to the ACO or directly to the participating providers) and the internal funds flow (the distribution of dollars from the ACO to the provider members). As providers contemplate joining an ACO, it will be important to understand funds flow structure and the methodology on which shared savings will be distributed. The characteristics of these funds flow arrangements are described below and illustrated in Figure 4.2.

1. External Funds Flow

The external funds flow will generally include the following major components:

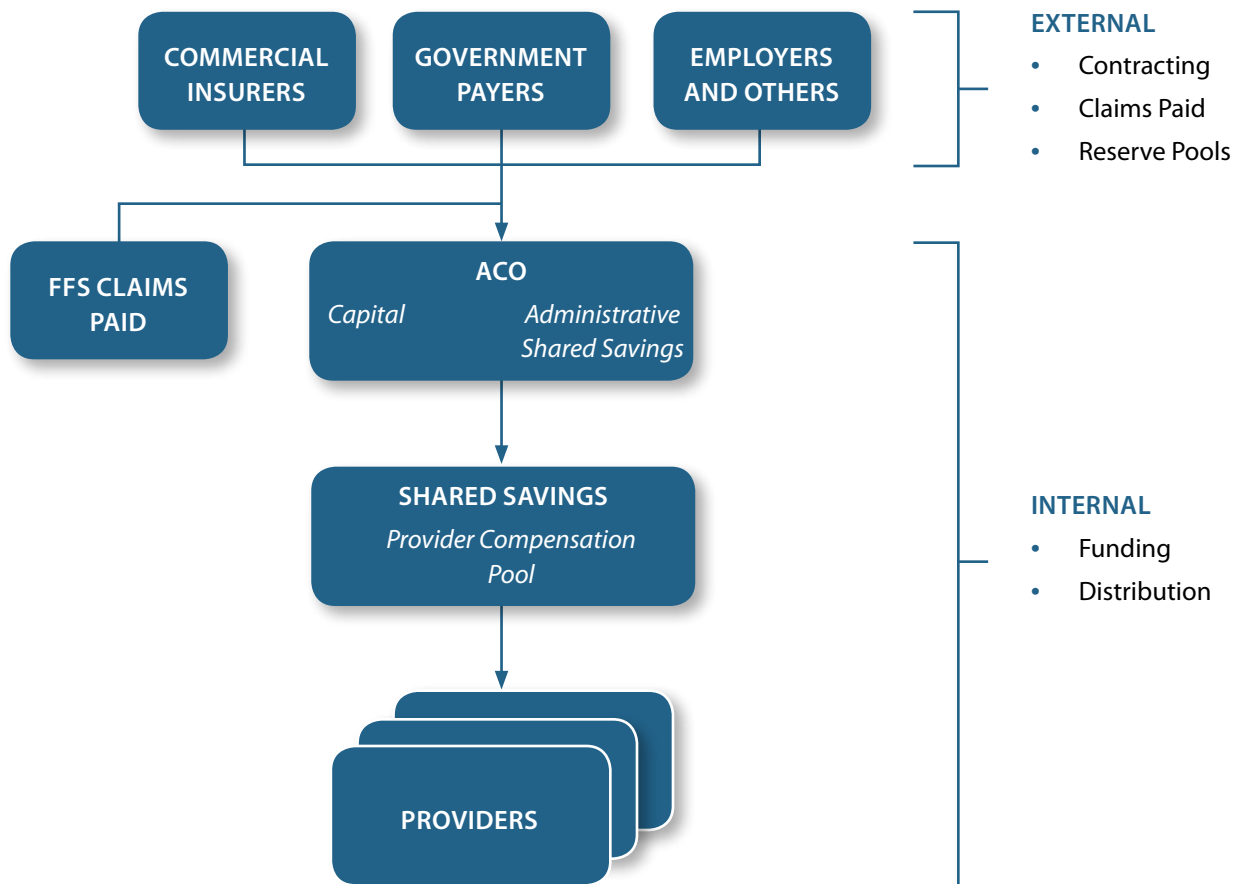
- The continued FFS reimbursement to ACO providers (as well as to other providers outside of the ACO who render care to patients).
 - Under the Shared Savings and Shared-Risk models, the FFS payments will generally remain at or near current levels.
 - Under the Global-Risk Model the magnitude of these payments may be decreased for ACO providers, with a higher percentage of the dollars distributed through shared savings funding.
- The distribution of bonus funds to the ACO based on performance in managing cost (i.e., shared savings) and meeting quality measures.
- Under some agreements, the ACO may also receive initial funding to support the development of care management capabilities.

2. Internal Funds Flow

The internal funds flow typically involves the following major components:

- The ACO will need to cover its internal costs of operation. These funds can either be provided by payments from the participating providers, or can be deducted from payments received from the payers with the balance distributed to ACO providers.
- The second major component of the internal funds flow is the distribution of bonus payments among participating providers. This distribution will be based on a methodology defined by the ACO and should be structured to both recognize the individual and collective contributions of participating providers.
 - These methodologies will typically vary depending on provider type (e.g., PCP versus specialist) and may differ by contract.
 - It will be critical for physician organizations to understand and be comfortable with the methodology for the distribution of these funds by contract.
 - It is also important to understand the process by which these methodologies are established and changed given the governance and management structure of the ACO.

FIGURE 4.2 | Typical Funds Flow



D. RISK MITIGATION

It is also important to recognize that more advanced value-based payment models inherently involve the possibility of financial loss if the provider organization does not perform well under the defined economic arrangements. The risk of any such loss can and should be mitigated by the ACO, but participating provider organizations should understand:

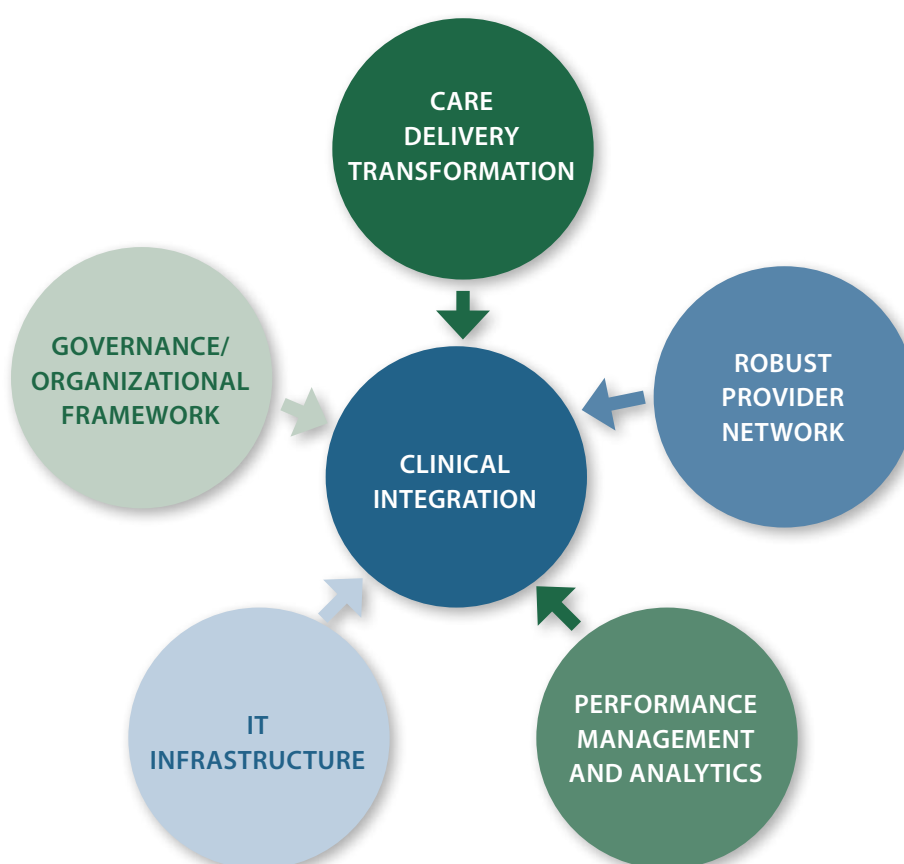
- What mitigation measures have been taken by the ACO to guard against the possibility of loss under the risk-based contracts.
 - Do they have systems in place to measure the performance of the ACO so that the risk of loss can be identified early to allow for corrective measures to be taken?
 - Has the ACO secured reinsurance to mitigate the costs if performance targets are not met?
- Under what scenario(s) would participating providers face financial liability for poor performance of their group or the network as a whole.

V. Achieving Clinical Integration

In order for providers to make a real impact on the health status of the patients they serve and in turn be capable of transitioning to reimbursement models that are based on performance in managing a population, true clinical and financial integration must be achieved. Most providers currently remain largely dependent on a productivity-based system and cannot simply “flip a switch.” As such, the pacing of the movement to value-based care is critical. Achieving clinical integration without payment reform will leave providers in a situation in which they have incurred additional costs associated with care management, but are not able to share in the savings associated with improved care for their patient population.

Value-based integrated delivery systems, such as ACOs, are built upon five essential components, which are illustrated in Figure 5.1 below.

FIGURE 5.1 | Essential Components of an Integrated Delivery System



The end-state model is a clinically integrated network of providers that follow common clinical protocols, have aligned measures and incentives based on improved value, and obtain joint payer contracts that include reimbursement arrangement which recognize and reward cost-effective and evidence-based care. This comprehensive care delivery network, coupled with these essential capabilities, enables organizations to align reimbursement mechanisms with population health management strategies.

As they plan for the future and react to the changing reimbursement environment, physicians will need to assess their current capabilities and ability to transition into a clinically integrated network built upon the components depicted in the figure above. Each of these components is detailed in the subsections on the following page.

A. CARE DELIVERY TRANSFORMATION

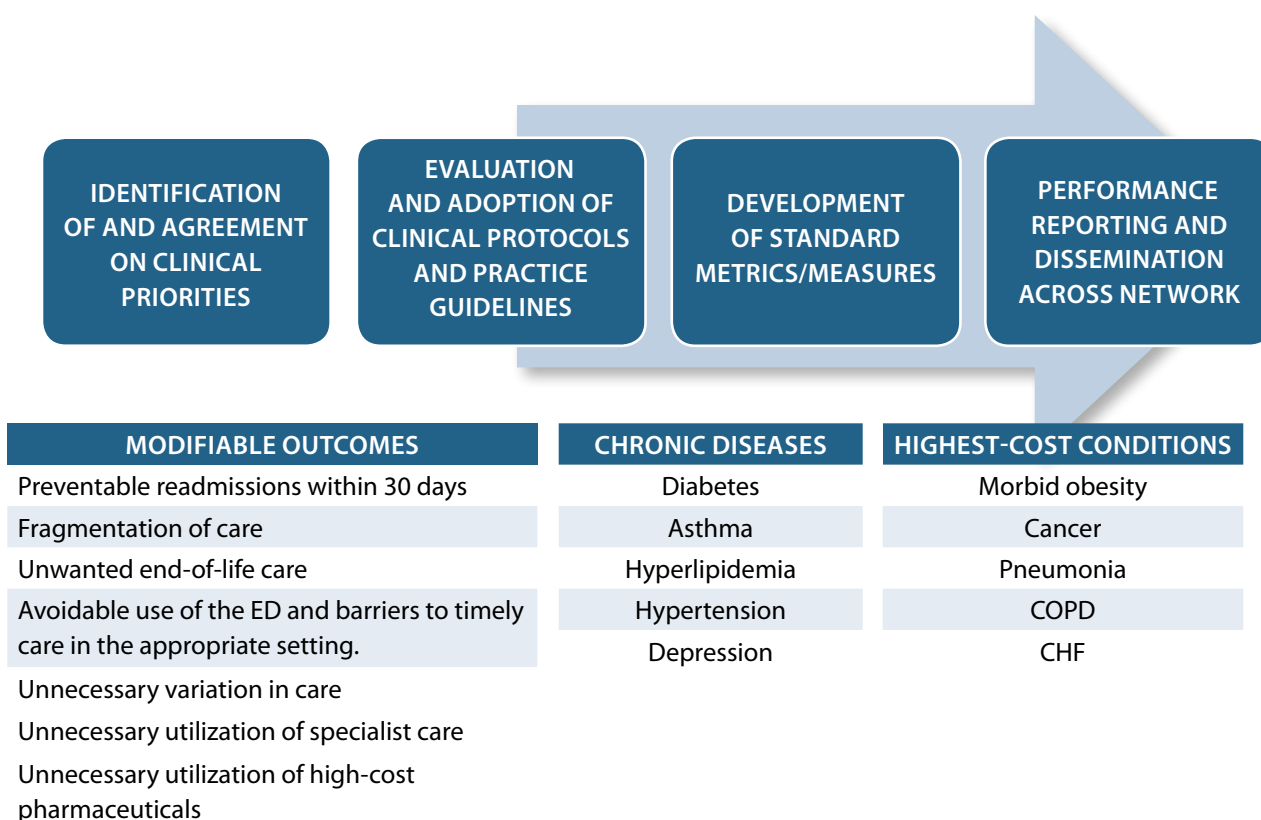
Successful care delivery transformation efforts are based on the ACO's ability to identify and monitor high-risk individuals, apply evidence-based practice guidelines, coordinate care between providers, and encourage patient self-management through education and patient tools — incorporating all the essential components of a clinically integrated organization (e.g., ACO) with population management capabilities.

1. Disease Management

Most ACOs approach clinical integration through the identification of an array of processes and interventions designed to improve quality and efficiency; some of these might be related to conditions covered by evidence-based protocols, while others could span a broad range of clinical conditions.

Interventions that are targeted to specific patient populations and clinical areas typically have a greater impact on quality improvement and cost. The most immediate areas for opportunity are often not a secret, and as demonstrated in Figure 5.2, they include modifiable outcomes, chronic diseases, and highest-cost conditions. Targeting higher-risk patients will optimally result in a greater likelihood of reduced costs and utilization. For example, chronic diseases are generally responsible for 75% of overall health care spending. Ultimately, the evaluation and adoption of evidence-based clinical protocols and practice guidelines targeted for these patient cohorts can result in fewer preventable complications and emergency department (ED) visits, shorter average hospital length of stay (LOS), and less gaps in care.

FIGURE 5.2 | Key Requirements for Disease Management



2. Care Coordination

Delivery system redesign entails moving from a reactive to a proactive delivery system, in which planned visits are coordinated through a team-based approach. Care coordination can refer to a number of strategies that encourage greater collaboration and teamwork among health care providers, as well as emphasize overall responsibility for the entire care process. Examples include:

- *Care Transitions* — Interventions aimed at improving follow-up care and communication across providers in a continuum of care settings. Examples include the sharing of patient records, follow-up calls, and medication review and reconciliation.
- *Hospitalists* — Designated physicians with technical expertise in treating primary conditions leading to inpatient admissions as well as managing comorbidities across all levels of care.
- *Guided Care* — Model developed by Johns Hopkins Medicine in which primary care practices hire a high-skilled nurse to track, assess, and manage patients with multiple chronic illnesses.²³
- *Patient-Centered Medical Home* — Hybrid care delivery and payment reform model based on the active involvement of a PCP who works to integrate and coordinate care through increased access to care, prevention measures, patient self-management, and shared decision making. Physicians are provided a monthly management fee to support investments in health care IT, management tools, and care coordination activities.

The steps that are necessary to change the way that care is delivered are difficult and require not only new kinds of financial investments, but also time and effort on the part of physician leaders and clinicians.

3. Patient Engagement

Ensuring that patients have access to information that can help them make informed decisions about their health care, as well as identifying and developing resources to support healthy lifestyles, are essential components of care delivery transformation. Patients who are knowledgeable about and engaged in their treatment are more likely to continue treatment and adhere to provider advice, which ultimately improves overall outcomes, enhances patient satisfaction, and reduces avoidable complications. Examples of strategies that promote patients' engagement in their care include:

- Wellness and behavioral programs focused on providing patients with education on self-care and health maintenance strategies, as well as professional support to carry out these recommendations.
- End-of-life care management and planning.
- Educational videos, Web- and/or paper-based information guides, and counseling sessions that help patients understand treatment options, outcomes, risks, and benefits.
- Benefit design structures that enable patients to share in the savings (e.g., through reduced co-payment/coinsurance) when they seek care from ACO providers that have demonstrated better results in both quality and cost of care.

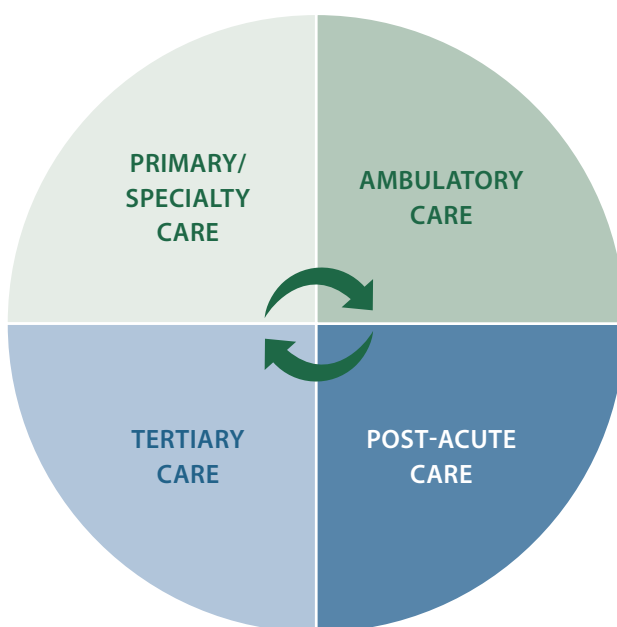
Education and the coordination of available tools both help to engage patients in the ownership and management of their conditions.

²³www.guidedcare.org

B. ROBUST PROVIDER NETWORK

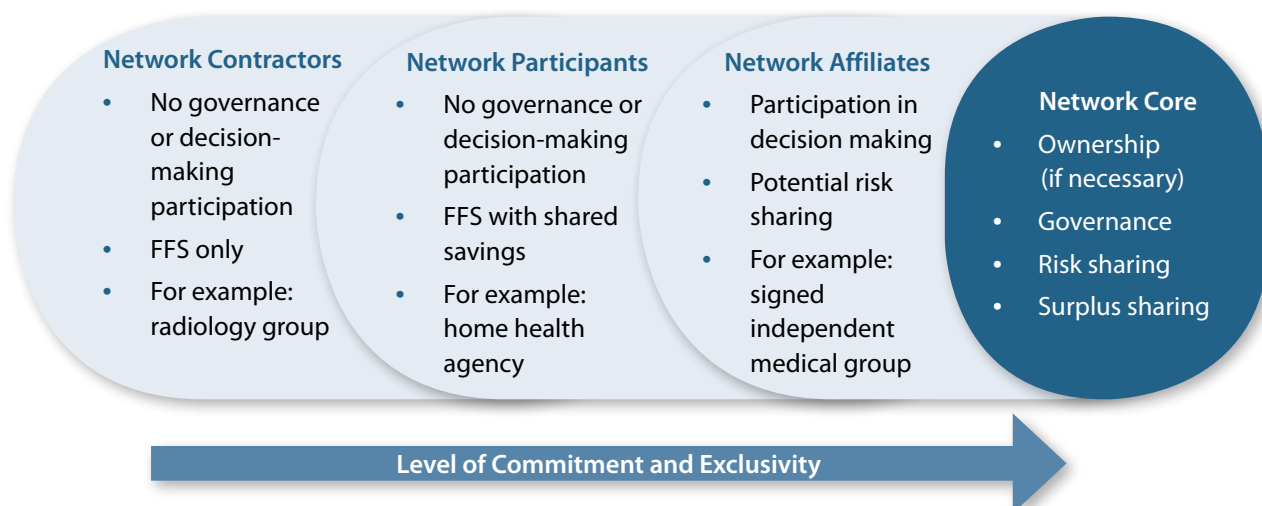
One of the Federal Trade Commission's requirements for a clinically integrated network is the participation of both PCPs and specialty care physicians, with a mandate of in-network referrals. As such, a physician network of sufficient size and with adequate specialty representation is necessary to support effective management of care across all settings and specialties. As demonstrated in Figure 5.3, the network should provide ready access to primary, specialty, post-acute, and tertiary care providers within inpatient and ambulatory settings, as well as other facilities that support the continuum of care for the community.

FIGURE 5.3 | Robust Provider Network Composition



Physicians who meet the criteria for participation/membership in the network may be expected to adhere to common protocols and experience variation in payment based on performance. The network may also include participation tiers that vary based on the level of commitment and exclusivity related to clinical integration efforts, as demonstrated in Figure 5.4.

FIGURE 5.4 | Typical Network Tiers



Physicians may be limited to specific tiers based on specialty type or practice affiliation. Nonetheless, it is important for physicians to understand the risks and opportunities associated with participation within the various tiers.

C. PERFORMANCE MANAGEMENT AND ANALYTICS

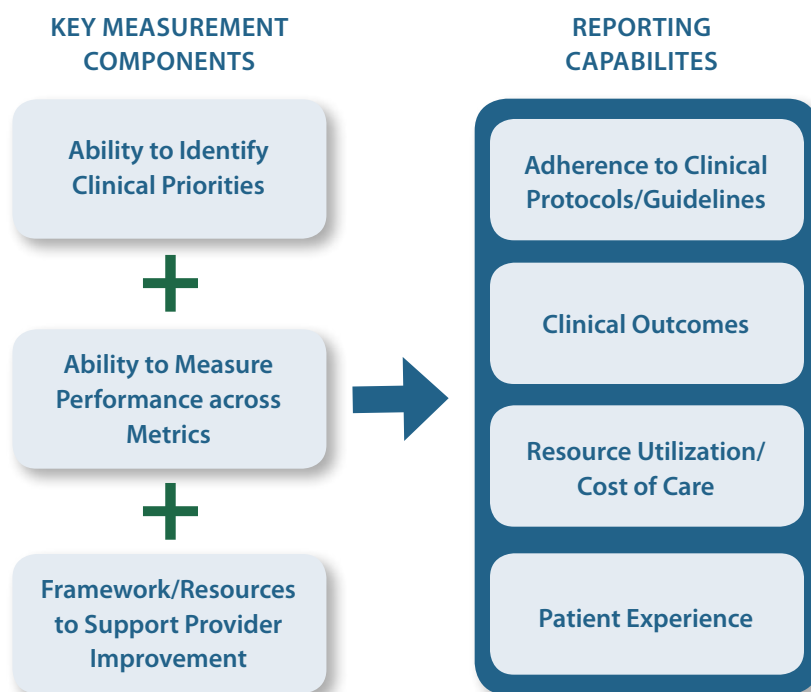
A key component of clinical integration is the gathering and monitoring of data regarding organizational and provider performance. Performance results give providers the information that they need to improve patient care, incorporate patient feedback into care delivery, and demonstrate to the public that cost savings and care improvement are occurring simultaneously.

Because ACOs are inherently data-driven, the management and analysis of data are core organizational requirements. Additionally, a quality measurement strategy is needed to ensure that the financial benefits of maintaining cost thresholds are contingent upon achieving care quality goals. As illustrated in Figure 5.5, organizations must develop information systems that are capable of supporting:

- The identification of initial clinical priorities and opportunities for improvement across the target population.
- Patient attribution related to the care provided by clinically integrated network members.
- Organizational and provider-level performance across approved metrics.

Beyond the information system requirements, dedicated resources — physician and administrative — to support report generation and facilitate peer-to-peer conversations with members of the clinically integrated network related to performance are vital to the success of an ACO.

FIGURE 5.5 | Key Measurement Components and Reporting Capabilities



While many organizations may be able to track only simple performance measures at the outset, their tracking of patient-centric results is likely to improve as the ACO evolves. Table 5.1 on the following page summarizes the critical components and considerations for measuring health care quality in an ACO.

TABLE 5.1 | Key Performance Measurement Considerations²⁴

Selecting Measures	Measures should track the results along the continuum of care, covering a wide range of services and quality of care goals, including care coordination, population health, overuse, and patient engagements. Measures should be well-established and preferably nationally endorsed.
Data Sources and Collection	Quality measurement relies on multiple data sources, including claims data (i.e., medical and pharmacy), laboratory and clinical records, electronic medical/health records, registries, and patient-generated information, such as patient surveys.
Standard Set of Measures	A standard set of ACO measures based on administrative claims data can progressively be expanded over time using clinical and other data sources.
Targets	Under the accountability-payment framework, financial incentives are contingent upon providers meeting or exceeding performance targets.
Performance Circulation	Various methods of calculating performance results exist, including the use of risk adjustment and composite scores.
Validation of Measures	Verification processes should ensure that all calculations are done in accordance with technical specifications. To evaluate the effectiveness across the ACO, the validation process should verify data collection and aggregation methods are implemented consistently.
Public Reporting	A core principle of ACOs is to be accountable for the quality of care provider. As such, public reporting of the quality performance is a key aspect of implementing an ACO quality improvement program.
Consistency with other Reforms	There is a wide range of payment reform initiatives, including expanding use of P4P programs, medical homes, and ACOs. Each of these requires the use of performance measures. Having consistent or standardized measurements across these initiatives would greatly assist in the evaluation of these programs.

As the ACO matures and further develops its infrastructure to support more comprehensive care improvement activities, the organization should be able to more effectively capture clinical outcomes and patient experience measures. In turn, this should facilitate the implementation of more sophisticated payment systems and other incentives that rely more on performance than volume.

D. IT INFRASTRUCTURE

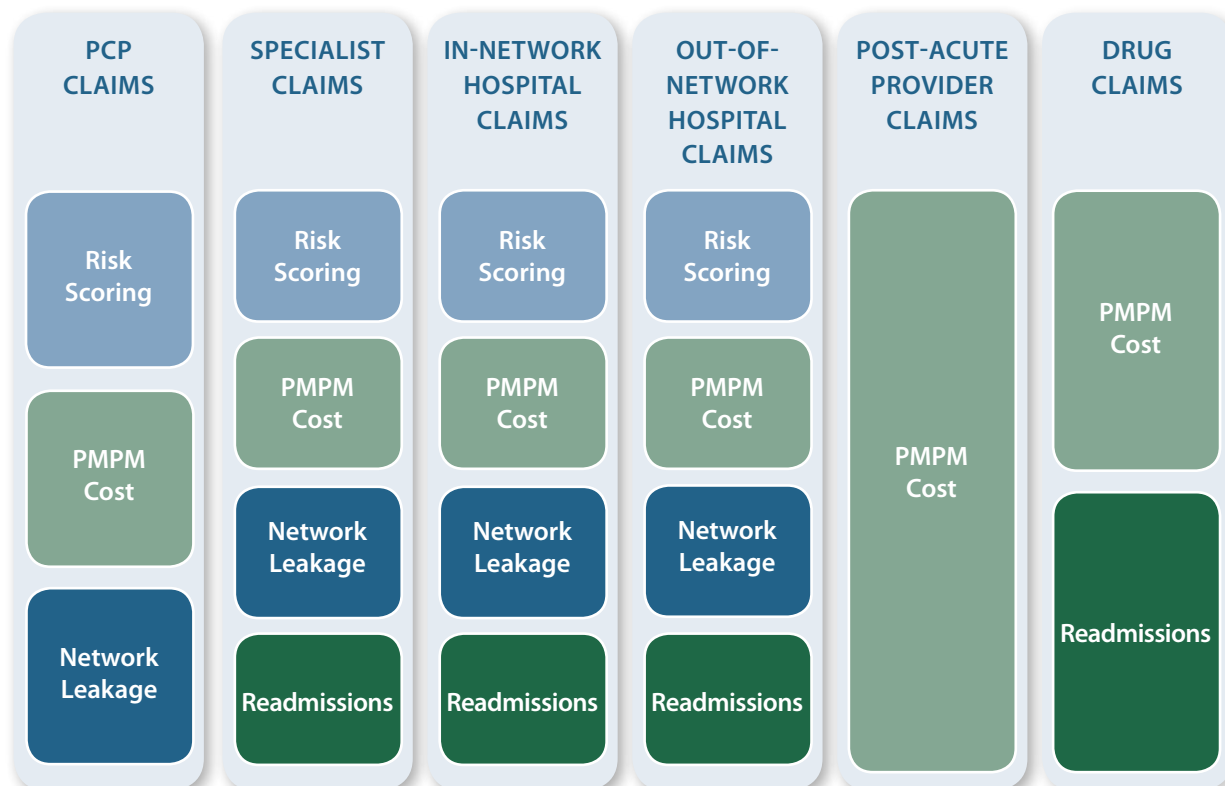
Fostering an information-driven culture of accountability through the creation of the necessary electronic infrastructure is paramount. Reporting requirements internally and externally will also continue to substantially increase under health care reform and new reimbursement models. More importantly, developing the capabilities to analyze and report performance, as previously discussed, is central to the ACO concept and particularly to aligning the incentives of physicians and hospitals toward improved value. Demonstrating this value goes beyond simple volume and length-of-stay statistics. Reporting the necessary statistics is just the first step. Enhanced analytics provide the necessary information to maximize performance and seek new incentives related to:

- Utilization (e.g., procedures, admissions, visits, referrals)
- Maintenance (e.g., population health, wellness)
- Outcomes (e.g., readmissions, infections, survival rates)
- Processes (e.g., Lean, Six Sigma)

²⁴ACO Toolkit, Accountable Care Organization Learning Network, Engelberg Center for Health Care Reform at Brookings, The Dartmouth Institute for Health Policy & Clinical Practice, January 2010.

IT linkages are vital to the development of an ACO, as well as the success of the organization in tracking provider performance, identifying variation, and reporting to enable compliance. It is also critical to have the IT tools that allow information to be shared across the continuum of a patient's episode of care, as the ACO environment requires real-time data access and analytical capabilities, as shown in Figure 5.6.

FIGURE 5.6 | Required Claims Data to Manage Total Cost of Care²⁵



The Federal Trade Commission defines a clinically integrated organization as being composed of six main elements, including integrated IT, whereby:

- Network participants can efficiently exchange information regarding patient and practice experience.
- Utilization claims can be gathered, analyzed, and communicated in order to improve treatment quality, rates of utilization, and cost containment.
- Physician compliance and performance, in accordance with collective physician-authored benchmarks and standards, may be measured.

By identifying the most efficient/effective IT solution for providing clinical information at the point of patient care, the ACO will enable information-driven care in support of superior value (cost/outcomes) and the creation of a clinically integrated network. Such a solution should encompass physician performance intelligence software, disease registry/clinical data exchange capabilities, population management/data aggregation tools, financial capabilities, and payer IT platform integration. Specifications for each of these IT solution capabilities are summarized in Table 5.2 on the following page.

²⁵ Analytics for ACOs: *Measuring the Depth Before Diving In*, Singletrack Analytics, LLC, 2011.

TABLE 5.2 | IT Solution Business Capabilities

BUSINESS CAPABILITIES	FUNCTION	IMPACT TO ACO
Physician Performance Intelligence Software	<ul style="list-style-type: none"> Enables physicians to track their performance in relation to their peers over time. Increases the ability of managers to measure the performance of physicians in an efficient and reliable manner. Identifies unnecessary variance in care among providers. Tracks performance for specific, critical measures to reporting and payment. 	<ul style="list-style-type: none"> Provides the ACO with detailed analysis regarding physicians' current and historical performance on a regular basis. Enables the ACO to create score-cards, dashboards, and summary reports that would encourage continuous improvement. Provides comprehensive and need-based reporting to allow for the sharing of performance data with other stakeholders.
Disease Registry/Clinical Data Exchange Capabilities	<ul style="list-style-type: none"> Utilizes guidelines to provide real-time clinical prompts to guide clinical decision making at the point of care. Identifies patients with lapses in care who require follow-up treatment, testing, and/or preventive services. 	<ul style="list-style-type: none"> Ensures provider interaction and coordination of care. As providers start participating in health information exchanges, provides detailed patient-specific data to aid in diagnosis and treatment.
Population Management/Data Aggregation Tools	<ul style="list-style-type: none"> Manages total costs and quality across a defined population, including risk-based contracts and the employee population over time. Identifies high-cost/utilization cohorts to target with care management interventions. 	<ul style="list-style-type: none"> Creates a holistic view of population's care experience, utilizing data from payers, hospitals, physicians, and other ancillary providers.
Financial Capabilities	<ul style="list-style-type: none"> Integrates the efficient payment allocation and tracking system with the performance management system. 	<ul style="list-style-type: none"> Enables quality-based payments.
Payer IT Reform Integration	<ul style="list-style-type: none"> Compares the actual ACO results to benchmarks using payer analytic capabilities based on the ACO's own performance and benchmark data. Enables real-time access to payer data transmission and analytic capabilities for credentialing, electronic claim submission, and payment estimation. 	<ul style="list-style-type: none"> Leverages real-time data analysis and transmission to keep the ACO updated on the recent medical history of the patient.

E. GOVERNANCE/ORGANIZATIONAL FRAMEWORK

1. Committee Framework

The centerpiece of a clinical integration program is a formal structure for decision making related to clinical improvement initiatives, measurements for performance, and interventions to achieve care improvements. Most often this takes shape through a committee structure with significant physician participation and progression into specific committee and leadership roles. Examples of necessary and/or required committees are demonstrated in Table 5.3.

TABLE 5.3 | Potential Committee Framework

COMMITTEE TYPE	CHARGE OF COMMITTEE
Oversight	<ul style="list-style-type: none">• Strategic and clinical planning• Communications• Workforce planning• Alignment and policy development• Contracting strategy/oversight• Budget development and management
Contracting	<ul style="list-style-type: none">• Contract execution• Financial performance• Funds flow development
Clinical Integration	<ul style="list-style-type: none">• Clinical focus areas• Performance measures• Care delivery models• Utilization management/quality assurance
Network Development	<ul style="list-style-type: none">• Provider network development• Recruitment/staffing
Data Analytics	<ul style="list-style-type: none">• Information management• Reporting• Business intelligence• Infrastructure

2. Physician Leadership

While a critical factor for success is to have physicians who are engaged in and dedicated to the continuous evolution of the organization, physician leadership is also paramount for the success of an ACO. This ensures that physician leaders and participants feel ownership of the program and remain committed to providing quality patient care.

Transformation of the care delivery model cannot be accomplished unless physicians have enterprise-level empowerment, incentive, and accountability. As such, a committee structure with significant physician participation and opportunities for specific committee and leadership roles is essential. While it is likely that no two ACOs will be organized and operated in the same manner, physician leadership is necessary for effective collaboration and program development within select committees that are more clinically driven and patient-centered, such

as those charged with oversight and clinical integration. Other committees that could benefit from physician leadership include network development and data analytics.

Whether they are public or private, most ACO contracts also have stringent requirements for physician representation in an administrative and management capacity, such as a governing board. The Patient Protection and Affordable Care Act (PPACA) mandates that public ACOs have a mechanism for shared governance. As such, CMS requires that at least 75% of the ACO's governing body be composed of ACO participants. Private ACO contracts will also establish within their bylaws similar requirements for governing boards with targeted physician representation thresholds.

True clinical integration not only facilitates the path to pursuing population management initiatives, but also produces value for all participants.

Value is created for the marketplace through the delivery of:

- Ongoing improvement
- Stable/cohesive network
- Standardized measurement, intervention, and communication of results
- Reduction of unnecessary waste
- Improved clinical outcomes and health

Value is created for providers by:

- Creating a means to reimburse ACO participants for investments in the collaboration necessary to improve care
- Promoting collaboration among physicians, hospitals, and post-acute care organizations
- Fostering innovation and experimentation

Most ACOs have worked hard and diligently to build the foundation for clinical integration, and as demonstrated within this section, they require and need physician engagement and leadership in order to continue evolving toward a value-based environment.

VI. How to Approach an ACO

Once the decision has been made to join an ACO or integrated delivery network, determining which entities to approach and establishing the criteria for your ultimate decision will be important initial steps. Taking the time to thoroughly investigate your options and determine whether or not a particular ACO is a good fit for your practice is integral to the long-term success of an ACO arrangement. Up-front preparation will support successful conversations and ultimately elicit the information necessary for your practice to make a knowledge-based decision when choosing an ACO to join.

FIGURE 6.1 | Steps for Approaching an ACO



The subsections below are intended to serve as a resource in the decision-making process by providing an overview of the strategic considerations that must be carefully vetted when evaluating options for ACO participation.

A. KNOW YOUR READINESS LEVEL

As thoroughly discussed in *Section II — Assessing Your Practice for Readiness*, taking the time to determine your practice's readiness level is important. Understanding current capabilities and potential deficiencies is essential in establishing the level of financial investment and operational changes that will need to be implemented in order to successfully engage in an ACO arrangement. The identification of deficiencies can also help to drive the decision-making process by highlighting functional capabilities that could potentially be supported by select ACOs. Understanding the level of support that is provided by the ACO and its expectations related to the practice's timeline for meeting readiness criteria is key to determining whether a particular ACO will be a good fit.

B. DETERMINE WHICH ACOS TO APPROACH

Determining which ACOs to approach may seem like a daunting task, but with a little research, this important endeavor becomes easier. Before initiating research, it may also be helpful to identify key selection criteria that will drive your evaluation and decision-making process.

Also consider taking the time to speak with colleagues who are already engaged in the ACO about their experiences. Questions to consider asking these individuals may include:

- What level of support did the ACO offer at the point of contracting?
- What level of support did the ACO offer to assist the practice with the on-boarding process after it had officially joined the network?
- How is the relationship as a whole between the practice and the ACO?
- How are problems or concerns dealt with?
- Does the ACO provide consistent feedback regarding metrics and performance?
- Is there an ongoing dialogue between the ACO and physicians?

- How does the ACO communicate information concerning and provide support related to clinical, quality, and cost-based metrics?
- If the individual's practice has been with the ACO for a while, what advice does he/she have for a practice starting the process?

C. FORMULATE QUESTIONS FOR DISCUSSION WHEN APPROACHING AN ACO

Before engaging in discussions with various ACOs and attempting to determine which one may be the best fit, and in addition to the points of consideration outlined throughout this guide, some questions that you may want to ask during the vetting process include:

- What level of support does the ACO provide in terms of on-boarding physician practices that are joining the ACO?
- What are the costs associated with participation in the ACO?
- What are the details of the data reporting timeline?
- How does the ACO communicate information concerning and provide support related to clinical, quality, and cost-based metrics?
- Does the ACO provide a process and contact person for questions, concerns, and/or issues that might arise?
- How much time must be committed to participating in the ACO?
- If I decide to leave the ACO at any point in the future, what is the process for doing so?
- What are the requirements related to exclusivity to the given ACO, and what are the expectations/requirements for any existing relationships with other providers not participating in the ACO?

The American College of Physicians (ACP) recommends that physicians ask the following questions before joining an ACO:

- How would I be represented on the organization's governing body?
- What would the ACO require of my practice as far as administrative and organizational tasks? What data would need to be shared?
- What kind of practice transformation would the organization expect regarding EMR system implementation, case management, access, etc.? Will the ACO offer any financial or in-kind assistance in this transformation?
- What shared savings can the ACO reasonably expect to earn, and how would those shared savings be distributed?
- Does the potential exist for losses to accrue that I would have to pay back? What maximum risk would I face?
- Would I be adequately protected from penalties related to federal and state laws?

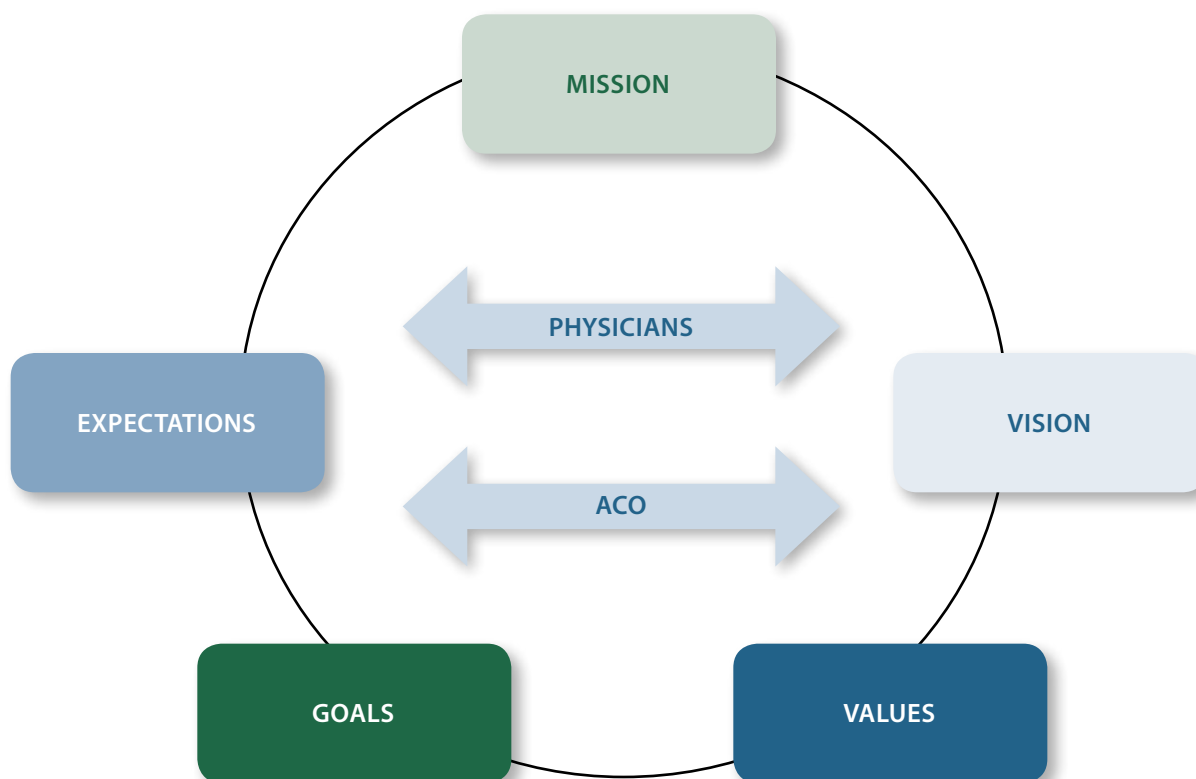
Source: http://www.acponline.org/advocacy/where_we_stand/policy/statement_of_principles.pdf.

D. INITIATE CONTACT WITH POTENTIAL ACOS

If you are interested in approaching an ACO, contact its medical director, its director of operations, or another high-level administrator in the organization to find the appropriate individual who can help answer your questions.

It will be important to take a moment to understand your mission, vision, values, goals, and expectations of the ACO and whether they are aligned with potential organizational partners.

FIGURE 6.2 | Key Areas of Alignment



ACOs and their participating physician practices must work together toward shared goals. Understanding your practice's readiness, the specific needs of your group, and the operations and expectations of the ACO that you are considering, as well as asking the right questions and truly understanding the answers, will help you make an informed decision as to whether or not joining a particular ACO is a good decision for your practice.

Appendix — ACO-Related Resources

The following resources may provide some perspective on issues that physicians may want to consider when preparing to join an ACO:

- “ACOs and Other Options: A ‘How-to’ Manual for Physicians Navigating a Post-Health Reform World,” 4th edition, AMA, Copyright 2010–2012: www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf (.pdf, 166 pages)
- Z. Song et al., “Health Care Spending and Quality in Year 1 of the Alternative Quality Contract,” *The New England Journal of Medicine*, 365:909–918, 2011: www.nejm.org/doi/pdf/10.1056/NEJMsa1101416 (.pdf, 10 pages)
- H. Meyer, “Many Accountable Care Organizations Are Now Up and Running, If Not Off to the Races,” summary paper highlighting the successes and challenges facing ACOs, *Health Affairs*, 31:2363–2367, 2012: <http://content.healthaffairs.org/content/31/11/2363.full>
- P. Markovich, “A Global Budget Pilot Project among Provider Partners and Blue Shield of California Led to Savings in First Two Years,” *Health Affairs*, 31:1969–1976, 2012: <http://content.healthaffairs.org/content/31/9/1969.full>
- M.C. Shields, P.H. Patel, M. Manning, and L. Sacks, “A Model for Integrating Independent Physicians into Accountable Care Organizations,” *Health Affairs*, doi:10.1377/hlthaff.2010.0824, 2010: <http://content.healthaffairs.org/content/30/1/161.full>

RESOURCES FOR UNDERSTANDING THE LOCAL ACO LANDSCAPE

Your practice should determine which ACOs are currently active in your geographic service/market area. MMS offers resources to support market knowledge, including the following materials:

- **Map of Massachusetts ACOs as Designated by CMS**
www.massmed.org/ACOMap (.pdf, 2 pages) MMS member login required.
- **Massachusetts Health Care Delivery System Roadmap**
www.massmed.org/healthcareroadmap (.pdf, 2 pages) MMS member login required.
- **Map of Large Physician Groups (Over 100 Physicians)**
www.massmed.org/groupmap (.pdf, 1 page) MMS member login required.



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