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# Are you prepared for ACO contracting?

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Providers and provider networks increasingly have the opportunity to participate in an Accountable Care Organization (ACO) arrangement, sometimes under a different name (e.g., care coordination arrangements). These models give providers the opportunity to play a more active role in managing care for a particular population, but they can raise a number of tricky compliance issues.

The original ACO model is the Medicare Shared Savings Program (MSSP) model, born of the Affordable Care Act, which quickly inspired many other value-based models and variations in the commercial world. In essence, in all of these models a group of providers agrees to be "accountable" for the cost and quality of care provided to a defined population. The providers continue to be paid on a fee-for-service basis, but the quality of care they provide is measured against agreed-upon metrics, and the cost of care per covered life is measured against a target budget. If the quality metrics are met and the providers come in under budget, then the savings are shared between the payer and the providers. Commercial health plans commonly enter into these arrangements with providers or provider networks, and large employers have even started contracting directly with providers and provider networks to develop ACOs for their self-funded plans.

The following points offer general guidance for providers to consider as they begin the process of analyzing and negotiating these arrangements, and avoiding common compliance pitfalls.

## Types of ACOs

Is the agreement with an MSSP ACO, or with a commercial health plan, or is it a "direct-to-employer" contract with a self-funded employer plan? Under each of these models, a different set of laws and regulations will govern the arrangement.

Does the agreement cover a single service line in which all the covered lives have identical benefits and benefit structures, or does the agreement cover multiple service lines, in which different patient populations have different benefit designs (e.g., with a large, commercial health plan)? The latter type of arrangement will generally be more complex to manage.

Do you know the payer (e.g., a large, national plan) or is it a relative newcomer? Are you satisfied with the financial wherewithal, integrity and reputation of the payer?

## ACO patients

Do the patients whose cost and quality of care will be attributed to the ACO providers "opt into" the ACO model and select an ACO provider to serve as their primary care physician (PCP)? Or, are they "attributed" to the ACO (e.g., based on the providers from whom they receive services) and potentially unaware that they have a PCP? Are patients aware that there is a network of providers "accountable" for the cost and quality of their care, who may be trying to coordinate the care they receive? It is generally easier to manage the care of patients who have opted into an ACO and selected a PCP. Engaged and informed patients may also be more likely to visit their PCP and use low-cost (or free) preventive health care services that can improve patient outcomes and improve an ACO's performance.

In what service area do patients attributed to the ACO work or reside? How is the service area defined? Is the service area of a reasonable size, or is it so large that patients will be required to travel unreasonable distances to obtain services?

If patients are attributed to the ACO providers, how is this done? Is it based on where the patient receives a plurality of the patient's primary care, or the patient's last visit to a primary care physician, or are other specialties involved? What time period is being measured? It is important for providers to consider whether an ACO's attribution process was guided by thoughtful, patient-oriented principles. An ACO that attributes patients to providers without the requisite level of care may be a cause for concern.

When will the ACO provider be notified of which patients are attributed to the ACO? Will patients be assigned or attributed to the ACO for short periods, or is there a minimum timeframe? How, if at all, will patients be involved in this process?

If the patient "opts into" the ACO and selects a PCP, does the benefit design of the patient's health plan create a financial incentive for the patient to stay within the ACO network? Such incentives can be powerful motivators for patients and increase an ACO's chances of obtaining financial success.