

# Provider Checklist **Standardized Plan ACO Reporting for Customers (SPARC)**

**PURPOSE**

Purchaser-customer (“Company”) may benefit, in certain circumstances, from meeting directly with an Accountable Care Organization (ACO) to learn more about how it operates as well as its arrangement with Company’s Administrator. For example, if Company has a particularly sizable population receiving care from an ACO offered by its Administrator, Company may want more complete information than it has received from Administrator about how the ACO coordinates patient care. Company can use this checklist during a meeting with the ACO to get answers to important questions.

**CHECKLIST**

The questions are organized into categories, which Company can prioritize based on its specific interests.

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| **Category** | **Questions** | **Notes (ACO Provider Response)** |
| **I. WHAT IS THE PROVIDER MAKEUP OF THE ACO?** | 1. Is the ACO led by a hospital, primary care physicians or specialist physicians? |  |
| 2. What is the breakdown of provider types within the ACO (%)? |  |
| 3. What is the management structure of the ACO? |  |
| **II. IS THERE A COMPREHENSIVE ELECTRONIC HEALTH RECORD?** | 1. Does the ACO require all of its participating providers to use a shared EHR? If not, what proportion of providers in the ACO use a shared EHR and are there plans to migrate all participating providers to a single platform? |  |
| 2. Do the providers participating in the ACO have access to the records of all assigned/attributed patients? |  |
| 3. Can patients gain access to the EHR to enhance participation in their own care (e.g., see lab results, make appointments, read the physician’s notes)? |  |
| 4. Does the EHR identify patients that are assigned/attributed to the ACO? |  |
| **III. HOW COMPREHENSIVELY DOES THE ACO MANAGE CARE?** | 1. Please describe how providers participating in the ACO manage care to ensure that assigned/attributed patients receive needed, not duplicative care. Please provide an example. |  |
| 2. Does the ACO have a process in place for reviewing daily admissions? If so, who conducts these reviews (e.g., utilization review nurse, physician, both)? |  |
| 3. Does the ACO receive data from Company’s Administrator on all medical claims incurred by assigned/attributed patients? If so, what is the frequency with which Administrator provides the data? How does the ACO use it? |  |
| 4. Does Administrator provide the ACO with behavioral health and pharmacy data? If so, what is the frequency with which Administrator provides these data? How does the ACO use it? |  |
| 5. Does Administrator notify the ACO when assigned/attributed members use the emergency room or are admitted to the hospital? If so, how soon after the patient is admitted does Administrator notify the ACO? What does the ACO do upon notification? |  |
| 6. If the ACO is hospital-owned, what is the business case for reducing admissions? |  |
| 7. How quickly can the ACO identify out-of-network care? |  |
| **IV. HOW DOES THE ACO ENGAGE PATIENTS?** | 1. How does the ACO reach patients who are overdue for tests/appointments or in need of care management? |  |
| 2. Does the ACO ask assigned/attributed patients to set goals for their health? If so, how does the ACO work with patients to meet those goals? |  |
| 3. How is the communication about patients handled among primary care physicians, specialists and care coordinators? What is the frequency of this communication? |  |
| 4. What is the role of non-clinicians in reaching out, providing navigation support or providing care coordination to assigned/attributed patients? |  |
| 5. Do ACO providers participate in shared decision-making with patients? |  |
| 6. Do ACO providers communicate with patients beyond face-to-face interactions (e.g., text, email, or chat)? |  |
| **V. WHAT IS ACO PROVIDERS’ EXPERIENCE WITH PAYMENT REFORM & QUALITY MEASUREMENT?** | 1. What payment arrangement does the ACO have with Company’s Administrator or other health plan partners (e.g., shared savings, shared risk)? |  |
| 2. If the ACO receives shared savings or other financial incentives, how do the financial incentives reach the front-line health care providers? |  |
| 3. If there is a shared risk arrangement and the claims associated with assigned/attributed patients is greater than the target budget, how is the overspending handled? |  |
| 4. Are the ACO providers participating in other payment reform initiatives (e.g., Medicare Pioneer or Shared Savings Program, Bundled Payments for Care Improvement, etc.)? |  |
| 5. Does the ACO have experience with capitation (dollar amount PMPM)? Please describe. |  |
| 6. Does Company’s Administrator and/or ACO have a plan to migrate to a shared risk arrangement? If so, what is the timing? |  |
| 7. Is some proportion of individual provider’s compensation tied to quality (e.g., 20% of provider’s payments are tied to his/her quality score)? |  |
| 8. How does the ACO track quality internally? |  |
| 9. What are the greatest opportunities for quality improvement within the ACO? How is the ACO addressing it? |  |
| **VI. HOW DO PROVIDERS IN THE ACO RECEIVE AND REACT TO COST & QUALITY INFORMATION?** | 1. Do providers participating in the ACO receive cost and quality information on their own performance? If so, how often? Please provide a sample report, along with a description and example of how providers use it. |  |
| 2. Do providers participating in the ACO receive cost and quality information on other participating providers’ performance? If so, how often? Please provide a sample report, along with a description and example of how providers use it. Specify if and how they use the information to make referrals. |  |
| 3. Can ACO providers see variations in practice patterns across providers within the ACO? Please provide an example of how the data can be used to reduce practice variation. |  |