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PRACTICE SUPPORT

Considerations For Joining an Accountable Care Organization (ACO)

An ACO is a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program. Contracts with commercial payors or Medicare Advantage may include quality incentive payments in addition to the shared savings program. CMS has more information at: https://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations

Before joining an ACO, a practice should be prepared with the following:

- Have a 2015 CEHRT certified EHR and updated to the 2015 edition of the Cures Act
- Practice efficient clinical workflows
- Possess Patient Centered Medical Home (PCMH) qualities
- Understand financial risks within an ACO
- Understand the participation requirements of the ACO
- Ensure the ACO's model and current performance aligns with your interests
- Know what matters to you is supported by the ACO and the ACO contract

What should a practice consider regarding the financial risks of the ACO?

- Timeline of financial risk
- The process to decide to move to risk or take on more risk
- Clinician and practice manager involvement in these decisions
- ACO participants' ability to leave the ACO if the level of risk becomes too high
- ACO's investment strategies to reduce the likelihood of shared losses
- Evaluate how the ACO's features and benefits compare to the Making Care Primary Model (MCP)

What are other considerations of the ACO?

- Practice costs or fees to participate (initial, monthly, annual, etc.)
- Confirm the names and number of ACO practice members in your cohort
- Learn if the membership is limited to primary care or includes specialists, hospitals, behavioral health, skilled nursing facilities, pediatrics and/or adult medicine
- Know if the membership is considered high quality
- Check in with members to assess satisfaction with performance
- Find out the number of covered lives each year and if any significant changes
- Know the aggregate and per practice average payout each year
- See if they provide additional services and at what cost- software, website, data analytics, data dashboard, software integration into EHR, registry, community health worker, behavioral health integration, care management for high-risk patients, social drivers of health referral and management, embedded CIN to accomplish AMH for Medicaid Managed Care, contracting negotiation with Medicaid standard/tailored health plans and other payors
- Research ACO ownership structure and funding sources, leadership team and if they are accessible to practice leadership

- Confirm if ACO has strategic plans for mergers and acquisitions, new payor contracts, etc.
- Know the administrative and financial obligations your practice leadership, providers and staff will be required to provide (upfront, weekly, monthly, annually, etc.)

What are the ACO's contract choices-do you have to join all or can you pick?

- MSSP, REACH, Medicare Advantage Plans, Blue Premier
- Do you want to be in multiple ACOs?
- Can you be in multiple ACOs for various contracts?

What are the ACO's Quality Payment Program (QPP) track and future plans?

- QPP has two tracks from which clinicians can participate:
  - ***Advanced Alternative Payment Models:*** Include Shared Savings Program Track 2, Track 3, Level E of the BASIC track, ENHANCED track, and the Medicare ACO Track 1+ Model.
  - ***Merit-Based Incentive Payment System (MIPS):*** Includes MIPS eligible clinicians who are in ACOs participating in the Shared Savings Program under Track 1, and Levels A, B, C, and D of the BASIC track.
    - What will the ACO report on your behalf and what will you be required to report to QPP?
    - What will the expectations be of you and the ACO within the QPP track (consider clinical and administrative workload)?
    - What Quality measures will be required?

Definitions to Know with ACOs

- **Clinically Integrated Network (CIN):** A group of independent physicians joining together to identify and improve quality and care while reducing costs.

- **Quality Payment Program (QPP):** An incentive program mandated by the Medicare Access and CHIP Reauthorization Act of 2015 in which clinicians have 2 options to participate in value based care to obtain incentives from Medicare**.**

- **Upside Risk:** One sided risk model allowing providers within an ACO to share in healthcare savings. If costs are below benchmark providers will get shared savings, but if costs are above benchmark, there is no financial penalization.

- **Downside Risk:** Providers in this type of ACO can lose revenue or have to refund payers if they go over a predetermined budget.

- **Two sided financial risk:** An ACO track including both upside and downside risk.

- **Medicare Shared Savings Program (MSSP):** One of multiple ACO models with various tracks to choose from in order to move from volume toward value and outcomes for Medicare beneficiaries. A Shared savings program is an alternative payment model that promotes population accountability, care coordination, and investment in quality and efficiency.

- **BASIC track:** Under Pathways to Success rule from CMS, this is one of 2 tracks within MSSP allowing ACOs to move from shared savings only through five levels of financial risk and reward over two to three years. Included in the Basic track are levels A through E.

- **ENHANCED Track:** Under Pathways to Success rule from CMS, this is one of 2 tracks within MSSP where an ACO is in a 2-sided risk agreement from the beginning, with high financial risk and high potential

reward.

- **MSSP Track 1:** An ACO track where participants can participate in upside risk for 2 years before moving directly into a 2 sided risk agreement. Equivalent to the Basic Level A and B.
- **MSSP Track 1 + model:** An ACO track where participants can participate in a 3 year upside and then a limited downside risk (less risky than track 2 or 3) agreement. Equivalent to the Basic Level E.
- **MSSP Track 3:** Equivalent to the Enhanced track, this track requires ACOs to be in a 2 sided financial risk agreement, which has high financial risk and high potential reward.
- **BASIC and ENHANCED comparison chart:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf
- **Alternative Payment Model:** A QPP payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population (https://qpp.cms.gov/apms/overview).
- **Advanced Alternative Payment Models:** A track of the QPP that allows an ACO a 5 percent incentive, APM specific rewards, and exclusion from MIPS by achieving threshold levels of payments or patients (https://qpp.cms.gov/apms/overview). BASIC Level E and Enhanced track are considered Advanced Alternative Payment Models.
- **Care Coordination:** Involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. (https://www.ahrq.gov/ncepcr/care/coordination.html)

How can you get more information or coaching assistance?

- For more information or to consult with an NC AHEC Practice Support Coach, contact us at practicesupport@ncahec.net.