Introduction to Accountable Care Organizations & Alternative Payment Models

Transcript from Live Session

Tuesday, August 11, 2020

April Faulkner:

The Quality Insights QPP Support Center team welcomes you to today's webinar: Introduction to Accountable Care Organizations & Alternative Payment Models. We will review just a few items before we begin the presentation. All participants entered today's webinar in a listen-only mode. Should you have any questions during today's presentation, please type them into the Q&A box at the bottom right of your screen. We will answer as many questions as time allows. Today's webinar is being recorded. The recording, along with the slide deck and a transcript of the webinar, will be posted on the Quality Insights QPP Support Center website within the next few days.

April Faulkner:

These resources can be found on the archive events page. I've posted a link to that webpage in the chat box. At this time, I would like to introduce our presenters. Joining us today are two members of the Quality Insights QPP Support Center team: Lisa Sagwitz and Gary Rezek. I will turn the presentation over to them to get us started.

Gary Rezek:

I'll start with a disclaimer that everything you are about to hear today is valid as of today. Changes can and will occur, and at the end of the presentation, we'll be showing you some resources where you can be informed and stay up-to-date with any changes that might occur. So we're going to talk about Accountable Care Organizations and Alternative Payment Models, ACOs and APMs. We'll talk about what those infinities are and how they're related to one another. We're going to talk about some common established ACOs and APMs and what criteria make them different from one another, and how those different criteria relate to the Quality Payment Program.

We will briefly introduce some new ACO options, which we'll be starting in 2021, and then we'll be showing you some facts and figures that show the level of participation and the financial impact of ACOs. We'll also be showing you how to find ACOs near you and how to check your ACO status as it relates to QPP participation. We will talk about risks and benefits of participation in ACOs, and the many factors that play into deciding which ACO, if any, to join, so we want you to be aware of some of these factors. Then we will briefly introduce Clinical Innovation Networks, CINs, and how they relate to ACOs. Finally, we'll talk about some resources where you'll be able to get more information and have your questions answered. At this time I'll pass the presentation over to Lisa Sagwitz.

Lisa Sagwitz:

Thanks, Gary. Hello everyone. Today what we're going to do is have a basic presentation on ACOs and APMs to introduce you to the topic. There will be resources throughout these slides with additional information if you would like to view that at a later time. It's a complicated topic, so I just wanted to let you know that Quality Insights is here to help you. This is to introduce you to the concept, but we're here now, next week, next month, next year, to help you through this.

Lisa Sagwitz:

So getting started, you know that we're in the fourth year of the Quality Payment Program. It replaced Meaningful Use, and there are two paths that you can take. So I'm going to talk about the green hexagon on the left first, and I'm going to call that "path one." So if you can, just envision path one, the

green MIPS one. When we have the Quality Insights webinars, we typically focus on that aspect. That's for a provider or a practice not in an ACO and they're reporting, if they qualify, for Quality, Promoting Interoperability, Improvement Activities, and they're scored on the Cost category, and the practice does that all on their own.

Then the second path, which I'll call “path two,” that's the blue hexagon. You'll see that it says advanced APMs, the path two, or that blue hexagon, represents all the ACOs and all the APMs. We'll talk about advanced APMs, but I'm also going to talk about MIPS APMs. So when I talk about MIPS APMs, think of path two, the blue hexagon, and I'll remind you of that throughout the presentation. Then just know that CMS would like to see clinicians transition from MIPS, the green hexagon in path one, to an advanced APM over time.

Lisa Sagwitz:

So on our next slide, we're going to get the definition of what is an ACO. It's an accountable care organization, it's a group of doctors, hospitals or other healthcare providers or it could be just a group of doctors who come together to give coordinated high quality care to their patients. The goal is to ensure patients get the right care at the right time while avoiding unnecessary duplication of services and prevent medical errors.

So you may be thinking if you're in a private practice, well we do this now. It's exactly what you'll be doing just at a higher level. ACOs have been increasing in popularity. They first started with just Medicare, but now we're seeing them with Medicaid and commercial payers. We'll talk about that a little more in the slides. Payment is provided for high quality, cost efficient care.

Lisa Sagwitz:

So, what is an APM? It's a term for Alternative Payment Model, and for simplicity during this webinar, I want you to think of ACOs and APMs as the same thing, they're interchangeable. So, participation in an ACO is the usual form of participation in an APM. There are different types, they can cover particular populations. They started as Medicare patients but they can cover other types or specific clinical conditions. You'll see there are cancer ones, end-stage renal disease, joint replacement, and they can also cover episodes of care. Think of path two, the blue hexagon MIPS APM, advanced APM. The fact that most advanced APMs are MIPS APMs, and then the all-payer, other payer option that's becoming more popular.

Lisa Sagwitz:

This slide shows some of the more popular ACOs that I deal with. So, you know that Quality Insights covers small practices in four states: Pennsylvania, West Virginia, Delaware and New Jersey. So these are the most common types of ACOs that I see. So, the MSSP or Medicare Shared Savings Program is the most popular one that I encounter with practices. There's a basic level A to D and then there's the basic level E. We'll talk about the MIPS APMs and the advanced APMs. I may use terms like “one-sided risk model” and “two-sided risk model.” When the ACOs first started, most of them were one-sided risk models. So there was no financial downside to being in an ACO or starting an ACO. If you did well, great, and if you didn't, it was okay, there was no skin in the game. Well, now CMS wants two-sided risk models, they want the organizations to do well and show good quality care and cost savings. But when you do have skin in the game, the financial reward can be that you do make more money, but if you

don't perform well as an ACO, you can also lose money. There is the all-payer model that's becoming more popular. So again, when these first started, it was just the straight Medicare patients. Now we're seeing the ACOs evolve with Medicare Advantage and Medicaid and private commercial insurances. So, if you're offered an opportunity to be part of an all-payer model, that could be appealing, or your current ACO may be moving toward that model, because that's going to encompass a larger group of patients.

You'll hear me talk about track one, track one plus, track two, track three. There's a model called Comprehensive Primary Care Plus, we refer to it as CPC+ for short, and that particular ACO has 18 geographic regions in the United States. So for the four states that we serve, those are popular in the Philadelphia area and New Jersey. The Next Generation ACO model, CMS has extended that until December of 2021. The Comprehensive Care for Joint Replacement model, we call CJR, and that one has a little bit of a one-off. So with an orthopedic practice, only orthopedic surgeons who perform hip and knee replacements are in that model. So generally in an ACO, everybody participates. So in an orthopedic practice, maybe a hand specialist or a spine specialist, they would not be in the CJR model, just the hips and knees.

There's an Oncology Care Model, and CMS has extended that until 2022. There are disease-specific models. An example would be the end-stage renal disease model. Now, that last link has a nice site to look up different types of ACO information, and I'm going to take you to two different sites during today's presentation. I will share my screen and take you to that site. If you can see this, it says CMS.gov at the top, and the Innovation Center, and there are 88 different ACOs listed here. They're organized, they tell you if they're ongoing or no longer active. Here's the ESRD one that I mentioned, there's the Next Generation one, the CJR one. So let's take a peek at the Next Generation one. If this would be something that you're considering. So we can see that it is currently in place and there are 41 ACOs in the country. When I click on Learn More, there is a wealth of information that displays. So you can see by the circles where those Next Generation ACO models are. There is some background, the model details, the financial and quality results, showing how well they've done over the years, and a lot of other resources. So I thought that was important to show you. We will go back to the slides again for a minute or two.

Lisa Sagwitz:

So some exciting news: there are two new ACOs being introduced for 2021. So, if an organization approaches your practice about the Direct Contracting model, there is the link that will give you more details on that. There are two different options: the global and the professional, and that will start April 1, 2021. Normally, the ACOs run January 1 through December 31 for a year. So this is a little bit of a one-off, and then the other new ACO coming is called Primary Care First, and the link is in the slides if you want more information about Primary Care First.

Lisa Sagwitz:

So the next couple of slides include information about the Medicare Shared Savings Program, the MSSP. As we go through this, I'd like you to look at the bottom of the chart and read up. So in the first column, performance year, in 2012 when the ACO started and they were basically just Medicare patients, there were about 220 ACOs in the country. So if we move up to 2020, you can see now we have about 517 ACOs in the country. So it's significantly increased year after year. The third column represents the

assigned beneficiaries in the ACOs. Again, in 2012, there were 3.2 million patients, we're currently at about 11.2 million. So again, year after year, that number increases. The fourth column lists shared savings. The first year, about $315 million was saved with quality patient care. And again, year after year, that gets better and better.

Lisa Sagwitz:

On our next slide, we're going to talk about a few of the terms. So, you'll see in column two, it references if a track is one-sided or two-sided, and you'll remember that in the one-sided model there's no skin in the game, but that's not where CMS wants ACOs to be, they want them to be in the two-sided risk model. So, the number of ACOs for levels A and B in track one are the highest: 191 and 134. So the majority of the ACOs are still in that one-sided model but they will be moving to two-sided. Then level C and D, while it is a two-sided model, it's not an advanced APM, that's in the last column. Advanced APMs generally offer a 5% lump sum payment. Then when we talk about basic level E, a two-sided risk model, there's 69 in the country. There's an enhanced track, the track one plus model that was introduced a few years ago and then track two.

Lisa Sagwitz:

Then on this slide, what I'd like you to focus on is while ACO composition makes up different entities, the majority is physicians and non-physicians at about 463,000. So within a practice, everybody is part of an ACO, not just your doctors, your nurse practitioners and your physician assistants.

Lisa Sagwitz:

The next slide is interesting. It's a map of the United States, and you can see the hot spots in dark blue, the heavy concentrations of ACOs. So in California, they have the most ACOs, there are 67. You can see Florida has a heavy concentration, and then along the East Coast and the practices that we serve, there's also a heavy concentration of ACOs. The link at the bottom of this slide takes you to this map and some of those fast fact documentations. Okay, now we're going to go to another website. I will share my screen in just a minute. If you are interested in knowing about the MSSP ACOs in your area, in the Q&A box, type in the city and state that you're in and we'll visit those in just a minute.

I'm in Pittsburgh, Pennsylvania. You can see when I click that link, I'm in data.cms.gov. I'm looking at the 2020 MSSP ACOs, the most popular ones that I see. In this box, you would put in your city and state, so I put in Pittsburgh, Pennsylvania, and these purple dots represent the MSSP ACOs by me. So I'm going to click on the first one, and it's Physician Partners of Western Pennsylvania. There's the ACO number: A3547. It tells me it serves Pennsylvania. There's the website to get additional information, a contact person, an email and also a phone number. Then with that ACO number, the A3547, if I go to the bottom of the screen, by that number you can get additional information about the ACO.

So, also in my area, there's a Keystone Clinical Partners, again all the same information, moving a little north, the Bridges Health Partners ACO, and also to the north, the Heritage Valley ACO. What I'd like to call attention to, is the ACO service area is not just Pennsylvania, but parts of Ohio and West Virginia for this particular ACO. So April, has anybody typed in a city and state that they'd like to get some information on?

April Faulkner:

Yes, we have gotten a couple. Lisa, can you take us to Hoboken, New Jersey first?

Lisa Sagwitz:

Absolutely. I'm going to zoom out from Hoboken because I want to see what purple dots are there. So let's pick this one first, and that shows an ACO called The Physicians Alliance. It's ACO number A4592, and that serves not just New Jersey, but Louisiana, Mississippi, New York, Oklahoma, Tennessee and Texas, so quite a few. There's the website. So if that's an ACO that you're thinking of joining or you want to investigate, you can find additional information and the contact person on this site. Here's the Holy Name Medical Center ACO that serves New Jersey, Hackensack that serves both New Jersey and New York. So you get the idea, locate the city that you live in and just move to the purple dots that are around you. Did anyone else want a city or state quickly looked at?

April Faulkner:

We do have a few more. Our next stop is Darby, Pennsylvania.

Lisa Sagwitz:

And I know there's a practice that sent a question in for us from Darby, Pennsylvania, and you are close to Philadelphia, which has quite a few ACOs in your area. So I'm going to click on this purple dot and that shows Crozer ACO, and they serve both Pennsylvania and Delaware. Then over here is Einstein Care Partners. They serve just Pennsylvania practices. Delaware Care Collaboration serves not just Pennsylvania, but Delaware and Maryland. This might be getting a little farther away, LCC ACO, but you get the idea, just appropriately pull up what's closest to you. And again, these are the Medicare Shared Savings Program ACOs, there are other models and I showed you on the previous link how to look at those. So, thanks for sending them in.

Lisa Sagwitz:

So, now we'll talk about MIPS APMs. Remember when we first started, I said to keep your focus on path one- green MIPS, and path two-the blue hexagon for the ACOs. So, even though this says MIPS APM, we're still on path two, the blue hexagon for the ACOs. So for a MIPS APM, three criteria must be met. They need to have a participation agreement with CMS, so the ACO has that CMS agreement, and then the ACO also has agreements with each practice or each provider to be in that ACO. The second criteria is to include one or more MIPS eligible clinicians on a participation list; that's easy. Three, base payment incentives on performance. That's either at the APM level or at the eligible clinician level on your cost or utilization and quality measures. There is a link there if you'd like to read more about MIPS APMs.

Lisa Sagwitz:

So next we'll talk about advanced APMs or advanced ACOs. We're still on path two in blue. It's just another track in the Quality Payment Program that there are three criteria. This is a little bit harder to achieve for an advanced APM. So, 75% or more of the practices need to be on a certified EHR. They must provide payment for covered professional services based on quality measures, comparable to those in the MIPS Quality performance category, which is path one, the green. So there are 10 quality

measures that CMS wants an ACO to work on. Then those are reported by the ACO with a method called CMS Web Interface. Then three, you need to have significant site financial risk, skin in the game or be a medical home model.

So if you are in an advanced APM, what you want to look for, and I will show you how to find this, is to be a qualifying APM participant or QP. So what that means is a certain level of a number of patients and payment is going through that ACO for your patients. Then with that, you're offered a 5% lump sum incentive when you achieve that QP status. So, if you're on path one, the green MIPS, where you're an independent practice and you're reporting everything on your own, you know for the last couple of years, even if you've scored 100 MIPS points or very close to it, you've been getting about a 1 ½ or 1.7%, increase for each individual Medicare Part D claim. So when you're an advanced APM and you're getting a lump sum 5% payment, that's significantly more. So that is an incentive to being in an advanced APM. Just a reminder, again, that most advanced APMs are MIPS APMs, and the last link there has more information on the topic if you'd like to look at it.

Lisa Sagwitz:

So how do you find out if you're a QP? How do you even know if you're in an ACO? So oftentimes we'll talk with a practice, with a new office manager who doesn't have a lot of history, and we'll have a conversation, and she'll say, "I really don't know if we're in an ACO." Sometimes we talk with staff members who weren't aware that their doctors signed an ACO contract. So this screen may look familiar to you, it's on the website qpp.cms.gov and it checks participation status. That's where everybody goes to enter their provider NPI number and check all years and see if they need to report or not. We'll also be able to see if you're in an ACO here and if you're a QP or not.

Lisa Sagwitz:

So the next two slides are actual screenshots of one of the doctors that I work with that's in a MIPS APM. So you can see in green, there's a circle with a check mark in green, it says, "MIPS APM." And under reporting requirements, it tells us this clinician is required to report because they participate in a MIPS APM and exceeded the low volume threshold. Then for reporting options, it tells us that this doctor should submit Promoting Interoperability at the group or individual level, unless he's exempt, and you can ask your ACO if you need to report this or not. So that means this particular doctor, between January and March, will be reporting his own Promoting Interoperability data. Then the APM will take care of the Quality data with those 10 designated quality measures through that CMS Web Interface. Then the payment adjustment will be based on scoring under the APM scoring standard.

Lisa Sagwitz:

So on the next screen, it will also tell you if you're a qualifying participant or a partial qualifying participant, and this doctor does happen to be a QP. So, APM participation, that first blue line where we had the doctor's name blocked out, tells me he's a participant in an APM. The second blue line lists the name of the ACO that he's part of. And again, we just blocked it. Then under APM details, this tells me it's a MIPS APM. Remember I told you that a MSSP (Medicare Shared Savings Program) is the popular model and it is basic level A to D. And then he exceeds the low volume threshold and the Medicare patient allowable charges. So this tells me that this doctor is in a MIPS APM and what he needs to do.

The important thing I want to mention again is if you're seeing this and are unsure, contact us. We're happy to help you and walk you through all of this and explain it.

Lisa Sagwitz:

So next, we're going to talk about reasons why you might want to join an ACO. So first, you can reduce cost and increase savings. With an ACO, providers are incentivized to keep patients healthy, avoid unnecessary procedures and keep patients out of the hospital and ER with preventative care. When an ACO is successful, everyone gains by improved care delivery, improved health outcomes and lower healthcare costs. You saw that on a previous chart. Certain clinical quality measures are utilized- the 10 that I mentioned, as well as administrative data and patient experience of care surveys.

The second reason is strategic partnerships with other providers. So, sometimes it's difficult for an independent practice that prefers autonomy to share accountability for profits and losses. You're forging new partnerships that can also help your independent practice gain leverage. It can be smart business as well as improve overall patient care.

The third reason is greater reach within provider networks. An important goal of an ACO is to work with other healthcare providers as partners. So when you're working within your ACO network, accountability, tools, resources, risk and referrals are all shared. Providers can be more strategic in tracking patient care. So if a physician needs assistance with a particular condition or an injury, they may collaborate on treatment strategies with other doctors in the ACO.

The fourth reason is increased retention and acquisition of patients. The patients in their care are the focus, which results in better care, enhanced retention and encourages other beneficiaries to follow. Care measures include things like providing timely care, appointments and information, effectively communicating with patients, ensuring your office staff are helpful, courteous and respectful, receiving high care quality ratings from your patients, that's via the surveys, promoting and educating patients on preventative health, sharing decision making with participating providers in your ACO, and properly reporting on patients' health status. Again, a lot of this is what you're already doing now within your practice. It's just at a bigger level.

Number five is more control over patient care. So many ACOs are physician led, and this is something you might want to ask if you're considering joining an ACO. Who runs it? Oftentimes when they're physician led, they allow providers to administer the care patients need. Tests and procedures can be ordered as a precaution rather than considered excessive or unnecessary based on insurance benefits. Again, preventative health measures are utilized, like pneumonia vaccines, weight screening, tobacco cessation, screening for depression, colorectal cancer, blood pressure and mammography.

The last reason is access to more advanced technology. Sharing data between doctors is convenient if you have the right technology in place. On your own it can be hard for a small practice to afford and implement point of care technology. So having shared access to technology through an ACO is a big bonus. You get to see the bigger picture. Then with accessible data, organizations contract compliance, share treatments and beat performance standards. Remember, in an advanced APM, most of the practices are on an EHR.

Lisa Sagwitz:

Next we'll talk about some risks, some considerations of joining an ACO and some questions you might want to ask. The level of risk varies with each ACO model. Read your contract. Medicare Shared Savings ACOs are required to take risk within five years or less based on their revenue. So if you're joining an ACO, an MSSP track one that's been in existence, know where they are and when they have to take that leap to the two-sided model. It's important for clinicians to understand the previous and current performance of an APM. You want to know how well they're doing or not.

Some other considerations to consider: can you use your current EHR for maybe the first year or two, but then you'll be asked to move to a preferred EHR? Is there a cost to join? What's the time commitment? Maybe you need to attend a monthly meeting. What about data analytics? How are they provided to you? How do you send them? What type of support is available? Often a lot of these soft costs are included with an ACO, which is a nice thing to have for a small practice that doesn't have a big staff. Also, do you have input in the governance of the ACO or would you like to be on a committee for a topic that's important to you? What data do you need to report? Will you have to learn how to send information? Will an ACO representative come into your practice to abstract it? Does an interface need to be developed? How does that work? Sometimes the ACOs have representatives that visit the practices once a month or once every couple of months and review what the priorities are and what they're working toward. So just understand what that is. Next we're going to turn the presentation over to Gary and he's going to review a few slides.

Gary Rezek:

Thanks, Lisa. We'll review a few facts about ACOs. All providers in the practice belong to an ACO except in the case of joint replacement surgery and they belong in their own ACO category, the Comprehensive Care for Joint Replacement model or CJR. That's apart from other orthopedic specialty areas. Providers can belong to more than one ACO if they bill under more than one TIN. Other situations can also result in participation in multiple APMs. For example, a joint replacement surgeon might belong to the CJR model as well as the APM that their local hospital is a member of. Typically, you'll sign up for participation in the fall for an ACO contract starting January 1. Older contracts were three years, but new contracts are typically five years.

Gary Rezek:

So, I'm part of an ACO, now what? What have you gotten yourself into? Well, ideally participation will be beneficial to your practice. You're part of a team, so all practices in the ACO contribute to your overall success. The ACO participation will cover much of the administrative work required for reporting. You will likely report the Promoting Interoperability category, which covers things like the exchange of health information through e-prescribing or reporting to a health information network or clinical data registry. But as a small practice, you might be eligible for a hardship exception in this category, and that's something you would have to check with your ACO. The ACO will report quality data for the 10 quality measures through the CMS Web Interface. You might be asked to provide information for specific patients to complete this reporting category. But ultimately, as an ACO participant, at least some of the burden in participating in the Quality Payment Program should be reduced as compared to reporting as an individual clinician. As Lisa described earlier, participants in high performing ACOs might

be eligible for a 5% lump sum payment, which will occur two years after the reporting year. There are additional perks, which may include EHR and IT support and the exchange of information with the other participating practices in your ACO, so information sharing. Lisa, I'll hand it back to you.

Lisa Sagwitz:

Thanks, Gary. So when I was learning about the ACO and the APMs and trying to figure it all out, Clinically Integrated Networks or CINs, was another term that was popping up. The definition of a CIN is a group of independent physicians that come together to identify and improve the quality of their offerings, providing a safe harbor against antitrust laws to collectively negotiate better rates with insurers and generate documentation to show improvement. So, physicians that are in the CIN may or may not have Medicare patients. Those that would not have Medicare patients, which is popular in an ACO, might be pediatricians and obstetricians.

So one day I was talking with a large group and they had both a CIN and an ACO. And I said, "I'm really having a hard time trying to understand this." And the answer was so simple. Someone told me when they have their monthly meetings, they start with the CIN meeting and all the providers are there. When the CIN meeting is done, then the pediatricians and obstetricians and doctors who don't have Medicare patients get up and leave, then the ACO meeting starts. One other thing, CINs can have financial rewards, so that can be a good thing. CINs are platforms that can build an ACO. What is important to know is that CINs and its participants do not have to attest or report any information to the Quality Payment Program, so it is completely separate. There's a nice link on this slide to a CIN article if you want more information on it.

Lisa Sagwitz:

So just summarizing what we've talked about today. And again, we don't expect you to remember all of this, the slides and the recording will be there as a reference, and we at Quality Insights are happy to help you anytime you need our help with this. But belonging to an ACO or an APM has benefits and risks. There could be a cost to join. You have to look at the return on your investment and we can help you through the qpp.cms.gov website with your HARP account. We can look at your Medicare volume and revenue, know how you've performed in past years on MIPS and do some calculations. Would it make sense to be part of an advanced APM that will get a 5% lump sum payment versus maybe a MIPS APM that you might be making roughly the same? Is that just Medicare patients or additional ones with this all-payer model? You want to talk to other practices that are in an ACO now and ask about their experiences. Does your practice want to be part of a larger group contributing towards the health and care coordination of a group of ACO patients? If you join an ACO and it doesn't work out, what does it take to get out of it? Is it just a one year commitment? Note that there can be a higher Physician Fee Schedule being in an ACO starting in 2026.

Lisa Sagwitz:

On the next couple of slides, we have some resources for you. So if you want to do some additional reading, there are links throughout this presentation, but the main website with all the QPP information is qpp.cms.gov. Probably most of you have that bookmarked on your desktop. So in the white ribbon at the top of the screen, select APMs and there'll be a drop down with information to read. Also in that white ribbon, you'll see an ‘ABOUT’ tab and under that is the Resource Library. Some of the documents

listed on this page have built-in links. There's also an organization called the National Association of ACOs. The link is there for them as well as the CMS Innovation Center, so that's how to get more information on ACOs and APMs. And again, just remember, we're here to help you whether you need us now, next month or next year, we are happy to provide assistance.

April Faulkner:

At this time we'll move into the Q&A portion of today's program. If you have any questions for our presenters, feel free to enter them in the Q&A box at the bottom right of your screen. I have not received any questions yet. So we're going to just pause for a moment in case anyone has anything to enter, but I do also want to note, if questions come to mind after the event, you can always reach out to us, as Lisa said, and I have up on the screen right now our email address, our phone number and our website. Someone asked if we could show the summary slide again, so we're going to go back to that.

Lisa Sagwitz:

Absolutely. Hi, Dr. Rago. For the summary, just know that ACOs do have risks and benefits, and you want to know what they are going in. There could be a cost to join. You want to know your return on investment. Look under your HARP account on qpp.cms.gov to check where you are now with your Medicare revenue, your patients, what you're getting from the MIPS program and do some general calculations. Does it make financial sense to move into an ACO, and a one-sided or a two-sided risk model? Talk with other practices who are already in an ACO – what do they like or not like about it? Does your practice want to be part of a larger group? Are you interested in knowing what the bigger picture is for those patients? If you join an ACO, you want to know in your contract what it takes to get out of it. Maybe at the end of the year, if you're not happy with things, you can exit and go back to the MIPS program, the one with the green hexagon. But remember, CMS does want practices to move into the ACO model. Also know that your fee schedule could be higher in 2026.

April Faulkner:

Lisa, we did receive a few questions. Do you have any advice on how a physical medicine and rehabilitation practice can join an ACO?

Lisa Sagwitz:

ACOs are comprised of primary care physicians as well as specialists. So, I think your starting point would be to go to the two different websites that I showed you, type in your city and state and see what's around you. Start to talk with other practices similar to yours, ask them if they're in an ACO, and then you could reach out. Maybe there are two or three ACOs in your area. Get the contact person's name and email and phone number and reach out to them and say, "Can you tell me a little bit about your ACO? What would be some benefits if I join, and do they need my specialty in the ACO?"

April Faulkner:

Okay, thank you. We did receive a comment. We have approached a few local ACOs and have not received much interest.

Lisa Sagwitz:

I mean, that can happen. If an ACO is content where they are, they may not necessarily be reaching out and looking to enlarge. So if you'd like to be part of an ACO, definitely it's like a job interview, you want to bring to the table all the positive things that your practice does: your MIPS scores have been in the 90s or 100 MIPS points over the past few years, you have an EHR in place, you have the interest to be part of a larger picture and you want to do the networking. So if you have a definite interest in an ACO, share everything that you can do to help them.

April Faulkner:

Lisa, that same person provided more information: Some have suggested that we start offering physical therapy service as a way in. Does that make sense?

Lisa Sagwitz:

Interesting comment. First, and this is my personal opinion. Does that make sense to your practice? Is that something your practice would like to offer and maybe start on a small scale? If this is an ACO that you'd like to get into, have a conversation. If we start with some PT and are successful in our practice, when could we expect to get into your ACO? Again, the job interview kind of concept, and there may not be any promises but at least you will get an idea. I've not heard of that before, but I don't think it's unreasonable, and it could be a need that particular ACO has. So again, you would keep your group of patients and if they're looking for a physical therapist, that could be an asset for you.

April Faulkner:

Okay. Another question came in: When we look at ACOs, can we see how well they did for 2019?

Lisa Sagwitz:

So the 2019 data has just become available recently for the Quality Payment Program. The ACOs have that data and they are starting to let their participants know. There will be a point, I believe in the next month or two, and this is per ACO, that they will start to publish it on their websites. The one site that I showed you to look at the non-Medicare spending did have financial reports and performance reports per year that you can look at. So, Dr. Rago, if you want me to show you something in particular, we can definitely set up a GoToMeeting and see what information is available to help you.

Lisa Sagwitz:

Before we end, there was one question that came in prior to the webinar. She asked, with only a general limited understanding of an ACO and APM, what is a good starting point to evaluate the advantage to our small practice of joining one? So if today's webinar did not help, please type in the Q&A section that you'd like to have an individual conversation about that and we're happy to contact you.

April Faulkner:

All right, that takes care of all of our questions. Thank you, Lisa. Thank you, Gary, for sharing this informative presentation, and thanks everyone for joining us today. Please note that when you close out of today's session, you will be automatically directed to a very brief evaluation. Please take a moment to

complete it, we greatly appreciate your feedback and comments. Also, the next editions of QPP live will be held next Thursday, August 20 at 9:30 a.m. We've posted a registration link in the chat box and encourage you to sign up today. Thanks again everyone for joining us, and have a great rest of the day, the session has now concluded.

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