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Meet the Presenter…

Heidi Kocher
JD, MBA, CHC
Counsel
Liles Parker, PLLC

On the topic:
Accountable Care Organizations and Their Impact on Your Future
Accountable Care Organizations and Their Impact on Your Future

Is Joining One Good for Your Practice?

Heidi Kocher
JD, MBA, CHC
Counsel, Liles Parker, PLLC

Introduction

• The Affordable Care Act:
  • The Policy change under the Act that has the most potential to impact future operations of almost all sectors of health care in the U.S.
  • DHHS and CMS required under the Act to find methods to control cost of health care delivery and improve quality of care.
  • Prediction of experts? – “more than 200 million Americans covered by an ACO by 2016…more than 700 operational today.”
  • How will this change affect your “bottom line” in the future?

("129 Accountable Care Organization," 2014)
Healthcare Reform and the Center for Innovation

- CMS – As mandated in the Affordable Care Act, CMS to test other reimbursement models and create additional demonstration programs to improve quality of care, coordination of care, and to reduce growth of healthcare expenditures.

- The Problems:
  - Aging Population
  - Sicker Population
  - Increasing Technology
  - Escalating costs of providing health care
  - Jeopardy of the Medicare Trust Fund
  - More covered by health insurance as established under the ACA – but often with high deductibles and cost-shares.

What’s up, Doc?

- Aging Population
- Multiple Chronic Conditions
- Increasing Costs
- Lower Reimbursement
Aging Population

**CHART 2**

Longer Life Expectancy Means Longer Enrollment in Medicare

The average life expectancy in the United States has increased since Medicare was created, but the program's eligibility age has remained constant at age 65. As a result, seniors collect benefits almost three times longer than when the program started.

Note: Some figures from 2009 through 2020 have been extrapolated.

**SECTION 1: DEMOGRAPHICS AND PREVALENCE**

In 2015, among our study population of Medicare beneficiaries, conditions such as high blood pressure, high cholesterol, heart disease and diabetes were highly prevalent. In addition, more than two thirds, or 21.4 million beneficiaries, had at least two or more chronic conditions. Given the high prevalence of comorbidities, focusing on multiple chronic conditions is essential towards furthering our understanding of the scope of the problem, identifying research gaps and targeting interventions. In addition, we must also understand the variation in both specific chronic conditions as well as multiple chronic conditions across demographic groups. For example, as women live longer than men the prevalence of specific and multiple chronic conditions will be higher for them. Similarly, chronic conditions tend to be more prevalent among beneficiaries eligible for Medicare and Medicaid benefits, known as the dual eligible beneficiaries, who tend to be a vulnerable population comprised of beneficiaries who are disabled or 85 years of age and older.

"High blood pressure was the most common chronic condition and this was true across age groups, for men and women as well as dual-eligibles"
"Two-thirds of Medicare beneficiaries had multiple chronic conditions"

Figure 1.2a Percentage of Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>32%</td>
</tr>
<tr>
<td>2 to 3</td>
<td>32%</td>
</tr>
<tr>
<td>4 to 5</td>
<td>22%</td>
</tr>
<tr>
<td>6+</td>
<td>14%</td>
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</tbody>
</table>

DATA HIGHLIGHTS:
Among the 15 chronic conditions examined, the prevalence of multiple chronic conditions was high, with over two-thirds of beneficiaries having two or more chronic conditions and 14% having 6 or more chronic conditions.

SECTION 2: MEDICARE SERVICE UTILIZATION

"Beneficiaries with multiple chronic conditions were more likely to be hospitalized and had more hospitalizations during the year"

Figure 2.1 Percentage of Medicare FFS Beneficiaries by Number of Inpatient Admissions and Number of Chronic Conditions: 2010

DATA HIGHLIGHTS:
As the number of chronic conditions increased so did:
- Only 4% of beneficiaries with 0 or 1 chronic condition were hospitalized less than 1% were hospitalized 3 or more times during the year.
- Amongst two-thirds of beneficiaries with 6 or more chronic conditions were hospitalized and 37% had 3 or more hospitalizations during the year.

1. Post-acute care services are provided in four settings - skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities and the home i.e. home health visits. Post-acute care services are received after discharge from an acute care hospitalization.
Medicare Reimbursement Trend

Source: Medical Group Management Association (MGMA) 2013 Compensation and Production Survey

Impact of Affordable Care Act (ACA)

- ACA’s potential impact on patients and providers
  - Government policy changes – impact on patients
  - Reimbursement - impact on providers
  - Legal aspects of Accountable Care Organizations
  - Impact on the medical practices' current and future trends
  - Expectations for ACOs in the future
  - Is joining an ACO in your practice’s future?
One Important Goal of ACA

• Formation of networks of physicians, hospitals and other health care providers to share the goals of:
  – Coordinated patient care
  – Higher quality of care
  – More efficient care
  – Improved patient experience
  – Improved health of populations

ACA Encourages Formation of ACOs

• ACO – Accountable Care Organization – 744 total ACOs
  – 89 joined in December 2014
    • Estimated 15.7 million beneficiaries in private or Medicaid ACOs
  – 132 different payers
  – Medicare program
    • Providers can earn higher reimbursement if they keep their patients healthy.
    • Currently around 7.8 million + Medicare beneficiaries are in an ACO
  – Combined with the private sector, the results are more than 428+ provider groups participating in an ACO organization. – an estimated 14% of the U.S. population.
    • In today’s world, you as a patient, could be a part of one and not even know it.
  – Will ACOs result in higher efficiency and quality of patient care?
    • Some feel that ACOs are the answer to an inefficient payment system that rewards providers for provider more services – not better care.
    • Some Economists feel that the greater the consolidation of health care services may lead to inefficiency and even higher cost

(Muhlestein, 2015)
What Is an ACO?

A network of physicians, providers and/or hospitals joining together, sharing the goals of providing better, coordinated care to patients, while reducing unnecessary spending to provide that care.

- Must be a separate legal entity.
- Under the Medicare program, each ACO has to manage a minimum of 5,000 Medicare beneficiaries for at least three years.
- The foundation of the ACO is the Primary Care Physician (PCP)
- The Objective – To bring together all of the "component parts of patient care " to ensure that all providers are working together, experiencing the possibility of risks and/or incentives to provide integrated care services in a “team” environment. That environment being one in which the providers work together to accomplish the goal of “higher quality of care provided with integrated, lower costs”.
- “Patient-Centered Medical Home”

Who Are the Players?

- As mentioned, an ACO can include several types of providers:
  - Physicians
  - Hospitals
  - Post-acute providers
  - Private companies like Walgreens.
- Each ACO must have PCPs, who serve as the “treating” doctor to direct the care of the patient.
- Currently, more than half of Medicare ACOs are operated by physicians and do not include a hospital partner.
- In private ACOs, insurers can also be a player, although they cannot direct or be in charge of medical care. Some of the largest carriers such as Humana, UnitedHealthcare and Cigna have formed their own ACOs in the private sector – these appear to be growing in number and size at the current time.
- Other physicians align with hospitals who have the structure in place necessary to facilitate larger organizations.
- In many areas, hospitals are buying up physician practices with the goal of forming an ACO in which the hospital directly employs the providers or manages the provider practices. Hospitals often have the resources for financing these entities.
ACO Programs at CMS

Medicare offers several ACO programs, including:

1. **Pioneer ACO Model** - Health care organizations and providers already experienced in coordinating care for patients across care settings (will end December 2016)
2. **Medicare Shared Savings Program (MSSP)** - For fee-for-service beneficiaries
3. **ACO Investment Model** - For Medicare Shared Savings Program ACOs to test pre-paid savings in rural and underserved areas
4. **Advance Payment ACO Model** - For certain eligible providers already in or interested in the Medicare Shared Savings Program
5. **Next Generation ACO Model** – for ACOs experienced in coordinating care for patient populations, with higher levels of risk & reward. Anticipating 15-20. Will be successor to Pioneer model
6. **Comprehensive ESRD Care Model** – 13 ESRD Seamless Care Organizations (ESCOs); large ESCOs – savings & losses shared; small ESCOs – only savings shared
7. **Investment Model** – prepaid shared savings, designed for rural areas

How many ACOs are there? How do they differ?

- Medicare vs. Non-Medicare
- 19 Pioneer ACOs – for entities already experienced in coordinating care for patients across settings. Examples: Allina (Minnesota), Banner (Arizona), Dartmouth Hitchcock (Massachusetts)
  - Cover 622,265 beneficiaries
  - 15,000 beneficiaries in ACO
  - Greater risk, greater reward
  - Initially 32 entities
  - Will end December 2016
Regional Data – ACOs and Assigned Beneficiaries

<table>
<thead>
<tr>
<th>Region</th>
<th>ACOs</th>
<th>Assigned Beneficiaries</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Boston</td>
<td>(CT, ME, MA, NH, RI, VT)</td>
<td>31 396,030</td>
<td>15.2%</td>
</tr>
<tr>
<td>2 - New York</td>
<td>(NJ, NY, PR, VI)</td>
<td>44 547,055</td>
<td>10.2%</td>
</tr>
<tr>
<td>3 - Philadelphia</td>
<td>(DE, DC, MD, PA, VA, WV)</td>
<td>43 495,059</td>
<td>9.5%</td>
</tr>
<tr>
<td>4 - Atlanta</td>
<td>(AL, FL, GA, KY, MS, NC, SC, TN)</td>
<td>91 949,456</td>
<td>8.6%</td>
</tr>
<tr>
<td>5 – Chicago</td>
<td>(IL, IN, MI, MN, OH, WI)</td>
<td>59 925,875</td>
<td>10.6%</td>
</tr>
<tr>
<td>6 – Dallas</td>
<td>(AR, LA, NM, OK, TX)</td>
<td>41 391,989</td>
<td>6.9%</td>
</tr>
<tr>
<td>7 - Kansas City</td>
<td>(IA, KS, MO, NE)</td>
<td>21 287,838</td>
<td>2.1%</td>
</tr>
<tr>
<td>8 - Denver</td>
<td>(CO, MT, ND, SD, UT, WY)</td>
<td>9 89,932</td>
<td>5.7%</td>
</tr>
<tr>
<td>9 - San Francisco</td>
<td>(AZ, CA, HI, NV)</td>
<td>43 389,896</td>
<td>5.6%</td>
</tr>
<tr>
<td>10 – Seattle</td>
<td>(AK, ID, OR, WA)</td>
<td>5 94,822</td>
<td>4.5%</td>
</tr>
</tbody>
</table>
Pioneer ACOs Outcomes

- 15 generated savings, and 11 generated savings beyond minimum savings rate, sharing $82 million.
- 5 generated losses, with 3 having losses beyond minimum loss and paying CMS $9 million
- In 2014, saved total of $120 million
- Mean quality scores increased from 85.2% in 2013 to 87.2 percent in 2014
Types of ACOs cont.

• 333 Medicare Shared Savings Program ACOs
  – 7.3 million beneficiaries
  – 99% one-sided model

Map of MSSP ACOs
MSSP ACOs Outcomes

- 92 had savings beyond MSR, with performance payments of $342 million
- No Track 2s owed CMS
- 89 saved, but did not save enough to share in savings
- Total net savings to Medicare = $341 million

Key Changes to MSSP for 2016

- New Track 3 option – higher level of shared savings/losses (75%, instead of 50%), waiver of 3 day inpatient rule for SNFs, prospective patient assignment
- Updated Quality metrics
- Earlier and improved data sharing from CMS to ACOs, still allowing benees to decline sharing
- Primary care provided by NPs, PAs, CNSs included in patient assignment methodology. Some specialties (derm, general surgery) removed
- Track 1 participants can stay in Track 1 for 1 more year
- Benchmarks adjusted – allows focus on savings and year-over-year cost improvements, instead of just beating last year’s performance. Includes local variations in costs
Investment Model ACO

- ACO started in 2015 or 2015:
  - Upfront fixed payment
  - Upfront variable payment based on # of beneficiaries
  - Monthly payment based on # of beneficiaries
- ACO started in 2012-2014
  - Upfront variable payment based on # of beneficiaries
  - Monthly payment based on # of beneficiaries
- Targets rural, underserved areas to promote expansion of ACOs
- ACO can’t include hospital unless CAH or IPPS hospital with <100 beds
- Not owned or operated by health plan
- Must participate in MSSP plan

Legal Requirements for ACOs

- Separate legal entity
  - Addresses Stark, AKS, anti-trust concerns
- 75% of board seats must be ACO participants and include Medicare beneficiary
- Comprised primarily of primary care physicians
- Must have at least 5,000 Medicare beneficiaries
- Must have “sufficient number” of PCPs to meet needs of beneficiaries
Legal Requirements (cont.)

- PCPs can participate in only one ACO; specialists can participate in more
- Minimum 3 year contract
- Compliance program
- Conflict of interest policy & disclosures
- Clinical management by board-certified & licensed physician of ACO participant
  - Must be physically present on regular basis at ACO participant’s location

How Do ACOs Impact the Patient?

- Physicians and hospitals:
  - Refer patients to hospitals and specialists within the ACO network
  - Patients are still free to see providers of their choice outside the network and the cost would not be higher.
  - Providers participating in an ACO are required to inform patients that they can choose to go to another provider if they so choose.
  - Patients can decline to have their data shared within the ACO.
Reimbursement for ACOs

- In FFS, providers are generally paid for each service provided – each visit, test and procedure.
- ACOs still utilize FFS, but create incentives by offering bonuses when providers are more efficient
  - Both physicians and hospitals have to meet specific quality benchmarks
  - Focus is on prevention and managing the provision of higher quality of care while accomplishing the reduction of cost to those patients with chronic conditions.
  - Therefore, providers and hospital stand to earn more reimbursement for keeping their patients healthy and out of the costly inpatient environment.
  - If an ACO is unable to accomplish these goals, it could be stuck with large cost of investments incurred to create the ACO and providing services. In addition, an ACO may be subject to a penalty if it does not meet the benchmarks.
  - However, physician ACOs could apply to receive advance payments to help build the ACO to accomplish coordinated care.

Payments

- Risk vs. Reward
- One-sided model
- Two-sided model
- New Track 3 for 2016 – two-sided model on steroids
- Key issue is “patient stickiness”
MSSP One-sided model

- No risk sharing during 1st contract (no downside risk) – bonus (smaller), but not penalty
- Must meet quality score standards BEFORE can share in savings
- 50% share of savings
- BUT must meet or exceed Minimum Savings Rate in order to share in savings
  - 2% for large ACOs (60,000+), up to 3.9% for small ACOs (5,000+)

MSR – One-sided model

<table>
<thead>
<tr>
<th>Number beneficiaries</th>
<th>MSR (low end of assigned beneficiaries)</th>
<th>MSR (high end of assigned beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000–5,999</td>
<td>3.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td>6,000–6,999</td>
<td>3.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td>7,000–7,999</td>
<td>3.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>8,000–8,999</td>
<td>3.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>9,000–9,999</td>
<td>3.1%</td>
<td>3.0%</td>
</tr>
<tr>
<td>10,000–14,999</td>
<td>3.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>15,000–19,999</td>
<td>2.7%</td>
<td>2.5%</td>
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<tr>
<td>20,000–49,999</td>
<td>2.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>50,000–99,999</td>
<td>2.2%</td>
<td>2.0%</td>
</tr>
<tr>
<td>60,000 +</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
MSSP Two-sided model

• Both savings and losses are shared
• Must meet quality score standards BEFORE can share in savings
• 60% share of savings
• Must meet Minimum Savings Rate of 2%
• If losses are greater than Minimum Loss Ratio, must repay portion of losses, up to 60%

Beneficiary Assignment

• Beneficiaries are assigned to ACO if received a plurality of services from primary care physicians in ACO
  – Internal medicine, general practice, family practice, geriatric medicine
• If bene doesn’t receive plurality of primary care from PCPs in ACO, then assigned if receives plurality of primary care services from other ACO professionals (NP, clinical nurse specialist, PA, non-primary care physician)
Beneficiary Assignment (cont.)

- Benes assigned RETROSPECTIVELY at end of year (this will change going forward)
- Only benes who have traditional FFS Medicare (A/B). No benes who have Medicare Advantage
- Bene must have had at least 1 primary care service performed by ACO participant, based on TIN

ACO Quality Measures

- 33 measures
  - 22 from ACO Group Practice Reporting Option
  - 7 from patient/caregiver experience
  - 3 from claims data
  - 1 from EHR Incentive Program data
- 1st year – just reporting of data
- 2nd & 3rd years – phased in & based on comparison to benchmarks, which ultimately will be 3 previous years data
- Pay for reporting vs. pay for performance
## ACO Quality Measures

### Table: ACO Quality Measures

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>ACO #1</td>
<td>Starting Timely Care, Appointments, and Information</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>Patient/Caregiver Experience</td>
<td>ACO #2</td>
<td>How Well Your Doctors Communicate</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>Patient/Caregiver Experience</td>
<td>ACO #3</td>
<td>Patients’ Rating of Doctor</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>Patient/Caregiver Experience</td>
<td>ACO #4</td>
<td>Access to Specialization</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>Patient/Caregiver Experience</td>
<td>ACO #5</td>
<td>Health Promotion and Education</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>Patient/Caregiver Experience</td>
<td>ACO #6</td>
<td>Shared Decision Making</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
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### 2015 Quality Benchmarks

#### Appendix A: 2015 Reporting Year ACO Quality Measure Benchmarks
ACO Quality Measures

Data collected via
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (patient experience)
- Claims
- Electronic Health Record (EHR) Incentive Program data
- ACO Group Practice Reporting Option (GPRO) Web Interface

Systems Integration

- EHR must be able to track relevant data
- EHR must be able to export data to ACO
- ACO will export certain data via “Web Interface” based on sample of beneficiaries
- Issues – system security
  - Implicates HIPAA security issues
- Data analytics
HIPAA Issues

• OHCA
  – 2+ Covered Entities who participate in joint activities & share PHI to manage joint operations
  – Clinically or operationally integrated
  – Allows MD who has no relationship with patient to access PHI for TPO with single NPP
  – No BAA needed between entities

• Business Associate Agreements
  – IF ACO is separate legal entity, then is BA of OHCA,
  – Not a Covered Entity (health care provider, plan or clearinghouse)

Other Privacy Issues

• Remember state law issues
• Beware of genetic, drug/alcohol, sexually transmitted disease and mental health records
• Remember “minimum necessary”
• Ability of patients to opt out of certain data sharing
• What if patient pays out of pocket?
  – No data can be shared, even for relevant quality measure
HIPAA Security Issues

- Access to data
  - Who has rights?
  - User IDs, passwords?
- Storage of data
- What if Breach –
  - At ACO
  - At participating physician
- Security Risk Analysis – who conducts?
  At what level?

Clinical Integration

- Patient registries
- Health Information Exchanges
- Clinical coordinators
- Patient-Centered Medical Home
ACO Compliance Program

• Designated official reporting to governing body
• Mechanisms for identifying & addressing compliance issues
• Anonymous reporting of potential problems
• Compliance training for ACO, ACO participants, ACO providers/suppliers
• Reporting probably violations of law to enforcement agencies

Auditing & Monitoring

• Who will audit?
  – ACO staff? Physician staff? Outside contractor?
• What will be audited?
  – Costs
  – Outcomes
  – Underlying medical records & data
  – Risk analysis?
• What about corrective actions?
  – Who will implement?
• Cost?
What Are the Results at This Time?

- First two years of the Medicare ACO program:
  - Provider groups saved a total of $417 million (CMS)
  - In 1st year, of the 114 participating in the Shared Savings Program ACOs, 54 had lower spending than projected. However, only 29 generated enough in savings to qualify for a share of the savings.
- After 2 years, Pioneer ACOs saved $384 million, or $300 per beneficiary per year


ACO Impact on the Physician Practice of Medicine?

- Alternatives/Choices
- Impact of patient population in your area
- Impact of specialty and insurance leverage
- The burdens and costs of reporting?
- The impact of EHRs on physician services?
- The future of the independent physician?
What is the future?

- CMS announcement in January 26, 2015 that 30% of payments will be under alternative models by end 2016 & 50% by 2018
- “Next Generation” ACO – announced March 10, 2015 – higher levels of risk & reward, smooth ACO cash flow, prospectively set benchmarks, prospectively assigned beneficiaries, telehealth & home care services, “better tools”

("Next Generation Accountable Care,” 2015)

Considerations / Tips

1. Become knowledgeable of the basic aspects of Accountable Care Organizations in order to be able to understand your practice’s alternatives for the future.

2. Analyze your current practice situation – where are you now? Where do you want to be in the future? What are your objectives and goals? How can you best accomplish these? Do you have the right systems and support?

3. Infrastructure is key – people, systems. Transformation in way care is delivered, not just in payments

4. It’s all about the data – where are you? Paper, EHR? What is everybody measuring? Who decides what is important? Who decides format, frequency of collection, data adequacy? Will you need to standardize on a particular EHR?

5. One of the most important points in any business decision making consists of the legal aspects of your decision. Become familiar with the appropriate questions to ask and where to look for resources to help you in accomplishes your decision with the overall goal of legally protecting your provider and entity.
Considerations / Tips (cont.)

5. What will it cost you? What new or unusual expenses will you have? What recurring expenses? What will the ACO allow you in costs / contributions?


7. What about your non-ACO patients?

8. If it doesn’t work out, can you get out? What impact will that have?

Tools

• CMS --
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

• American College of Physicians --
  https://www.acponline.org/running_practice/delivery_and_payment_models/aco/

• American Academy of Family Physicians --
References


Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp

• Contact information:
  Heidi Kocher, Esq.
  Email: hkocher@lilesparker.com