ACOs: A Survival Option for Independent Practices

Focus Paper

Ann M Roemen, MBA, FACMPE

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Value based reimbursement is the future. It is part of the healthcare landscape now, but only to a limited degree. In the not too distant future, fee for service will be limited and value-based reimbursement will be the payment methodology for most healthcare services.

The federal government is leading the way in developing innovative models to test value-based reimbursement. Medicare has established an aggressive schedule to move 90% of payments from fee for service to value-based payments and 50% of fee for service payments to alternative payment models by 2018.

Medicare unveiled its first Accountable Care Organization (ACO) model, the Medicare Shared Savings Program (MSSP), in 2012. Since that time, there have been a number of other ACOs introduced. All are focused on improving care, saving money and sharing in that saved money. Some are risk-free and some share risk. Some are disease specific and some receive advance payment from the federal government to aid in set-up.

While accountable care organizations will be woven into the fabric of the future of healthcare in the United States, participating in ACOs is not a possibility for practices which do not have a minimum of 5,000 Medicare beneficiaries. That number was established, by Medicare, as a base, for practices to be considered for participation.

Historically, fraud and abuse laws prohibited independent practices from working together to achieve the goals of the ACO. Coordinating care, sharing cost data and referring patients to each other to attain savings was illegal. When it was determined that this large pool of providers would never be able to participate, the Secretary of Health and Human Services (HHS) removed a major barrier to entry. The Anti-kickback, Stark, and Civil Monetary Penalty laws were waived as necessity for independent practices to participate in ACOs.

Introduction
The future of healthcare reimbursement is based on payment for quality. Accountable Care Organizations (ACOs) offer an opportunity for medical practices to gain experience in value-based reimbursement, and in some cases, in a non-risk bearing format. They also serve as a platform for physicians to enhance the quality of care, reduce costs and improve health outcomes.

Coordinating care is a central tenet of an ACO. It is intended to help ensure that patients, especially the chronically ill and most vulnerable, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. (Innovation Center ACO Models, n.d.)

Operating an independent physician practice is difficult. Healthcare regulations have become more complex increasing overhead costs and challenging the viability of the practice. As physicians contemplate their role in the new world of healthcare where fee for service will be no more, or at least greatly reduced, the thought of compliance, quality reporting and mere survival are exhausting and overwhelming.

As administrative requirements have become overly burdensome, the employed model has become increasingly more attractive, especially to the solo practitioner and those practicing in small practices. The trajectory toward employment is staggering. In 2012, 53.2% of physicians were practice owners. In 2014, that number was 50.8%. In 2016 it was 47.1%. (AMA 2017 Physician Practice Benchmark Survey)

Aside from joining a larger group, options for small practices to stay independent have largely been limited. Clinical Integration is one option, but is very difficult to achieve. It allows otherwise unrelated groups, sometimes in the form of an Independent Physician Association (IPA) or Physician Hospital Organization (PHO) to collectively negotiate payer contracts. Practices choosing the clinical
integration path must prove that achieving quality goals is only possible with the ability to collectively contract with payers. Due to federal fraud and abuse regulations, including Stark and the Anti-Kickback Statute (AKS), such organizations face intense scrutiny by the Federal Trade Commission (FTC) which makes the determination as to whether or not the entity is sufficiently integrated, financially or clinically. Groups face severe financial penalties – and even closure should the FTC determine they do not meet the integration requirements. These same laws also prohibited independent practices from collaborating in model programs for shared savings.

The Centers for Medicare and Medicaid Services (CMS) recognized that these laws were a barrier to independent practices becoming involved in innovative cost-saving models programs. In collaboration with the Office of Inspector General (OIG), the FTC, and the Secretary of Health and Human Services (HHS), waivers of these laws were granted as an incentive to engage and encourage independent practices and facilities to work together. These waivers allow independent groups, with no legal or financial ties, to develop innovative approaches to improving care and reducing the cost of care, without fear of prosecution for violating the law. These waivers give broad discretion to groups in developing initiatives and incentivizing desired changes in behavior. With built-in requirements for quality improvement and cost savings, clinical integration is obtained when a medical practice joins an ACO.

**Purpose**

The purpose of this paper is to take an in-depth look at ACOs, in particular, MSSPs and how they can be used as a mechanism for independent practices to achieve the Institutes of Health triple aim of reducing costs, improving quality, engaging patients in their care, and at the same time, making independent practice more sustainable.

**Background**
Accountable care organizations (ACOs) are groups of healthcare providers who have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. The goals of an ACO are in line with the Institute for Healthcare Improvement’s (IHI) triple aim of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. (Institute of Health, n.d.)

Medicare ACOs serve more than 10.5 million beneficiaries with hundreds more commercial and Medicaid ACOs serving millions of additional patients. (National Association of ACOs, n.d.) Physicians in general have operated in a fee for service environment, but this model is rapidly changing, on the federal level with Medicare, on the state level with Medicaid and with commercial payers as well.

CMS has a number of model programs, but the Medicare Shared Savings Program (MSSP) is the largest and is the program on which this paper will focus. The MSSP was derived from the Physician Group Demonstration Project, which started during the George W. Bush administration, and the MSSP was permanently authorized by the Patient Protection and Affordable Care Act (PPACA) of 2010 and signed into law by then President Barack Obama. The MSSP began in 2012 with two participation options, Track 1 and 2. MSSP Track 3 was added in 2016 and Track 1+, was added in 2018.

As shown in Table one, MSSP track 1 has no downside risk. It has the most appeal, as it allows groups to gain experience in a quality based program with no risk of financial penalty. When saving and quality targets are met, track 1 ACOs share savings with Medicare. If targets are not met, there are no penalties. ACOs are limited to two – three year agreement periods in track 1. After a maximum of six years, track 1 ACOs must move to a risk bearing MSSP.

Tracks 1+, 2 and 3 all require certain levels of downside risk but have other benefits such as the opportunity to share in greater amounts of savings generated by the ACO. There is also the option for additional waivers from certain Medicare rules.
Table 1 - Shared Savings Program ACO Participation Options

The Shared Savings Program offers different participation options (tracks) that allow ACOs to assume various levels of risk.

<table>
<thead>
<tr>
<th>Track</th>
<th>Financial Risk Arrangement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One-sided</td>
<td>Track 1 ACOs do not assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.</td>
</tr>
<tr>
<td>2</td>
<td>Two-sided</td>
<td>Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.</td>
</tr>
<tr>
<td>3</td>
<td>Two-sided</td>
<td>Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk, but may share in the greatest portion of savings if successful.</td>
</tr>
</tbody>
</table>

*The Track 1+ Model is a time-limited CMS Innovation Center model. An ACO must concurrently participate in Track 1 of the Shared Savings Program in order to be eligible to participate in the Track 1+ Model.

In 2015, then secretary of Health and Human Services (HHS), Sylvia Burwell announced that her agency would begin focusing its energy on incentives, as shown in Figure one, to move to higher value care. More specifically she stated that the agency’s goal was to have 85% of all Medicare fee-for-service (FFS) payments tied to quality or value by 2016 and 90% by 2018. An additional goal was to have 50% of payments tied to alternative payment models (APMS), such as ACOs, by the end of 2018. (Japsen, 2015)

Figure 1
By early March of 2016, Medicare estimated that it had already hit its first target, 11 months ahead of schedule. This milestone was hit in part by 121 new ACOs joining the Medicare program that year.

**Current Status**

In 2018, there were 480 MSSP ACOs, 17% more than 2017. Of those, 101 were in risk-bearing ACOs, compared to 42 in 2017, an increase of 140%. Part of the draw to the risk-based ACOs is that, in its move to the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS designated Tracks 1+, 2 and 3 as Advanced Alternative Payment Models (APM) which makes them eligible to receive automatic 5% annual lumps sum increases to Medicare physician payments 2019 - 2024. While the financial incentive is desirable, it is a financial gamble of earning 5% and taking on the risk of having
to pay back losses if they are incurred. In addition, once an ACO becomes risk bearing, it cannot move back to Track 1.

A medical practice needs to evaluate the potential risks and rewards. If the risk of having to pay back losses is too much to take on, it might be advisable to take the time to gain experience in a non-risk bearing track one ACO.

While track one ACOs are not advanced APMs, they are recognized as advanced Merit-Based Incentive Payment System (MIPS) organizations and as such, they receive preferential treatment in the scoring process of MIPS quality reporting.

Because physician-led ACOs are more flexible, providers can not only stay independent but maintain control over their mix of payers and the payment models they choose to support. These ACOs can also include more than just independent physicians. They can include hospital and employed physicians, with the leadership of the ACO controlled by the physicians.

This approach is only gaining momentum, as the majority of physicians say they would prefer to stay in private practice and not sell to a larger entity. Providers are seeing that these programs are positioning them to better meet the changing expectations of patients. (Giannulli, 2016)

Large healthcare systems do participate to a limited degree in MSSP ACOs. However, one of the key components of an ACO is to reduce costs, which includes reducing hospital utilization, one of the most costly locations for care. Large healthcare systems rely on admissions, or “heads in beds”, for a large portion of their revenue stream, thus have limited incentive to reduce hospital utilization. Indeed, those which own Critical Access Hospitals (CAH) are further incentivized to place patients in swing beds in these facilities for skilled nursing services, as they are very profitable.
Unlike hospital-employed groups, independent primary care groups can work to reduce healthcare costs without the conflicting incentives to fill hospital beds and keep specialist practices busy and incomes high. (Casalino, et al., 2016)

As shown in Table two, Physician-led ACOs have proven success. 2016 MSSP performance results, shared by CMS, showed that 45% of physician-owned ACOs were successful in achieving savings, as compared to 23% of ACOs that include a hospital.

**Table 2**

<table>
<thead>
<tr>
<th>Entity Type Based PECOS and Participant List Data</th>
<th>All ACOs</th>
<th>Shared Savings</th>
<th>Positive w/in Corridor</th>
<th>Negative w/in Corridor</th>
<th>Negative outside Corridor</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ACOs</td>
<td>432</td>
<td>31%</td>
<td>25%</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Physician Only</td>
<td>134</td>
<td>45%</td>
<td>22%</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td>FQHC/RHC</td>
<td>58</td>
<td>31%</td>
<td>28%</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>Hospital</td>
<td>226</td>
<td>23%</td>
<td>26%</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>Post Acute Care Facility</td>
<td>8</td>
<td>38%</td>
<td>13%</td>
<td>38%</td>
<td>13%</td>
</tr>
<tr>
<td>Other Facility</td>
<td>6</td>
<td>33%</td>
<td>17%</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: RTI analysis of PY 2016 financial reconciliation data. Note: Due to rounding, percentages may not sum to 100 percent.

**Considerations for Joining**

Not only is the federal government’s aggressive timeline for moving from fee-for-service payment to value based reimbursement, reason for physician practices to get on board, commercial payers are and will continue to follow suit. UnitedHealth one of the largest health insurance payers in the industry, announced in 2015 that it was committed to increasing payments that are tied to value-based arrangements to $65 billion by the end of 2018. (Japsen, 2015) This type of reimbursement is on the fast-track to becoming the norm.
While reimbursement is the primary driving force behind the ACO movement, so too is improving the quality of care for patients via coordination of care, disease management, care protocols and a reduction in unnecessary services. Physicians have forged relationships with their patients and are in a position to influence patient behavior, resulting in improved outcomes and potential financial savings.

In order to be approved by CMS, an entity forming an ACO must have at least 5,000 fee-for-service Medicare beneficiaries who can be attributed to the primary care physicians comprising the ACO. Beneficiaries in a commercial or Medicare Advantage plan are excluded from attribution, also known as assignment.

Patient attribution is determined in two steps. Step one is based on a plurality of visits with primary care physicians, defined as Family Medicine, Internal Medicine, General Practice, Geriatric Medicine or Pediatric Medicine. In 2018, advance practice practitioners were added to the list of primary care providers. These individuals, nurse practitioners and physician assistants, may have beneficiaries assigned to them, but there is a requirement that they see a primary care physician at least one time each year.

Step two of assignment includes nineteen additional specialties, again, looking at plurality of visits greater than those of a primary care physician, including cardiology and endocrinology. There are also twenty-five specialties excluded from assignment. Primary care physicians are limited to joining one ACO. Specialists are allowed to join as many ACOs as they wish. Assignment is important to achieve the number of lives CMS requires to be an ACO. Adding specialist physicians is a way to engage others in the development of quality initiatives and control costs.

While one physician out of three identifies as independent, in 2016, 38% of physicians in the United States were still working in practices comprising five or fewer physicians. (Natacha Lemaire, 2018) Small independent practices, by themselves, may not have the required minimum number of
beneficiaries, so partnering with other groups or hospitals to get the number of required beneficiaries makes participation feasible. Partnering with others to form an ACO is a good option for those practices wishing to remain independent.

Capital to develop the ACO infrastructure is another consideration. Coordinating care will require investments in technology and data analytics. It may also require hiring case managers or nurse navigators to advance the initiative of care coordination. If multiple EHR (Electronic Health Record) platforms are used, a substantial amount of money may be needed to achieve interoperability.

Some physician-only ACOs have been able to obtain management information technology software, and to build care coordination and compliance infrastructure from third-party vendors willing to accept a contingency payment based on potential savings. (Robeznieks, 2018). These groups enter into agreements to share future savings with the vendor. Such an arrangement can remove a significant obstacle to ACO success. Private equity firms and payers are another option to reducing the outlay of capital to purchase extensive software solutions.

When choosing partners in the ACO, physicians should take into consideration the characteristics of these partners that are of value to them. These choices aren’t just about meeting the basic requirements for CMS approval, but how these choices will impact ACO’s ability to achieve its goals of reducing cost, improving the quality of care and engaging patients in their own care.

Physicians might want to start by developing a checklist of priorities as it pertains to who would be ideal partners in the ACO. Considerations might be independent physicians who are like-minded, forward thinking, self-motivated, respected in the community and thought of as a leader. Composition is not only important to achieve the required number of beneficiaries, but also to better manage the total cost of care wherever care is provided. Primary care physicians are required, but specialists should also be
considered as they can also be critical to cost-savings. Hospitals, health systems, skilled nursing facilities, home health agencies and equipment suppliers could also play an important role.

Including other healthcare entities in the ACO will allow for greater levels of care coordination and collaboration. When the full continuum of care is engaged, the likelihood of success is much greater. Together the physicians can develop chronic disease management programs and hold each other accountable.

If not already doing, ACOs can implement a robust program to generate revenue via other services for which Medicare reimburses. These services are intended to improve the overall health of beneficiaries, prevent chronic illnesses – or catch them early, and to help reduce overall costs by reducing utilization. These services include annual wellness visits, chronic care management, transitional care management and advance care planning.

**Benefits of Joining**

Independent practices coming together to form an ACO helps to solidify and preserve the common goal of remaining independent. It is an alternative to joining a hospital or health system allowing for groups to work together in ways that are not possible outside the ACO model; and it lays the groundwork for contracting with commercial ACOs.

ACOs are not limited to working only with groups of providers in the same city, state or region. Some ACOs work together with a multitude of other groups under the umbrella of a national ACO. As with most business ventures, spreading out the risk over more healthcare providers lessens the individual potential financial burden. In addition, spreading the risk over a larger pool of beneficiaries increases the likelihood of achieving savings. Some suggest a minimum of 15,000 attributable lives for success; others suggest 50,000, but many with much less have achieved savings. Table three, shows the performance of MSSPs based on the size of the ACO as measured by number of assigned beneficiaries.
Perhaps one of the most important benefits to an ACO is the waivers of the federal Stark Act and the Anti-kickback Statute (AKS). These waivers allow physicians in an ACO to collaborate with unaffiliated practices and hospitals in ways that would not have been allowed in a traditional legal environment. These waivers allow the ACO to create incentives to change behavior and achieve the goals of the ACO. These incentives can be designed around care coordination, reducing utilization of services, referral relationships, providing patient transportation, aligning with ancillary providers such as home.

Table 3

<table>
<thead>
<tr>
<th>Benchmark Performance by ACO Size (Based on Total Assigned Beneficiaries) and number of ACOs</th>
<th>ACOs with expenditures below their benchmark (i.e., spent more than expected costs)</th>
<th>ACOs that earned shared savings</th>
<th>Total Benchmark Minus Assigned Beneficiary Expenditures as % of Total Benchmark*</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;7,971 Assigned Beneficiaries N=98</td>
<td>35%</td>
<td>23%</td>
<td>42%</td>
</tr>
<tr>
<td>7,972 - 12,545 Assigned Beneficiaries N=98</td>
<td>44%</td>
<td>26%</td>
<td>31%</td>
</tr>
<tr>
<td>12,546 - 21,214 Assigned Beneficiaries N=98</td>
<td>57%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>21,215 - 149,633 Assigned Beneficiaries N=98</td>
<td>57%</td>
<td>16%</td>
<td>27%</td>
</tr>
</tbody>
</table>

health and skilled nursing facilities (SNFs). The waivers allow ACOs to be creative and innovative in the way they deliver care.

There are five waivers:

1. Pre-participation waiver
2. Participation Waiver
3. Shared savings distribution waiver
4. Physician self-referral waiver
5. Patient incentive waiver

These waivers allow for an ACO to take certain actions, if they are for the purposes of the ACO, which would not have been allowed in a traditional legal environment such as:

- Incentive payments for participating in initiatives that are used to change practice behaviors
- Referrals that help the ACO achieve its goals
- Incentivizing providers for participation in care coordination guidelines;
- Purchasing items for other participants that will assist them in achieving the goals of the ACO i.e. capital purchases;
- Entering into financial arrangements with other entities i.e. vendors, SNFs, etc.
- Sharing of data to better coordinate care
- Other actions or care coordination that serves the ACO’s purposes of lowering costs or improving quality of care.

The possibilities for initiatives, if they serve the purpose of the ACO are nearly limitless. Physicians can be creative in developing new and better way of caring for patients, and involve entities outside of the
medical practice who can contribute positively to the desired outcome. The ability to structure initiatives is a significant tool to benefit primary care physicians and their patients.

For those physicians belonging to a Physician Hospital Organization (PHO) or Independent Physician Association (IPA), the physician network may already be established and the infrastructure may be in place that would facilitate the development of an ACO.

It is critical to keep in mind how the waivers work. Waivers require that arrangements be “reasonably related to the purposes of the Shared Savings Program”, which include:

1. Promoting accountability for quality, cost and overall care of the Medicare population
2. Managing and coordinating care for Medicare fee-for-service beneficiaries through the ACO
3. Encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery (Stephen H. Siegel, 2016)

Promoting evidence-based medicine and patient engagement would be considered “reasonably related”.

The pre-participation and participation waivers protect bona fide ACO investment, start-up, operating, and other arrangements that carry out the goals of the Shared Savings Program. Specific conditions must be met to be protected under the pre-participation waiver, among other things, a good faith effort to establish an ACO within a target year.

The shared savings distribution waiver allows for the distribution and use of savings including sharing with ACO participants and its providers and suppliers. The plan for distribution of savings must be included in the application to CMS. CMS gives ACOs the latitude to devise a distribution plan that works best for the ACO. It is common for ACOs to retain a portion of savings to offset start-up and administrative costs.
The physician self-referral waiver protects the ACO when it distributes MSSP savings to participants, providers/suppliers during the year in which the savings were earned; or for activities necessary and related to the ACOs participation in the MSSP.

The patient incentive waiver is meant to increase patient engagement. There must be a reasonable connection between the incentives and the medical care of the beneficiary. Financial incentives are not applicable. (April Simmons, 2016) Some ACOs use this waiver to assist beneficiaries with travel to appointments as a way to improve no-show rates, improve patient compliance and overall, improve the health status of the patient.

In addition to the opportunity to improve healthcare, there are many benefits to independent physicians and facilities joining together as an ACO. Through an ACO, they can legally share data, engage in contracting with payers, take advantage of group purchasing and collectively do Medicare Access and Chip Reauthorization Act (MACRA) reporting under the Merit-based Incentive Payment System (MIPS).

When a practice joins an MSSP ACO, the ACO takes on the responsibility of quality reporting for all participants. This reporting is completed by the ACO, relieving a tremendous burden from the medical practice.

There are four components of MIPS reporting, of which the ACO reports on three; quality, clinical practice improvement activity (CPIA), Resource Use (cost). Table four shows each category and its corresponding weight, for both ACO participants and non-ACO participants.

Quality measures are pre-selected by CMS. See Appendix B. CMS selects beneficiaries for each of the clinical quality measures, for which there were 17 in 2018, and sends the list, by measure to the ACO. The ACO must report on a minimum of 248 beneficiaries per measure. This reporting through the Group Practice Reporting Option (GPRO) begins each year in January and
is completed in March. This benefit has the potential to limit or eliminate completely the current quality improvement reporting to CMS that a group does on its own.

The Clinical Practice Improvement Activity (CPIA) category, in an independent practice requires the reporting of up to four activities. Since clinical practice improvement is an inherent goal of the ACO, ACOs receive a full score for this performance category and do not need to submit additional information for MIPS. Full score is to the benefit of all participants in the ACO.

Resource Use (Cost) was weighted at zero for both 2017 and 2018 and is being evaluated for future measurement.

Advancing Care Information (ACI) is the only category for which the participants (hospitals, medical practices) are responsible. This category was formerly known as Meaningful Use. ACO participants must report separately for this measure.

CMS evaluates an ACO as one cohesive entity and will combine the weighted scores of the performance categories to determine a MIPS Composite Performance Score (CPS). MIPS payment adjustments will be applied at the unique Tax Identification Number (TIN) level for each MIPS Eligible Clinician (EC) in the ACO, with all receiving the same MIPS payment adjustment. Positive adjustments are applied to Medicare Part B payments on a per claim basis for claims with dates of service during the payment adjustment year.

Table 4
MIPS Performance Categories & Weights for the 2017 reporting year, affecting 2019 payment.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>ACO Weights</th>
<th>Non-ACO Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>20% (maximum points automatically assigned)</td>
<td>15%</td>
</tr>
</tbody>
</table>
In addition to the MIPS quality reporting measures, the ACOs quality performance, for shared savings only, takes into account claims-based measures for readmissions and unplanned admissions as well as patient/caregiver satisfaction as measured in a survey called Consumer Assessment of Healthcare Providers and Systems (CAHPS). A vendor for the CAHPS survey is selected from a list of CMS approved companies and paid for by the ACO.

In an ACO’s first year, quality reporting is measured by *complete reporting*. Complete reporting means that as long as the ACO accurately reports on the minimum number of required patients, per measure, it will receive the full score. In the second and subsequent years, most quality measures will be evaluated on performance. Newly added measures are reporting only measures for the first two years of inclusion on the measures list. Most will move to performance measurement after two years, but not all.

Individual practices in the ACO continue to be eligible for bonuses under MIPS. As participants in an ACO they are also eligible for shared savings under the Medicare Shared Savings Plan. If the ACO meets or exceeds the Minimum Savings Rate (MSR), set by CMS, it is eligible for up to 50% of the savings based on quality performance. Physician leadership is critical in devising strategies to improve quality scores and to reduce the cost of providing care.

The goal of the ACO is to lower the total cost of care for its attributed lives. CMS provides no roadmap to achieving success. Rather, it relies on ACOs to be innovative and implement approaches that would work best in one’s own market. ACOs rely heavily on data provided by CMS on a monthly basis. These files, Claims and Claims Line Feeds (CCLF) give the ACO and physicians access to data they have never had the opportunity to see. This data shows claims processed for all beneficiaries assigned to the
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ACOs. Physicians have the ability to see where their patients are obtaining healthcare services and how much Medicare is paying for those services. Since Medicare beneficiaries are not limited to where they can seek care, this data gives the ACO and physicians valuable information critical to determining where the opportunities are for achieving the goals of the ACO.

ACOs are able to drill down into the data to find expensive places of care, review length of stay by facility type, and identify trends in utilization and cost. This data can be used to develop initiatives to influence behavior and adjust referral patterns. With this information, physicians are empowered like never before to engage in meaningful discussions about how to make changes that will have the most impact. It can also be used to engage in discussions with others for whom change is desired and it can be used to determine who the ACO might want to consider for future partners and/or participants.

Some ACOs use this data to negotiate with post-acute care providers to encourage better management of length of stay and improve outcomes. Score cards can be developed using data from nursing home compare, as well as claims data, to demonstrate to the facilities the criteria ACO participants will use in determining where to send patients. The score cards can be used to determine which facilities will be preferred locations for patients. Score cards serve as an impetus for facilities to modify behavior if they want to continue receiving referrals from ACO participants.

This information can be used to identify areas of potential improvement. For instance, locations of care by cost and length of stay. It can also be used to track physician participation in ACO initiatives. For example, completion rates for annual wellness visits (AWVs), number of patients enrolled patients in Chronic Care Management (CCM) or Transitional Care Management (TCM) or a physician’s performance on quality measures.

In addition to monthly claims files, CMS also provides quarterly reports which include expense and utilization for the ACO. This report includes expenditures per beneficiary assigned to the ACO in a number of categories including hospital in-patient stay, Skilled Nursing Facilities (SNF), imaging and
hospice. It also compares the ACO expenses to those of all other MSSP ACOs and national fee for service. This data too can be used to identify areas of potential opportunity for improvement.

Participating in an MSSP ACO allows a medical practice to gain experience with value-based reimbursement while it is still optional and not adopted broadly. This experience will prepare a group not only for additional value-based arrangements with commercial payers, but for risk-based arrangements in the future. It will also help a medical practice negotiate better commercial contracts by demonstrating ACO success in the MSSP framework.

A physician-led ACO gives physicians the opportunity to be in lead governance roles and to be engaged in decision making as it pertains to how they practice. Physicians can be the key drivers in determining what activity the ACO should pursue that will have the greatest impact on patients and the cost of care.

Another significant benefit given to participants in an ACO is automatic clinical integration. Clinical integration, which is otherwise very difficult for independent groups to achieve, is accomplished with participation in an ACO. It allows for groups to maintain their independence and at the same time benefit from the economies of scale that integrated delivery systems enjoy. Clinical integration for payer contracting can be a significant defensive move in an increasingly difficult payer marketplace.

Clinical integration would also make it possible for otherwise unrelated independent practices to develop a separate Management Services Organization (MSO), a legal entity created to provide management and administrative services. Among other things, the MSO, to which physicians would buy into, could be used for group purchasing, recruitment of physicians and clinical staff, providing billing services, and negotiating health insurance coverage for its members.
ACOs may also be an attractive recruitment tool. The potential additional earning potential, from shared savings, may be appealing to a recruit. They could also be used to offset the cost of a potential income guarantee. For physicians just finishing their residency program, if the residency program participated in an ACO, the practice would simultaneously benefit from the experience of the individual’s experience in value-based care.

If the practice joins with other groups to form the ACO, the added numbers of physicians and other providers offer potential stability in the ever-changing medical practice world. The collaboration with other independent groups offers the opportunity to share expenses, negotiate group discounts and the ability to set up other ventures to create additional revenue streams.

**Barriers to Entry**

Panel size for independent practices can be a challenge. To qualify for participation in a Medicare ACO, there is a requirement of a minimum of 5,000 assigned beneficiaries. This requirement alone could prevent a practice from participating on its own. As practices become more consolidated, independent primary care physicians can be particularly hard to find. Utilizing the participation waivers of Stark and the Anti-Kickback Statute (AKS) and joining forces with others makes this number more attainable.

Independent physician practices should not limit their participant selection only to their city, state or region. The waivers offer the opportunity to collaborate with others. There is not a geographic limitation to this. There are opportunities through professional associations and organized national ACO groups.
For some, joining an ACO might be seen as a threat to their autonomy. An ACO would need to critically evaluate whether practice is a fit for the ACO. Without the engagement and commitment of all physicians, attaining the goals of the ACO will be limited or perhaps impossible.

ACOs are associated with considerable start-up costs. Tom Scully, former CMS Administrator, estimates startup costs to be at least $30 million in a midsized market.\(^\text{17}\) The estimated cost of starting and operating a physician ACO in the first year was more than the CMS estimate of $1.8 million (Erwin A. Blackstone, 2016)

As shown in Table five, based on a survey of membership the National Association of ACOs (NAACOS) found that the cost varied considerably between single ACOs and multi-ACOs with centralized operations across many ACOs.

<table>
<thead>
<tr>
<th>Table 5</th>
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<table>
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<th>Estimated ACO costs for participating in the MSSP, by all survey responses and ACO type:</th>
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<table>
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<th>ACO type</th>
<th>Clinical and care management</th>
<th>Health care information technology, population analytics, and reporting</th>
<th>ACO management, administration, financial, legal, and compliance</th>
<th>Other (sum or all other operating costs)</th>
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<tr>
<td>Type: Single ACOs</td>
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<td>$143,070</td>
<td>$1,943,276</td>
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<td>Type: Multi-ACOs (centralized operations across many ACOs)</td>
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<td>Averages of all survey responses</td>
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<td>$1,622,032</td>
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There are opportunities to work with others to help fund the start-up of an ACO. Some work with venture capitalists, vendors, payers or ACO management companies, often making arrangements for contingency payments based on future savings. This is a financial risk for any entity looking to invest in an
ACOs: A Survival Option for Independent Practices

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ACO, and independent physicians may again consider the obligations to another entity a threat to their autonomy.

In addition to inpatient care, one of the most expensive places of care is post discharge facilities, in particular skilled nursing facilities. A challenge to managing this cost is the limited involvement of primary care physicians in the discharge process. With the rise of the use of hospitalists fewer primary care physicians hold hospital privileges, leaving recommendations and decisions regarding discharge disposition to those in the hospital – some of which may have a financial incentive to send patients to their own facilities. This can make it very difficult to control costs when the hospital and skilled nursing facilities are not participants or at least engaged in some way with the ACO.

Coding is critical to how CMS establishes the benchmark for the ACO. Benchmarks are based on historical expenditures of the ACOs assigned beneficiaries. They also take into account the illness severity of these patients, as reflected in hierarchical condition categories (HCCs). HCCs are based on physician use of diagnosis codes. If a practice has not been actively coding all of the pertinent diagnosis codes for each patient annually, Medicare will not have an accurate representation as to the illness acuity of the ACOs assigned beneficiaries. This will result in a benchmark that would likely be lower than what it should be, making achieving savings either difficult or impossible. Including a medical practice not well versed in risk-based coding, could have a negative impact on an ACOs financial success.

Potential Risks

One potential risk to a physician or group considering joining an ACO is that the quality reporting of all participants is aggregated for calculation under MIPS. Thus, if a primary care group which does a poor job in quality performance, joins an ACO, the MIPS score will reflect, in aggregate the performance of each individual practice. A lower performing participant has the potential to decrease fee for service payments, from Medicare, for a better reporting practice.
One of the potential drawbacks to forming an ACO with other independent practices is that quality outcomes are measured in aggregate, so if one entity is more advanced than another, their quality score could be negatively impacted by those groups which are not as experienced, or have less favorable outcomes. In addition, due to the independent nature of these practices, it can also more challenging to reach agreement on care protocols, and to enforce compliance.

At this time, CMS has a limit as to the amount of time an ACO can remain in a non-risk bearing model. If an ACO determines, after the allotted six years, that it is not ready to take on risk, it may have to disband or create a new ACO consisting of a substantially different make-up of providers, which may prove difficult at best. If the ACO disbands, all of the waivers, that were potentially used to form collaborations and help achieve the goals of the ACO of improving care and reducing costs, will also go away.

**Conclusion – The Future**

ACOs are in their infancy and continue to evolve. One of the biggest issues facing CMS is how to incentivize more clinicians to move to a risk-based model. At the end of 2018, 81 track one ACOs will be completing their sixth and final year in this model. While taking on risk is the ultimate goal, the question remains of how much experience in a track one model is needed before a group is comfortable taking on risk.

ACOs that started in the Medicare Shared Savings Program (MSSP) Track 1 in either 2012 or 2013, by law are supposed to move to risk in 2019. NAACOS surveyed 82 ACOs that began in those years and 71% of them said they are likely to leave the program if they must assume risk. Lobbying efforts have been underway to convince CMS that these non-risk ACOs should get another three-year performance period to help them better prepare for taking on risk. The majority of those surveyed by NAACOS, 76%, said they would remain in the program if CMS granted that request. (Dickson, 2018)
While risk-based models provide for a greater share in savings, performance results of these models demonstrate that the economics of it are impractical especially for groups which do not have the financial resources to survive should losses occur.

The Medicare Payment Advisory Commission (MedPAC) in its June 2018 report to congress stated that two-sided risk models best meet the commission’s principles because they encourage clinicians to be responsible for the quality and cost of care for beneficiaries. (HOW to list source).

MedPAC points out issues with current models, including the use of the CMS established benchmark as the measurement of financial performance. The benchmark was designed to be equitable across the country while costs and utilization are highly variable depending on where a beneficiary resides. This variation has resulted in shared savings for those areas which have had high use and cost and little or no savings for those located in areas of the country that are already efficient.

Critical to the success of ACOs formed by otherwise unrelated entities is the waiver of Stark and AKS. As recent as June of 2018, CMS released a Request for Information (RFI) on possible regulatory changes to Stark. They were seeking input from the healthcare industry on how to further reduce regulatory burdens and dismantle barriers to value-based care transformation. CMS is concerned that the Stark Law may have a negative effect APMs and other value-based arrangements. (Wallfisch, 2018) Further revisions to the Stark Law may give ACOs more flexibility in creating innovative approaches to achieving the triple aim and perhaps make it even more attractive to independent physician practices.

A long-term issue for ACOs, is whether or not hospitals are a viable participant in ACOs. They may have conflicting interests but yet may have more resources to help with assuming risk. So, as an ACO considers its future beyond its non-risk life, it may consider a hospital or other partner to help bear the burden of risk.
Gaining experience with an ACO, regardless of what they may look like in a year or two, makes a physician practice appealing to other payers. Commercial payers find value in groups which can demonstrate success in quality reporting, care coordination and reducing the overall cost of care. It is also a fast track to clinical integration allowing for continued independence and an avenue of unified strength for independent practitioners.

The financial future of healthcare is in value-based reimbursement. Survival of a medical practice, whether independent or not, will require changing to this mode of operation. Being a participant in an ACO, particularly a non-risk based ACO, can serve as a stepping stone to the future and a may be a viable one for physicians intent on remaining independent.
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https://portal.cms.gov


APPENDIX A
Abbreviations

ACI – Advancing Care Information
ACO – Accountable Care Organization
AKS – Anti-Kickback Statute
APM – Advanced Payment Model
APM – Alternative Payment Model
AWV – Annual Wellness Visit
CAH – Critical Access Hospital
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CCLF – CMS Claims Line Feed
CCM – Chronic Care Management
CMS – Centers for Medicare and Medicaid Services
CPIA – Clinical Practice Improvement Activity
EC – Eligible Clinician
EHR - Electronic Health Record
FFS – Fee for Service
FTC – Federal Trade Commission
GPRO – Group Practice Reporting Option
HHS – Health and Human Services
IHI – Institute for Healthcare Improvement
IPA – Independent Practice Association
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MACRA – Medicare Access and Chip Reauthorization Act

MedPAC – Medicare Payment Advisory Commission

MIPS – Merit-based Incentive Payment System

MSR – Minimum Savings Rate

MSSP – Medicare Shared Savings Plan

OIG – Office of Inspector General

PHO – Physician Hospital Organization

PPACA – Patient Protection and Affordable Care Act

SNF – Skilled Nursing Facility

TCM – Transitional Care Management

TIN – Tax Identification Number
## Appendix B

### ACO Quality Measures

Table 3. 2018/2019 Reporting Year ACO Quality Measure Benchmarks

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### ACOs: A Survival Option for Independent Practices

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- **ACO-8**: Risk-Standardized, All Condition Readmission
- **ACO-35**: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- **ACO-36**: All-Cause Unplanned Admissions for Patients with Diabetes
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- **ACO-38**: All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- **ACO-43**: Ambulatory Sensitive Condition Acute Composite
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<td>70.00</td>
<td>80.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>ACO-42</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>At-Risk Population</td>
<td>ACO-40</td>
<td>Depression Remission at Twelve Months</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Depression</td>
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<tr>
<td>At-Risk Population</td>
<td>Diabetes</td>
<td>ACO-27: Diabetes Mellitus: Hemoglobin A1c Poor Control</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>29.90</td>
<td>34.33</td>
<td>38.81</td>
<td>43.32</td>
<td>48.21</td>
<td>53.64</td>
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<td>Diabetes Composite</td>
<td>ACO-27 &amp;</td>
<td>ACO-27: Diabetes Mellitus: Hemoglobin A1c Poor Control</td>
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<tr>
<td></td>
<td>ACO-41</td>
<td>ACO-41: Diabetes: Eye Exam</td>
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</table>
### Hypertension (HTN): Controlling High Blood Pressure

<table>
<thead>
<tr>
<th>At-Risk Population</th>
<th>ACO-28</th>
<th>Hypertension (HTN): Controlling High Blood Pressure</th>
<th>R</th>
<th>P</th>
<th>P</th>
<th>30.00</th>
<th>40.00</th>
<th>50.00</th>
<th>60.00</th>
<th>70.00</th>
<th>80.00</th>
<th>90.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>At-Risk Population</td>
<td>ACO-30</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>R</td>
<td>P</td>
<td>P</td>
<td>30.00</td>
<td>40.00</td>
<td>50.00</td>
<td>60.00</td>
<td>70.00</td>
<td>80.00</td>
<td>90.00</td>
</tr>
</tbody>
</table>

*Measures introduced in the 2017 PFS final rule for which the phase-in schedule applies beginning with Performance Year (PY) 2019. Benchmarks for measures that phase in-to pay-for-performance in 2019 will be published before the start of PY 2019.

†ACOs in their second agreement period will be assessed using the same pay-for-performance phase-in schedule as a PY3 ACO in its first agreement period.

˅Measure was updated for PY 2017 to align with the Quality Payment Program and is set at pay-for-reporting for all ACOs for PY 2018. Benchmarks will be provided for PY 2019.