



# ● Meaningful Use and ACO's 101

**Stephen C. Spain, MD, CPC**

President Tyler, Texas Chapter

AAPC NAB member

Family Physician

CEO, Doc-U-Chart Practice Consultants

**Annie Boynton,**

BS, RHIT, CPCO, CCS, CPC, CCS-P, CPC-H, CPC-P, CPC-I

President Worcester, MA Chapter

AAPC NAB member

Director Communication, Adoption &  
Training Provider Regulatory Programs  
UnitedHealthcare





# Meaningful Use and ACO's 101

What are these things, and...

...Why do coders need to  
care?



# Objectives

- Understand Meaningful use measures and their impact on the provider practice
- Recognize the value of the expansion of Meaningful Use measures
- Understand how meaningful use and ACOs relate to each other.
- Recognize the challenges in the US healthcare system with regard to cost, affordability, and quality.
- Understand key differences between Fee for Service, HMOs and Accountable Care
- Recognize Various healthcare reimbursement models/mechanisms
- Understand key elements of the final regulations for ACOs
- Review ACO requirements and the practice technological infrastructure needed to meet them
- Understand the basic tenants of forming an ACO
- Recognize the value to the coding profession of Meaningful Use and ACO's
- Know what to do next regarding the implementation of ACO's and Meaningful Use.





“Quality” is the common  
theme





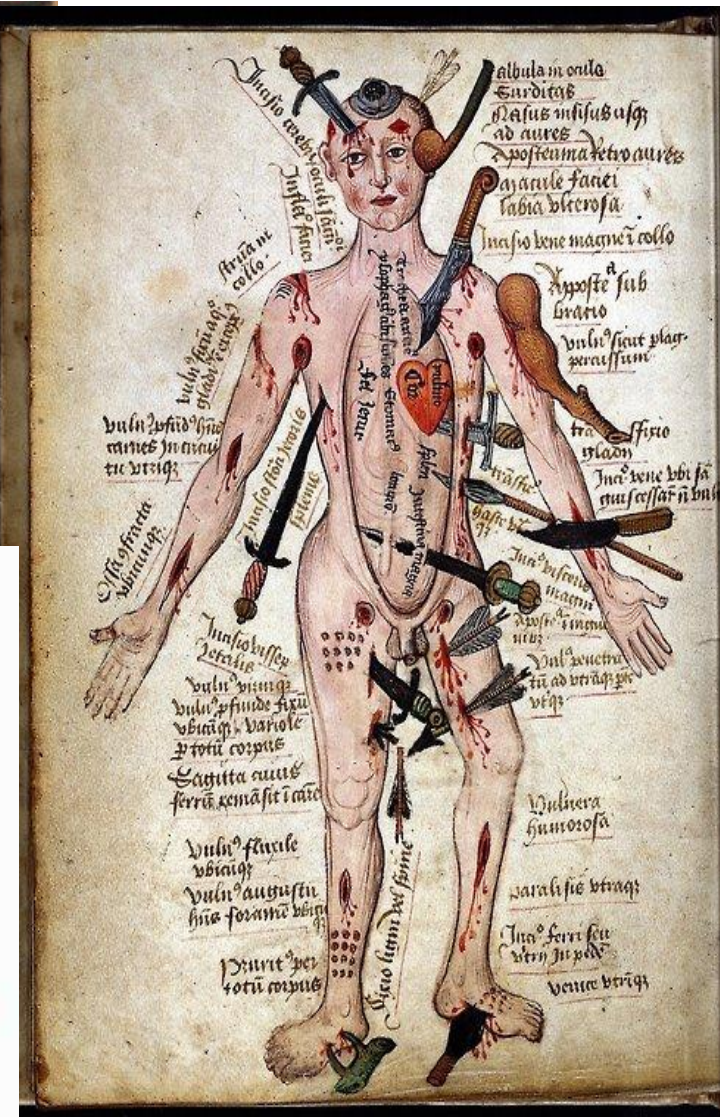
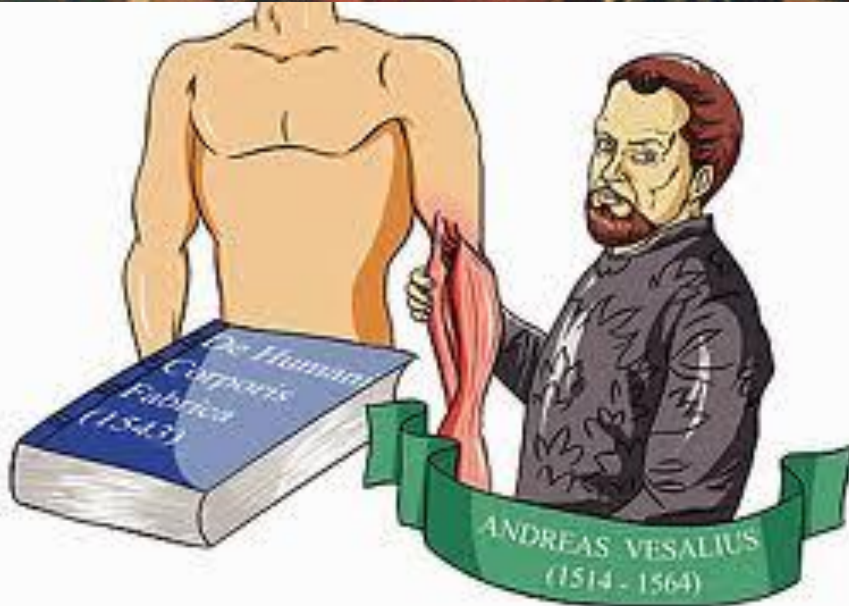
## Food for Thought

*“The past 50 years have been marked by advances in the science of medicine. The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered”.*

-Charles H. Mayo  
January, 1913



# The history of healthcare





# The history of healthcare

## THROAT DOCTORS VOTE OLD GOLD BEST FOR YOUR THROAT



"A MAN, I TESTED the 4 leading cigarette brands with a group of throat specialists. 'Doctors,' I said, 'the names of these cigarettes are covered up. Don't try to guess which is which. Just smoke them—and tell me which cigarette is easiest on the throat.'"

"They did that . . . And again OLD GOLD won by a big majority."

Quoted ROBERT RIPLEY,

CREATOR OF "BELIEVE IT OR NOT"

Voted the best for taste and throat comfort.

"Throat doctors know what harsh tobacco does to throat membrane. They voted for O. G. because its clean, non-ripened gummed tobacco is like honey to the throat. You can't hide O. G.'s lighter signature. Its throat ease wins . . . even when the name is covered up."



### CERTIFIED PROOF

"I hereby certify that the following is the correct score of the cigarette test conducted by Ripley, among Throat Doctors, with 100 in 100, Brand A 80, Brand B 20, Brand C 10, Brand D 10."

Quoted J. B. in 1930-1931  
Famous Public Opinion  
and Research, New York

**Not a Cough in  
a Carload**

Test in an Old Gold Character Reading . . . Test in an Old Gold Character Reading . . . Test in an Old Gold Character Reading . . . Test in an Old Gold Character Reading . . . Test in an Old Gold Character Reading . . .





# The history of healthcare







# Medicine in Modern Times

- Improving access to care
- More medical schools
- More medical specialty societies
- Advances in services and tools
- Advances in treatments
- Centers for advanced treatment
- Improved outcomes, healthier population
- Higher cost



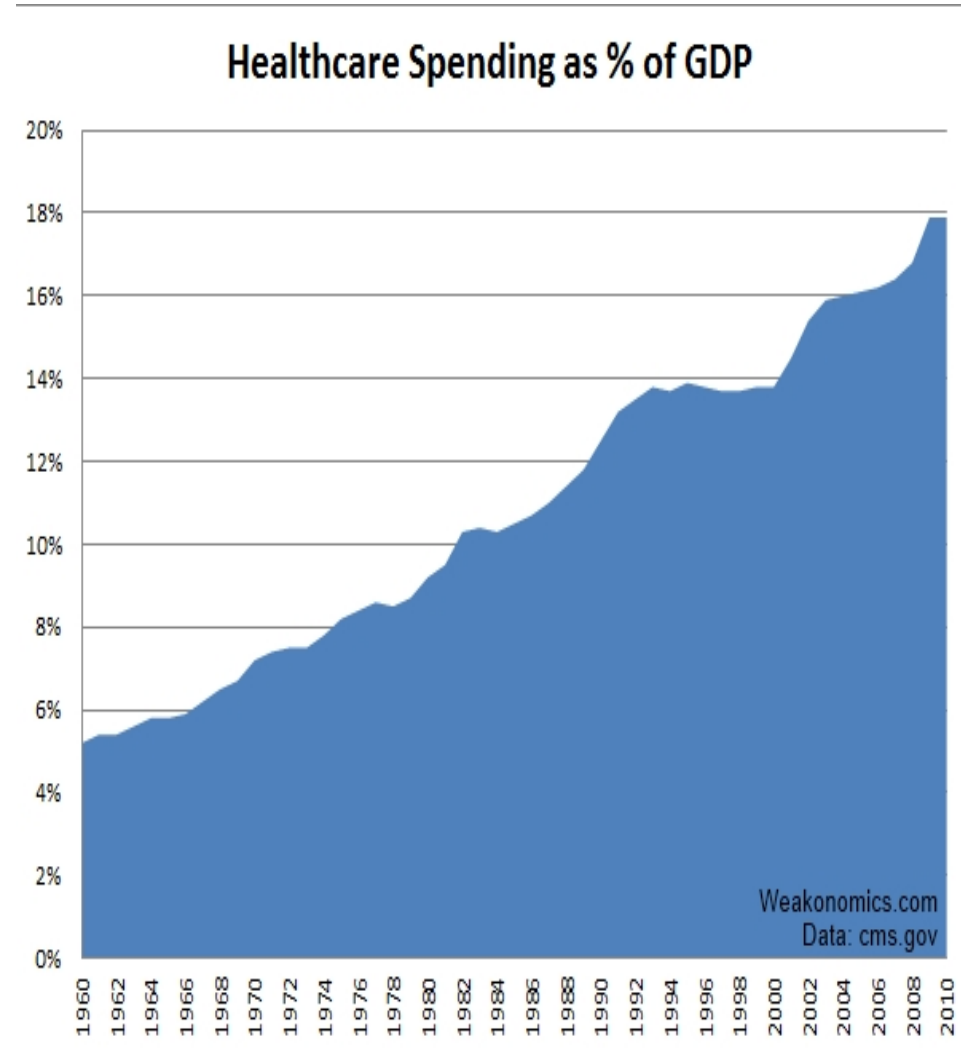
# The effects of rising costs

- Employees generally fared well
- The unemployed, particularly the elderly and disabled, were at a disadvantage
- “The Great Society”
- Federal healthcare spending will soon eclipse all private spending on healthcare
- Healthcare is a HUGE expense
- We must be frugal



# US Healthcare % of GDP

- The health share of GDP is projected to reach 17.3 percent in 2009 and 19.3 percent by 2019.
- CMS predicts total U.S. health spending in 2019 will be **\$4.5 trillion!**
- *That's \$2 trillion more than in 2010!*

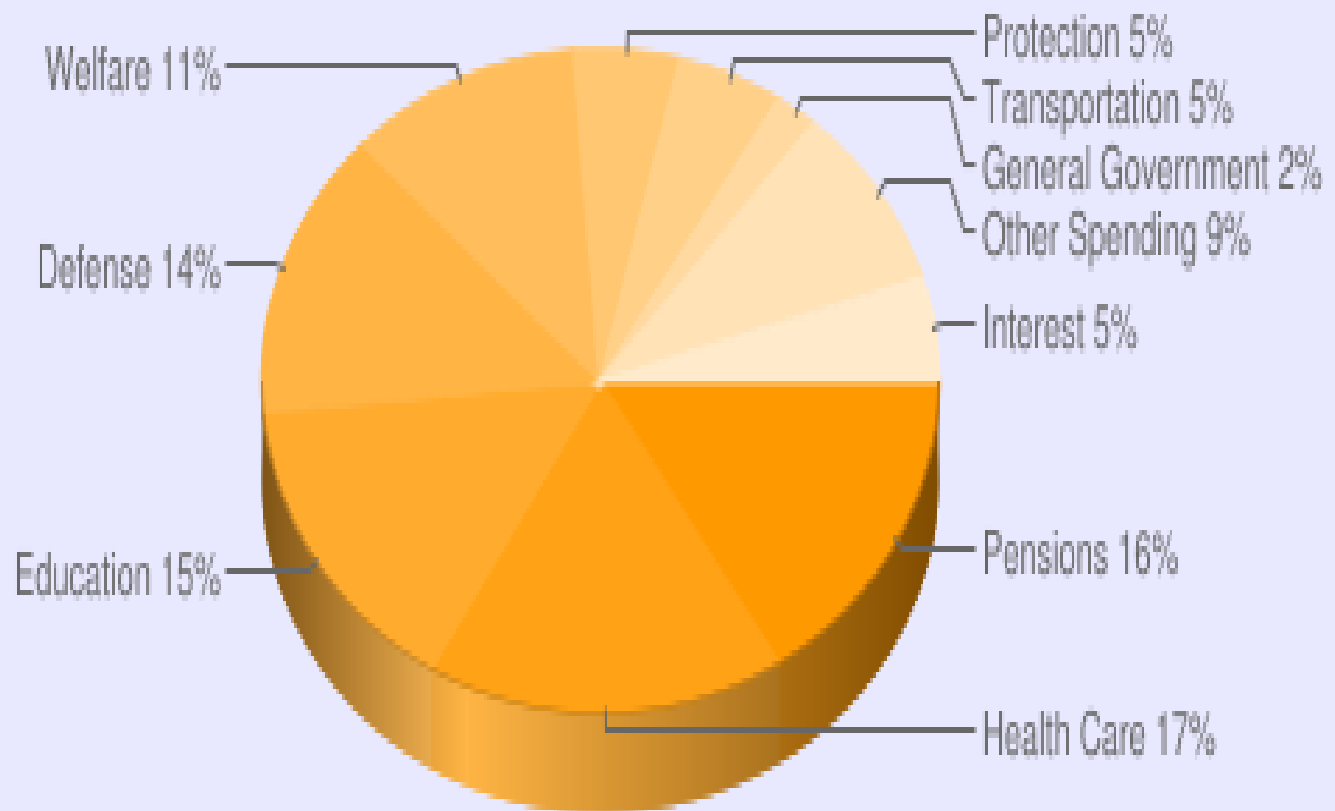




# Where does all the money go?

## Healthcare is the largest expenditure in our federal budget.

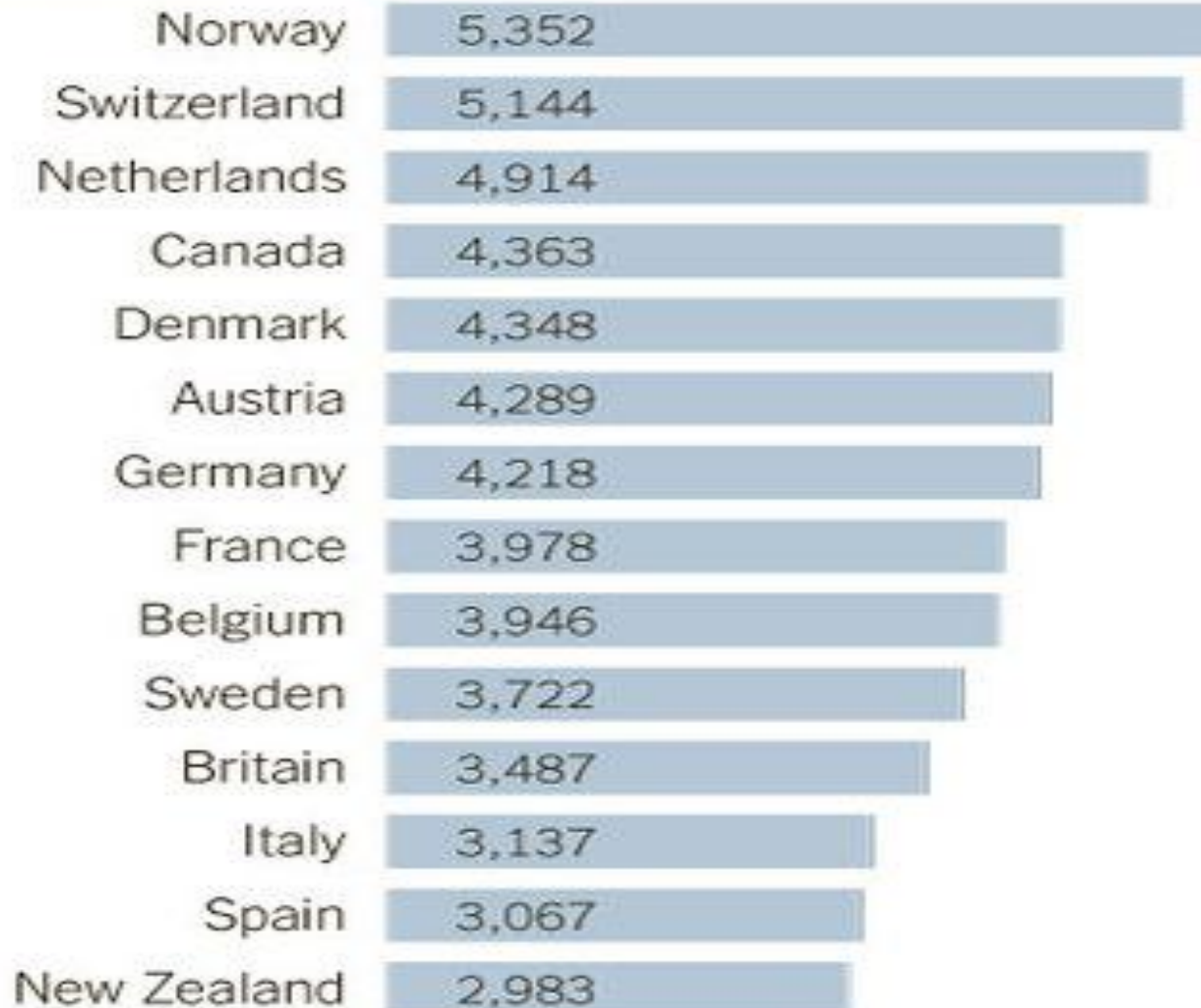
Total Spending for United States - FY 2012





## Spending on Health Care Per Person

**United States** **\$7,960**



Figures are for 2009, the latest data available for all countries. Adjusted for purchasing power parity.



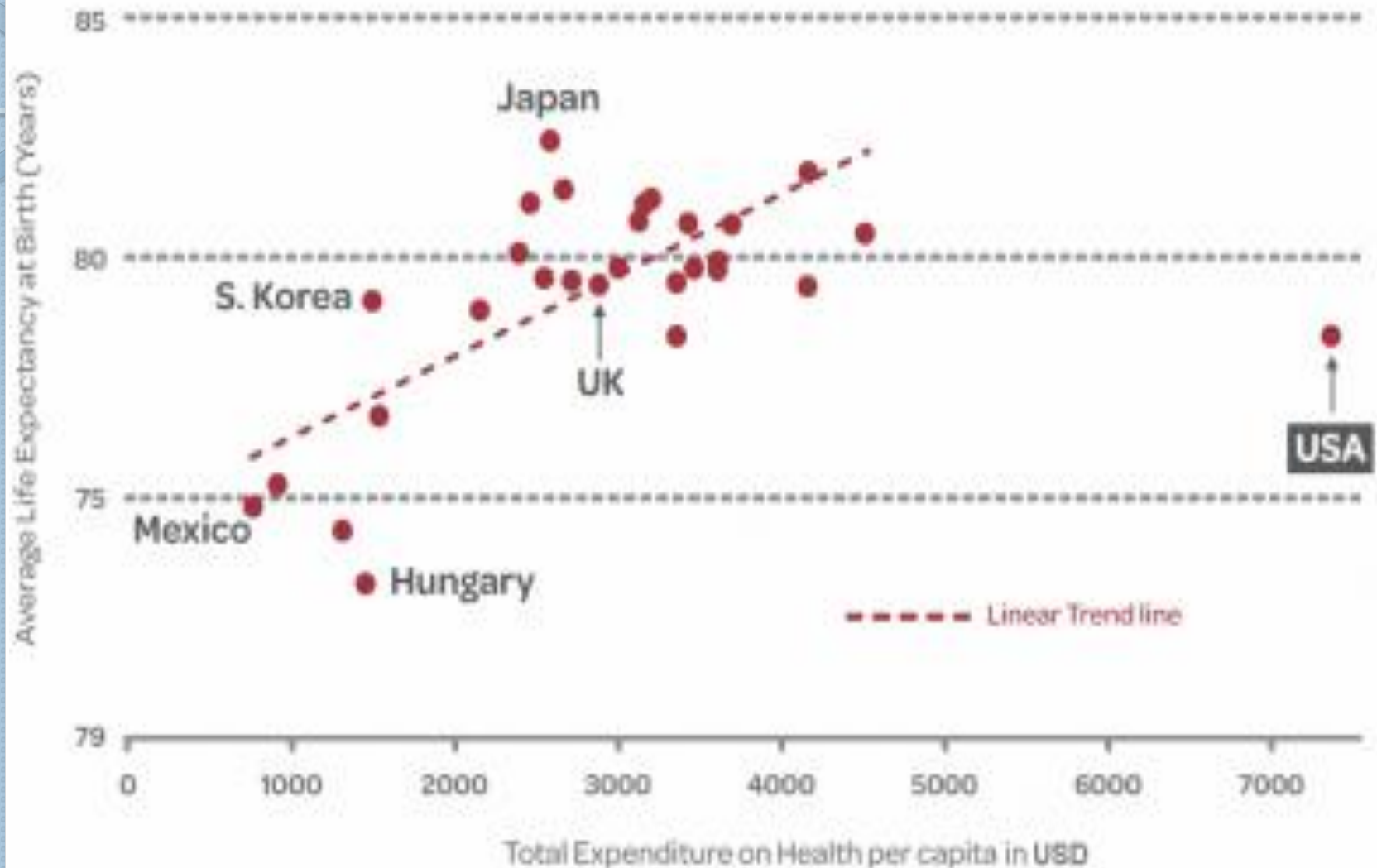
# The Rising Cost of Healthcare

- In 2010, the United States spent \$2.6 trillion on healthcare.
  - *That's about \$8,000 per American.*
- Consider:
  - If we stacked single dollar bills on top of one another, \$2.6 trillion would reach more than 170,000 miles — nearly three-quarters of the way to the moon!
  - 2.6 Trillion is the entire GDP of France (5<sup>th</sup> largest economy on the planet)





## Healthcare Spending per capita vs. Average Life Expectancy Among OECD Countries



***Spending more doesn't make us healthier!***



# The Relationship Between Cost and Quality

- Cost studies have shown that higher costs have no relation to higher quality.
- 20% to 30% of healthcare spending does not improve health outcomes
  - We pay for either too much, too little, or the wrong type of medical treatments and technologies, relative to the evidence of their effectiveness
- Studies have shown that rising spending is not due to the aging of the U.S. population





# Complexity, Access, Affordability

- For those with Employer sponsored health plans
  - Access and care are top notch
- For those participating Medicare, Medicaid, TRICARE, or the VA
  - Access and care are good – but often fragmented – many are paying for few (this is socialized medicine folks!)
- For nearly 32 million uninsured or underinsured Americans, getting affordable access to quality care is similar to a third world country.



# So why the emphasis on quality?

- Most services are high quality
- There will always be some “rotten apples”
- The “bad eggs” generate concern about wasted resources
- Concern leads to action to stop waste and ensure quality services across the board
- The taxpayer does not want to be “ripped off”



# Healthcare Delivery Definition of Quality?

- Enduring
- Exceeds expectations
- Satisfying
- Good value received for the dollars spent



# Healthcare Reimbursement

## Definition of Quality

- From a payers perspective, if services result in lower overall spending, then they are of “value”
- Good value received for the dollars spent



# EBM...what is it?

- Evidence Based Medicine
- Trying to identify those treatments and practices that are proven to be of benefit
- Using double blinded, controlled studies as the basis for as many treatments as applicable.
- Example: B-12 injections
- Example: X-ray for acute ankle sprain



# CMS tries an experiment

- Premier Hospital Quality Improvement Project
- Incentive payments for reporting quality measures
- “Pay for Performance”
- Measures were closely linked issues, treatments, or observations that had potential to either save or waste money



# CMS tries an experiment

- The Premier Hospital Quality Improvement Project was very successful
- For extra pay, providers would report data
- Not much was done with the reported data
- The PQRI concept was born of the success of the Premier Hospital Quality Improvement Project



# PQRI

- Physician's Quality Reporting Initiative
- Relies on "Measures"
- CMS enlisted help in developing measures
- AMA and other groups participated
- Several hundred measures are now being reported and tracked
- There are measures that are pertinent for virtually any type of healthcare provider



# How does Quality Reporting work?

- For example pneumonia vaccine
- Providers reports vaccine status
- If unvaccinated, vaccine is given and reported with corresponding code
- More vaccinated patients means fewer cases of disease and treatment
- Less instance of illness saves healthcare dollars



# How does Quality Reporting work?

- Several years of experience now shows providers will report quality measures:
- For vaccines,
- Preventive screenings,
- Health counseling,
- Effective disease treatments



# PQRI in Practice

- Quality measures pertinent for every type of provider
- Provider chooses at least 3 applicable measures to report
- Reporting can be claim based, 3<sup>rd</sup> party registry, or integrated into EHR



# PQRI in Practice

- Example: Endocrinology
- Selects at least 3 measures:
  - Hgb A1C with poor control A1C>9%
  - LDL controlled LDL-C < 100mg/dl
  - High BP controlled BP< 140/90
- A minimum of 3 measures must be reported for at least 80% of eligible Medicare encounters for the one year period



# PQRI in Practice

- Incentive is earned for successfully reporting at least three measures for the year
- No way to track progress
- Check arrives, if earned, as much as 6 months after the end of the reporting year
- The bonus is 0.5% of all Medicare revenues received for the year



# PQRI in Practice

- Incentive payments are phased out in 2014
- Penalties for not participating go into effect in 2015
- Initially 1.5%, increasing to 2% in 2016
- For those not now participating, there will be keen interest in learning how to comply with PQRI as penalties are phased in!



# PQRI: Moving Forward

- Not much being done with data now
- Desired effect of reporting more passive in nature
- Number of quality measures are ever expanding
- Look for CMS to mandate measures and for many more than 3 to be required
- No longer an 'Initiative'. Now the Physician Quality Reporting System:

PQRS





# Accountable Care Organization

- Like an HMO, but not exactly...
- Patients must be included on decision making boards
- Members are free to seek healthcare outside the ACO, using their regular Medicare benefits
- This freedom of choice will be a strong incentive for the ACO



# CMS Introduces the ACO

- Placeholder Video #1



# Healthcare Reimbursement Models & Mechanisms

Reimbursement refers to compensation or repayment for healthcare services. In United States healthcare, services are often provided before payment is made using a number of models/mechanisms:

- CMS Acute Inpatient PPS (IPPS)
- CMS Outpatient PPS (OPPS)
- CMS Skilled Nursing Facility PPS (SNF PPS)
- CMS Home Health PPS (HH PPS)
- CMS Inpatient Rehabilitation Facility PPS (IRF PPS)
- CMS Inpatient Psychiatric Facility PPS (IPFPPS)
- CMS Long-term Care Hospital PPS (LTCH PPS)
- Medicare Advantage (MA) Program (CMS HCC)
- CMS Fee Schedules (MPFS)
- Fee for Service (FFS)
- Pay for Performance (P4P)
- Ambulatory Payment Classifications
- Adjusted Clinical Groups (ACG)
- Diagnosis-Related Groups (DRG)
- Day Procedure Groups (DPG)
- Clinical Risk Groups (CRG)
- Outcomes and Assessment Information Set (OASIS)
- Resource Utilization Group (RUGs)
- Resource Based Relative Value Scale (RBRVS)



# Fee for Service

- Most common reimbursement model in US Healthcare
  - Providers/Facilities are paid based on
    - Number of services performed
    - Number of beds filled (inpatient)
  - Doctors traditionally get paid only for face-to-face encounters and specific tests or treatments



# Comaparison ACO vs PQRI

- **ACO**

- Newer
- May not be viable
- PPACA
- Only 33 measures
- Voluntary

- **PQRI**

- 5 year history
- CMS likes them
- Pre-PPACA
- 100's of measures
- Bonus now, penalty later for NOT complying!



# HMOs vs. ACOs – What's Different?

## Capitation (1990's) vs. ACOs (2010's)

- Insurance Industry Driven
- Fragmentation
- Adversarial relationships
- Focus on “doing”
- One-to-one care
- Gatekeeper
- Perverse financial incentives
- Focus on volume/intensity
- Provider Driven
- Integration
- Cooperation
- Focus on managing a population
- Team-based care
- System management
- Aligned incentives
- Focus on quality and efficiency



# How ACOs are Different from Managed Care

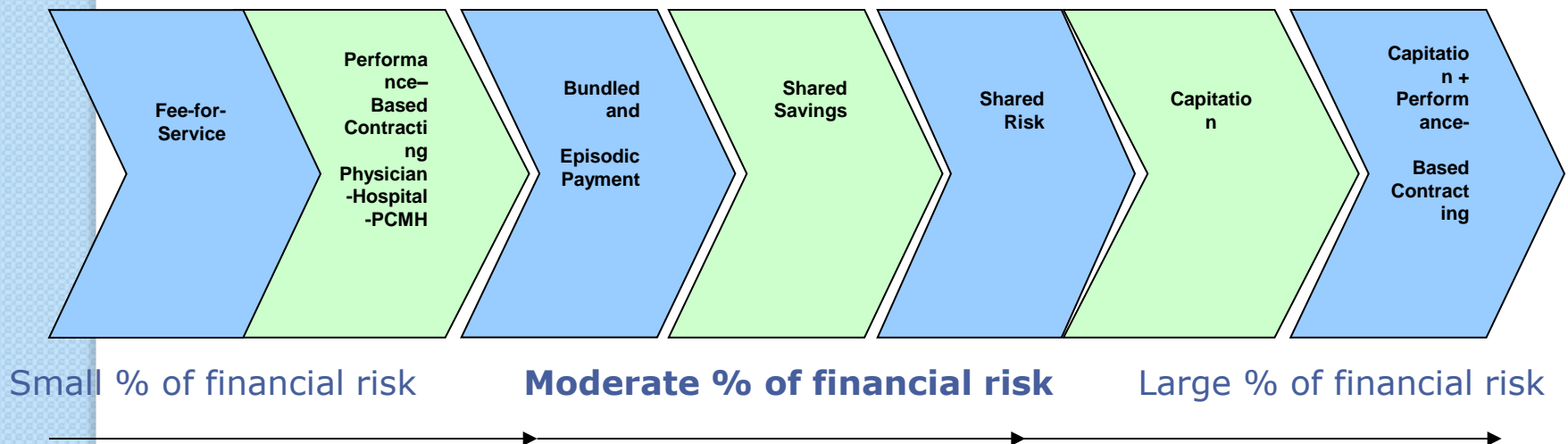
- Patients who don't like how they are being treated in an ACO can go elsewhere, an option not afforded under managed care.
- ACO is meant to reward doctors and hospitals who keep their patients out of the hospital.
  - Even if that means serving patients in new ways.
- Managed care has always been the most restrictive form of healthcare.



# Risk, Risk, Risk....

**Tomorrow's health care system will be defined by greater accountability, robust quality and cost outcomes, and more integration among providers**

## Level of Financial Risk



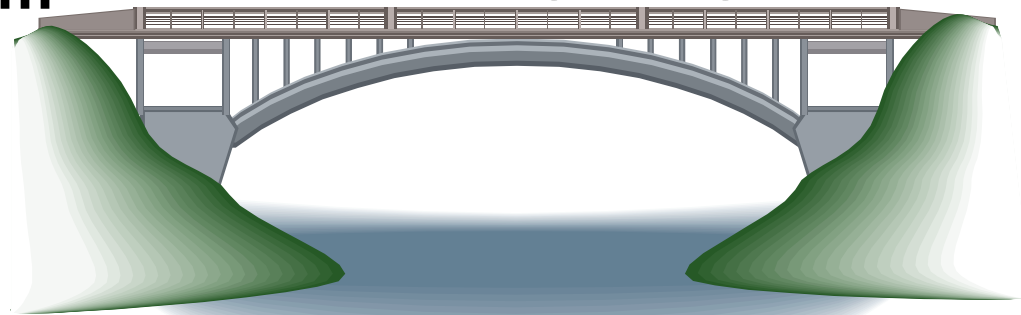


# From Fee for Service to Accountable Care

**Current  
FFS  
System**

**What will bridge the gap?**

**Accountable  
Care**



## **Accountable Care Core Components**

**People  
Centered  
foundation**

**Health Home**

**High Value  
Network**

**Population  
Health Data  
Management**

**ACO  
Leadership**

**Payer  
Partnerships**



# What is an ACO?

- Accountable Care Organization
  - Formalized under the Patient Protection and Affordable Care Act
    - Section 3022 of the Affordable Care Act added a new section 1899 to the Social Security Act that requires the Secretary to establish the Shared Savings Program.
  - Final Rule issued October 20, 2011
  - Launched by Medicare on January. 1, 2012
  - Creates incentives for health care providers to work together to treat an individual patient across care settings including:
    - Doctor's offices
    - Hospitals
    - Long-Term Care Facilities.
  - Provider participation is purely voluntary.
  - Key Goals:
    - Reduce health care costs
    - Coordinate care
    - Reduce duplication of care
    - Prevent Medical Errors
  - *ACO rules represent 7 pages of the ACA legislation – yet one of the most talked about provisions.*





# Accountable Care Organization

- Provides all necessary medical services
- A new type of insurance network
- The ACO receives a lump sum payment for providing services to at least 5,000 beneficiaries
- The ACO has carte blanche to use just about any means they can come up with to save money while providing quality care



# Hmmm, Sounds like Anti-Trust to Me...

- Federal Trade Commission (FTC) and U.S. Department of Justice issued a "Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program."
- The proposed approach is to divide ACOs into three categories, based on how much business each does in a defined geographic area.
- The largest ACOs will face a mandatory review from either the DOJ or FTC and can't move ahead without approval.
- FTC and DOJ promise an expedited process.



# Who Can Participate in ACOs?

- ACO professionals (physicians, hospitals and other eligible health care professionals) in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Critical access hospitals
- Rural Health Clinics
- Federally qualified health centers



# The Purpose Driven ACO

- The goal of an ACO is to deliver:
  - Better Access
  - More Coordination
  - Enhanced Communication
  - Data Needed
  - Better Outcomes
  - Better Quality
- Physicians, facilities and health care professionals will have access to more information about their Medicare patients' medical history and can seamlessly communicate with a patient's other physicians/care providers.



# How do ACOs work?

- ACOs create incentives for
  - Physicians
  - Facilities
  - Health care professionals
- They must be able to collaborate/coordinate patient care across care settings including
  - Physicians' offices
  - Hospitals
  - Long-term care facilities
- The Medicare Shared Savings Program will reward those ACOs that
  - Lower growth in health care costs
  - While also meeting quality of care standards



# **Know the basic ACO “Lingo”**

- Pioneer Accountable Care Organization Model
- Advance Payment Accountable Care Organization Model
- Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs)



# Pioneer Accountable Care Organization Model

- For Early Adopters
- Designed for those who are already experienced at providing integrated care across settings.
- Tests a rapid transition to a population-based model of care
- Engages other payers in moving toward outcomes-based contracts
- The initial group of 32 Pioneer sites
- Expected to rapidly demonstrate what can be achieved when highly coordinated care is provided to Medicare beneficiaries





# **Pioneer ACOs**

## **Introduction from the Source**

Placeholder Video #2



# Advance Payment Accountable Care Organization Model

- For physician-owned and rural providers including:
  - Certain critical access hospitals
  - Federally qualified health centers
  - Rural health clinics
- Provides additional support in the form of additional start-up resources to
  - Build the necessary infrastructure
  - New staff
  - Information technology systems
- The advance payments would be recovered from shared savings achieved by the Accountable Care Organization



# Advanced Payment ACO Model – Payment Method

- Under the Advance Payment ACO Model, participating ACOs will receive three types of payments:
  - *An upfront, fixed payment:*
    - Each ACO will receive a fixed payment.
  - *An upfront, variable payment:*
    - Each ACO will receive a payment based on the number of its historically-assigned beneficiaries.
  - *A monthly payment of varying amount depending on the size of the ACO:*
    - Each ACO will receive a monthly payment based on the number of its historically-assigned beneficiaries.



# Advanced Payment ACO Model – Payment Method

- The Advance Payment ACO Model is open only to two types of organizations:
  - ACOs that do not include any inpatient facilities AND have less than \$50 million in total annual revenue.
  - ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than \$80 million in total annual revenue.



# The 3 Elements of an ACO in the MSSP:

- The 3 Elements of an ACO Will Serve as Our Roadmap to the MSSP
  - A legal entity which is comprised of an eligible group of ACO participants with shared governance that work together to manage and coordinate care for Medicare fee-for-service beneficiaries.
  - Defined patient population of at least 5,000 Medicare fee-for-service beneficiaries attributed to it based on patients' use of primary care services.
  - Assumes accountability for the quality and total costs of care of defined patient population across all Medicare Part A and B services for at least **3 years**.
- Lengthy application process to CMS to gain acceptance into the MSSP



# Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs)

- Rewards ACOs that lower their health care costs while meeting performance standards on quality of care and putting patients first.
- Allows providers who voluntarily agree to work together to coordinate care for patients and who meet certain quality standards to share in any savings they achieve for the Medicare program.
- ACOs which elect to become accountable for shared losses have the opportunity to share in greater savings.
- ACOs must coordinate and integrate Medicare services
  - Success is monitored by 33 quality measures organized in four domains.
- Higher the quality of care + Lower healthcare cost growth = more shared savings.



# ACO Information Technology Needs

- Hospital EMR (including CPOE)
- Physician Office EMR
- Health Information Exchange (HIE) or Integration Engine to connect the Continuum of Care
- Population Health Data Management System
- Robust Business Intelligence/Predictive Analytics Platform
- Consumer Health Platform/Portal



## What ACOs Won't Do

- The ACO model does not restrict which doctors or hospitals a patient can visit.
- No one (provider, facility, or patient) is forced to join an ACO or seek care from an ACO.
- ACOs do not have gatekeepers!
  - Patients retain full choice in the physicians they see.
  - Patients can choose to see physicians outside of the ACO if they wish



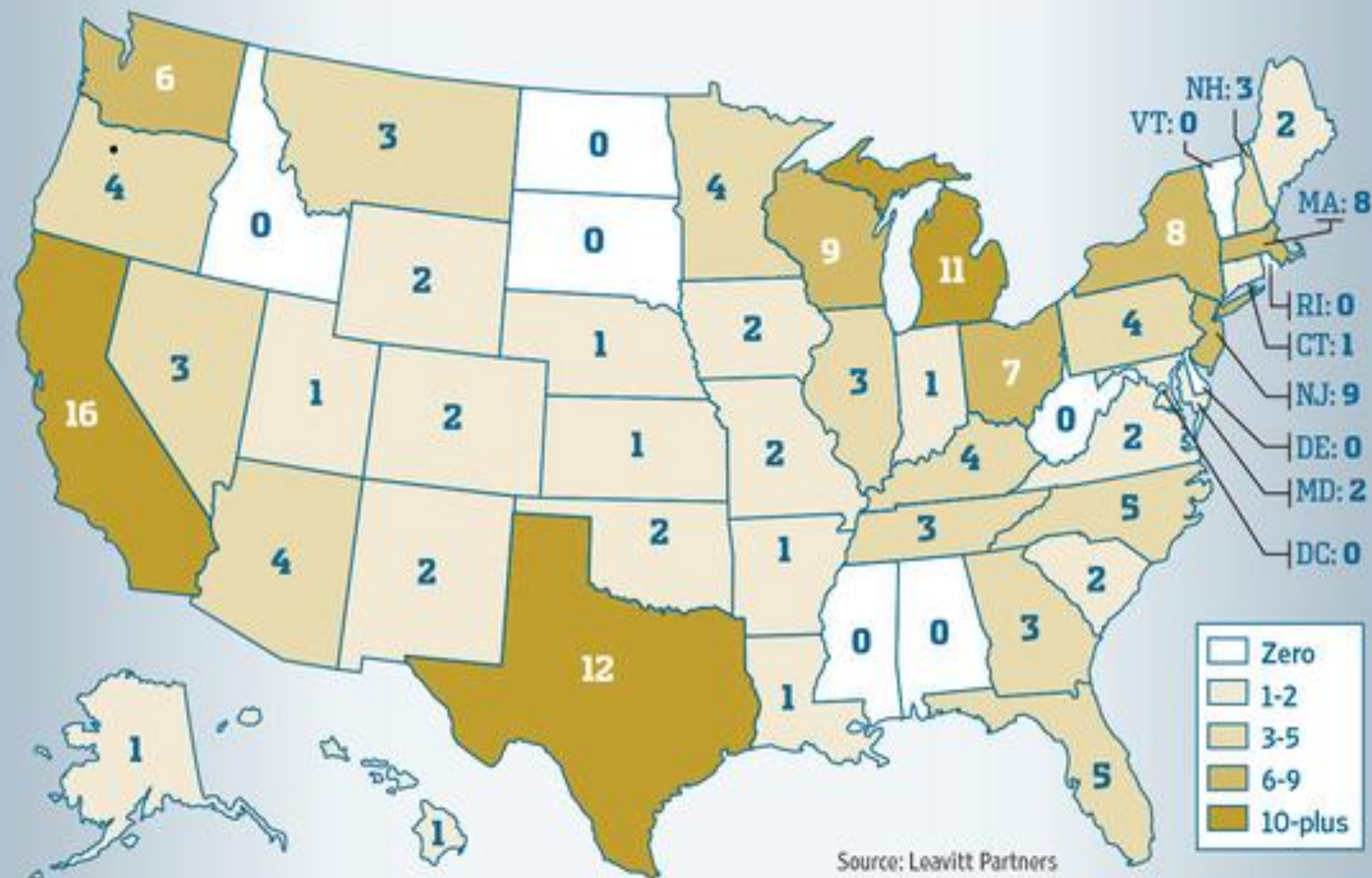
# Accountable Care Concept is Catching On!

- Outside of Medicare, hundreds of provider organizations are already working with private health plans toward contracts containing the core elements of the ACO model:
  - Payment tied to improving patient care across the continuum and reducing overall spending growth.
  - Other ACO related initiatives are emerging at the regional or state level (e.g., Vermont) or through state Medicaid programs (e.g., New Jersey and Texas).
  - At least 12 states have enacted legislation to facilitate accountable care reforms.



# The Spread of ACOs

The number of accountable-care organizations affiliated with hospitals in each state





# How Will Patients Know If They Are In An ACO?



- Under the final rule, those participating in an ACO must notify the Medicare beneficiary/patient.
- The beneficiary may choose to receive services from that physician, facility or other health care professional or seek care from others that are not part of the ACO.





# Quality Measures/Standards

- The final rule adopts 33 individual measures of quality performance that will be used to determine if an ACO qualifies for shared savings.
  - Span four quality domains:
    - Patient Experience of Care
    - Care Coordination/Patient Safety
    - Preventive Health
    - At-Risk Population



# Quality Measures: Patient Experience of Care 1-7

## • **Goal – Better Care for Individuals**

### ◦ 7 Measures:

- How Well Your Doctors Communicate
- Getting Timely Care, Appointments, and Information
- Patients' Rating of Doctor
- Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Health Status/Functional Status
  - All use Surveys as method of data submission



# Quality Measures:

## Care Coordination/Patient Safety 8-13

- **Goal – Better Care for Individuals**
  - 6 Measures:
    - Risk-Standardized, All Condition Readmission
    - Ambulatory Sensitive Conditions Admissions including:
      - Chronic Obstructive Pulmonary Disease
      - Congestive Heart Failure
        - Use Claims as method of data submission
    - Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment
      - Use EHR Incentive Program as method of data submission
    - Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
    - Falls: Screening for Fall Risk
      - Use GPRO Web interface as method of data submission



# Quality Measures: Preventive Health 14-21

- **Goal Better Health for Populations**
  - 8 Measures:
    - **Influenza Immunization**
    - **Pneumococcal Vaccination**
    - **Adult Weight Screening and Follow-up**
    - **Tobacco Use Assessment and Tobacco Cessation Intervention**
    - **Depression Screening**
    - **Colorectal Cancer Screening**
    - **Mammography Screening**
    - **Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years**
  - All use Group Practice Reporting Option (GPRO) Web Interface as method of data submission



# Quality Measures: At-Risk Population 22-33

- **Goal Better Health for Populations**

- 12 Measures Divided into several population categories:

- **Diabetes Composite (All or Nothing Scoring):**

- Hemoglobin A1c Control (<8 percent)
- Low Density Lipoprotein (<100)
- Aspirin Use
- Tobacco Non Use
- Blood Pressure <140/90

- **Diabetes Mellitus**

- Hemoglobin A1c Poor Control (>9 percent)

- **Hypertension (HTN)**

- Blood Pressure Control

- **Ischemic Vascular Disease (IVD)**

- Complete Lipid Profile and LDL Control <100 mg/dl
- Use of Aspirin or Another Antithrombotic

- **Heart Failure**

- Beta- Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- **Coronary Artery Disease (CAD) Composite: All or Nothing Scoring:**

- Drug Therapy for Lowering LDL-Cholesterol
- Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

- All use GPRO Web Interface as method of data submission





# **Accountable Care in Action - A Success Story!**

- Placeholder Video #3



# Reporting

- Measures will be reported through a combination of:
  - Web interface for clinical quality measure reporting
  - Patient experience of care surveys
  - CMS claims data
- CMS will also administer and pay for the patient experience of care survey for the first 2 years of the Shared Savings Program, 2012 and 2013
- ACOs will be responsible for selecting and paying for a CMS-certified vendor to administer patient surveys beginning in 2014.



# Quality Performance Scoring

- First year –
  - CMS will define quality performance standard at the level of complete and accurate reporting for all quality measures.
- Subsequent years –
  - Quality performance standard will be phased in
    - ACOs must continue to report all measures but will eventually be assessed on performance.



# Quality Performance Scoring

- Year 1:
  - Pay for reporting applies to all 33 measures.
- Year 2:
  - Pay for performance applies to 25 measures.
  - Pay for reporting applies to eight measures.
- Year 3:
  - Pay for performance applies to 32 measures.
  - Pay for reporting applies to one measure that is a survey measure of functional status.
  - CMS will keep the measure in pay for reporting status for the entire agreement period. This will allow ACOs to gain experience with the measure and will provide important information to them on improving the outcomes of their patient populations.



# Benchmarks

- CMS will establish national benchmarks for ACO quality measures
  - Using existing Medicare claims data
  - Outcomes of first reporting year of ACOs
- Benchmark data will be released second performance year
  - When the pay for performance phase-in begins
- For pay for performance measures
  - Minimum attainment level will be at a national 30 percent/30<sup>th</sup> percentile of the measure



# Benchmarks

- Performance benchmarks will be national and established using
  - National Fee-For-Service (FFS) claims data
  - National Medicare Advantage (MA) quality reporting rates
  - Or a flat national percentage for measures where MA or FFS claims data is not available.
- Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance.
- Performance at or above 90 percent or the 90th percentile of the performance benchmark will earn the maximum points available for the measure.
- ***The better the outcome the more rewards the ACO will reap.***



# How Will Shared Savings be Calculated?

- Medicare will continue to pay individual physicians, facilities, health care professionals and suppliers for specific items and services as it currently does under the original Medicare plan payment systems.
- CMS will develop a benchmark for each ACO against which its performance is measured.
- Benchmarks will be used to whether the ACO qualifies receive shared savings or be held accountable for losses.





## **Incorporation of the Physician Quality Reporting System (PQRS) into the Medicare Shared Savings Program (MSSP)**

- The Affordable Care Act allows CMS to incorporate the Physician Quality Reporting System reporting requirements and incentive payments into the Shared Savings Program.
- ACO participants that include providers/suppliers who are also eligible professionals for purposes of the Physician Quality Reporting System will earn the Physician Quality Reporting System incentive as a group practice under the Shared Savings Program.
- By reporting required clinical quality measures through the ACO Group Practice Reporting Option (GPRO) web interface, in each calendar year reporting period the ACO fully and completely reports the ACO GPRO measures.
- There is no duplicative reporting required for providers who are also in an ACO!



# What Will Prevent ACOs from 'Cherry Picking' Patients?

- The final rules include protections to ensure patients do not have their care choices limited by an ACO.
- CMS has proposed a vigorous monitoring plan that includes analyzing claims and specific financial and quality data.



# Accountable Care Organizations

- Focus on Quality results
  - Lower Healthcare costs
  - Patient Centric
  - Better Care Coordination
  - Incentivizes Better Outcomes
  - Improved Communication
- 
- *Quality is the future of US healthcare!*



# ACO Humor: What the heck is an ACO?

- Placeholder Video #4



# Summary

- Healthcare is changing...what else is new?
- The payers want VALUE...don't we all?
- These new systems are designed to enhance value and save money
- Providers are going to have to adapt to provide services AND report quality measures
- SCOTUS



# The Future...

- 0.5% is not a huge incentive
- 2.0% penalty will be a strong incentive!
- Expect PQRS interest and participation to EXPLODE in the next three years!
- Private insurers are implementing PQRS and ACO's
- Private Insurance involvement will further drive participation



# The Future...

- Experience in quality reporting will ease ACO participation
- PQRS implementation could be a smart strategy to prepare for integration into an ACO



# The Future:

## What do ACOs mean for Coders?

- JOB SECURITY!
  - The foundation of ACOs revolve around data that is provided by coding diagnoses and procedures.
  - Outcomes measures, incentive and quality monitoring are all fundamental to the success of ACOs.
  - But Coders will need to educate themselves about these critical initiatives....



# The Future...

- How can coders take advantage?
  1. Understand Meaningful Use, PQRS and ACO's
  2. Discuss these programs with your colleagues and superiors
  3. Learn the quality measures that apply to your area of expertise
  4. Know how to find documentation for your quality measures



# The Future...

- How can coders take advantage?  
(cont.)
- 5. Develop tools for easier documentation of quality measures
- 6. Develop tools and processes to tabulate quality measures reporting
- 7. ?



**?? Questions ??**





# Speaker Contact

- Stephen C. Spain,  
MD, CPC  
President Tyler, Texas Chapter  
AAPC NAB member  
Family Physician  
CEO, Doc-U-Chart Practice  
Consultants  
[sspain@docuchart.com](mailto:sspain@docuchart.com)

- Annie Boynton,  
BS, RHIT, CPCO, CCS, CPC, CCS-P,  
CPC-H, CPC-P, CPC-I  
President Worcester, MA Chapter  
AAPC NAB member  
Director Communication, Adoption &  
Training Provider Regulatory  
Programs  
UnitedHealthcare  
[annie\\_boynton@uhc.com](mailto:annie_boynton@uhc.com)





# Meaningful Use and ACO's 101

AAPC CEU Code #