



# ACO and EHR

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# WHO WE ARE Sites & Statistics

## HOSPITALS

23 acute care hospitals  
6 managed hospitals  
3 heart hospitals  
1 rehab hospital

## AMBULATORY SERVICES

206 clinic locations  
23 urgent care centers  
8 ambulatory surgery centers  
4 retail clinics

## MEDICAL STAFF & CO-WORKERS

36,000 co-workers  
1,528 integrated physicians  
4,610 medical staff  
*(includes integrated physicians)*  
618 advanced practitioners

## UTILIZATION

3,937 staffed beds  
535,704 ED visits (FY10)  
6,325,640 outpatient visits (FY10)  
159,295 inpatient discharges (FY10)



The Cardinals celebrate  
after they won Game  
Series in St. Louis.

L.G. PATTERSON/MLB.COM





PHOTO © AP

The Cardinals celebrate after the Rangers' David Murphy flies out to end Game 7.

MATT SLOCUM/AP





Albert Pujols and Lance Berkman (right) congratulate each other after scoring in the first inning on David Freese's double.

L.G. PATTERSON/MLB.COM



PHOTO 8 OF 12

Lance Berkman holds the Commissioner's Trophy after Cardinals beat the Rangers

BRAD MANGIN/MLB PHOTOS VIA

# What is an ACO?

- **Accountable**
  - **Care**
- **Organization**

# ACO

A set of providers (or provider organizations) who are accountable for the quality and cost of care delivered to a defined population of patients.

# CMS Pioneer Model

- CMS has proposed a pioneer CMS Model
- Separate from the Medicare Shared Savings Program, the CMS Innovation Center is offering the Pioneer ACO Model for more experienced organizations and providers who already coordinate care across multiple settings so they can reap the rewards earlier than Shared Savings participants.

# Where did ACO come from?

- ACOs emerged as a solution to the rising costs of care and overutilization in the fee-for-service model
  - The ACO model eliminates some of the financial incentives to over-treat patients

# When did the ACO concept start?

- While ACOs are not a new concept, they have gained attention recently because of their inclusion in the health reform legislation

# ACO CMS MODEL: Be Aware!

- Beta sites have complained that the following make ACOs difficult to implement:
  - Operational reorganization
  - Reporting requirements
  - Financial risk
- Ten medical groups participating in the Physician Group Practice Demonstration project (basis of the Shared Savings Program) have indicated that they would not participate in the program without changes.
- CMS has published a revised final rule
  - *Stay Tuned, we will discuss in a few!*

# Original CMS ACO Requirements

Identify and document a plan for promoting objectives outlined in the program, including patient centeredness and use of evidence-based medicine.

Meet quality targets that CMS specifies.

Reduce Medicare expenses by at least a specific percentage (which varies based on the number of beneficiaries in an ACO and the amount of risk the ACO takes on).

# Original CMS ACO Requirements

## Quality Reporting

ACOs need to report on 65 quality measures in five domains:

- Patient/caregiver experience

- Care coordination

- Patient safety

- Preventive health

- At-risk population/frail elderly health

# CMS ACO Requirements

In the first year:

ACOs must report on all measures, but they do not need to meet any minimum quality levels (Note that CMS has not yet proposed or established any quality thresholds).

Subsequent years, quality scores will factor into an ACO's shared savings bonus payment.

# ACO Performance

## Performance Benchmark

- Must achieve in all domains to get maximum quality score (and maximum shared savings)
- CMS will establish for each quality measure (based on Medicare fee-for-service claims data and Medicare Advantage quality performance rates)

## Performance score between quality benchmark and minimum attainment level

- Quality scored on a sliding scale (80% performance level = 1.85 quality points; 70% performance level = 1.7 quality points, etc.)
- Won't get full shared savings percentage, but will get some shared savings

## Minimum Attainment Level

- Must be met for all domains in order to stay in the program
- CMS currently considering 30% or 30th percentile of Medicare FFS or Medicare Advantage rate, depending on available data

# CMS Proposal for ACO

- Must report yearly and the quality scores be made public. Reporting mechanisms are listed below.
- Medicare claims data, which CMS would obtain from its own systems. CMS has also indicated they would periodically provide claims data to ACOs so they can monitor their expected populations.
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey, which asks patients about their recent experiences with physicians and their staff.
- The ACO Group Practice Reporting Option (GPRO) tool, which would allow ACOs to submit clinical information from EHRs, registries, and administrative data sources. A similar tool is used in the Physician Quality Reporting program. CMS is proposing that this tool be refined and upgraded to also support ACO reporting.

# Medicare Cost Savings

- ACO needs to reduce Medicare expenses by at least a specific percentage before it is eligible to receive a share of the amount saved.
  - CMS establishes a cost benchmark for each ACO based on past data, beneficiary characteristics, and the projected amount of growth in national Medicare expenditures.
  - This benchmark is the amount CMS expects an ACO to spend on its Medicare fee-for-service beneficiaries.
- CMS also establishes a Minimum Savings Rate (MSR) for each ACO, which varies based on the number of beneficiaries and the program track an ACO selects.
  - To be eligible for shared savings payments, an ACO's savings must at least equal the MSR.
  - The MSR is intended to minimize the chance that an ACO demonstrates savings simply due to normal cost variance rather than specific cost-saving measures the ACO has taken.
- After an ACO exceeds the MSR, it is eligible to receive a percentage of its Medicare savings.
  - The specific percentage, known as the sharing rate, is determined by quality measure performance scores. The proposed rule also establishes a shared savings payment limit, which is a percentage of an ACO's cost benchmark.

# Program Structure

	Track 1 (one-sided risk model)	Track 2 (two-sided risk model)
Program structure	<p>Years 1 and 2: ACOs are eligible for shared savings if they spend less than the per-person cost benchmark. If an ACO exceeds the benchmark, they are not responsible for any shared losses in these years.</p> <p>Year 3: ACOs switch to a two-sided risk model and are eligible for shared losses as well as shared savings.</p>	<p>ACOs are eligible for shared savings and responsible for shared losses in each year they participate.</p>
Minimum Savings Rate and Minimum Loss Rate (if applicable)	<p>The Minimum Savings Rate is determined by population size (the higher the population, the lower the MSR). For example, an ACO with 10,000 patients would need to save less per patient than an ACO with only 5,000 patients.</p>	<p>The Minimum Savings Rate is 2%, regardless of the ACO's population size.</p> <p>The Minimum Loss Rate for shared losses is 2%.</p>
Shared savings potential	<p>ACOs are eligible to receive a maximum of 52.5% of their Medicare savings.</p> <p>(50% baseline with an FQHC / RHC incentive of up to 2.5%)</p>	<p>ACOs are eligible to receive a maximum of 65% of their Medicare savings.</p> <p>(60% baseline with an FQHC / RHC incentive of up to 5%)</p>
Maximum payout	<p>The maximum payout for savings is 7.5% of an ACO's benchmark.</p>	<p>The maximum payout for savings is 10% of an ACO's benchmark.</p>

# Governance

- The proposed rule requires the formation of a separate ACO legal entity with a governing body that is at least 75% controlled by ACO participants and includes a community stakeholder organization and Medicare beneficiary representative
- Participants
  - ACO 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
  - Other groups as the Secretary of Health and Human Services deems appropriate
  - Must have at minimum 5,000 eligible Medicare beneficiaries.
  - Providers must come from typical primary care specialties (General Practice, Internal Medicine, Geriatrics, and Family Practice).
  - Providers from other specialties can participate in ACOs, but patients for whom they are the primary care providers are not included in an ACO's eligible beneficiary count.
  - May organize but participate in an ACO (They don't submit required data elements)
    - Federally qualified health centers (FQHCs)
    - Rural health centers (RHCs)
    - Skilled nursing facilities (SNFs), nursing homes, and long-term care hospitals (LTCHs)
    - Critical access hospitals (CAHs) that elect to bill outpatient services under the standard method (Method I) as described in the Patient Protection and Affordable Care Act

# The Affordable Care Act

- The Shared Savings Program must begin on January 1, 2012.
- Each ACO must make at least a three-year commitment to participate in the program.
  - CMS plans to have an annual application process, though they have not determined an application deadline.
  - ACOs' three-year period would begin on January 1 of the year following their application's approval. To provide additional flexibility in the first year of the program, CMS is considering an additional start date of July 1, 2012. An ACO that started on this date would have an initial agreement period of 3.5 years and an 18-month "first year."

# Issues

- Risk
  - No control of patient population. Risk assessed at end of year.
  - Empanelled Patient identification at end of year
  - Risk based upon identification of active patient problems
    - ACO pilot sites struggled to identify sickest patients
      - Unable to associate risk based upon reported diagnoses
      - Unable to identify at risk patients based upon active problem lists
- Patient adherence/cooperation with therapeutic plan

# Final Rule

[http://www.ofr.gov/OFRUpload/OFRData/2011-27461\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf)

- Medicare Shared Savings Program
  - Fee-for-service physician joins ACO gets support to care for the patient, improve coordinated care, and share in savings if realized.
- The number of quality measures that ACOs must satisfy to split any savings with Medicare is down from 65 to 33.
- ACOs no longer must have at least 50% of their primary care physicians qualify in the government's eyes as meaningful users of electronic health record (EHR) systems.
- Physicians can choose to participate in an ACO model where they do not risk losing money, at least not in the first 3-year contract. In addition, they can receive more in shared savings than originally envisioned.
  - ACOs can participate in the one-sided model for all of the first contract period.
- Physician-owned ACOs as well as those in rural America can receive an advance payment of future shared savings to invest in the information technology and extra staffing that these organizations need to succeed
  - Payment can be upfront fixed
  - Payment can be upfront based upon Medicare patient population
  - Payment can be monthly based upon Medicare patient population

# Final Rule

- Comprehensive Primary Care Initiative
  - CMS will pay monthly fees to physician practices that:
    - Help chronic patients follow personalized care plans
    - Deliver preventative care and access 24-hours daily
    - Engage patients and families in own care
    - Coordinate with other doctors (specialists)
  - Physicians will know in advance which of their Medicare patients are being attributed to the ACO, so that they work with those patients as true partners in achieving better outcomes: Beneficiaries would be attributed to the ACO on a prospective rather than a retrospective basis.

# Final Rule

- Recognition of the role of internal medicine subspecialists in providing primary care: In situations in which a beneficiary has not received their primary care services from a defined primary care physician, attribution can be linked to any other ACO professional that provides a plurality of primary care services. This reflects recognition that certain specialty/subspecialty providers do provide primary care services to some Medicare beneficiaries.

# Final Rule

- Anti-trust barriers: In addition, the administration has offered needed guidance from the Department of Justice and Federal Trade Commission regarding ACO participation within the CMS Shared Saving Programs. CMS and the HHS Office of the Inspector General also released an Interim Final Rule that waives provisions of the Physician Self-Referral Law, the Federal anti-kickback statute, the Civil Monetary Penalty (CMP) law prohibiting hospital payments to physicians to reduce or limit services (the Gain sharing CMP), and the CMP law prohibiting inducements to beneficiaries (the Beneficiary Inducements CMP) to ACO's approved under the Medicare Shared Savings ACO program.

# How to Comply: Use an EMR

- Reporting
- Population Management
  - Care Coordination
- Decision Support
- Use of a PHR
- Telemedicine
- Need
  - Information Portability – share the record
  - Proper stratification of patient risk
    - Proper diagnostic identification

# Chart Review

Filters
 Preview
 Refresh
 Select All
 Deselect All
 Review Selected
 Route
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[Encounters](#)
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[Media](#)
[Misc Reports](#)
[Pat Sum Extra](#)

30 records loaded, more records to load

Default Filter

No filters applied

	Enc Date ▾	Filing Date	Bkmk	Encounter Type	Category	Status	Author	Author Type
	10/18/2011	10/18/2011 04:16 PM		Telephone	Telephone Encounter	Signed	EVERS, DEIRDRE D	
	10/18/2011	10/18/2011 04:03 PM		Telephone	Telephone Encounter	Signed	MARLER, KAREN	
	10/18/2011	10/18/2011 02:41 PM		Office Visit	Progress Note	Signed	MILLER, SHANNON L...	Nurse Practitioner
	10/14/2011	10/18/2011 10:37 AM		Telephone	Telephone Encounter	Signed	MCDERMOTT, JAMIE L	
	10/14/2011	10/14/2011 02:00 PM		Telephone	Telephone Encounter	Signed	MCDERMOTT, JAMIE L	
	10/14/2011	10/14/2011 01:39 PM		Telephone	Telephone Encounter	Signed	MCDERMOTT, JAMIE L	
	10/12/2011	10/13/2011 02:58 PM		Telephone	Telephone Encounter	Signed	MCDERMOTT, JAMIE L	
	10/12/2011	10/13/2011 02:02 PM		Telephone	Telephone Encounter	Signed	SPIVEY, JOHN, MD	Physician
	10/12/2011	10/13/2011 01:59 PM		Telephone	Telephone Encounter	Signed	GORDY, SARAH T	
	10/12/2011	10/13/2011 01:42 PM		Telephone	Telephone Encounter	Signed	EDMUNDS, KAMI R	
	10/12/2011	10/12/2011 11:32 AM		Telephone	Telephone Encounter	Signed	GORDY, SARAH T	
	10/12/2011	10/12/2011 10:48 AM		Telephone	Telephone Encounter	Signed	SPIVEY, JOHN, MD	Physician
	10/12/2011	10/12/2011 09:10 AM		Telephone	Telephone Encounter	Signed	EDMUNDS, KAMI R	
	10/10/2011	10/11/2011 02:32 PM		Admission (Di...	Discharge Instruct...	Available	STL SCANNING,HIM	(Other)
	10/10/2011	10/11/2011 02:32 PM		Admission (Di...	Medical Consent	Available	STL SCANNING,HIM	(Other)
	10/10/2011	10/11/2011 02:32 PM		Admission (Di...	History and Physical	Available	STL SCANNING,HIM	(Other)
	10/10/2011	10/11/2011 02:32 PM		Admission (Di...	Anesthesia	Available	STL SCANNING,HIM	(Other)
	10/10/2011	10/10/2011 08:21 AM		Admission (Di...	Operative Report		MARSH, JEFFREY L, MD	Physician
	10/10/2011	10/10/2011 07:21 AM		Admission (Di...	OR Anesthesia		KOSA, JANE E, MD	Anesthesiologist
	10/10/2011	10/07/2011 09:56 AM		Admission (Di...	Progress Notes		MCKAY, LINDA, RN	Registered Nurse
	10/10/2011	10/07/2011 09:53 AM		Admission (Di...	Progress Notes		MCKAY, LINDA, RN	Registered Nurse
	10/10/2011	10/07/2011 09:47 AM		Admission (Di...	Progress Notes		MCKAY, LINDA, RN	Registered Nurse
	10/10/2011	10/07/2011 09:33 AM		Admission (Di...	Progress Notes		MCKAY, LINDA, RN	Registered Nurse
	10/4/2011	10/04/2011 03:48 PM		Office Visit	Patient Instructions	Signed	MILLER, SHANNON L...	Nurse Practitioner
	10/4/2011	10/04/2011 03:59 PM		Office Visit	Progress Note	Signed	MILLER, SHANNON L...	Nurse Practitioner
	9/26/2011	09/26/2011 03:07 PM		Telephone	Telephone Encounter	Signed	DEROUSSE, KRISTEN	
	9/23/2011	09/23/2011 11:09 AM		Telephone	Telephone Encounter	Signed	GORDY, SARAH T	
	9/23/2011	09/23/2011 08:32 AM		Telephone	Telephone Encounter	Signed	SPIVEY, JOHN, MD	Physician

Chart Review

Filters Refresh Select All Deselect All Review Selected Route

Encounters Notes Meds Procedures Labs Images Other Ord Card Referrals Episodes Code Status Letters Media Misc Reports Pat Sum Extracts

29 records loaded, more records to load

No filters applied

Status Da...	Description	Status	Exam Ended	Provider	Encounter Type	Order Date	Accession
10/03/2011 1015	XR MANDIBLE 4+ VW	Final res...	10/03/2011 ...	Marsh, Jeffrey L, MD	Hospital Enc...	10/03/2011	A970820
10/03/2011 0954	XR SKULL LESS THAN 4 VW	Canceled		Marsh, Jeffrey L, MD	Hospital Enc...	10/03/2011	A970820
08/05/2011 1135	XR MANDIBLE LESS THAN...	Final res...	08/05/2011 ...	Marsh, Jeffrey L, MD	Hospital Enc...	08/01/2011	A895858
06/16/2011 1551	XR CHEST PA AND LATERAL	Final res...	06/16/2011 ...	Grimmer, Jennifer, NP	Hospital Enc...	06/16/2011	A833621
06/01/2011 0544	XR CHEST PA AND LATERAL	Final res...	06/01/2011 ...	Schlesinger, Daniel, MD	Hospital Enc...	06/01/2011	A812427
05/29/2011 1926	XR CHEST PA AND LATERAL	Final res...	05/29/2011 ...	Ruecker, Karen E, MD	Hospital Enc...	05/29/2011	A810170
04/05/2011 1147	XR CHEST PA OR AP	Final res...	04/05/2011 ...	Spaulding, Janelle, MD	Hospital Enc...	04/05/2011	A741849
04/04/2011 1059	XR CHEST PA AND LATERAL	Final res...	04/04/2011 ...	Thierauf, Stephen E, MD	Hospital Enc...	04/04/2011	A739883
03/14/2011 1300	CT HEAD MAXILLOFACIA...	Final res...	03/14/2011 ...	Forsen, James W, MD	Hospital Enc...	02/25/2011	A713583
03/14/2011 1300	CT 3D RECON W INDEP...	Final res...	03/14/2011 ...	Forsen, James W, MD	Hospital Enc...	03/14/2011	A713703
01/24/2011 1000	XR CHEST PA AND LATERAL	Final res...	01/24/2011 ...	Thierauf, Stephen E, MD	Hospital Enc...	01/24/2011	A651469
11/15/2010 2054	XR CHEST PA AND LATERAL	Final res...	11/15/2010 ...	Soehngen, Kristen K, MD	Hospital Enc...	11/15/2010	A568149
11/13/2010 1005	XR CHEST PA AND LATERAL	Final res...	11/13/2010 ...	McBride, Megan, DO	Hospital Enc...	11/13/2010	A565594
06/10/2010 1229	XR CHEST PA AND LATERAL	Final res...	06/10/2010 ...	Thierauf, Stephen E, MD	Hospital Enc...	06/10/2010	A366949
05/06/2009 1607	XR CHEST PA AND LATERAL	Final res...		McBride, Megan, DO	Office Visit	05/05/2009	00001...
03/27/2009 1515	XR CHEST PA AND LATERAL	Final res...		McBride, Megan, DO	Office Visit	03/27/2009	00001...
10/21/2008 1641	XR CHEST PA OR AP	Final res...		Spivey, John, MD	Inpatient Hist...	10/21/2008	00001...
10/16/2008 0545	XR CHEST PA OR AP	Final res...		Lynch, Robert E, MD	Inpatient Hist...	10/16/2008	00001...
10/15/2008 0615	XR CHEST PA OR AP	Final res...		Coln, Charles E, MD	Inpatient Hist...	10/15/2008	00001...
10/14/2008 1740	XR CHEST PA OR AP	Final res...		Lynch, Robert E, MD	Inpatient Hist...	10/14/2008	00001...
10/14/2008 1355	XR CHEST PA OR AP	Final res...		Forsen, James W, MD	Inpatient Hist...	10/14/2008	00001...
10/14/2008 1305	XR CHEST PA OR AP	Final res...		Forsen, James W, MD	Inpatient Hist...	10/14/2008	00001...
08/12/2008 1158	XR CHEST PA AND LATERAL	Final res...		McBride, Megan, DO	Office Visit	08/12/2008	00001...
08/12/2008 1134	XR CHEST PA AND LATERAL	Canceled		McBride, Megan, DO	Office Visit	08/12/2008	
08/04/2008 1108	XR SKULL COMPLETE 4+ VW	Canceled		Marsh, Jeffrey L, MD	Outpatient Hi...	08/04/2008	00001...
08/04/2008 1108	XR SKULL < 4 VW	Final res...		Marsh, Jeffrey L, MD	Outpatient Hi...	08/04/2008	00001...
07/02/2008 1303	XR UPR GI	Final res...		Spivey, John, MD	Outpatient Hi...	07/02/2008	00001F...
03/07/2008 0545	XR CHEST PA OR AP	Final res...		Sample, Theodore G, MD	Outpatient Hi...	03/06/2008	00001...
03/06/2008 0515	XR CHEST PA OR AP	Final res...		Sample, Theodore G, MD	Outpatient Hi...	03/05/2008	00001...



### Encounter Messages

ID#	Read	Date	Time	From	To	Subject
730903	Y	10/24/2011	1:04 PM	Julie Van Cleave	[REDACTED]	<a href="#">RE: Non-Urgent Medical Question</a>
730876	Y	10/24/2011	12:59 PM	[REDACTED]	Megan McBride, DO	<a href="#">RE: Non-Urgent Medical Question</a>
730807	Y	10/24/2011	12:43 PM	Julie Van Cleave	[REDACTED]	<a href="#">RE: Non-Urgent Medical Question</a>
728619	Y	10/23/2011	2:11 PM	[REDACTED]	Megan McBride, DO	<a href="#">Non-Urgent Medical Question</a>

### Allergies as of 10/23/2011

Date Reviewed: 10/22/2011 Reviewed By: Patricia Bz

No Known Allergies

### Progress Notes

Julie Van Cleave 10/24/11 12:39 PM Signed  
From: [REDACTED] RONALD  
To: Megan McBride, DO  
Sent: Sun Oct 23, 2011 2:11 PM  
Subject: Non-Urgent Medical Question

A friend of mine recommend teething tablets for Ronnie, saying it was all-natural, etc. I was wondering what your opinion is of this? Is it safe? Do they help? Are there certain brands you would recommend? Or is this something I should stay away from?

Thanks in advance,  
Chris [REDACTED]

### Routing History

None

### Questionnaire Answers



# PHR Demonstration

- Patient access to secure messaging
- Patient access to health maintenance
- E-visits
- Telemonitoring
- Legal/Social Issues
  - Age – elder care, adolescence
  - Access – “Proxy” versus “Grant Access”

## Welcome Brian

Connect with your doctor and manage your healthcare online. Select from the options below or from the menu above to view test results, schedule appointments, renew prescriptions, send messages to your doctor and much more.



FAQ



Support



### Message Center

- ▶ Inbox (34)
- ▶ Contact Your Doctor



### Appointments

- ▶ Schedule an Appointment
- ▶ Upcoming Appointments



### Medical Records

- ▶ Test Results
- ▶ Health Summary
- ▶ Medical History
- ▶ Wallet Card



### Prescriptions

- ▶ Renew Your Prescriptions
- ▶ Medications



### Health Reminders

- ▶ Health Reminders (Yes)



### Billing

- ▶ Bill Pay/Account Summary
- ▶ Insurance Summary

# Questions?

We appreciate the opportunity to Speak!

- Thank You
- Contact Information
- Dr. Michael G. Hunt
  - Mercy, Center for Informatics
  - Chief Medical Information Officer – Ambulatory
  - [michael.hunto@mercy.net](mailto:michael.hunto@mercy.net)
- Dr. Megan McBride
  - Mercy Pediatrics, Fenton, Missouri
  - [megan.mcbride@mercy.net](mailto:megan.mcbride@mercy.net)