NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

UNDER THE MICROSCOPE

NOVEMBER 5, 2013

THE ACCOUNTABLE CARE ORGANIZATION (ACO) TRAIN IS LEAVING THE STATION: ARE YOU ON BOARD?

ISSUE.

A 2006 Institute of Medicine report ("Performance measurement: Accelerating improvement") called for efforts to foster shared accountability among all providers for the quality and cost of care. Accountable Care Organizations (ACOs) represent a key response to this most recent IOM call to action. The term is used to describe networks of clinicians, hospitals or other health care providers who join together voluntarily to share responsibility for providing coordinated, high-quality care to their patients that both reduces costs and improves health outcomes.

This health program and financing concept has become the new hot buzz word, particularly since enactment of the Affordable Care Act (ACA) which named ACOs as a new Medicare payment model. Already, according to HHS, ACOs already serve some 4 million Medicare beneficiaries. In fact, HHS says that under the ACA, ACOs will save as much as $960 million in Medicare dollars alone during their first 3 years of operation. And both dollars and persons served are likely to rise much higher as the ACA's Medicaid ACO demonstrations get underway. With data like these, without a doubt, these new health care delivery entities are here to stay, at least for a while.

So, what exactly are ACOs? Why are they suddenly the latest buzz word in health care service organization and financing? And what relevance do they have for behavioral health? This installment of *Under the Microscope* explores answers to those questions, describing the nature of ACOs, their genesis, their promise and the role behavioral healthcare can and must play in their development, implementation and ongoing conduct.

ANALYSIS.

THE ABCS OF ACOS.

ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. While ACOs have their public health genesis in the literature of the 1990s, their inclusion in the Affordable Care Act as an alternative to Medicare fee-for-service patients and as a demonstration for children's care under Medicaid has given them legs both within public sector health care and in the private sector. The former program, already underway, is called the *Shared Savings Program*. ACOs must apply for Shared Savings Program status. When granted, each accepted ACO is required to manage the health care needs of no fewer than 5,000 Medicare beneficiaries over the course of at least three years and to demonstrate both savings and care quality.

Aim. Whether functioning in the public or private sector, the general aim of these provider-led organizations is to better coordinate and provide patient-centered, high-quality and timely care that can reduce preventable hospitalizations, improve health outcomes and lower costs associated with acute care and recurring, unmanaged chronic illnesses. By coordinating care, ACOs can help ensure that

patients—particularly those with chronic illnesses—get the right care at the right time, reducing unnecessary duplication of services and preventing medical errors. Not surprisingly, most ACOs have a particularly strong primary care emphasis. Collectively, members of the ACO are accountable for quality and total per capita costs across the full continuum of care for the patients they serve. Unlike fee-for-service payment which reimburses for each test and procedure, ACO payments are linked to performance measures that not only demonstrate lower overall costs, but, critically, also show quality improvements that advance overall patient health.

Quality versus Quantity. Unlike HMOs and other earlier models, ACOs cannot scrimp on care to save dollars. Thus, regulations built following enactment of the ACA require that ACOs demonstrate quality of care. They also include strong protections to ensure patients do not have their care choices limited by an ACO. ACOs are rewarded for putting patients first. Specific quality benchmarks were identified that assess ACO service quality as well as cost savings designed for Medicare beneficiaries who participate in the fee-for-service Parts A and B rather than in the private Medicare Advantage plans. In order to share in any savings realized, the Medicare ACOs must meet benchmarks across 5 key service areas:

- Patient/caregiver care experiences
- Care coordination
- Patient safety
- Preventive health
- At-risk population/frail elderly health.

The benchmarks are assessed annually and adjusted to reflect beneficiary characteristics and other factors that could affect the need for health care services. If, based on the benchmark findings, ACOs save money by getting beneficiaries the right care at the right time, such as improving access to preventive and primary care so fewer patients need to be seen in emergency rooms, the ACO and Medicare share in those savings. On the other hand, ACOs that do not meet quality standards do not share in program savings, and over time, can be held accountable.

Structure. To achieve the optimal human and economic outcomes expected of Medicare ACOs, teams of doctors, hospitals and other health care providers and suppliers work together to improve care for patients by focusing on the whole person, not a specific ailment, both across the lifespan and health-illness continuum. A specific primary care provider—usually a physician—is at the heart of each patient's care, managing the provision of care to a person from wellness and prevention through chronic care management and recovery. Interconnectedness across team members—and beyond, as necessary to meet an individual's specific health needs—is fostered through extensive use of electronic information sharing, maintenance of e-health records and ongoing communication.

The organizational structure of an ACO is not monolithic. Some ACOs may choose to create a single, fully integrated organization with a CEO and functioning divisions. Others may prefer a somewhat looser confederation of partners that are brought together under a structural umbrella that provides coordination alone. Each has benefits and liabilities, particularly for behavioral health which, by statute and regulation, cannot be the entity of record when establishing an ACO.

The emphasis on coordinating and managing care to save dollars may sound familiar. Some see ACOs as a 21st century reincarnation of health maintenance organizations (HMOs) of 30 years ago. It has been suggested by some health policy experts that, when it comes to reducing health care costs, ACOs have the potential to perform like HMOs without the latter's liabilities. Like HMOs, ACOs are motivated to provide effective care through a carrot-or-stick approach. The ACO receives a projected, annual per-patient budget. If, at the end of the year, the cost of caring for the patient comes in below that level, ACO members share the savings. But, two key features distinguish today's ACOs from yesterday's HMOs. Unlike HMOs, ACOs share in the savings *only* if they also meet specific quality standards that assure that best practices and care excellence weren't sacrificed to curb costs. Moreover, unlike HMOs, ACO's don't limit consumer options by controlling patient referral patterns. Patients are able, instead, to opt for care beyond the network at no additional cost. This is precisely how ACOs are working under the ACA.

WHO IS FORMING ACOS?

Provider participation in an ACO is voluntary and involves a willingness to reject the traditional fee-for-service approach in favor of a "value-based" reimbursement program that shares risks and rewards quality of outcome. That said, a broad array of entities could choose to form or become an ACO: multispecialty medical groups, physician-hospital organizations and organized or integrated delivery systems, among others. In the main, organizations most likely to form ACOs serving Medicare or ACA-insured populations include county and other public hospitals, federally qualified health centers (FQHCs), primary care practices and rural health centers. Some provider organizations already are functioning as ACOs. In fact, according to CMS, over 425 hospitals have signed on as Medicare ACOs. Others entities have structures that can rapidly be evolved to support the required data and service requirements of an ACO. And still other entities may need more time and support to provide the care and cost benefits of an ACO.

However, behavioral health organizations or providers *cannot* themselves form a Medicare ACO. Under the ACA's Section 2706 (just two pages buried deep in the 974 page law), behavioral health entities aren't included among the list of entities that may be authorized to establish Medicare ACOs directly. That means we must become good colleagues and collaborators, willing to work with ACO-eligible health care groups and organizations in our counties to establish an ACO partnership. This includes creating partnerships with primary care provider groups, public or private hospitals FQHCs, or consortia of private practitioners to develop a full-service, whole-person focused ACO care consortia.

A ROLE FOR BEHAVIORAL HEALTH AND ACO ALTERNATIVES

While our field cannot directly establish Medicare ACOs under the ACA, the good news is that there are a few options to advance ACO-like entities under the ACA that "lead" with behavioral health. Those opportunities come through the ACA's emphasis on *integrated* care and the ability to amend Medicaid state plans to establish *health homes* and *medical homes*—both means of undertaking integrated, whole-person care for a population that, for the most part, is not covered under Medicare and its ACO provisions. Like ACOs, the patient-centered medical and health home models both put the consumer first and respond to the need for increased provider communication to coordinate whole-person care and reduce unnecessary or duplicative costs. Both models include patient care teams, self-service health information, and access to electronic health records for key stakeholders. The difference between the two? The medical home is operated from a primary care base; the health home is operated from a behavioral health care base.

The ACA's movement toward integrated care through ACOs and these other ACO-like entities is particularly compelling for our field. It marks yet another major step toward bringing body and brain together in health care at last. Even more important, because the ACA's emphasis in health coverage is on people who have been chronically uninsured, integrated care holds out hope to meet the panoply of diverse health issues facing many people with behavioral disorders who historically have fallen through the health care cracks.

Integrating care for these at-risk populations with behavioral disorders through ACO models offers early intervention and treatment to reduce comorbid physical conditions that can reduce life expectancy by as many as 25 years. Concomitantly, integrated care can lower unnecessary visits to the emergency room for physical complaints, prevent some problems before they arise, and lower the risks for exacerbations of existing chronic problems. Moreover, broadening the use of electronic medical records and information sharing across hospitals and health systems not only can improve the quality of care but also the efficiency of care for people with both physical and behavioral disorders. If we are vigilant and engaged partners in creating local integrated care models such as ACOs, we can help replace today's fragmented, episodic and siloed care with a system that works with consumers across their full range of health needs, from prevention to recovery, and across their entire lifecycle.

Our behavioral health community has been working toward this very goal of whole-person-focused care for a long time. How we take the next steps, and what steps we take, are both critical as the ACA moves forward. But first, we need to embrace this new way of looking at care, of looking at integrated electronic health records, of working with new groups of providers and consumers in the delivery of care. We need to ensure that behavioral health is an integral part of the ACA's new integrated health landscape, but we need to do so without losing our identity as a discipline.

NEXT STEPS.

As noted earlier, becoming a part of the movement toward ACOs is a natural step in the evolution of behavioral health as an integral part of overall health. Making the transition from separate siloed care to integrated collaborative care; from a diagnosis focus to a whole person focus; and from an emphasis on emergent care to an orientation that spans prevention through recovery will not necessarily be easy, but it is necessary. And then, after making that transition, the process of making ACOs work begins. That, too, will require many changes, from a philosophical redirect that emphasizes quality of care over quantity of care to new ways of tracking patient progress, including both greater reliance on electronic methods and new analytics. Further, given the ACA's emphasis on Medicare, expanded Medicaid, and previously uninsured people—all populations at high risk for multiple health problems—ACOs will need to tailor interventions to meet their often complex needs – including their behavioral health needs.

The payoff in both public dollars saved and lives improved for the people we serve could be substantial. Yet, according to an informal survey NACBHDD Director Manderscheid took at a recent meeting, too few in our field are getting involved in ACO development or even are getting educated about ACOs. In fact of 100 people surveyed informally, only two said they were getting up to speed on ACOs. That's not good.

The challenge is upon us. How can we transition from segregated care and carve out services to integrated care and coordinated/collaborative services? How can we help focus on the whole person and not just a specific illness, syndrome or disease? How can we be an integral part of the coming ACO movement? And how can we help accomplish that aim without the loss of an identity and central role for behavioral health? What specific practical steps can we take can to assure that the behavioral health community in general, and those of us involved in county behavioral health, in particular, are moving forward on ACOs?

- *Educate ourselves* and our colleagues about ACOs, health/medical homes, and the role behavioral health can and must play in each. We need to read the history, the science, and the policy of ACOs . We need to fully understand the importance of communication across disciplines and the value of shared electronic recordkeeping.
- *Know what we have to offer*. Gather information about the costs of providing evidence-based, patient-centered behavioral health care and the costs of NOT providing that care. Identify the services that can be brought to an ACO solely by the behavioral health community and the value added those services can have for the people to be served by the ACO.
- *Get in the door and be at the table* to assure that county behavioral health has a role in local Medicare ACOs, including those created by FQHAs. Bring information to the table the about the value of integrating behavioral health as part of a whole-health approach from both economic and quality of care perspectives and suggest how the addition of a Medicaid plan health/medical home amendment can magnify and multiply the ACO approach to health care in other high-risk, high-cost populations in need of health care.
- *Gather and share data* that demonstrate the importance of behavioral health to overall health and, ultimately, to improved public health and lower health care costs (e.g., significant disability caused by behavioral disorders; rates of comorbid physical conditions; etc.)
- *Know about and share examples* of coordinated care that have worked elsewhere. Perhaps they can be adapted to local needs where we live. [Two good examples: (1) The 15 coordinated care organizations (CCOs) that are operating in Oregon. Nine in every 10 Oregon Health Care members are enrolled in a CCO. Learn how these entities are helping people in Oregon and how

this model might work for you. (https://cco.health.oregon.gov/Pages/Home.aspx). (2) The Camden (NJ) Coalition of Healthcare has demonstrated how integrated care saves dollars and lives among the most at-risk people in need of care. (http://www.camdenhealth.org)]

- *Share learnings* among colleagues in the community and beyond. Form a learning community to move the ACO agenda for integrating behavioral health in home counties and states nationwide.

The train is about to leave. The ACA and ACOs are moving forward. It's time to get on board or get left behind.

Researched and written by Teddi Fine, MA