

ICCMHC Spring Quarterly Conference

**Opportunities and Challenges under
the ACO and Integrated Medical
Health Home Environment**

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Health Care Reform: Understanding the Context

- ▶ Escalating costs
- ▶ Shrinking Revenue
- ▶ Calls for accountability
- ▶ Pressures from stakeholders (patients, providers, payers, etc.)
- ▶ Health care reform offers the opportunity to build from local strengths to meet the challenges.
- ▶ Health Homes and Accountable Care Organizations are tools permitted to achieve the goals.

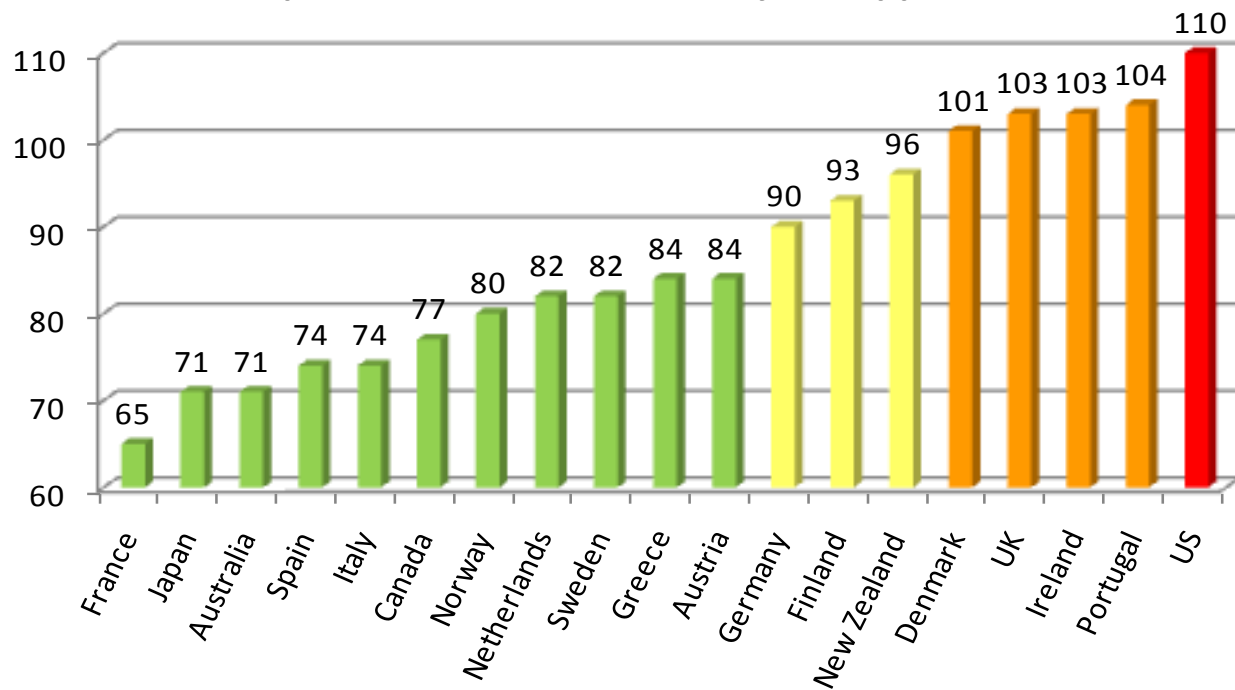
Section 2703 of the Affordable Care Act

- State Option to Provide Health Homes for Enrollees with Chronic Conditions.
- Health homes qualify for 90% Federal medical assistance percentage (FMAP) rate for first eight fiscal quarters.
- CMSs overarching approach (also know as “The Triple Aim”) to improve health care by:
 - Better Healthcare for Individuals
 - Improving the Health of Populations
 - Reducing the Per Capita Costs of Health Care

Leading to the Two-Part Problem: Quality

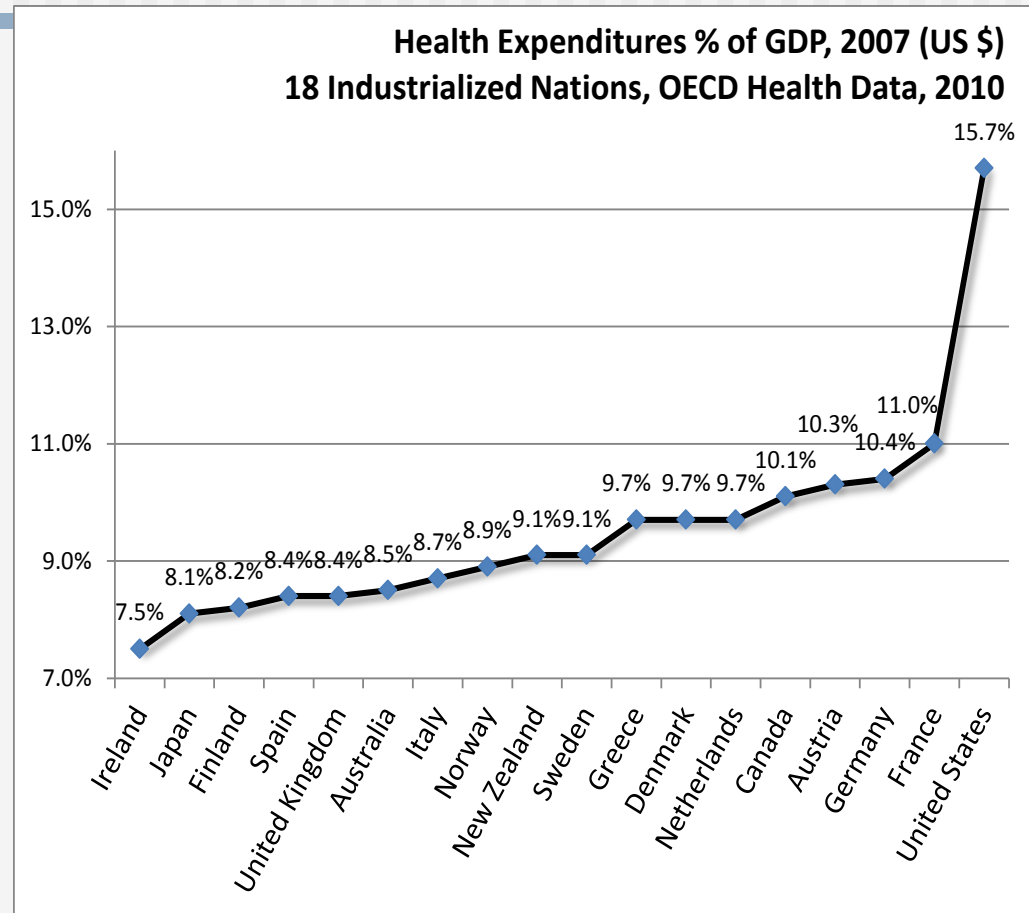
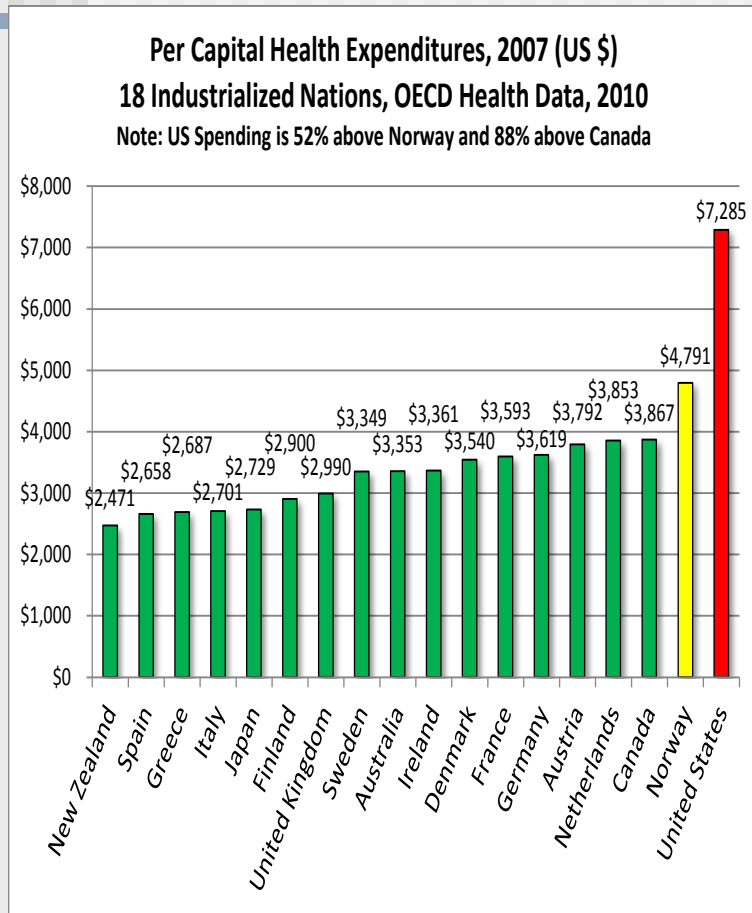
Preventable Deaths* per 100,000 Population in 2002-2003 (19 Industrialized Nations, Commonwealth Fund)

(* by conditions such as diabetes, epilepsy, stroke, influenza,
ulcers, pneumonia, infant mortality and appendicitis)



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The Two-Part Problem: Cost



The BIG Fix...

- Better Health for Populations
- Better Care for Individuals
- Reduced Costs through Improvement of health outcomes.
- By creating Organized Systems of Care for the Other 90% through Payment Reform and Service Delivery Redesign



Components of the BIG Fix

Fixing the problem can be described as:

- Moving further upstream with ***prevention & early intervention*** services to prevent health conditions from becoming *chronic* health conditions



Components of the BIG Fix

Fixing the problem can be described as:

- Dramatically improving the ***management of chronic health conditions*** for the 45% of Americans with one or more such conditions whose treatment draws down 75% of total medical costs



Components of the BIG Fix

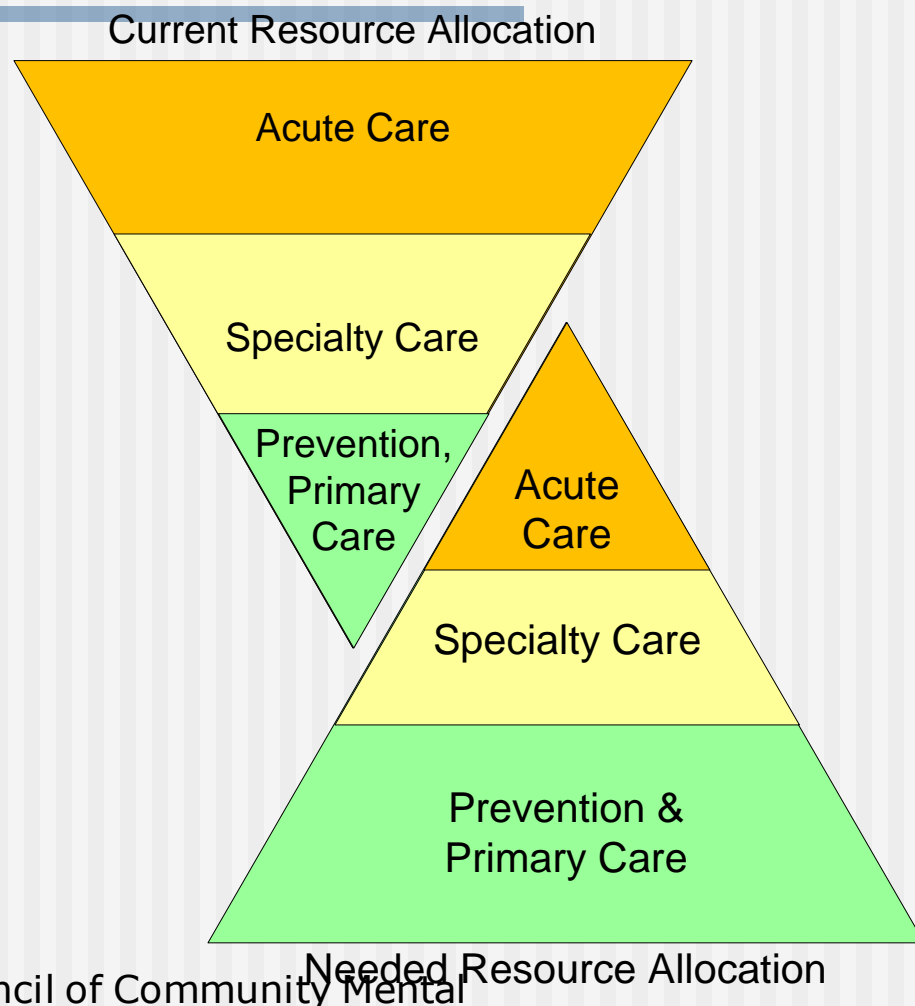
Fixing the problem can be described as:



- Reducing ***errors and waste*** in the system
- ***Reducing incentives*** for high cost, low value, procedure-based care

Delivery System Redesign: *the Elephant in the Room*

- ▶ Need to invert the Resource Allocation Triangle
- ▶ **Prevention Activities** must be funded and widely deployed
- ▶ **Primary Care** must become a desirable occupation and
- ▶ **Decrease Demand** in the **Specialty** and **Acute Care** Systems
- ▶ These are dramatic shifts that will not ***magically*** take place

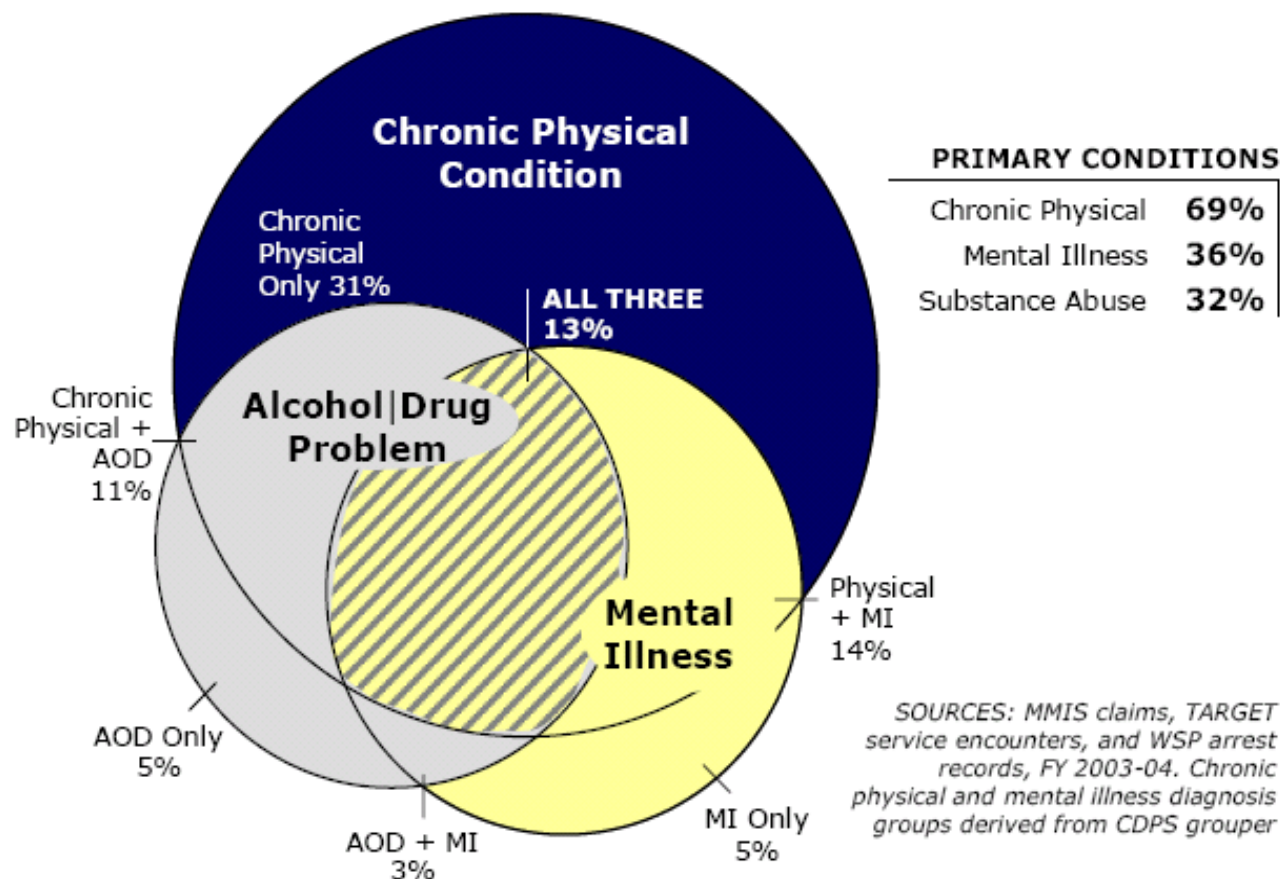


We Can't Bend the Cost Curve without addressing MH/SU Disorders

Co-occurring Diagnoses and the GA-U Population

52 percent had substance abuse or mental illness identified

31 percent had a chronic physical condition only



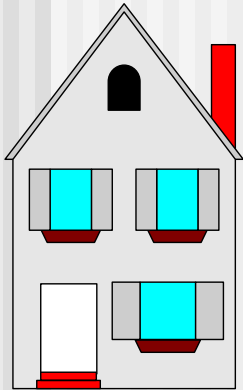
Washington DSHS | GA-U Clients: Challenges and Opportunities August 2006

How do we Flip the Triangle?

Institute for Healthcare Improvement Triple Aim

- Improve the Health of the Population
- Enhance Patient Experience (quality, access, reliability)
- Reduce (or at least) Control Costs

Where the U.S.
Healthcare
System is
headed
(*at a glance*)



Person
Centered
Medical
Homes

Increase Preventive Care

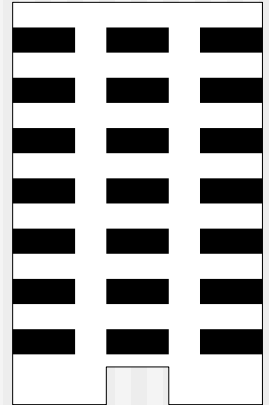
Expand the use of
Evidence-Informed Care

Promote Early Intervention

Decrease Overuse and
Underuse of Services

Improve the
Coordination of Care

Reduce Error Rates



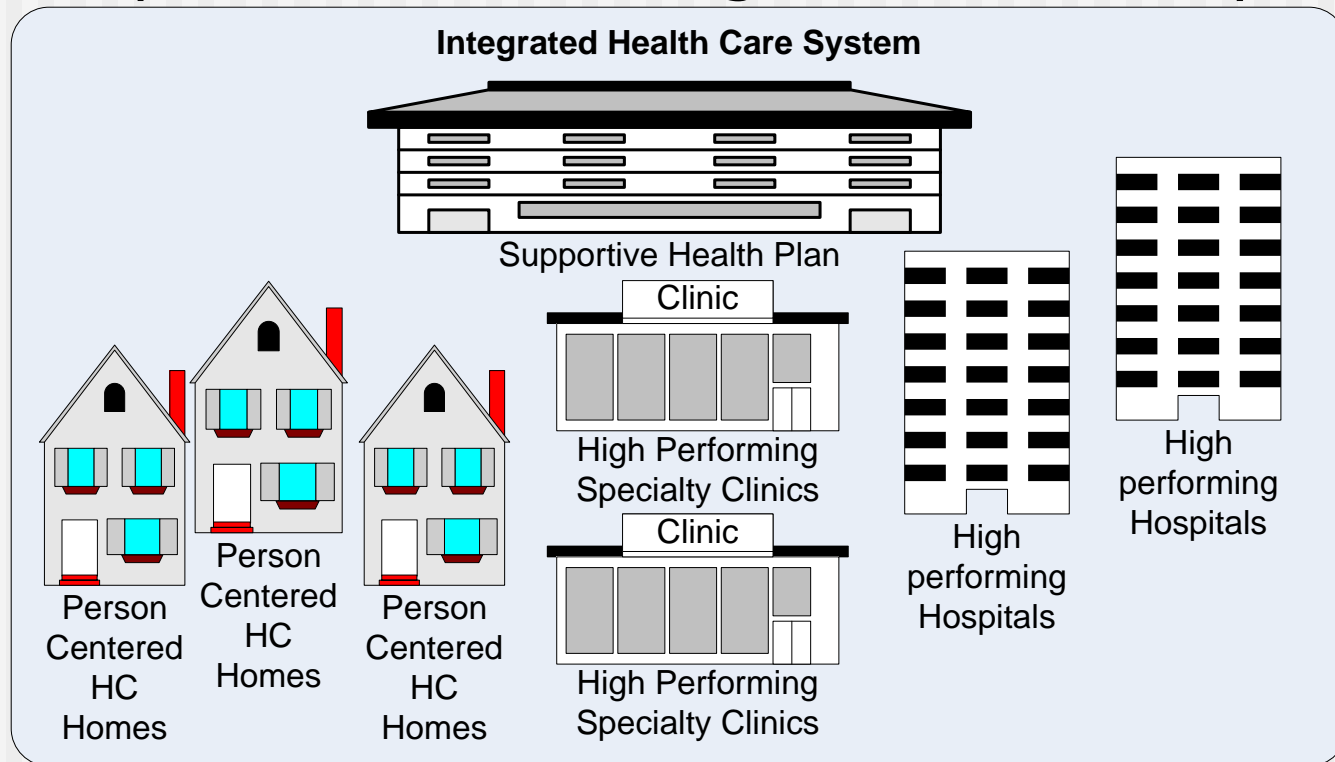
Inpatient:
Reducing
Errors &
Waste

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Integrated Health Systems...

The Holy Grail

Global Capitation to an Integrated Health System



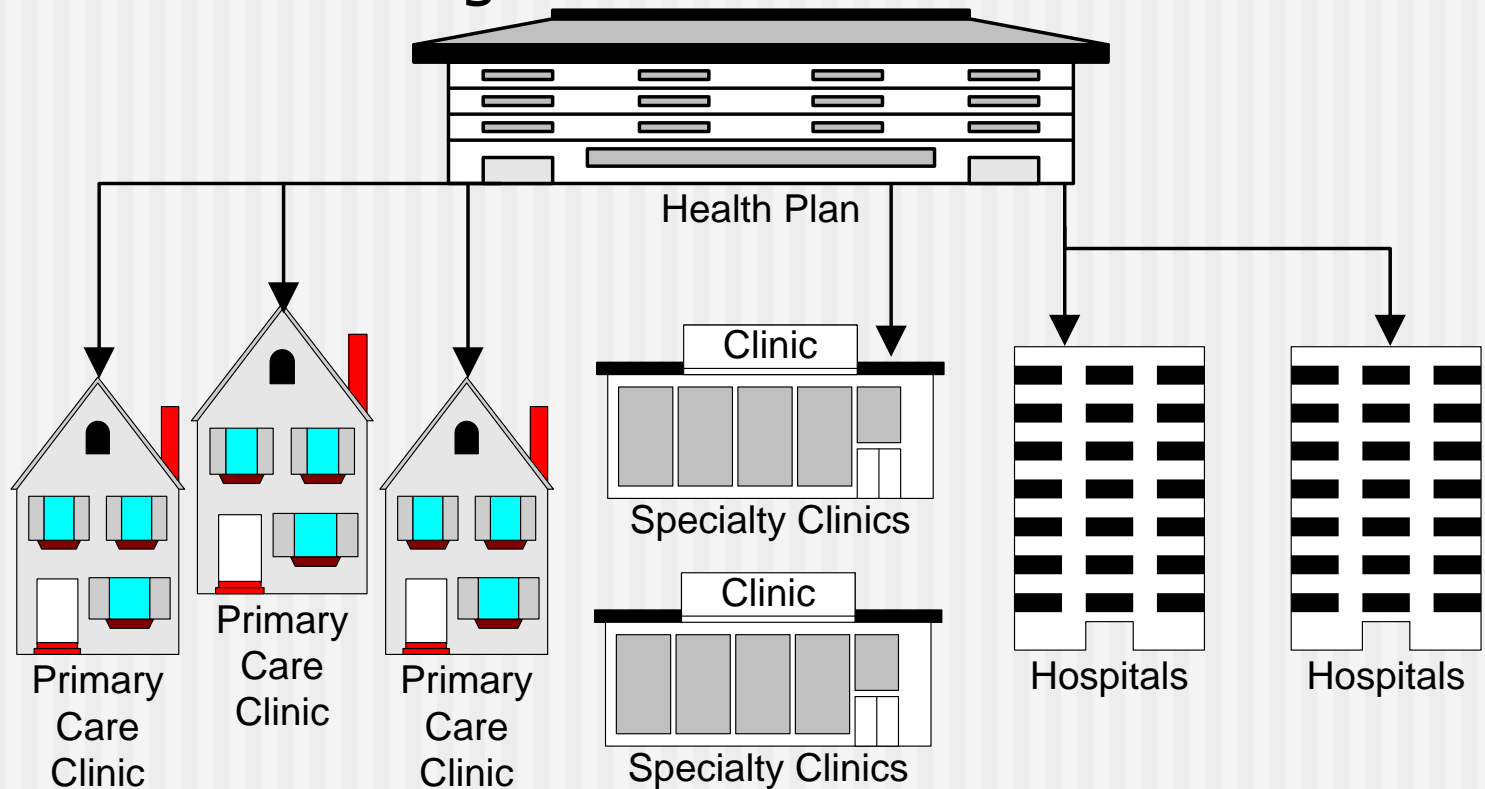
But... Integrated Health Systems represent only
10%
of the US Delivery System

Meanwhile...

The Status Quo

Fee-For-Service, Non-Integrated Model:

All the wrong incentives and disincentives



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Medical Homes:

Primary Care Clinics that Look and Act Differently

Picture a world where everyone has

- An **Ongoing Relationship** with a PCP
- A **Care Team** who collectively takes responsibility for ongoing care
- And **Provides all Healthcare** or makes **Appropriate Referrals**
- Helping ensure that
- **Care is Coordinated /Integrated**



And where...

- **Quality and Safety** are hallmarks
- **Enhanced Access** to care is available (evenings & weekends)

And **Payment** appropriately recognizes the **Added Value**

Medical Home Outcomes:



- ▶ Lowers health costs;
- ▶ Increases quality;
- ▶ Reduces health disparities;
- ▶ Achieves better outcomes;
- ▶ Lowers utilization rates; and,
- ▶ Improves compliance with recommended care.

Health Home Population Criteria

- Eligible individuals with “chronic conditions”.
- Section 1945(h)(2) include mental health condition, substance use disorder, asthma, diabetes, heart disease, and BMI over 25.
- Eligibles must minimally have at least two chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition.
- States can elect to limit eligibility to some chronic conditions and can target individuals based on severity of chronic conditions.

Person-Centered Health Home in a Mental Health and Substance Abuse Setting Provides:



- Preventive screening and health services
- Acute primary care
- Women's health
- Management of chronic health conditions
- Access to lab, x-ray, medical-surgical specialties and hospital care.

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Integrated Practice Culture



- ▶ Practice culture of primary care requires:
 - Consultative BH interventions
 - Fast pace brief interventions
 - High volumes of persons seen
 - Immediate access, availability and visibility where interruptions are ok
 - New vocabulary
 - Different documentation and tracking systems

Primary Behavioral Health Care Integration Program – SAMHSA/HRSA Center for Integrated Health Solutions Grant

- Awarded to the National Council for Community Behavioral HealthCare
- Four years; \$5.3 Million/year
- Target Audience
 - SAMHSA Grantees
 - HRSA Grantees
 - General Public
- Services
 - Training and Technical Assistance
 - Knowledge Development
 - Prevention and Wellness
 - Workforce Development
 - Health Reform Monitoring and Updates

Primary Behavioral Health Care Integration (PBHCI) Program - Grantees

- Program purpose
 - To improve the physical health status of people with SMI by supporting communities to coordinate and integrate primary care services into publicly funded community-based behavioral health settings, including substance abuse service organizations
 - 56 Centers chosen in two cohorts
- Expected outcome
 - Grantees will enter into partnerships to develop or expand their offering of primary healthcare services for people with SMI, resulting in improved health status
- Population of focus
 - Those with SMI served in the public behavioral (MH/SA) health system

Health Home Payment Methodology



- ▶ The Affordable Care Act permits States to structure a tiered payment methodology that accounts for the severity of each individual's chronic condition and the "capabilities" of the designated provider, or the team of health professionals.
- ▶ Flexibility is afforded to States to propose alternative models of payment not limited to a PM/PM.

Another Fix – Healthcare Payment Reforms

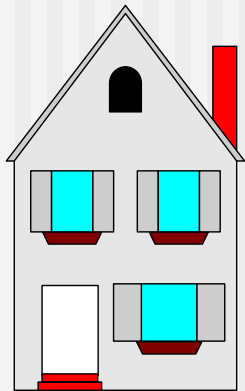
- To achieve the goals of health delivery transformation will require new payment models to achieve the goals of increased access, improving quality and reducing costs.
- Center for Medicare and Medicaid Innovation was established to examine and pilot-test new models for payment and delivery of healthcare.

Four Healthcare Payment Reform Models

1. Tying payments to evidence and outcomes rather than to units of services.
2. Reimbursement for the coordination of care in a medical home. (CCNC)
3. Bundling payments for physician and hospital services by episode or condition. (case rates)
4. Accountability for results – patient management across care settings. (defined population of beneficiaries – an ACO is responsible for achieving certain quality benchmarks and for keeping costs below defined thresholds.

Medical Homes: Value-Based Purchasing

- ▶ Fee for Service is headed towards extinction
- ▶ Health Care Home models will begin with a 3-layer funding design with the goal of the FFS layer shrinking over time
- ▶ Being replaced with case rate or capitation with a pay for performance layer



Person
Centered
Medical
Homes

Case Rate

- Prevention, Early Intervention, Care Management for Chronic Medical Conditions

Fee for Service/ PPS

- Per Service Payment
- Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls

Bonus

- Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)

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Value-Based Purchasing – Other Strategies

- Pay for Performance funding layer
- Differential Rates for providers that use published Practice Guidelines (EBPs)
- Capacity-Based Funding to kick start innovations
- Funding to community organizations that improve health status and bend the cost curve

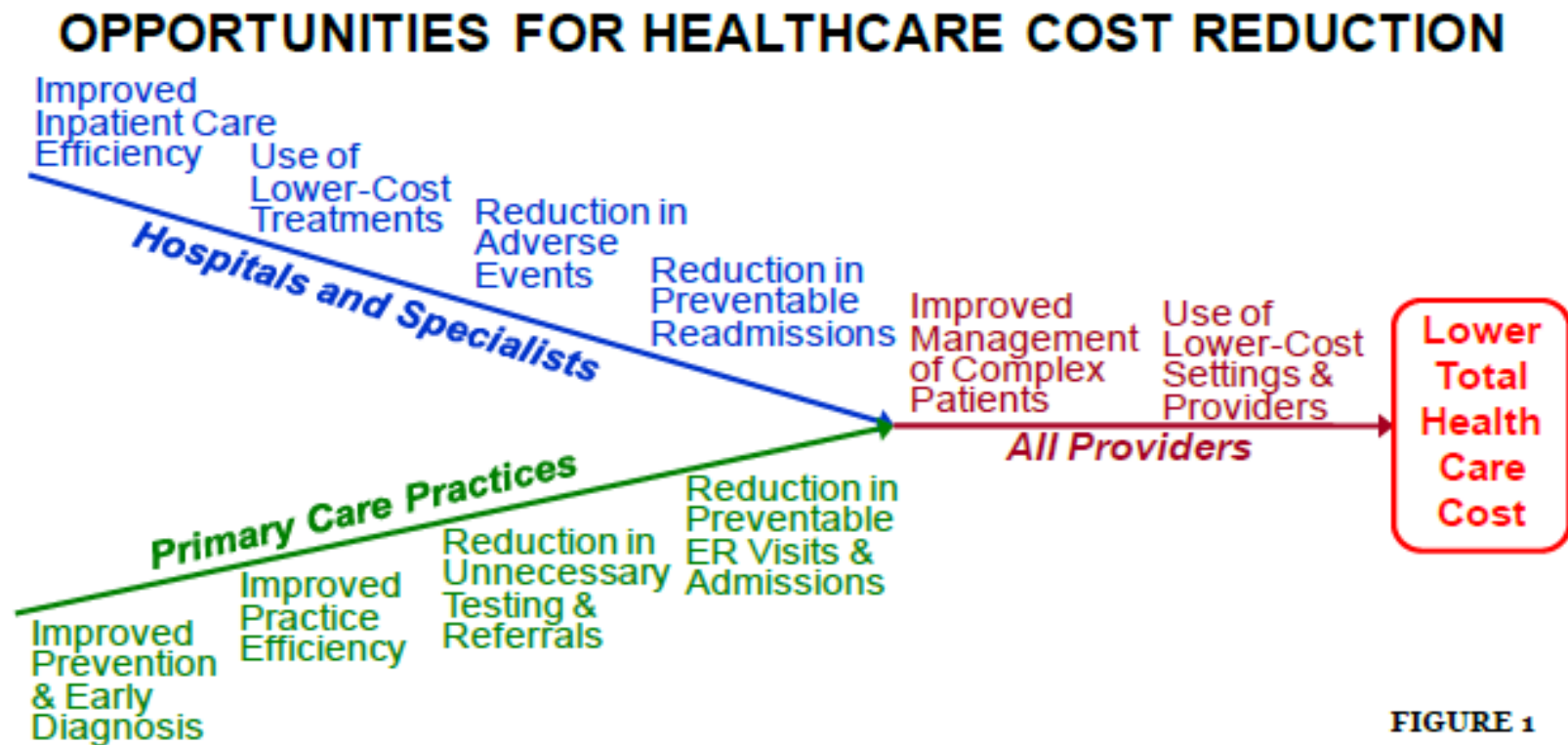
Provider
Bonuses &
Incentives

Differential
Rates

Capacity-
Based
Funding

Community
Incentive
Pool

But...It takes more than a high performing Health Homes to achieve the Triple Aim



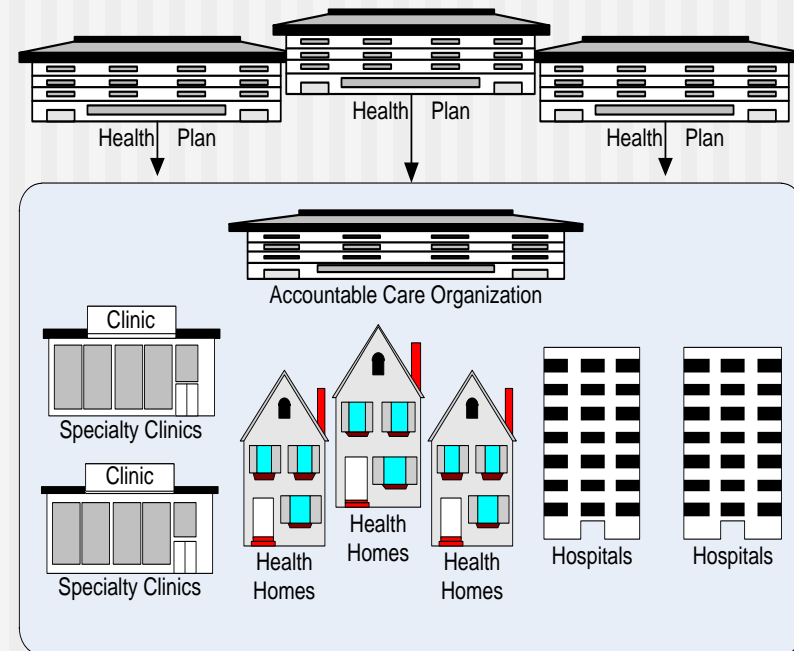
Harold Miller, Center for Healthcare Quality and Payment Reform, How to Create Accountable Care Organizations, www.chqpr.org

Accountable Care Organizations

Creating *the Healthcare Neighborhood*

ACOs:

- are **provider groups** that accept responsibility for the cost and quality of care delivered
- are the **organizing infrastructure** to help health homes coordinate care with specialists, hospitals and other parts of the healthcare delivery system.
- **manage new payment models** that incentivize prevention, early intervention and supports for persons with complex and costly health conditions.



It's About Medicare

- Must be Medicare approved to share in savings.
- Applies to only a portion of Americans with Medicare – only those in traditional fee-for-service Medicare because this plan pays for “volume and not for value”.
- Medicare beneficiaries can switch primary care providers as often as they like.
- Note: The Patient Protection and Affordable Care Act also includes references to a pediatric Medicare ACO, but those regulations have not yet been promulgated.

Assignment

- Medicare beneficiaries are “assigned” to an ACO based on where they receive the plurality of primary care services
 - Can only be assigned to a primary care physician (ie, not to NPs, PAs, etc.)
 - Primary care physicians limited to those with specialty in general medicine, family medicine, internal medicine, or geriatrics (ie, no psychiatric specialties)
- Virtual “assignment” for purposes of measuring quality and costs
 - Medicare beneficiaries can switch primary care providers as often as they like.

The ACO Concept for Success

- Accountable – 65 Performance Measures
- Innovative Care Redesign and Cost Effectiveness
- Built Around Consumer
- Team-Based Care
- Aligned Incentives to achieve the Triple Aim
- Requires relevant, timely data
- Shared savings between the ACO and Medicare Trust Fund

ACOs Must Improve Quality of Care – Measured Under Five Domains – Designed With *Consumers In Mind*



Performance standards in the following domains must be met to share in savings:

- Patient Experience
- Care Coordination
- Patient Safety
- Preventative Health
- At-risk Population/Frail and Elderly Health
 - Specific Behavioral Health Measures:
Only 1? Huh?!

One-Sided Financial Risk Model

ACO: Track 1

- Sharing of savings only for the first two years and sharing of savings and losses in year three.
- Allows for entry at lower risk for smaller ACO or an ACO with less experience in risk models.
- Savings is calculated as a percentage of the target benchmark of savings the ACO must exceed to qualify in a given year.
- Shared savings reconciled annually
- Switch to Track 2 in 3rd Year

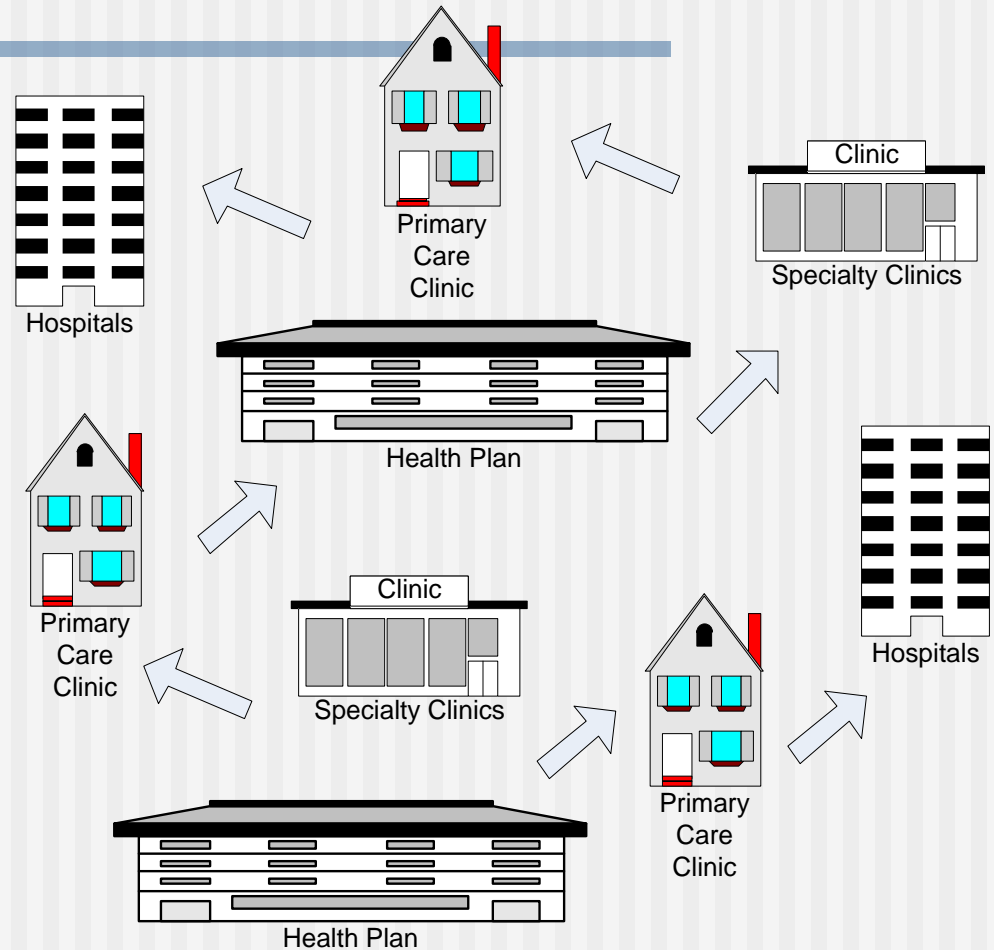


Two-Sided Financial Risk Model: Track 2

- Share in losses and savings for all three years.
- Higher sharing rates than available in the One-Sided model.
- More experienced systems could select this model to achieve greater savings.
- The maximum sharing percentage is 60% for the ACOs in the two-sided model compared to 50% in the one-sided model.
- In both models, the ACO must meet the quality standards achieve savings exceeding the minimum saving rate to share in savings.

So, How Do These Things Get Started?

- ▶ All healthcare is local
- ▶ ACOs are being organized by hospitals and physician practices, multi-specialty group practices without hospitals, health plans, groups of primary care practices, existing integrated health systems, existing independent practice associations...



Proposed Rules for ACOs - Who Can Become an ACO?

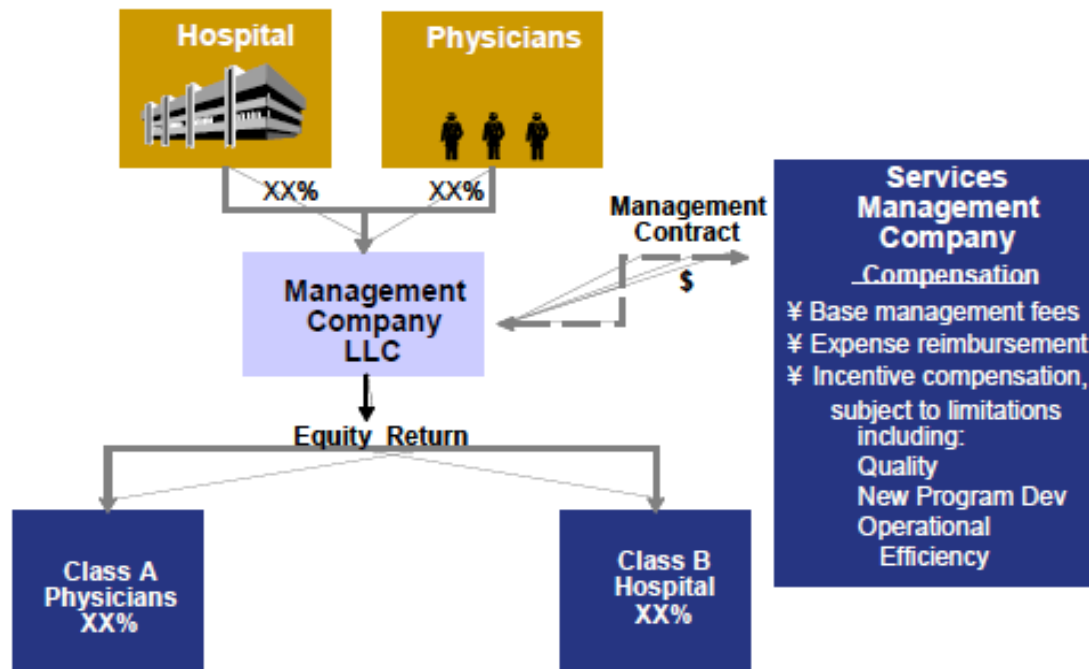
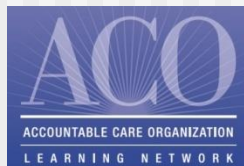
- ACO Professionals are defined as ACO Professionals include physicians, physician assistants, nurse practitioners or clinical nurse specialists with primary care specializations in general practice, internal medicine, family practice, and geriatric medicine.

Eligible Providers to Participate as ACOs

- ACO professionals in group practice arrangements
- Network of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Other providers of services and suppliers as the Secretary determines appropriate
 - Note: FQHC, RHCs, and many CAHS can not create their own ACOs, but can participate as part of another ACO.
 - ACOs that include FQHCs/RHCs eligible for higher savings.

ACOs are Legal Entities

- ▶ The most common legal form is expected to be a Limited Liability Company (LLC) owned by the entities that organize the ACO and their invitees



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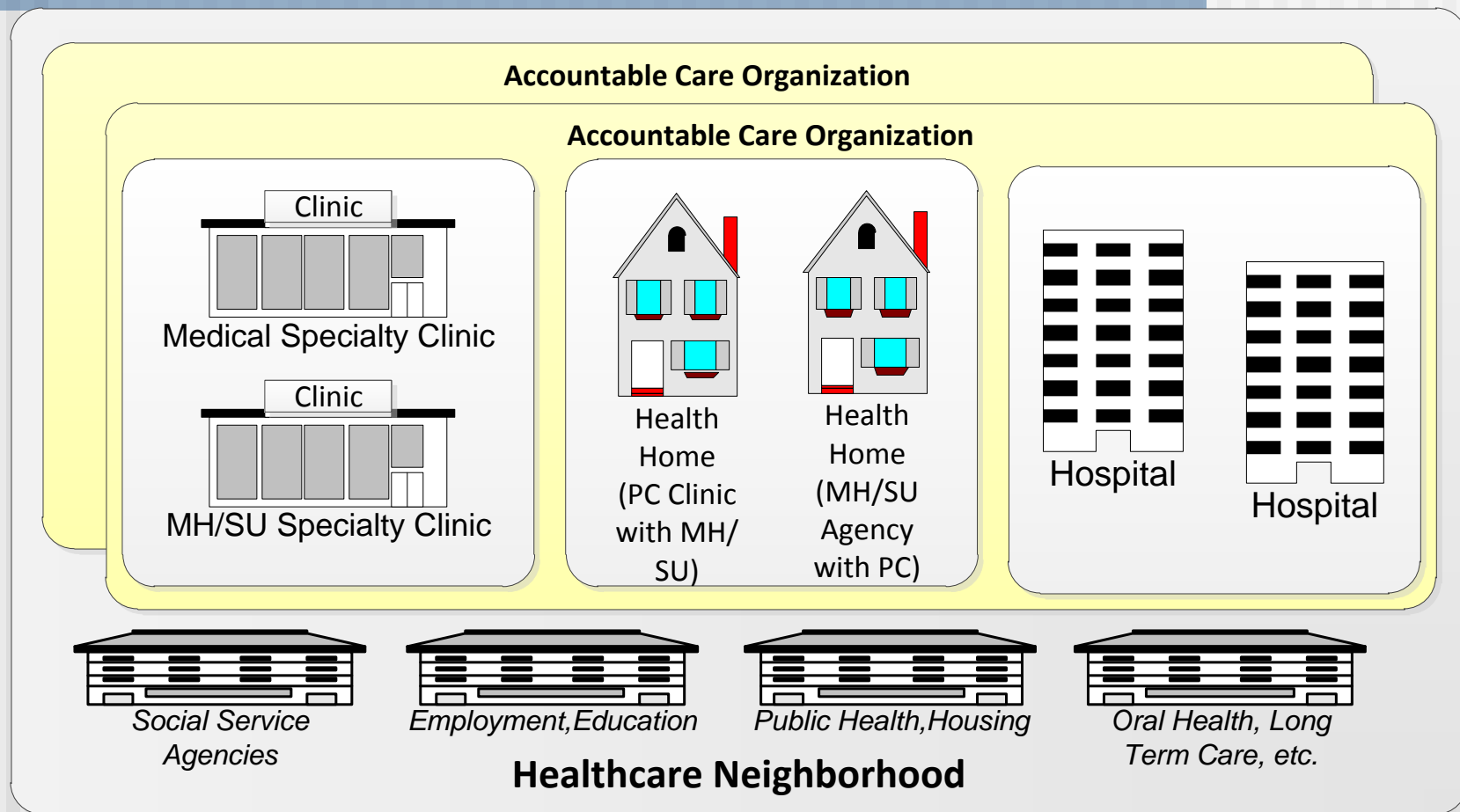
Patient Centeredness

- Medicare beneficiaries retain their right to see any provider of their choice
- To show that the ACO is patient centered, ACO must:
 - Conduct CAHPS beneficiary experience of care survey and show how ACO will use results to improve care over time
 - Patient involvement in ACO governance
 - Process to evaluate health needs of the ACO's assigned population, including consideration of diversity
 - Systems to identify high-risk individuals and processes to develop individualized care plans.

Patient Centeredness

- To show that the ACO is patient centered, ACO must:
 - Have a mechanism for coordination of care
 - Have a process to communicate clinical knowledge/evidence-based medicine to beneficiaries in way that is understandable to them
 - Measure clinical performance by physicians across practices and use the information to improve care over time. 42 CFR 425.5(d)(15).

Which requires the Customization of the Accountable Care Organization



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So How does the Behavioral Health Delivery System Fit into the new Healthcare Ecosystem?

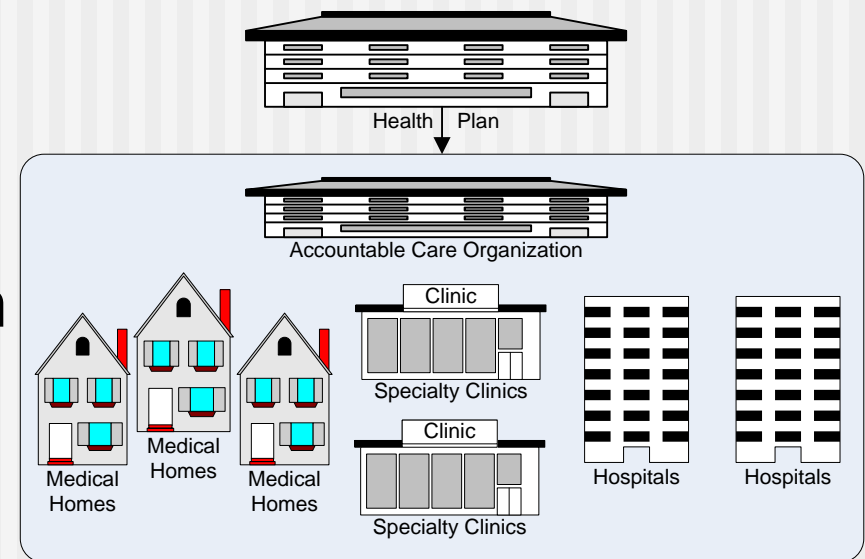


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How should Behavioral Health Providers Prepare?

Four Choices...

1. Become a **Preferred Provider** for the ACO
2. Become an **Acquisition Target** for one of the “big dogs”
3. Become a **Member** of the ACO



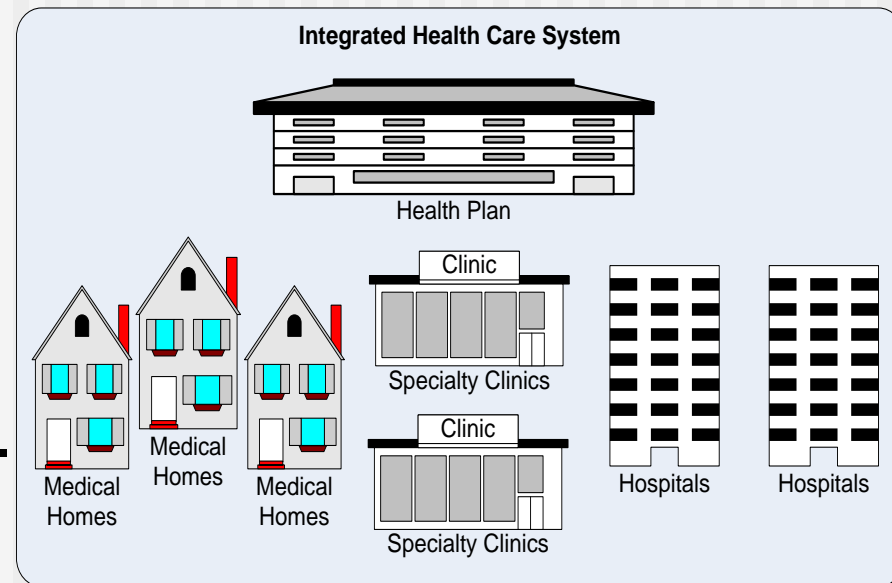
What Role Can Community Behavioral Health Providers Play?

- The Triple Aim cannot be achieved without robust person-centered health homes.
- ACOs are primary care-centric.
- FQHCs and Rural Health Clinics don't submit encounter data in CPT/HCCS format with clinician identifier and specialty, which is the basis for assigning patients to an ACO.
- Behavioral health providers **cannot** be ACO professionals because they are not primary care providers.
- Behavioral health providers can be included in an ACO as other non-primary care providers are included such as cardiologists, nurses, etc.

How do Behavioral Health Providers Prepare?

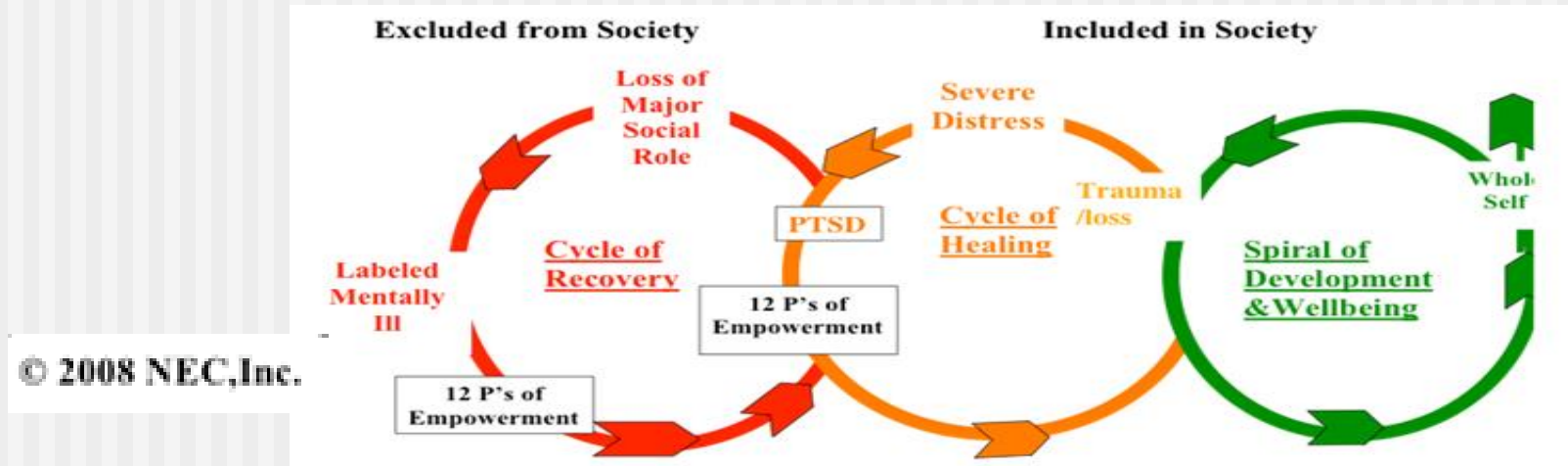
Integrated Healthcare System Choices:

- Have PCPs on site supported by a full care team. PCPs would be ACO professionals.
- Be a true Health Home with all health care provided.
- Create a consortium of BH Providers and contract with the IHS as a **Provider Network**
- Become an **Acquisition Target** and become part of the IHS' BH Division

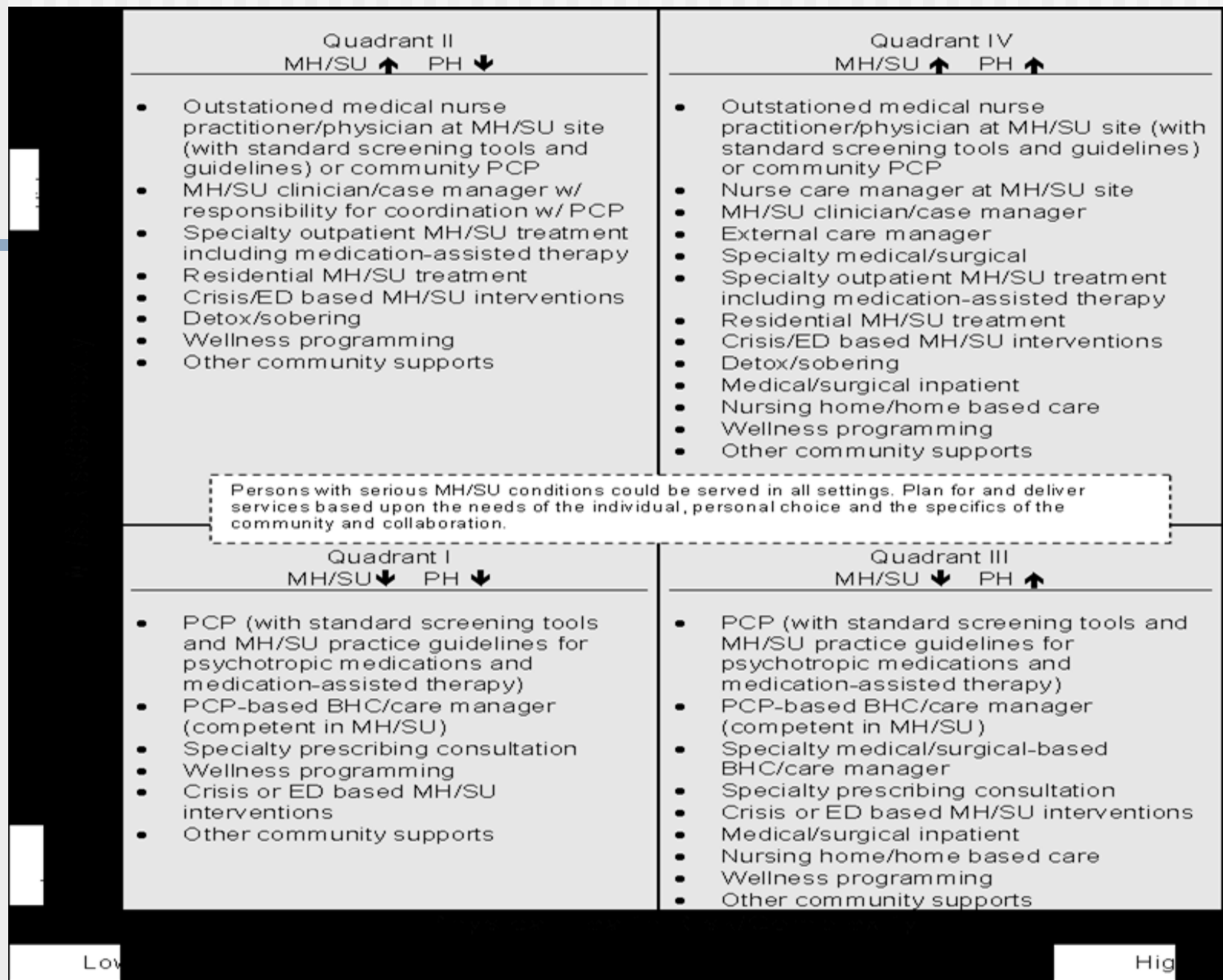


The Role of CBHOs as Wellness and Recovery Centers

- ▶ Distinctive Competence and Competitive Advantage for CBHOs
 - Ability to provide a true “holding environment” for persons with serious MH/SU disorders
 - That help consumers towards wellness and inclusion in society
 - Which are the two components necessary to bend the cost curve



The Four-Quadrant Model



The Person-Centered Health Home Quadrants 1 and 3

Quadrant 1

- ▶ PCP (with standard screening tools and MH/SU practice guidelines for medication-assisted therapy)
- ▶ PCP-based BHC/care manager (MH and SU competent)
- ▶ Specialty prescribing consultation
- ▶ Wellness programming
- ▶ Crisis/ED based SU interventions
- ▶ Other community supports

Quadrant 3

- ▶ PCP (with screening tools/guidelines)
- ▶ PCP-based BHC/care manager (MH and SU competent)
- ▶ Specialty medical/surgical-based BHC/care manager
- ▶ Specialty prescribing consultation
- ▶ ED based SU interventions
- ▶ Medical/surgical inpatient
- ▶ Nursing home/home based care
- ▶ Wellness programming
- ▶ Other community supports

The Person-Centered Health Home Quadrants 2 and 4

Quadrant 2

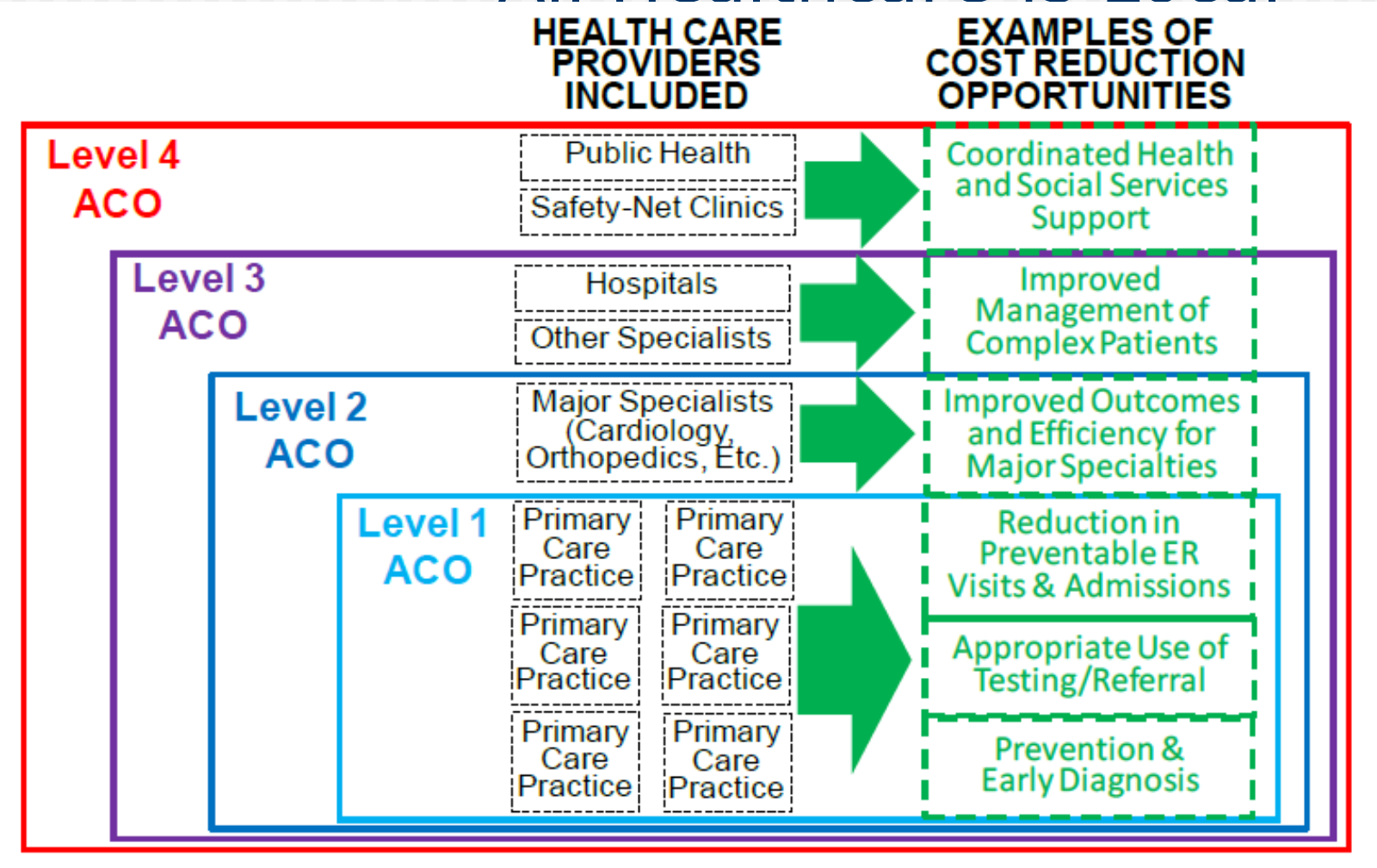
- ▶ Outstationed medical NP/PCP
- ▶ SU clinician/case manager w/ responsibility for coordination w/ PCP
- ▶ Specialty outpatient SU treatment including medication-assisted therapy
- ▶ Residential MH/SU treatment
- ▶ Crisis/ED based MH/SU interventions
- ▶ Detox/sobering
- ▶ Wellness programming
- ▶ Other community supports

Quadrant 4

- ▶ Outstationed medical NP/PCP
- ▶ Nurse care manager/SU site
- ▶ MH/SU clinician/case manager
- ▶ External care manager
- ▶ Specialty medical/surgical
- ▶ Specialty outpatient MH/SU treatment
- ▶ Residential MH/SU treatment
- ▶ Detox/sobering
- ▶ Crisis/ED based MH/SU interventions
- ▶ Medical/surgical inpatient
- ▶ Nursing home/home based care
- ▶ Wellness programming

Four Levels of ACO:

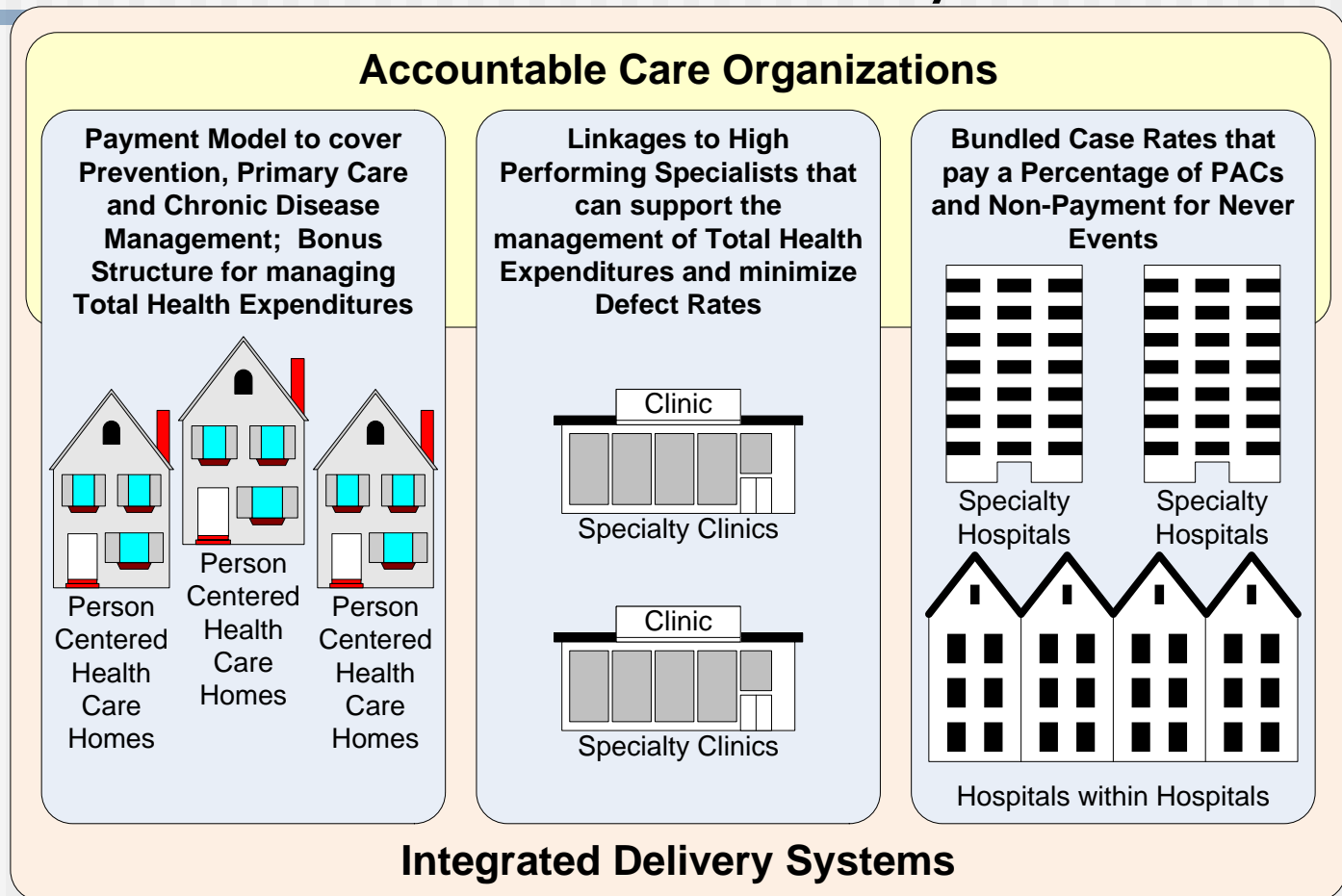
All Healthcare is Local



Harold Miller, How to Create an Accountable Care Organization, www.chqpr.org, page 18

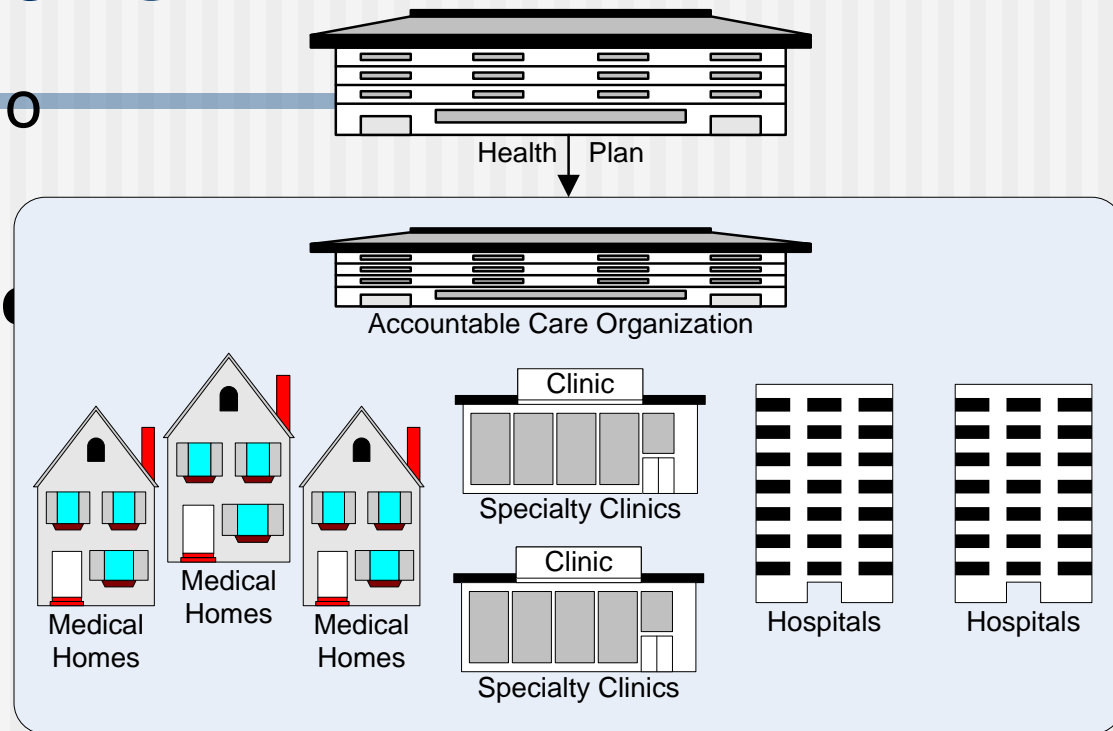
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So Tell Me Again... How does the Behavioral Health Delivery System Fit into the new Healthcare Ecosystem?

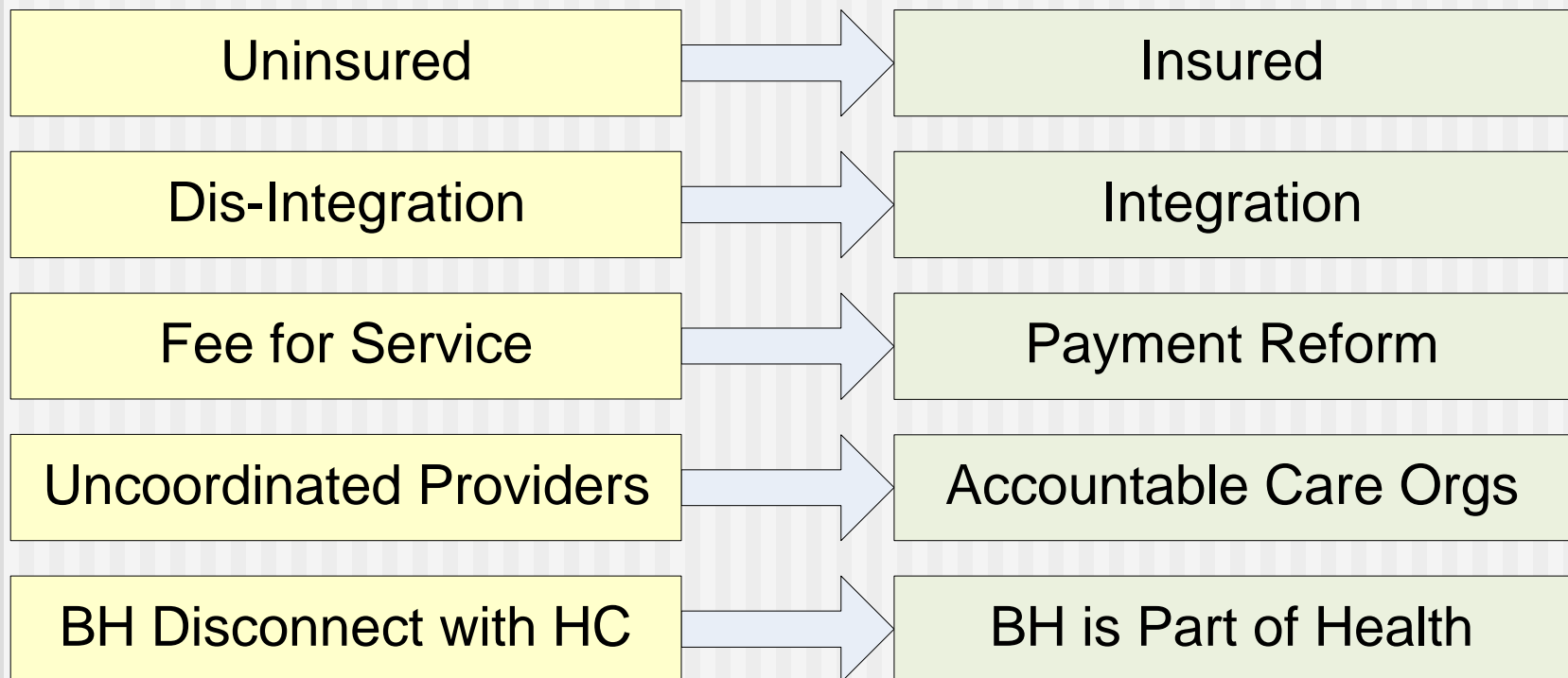


How do Behavioral Health Providers Prepare?

- I'm going to skip "do nothing"
- Become a **Preferred Provider** to the ACO
- Become a **Member** of the ACO
- Fully integrate primary care and behavioral health care – create a person-centered health home



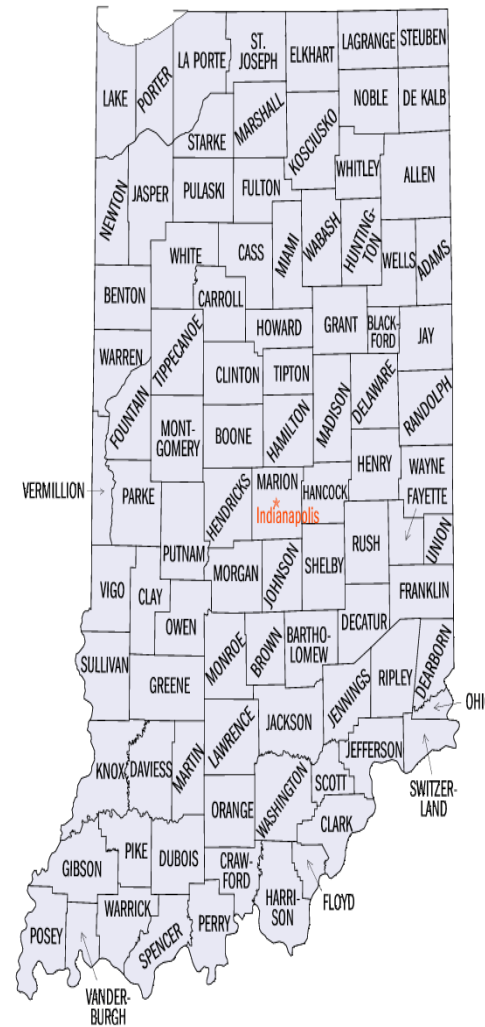
Many Wheels are Turning



Are State MH Authorities Ready?

How will things will unfold in Indiana?

- **Low Change System:** Some states will acknowledge the existence of clinical dis-integration but not recognize the financial impact and not be adequately swayed by the social justice issue related to early mortality. These states will take little or no action to promote clinical integration and will not actively remove the barriers to integrated clinical designs. These states will move forward on healthcare payment reform, per the options described above, but take a laissez faire approach to promoting primary care/behavioral health integration. In this environment, it will be up to the health plans, accountable care organizations, primary care providers and MH/SU providers to integrate – or not.
- **High Change System:** Other states will buy into the hypothesis that it will be impossible to bend the cost curve without addressing the healthcare needs of the serious mentally ill and the behavioral healthcare needs of all safety net residents. These states will promote robust primary care-behavioral health integration efforts at the service delivery level. These states will include MH/SU in their payment reform redesign efforts in the variety of ways described below.
- **Moderate Change System:** A third group of states will fall somewhere in the middle, promoting clinical integration where it can be tacked onto other efforts, with varying degrees of robustness.



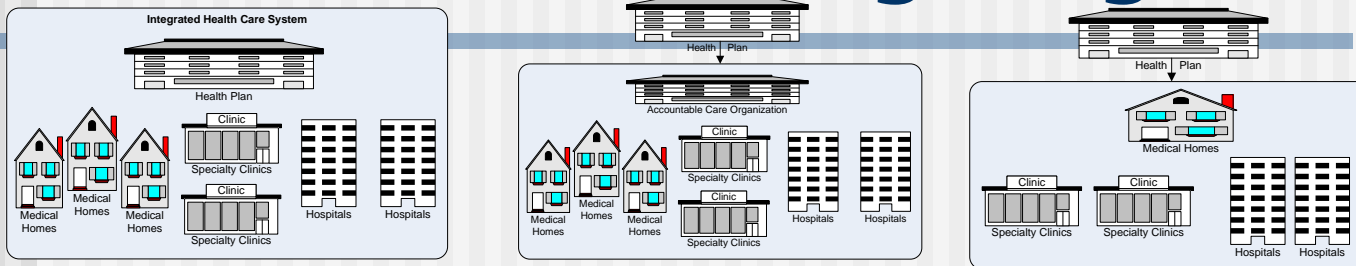
How Do Carve-Outs Fit with ACO Development?

Things get really exciting when we think about MH/SU Carve-In and Carve-Out models

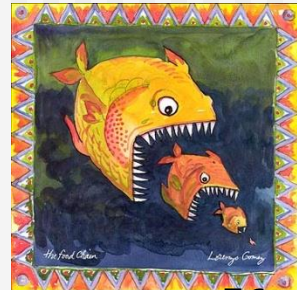
	Low Change	Moderate Change	High Change
Carve-In	Carve-in will continue to be used to organize service delivery integration; very few examples of this model	Carve-in will continue to be used to organize service delivery integration; very few examples of this model	Carve-in will continue to be used to organize service delivery integration; very few examples of this model
Carve-Out	Carve-out will remain in place; it will be up to the plans and providers to integrate	Carve-out will likely remain in place but large emphasis will be placed on building contractual relationships at the health plan and service delivery levels to promote and support integration	Higher probability that carve-out will be replaced with carve-in; carve-outs will need to develop robust case for demonstrating that current design will do a better job than a carve-in integrating at the service delivery level
Fee for Service	States will likely move their Medicaid health care into managed care and may carve-in or carve-out MH/SU	States will likely move their Medicaid health care into managed care and will lean towards carving in MH/SU	States will likely move their Medicaid health care into managed care and will probably carve-in MH/SU

Get ready...

it's going to Happen



- Cannot bend the cost curve without addressing the needs of persons with MH/SU disorders
- Fee for Service is going away
- Value-Based Purchasing models will be the model
- High Performing, Recovery-Oriented behavioral health Providers can improve health status & bend the curve
- Participating at the System Management Level (IHS, ACO) is an important survival strategy



Where Can You Get Support?

- Center for Integrated Health Solutions

[http://www.thenationalcouncil.org/cs/center for integrated health solutions](http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions)

Q&A



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