

Accountable Care Organizations and Behavioral Health

Indiana Council of Community Mental Health Centers

October 11, 2012



Indiana Hospital Association

What is an ACO?

“An accountable care organization is a group of providers or suppliers or a network of groups, often affiliated with a hospital, that are jointly responsible for the cost and quality of health care provided to Medicare beneficiaries because they receive bonuses when they provide exceptional or low-cost care and are penalized for low-quality or high-cost care”

Accountable Care Organizations



What is an ACO?

“The ACO model is a reaction to the failure of the fee-for-service payment system, which offers incentives to provide excessive services but not to devote resources to managing chronic disease or coordinating care.”

What is an ACO?

- ACO's fall under a broader category of Medicare "*Shared Savings Programs*"
- ACO's take up only seven pages of the massive ACA law
- When the Obama administration released its proposed rule on ACOs, it was so onerous and risky, nobody wanted to try
- Eventually they changed the rule
- They also created "Pioneer ACO's" to attract systems to try it out

How will quality be measured?

CMS will monitor 65 quality measures grouped into five domains:

- patient and caregiver experience
- care coordination
- patient safety
- preventive health
- health of at-risk and frail elderly populations

Effect on reimbursement

Through a complicated method a base year FFS cost will be established for the recipients covered by your ACO. Your potential savings will be derived from the costs you incur to provide their care in your ACO.

Providers and suppliers participating in a Medicare ACO will continue to receive traditional Medicare FFS payments under Medicare Parts A and B and also will be eligible to receive a portion of the shared savings if successfully satisfying quality performance standards and reducing health care costs.

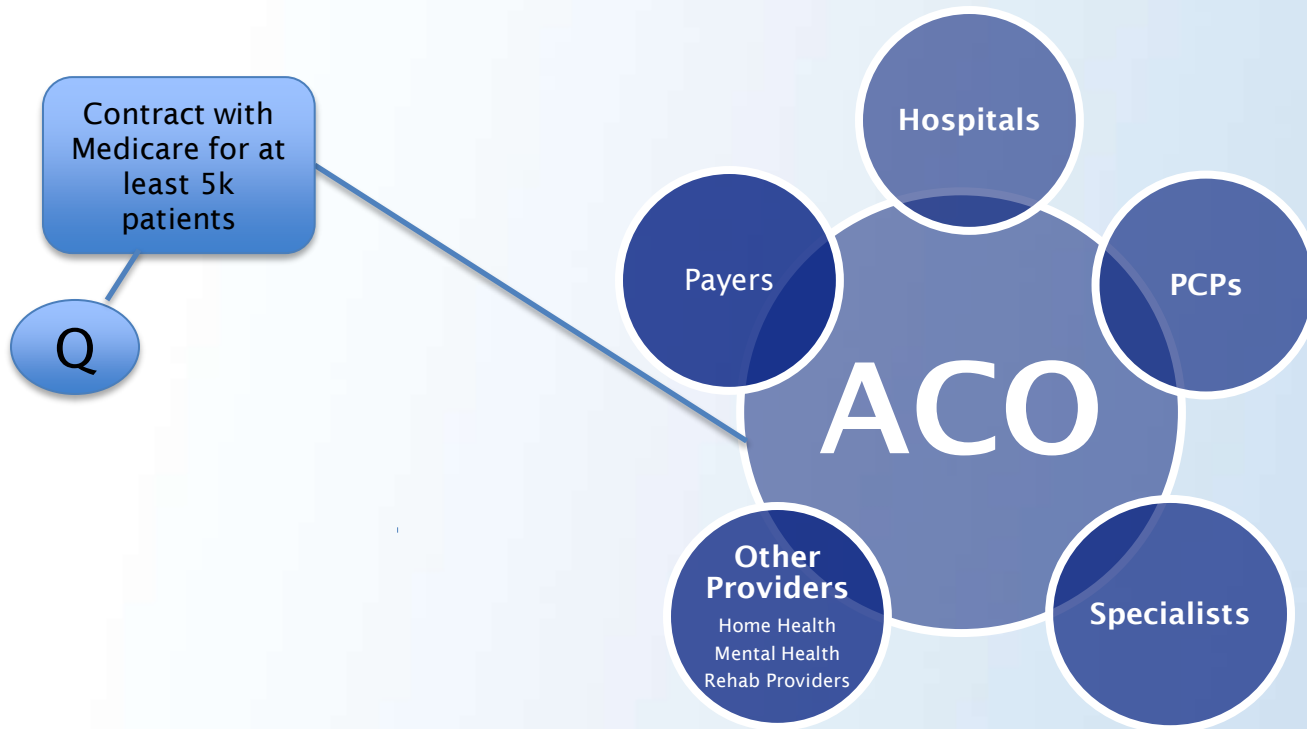
Accountable Care Organizations



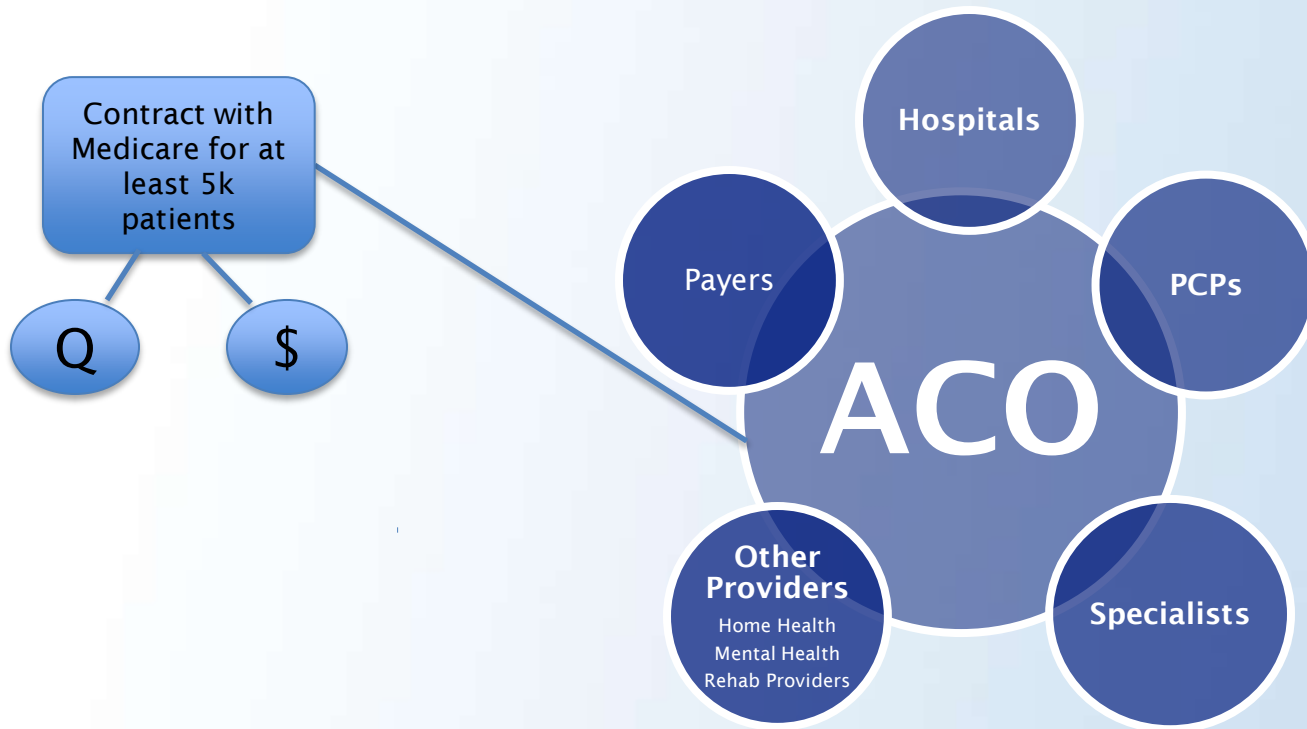
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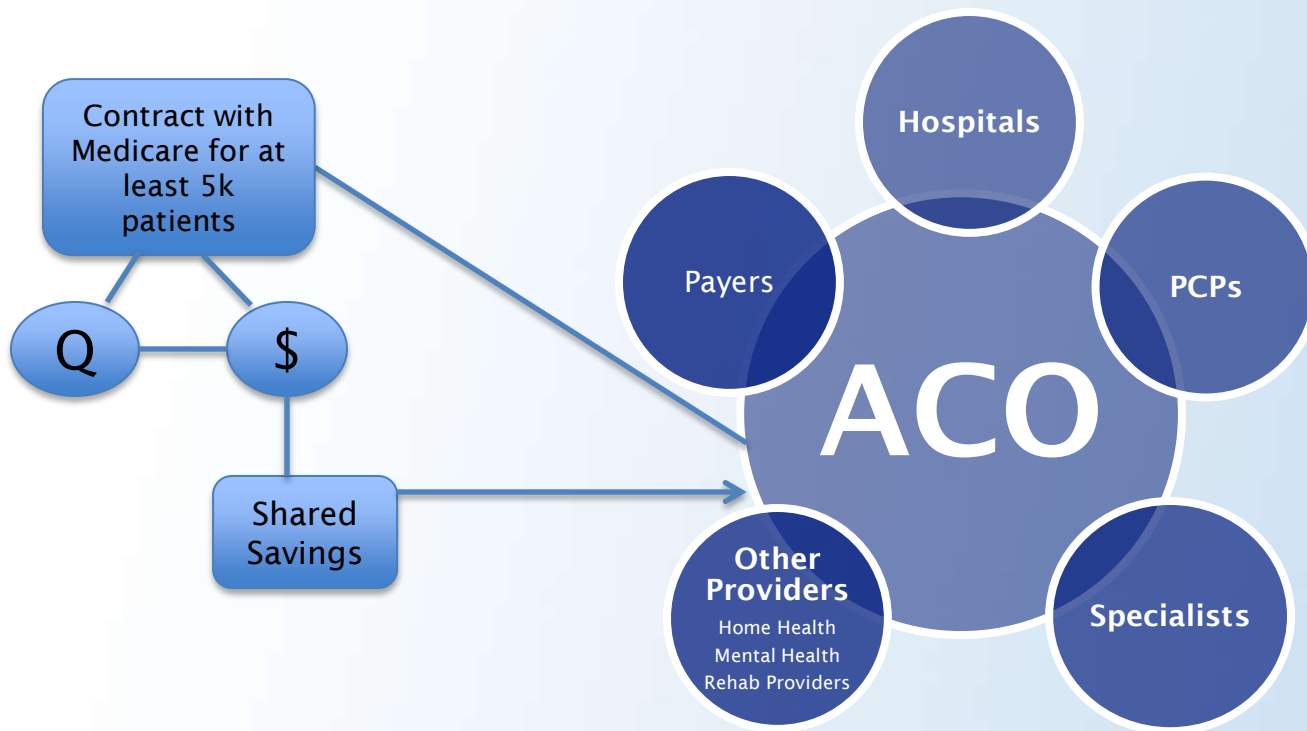
Accountable Care Organizations



Accountable Care Organizations



Accountable Care Organizations



What is an ACO?

- Patients will still retain choice of physicians and hospitals, *even though the ACO is at risk for the cost of their care*
- Success will depend on well-integrated patient care and information systems to assure reduction of waste, redundancy, and unnecessary procedures or admissions
- An inpatient admission may be considered a failure of the system, for CHF, Diabetes, and other chronic diseases.
- The system will have to really “know” the patient and assure that the right care at the right time at the right place isn’t left to chance.

History of the ACO model

- The phrase is attributed to Dr. Elliot Fisher of Dartmouth Medical School
- Dr. Fisher has led the Dartmouth Atlas Project — that documents the variation in care across the United States.
- Dartmouth Atlas has focused on both the *quality* of health care as well as its *cost*.
- Their findings:
 1. wide variations in the cost of care across the country
 2. regions that spend more per patient do not necessarily obtain better outcomes

History of the ACO model

In 2006, Dr. Fisher noted this problem could be addressed by creating virtual organizations consisting of doctors and hospitals who accept the responsibility and risk for the quality and cost of the care.

They could be rewarded by sharing in the financial savings obtained through reducing the cost of the care.

This idea became attractive to many researchers and ultimately became an important part of the ACA's Shared Savings Program.

How many ACO's?

- CMS expected 75 to 150 ACOs forming in the first 3 years to provide care for 1.5 million to 4 million beneficiaries.
- July 9, 2012 CMS announced 89 new ACO's bringing the total nationally to 154, serving 2.4 million Medicare beneficiaries
- Indiana now has four approved ACO's:
 - Franciscan Health Pioneer ACO (12, 2011)
 - Deaconess Care Integration, LLC
 - Franciscan AHN ACO, LLC
 - Indiana University Health ACO, Inc.
- Applications will now be accepted only annually

How many ACO's?

“News Release:

Indianapolis, IN---Two of the largest healthcare systems in Indiana will partner with six area hospitals that are part of the Suburban Health Organization (SHO) to launch an accountable care consortium (ACC) focusing on innovative healthcare solutions ***for employers and commercial markets***. The goal of the partnership is to improve the quality of patient care, while lowering the cost of healthcare delivery. The ACC will be a separate entity with its own board and CEO. ***It is not connected to a federal government initiative.***”

Inside Indiana Business October 8, 2012

How many ACO's?

Community Health Network

St. Vincent Health

Suburban Health Organization:

- Hancock Regional Hospital
- Hendricks Regional Health
- Henry County Hospital
- Johnson Memorial Hospital
- Riverview Hospital
- Witham Health Services

Scale:

- 32 Hospitals
- Numerous O/P facilities
- 1,700 employed physicians

Will ACOs work?

- It is an experiment
- It has been a tough sell to some of the poster children for integration (Mayo, Geisinger, Cleveland Clinic)
- It is still controversial
- It takes capital, risk, integration, and physician/hospital trust. Some of these are in short supply in hospitals.
- “The problem with this movie is that we’ve actually seen it before, and it was a colossal and expensive failure”.

-Jeff Goldsmith, Health Affairs

The ACA and Behavioral Health

- Should facilitate the integration of behavioral healthcare into the broader care continuum
- While it pertains to Medicare & Medicaid, the private insurers may quickly adopt the same principles
- In Medicaid, the ACA creates a “health home” program to promote integrated care, including behavioral health
- Beneficiaries with serious or persistent mental illness, substance abuse disorder, or with a co-morbid medical condition are eligible to participate

The ACA and Behavioral Health

- New incentives/penalties for providers to manage patient transitions among settings and providers of care
- Hospitals are now paying rigorous attention to the reasons for readmission of patients
- There is a greater likelihood of readmission among patients with a comorbid behavioral health condition
- Expansion of insurance coverage to 32 million Americans should help improve access
- Supporting workforce development grants and other efforts to expand workforce
- Support for tele-medicine to create rural access

ACA Impact on Performance Measurement and Reimbursement

1. Value- Based Purchasing
 - 70% Clinical Process Measures
 - 30% HCAHPS
2. Reducing Readmissions
3. Reducing Hospital Acquired Conditions

The Stakes are Increasing!

Potential Negative Impacts to Base DRG Payments....

Fiscal Year	VBP	Readmissions	HAC	Total
2013	1.00%	1.00%	-	2.00%
2014	1.25%	2.00%	-	3.25%
2015	1.50%	3.00%	1.00%	5.50%
2016	1.75%	3.00%	1.00%	5.75%
2017	2.00%	3.00%	1.00%	6.00%

**An example of implementation of the ACA
principles:**

Montefiore

New York City

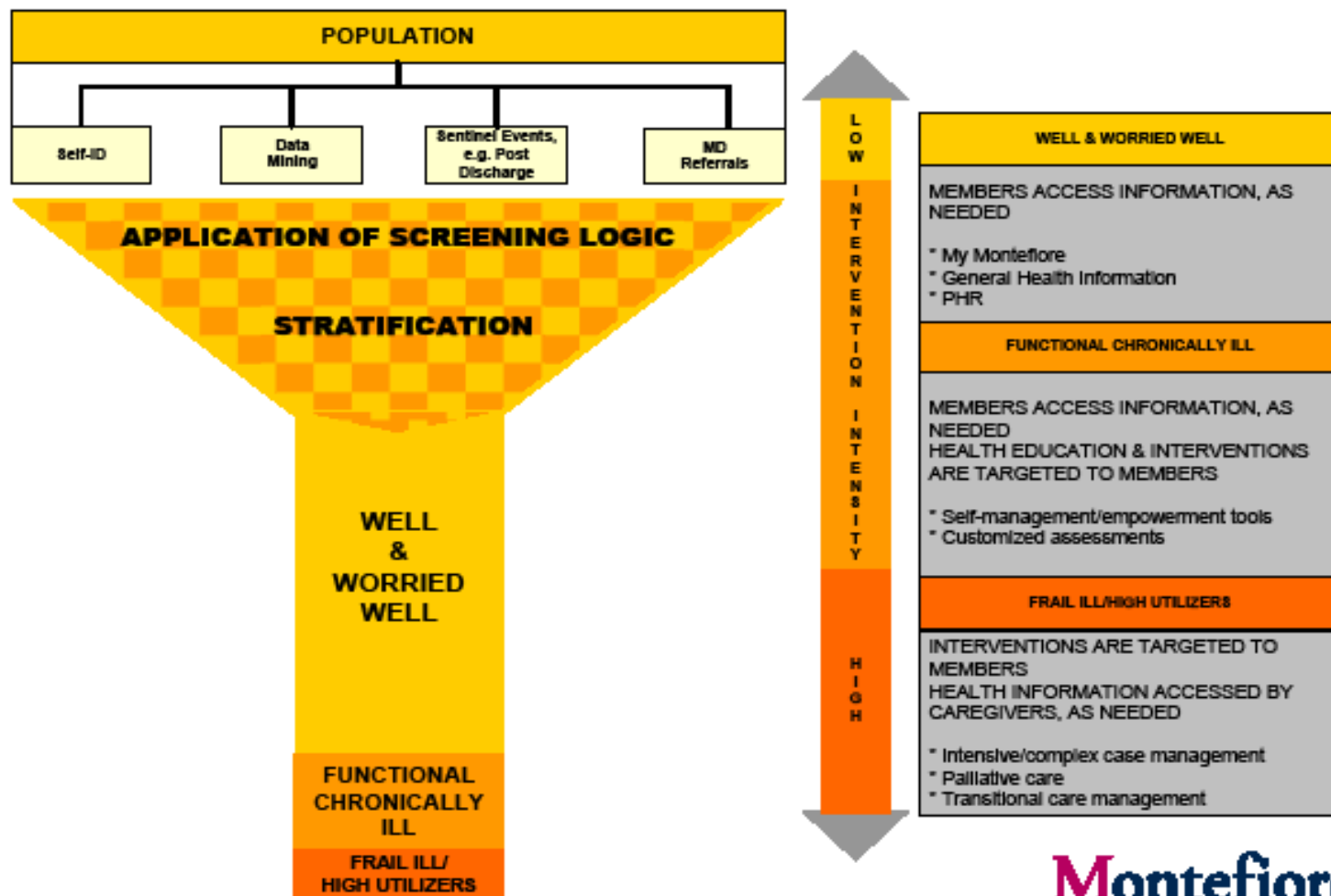
Montefiore

Care Coordination for Dual Eligibles and Other Vulnerable Populations: A View From the Bronx

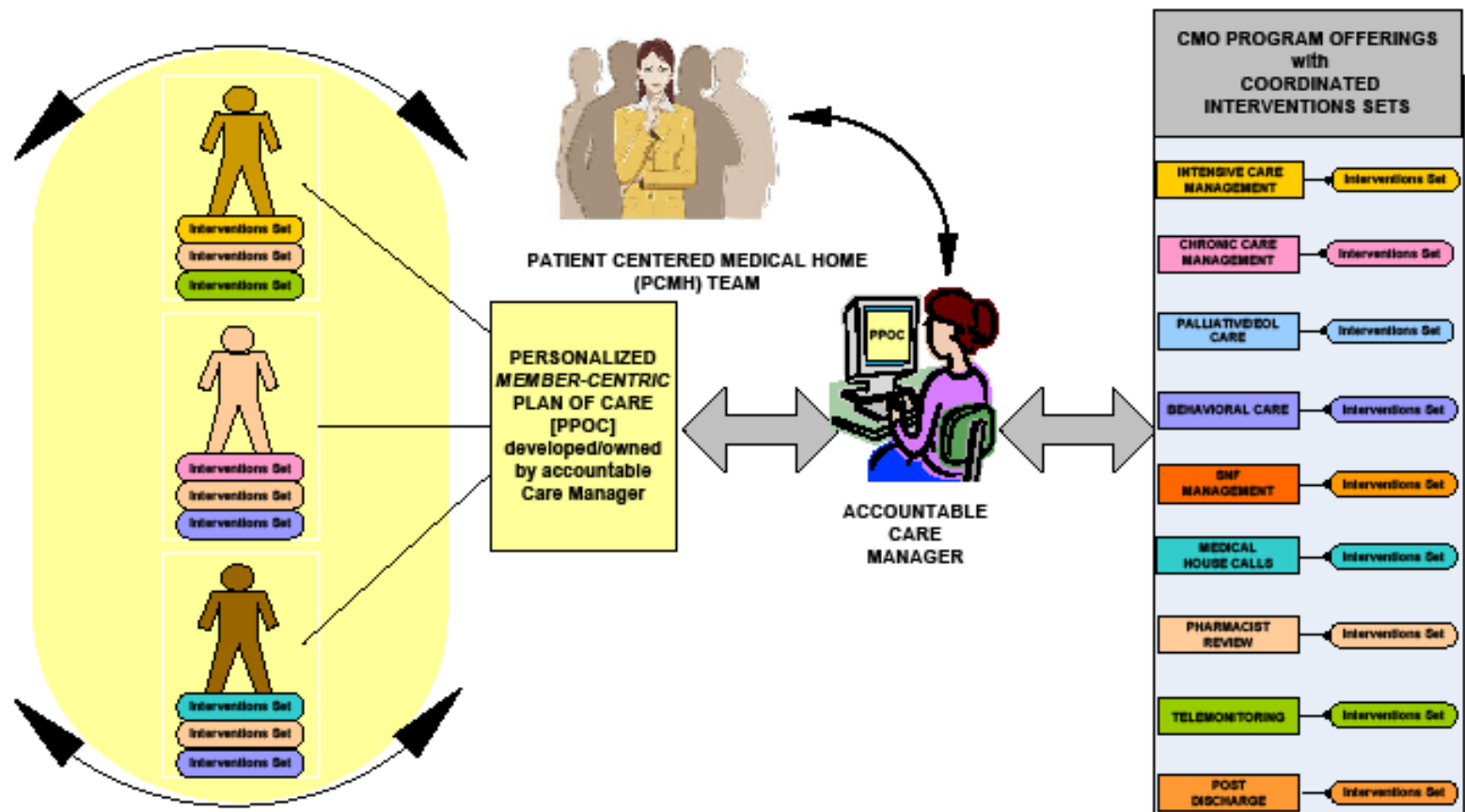
Presentation to the American Hospital Association
May 7, 2012

Anne Meara, RN, MBA
Associate VP, Network Care Management

Population Health Management Strategy



Care Guidance Interventions





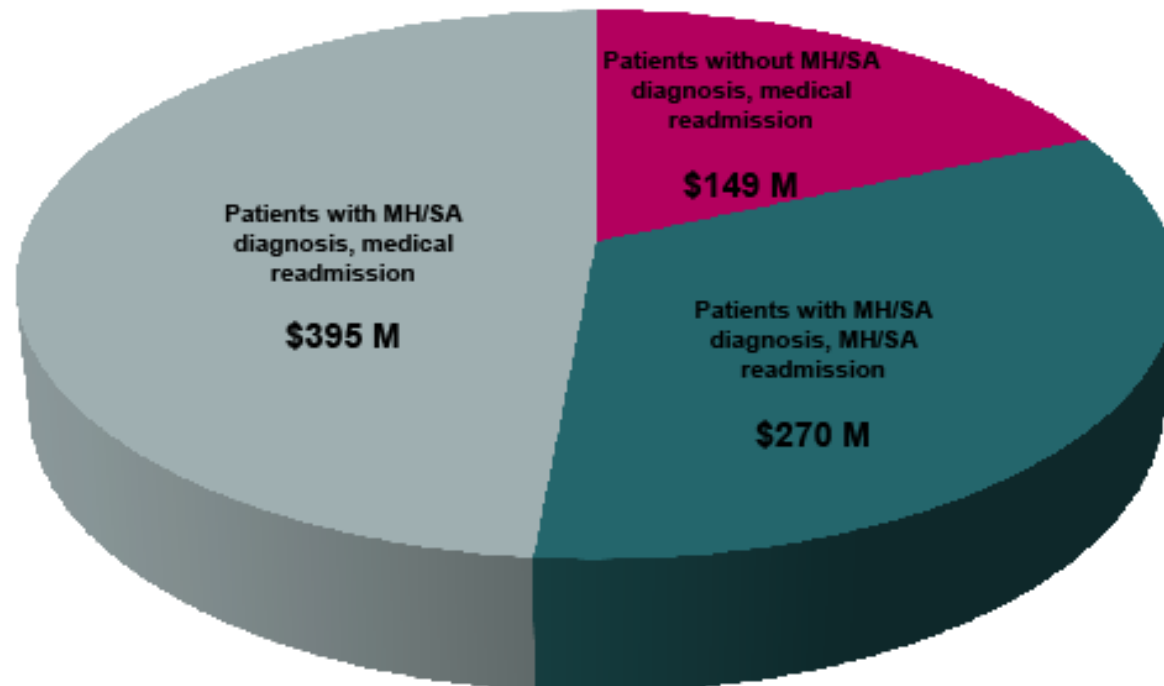
Key Areas of Focus in Coordinating Care for Duals and Other Vulnerable Populations

Care Coordination for Vulnerable Populations

- **Individual Level**
 - Adapt assessment tools to focus on medical as well as psychosocial issues
 - Expand capability to work with participants face-to-face
 - Incorporate tools to support individual behavior change
- **Provider Level**
 - Improve access and availability
 - Build patient centered medical home (PCMH) infrastructure
 - Incorporate mental health/ substance abuse expertise into interdisciplinary care management teams
- **System Level**
 - Support organizational behaviors that contribute to reducing preventable utilization
 - Partner with other providers/agencies to create integrated comprehensive care plans
 - Develop IT infrastructure to support cross-organizational communication and data exchange

Impact of Mental Health/Substance Abuse on Medical Expense

Potentially Preventable Readmissions (PPR's)



NYS Medicaid 2007

Costs of Patients with Chronic Medical Illness (CMI) and Mental Disorders (PMPY)

	Mental Disorder and CMI N=405		CMI Only N=6282
Total*	\$24,262	vs.	\$12,592
Medical Claims Costs	\$22,735	vs.	\$12,566
Mental Health Claims Costs	\$1,527	vs.	\$25

Based on analysis of one plan's Medicare Advantage claims from July 2009 to June 2010

Synergy Program

- Goals:
 - Implement evidence-based models for treatment of depression and/or alcohol abuse with chronic medical conditions (Diabetes, CAD, and/or CHF)
 - Develop a cost effective joint medical and behavioral care management “synergy” team to support and manage these patients that results in improved clinical outcomes and patient and provider satisfaction
- Team members:
 - Consultant Psychiatrist
 - Behavioral Health Managers – LCSW and RN (BHM)
 - Accountable Care Managers – RN
 - PCPs and other staff in patient centered medical homes

Synergy Program

- Members with diabetes, CHF or CAD and depression or ETOH identified using data mining tool
- Members screened by Behavioral Health Manager using PHQ9 and AUDIT-C
- Interventions
 - Collaborative Care for Depression
 - SBIRT (Screening, Brief Intervention, Referral to Treatment) for At-Risk Alcohol Use
 - Psychiatry Consultation and Short Term Therapy
 - Intensive Case Management for Complex Patients (using Care Guidance model)
 - Telephonic Psychotherapy for Depression and At-Risk Alcohol Use

Synergy Program: Preliminary outcomes (minimum 8 weeks of treatment)

- 46% of patients with threshold depression (n=50) had a clinically significant (5 point) reduction in PHQ9 score (mean scores decreased from 15.0 to 7.9)
- In subset of patients with HbA1c>8 and PHQ9>10:
 - Mean PHQ9 reduced from 15.2 to 10.8 (29% reduction)
 - Mean HBA1c reduced from 9.56 to 8.40 (12% reduction)
 - Mean LDL was reduced from 130.2 to 125.0 (3% reduction)
 - 59% of this subgroup had a HgBA1c reduction of 0.5 or greater

Predictions

- Accountability is here to stay
- It may take many forms
- The fee-for-service, volume-based payment system is recognized as creating the wrong incentives driving up costs
- Behavioral Health will be an integral part of reducing cost of care along the continuum, readmissions, etc.
- Hospitals will have more reasons than ever to collaborate with behavioral health to reduce readmissions, reduce ER admissions, and overall cost of care

It's a Whole New World Out There



Questions?

Thank you!