

ACO 101

**An Introduction to Accountable Care Organizations
for Substance Use Disorder Prevention & Treatment Providers**

*Presented by
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Accountable Care Organizations

- **Q: What is an “accountable care organization”?**
- **A:** An Accountable Care Organization, also called an “ACO” for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.
- For ACO purposes, “assigned” means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

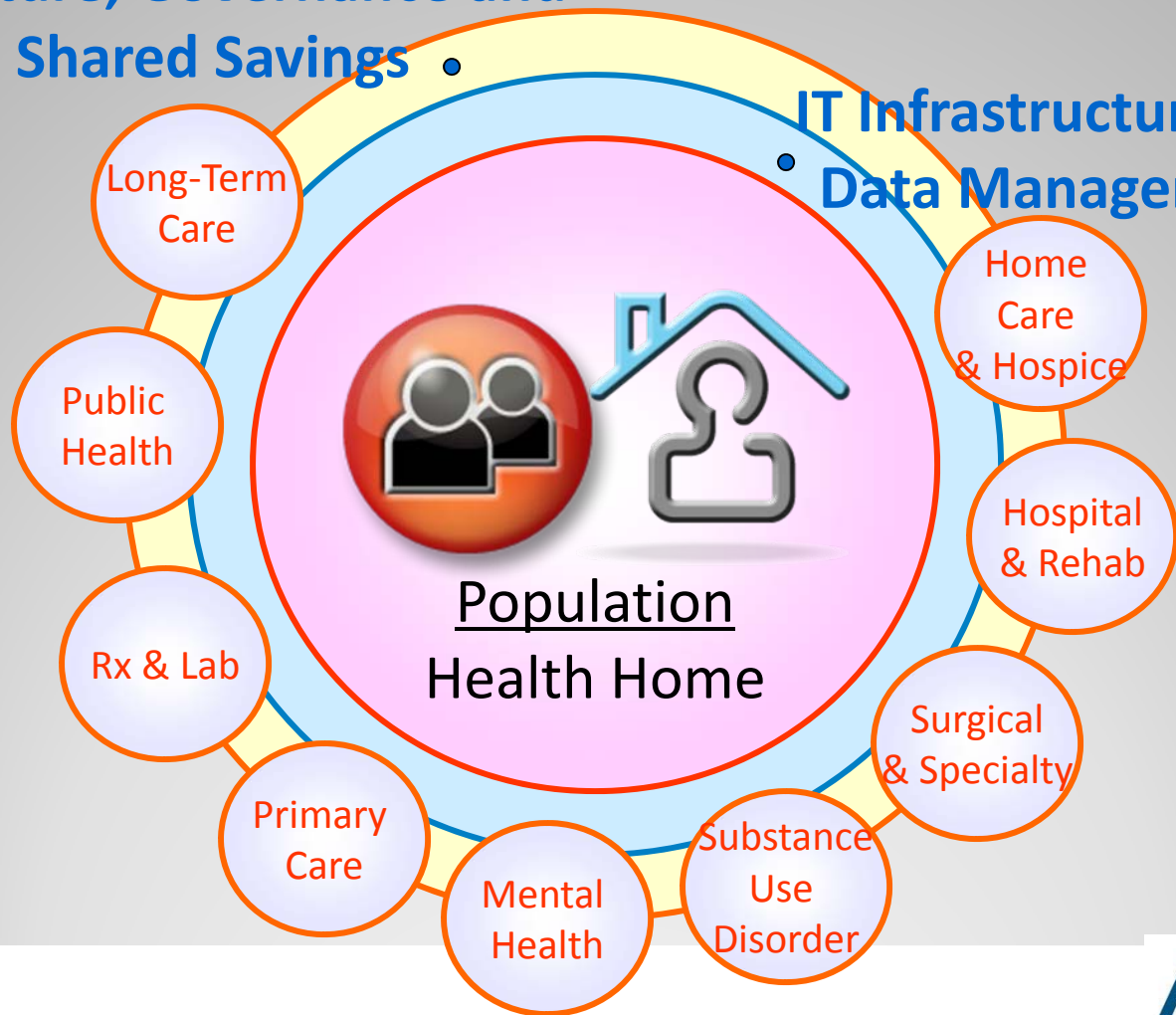
- Hallmarks of ACOs include preventive care to keep people healthy, as well as communication and collaboration between providers to prevent errors and duplication of costly services.
- A product of the Affordable Care Act (health care reform) designed specifically for Medicare and Medicaid. Some state Medicaid agencies already using different names like Coordinated Care Organization (CCO)

What is an ACO?

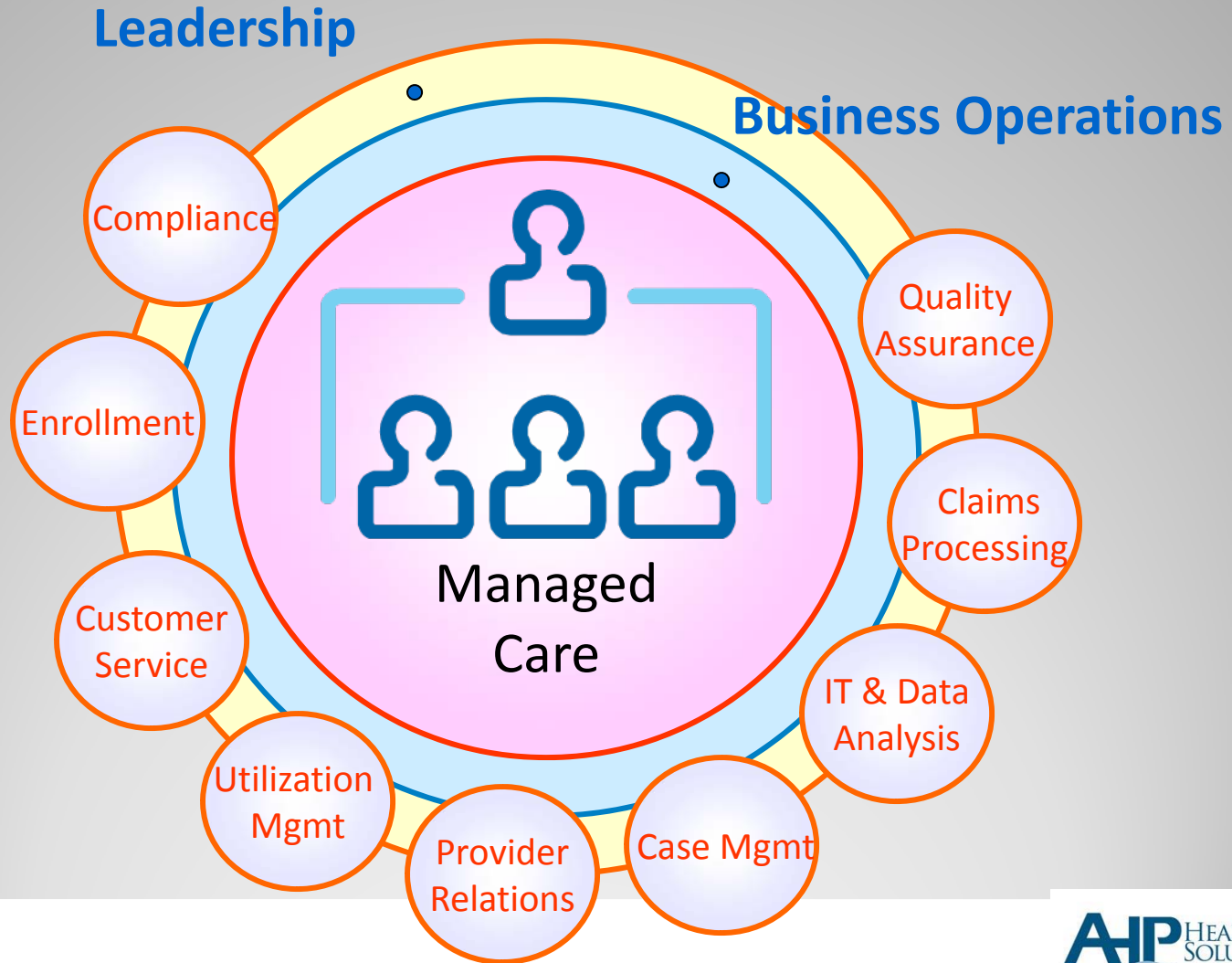
ACO Organizational Model

Structure, Governance and
Shared Savings

IT Infrastructure and
Data Management



ACO Functions



ACO Goals

- Promote development of **new systems** of care
- Change provider culture and incentives from fragmented FFS
- **Lower costs** while **improving population health**
- Measure both **quality** and **financial** performance
- Hold provider systems accountable for both cost and quality of care for **assigned patient populations**

ACO Innovations

Minimize “barriers to entry” for patients and providers:

- Patients attributed, not enrolled
- No benefit or network restrictions; no lock-in; no prior-auth

Flexibility for providers to form different kinds of ACOs

- Flexible payment model (e.g., can include bundling, Medical Homes)
- “Bonus only” shared savings
- “Symmetric risk” shared savings
- Partial capitation and shared savings

Receiving shared savings requires first achieving quality threshold

ACO Reimbursement

- Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the fee-for-service payment systems.
- The proposed rule would require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings, or be held liable for losses.

Global Payment

- **Definition.** Global payments are fixed-fee payments for the care and services that patients might receive in a given span of time such as a month, quarter or year. Global Payments are akin to Case Rates and Episode Rates. Global payments put providers at-risk financially for the occurrence of conditions as well as the management of those conditions.
- **Purpose.** Global payments are designed to contain costs and reduce the incidence of unnecessary services, promote integration and coordination of services. Global payments can also feature incentives to improve the quality of care.

Global Payment

- **Potential Issues.** Global payments might induce providers to cut back on necessary care and to admit/select less expensive patients into their programs.
- Global payments involve significantly more complex financial management, requiring infrastructure and personnel to manage risk.
- Small providers may not be able to take on risk due to this complexity and any state regulations concerning financial solvency where risk exists.

ACOs – Two Tracks

- To provide an entry point for organizations with varied levels of experience with and willingness to take on risk, the proposed rule would allow an ACO to choose one of two program tracks.
- **The first track** would allow an ACO to operate on a *shared savings only* track for the first two years, but would then require the ACO to assume the risk for shared losses in the third year.
- **The second track** would allow ACOs to share in savings and risk liability for losses beginning in their first performance year, in return for a higher share of any savings it generates.

ACO

- **Q: What forms of organizations may become an ACO?**
- **A:** The statute specifies the following:
 1. ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
 2. Networks of individual practices of ACO professionals,
 3. Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
 4. Hospitals employing ACO professionals.
 5. Other Medicare providers and suppliers as determined by the Secretary

ACO

- **Q: What are the types of requirements that such an organization will have to meet to participate?**
- **A: The statute specifies the following:**
 - 1) Have a formal legal structure to receive and distribute shared savings
 - 2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
 - 3) Agree to participate in the program for not less than a 3-year period

ACO – requirements cont'd

- 4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
- 5) Have a leadership and management structure that includes clinical and administrative systems
- 6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
- 7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

ACO

- **Q: How would such an organization qualify for shared savings?**
- **A:** For each 12-month period, participating ACOs that meet specified quality performance standards will be eligible to receive a share of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount.

ACO

- **Q: Will beneficiaries that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?**
- **A: No.** Medicare beneficiaries will continue to be able to choose their health care professionals and other providers

ACO

- **Q: When will this program begin?**
- **A: January 1, 2012.** Agreements will begin for performance periods, to be at least three years, on or after that date.

Goals & Objectives



What Other Groups Are Saying

- ACOs should have the opportunity to review and verify the data CMS uses in developing performance standard scores before this data is required to be made public."
-- The American College of Physicians, on the issue of ACO performance scores.
- "The number of initial quality measures is ... onerous and operationally unrealistic."
-- The American Academy of Family Physicians, on a requirement for ACOs to report on 65 quality measures.
- "Specifically, for a small ACO, costs were estimated to be \$11.6 million and for a medium ACO to be \$26.1 million."
-- The American Hospital Assn., on a CMS projection that the average ACO startup cost would be \$1.8 million.
- "We urge CMS to ... think more broadly about the role that plans can play in partnering with CMS to achieve its objectives."
-- America's Health Insurance Plans, on the concept of building on private ACO models.

Population Health Management

- ACOs must develop a process for identifying patients who have complex needs (multiple chronic conditions) or are at high risk of developing such needs and provide them with wellness and prevention programs, disease management, and complex case management, as indicated
- ACOs must make available or support providers' use of electronic prescribing, meaningful use of health information, electronic health records systems, disease registries, and self-management tools
- *MH/SUD providers must be prepared to work in this environment and develop the necessary tools and resources as well as refined processes and workflow that support collaborative and coordinated care*






Incentives to Participate in an ACO

- Identified population
- Market share
- Some administrative fees for administrative duties
- Reliable referral sources within network
- Common values and objectives (coordination, cooperation, collaboration)
- Shared information (whole health)
- Shared savings (financial incentives)

Multiple Chronic Conditions

- The proportion of Medicaid beneficiaries with disabilities who are diagnosed with three or more chronic conditions ranges between 35% and 45%.
- The frequency of psychiatric illness among Medicaid beneficiaries with disabilities ranges from 29% to 49%.
- Psychiatric and substance use disorders are represented in three of the top five most prevalent pairs of diseases, or dyads, among the highest-cost 5% of Medicaid beneficiaries.

The **Cost** of Health Care in America

2009		17.6% of GDP
1999		13.8%
1989		11.8%
1979		8.6%
1969		6.7%

Source: CMS, Office of the Actuary, National Health Statistics Group

Market Research

- **Local Hospitals & Primary Care Networks**
 - Multi-specialty groups
- **State and Regional Health Plans and Managed Care Organizations**
 - State Department of Insurance
 - State Associations of Health Insurance Plans
- **Self-Insured Employers**
 - Regional and State Business Group on Health
 - Employers' Health Coalitions
- **Foundations**
 - Kaiser Family Foundation (website and newsletters)
- **Federal and State Agencies**
 - Medicaid, HHS, CMS, HRSA, and SAMHSA web sites

Contracting Imperatives

- Review contracts from multiple perspectives:
 - Legal
 - Financial
 - Clinical
 - Ethical
 - Practical Operational
 - Strategic

Strategic Concerns

What makes your decision to contract "strategic?"

- The contract reflects your vision, your image of what it is you're becoming
- It supports your mission, how it is that you will strive to realize your vision
- It helps you accomplish organizational goals and objectives

Thank You

Questions and Contact

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