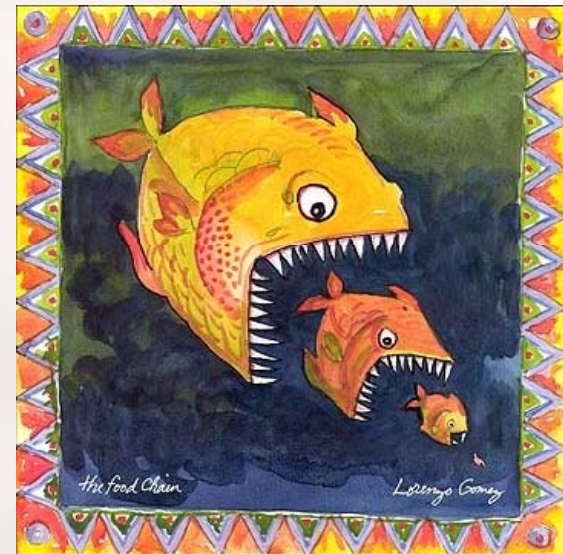


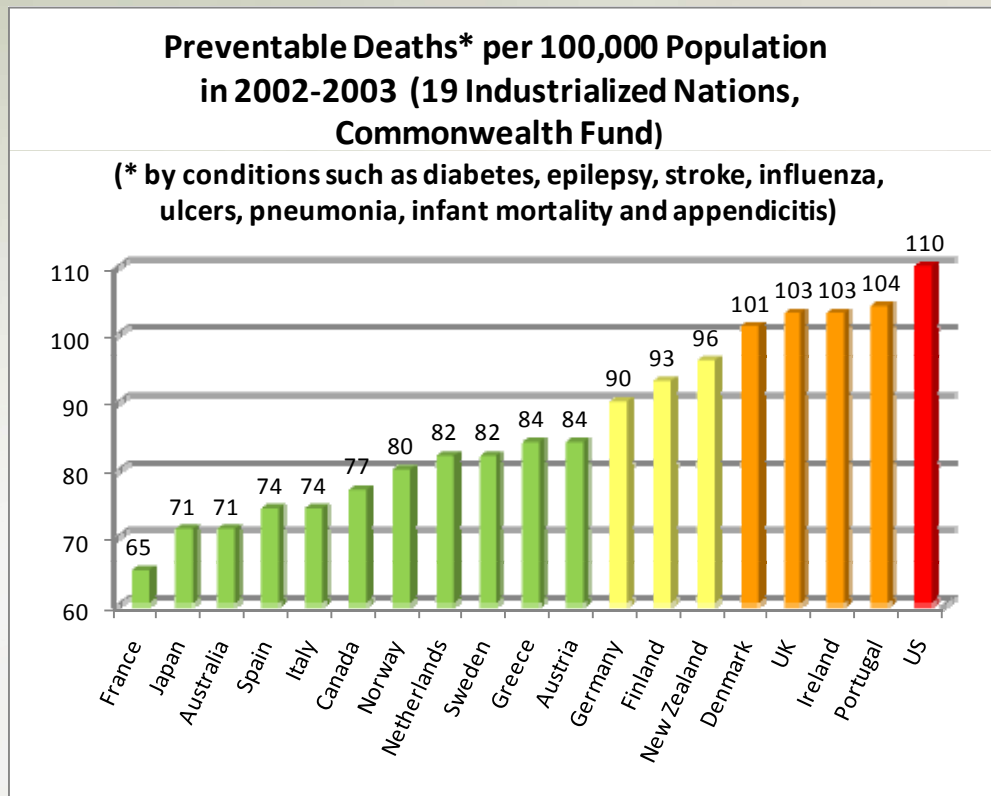
What is an Accountable Care Organization... And Why Should I Care?

Dale Jarvis, CPA
MCPP Healthcare Consulting
dale@mcpp.net



The Situation

"The American healthcare system is a dysfunctional mess." (Ezekiel Emanuel, MD, Chair of the Department of Bioethics at the Clinical Center of the National Institutes of Health)



As much as **30%** of health care costs (*over \$700 billion per year*) could be eliminated without reducing quality

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



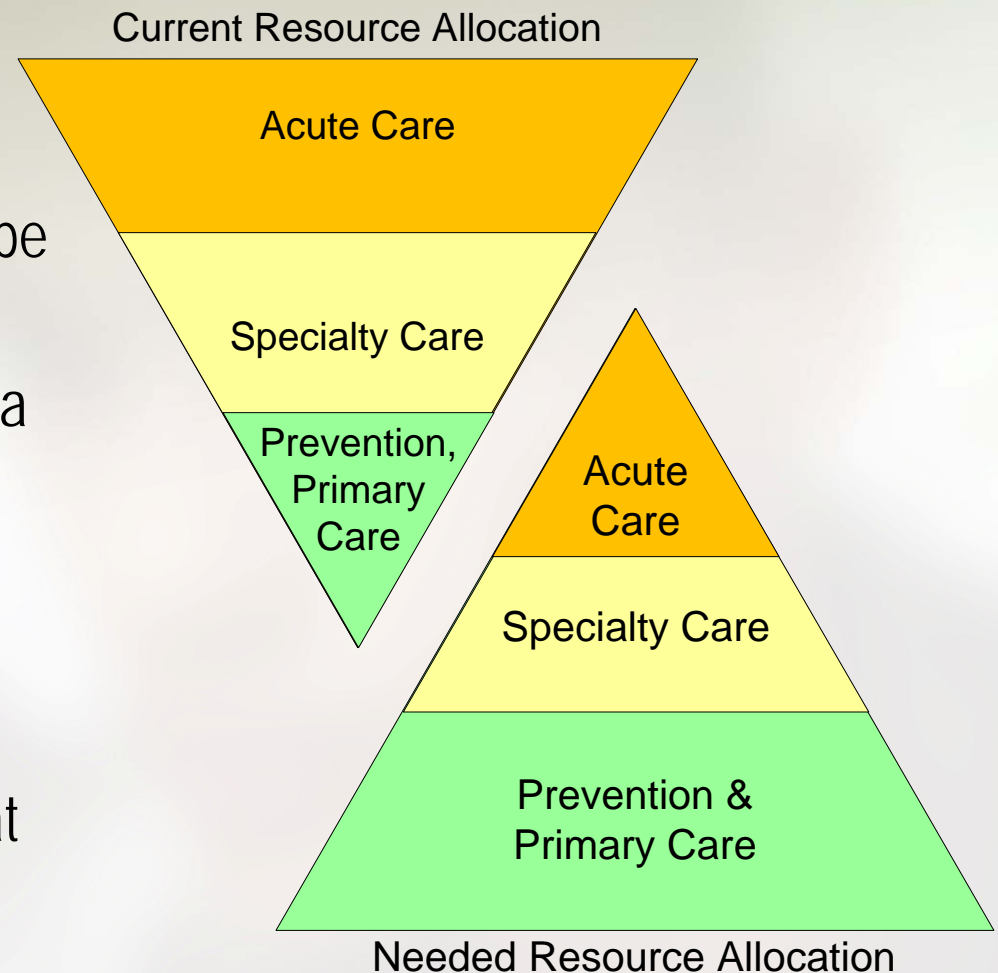
- Dramatically improving the *management of chronic health conditions* for the 45% of Americans with one or more such conditions whose treatment draws down 75% of total medical costs



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

Delivery System Redesign *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

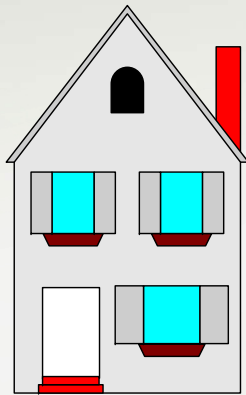


How do we "Flip the Triangle"?

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

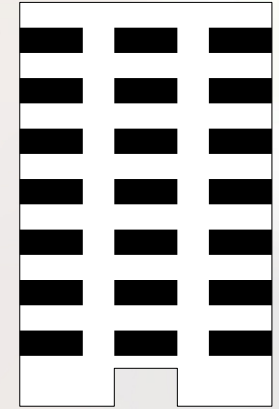
Expand the use of
Evidence-Informed Care

Promote Early Intervention

Decrease Overuse and
Underuse of Services

Improve the
Coordination of Care

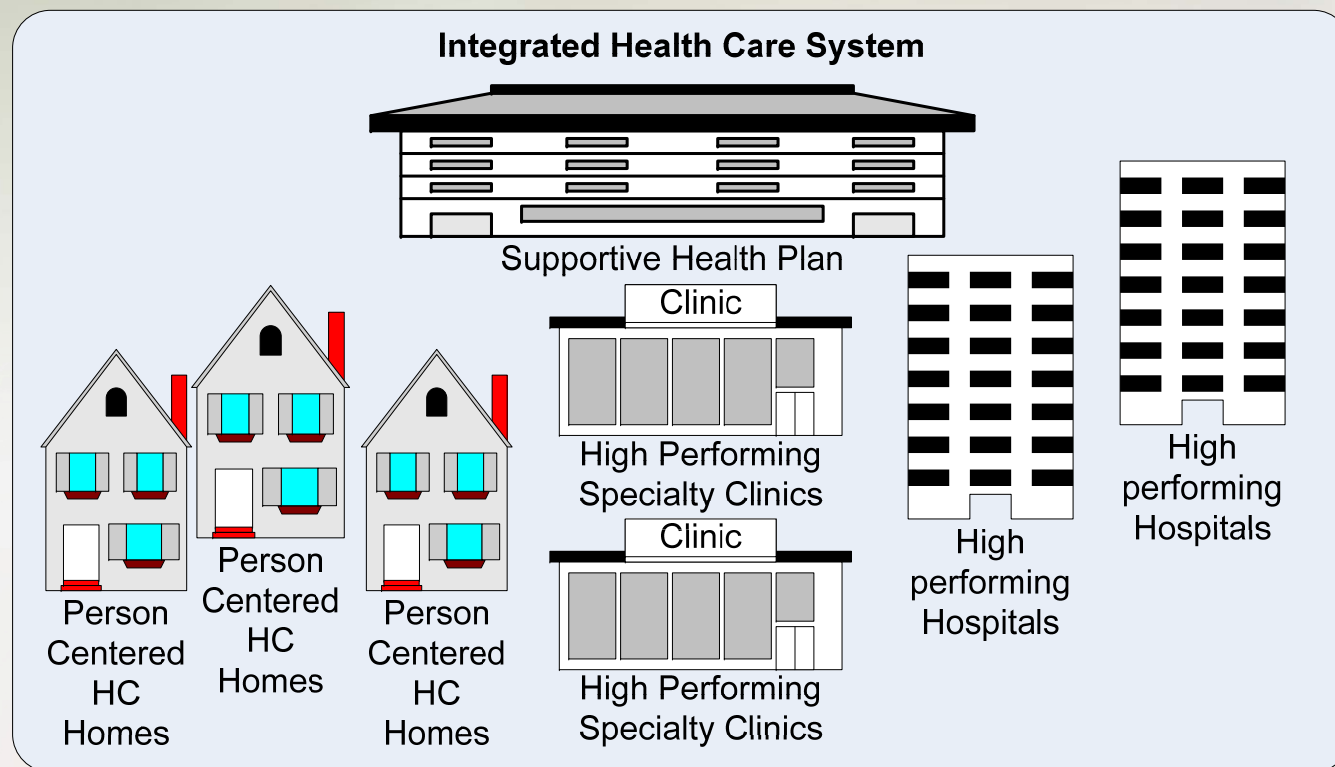
Reduce Error Rates



Inpatient:
Reducing
Errors &
Waste

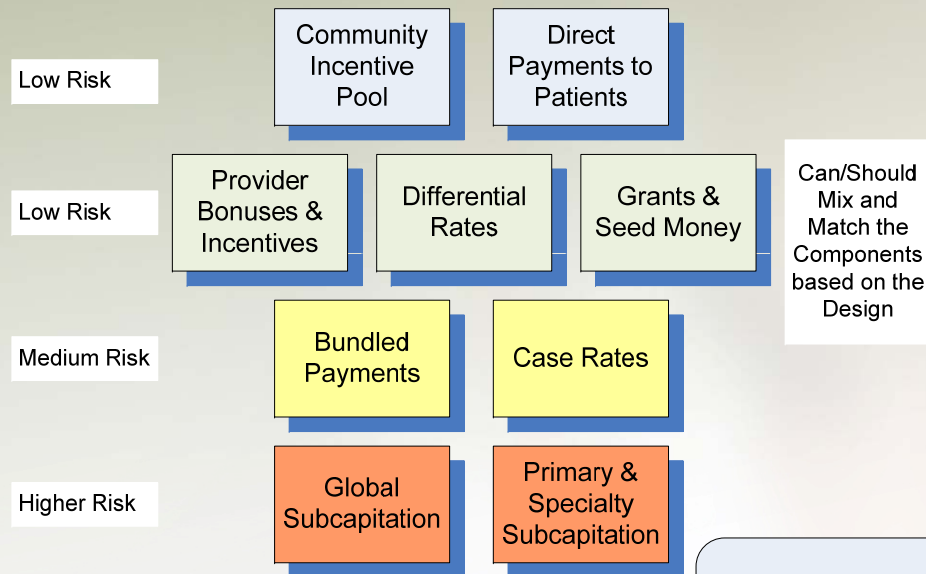
Integrated Health Systems – The Holy Grail

Global Capitation to an Integrated Health System

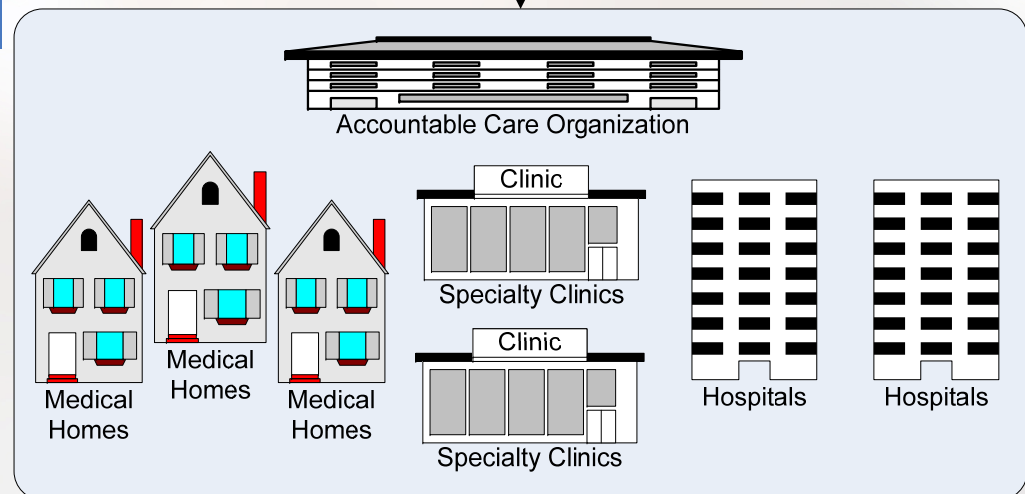
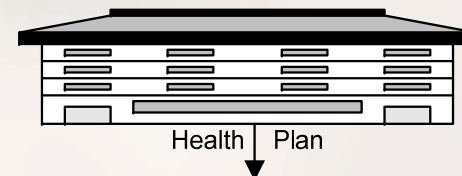


But... Integrated Health Systems represent only 10% of the Delivery System

What about the other 90 percent?



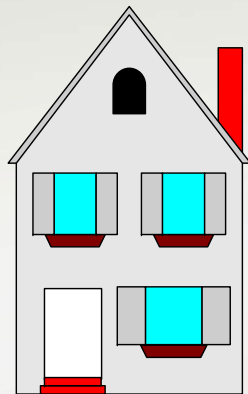
New Payment Models



New Organizational Structures

Value-Based Purchasing – Medical Homes

- 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

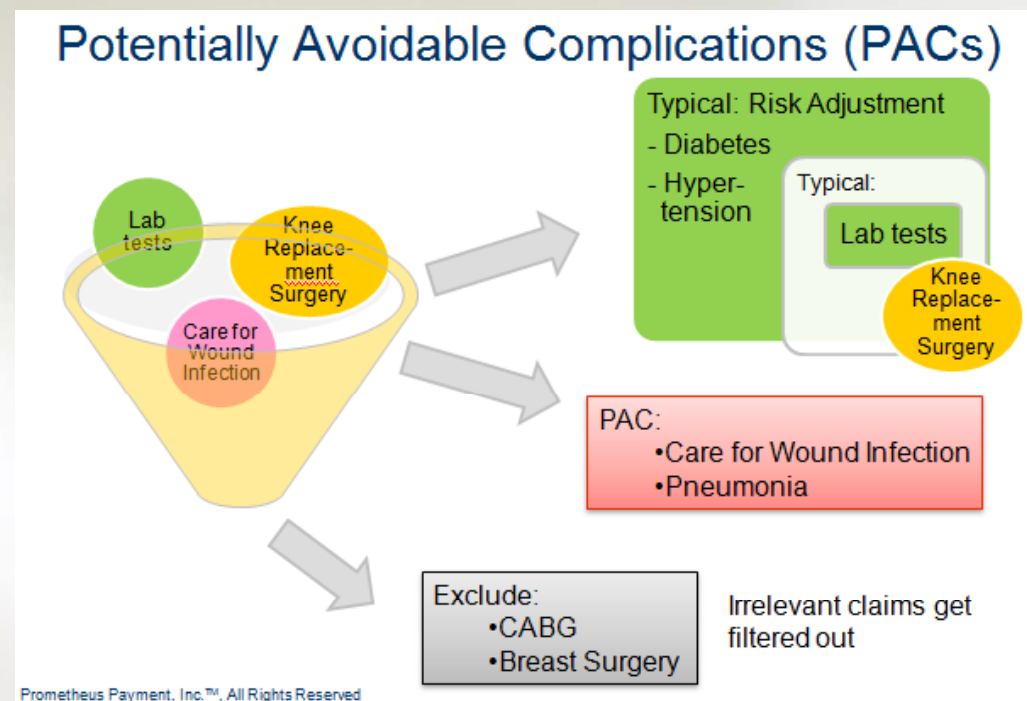
- Per Service Payment
- Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls

Bonus

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

Value-Based Purchasing – Inpatient Care

- Payment for inpatient care will bundle hospital and physician services
- Bundled payments that only pay for part of Potentially Avoidable Complications (PACs) will penalize providers that have higher error rates and reward those with lower PAC rates
- Bundled payments may include all costs in the 30 days post an inpatient stay, including any return to the hospital



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

So How does the MH/SU Delivery System Fit into the new Healthcare Ecosystem?

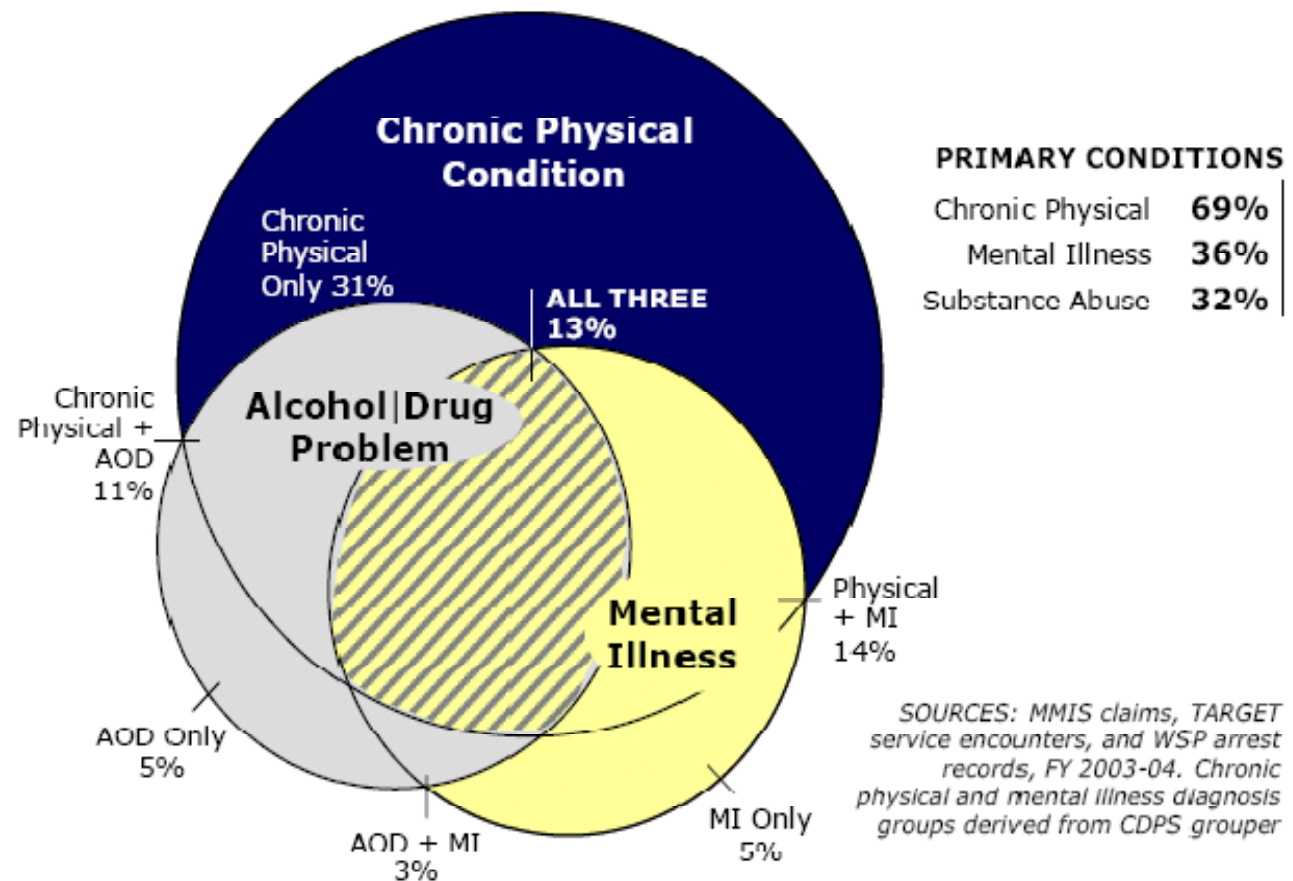


We Can't Bend the Cost Curve without addressing MH/SU Disorders

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



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

California Fee for Service Medi-Cal Analysis - 2007

	Medi-Cal FFS Total	Medi-Cal FFS SMI	Metric
Medi-Cal FFS Enrollees	1,580,440	166,786	11% SMI % of Total
Medi-Cal FFS Costs	\$6,186,331,620	\$2,395,938,298	39% SMI % of Total
Medi-Cal FFS Cost/Enrollee	\$3,914	\$14,365	3.7 SMI/Non-Ratio
Diabetes	4%	11%	2.8 SMI/Non-Ratio
Ischemic Heart Disease	2%	6%	3.0 SMI/Non-Ratio
Cerebrovascular Disease	1%	3%	3.0 SMI/Non-Ratio
Chronic Respiratory Disease	5%	13%	2.6 SMI/Non-Ratio
Arthritis	2%	7%	3.5 SMI/Non-Ratio
Health Failure	1%	3%	3.0 SMI/Non-Ratio
Inpatient Episodes	100	293	2.9 SMI/Non-Ratio
ER Visits	337	1,167	3.5 SMI/Non-Ratio
Inpatient Acute Days	609	2,094	3.4 SMI/Non-Ratio
Primary Care Visits	128	492	3.8 SMI/Non-Ratio
Specialist Visits	1,211	6,058	5.0 SMI/Non-Ratio

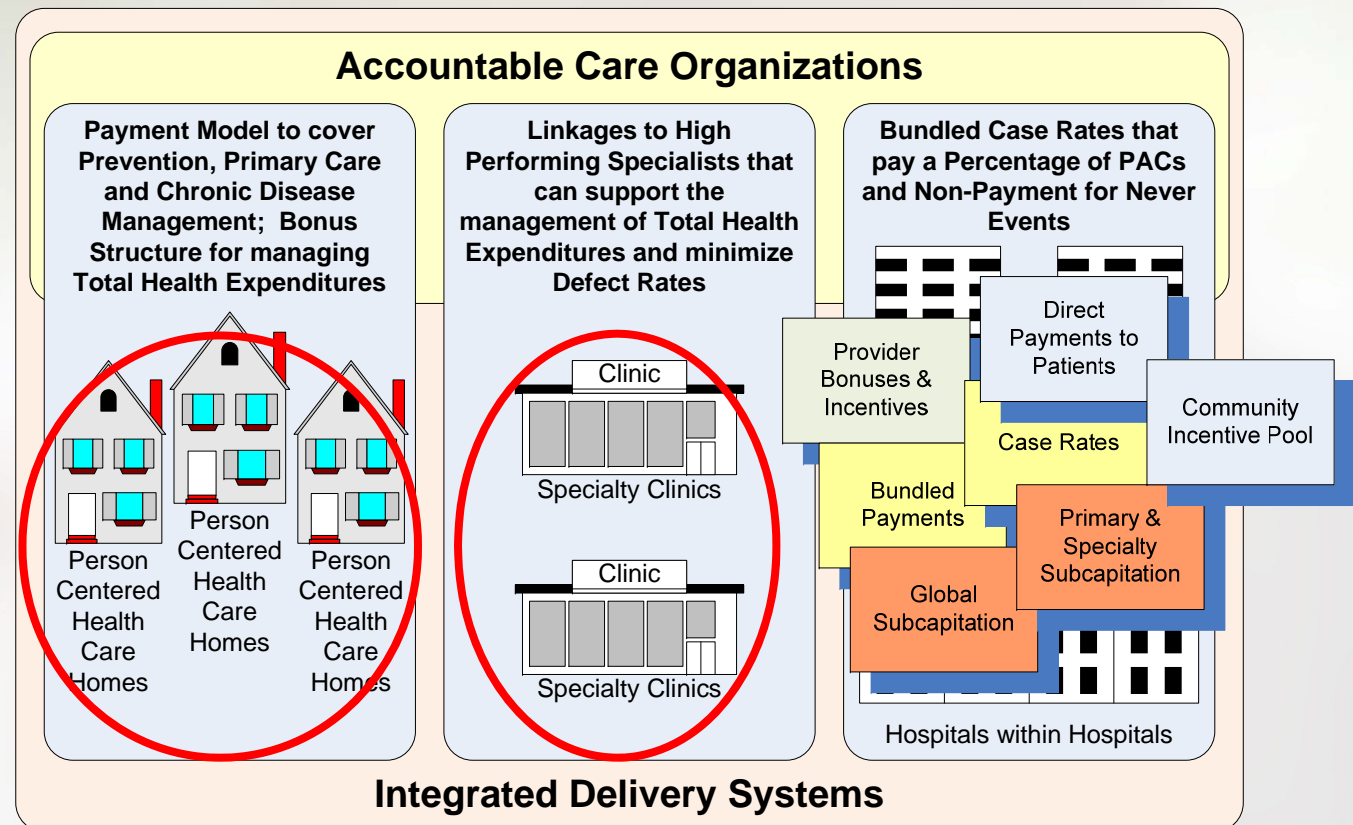
Prepared by JEN Associates, Cambridge, MA

So How does the MH/SU Delivery System Fit into this New Ecosystem?

The MH/SU delivery system has two roles to play:

- Integration of CBHOs into Person Centered Healthcare Homes
- High Performing, Recovery and Wellness-Oriented MH/SU Providers

And, in both cases, Providers will need to learn to operate within the payment reform rules



“Customization” of Medical Homes

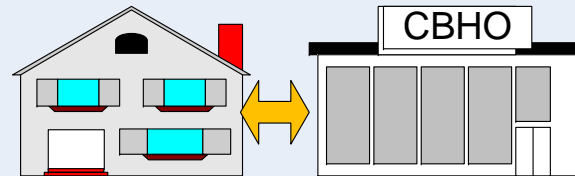
- Analogy: Generic Hospital Beds and ICU
- Customization of Medical Homes – different models for different needs
 - Seniors in nursing homes
 - Adults with a SMI
 - Inuits in rural Alaska
- Person-centered healthcare homes in CBHOs will be one of many designs used to bend the cost curve



Behavioral Health Customization: Person-Centered Healthcare Homes

Bi-Directional
Care:
Behavioral
Health in
Primary Care
and
Primary Care
in Behavioral
Health

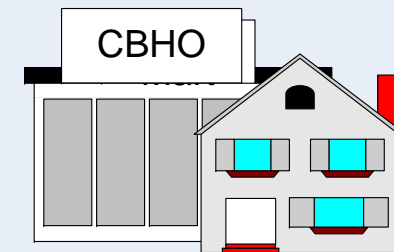
Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity



Primary Care
Clinic with
Behavioral
Health
Clinicians
embedded,
providing
assessment,
PCP
consultation,
care
management
and direct
service

Partnership/
Linkage with
Specialty CBHO
for persons who
need their care
stepped up to
address
increased risk
and complexity
with ability to
step back to
Primary Care

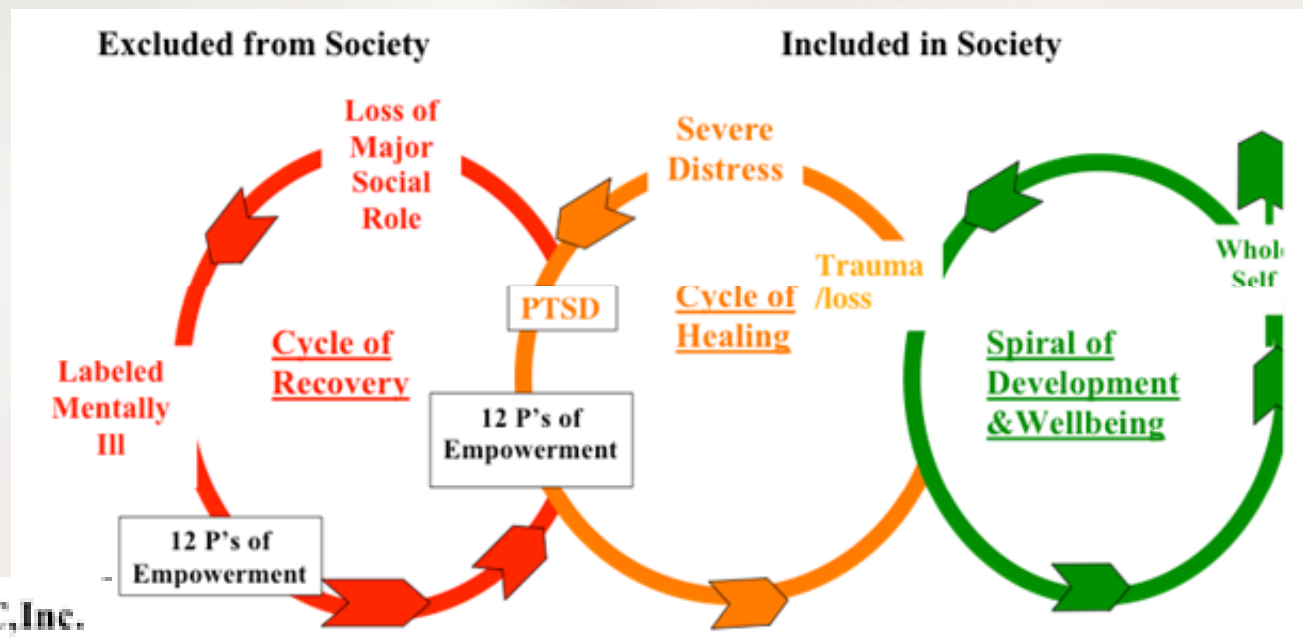
Clinical Design for Adults with Moderate to High BH Risk and Complexity



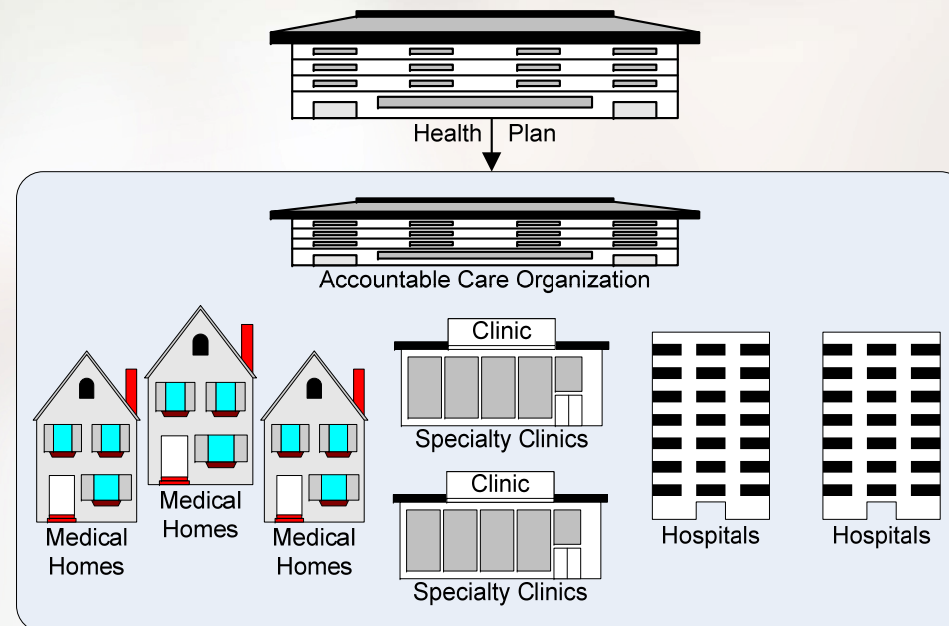
Community Behavioral Healthcare
Organization with an **embedded
Primary Care Medical Clinic** with
ability to address the full range of
primary healthcare needs of
persons with moderate to high
behavioral health risk and
complexity

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

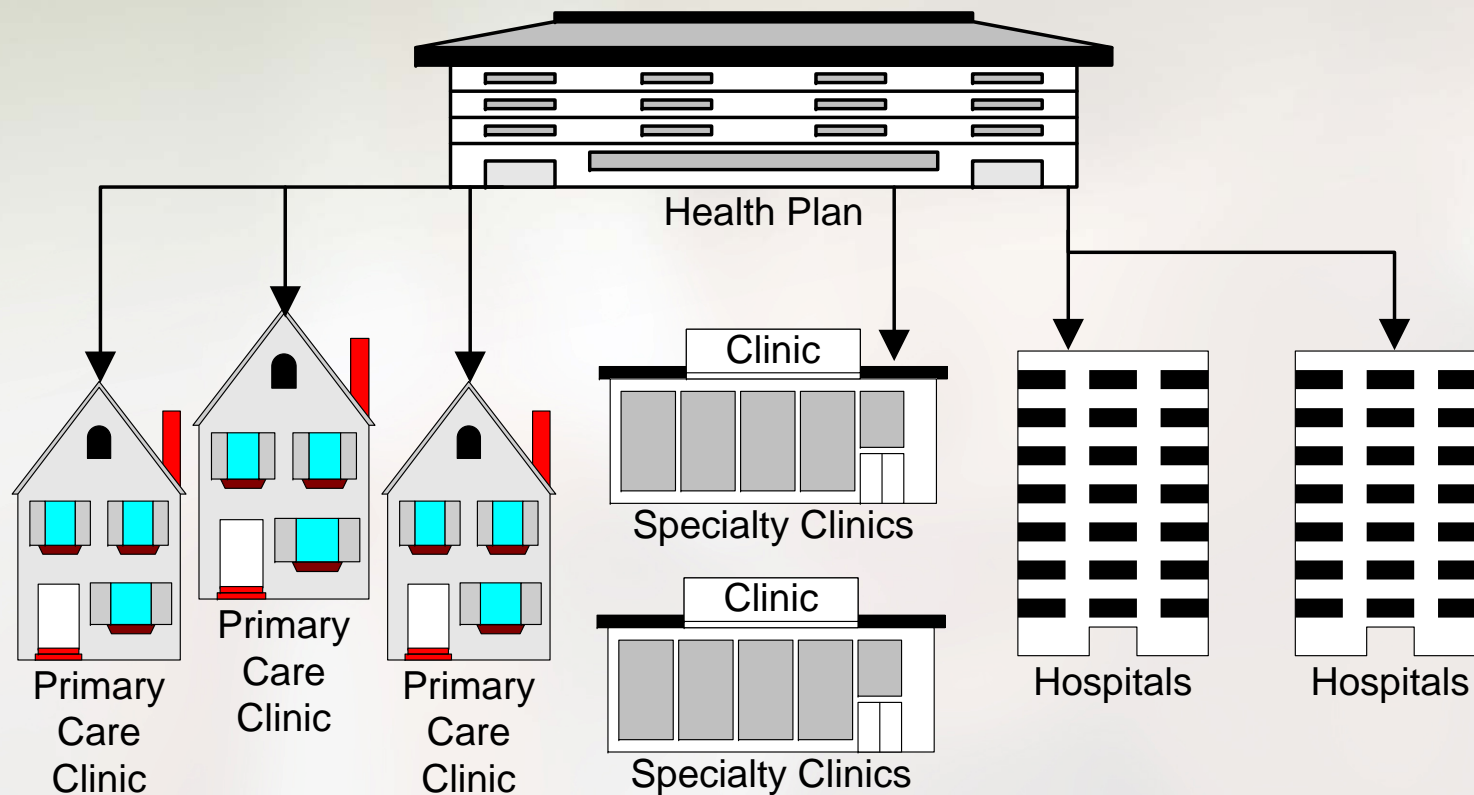


Key to Supporting New Service Delivery and Payment Models: Accountable Care Organization



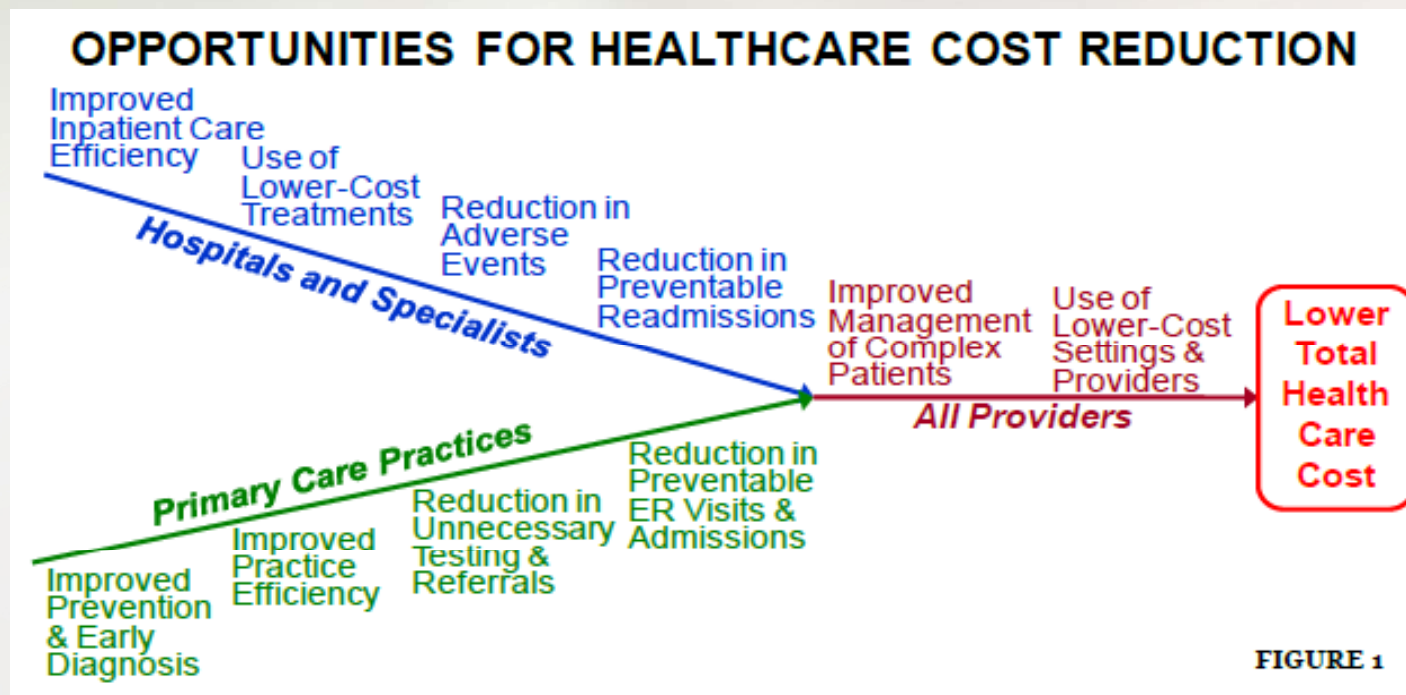
The Status Quo

- Fee-For-Service, Non-Integrated Model: All the wrong incentives and disincentives



Accountable Care Organizations (ACOs)

- ACOs dual purpose:
 - Organization structure for managing bundled payments for inpatient care
 - Vehicle for small to mid-sized primary care practices that want to become Person-Centered Medical Homes



ACOs are Coming: Federal Initiatives

- **Congress and CMS**: an ACO would have at least one hospital, a minimum of 50 physicians (primary care and specialists), commit to be in business for at least 3-5 years, and serve at least 5,000 patients
 - If the ACO met pre-established quality goals, it would receive an incentive payment
 - Penalties would be assessed if care did not meet the quality goals established
 - Incentive payments and penalties would be split between the members of the ACO
 - The providers in the ACO would follow best practices, be patient-centered and contribute to the development of best clinical practices to build standards of evidenced-based medicine
- **Medicare**: Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve (2012); foundation for bundled payments
- **Medicaid Demonstration Projects**:
 - Pay bundled payments for episodes of care that include hospitalizations (2010-2016)
 - Make global capitated payments to safety net hospital systems (FY2010-2012)
 - Allow pediatric medical providers organized as ACOs to share in cost-savings (2012-2016)

ACOs are Coming: State Initiatives

- Minnesota: H.F. No. 3709, as introduced - 86th Legislative Session (2009-2010)
Posted on Mar 18, 2010

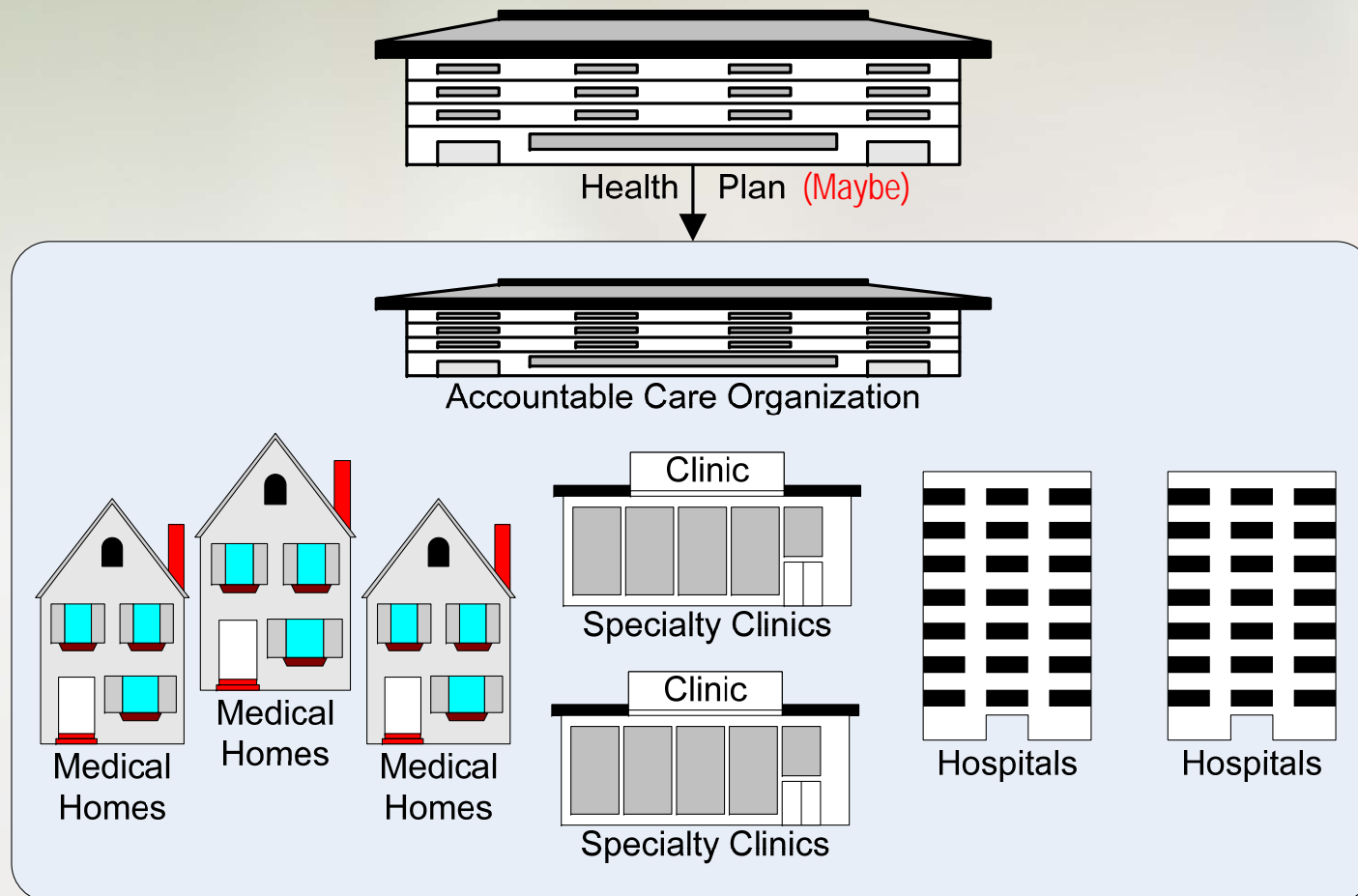
6.13 Sec. 10. Minnesota Statutes 2008, section 256B.0754, is amended by adding a
6.14 subdivision to read:
6.15 Subd. 3. **Accountable care organizations.** By July 1, 2011, the commissioner of
6.16 human services shall deliver services to enrollees in state health care programs through
6.17 accountable care organizations, and shall provide incentive payments to accountable care
6.18 organizations that meet or exceed annual quality and performance targets. Accountable
6.19 care organizations and incentive payments must meet the standards specified in Public
6.20 Law Number 111-XXX.

- Massachusetts: 1115 WAIVER AMENDMENT Submitted: March 1, 2010

On July 16, 2009, the Commission released a unanimously-approved final report, which recommended a shift by all payers to a system of global payments, through a framework of accountable care organizations (ACOs) and an emphasis on the medical home model... The Commonwealth is currently developing legislation to enact these recommendations, and looks forward to integrating them into the Commonwealth's upcoming Demonstration renewal.

Accountable Care Organizations (ACOs)

- Accountable Care Organization (ACO) Model

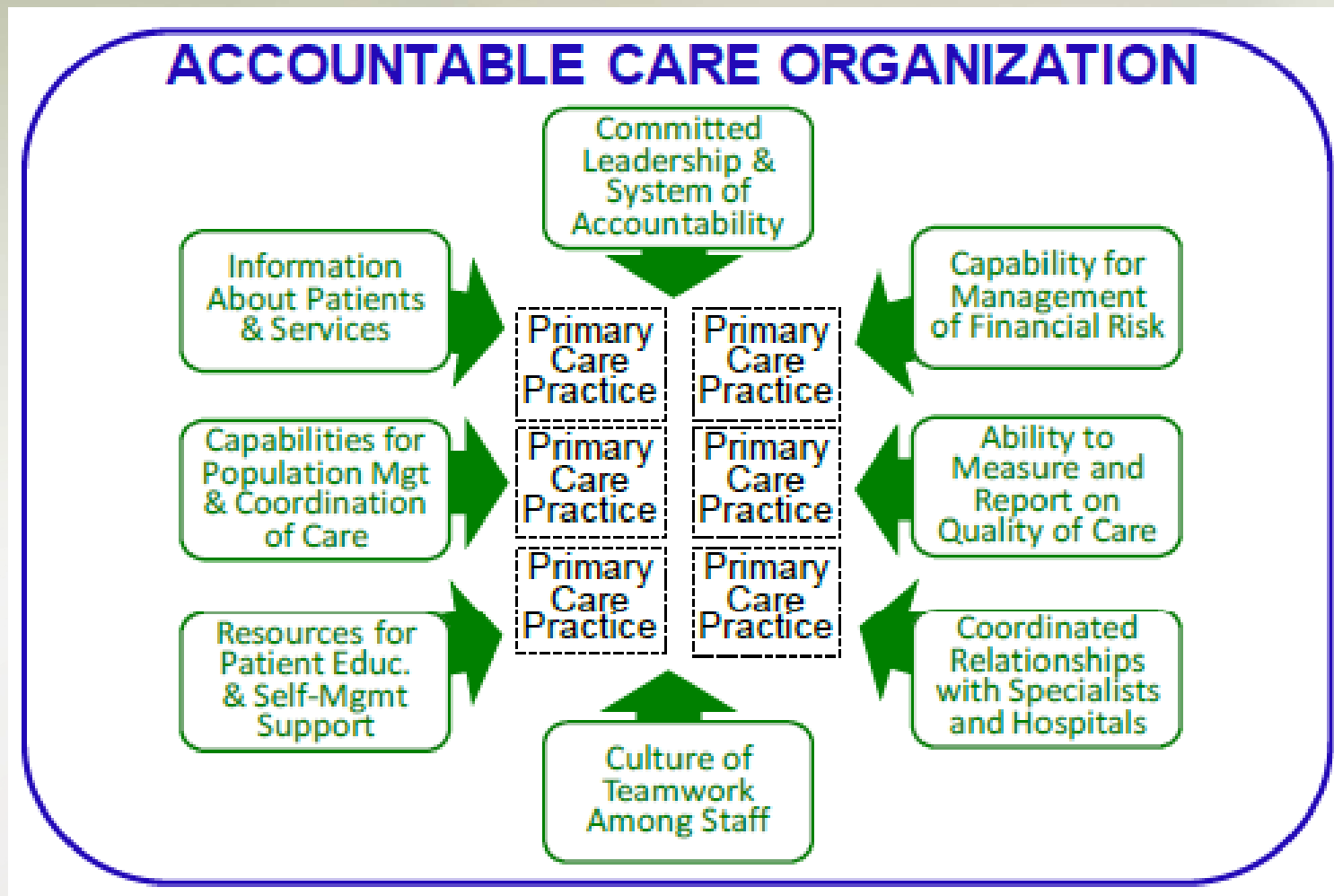


Who may be ready to become an ACO now?

Exhibit 1. Accountable Care System Models and Core Capabilities

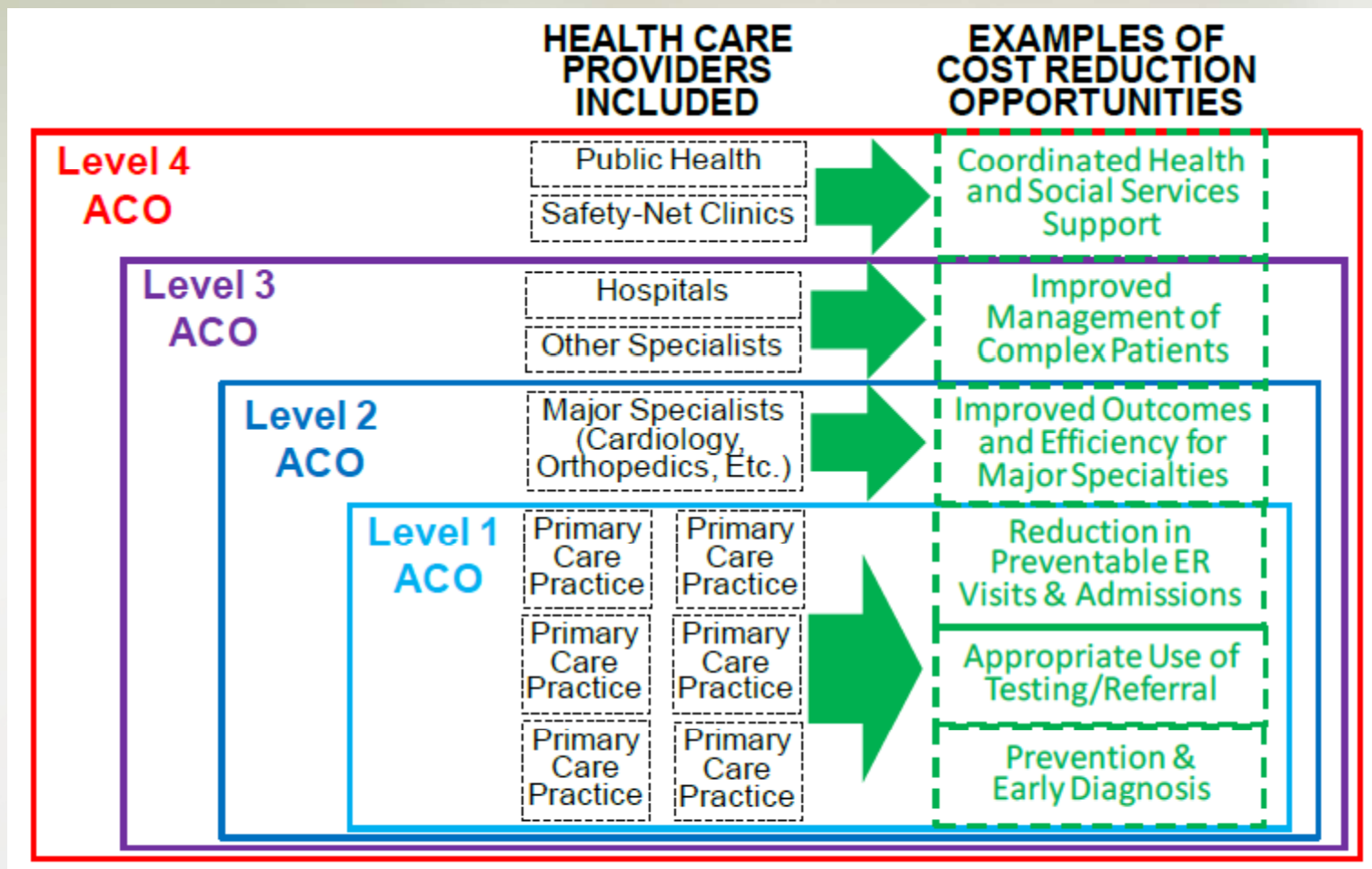
<u>Accountable Care System Models</u>	Redesign Care Processes	Teamwork	Care Coordination	<u>Core Capabilities</u>			
				Performance Accountability	Information Technology	Knowledge Management	Change Management
(1) Multi-Specialty Group Practice (MSGP) ^a	High	High	High	High	High	High	Medium
(2) Hospital Medical Staff Organization (HMSO) ^b	Medium	Medium	High	High	High	Low to Medium	Low to Medium
(3) Physician Hospital Organization (PHO) ^c	Medium	Medium	Medium	High	High	Medium	Medium
(4) Interdependent Provider Organization (IPO) ^d	Low	Low	Low to Medium	Medium	Low	Low	Low
(5) Health Plan Provider Organization / Network (HPPO/HPPN) ^e	Medium	Low to Medium	Low to Medium	Medium to High	Low to Medium	Low to Medium	Low to Medium

Level 1 ACOs: The Foundation

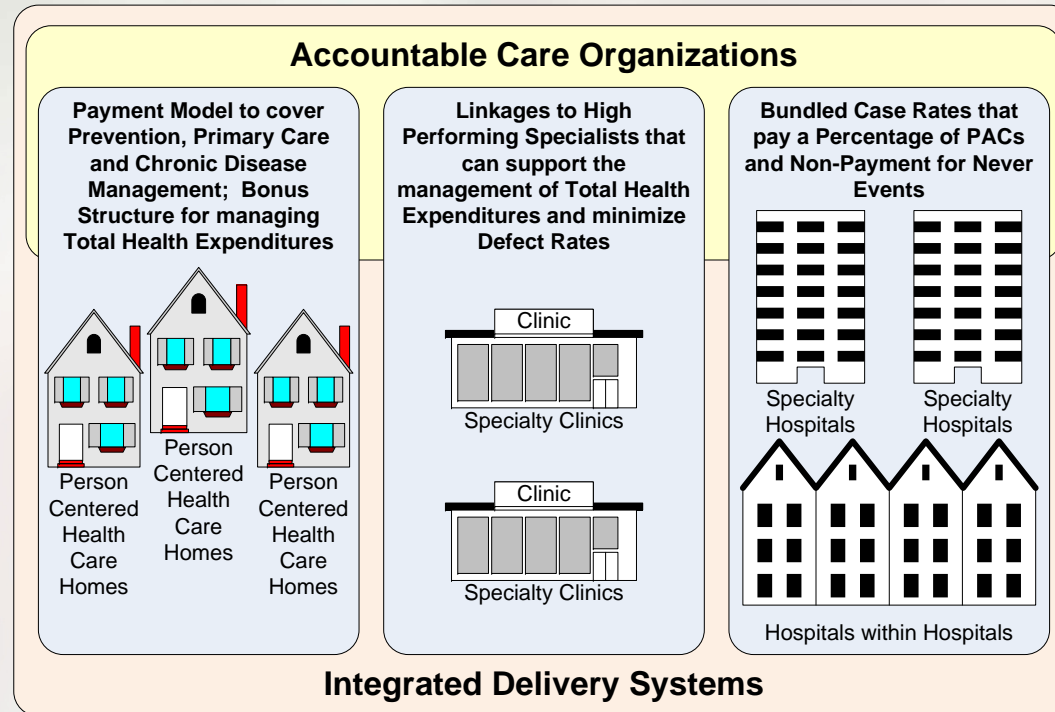


Four Levels of ACOs – All Healthcare is Local

- Four Levels of ACO are being proposed:



So Tell Me Again... How does the MH/SU Delivery System Fit into the new Healthcare Ecosystem?

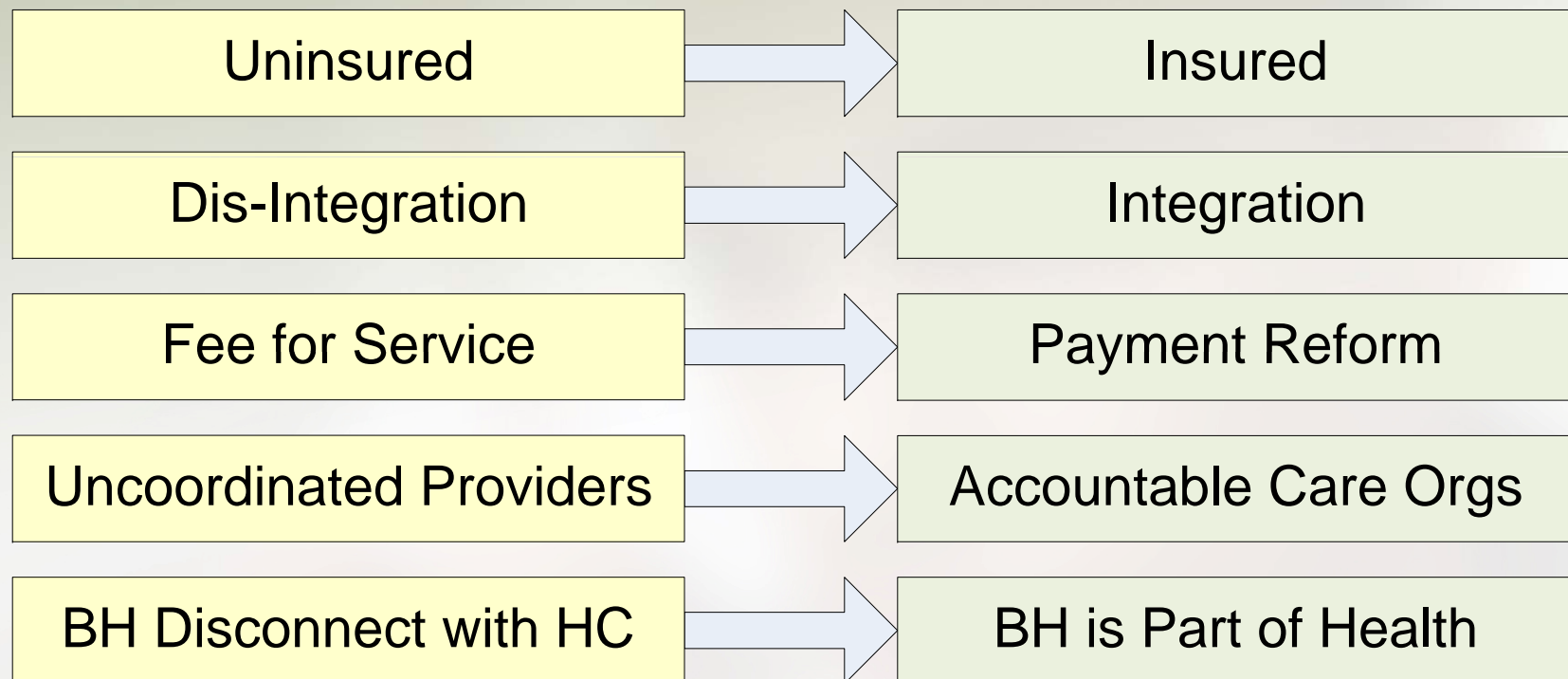


So How does the Behavioral Health System Fit into this New Ecosystem?

- We've learned from 50 years of effort that if you work in the BH Safety Net...
- Focusing inward to create a high-performing MH/SU Provider Organization does not always prevent you from ending up at the bottom...



Many Wheels are Turning



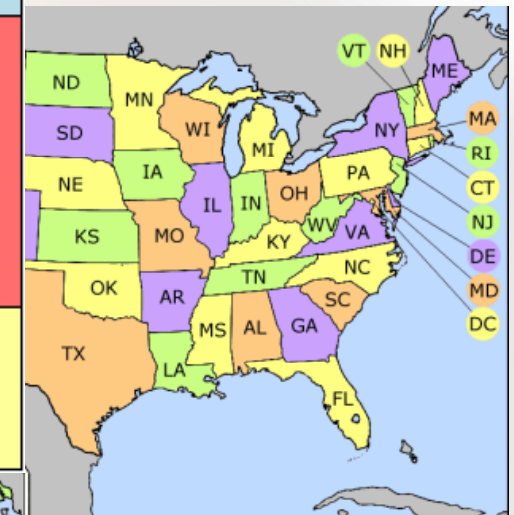
Are State MH Authorities Ready?

- Begin by assessing how things will unfold in your state

- **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

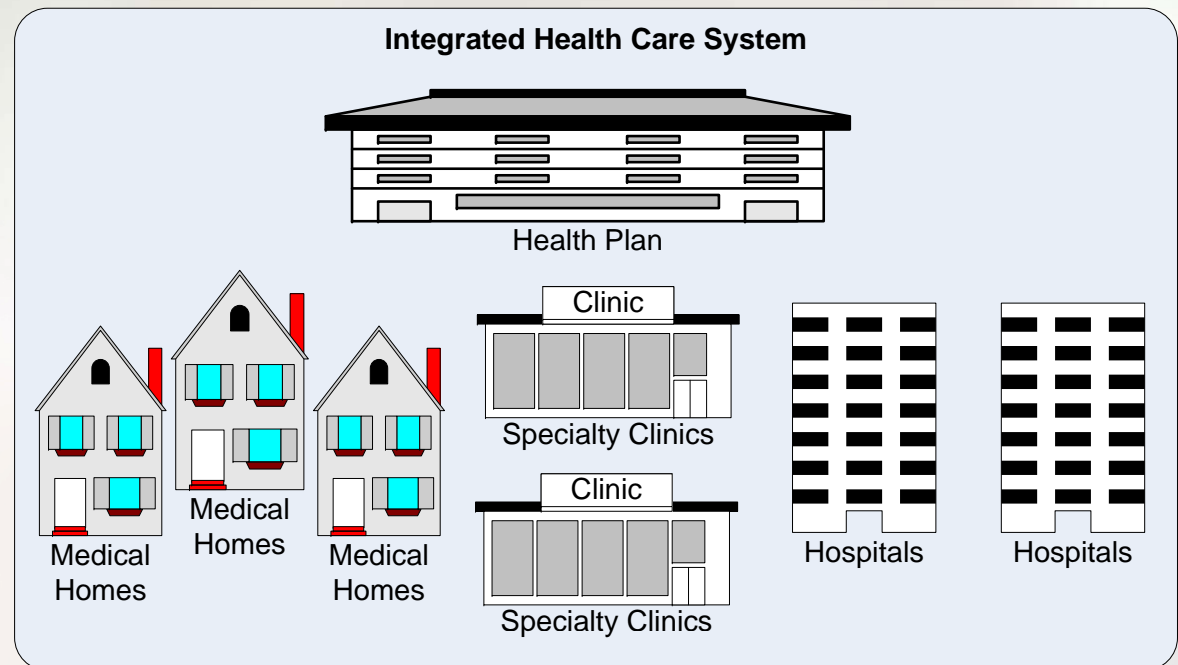
	Low Change	Moderate Change	High Change
Carve-In	Carve-in will continue to be used to organize service delivery integration; very few examples of this model	Carve-in will continue to be used to organize service delivery integration; very few examples of this model	Carve-in will continue to be used to 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

How do MH/SU Providers Prepare?

Integrated Healthcare System

- If you are operating in a state and community where integration efforts are under way and the IHS model is being pushed, your choices are:

- Do nothing and hope they ignore the SMI/SED population
- Become a **Preferred Provider** of an IHS
- Create a consortium of BH Providers and contract with the IHS as a **Provider Network**

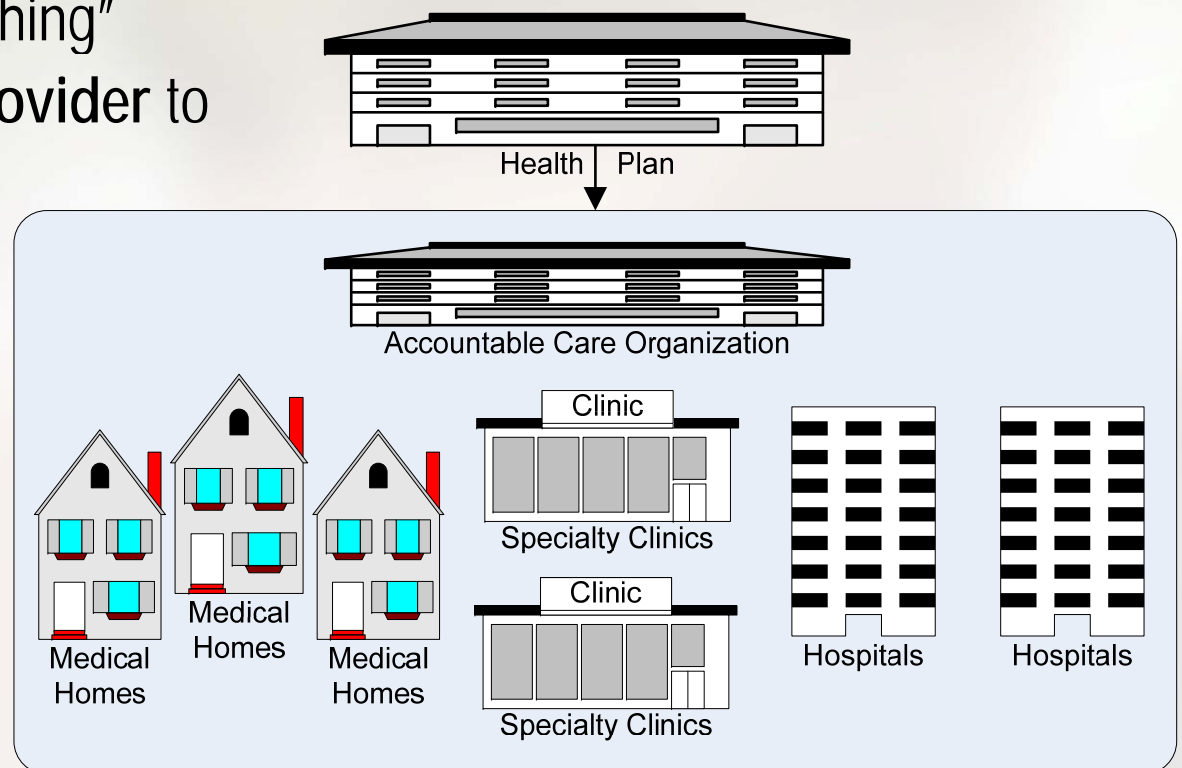


- Become an **Acquisition Target** and become part of the IHS' BH Division

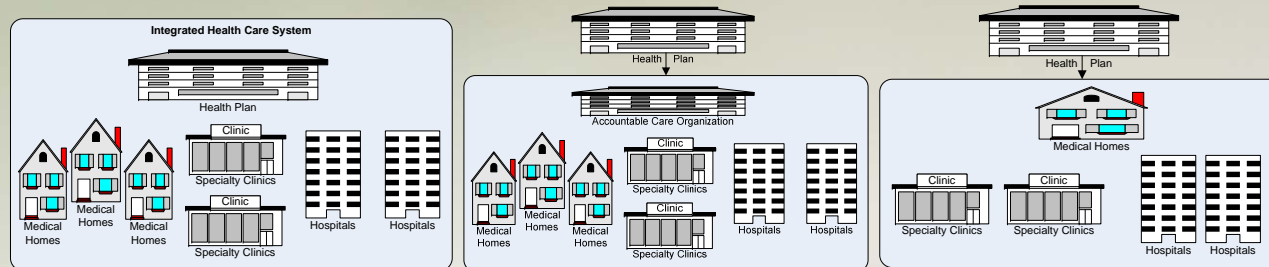
How do MH/SU Providers Prepare?

Accountable Care Organization

- If you are operating in a state and community where integration efforts are under way and the ACO model is being pushed, your choices are:
- I'm going to skip "do nothing"
- Become a **Preferred Provider** to the ACO
- Become a **Member** of the ACO
- Get in on the ground floor and become a **Founding Member/Owner** of the ACO



Get ready... it's going to Happen



- Medicaid, Medicare and Private Health Plans read the same studies I do and realize that they cannot bend the cost curve without addressing the needs of persons with MH/SU disorders
- Fee for Service is going away, to be replaced by Value-Based Purchasing models that offer risks and rewards to health and behavioral health providers and necessitate infrastructure development
- High Performing, Recovery-Oriented MH/SU Providers can play an enormously effective role in helping their healthcare partners improve health status & bend the curve
- Participating at the System Management Level (IHS, ACO) is an important survival strategy

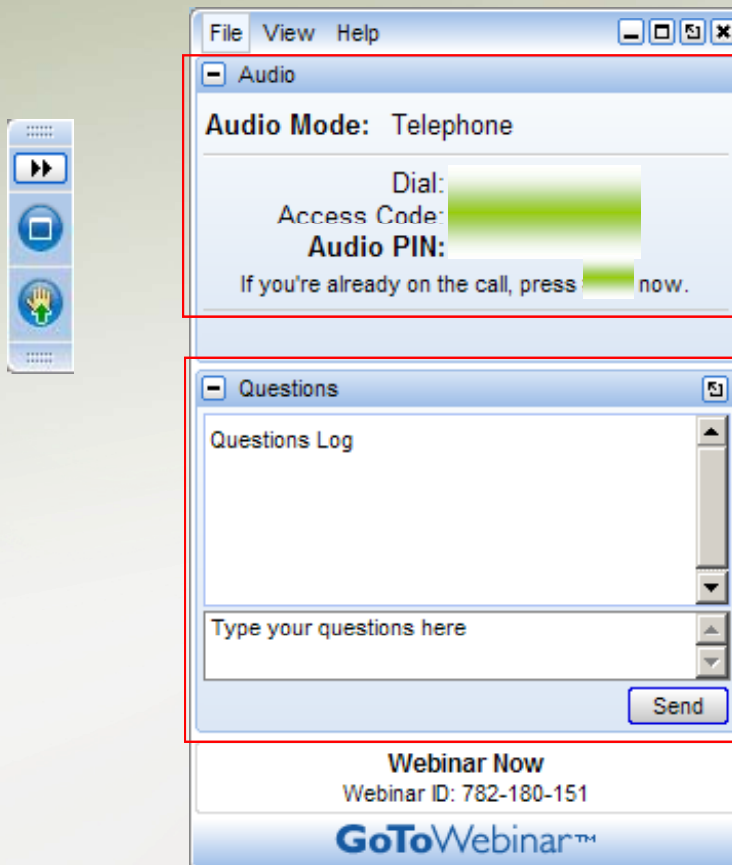


Q&A

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