Experience of Behavioral Health under Medicare Accountable Care Organizations (ACOs)

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Medicare ACOs

- The concept of the Accountable Care Organization (ACO) as a public health program element was initially promoted as an option for the Medicare program and, as proposed, offered little room for participation by behavioral health providers, either as lead entities in forming ACOs or as participants in ACO networks.

- The opportunity for behavioral health providers to become part of the ACO structure grew marginally with adoption of the final version of the regulations governing the Medicare Shared Savings program.

- But participation was still to be restricted by the attribution of patient outcomes to the patients' primary care providers and a continued limitation on which behavioral health providers could participate.

Promise of ACOs

- The promise that the ACO model could serve as a means of integrating behavioral and medical services in both the Medicare and Medicaid programs has not been achieved.

- Although researchers have found significant interest in integrating behavioral health providers into the ACO model, challenges have been posed by behavioral health workforce shortages and the slow adoption of costly health information technology by behavioral health providers lacking access to the Medicaid and Medicare meaningful use provider incentives available to other types of providers.

- Even within ACOs striving toward achieving integration, levels of integration vary among sites.

Medicare Shared Savings Program

- Nevertheless, the Federal public program Accountable Care Organization concept, as initially formulated by Congress and implemented by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Shared Savings program, was not one which welcomed or even envisioned the inclusion of behavioral health providers, either in forming ACOs or as participants in ACO provider networks.

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- Section 3022 of the Affordable Care Act authorized "ACO professionals" to form ACOs within a Medicare Shared Savings Program.

In doing so, it defined "ACO professional[s]" to include physicians, dentists, podiatrists, optometrists, chiropractors, PAs, NPs, or clinical nurse specialists, as long as those professionals were in:

- (1) group practice arrangements,
- (2) networks of individual practices,
- (3) partnerships or joint venture arrangements between hospitals and ACO professionals,
- (4) hospitals employing ACO professionals, or
- (5) any other groups of providers of services and suppliers the Secretary determines appropriate.

- Underlying statutory authority did not explicitly authorize any type of BH provider to form an ACO, although authorization for MD-formed ACOs arguably implicitly permitted psychiatrists, as physicians, to form ACOs.

“Screening for Depression.”

- In the final MSSP/ACO regulations published in November 2011, “at risk beneficiary” was explicitly defined for the first time to include an individual diagnosed with a mental health or substance use disorder.

- Of the 333 MSSP ACOs and 22 Pioneer (alternative model, developed as an afterthought in 2012, with higher levels of savings and risk) ACOs operating in 2014, all improved in 27 of the 33 quality metrics and 53 percent met spending targets set under the MSSP.

- However, only one of those 33 quality metrics was behavioral health-related—“Screening for Depression.”

Medicare Shared Savings Program (MSSP) Regulations

- In April 2011, when CMS first proposed the Medicare Shared Savings Program (MSSP) regulations using ACOs as a means to achieve value-based services and integrate care within the Medicare program, it further limited the types of entities that could be authorized to form ACOs.

- CMS limited the term “ACO professional” to only doctors of medicine or osteopathy. It then limited the definition of a “hospital” authorized to form an ACO to acute care hospitals subject to a prospective payment system.

- Those limitation eliminated the possibility that psychiatric hospitals might be permitted to form ACOs.

ACO Limitations

- Although CMS permitted their participation within an ACO network, the preamble to the proposed regulations explicitly prohibited federally qualified health centers (FQHCs) and rural hospital centers (RHCs)—entities that might be providing behavioral health services on-site—from forming ACOs.

- Further limiting the ability of behavioral health providers to form or participate in ACOs was the assignment of enrollees to participating entities based on the identity of enrollee's primary care physician, defined as a physician with a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine (but not psychiatry).

- The final regulations did permit assignment based on primary care services furnished by FQHCs and RHCs, but only via attestation by a primary care physician who directly provided services at the FQHC or RHC.

“At-Risk Enrollees”

- Although the proposed regulations included the statutory threat of sanctions for avoiding the provision of care for “at-risk enrollees,” it did not explicitly define “at-risk enrollees” to include individuals with mental illness or substance use disorders.

It did define the term to mean individuals who:

- (1) have a high-risk score under CMS’ HCC risk adjustment model;
- (2) are considered high cost due to having two or more hospitalizations each year;
- (3) are dually eligible for Medicare and Medicaid;
- (4) have a high utilization pattern; *or*
- (5) have had a recent diagnosis that is expected to result in increased cost ... all categories into which individuals with behavioral health conditions might be considered to fall.

- In the preamble to the proposed regulations, CMS suggested that a number of chronic conditions might fall within the final category, including depression and dementia, but the preamble language lacked the force of law.

Medicare Shared Savings Program Savings Remain Elusive

- Only 92 ACOs earned shared savings bonuses from CMS. Eighty-nine MSSP ACOs reduced costs compared to their benchmarks, but did not qualify for incentive payments because they did not meet the minimum savings threshold.

- The Pioneer ACOs, which were entities with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements, did somewhat better, but only about one-half — 11 of 21 — earned the shared savings necessary to encourage them to continue in the ACO initiative.

- By January 2016, the number of Medicare ACOs had grown to over 477 nationwide, serving nearly 8.9 million enrollees since the Medicare Shared Savings Program began in 2012.

- In January 2016, CMS announced it was launching a new ACO model called the Next Generation ACO Model (NGACO Model). The initiative was intended to facilitate the Administration's goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to alternative payment models by the end of 2016 and 50 percent by the end of 2018.

NGACO Model in 2016

- The twenty-one ACOs selected to participate in the NGACO Model in 2016 had significant experience coordinating care for populations through ACO initiatives and included provider groups ready to assume higher levels of financial risk and reward, but even they achieved only limited profitability, with only four of the Pioneer ACOs and two of the MSSP ACOs earning savings to that point.

- Research by the AHA suggested there had been several key success factors for the ACOs selected by CMS to participate in the Next Gen model.

- Factors included redefining organizational, clinical, & network structures to create a highly integrated care delivery system, & recognizing opportunities for partnership or collaboration that supported care “across the entire HC system.”

Impact of the Medicare Shared Savings Model on Mental Health

- Two studies published in the July 2016 *Health Affairs* suggested that Medicare ACOs had had only limited success in improving the management of mental health.

- In the first study ("Busch study"), Pioneer ACO contracts were found to have lowered spending on mental health admissions in the first year of the ACO contract, but not in subsequent years.

- Spending was not lowered at all by the non-Pioneer ACOs studied. ACOs were found to have resulted in no changes in mental health admissions, increased outpatient follow-up after mental health admissions, increased diagnoses of depression, or improved mental health status

Lack of Integration

- The authors of the Busch study suggested that ACOs might not be well-positioned to manage BH care because of limited organizational integration of BH and primary care providers, citing an earlier study that concluded “few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care.”

- The authors attributed this lack of integration to several causes: the traditional separation of behavioral and medical care providers, inadequate behavioral health care training for the primary care physicians authorized to form ACOs, and different regulatory and billing requirements for behavioral health and primary care.

- The authors said that all of these impediments made it challenging for mental health & PCPs to integrate their workflows & practice models within the ACO structure.

Behavioral Health Workforce Shortages

- Busch *et al* suggested that, given the limited integration of mental health providers in ACO contracts, using information systems that support referrals to high-quality mental health providers might help.

- But they warned that behavioral health workforce shortages were likely constraining referral efforts, and even the effective integration of behavioral health providers into ACO contracts.

More Mixed Results

- The second July 2016 *Health Affairs* article (hereafter referred to as the "Fullerton study") offered a more optimistic outlook than the first.
- The authors examined qualitative data from 90 organizations participating in Medicare ACOs from 2012 to 2015 and found mixed degrees of engagement in improving behavioral health care for their enrollees.
- The challenges found in the second study included those same workforce shortages, a lack of data availability, and the difficulty of finding sustainable financing models.
- All this, despite what the authors found to be a substantial interest in integrating behavioral health among the majority of the ACOs surveyed.

High-Cost Behavioral Health Enrollees

- Authors of Fullerton study focused on extent to which ACOs recognized & focused on BH as an important contributor to improving quality of care & generating savings, the types of approaches ACOs used to address BH , and the primary challenges they faced when trying to implement improvements in BH care.

- They found that almost all ACO personnel recognized the contribution of behavioral health disorders to high utilization and spending. At many ACOs, care coordination teams recognized that a greater percentage of their high-risk and high-cost enrollees had complex behavioral health and psychosocial needs.

- Furthermore, the ACOs recognized the connection between high-cost behavioral health enrollees and repeat hospitalizations, repeated uses of the emergency department, and longer than expected hospital stays.

Referral Networks

- Fullerton *et al* found that multiple ACOs adjusted their referral networks to better serve enrollees with behavioral health needs by improving connections to community resources, partnering with a behavioral health facility to improve access to care, and/or reorganizing internal behavioral health resources to improve access to and coordination with primary care providers.

- Some of the ACOs surveyed used FQHCs to provide integrated care, while others included as a partner a significant outpatient MH facility, such as a community mental health center or other large stand-alone mental health provider.

- Other ACOs created either contractual or informal partnerships with behavioral health organizations.

Challenges for Medicare ACOs: 1. A Scarcity of Behavioral Health Workforce

Both those ACOs that addressed behavioral health issues and those that did not identified the following challenges to doing so in the Fullerton study:

1. **A scarcity of behavioral health workforce** was frequently cited, either within the ACO itself or within the surrounding community to whom patients could be referred, particularly a lack of psychiatrists and other behavioral health professionals with expertise in substance use disorders.

- The geographic constraints of being located in a rural or remote area were often factors. Poor reimbursement rates, particularly low Medicaid reimbursement, were also considered a factor in the lack of a behavioral health labor pool by some interviewed in the Fullerton study.

- In addition, a number of interviewees noted that some types of licensed behavioral health providers could not bill Medicare directly, while others said many behavioral health care providers

2. The Challenge of Developing a Sustainable Funding Model for BH Services in a FFS-Based Reimbursement System

- ACOs interviewed by Fullerton *et al* said the FFS system and insurers that carved out behavioral health coverage drove the separation between behavioral and physical health care.

- Generally, ACOs funded behavioral health and care coordination by outside funding or funding from their profits, assuming providers would be unable to cover their salaries through billing.

3. ACO Personnel also Described Challenges related to **Sharing Mental and Substance Use Disorder Data**

- Due to extra security protection required for that data.
- Many ACOs blamed CMS's suppression of data for substance use disorder diagnoses or related procedures for a lack of reliable BH data for their enrollees.
- As a result, ACOs could not perform the same data analytics they could perform for other chronic diseases, nor could they use claims data to identify enrollees for additional outreach.
- ACO personnel also said privacy restrictions limited the use of internal electronic health record data to identify people with BH needs and hindered coordination of care between behavioral and physical health care provider sites.

4. ACO Personnel told the Fullerton Authors that both Enrollees and Providers Resisted Discussing Mental Health Issues

This challenge was attributed to:

- (i) cultural stigma;
- (ii) providers' resistance to screening for depression or mental health absent clear pathways for treatment or referral; and
- (iii) resistance from psychiatrists who feared the complexity of their patients' needs would increase if care for depression was provided in primary care settings where social workers treating less complex patients were the providers.

Thank You and Questions

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