

# Partnering with Health Homes and Accountable Care Organizations

Considerations for Mental Health and Substance Use Providers



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## About the National Council

The National Council for Community Behavioral Healthcare represents 1,800 safety net mental health and addiction treatment organizations. Collectively, these organizations serve 8 million low-income children and adults struggling with mental health and addiction disorders. These individuals and their families confront addictions, schizophrenia, bipolar disorder, and depression — as well as chronic physical health conditions. National Council members offer intensive psychiatric treatment and rehabilitation services that allow adults with behavioral health disorders to live successfully in the community and allow children with emotional disturbances to live at home and to stay in school.

The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement resources so that services are efficient and effective.



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# Overview

With private and public payers' growing awareness that they are spending enormous sums for poor outcomes, new service delivery models have been developed to address the healthcare system's problems with quality and cost. Of these models, the health home and accountable care organization (ACO) are likely to serve as foundational elements of healthcare's future. Pilot efforts have demonstrated the models' potential to improve quality while reducing costs. Increasing numbers of payers and providers are investing in them, and health reform's promotion of them will further accelerate their adoption.

Health homes and ACOs are responsible for providing the full range of healthcare services for the populations they serve. In April 2009, the National Council for Community Behavioral Healthcare released a report, "Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home," which described a person-centered healthcare home as one that is equipped to care for the whole patient and manage multiple, interrelated and chronic health problems.<sup>1</sup> Through new payment mechanisms, they will align their clinical and financial incentives to meet the triple aim of improved quality and patient experience and reduced costs. Neither health homes nor ACOs will be able to reach that goal without effectively addressing mental health and substance use (MH/SU). MH/SU providers must determine what kind of relationship they want with these entities and what they need to do to qualify as partners.

New guidelines are being developed that outline the skills and capacities MH/SU providers will need to work with health homes and ACOs. In October 2010, the American College of Physicians (ACP) released a position paper on what specialists such as MH/SU providers must do to partner effectively with health homes.<sup>2</sup> The ACP's principles will likely serve as the basis for standards for providers partnering with health homes. Also in October, the National Committee for Quality Assurance (NCQA) issued draft ACO standards for public comment.<sup>3</sup> The standards cover the range of care that must be provided through ACOs and how that care must be coordinated by primary care and specialty providers for an organization to achieve recognition as an ACO.

This paper offers a brief overview of health homes and ACOs, including recent and current efforts to promote them through health reform and other initiatives. It discusses the ACP's health home partner work and NCQA's draft ACO standards as they pertain to MH/SU providers. Options for structuring partnerships with health homes and ACOs are presented. The paper concludes with four action steps that MH/SU providers should take to prepare for partnering with these entities and a brief discussion of their place in the healthcare neighborhood of the future.

# Partnering with Health Homes and Accountable Care Organizations

## History of Health Homes vs. Medical Homes

In its position paper on specialists working with health homes, the American College of Physicians (ACP) uses the term patient-centered medical home, as does NCQA in its draft ACO standards. Health home is the term used in the Affordable Care Act (ACA). Elsewhere, variations of the same model are referred to as medical home, advanced primary care, and the person-centered healthcare home. The variety of names can be confusing. In some contexts, these terms are used interchangeably. In others, they signal differences in approach. Before turning to the ACP's work, it is worth briefly looking at the different terms and what they mean.

The term medical home has been in use for decades. It grew out of the pediatric field, where it described a model for addressing the complex health needs of children with multiple medical conditions. With its adoption by the larger healthcare field, it has come to signify a care model in which the patient has a designated primary care provider who operates as part of a care team with responsibility for coordinating the patient's overall healthcare needs.

More recently, the term patient-centered medical home (PCMH) surfaced, with the intent of underlining key elements that make a medical home model responsive to an individual's needs and activate patients to participate in their care. The model has been the basis for numerous efforts, including TransforMED and the Patient-Centered Primary Care Collaborative.<sup>4,5</sup> In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association issued a joint statement on the PCMH's core principles (see inset box).<sup>6</sup> It is also the term – and model – that NCQA used in developing its medical home standards.<sup>7</sup>

### Joint Principles of the Patient-Centered Medical Home

- **Personal physician**—Each patient has an ongoing relationship with a primary care provider who provides continuous, comprehensive care and serves as the patient's first contact;
- **Physician-directed medical practice**—The personal physician leads a team at the practice level which collectively takes responsibility for patients' ongoing care;
- **Whole person orientation**—The personal physician is responsible for providing for the patient's healthcare needs across the lifespan or appropriately arranging such care;
- **Care is coordinated** and/or integrated across all elements of the healthcare system (e.g., subspecialty care, hospitals, nursing homes) and the patient's community (e.g., family, community-based services);
- **Quality and safety** are hallmarks of the medical home;
- **Enhanced access to care** is available through mechanisms such as expanded hours and Web-based communication with patients;
- **Payment** is in line with the added value provided to patients through the PCMH.

As PCMH became commonly used, the National Council for Community Behavioral Healthcare advocated changing the term (and the model) to the person-centered healthcare home.<sup>8</sup> The National Council argued that the term better conveyed the critical role of MH/SU and self-management in effective, comprehensive primary care.

Complementing the National Council's position, the ACA uses the term health home. The act makes clear that the term was selected to convey that the comprehensive primary care model necessary to ensure quality and efficiency builds on the concept of medical homes, but must be explicit about the critical role of MH/SU and community supports.<sup>9,10</sup>

This paper uses the term health home when discussing the ACA and the future of the approach in general. PCMH is used when the work being addressed uses that term to refer to the specific model, as in the American College of Physicians and NCQA's work. Medical home is used as a generic term referring to the range of models previously implemented.

## **Health Homes and the Affordable Care Act**

The health home model is taking root across the country, and passage of the ACA will accelerate its adoption. The act established the new Center for Medicare and Medicaid Innovation which is tasked in part with developing new payment models that support health homes.<sup>11</sup> The ACA also provides for a new Medicaid program through which states will set up health homes for Medicaid enrollees with chronic conditions, including MH/SU issues.<sup>12</sup>

States can provide health home services to Medicaid enrollees on or after January 1, 2011 by electing this new option through a state plan amendment.<sup>13</sup> Under the program, health homes will provide timely, comprehensive care that includes care management, health promotion, transitional care, patient and family support, referral to community support services, and health information technology for the coordination of care. For the first eight quarters of the state plan amendment, the federal medical assistance percentage for health home-related payments will be 90 percent. States may propose alternative payment models for health home services (e.g., bundled payments), and the legislation sets aside funds for state planning grants.

In the program requirements, the importance of MH/SU is made very clear. The list of eligible chronic conditions begins with MH/SU disorders.<sup>14</sup> States are instructed to address MH/SU services regardless of which conditions are selected for focus, and they must consult and coordinate with the Substance Abuse and Mental Health Services Administration around their provision of MH/SU prevention, treatment, and recovery services.<sup>15,16</sup>

The Medicaid health home program builds on a host of medical home efforts around the country. A recent policy brief from Health Affairs / the Robert

Wood Johnson Foundation estimates that over 100 medical home projects have been evaluated to date.<sup>17</sup> The Patient-Centered Primary Care Collaborative, a large coalition of employers, payers, providers, and other stakeholders, supports PCMH policy and implementation, in part through pilots in 20 states.<sup>18</sup> TransforMED, a subsidiary of the American Academy of Family Physicians (AAFP), provides training and support to primary care practices working to adopt the PCMH model. The AAFP also recently published the evaluation of its extensive medical home pilot program, the TransforMED National Demonstration Project.<sup>19,20</sup> CMS has pilots underway through the Medicare Medical Home Demonstration Project.<sup>21</sup> As noted, NCQA established recognition standards for the PCMH in 2008 and will issue updated standards in 2011.<sup>22</sup> This substantial body of work makes clear that whether or not the ACA ultimately stands, health homes will likely play an important role in the future of the healthcare system.

### **The American College of Physicians' Patient-Centered Medical Home Neighbor**

Despite all the activity around PCMH, little attention has been paid to the role of PCMH partners – that is, the specialists like MH/SU providers that complement the services provided by primary care. The American College of Physicians seeks to fill this gap with its publication of core principles for the PCMH neighbor – a provider that partners with a health home to deliver specialty, subspecialty, or inpatient care.<sup>23</sup> The American College of Physicians' work appears poised to serve as the basis for establishing standards for PCMH partners such as MH/SU providers.

#### **Clinical Collaboration with the PCMH**

The PCMH neighbor concept is grounded in the understanding that there will be times when a patient needs care from a provider outside the PCMH practice. The PCMH care team covers a range of services, which may include MH/SU; however, specialty, subspecialty, and inpatient care is beyond many PCMHs' delivery capabilities. To meet their mission of providing and coordinating comprehensive care, PCMHs must have relationships with specialists, subspecialists, and hospitals. The ACP's position paper outlines options for forming such relationships with a PCMH and requirements for providers who will act as neighbors. Most of their recommendations pertain to specialists and subspecialists – obvious roles for MH/SU providers.

The ACP describes four types of clinical relationships that a PCMH may have with a neighbor provider around a particular patient:

- **Preconsultation exchange:** When the PCMH has a clinical question for the specialist that does not require a face-to-face visit or when the PCMH is preparing to send a patient to the specialist, they may have a limited exchange (sometimes called a “curbside consult”) to share information about the patient or offer treatment recommendations.



- **Formal consultation:** When a more involved assessment process or medical procedure is required, the specialist sees the patient once or up to a few times and returns the patient to the PCMH's care with recommendations for managing the condition.
- **Co-management:** In more complex situations, the PCMH and specialist may co-manage a patient's condition. They may share management of the illness, typically with the specialist providing expert advice and ongoing follow-up and the PCMH providing day-to-day management of the illness. In other cases, either the PCMH or the specialist takes the lead, serving as the first contact for the patient.
- **Transfer to specialty care:** When a patient has a complex health condition, the PCMH may transfer the patient to the specialist's care for the entire course of treatment. In these cases, the specialist acts as a PCMH for the patient and has to meet approved PCMH standards such as NCQA's recognition program.<sup>24</sup>

The type of clinical relationship required may change over time, as the patient's needs or condition evolves. It is determined on the basis of the nature and complexity of the patient's condition, the providers' professional judgment, and the patient's preference.<sup>25</sup> Evidence-based models for treating the condition should also inform decisions about the clinical relationship.<sup>26</sup>

### **Formalizing Collaboration through Care Coordination Agreements**

The ACP urges formalizing the structure of these clinical relationships through care coordination agreements (also known as service agreements or compacts).<sup>27</sup> A care coordination agreement outlines the kinds of referral, consultation, and co-management arrangements agreeable to the two parties, as well as the assignment of responsibility for care processes and outcomes resulting from those arrangements. It defines the core clinical data to be exchanged bidirectionally for each type of arrangement and specifies the time frame in which the flow of information must occur. It lays out procedures for handling self-referrals, secondary referrals, inpatient care, and the provision of emergency medical care when the PCMH is unavailable. To ensure patient-centeredness, it specifies how treatment options will be explained to patients and families and how decision-making will include patient and family choice. It also includes mechanisms for regular review of the agreement and evaluation of the parties' compliance.

A PCMH will likely have care coordination agreements with a number of specialists, subspecialists, and hospitals. Given that effective coordination will be a struggle for many organizations at the outset, ACP recommends that these agreements be kept simple and made as uniform as possible to facilitate coordination among all parties.<sup>28</sup>

### **Incentives for PCMH Neighbors**

The ACP encourages the development of nonfinancial and financial incentives to encourage specialists and subspecialists like MH/SU providers to seek recognition as PCMH neighbors and collaborate with the PCMH.<sup>29</sup> Nonfinancial incentives would include the flow of quality referrals to the neighbor. On the financial side, they propose that neighbors be compensated for the extra time and infrastructure required to deliver coordinated care, such as setting up care coordination agreements, exchanging clinical information, and providing informal consultations.

### **Gaining Recognition as a PCMH Neighbor**

Apart from the guidance around forming care coordination agreements, the ACP's guidelines for serving as a PCMH neighbor are fairly general, but they appear ready to map on to the types of criteria fleshed out in NCQA's PCMH recognition program. ACP proposes that recognized PCMH neighbors be able to:

- Ensure effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care;
- Ensure appropriate and timely consultations and referrals that complement the aims of the PCMH practice;
- Ensure the efficient, appropriate, and effective flow of necessary patient and care information;
- Effectively guides determination of responsibility in co-management situations;
- Support patient-centered care, enhanced care access, and high levels of care quality and safety;
- Support the PCMH practice as the provider of whole-person primary care to the patient and as having overall responsibility for ensuring the coordination and integration of the care provided by all involved physicians and other healthcare professionals.<sup>30</sup>

MH/SU providers wishing to participate as a PCMH neighbor will need to demonstrate their ability to fulfill these requirements. MH/SU providers may need to increase access to their services so they can provide consultations and see referrals quickly. They may need to strengthen their information systems to quickly and safely exchange clinical data with the PCMH. MH/SU providers that are skilled in collecting and working with data as a routine part of their clinical service delivery will be in a strong position to partner with PCMHs. While many MH/SU providers have taken up the concept of patient-centered care, they will need to demonstrate how it impacts their service delivery and outcomes. Overall, MH/SU providers that have a track record of effective partnership with federally qualified health centers or other primary care providers will have an advantage in demonstrating their capacity to support integrated service delivery and navigate shared treatment situations.



# Partnering with Accountable Care Organizations

Health homes are at the heart of accountable care organizations (ACOs). An ACO is a structure through which a group of providers with shared governance takes responsibility for the management and coordination of a defined population's total spectrum of care. While primary care delivery is the foundation of ACOs, they are also responsible for preventive, specialty, emergency, acute, and post-acute care. The ACO model is built on the principle that in placing the responsibility for a population's entire care continuum within a single entity with aligned clinical and financial incentives, care quality and patient experience will improve and costs will go down. Various organizations have been working on developing ACOs for several years now, and this year's passage of the Affordable Care Act (ACA) will accelerate their growth and adoption.

## Accountable Care Organizations and Health Reform

The ACA provided for the recently established Center for Medicare and Medicaid Innovation, which is tasked in part with developing new payment models that support ACOs and health homes.<sup>31</sup> The ACA also requires the Centers for Medicare and Medicaid (CMS) to create a Medicare shared savings plan for ACOs by January 1, 2012.<sup>32,33</sup>

CMS is in the process of developing regulations for how ACOs should be formed and evaluated for participation in the Medicare shared savings plan. They issued a request for information on ACOs and the proposed plan in November 2010, and plan to release the proposed regulations by mid-January 2011.<sup>34</sup> The ACA specifies several key elements and principles of ACOs that will have to be included.<sup>35,36</sup> An ACO's service population must consist of at least 5,000 fee-for-service Medicare beneficiaries. MH/SU providers and others participating in ACOs must deliver patient-centered, evidence-based care and promote patient engagement. They must also develop the ability to report on quality and cost measures, which will be used as the basis for determining the distribution of shared savings.

CMS will build its regulations in part on the lessons learned from ACO projects underway around the country. In 2005, CMS launched the five-year Medicare Physician Group Practice demonstration project through which 10 large multispecialty practices participated in shared savings from improvements in the quality and efficiency of care for Medicare beneficiaries.<sup>37</sup> The Engelberg Center for Healthcare Reform at the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice run the ACO Learning Network, which supports organizations' adoption of an ACO model. Over 100 organizations participated in its first cohort, and the program is entering its third year.<sup>38</sup>

CMS's ACO standards will be significant not only for how they will modify service delivery and alignment of incentives within Medicare, but for how they will accelerate existing work on ACOs and other public and private payers' investment in this area. However, it is important to note that the ACA builds on a substantial movement toward ACOs that is already underway. Regardless of whether the ACA ultimately survives current legal challenges, ACOs are likely to be an important part of healthcare going forward.

## **NCQA's Draft Standards for Accountable Care Organizations**

In October 2010, the National Committee for Quality Assurance (NCQA) issued draft ACO standards for public comment.<sup>39,40</sup> Outlining criteria for achieving and maintaining recognition as an ACO, the standards build upon existing initiatives and core principles developed by groups like the American College of Physicians, American Association of Family Practice, and American Medical Group Association.<sup>41</sup> Organizations can meet NCQA's ACO criteria at one of four levels, ranging from a minimal level of capability across the required domains to an advanced level of capability plus strong documented outcomes. These four levels are designed to provide organizations a pathway for developing fully as an ACO. With its track record of accrediting and certifying healthcare organizations, NCQA's criteria will likely influence CMS's ACO rulemaking and the development of ACOs in general.

### **Core Capabilities of the ACO**

The seven categories of ACO criteria are listed below. NCQA further operationalizes each criterion in its draft standards.<sup>42,43</sup>

- **Program Structure Operations:** The organization clearly defines its organizational and leadership structure. The organization has the capability to manage its resources effectively. The ACO arranges for pertinent healthcare services and determines payment arrangements and contracting.
- **Access and Availability:** The organization ensures that it has sufficient numbers and types of practitioners who provide primary and specialty care.
- **Primary Care:** Primary care practices within the ACO provide patient-centered care.
- **Care Management:** The organization collects and integrates data from various sources, including, but not limited to electronic sources for clinical and administrative purposes. The organization conducts an initial assessment of new patients' health. The organization uses appropriate data to identify population health needs and implements programs as necessary. The organization provides resources for, or supports, the use of patient care registries, electronic prescribing and patient self-management.

- **Care Coordination and Transitions:** The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and transitions.
- **Patient Rights and Responsibilities:** The organization has a policy that states its commitment to treating patients in a manner that respects their rights, its expectations of patients' responsibilities, and privacy. A method is provided to handle complaints and to maintain privacy of sensitive information.
- **Performance Reporting:** The organization measures and reports clinical quality of care, patient experience, and cost. At least annually, the organization measures and analyzes the areas of performance and takes action to improve effectiveness in key areas.

### **Participation in ACOs' Clinical and Administrative Operations**

To meet the NCQA's standards, ACOs will be responsible for clinical and administrative functions, and MH/SU providers will have opportunities to participate in both. On the clinical side, primary care will represent the majority of services provided, and the health home model is expected to be the main service approach. As described earlier, in the health home model, a primary care provider leads a team with responsibility for coordinating the patient's care. A MH/SU provider may serve on that care team, addressing the behavioral aspects of medical illnesses and risk factors as well as conducting brief MH/SU assessments and treatment. A MH/SU provider may also choose to serve as a health home for people with serious MH/SU conditions, either by achieving recognition as a health home itself or by partnering with an established health home (e.g., in partnership with a local federally qualified health center that has obtained NCQA health home recognition).

To cover patients' full range of healthcare needs, ACOs will need to ensure adequate availability of "high-volume" specialty providers.<sup>44</sup> Given the high prevalence of MH/SU conditions – both as a primary concern and as an issue comorbid with medical illnesses like diabetes, MH/SU practitioners will likely be designated high-volume specialists. MH/SU providers will of course be a natural source for such specialists, and ACOs will be looking to partner with MH/SU providers skilled in delivering high-quality, efficient MH/SU services.

On the administrative side, MH/SU providers delivering services through an ACO may participate in its oversight and utilization management activities. ACOs will be required to involve specialists, primary care providers, consumers or community representatives, and hospitals, if applicable, in the oversight of its operations.<sup>45</sup> Specialists such as MH/SU providers will participate as members of the ACO's board, a board subcommittee, or the ACO management staff. In addition, ACOs must have a utilization management (UM) plan that ensures patients receive appropriate care. Relevant specialists, including MH/SU providers, must be involved in the development of the UM plan and in the panels that make UM decisions.<sup>46</sup>

### **Incentives for Partnering with an ACO**

The draft NCQA standards specify that entities providing services through the ACO must be compensated in part on the basis of the ACO's performance. The opportunity to take part in shared savings plans like the one Medicare is developing is an important incentive for potential participants like MH/SU providers. Apart from that, the standards do not address the payment models to be used by ACOs. Given that most reimbursement models for ACOs include some type of innovative financing, it is likely that the final NCQA standards will address or at least leave room for new payment structures, such as those that cover the increased demands of coordinating care.

Like PCMH neighbors, ACO partners will benefit from nonfinancial incentives as well. These will include the flow of referrals from the ACO's primary care practices to the MH/SU provider and other specialists. They will also have the opportunities for new lines of business through their provision of clinical and administrative services within the ACO.

### **Qualifying for Partnership with an ACO**

All ACO partners will need to demonstrate their ability to help the ACO meet the triple aim of improving health, improving patient experience, and reducing per capita costs.<sup>47</sup> While there will be clear opportunities for MH/SU providers to participate in ACOs as part of a health home and as specialty providers, they will need to meet rigorous criteria to be eligible for participation. Some high-performing MH/SU providers may already be prepared to meet these criteria, but many will need to make important changes in their service delivery and operations to qualify.

**Health home approach.** With primary care at the core of ACO service delivery, the health home model is likely to be the preferred, if not required, approach. In fact, NCQA's draft standards propose giving automatic credit for some criteria to ACOs with a high percentage of recognized PCMHs.<sup>48</sup> MH/SU providers delivering services in an ACO's primary care practices will have to be able to function as part of a health home. This will involve activities like participating in team-based care, using standardized assessment tools to monitor treatment progress, coaching patients on self-management strategies, and systematically tracking and following up on referrals.<sup>49,50,51</sup> MH/SU providers will need to be familiar with the health home approach and able to work as an effective part of the health home team or affiliated specialist. As discussed previously, they may also go a step farther and serve as a health home for people with serious MH/SU conditions.

**Accessible care.** In line with health home standards, ACOs will be required to ensure the accessibility of healthcare services. Care teams will have to make available same-day appointments. They will also need to provide access to routine and urgent care outside typical office hours and be available to patients via secure electronic messaging and telephone for routine and urgent care needs and clinical advice.<sup>52,53</sup> To facilitate such

care, clinical information will have to be available after hours and in urgent situations.<sup>54</sup> Clinical information may take the form of personal health records, individualized care plans, and electronic health records. MH/SU providers wanting to participate as part of these care teams (as well as MH/SU providers functioning as health homes) must be prepared to deliver routine and urgent care outside typical office hours and provide timely communication, including clinical advice, to patients as specified. They will have to have systems in place to make clinical data available for after-hours and urgent care (see section below for more information on this requirement).

**Care coordination and transitions.** An ACO must have agreements with participating providers like MH/SU providers for care coordination and transitions (i.e., when patients move between providers or settings).<sup>55</sup> These procedures will include the exchange of clinical data (e.g., treatment summaries, laboratory results) to facilitate coordination and transitions. The ACO will have a process for tracking transitions and follow-ups to ensure that they are done in a timely, effective way. MH/SU providers will need health information systems to track care coordination and transitions and to collect and exchange data to facilitate those processes. Such systems will likely include electronic health records as well as local or regional health information exchanges developed by MH/SU providers in partnership with other community stakeholders.

**Cultural and linguistic competence.** An ACO's network of providers must include practitioners who can meet patients' cultural, racial/ethnic, and linguistic needs and preferences.<sup>56</sup> While the NCQA's draft standards do not provide much detail in this regard, MH/SU providers that are strong in cultural and linguistic competence and able to document their ability to work effectively with diverse populations will be an attractive partner to ACOs.

**Evidence-based guidelines.** ACOs will be required to follow evidence-based guidelines in the identification and care for three conditions which they select.<sup>57</sup> One of the three conditions must involve unhealthy behaviors, mental health, or substance use. In addition, the ACO must have a process for identifying and caring for individuals with complex or high-risk medical conditions, many of whom will have comorbid MH/SU issues.<sup>58</sup> MH/SU providers participating in the provision of care will need to have clinicians trained and skilled in the provision of evidence-based behavioral interventions as well as MH/SU assessments and treatments.

**Population health management.** ACOs must have a process for identifying patients who have complex needs 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.<sup>59</sup> To support these efforts, ACOs must make available or support providers' use of electronic prescribing, registries, and self-management tools.<sup>60</sup> MH/SU providers must be prepared to work in these modalities and incorporate the necessary tools and resources into their service delivery.

To facilitate population health management, ACOs will be required to use an electronic system, such as an electronic health record or registry, to track a minimum

specified set of patient and clinical data (e.g., preferred language, body mass index, prescriptions). ACOs must ensure that all participating providers have electronic access to these data. The system must be searchable and capable of generating reports, and providers must be able to modify its contents.<sup>61</sup> If the ACO maintains separate registries such as a depression registry, it must make the registry available to the relevant providers as well. MH/SU providers will need to be able to participate in such electronic systems, making use of the data to deliver population-based care.

**Performance evaluation.** ACOs must distribute practice-level performance reports to all participating providers and ACO-level performance reports at least annually to the public.<sup>62</sup> Reports will include valid clinical measures, cost data, and patient experience findings.<sup>63</sup> ACOs will use these reports to identify and address areas of improvement, and they will form the basis for the evaluation of shared savings eligibility. NCQA notes that the performance reporting requirement will likely shift to performance benchmarking once ACOs have demonstrated their ability to collect valid and reliable performance data.<sup>64</sup>

MH/SU providers will have to participate in these activities, establishing procedures to regularly submit data from sources such as claims or encounters, electronic health records, pharmacy, and laboratory tests.<sup>65</sup> In fact, ACOs may choose to require such data from organizations that are neither part of its legal entity nor a contracted agency, but receive referrals from the ACO.<sup>66</sup> The data will need to be in a format that allows for integration with data from other ACO providers.<sup>67</sup>

The ACO's primary care practices, including MH/SU providers recognized as health homes, will establish performance review procedures, including the regular review of performance data, evaluation of performance data compared to goals or benchmarks, identification of areas for improvement, and design of interventions to address gaps.<sup>68</sup> ACOs will need to demonstrate that they are including valid measures and methods in these processes.<sup>69</sup> MH/SU providers participating in health home care teams or functioning themselves as health homes will need to be skilled in such procedures.

While the list of requirements may seem daunting, MH/SU must be part of ACOs' service delivery, and MH/SU providers are obvious partners in these efforts. By developing competency in the health home approach, culturally competent evidence-based care, routine use of clinical data in service delivery, and interoperable health information systems, MH/SU providers will have a good foundation for qualifying as ACO partners.



# Preparing for Today and Tomorrow

With their focus on effective, coordinated care for the whole person, health homes and ACOs hold the potential for significantly improving the health and wellness of those they serve, including people with serious MH/SU conditions. Access to effective MH/SU services will be critical to the effectiveness of both ACOs and health homes. Regardless of the Affordable Care Act's ultimate fate, health home and ACOs will be foundational elements of the future healthcare system, and MH/SU providers must immediately begin positioning themselves to be recognized as qualified partners.

## **How Will You Structure Your Relationship with ACOs and Health Homes?**

Within the range of opportunities presented by health homes and ACOs, MH/SU providers need to determine the types of services they want to provide within or through these entities and the kinds of relationships they want to have with them. The ACP's PCMH neighbor standards and NCQA's draft ACO standards do not restrict the structure of the partnerships they form.

MH/SU providers may decide to merge with a health home or partner with them on a contract basis, placing MH/SU providers in the health home. A MH/SU provider may function as a specialty provider receiving referrals from the health home or ACO, with a business agreement that facilitates the referrals. It may also become a health home for people with severe MH/SU conditions – obtaining recognition as a health home or partnering with an entity (e.g., a federally qualified health center) that has health home status. Which path the MH/SU provider chooses to take will depend on the types of services it wishes to provide, how it wants to position itself in the larger health system, and the resources it has available.

## **How Will You Position Yourself as a Qualified Partner?**

For many MH/SU providers, partnering with health homes and ACOs will mean honing significant new skills and capacities. It is critically important that MH/SU providers assess their current ability to qualify for participation in these efforts and address the gaps they find.<sup>70</sup>

To ensure their readiness to participate in health homes and ACOs, MH/SU providers are urged to undertake the following action steps:

- 1. Prepare now for participation in the larger healthcare field**
  - a. Identify community partners and build relationships, especially with primary care;
  - b. Develop competency in team-based care and health homes in particular;

- c. Institute a measurement-based approach to care, incorporating standardized clinical assessment tools into routine service delivery;
- d. Gather data on population served in order to support recognition as a “high-volume” specialty provider; and
- e. Increase skills and knowledge in population health management, including wellness and prevention and disease management approaches.

## **2. Establish credentials as a high performer relative to the triple aim**

- a. Adopt quality tools and train staff in using them to track performance;
- b. Assess clients’ experience of care (including its patient-centeredness and cultural/linguistic competence) and address gaps;
- c. Document MH/SU and general health outcomes (e.g., body mass index) and implement a plan for improving areas of weaknesses; and
- d. Evaluate the cost and value of the care provided.

## **3. Ensure information technology readiness**

- a. Institute IT systems that are able to support:
  - i. Exchange of data within and outside the organization;
  - ii. Use of data as a routine part of clinical work;
  - iii. Performance review practices; and
  - iv. Management of new payment structures (including linking performance to payment).
- b. Reach out to community partners to begin forming local or regional health information exchanges.

## **4. Plan for an extended period of change**

- a. Implement a change management plan;
- b. Identify key resources and support network for staying current around new and emerging practice and financing models; and
- c. Invest in educating board and staff on operational and clinical changes.

The National Council works to support MH/SU providers’ development in these areas through educational materials, webinar series, learning communities, trainings, consultation programs, and its annual conference.<sup>71</sup>

## **Looking Ahead: The Healthcare Neighborhood**

MH/SU providers should also be looking to where healthcare will be heading next – beyond health homes and ACOs as currently construed. As these models are put in place, it will become clear that their goals will be fully met only by broadening their framework to include the larger community. As the Robert Wood Johnson Foundation’s Commission to Build a Healthier America concluded, good health is not achieved primarily in the healthcare provider’s office but through early childhood education, good nutrition, and healthy communities.<sup>72</sup>

The healthcare neighborhood of the future will connect the evolving health system with public health, social services, schools, and community groups to truly ensure people’s whole health across the lifespan. Equipped with their experience in working with the larger community and the new skills they develop in working with health homes and ACOs, MH/SU providers will be positioned to continue their growth and thrive in the healthcare neighborhood.

# Endnotes

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