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Accountable Care Organizations (ACOs): Opportunities for the Social Work Profession

Background

The accountable care organization is a new breed of health care provider, which embraces three core principles: patient-centered primary care, payment reform, and meaningful performance measurement. Specifically, an ACO is a network of hospitals, clinics, physician practices and other providers who work together to provide coordinated, integrated care for an assigned population of individuals and who receive financial compensation for meeting specific patient outcomes. The foundation of an ACO is the primary care medical home. All ACO enrollees are assigned a medical home provider (typically a physician or nurse), who is accountable for the all the healthcare services an individual receives. To be successful, ACOs must focus strongly on prevention and careful management of individuals with chronic disease. ACOs are also expected to contribute to the development of best clinical practices and to build standards for evidenced-based medicine.

Momentum for the ACO model has been building over time, through both public and private sector initiatives. Within the private sector, there are ACO-related payor and employer initiatives (Patient Centered Primary Care Collaborative, 2011); ACO accreditation programs (NCQA, 2011); and ACO training centers (Brookings-Dartmouth, 2011). The federal government recently introduced the **Medicare Shared Saving Program (MSSP)**, a unique set of rules for ACOs that will serve Medicare beneficiaries. Additionally, individual states are contemplating ACO programs for their Medicaid populations.

Social workers are active in current ACO-type organizations and can position themselves for additional opportunities within this promising health delivery model. Although much ACO development is occurring is the private sector, this practice perspective will focus primarily on ACOs that will operate within the Medicare Shared Saving Program–and social work opportunities therein.

CMS Regulations Regarding the Medicare Shared Saving Program

On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS) requested comments on its proposed rules for ACOs that will participate in the MSSP. Under the proposed rules, participating ACOs, which must have a minimum of 5000 Medicare enrollees, will receive financial incentives (or "shared savings") for reducing

In its commentary [on the Medicare Shared Savings Program], NASW advocated for the inclusion of professional social workers in Medicare ACOs and for strong protection for Medicare beneficiaries (NASW, 2011).

healthcare costs and meeting specific quality benchmarks in patient care and population health (DHHS-CMS, 2011). In its commentary, NASW advocated for the inclusion of professional social workers in Medicare ACOs and for strong protections for Medicare beneficiaries (NASW, 2011).

The proposed rules were informed by initial positive outcomes from the Medicare Physician Group Practice demonstration projects, which offer financial incentives to physicians for improving patient care and reducing the growth in Medicare expenditures (Berwick, 2011). The final CMS regulations on the MSSP are expected to go into effect on January 1, 2012. Despite current legal challenges to the Patient Protection and Affordable Care Act (P.L. 111-48), which authorized the MSSP, there is likely to be sustained interest in ACOs and the model is expected to be an important component of healthcare delivery going forward (National Council for Behavioral Healthcare, 2011).

The Driving Force Behind ACOs – Spiraling Costs of Chronic Disease Management

The ACO model is reflective of the health care industry's shift in recent years toward greater care coordination, particularly for individuals with multiple chronic conditions. Currently, half of all health care spending in the U.S. is devoted to individuals with three or more chronic conditions (Brody, 2011; Schoen, 2011). For many of these individuals, care is often poorly coordinated and rarely is one provider solely responsible for all the care a patient receives—resulting in fragmentation, unnecessary costs and a general lack of accountability. Moreover, the traditional fee-for-service reimbursement system encourages volume rather than coordinated care. The ACO model is designed to reverse this trend, by connecting payment to patient outcomes.

Accountable Care Organizations – The New Generation of HMOs?

The preliminary CMS rules make Medicare ACOs distinct from their organizational predecessors—HMOs. Unlike HMOs, ACOs are explicitly health care delivery organizations, rather than insurers that contract with a network of providers (Guterman, 2011). Also, ACOs that participate in the MSSP have no patient lock-in; individuals are free to receive care from providers outside the network. In order to succeed, ACOs will need to demonstrate to their enrollees the value of remaining in the ACO, from a coordination and quality of care perspective.

Another distinction from the HMO model is that individuals will be retrospectively assigned to Medicare ACOs, based on where they receive the plurality of their care. ACOs are incentivized to provide high quality care because if they fail to meet specific quality and cost benchmarks, they jeopardize their savings bonuses – and potentially their contracts (Gold, 2011). Medicare beneficiaries will also have a presence on the ACO governing body, allowing for a more active consumer role in ACO decision-making (DHHS-CMS, 2011). Furthermore, Medicare ACOs will need to consider diversity in their patient population and have a formal plan to address health disparities.

Where Do Providers Fit Within the Medicare ACO Structure?

Under the proposed rules, the following providers can form Medicare ACOs:

- Hospitals employing "ACO Professionals," currently defined as physicians, physician assistants, nurse practitioners and clinical nurse specialists. (Note: NASW has argued for expansion of this definition to include social workers.)
- Networks of physician practices
- Partnerships and joint ventures between hospitals and physician practices

While most patient care in an ACO will be provided within the medical home setting, many enrollees will continue to require a high degree of specialty care, which may be beyond the delivery capability of the ACO. As such, ACOs will be dependent upon providers in their "medical neighborhoods." A medical neighborhood is the constellation of external clinicians, specialists, agencies and community-based organizations providing health related services to patients in the ACO (Taylor, 2011). To manage costs, Medicare ACOs will need to collaborate efficiently with their "neighbors."

Efforts are underway to develop standardized care coordination and data sharing agreements for ACO medical homes working with external providers (American College of Physicians, 2011).

How are ACOs Structured?

Most ACOs are in the developmental stages. However, there are "ACO prototypes" currently in operation and these programs share common elements. These include:

- a strong primary care/medical home foundation
- multidisciplinary health care teams
- targeted care coordination interventions (focused especially on individuals with multiple chronic conditions)
- integration with behavioral health and substance use treatment
- sophisticated information systems that include electronic medical records
- formal partnerships with "medical neighbors" (Myers, 2010).

The following programs are ACO prototypes serving vulnerable populations such as Medicare beneficiaries, dually eligible Medicaid/Medicare beneficiaries, and children enrolled in Medicaid or CHIP (the Federal Children's Health Insurance Program). Notably, social workers play an active role in all of these programs.

COMMUNITY CARE ALLIANCE (CCA) – MASSACHUSETTS

CCA is a state-wide, consumer-governed pre-paid health system that provides comprehensive care for dually eligible individuals with complex needs, through a network of 25 community-based medical practices. The CCA medical home team, lead by a nurse practitioner and which includes social workers, nurses and paraprofessionals, provides a broad array of medical, behavioral and psychosocial services. (CCA physicians concentrate on enrollees requiring inpatient and specialty care.) Service provision is frequently home-based, and health professionals have broad leeway to order necessary services without prior approval from the health plan. The cost of providing the extensive care coordination services offered by CCA is offset by reduced hospitalizations and nursing home placements (Health Affairs, 2011).

MINNESOTA SENIOR HEALTH OPTIONS (MSHO)

MSHO is a Medicare/Medicaid program that enrolls 70 percent of Minnesota's dually eligible

**Mental health and substance use services may be provided within the medical home or in the medical neighborhood.*

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population. All MSHO members are assigned an individual care coordinator (a nurse practitioner, nurse or social worker). Care coordinators conduct risk assessments, serve as liaisons to physicians, monitor chronic conditions and transitions, facilitate medication management, and authorize home and community based services. MSHO data show reduced hospitalization rates for diabetes complications, asthma, pneumonia, and congestive heart failure for beneficiaries, when compared to the Medicare fee-for-service population (Parker, 2011).

COMMUNITY CARE OF NORTH CAROLINA (CCNC)

CCNC is a nonprofit organization made up of 14 networks with over 4,500 primary care physicians, providing care for more than one million Medicaid (adult and pediatric) and Medicare enrollees in the state. Using a medical home model, CCNC networks employ a mix of nurses and social workers as care coordinators for high cost, high risk individuals. CCNC compensates for care coordination by paying networks an enhanced per member/per month fee for this service. Data show improvements in management of diabetes, asthma and heart disease, and significant reductions in emergency department use among enrolled individuals (Abrams, 2011).

VERMONT BLUEPRINT FOR HEALTH

As part of its statewide Blueprint for Health Initiative, Vermont is piloting an enhanced medical home model in which "community health teams" (composed of nurses, social workers, nutrition specialists, community health workers and others) partner with primary care medical homes to coordinate care for individuals with chronic illness. Participating physician practices are aided by expanded health information technology capabilities, including a clinical tracking system and a statewide health information exchange network. The Vermont Blueprint for Health is a multi-payor collaborative, involving Medicaid, Medicare and three major commercial insurers, whose collective goal is universal coverage for all Vermont residents (VT Department of Health Access, 2011).

Opportunities for Social Workers in ACOs

The hallmarks of ACOs – medical homes, care coordination, integration of behavioral health services and community linkages to vulnerable populations – will mean new opportunities for social workers. As ACO development progresses, social workers are advised to become aware of - and involved in - ACO activity in their states and communities, to position themselves for an active role in these organizations. The following are suggested roles for social workers in ACOs.

CARE COORDINATORS, CASE MANAGERS AND PATIENT EDUCATORS

Care coordination provided through the medical home is the essential ingredient for ACO success – and few professions are as well prepared to take on this role as social work. Within ACOs, social workers are natural members of the medical home team. Indeed, the Agency for Healthcare Research and Quality (AHRQ) indicates that the sheer volume of community based services makes coordination between them and the medical home difficult – and that to be truly functional, the medical home needs dedicated staff available for care coordination activities (Myers, 2010). ACO medical homes that include social workers are better able to develop and maintain linkages to community and social services. Social workers can provide case management for the most medically fragile ACO enrollees, helping them transition among different levels of care, stabilize their social environments and adhere to their care plans. Many tasks that medical home social workers perform – such as patient education – also free up medical and nursing staff to perform other clinical duties.

BEHAVIORAL HEALTH PROVIDERS

Licensed clinical social workers (LCSWs) will play a critical role in ACOs, especially those ACOs with high caseloads of individuals with co-occurring chronic conditions and mental health and/or substance use disorders (NCBH, 2011). LCSWs can be embedded within primary care settings as members of the medical home team. In addition, LCSWs in community mental health centers or in private practice can

become "neighbors" to ACO medical homes, as specialty providers.

OUTREACH SPECIALISTS

Given the requirement for Medicare ACOs to address health disparities within their patient populations, social workers can play an important community outreach role for ACOs. With their skill in providing culturally and linguistically appropriate care, social workers can reach people with complex health and psychosocial needs in non-traditional settings. Similarly, social workers in ACO hospitals can offer care coordination services to individuals with high rates of emergency department use – and connect them to ACO medical homes (Gilliam, 2011).

SUPERVISORS FOR ACO COMMUNITY HEALTH WORKERS

Many ACO-type programs that focus on managing the health needs of individuals with multiple chronic conditions have found it advantageous to include community health workers on their medical home teams (Simon, 2011). Also known as "promotoras" or "health coaches," these paraprofessionals often live in the same communities where at-risk patients reside and understand the languages, cultures and challenges of these individuals (Gawande, 2011). Because of the psychosocial nature of many of the issues that community health workers address, professional social workers are often well suited to supervise these staff members.

HEALTH CARE "NEIGHBORS" FOR CONTINUUM OF CARE SERVICES

As noted above, ACOs will often need to contract for specialty care. Social work-led organizations such as geriatric care management companies, hospice and palliative care agencies, rehabilitation and long-term care facilities and nonprofit social service organizations may want to consider joining ACO networks as contractual specialty providers.

PARTICIPANTS IN ACO GOVERNANCE STRUCTURES

As described in the MSSP proposed rules, Medicare ACOs need to demonstrate a shared governance structure, which provides qualified ACO providers the opportunity to participate in organizational decision making. Any social worker within the ACO structure who possesses a Medicare tax identification number (e.g., an LCSW who is a Medicare provider) would be eligible to serve in the governance structure (DHHS-CMS, 2011). The proposed rules also include a requirement for beneficiary representation on the ACO governing body. NASW and others have suggested that CMS go further and require that Medicare ACO governing bodies also include advocates from community-based consumer organizations (NASW, 2011; Campaign for Better Care, 2011). Should this recommendation be approved, it would provide an additional opportunity for social work involvement in ACO governance.

ADVOCATES FOR VULNERABLE POPULATIONS

Social workers are needed to monitor activities within in their states to ensure that ACOs provide high quality, patient-centered care, particularly for dually eligible beneficiaries and other vulnerable populations. Many states view ACOs as a vehicle for promoting better value in health care spending and improving care delivery to their Medicaid populations (Purington, 2011). However, there is concern among patient advocates that some states, when converting their Medicaid programs into ACOs, may reduce benefits, change cost-sharing arrangements, or make other modifications that can harm beneficiaries (Georgetown University Center for Children and Families, 2011). Social workers can partner with other advocates in their states to ensure that Medicaid ACOs have patient protection measures including robust quality standards; patient-centered policies and practices; data-driven efforts to identify and reduce health disparities; and processes to inform beneficiaries about the financial incentives of their providers (Campaign for Better Care, 2010).

MEMBERS OF COMMUNITY HEALTH TEAMS

An unrelated, but complementary opportunity emerging from the Affordable Care Act will allow social workers to provide support for ACOs through community-based teams. The Affordable Care Act authorizes federal grants for

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"community health teams" (CHTs). CHTs are state-run, federally funded multidisciplinary teams, which will collaborate with local primary care providers to coordinate disease prevention, chronic disease management, care transitions, and case management for individuals, with priority given to those with chronic illness (DHHS-CMS, 2011). Similar to the Vermont program described above, CHTs will likely support ACO medical homes. As vital members of these teams, social workers should keep apprised of state activity to apply for these grants, when federal funding is appropriated.

Conclusion

Most health care analysts agree that the traditional fee-for-service health system is unsustainable and will be replaced, over time, by a system that connects payment with coordinated care and improved outcomes. ACOs are integral to this new health care delivery system. And to be successful, ACOs will need competency in integrated, team-based care, solid connection to community partners, skills and knowledge in prevention and population-based care, particularly for populations experiencing health disparities, and expertise in chronic disease management. The social work profession, with expertise in all of these areas, is poised to be a vital component of these new provider organizations.

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