NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

FORMULA FOR SUCCESS:

Creating Successful Affiliations

MARCH 2013

Paper authored by Paul O'Shea, MBA, CPA, President, O'Shea Associates, LLC, for the National Council.

For more information or to share comments about this paper, contact Mohini Venkatesh, Senior Director, Public Policy, National Council, at MohiniV@thenationalcouncil.org.

About the National Council

The National Council for Community Behavioral Healthcare (National Council) is the unifying voice of America's community mental health and addictions treatment organizations. Together with our 2,000 member organizations, we serve our nation's most vulnerable citizens — the more than 8 million adults and children living with mental illnesses and addiction disorders. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life.

The National Council pioneered Mental Health First Aid in the U.S. and has trained nearly 100,000 individuals to connect youth and adults in need to mental health and addictions care in their communities.

Blog with us
www.MentalHealthcareReform.org

Follow us on Twitter
http://twitter.com/nationalcouncil

Become our fan on Facebook
www.facebook.com/TheNationalCouncil

Watch us on YouTube
www.youtube.com/user/NationalCouncil

Browse photos on SmugMug
www.TheNationalCouncil.smugmug.com

1701 K Street NW, Suite 400
Washington DC 20006
Phone: 202.684.7457
E-mail: Communications@thenationalcouncil.org
Web: www.TheNationalCouncil.org

Introduction

Since the passage of the Affordable Care Act, healthcare stakeholders have been grappling with how to make integrated health systems such as person-centered healthcare homes and accountable care organizations a reality. Identifying the formula for success for establishing a sustainable method to realign the financial, operational, and clinical functions among provider organizations to meet the clients' overall healthcare needs is no simple task. In actuality, these efforts have long been underway in communities across the country; well before passage of the Affordable Care Act, state governments, foundations, private payers, and others have supported local experiments to integrate services.

We have learned much from the early adopters that helped us understand everything from workforce training, clinical capacity, revenue cycle management, staffing, health information technology, population health management to other fundamentals of integration. As the foundation of all of these efforts, the affiliations you establish with other provider organizations can help fill gaps in your service capacity, broaden your reputation in the community, and promote financial sustainability. With your organizational mission and strategic goals in mind, the details of these affiliations — the contractual agreements, memoranda of understanding, and other legal documents — should be carefully considered. This paper provides an overview of common affiliations pursued under the Affordable Care Act, a description of the various types of affiliations provider organizations can establish, and case studies of the affiliation relationships pursued by community behavioral health organizations around the country.

Background

On March 23, 2010, President Obama signed HR 3590, the "Patient Protection and Affordable Care Act" (ACA), into law. This law's creators envision that it will dramatically change the healthcare system in the United States, including the role of community behavioral health organizations (CBHOs).

This law includes the requirements to become an accountable care organization (ACO), a legal entity recognized and authorized under applicable state law and made up of a group of healthcare providers associated with a defined population of Medicare patients that will be held accountable for the quality and costs of care delivered to that population. The care is defined through an essential health benefit package that will be offered to Medicare beneficiaries and includes mental health and behavioral health services that the secretary of the U.S. Department of Health and Human Services must define and update at least annually.

Although ACOs under the ACA focus only on Medicare populations, a host of states are producing legislation that establishes similar entities for Medicaid populations. Although these organizations have different names, including coordinated care organizations (CCOs), integrated care organizations (ICOs), primary care clinician plans (PCCPs), regional care collaborative organizations (RCCOs), they all establish entities comprised of a group of providers serving a defined population through a common coordinated and integrated approach. For the purposes of this document, these entities will be collectively identified as ACOs.

It is anticipated that insurance companies, managed care organizations, and medical systems will form ACOs. In any case, these entities will not have the ability to deliver all the required services themselves and will be required to partner with other healthcare providers. The ACO concept envisions the development of legal agreements among hospitals, primary care providers, specialists, and other providers to align the providers' incentives to improve health quality and slow the growth of healthcare costs.

These developments represent a significant opportunity for providers of community behavioral health services. Very few medical systems have the breadth of services available to treat clients with serious mental illnesses and addictions. Thus, legal agreements will be necessary between these systems and providers of behavioral health services to integrate primary and behavioral healthcare successfully. As behavioral health systems, for the most part, do not offer primary care, one strategy would be for CBHOs to develop that capability. However, because primary care is not part of a CBHO's core business or part of their mission and developing new services at a time of rapid change may be risky, it may make better sense to develop agreements with the newly forming ACOs.

State Experiences

Massachusetts

The Massachusetts experience is driven, in part, by the Executive Office of Health and Human Services, which issued a request for response for a new demonstration program targeted for as many as 115,000 Mass Health (Medicaid) members who are also eligible for Medicare ("dual-eligibles"). ICOs, (i.e., ACOs) would serve these dual eligible individuals, providing a full continuum of primary care and behavioral health services. These services are scheduled to begin April 1, 2013 and will require complete coordination of care.

At this point, it appears that partnerships of insurance companies and managed care organizations will be the recipients of these contracts to become ICOs. However, in other parts of the system, large medical systems are dramatically expanding their service delivery systems. In both cases, there are conversations with CBHOs to include them in service delivery, which would be accomplished through some type of affiliation arrangement.

Simultaneous to the development of the ICO program for dual-eligibles, Massachusetts is instituting payment reform for the primary care clinician plan. This program will provide a group of primary care providers a comprehensive payment for their client's health services and will include the option of having behavioral healthcare in their payment. In cases where behavioral health is included, it is expected that primary care providers will affiliate with CBHOs to deliver these services.

Colorado

The state Medicaid authority funds behavioral health services on a per member per month (PMPM) basis through organizations known as behavioral health organizations (BHOs) that are owned by partnerships between behavioral health providers and managed care companies.

Primary care for Medicaid clients is delivered largely on a fee-for-service basis, but is coordinated through regional care collaborative organizations (RCCOs). It is anticipated that the RCCOs and BHOs will consolidate in 2016 and integrated care will be the standard.

In the interim, one RCCO is funding a pilot program with Colorado West Inc., a community mental health center where behavioral health clinicians will work with primary health care practices and their clients. These clinicians offer their competency around behavior change with the expectation that coordinated care and healthier choices will lead to lower healthcare costs. Although this model has only been in operation for 5 months, it is already demonstrating reductions in emergency room use and in hospital readmissions. These relationships are currently solidified through purchase of service agreements.

A model for broadening this pilot for seven counties in Western Colorado serving 90,000 clients is in the process of being developed. Although not yet operational, the Colorado group has developed a logic model and detailed global payment budget broken out by disease state and population description per the four quadrant model (available at www.TheNationalCouncil.org).

The state applied to the Centers for Medicare & Medicaid Services (CMS) for an innovation grant to test integrated behavioral health and physical health funding. It is anticipated that the State will fund this new model if they are successful in that endeavor. The affiliation of seven different entities is necessary to operate this ACO. They will come together as members of a new non-profit entity set up to function as an ICO. There will be a two-tiered governance structure based on an agency's ability and/or willingness to accept risk.

Michigan

The behavioral health system for severe and persistent mental illness (SPMI) is funded in Michigan through the Prepaid Inpatient Health Plan (PIHP). Local authorities, set up through the county government, oversee and manage the network of providers. Behavioral health funding for clients, including Medicaid and state and county money, flows through these authorities. They, in turn, fund providers to deliver services through a contractual mechanism. They bill Medicaid through the state based, on-unit data provided by the local authorities who, in turn, receive it from the providers through an electronic system.

PIHP is also the vehicle for funding ambulatory health services for Medicaid patients. Most of the SPMI patients receive healthcare through health maintenance organizations (HMOs). People with chronic illnesses, in large part, are not enrolled in HMOs and receive care through traditional fee-for-service Medicaid.

The local authorities are required to have coordination agreements. These agreements address the integration of care with the HMOs for physical and mental health services. They outline the roles and responsibilities of the parties, the exchange of information, referral procedures, and medical and care coordination. To date, these agreements have not led to the level of integration that people anticipated and the agreements and relationships are currently being revisited.

Structural Options

Regardless of the form that care delivery systems take in a particular state, affiliating with other provider organizations can position you to enhance your clinical capacity. To ensure that an affiliation is of sustainable benefit to the organizations and the clients, it is critical to carefully consider the legal and structural arrangement that serves as the affiliation's foundation. The following lists various types of affiliations, from basic to comprehensive.

Referral Agreement

This can be the simplest and least restrictive type of relationship. However, as in all the options presented, the arrangement should be in writing and may be quite involved. It is important to keep in mind that federal fraud and abuse laws make it very clear that it is illegal to accept anything of value for a referral. It is also illegal to ask for something or offer it. No funds may be exchanged.

The agreement itself should neither restrict the agency as to whom they can do business with nor eliminate choice for the client population. It is a good mechanism to use when systems appreciate the value of each other's services, but may not be ready to enter into a more structured arrangement. It will serve to provide the CBHO with a continual source of new clients.

It is critical that the agreement contain at least the following items:

- Specific time frame of the agreement
- Services to be included in the agreement, making sure not to identify the more profitable services for increased referrals
- Detailed description of the client population to be served
- Outline of the geography to be covered
- Quality metrics to be shared, which may or may not include a record review
- Provision for the exchange of clinical data and identification of the electronic mechanisms to be used
- Reporting requirements for each party
- Cancellation clause

These agreements can lead to closer future relationships that may require another type of contract.

Purchased Service Agreement

Most medical systems that will develop ACOs do not have the breadth of services and experiences in behavioral health to provide the care necessary to treat individuals with serious mental illnesses and addictions. Therefore, they will look to CBHOs to fill that void. In many cases, a purchased service contract will be used. This agreement should contain all the elements outlined for the referral agreement; in addition, it should set forth the reimbursement methodology.

The contract could be funded based on a simple fee-for-service (FFS) arrangement based on volume. However, that would eliminate the myriad advantages anticipated under payment reform. The FFS agreement could be modified to reflect a shared risk and savings arrangement where a FFS payment is made, often with a withholding, and a final contract settlement occurs based on a pre-established criteria. This reconciliation should be made using both quality (defined metrics) and efficiency (costs and utilization) assessments.

Another methodology could be a pure capitated payment in which a CBHO would receive a standard PMPM payment with or without a final reconciliation as outlined above.

There are many varieties and nuances of these basic financial methodologies, but it is critical that as much data as possible be analyzed in order to guarantee to both parties that the agreement is balanced, fair, and not overly risky to either group.

Exclusive Provider Agreement

This arrangement has all the components of the previous agreements, but one or both parties contract with the other on the basis that each party would be the sole provider of the services detailed in the agreement. This type of contract is severely limiting and should only be entered into if it provides significant competitive advantages and or exceptional financial benefit.

For example, if there was one predominant ACO serving the area and multiple behavioral health providers, securing the relationship through an exclusive provider agreement may make sense. In addition, if an ACO is willing to make a significant financial commitment for capital or operating funds, such an agreement warrants consideration.

Operating Agreement

This type of agreement has no standard components. It is used when a larger entity (i.e., ACO) will have substantial operating control over a smaller entity (i.e., CBHO). It has the advantage of putting providers together operationally, which encourages effectiveness and efficiency, but not legally. It is not uncommon for the ACO to be given seats on the CBHO's board of directors. If the agreement is terminated for any reason, the board seats are vacated. This arrangement would be used when the CBHO is concerned about sustainability or does not have a strong management structure; it would provide the CBHO with a constant source of business and serve to assure operating efficiency.

Merger

In this form of affiliation either both entities would merge into a newly formed entity or the smaller group (i.e., CBHO) would merge into the larger (i.e., ACO). In all cases, a merger agreement would spell out details and articles of merger would be filed. The agreement should speak to the details of what the post merger entity would look like and the composition of the board, which would be made up of a given percentage of each entity's board members. The advantages of this transaction would be the administrative, programmatic, and fiscal synergies that would take place.

Acquisition

In non-profit corporate law, the power to elect the board, approve the budget, dispose of assets, appoint management, etc., are vested in the member(s) who in turn give this power to the board through by-laws. In an acquisition, there is a change of control whereby the entity being acquired assigns the rights of membership to the acquiring entity. In effect, there is a transfer of ownership with a change of control. Both corporate entities remain intact; however, the acquiring entity (i.e., ACO) often becomes the sole member of the acquired corporation (i.e., CBHO). In all cases, the parent company would receive designated board seats on the subsidiary board; in most cases, a parent board position or two would be offered to the subsidiary.

Either an acquisition or a merger would represent a very significant event in an organization's existence and should only be considered if the organization feels it would meaningfully promote and advance the mission. It is advisable to start the process through a negotiated affiliate agreement, followed by a process of detailed due diligence. Besides board composition, some of the other critical issues that must be addressed ahead of time include: budget; composition and designated responsibilities of senior management of both entities; severance agreement, where appropriate; assignments of other staff; pay rates and fringe benefit packages; personnel policies; medical records; management information systems; and a myriad other integration details, all of which are critically important to the ultimate success of the arrangement.

Conclusion

With careful consideration of the affiliation relationship being established with other groups, CBHOs can greatly benefit from new arrangements that enhance service capacity and ability to meet clients' overall healthcare needs. The move to capitated, or "global," payments incentivizes new relationships among providers, with particular attention given to relationships that support chronic disease management. Given the chronic nature of mental illness and addiction, and the high rate of multiple chronic conditions in this population, CBHOs are well positioned to take advantage of new service delivery arrangements.

For more information on the topics discussed in this paper, visit the SAMHSA-HRSA Center for Integrated Health Solutions website at www.integration.samhsa.gov and subscribe to the National Council's bimonthly newsletter, Compliance Watch, by going to https://store.thenationalcouncil.org.