Accountable Care Organizations and Occupational Therapy

Clarice Miller

Accountable care organizations (ACOs) are organized networks or systems that provide services to Medicare beneficiaries under the Patient Protection and Affordable Care Act of 2010 with an emphasis on chronic care management. ACOs were instituted under Medicare to achieve value-based purchasing as opposed to simply providing high-volume, fee-for-service care. ACOs must reduce annual care expenditures through Medicare-covered services. Occupational therapy services often play a role along the care continuum of an ACO. This article examines some of the opportunities for occupational therapy to contribute to ACO quality outcomes and value-based care and considers some barriers for full utilization of occupational therapy practitioners in alternative payment models. Evidence-based and client-centered care provided by occupational therapy practitioners can result in increased inclusion of occupational therapy as a valued component of ACOs and other value-based service models.

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As part of the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111-148), several new models of care provision were identified that could be implemented in Medicare, Medicaid, and the private insurance market. These models promote the movement toward value-based purchasing, primarily in the Medicare system. As this movement gains strength, analysis and understanding of new structures in the health care system will be critical in ensuring the recognition and inclusion of occupational therapy. This article reviews one approach to value-based purchasing and considers opportunities for occupational therapy practitioners to conduct research, modify practice, and advocate for occupational therapy's distinct value, which can directly relate to achieving the goals of many alternative payment models (APMs), especially those of accountable care organizations (ACOs).

This article identifies the development and implementation of one approach to value-based purchasing of health care: Medicare ACOs and occupational therapy's role within them. Currently, occupational therapy practitioners may serve beneficiaries enrolled in an ACO, or they may work in a hospital, skilled nursing facility, or clinic that is part of an ACO. However, practitioners may not know whether their patients are beneficiaries enrolled in an ACO, if their practice location is part of an ACO, or how their practice affects the quality metrics and outcomes of an ACO. Some of these problems are simply part of how ACOs are designed and implemented, but they also create barriers that prevent occupational therapy practitioners from accurately highlighting the importance of their services and from best serving their patients. This article attempts to inform occupational therapy practitioners, educators, and researchers about the concept of the ACO and to illuminate some of its features.

According to my review of several ACO guidelines, occupational therapy practice and reimbursement appear to remain largely unchanged under the ACO model; most Medicare services are still reimbursed under the fee-for-service payment model (Gold, 2016). That being said, as the health care system continues to emphasize value over volume, the burden of demonstrating the validity of occupational

therapy falls on individual practitioners and the profession at large. Practitioners must clearly demonstrate the use of evidence-based practice that yields measurable and meaningful outcomes without a high cost burden to ensure that their services will continue to be provided under APMs.

Many barriers exist to occupational therapy involvement in new payment models proposed by the Centers for Medicare and Medicaid Services (CMS), including, but not limited to, the uncertain direction of future payment models as a result of a changing administration, including a new Secretary of Health and Human Services and CMS director, and a lack of nonphysician practitioner involvement in the development of payment models. Although it is difficult to predict what steps will be taken next by CMS and the administration, the lack of a clear direction could provide an opportunity for suggestions to expand the use of covered benefits, such as occupational therapy, that are perhaps underutilized and the value of which are not fully realized in the traditional physician or hospital system–based new payment models.

Unless otherwise specified, this article refers only to CMS Medicare ACOs, not private insurance or corporate ACOs. The details of private ACO contracts under health insurance plans and related outcome measures are not as publicly available as those of ACOs overseen by CMS. However, the goals and purpose of private ACOs and CMS Medicare ACOs appear to be largely similar. Therefore, the conclusions presented and opportunities identified in this article should be considered applicable to all practitioners, not just those who may be associated with a Medicare ACO. Many of the trends identified in ACOs are indicative of the larger trend toward value-based care.

What Are Accountable Care Organizations?

The Shared Savings Program of Section 3022 of the ACA put forward ideas such as public–private partnerships, trials of episode-based payment initiatives, and primary care transformation that are tested through a new federal component, the Center for Medicare and Medicaid Innovation (Medicare Learning Network, 2014). In Medicare, one particular idea, the development of ACOs, was seen as promising because of its success in the private market (CMS, n.d.). Implementation began in 2012 and has rapidly grown to encompass care for about one-third of Medicare fee-for-service beneficiaries, which excludes those in Medicare Advantage programs (Medicare Payment Advisory Commission, 2018, p. 215). At the start of 2018, 656 ACOs were recorded as having CMS contracts, an increase from 562 in 2017.

CMS (2018a) established ACOs to improve "coordinated care [by ensuring] that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors" (para. 2). Medicare beneficiaries are entitled to all Medicare benefits through an ACO (CMS, 2018b). The goals of ACOs were similar to the overall goals of the ACA and are summarized in the Triple Aim: Improve patients' experience of care, improve health overall, and, through this, reduce cost growth (Institute for Healthcare Improvement, 2018). As CMS (2018a) defined ACOs, they addressed each of the following:

- ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high-quality care to their Medicare patients.
- The goal of coordinated care is to ensure that patients get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.

The structure of the CMS ACO APM was not a new concept. Private groups began experimenting with similar innovative care models before 2011 in an attempt to reduce costs and improve outcomes. The original inspiration for the CMS ACO payment model included health care delivery systems modeled by the Mayo Clinic, Cleveland Clinic, Geisinger Health System, and Intermountain Healthcare (Gold, 2011). The ACO model resembles that of a health maintenance organization, but ACO beneficiaries do not have to stay within a specific provider network to receive care. Integrated health networks also resemble ACOs but are funded by private insurance payers.

Quality

The primary incentive for physicians and hospitals to participate in a CMS ACO is the shared savings promised by CMS. When an ACO both delivers high-quality care and reduces overall spending, it shares in the financial savings it achieves for the Medicare program (Gold, 2016). To determine eligibility for receiving shared savings, CMS considers 31 reported quality measures in addition to overall dollars spent (CMS, 2018c, Table 1, p. 2). These quality measures aim to prevent ACOs from simply reducing services without improving care.

Of the 31 ACO quality measures required by CMS, at least 10 provide an opportunity for occupational therapy practitioners to directly affect the goals of the ACO without a significant change to current occupational therapy practice. ACOs may be open to discussions about how occupational therapy practitioners can have a positive impact on quality outcomes because the results of the quality measures directly affect their Shared Savings potential. Advocating for the use of occupational therapy practitioners to meet these goals could improve the presence and value of occupational therapy services in the ACO model.

ACO quality measures that can be directly related to occupational therapy services are as follows:

- ACO-13: Falls—screening for future fall risk
- ACO-16: Preventive care and screening—body mass index screening and follow-up
- ACO-17: Preventive care and screening—tobacco use, screening and cessation intervention

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- ACO-18: Preventive care and screening—screening for clinical depression and follow-up plan
- ACO-28: Hypertension—Controlling high blood pressure
- ACO-35: Skilled Nursing Facility 30-Day All-Cause Readmission measure (Smith et al., 2017)
- ACO-36: Unplanned admission for patients with diabetes
- ACO-37: Unplanned admission for patients with heart failure
- ACO-38: Unplanned admissions for patients with multiple chronic conditions
- ACO-40: Depression remission at 12 mo.

A Seat at the Table

Because of the uncertainty surrounding the future direction of CMS regarding value-based care structures, it is difficult to predict the nuances of future policy. However, the suggestions discussed in this section can improve the practice of occupational therapy and expand its role in alternative payment models. Every practitioner has an opportunity to push the wheel of innovation with support from appropriate ideas, education, and resources.

Individual practitioners and administrators can advocate for occupational therapy's involvement in an ACO by approaching leaders in their system to discuss how rehabilitative and habilitative services can contribute to the goals and cost savings of an ACO. In addition, practitioners and managers should participate in discussions about electronic health records (EHRs) and health information technology because these decisions may have an impact on the ease with which therapy services are integrated into any alternative payment model.

If occupational therapy practitioners and managers do not advocate in the systemic decision-making process or in determination of individual care plans for the inclusion of occupational therapy services, then who will? We practitioners must continue to spread the word about the benefits of occupational therapy, encourage increased and unconventional (though evidence-based) use of occupational therapy, and ensure that every member of the care team knows the valuable role occupational therapy practitioners play across the care continuum and in health care, home, and community settings.

Value of Therapy

To best integrate occupational therapy services into the ACO model, occupational therapy practitioners must demonstrate how current best practice aligns with the goals of an ACO without the need for drastic changes to the payment model. The American Occupational Therapy Association (AOTA; 2012) highlighted that

> occupational therapy practitioners can play an integral role in ACOs by utilizing their unique skills and qualifications: Assessments can focus on the improvement of a patient's quality of life and include evaluations of home safety, [activities of daily living and instrumental activities of daily living], participation, vision, ergonomics, driving, fall risk, swallowing, pediatric, and mental health. (p. 1)

Under an ACO, occupational therapy practitioners will most likely not have to make drastic changes in their approach to services because current best practice for occupational therapy practitioners closely aligns with the identified goals of an ACO. In current best practice, occupational therapy practitioners develop holistic client-centered care plans, play an active role on interdisciplinary teams, provide function and evidence-based interventions and evaluations, educate caregivers and patients on chronic disease management, and seamlessly integrate behavioral and physical health—all of which align with the current goals of all ACO models. Through the practice of sound, evidence-based occupational therapy, practitioners can contribute to the quality metrics, such as reduction of unnecessary hospitalizations and 30-day rehospitalizations, decreased incidence of falls, and participation in long-term disease management (AOTA, 2012, 2016).

As AOTA (2012) accurately identified, it is important for occupational therapy practitioners to continue to "clearly articulate their program of care, the cost of that care, their role on the team, and the expected outcomes of their care. Knowledge of existing effectiveness standards is essential" (p. 3). If practitioners are not able to document medical necessity and positive progress for short- and long-term disease management, it will be difficult to justify occupational therapy's role in value-based care. Therefore, all goals and outcomes must be meaningful and easy to understand, and they must use a common language. "Occupational therapy practitioners will be held accountable for providing high quality, patient-centered, evidence-based care at reduced costs" (AOTA, 2012, p. 3). So it is we who must articulate all that we can do.

Continuity of Care Through Electronic Documentation

The appropriate use of an EHR can improve quality, efficiency, and communication between providers and help reduce costs and medical errors (U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, 2018). In a value-based care system, it is important that occupational therapy practitioners accurately document the need for skilled therapy and demonstrate the use of evidence-based practice. Improving other providers' access to this information may facilitate understanding of occupational therapy's role in the care team.

CMS and Congress have repeatedly demonstrated their desire to incentivize clinicians to use EHRs through multiple laws (CMS, 2018c), such as the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), the Health Information Technology for Economic and Clinical Health Act (2009; Pub. L. 111-5), and the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (Pub. L. 114-10). With the advancement of EHRs, high productivity demands, and a system based on outcomes, it has become increasingly necessary to design a uniform EHR documentation outline that

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can be integrated into multiple platforms and used by the majority of practitioners. AOTA has taken steps to improve the integration of the occupational therapy profile into EHRs to improve the quality of occupational therapy services, but the profile has yet to be integrated into all documentation systems (AOTA, 2017). This is another area in which on-the-ground practitioners can use AOTA's resources to educate and inform managers and improve EHR collection of occupational therapy data in a consistent and useful manner.

The use of an integrated EHR across all stages of care could significantly improve provider efficiency and the quality of care provided. Having access to previous therapist and physician documentation can provide practitioners with a more complete picture of patients' status and goals. Integrated EHRs containing basic occupational profile information could prevent the need to start the evaluation anew at each stage of care. If occupational therapy practitioners are involved in EHR development, they can advocate for including appropriate resources and information in the EHR to improve quality of care. In addition, with increased integration, occupational therapy notes could potentially contribute to the algorithms used by ACOs to determine the quality outcomes that qualify an ACO for shared savings.

If such templates are integrated across systems, practitioners will have a unified system to communicate function and patient goals to other practitioners and clinicians. If practitioners are able to demonstrate their effectiveness in a common way, it will ease the transition for inclusion in ACOs and other APMs.

Billing

Government agencies, commercial payers, and other researchers know occupational therapy through billing practices (B. Hull, personal communication, November 2017). Accurate billing indicates scope of practice, reflects clinical reasoning and productivity, and contributes information to the determination of quality metrics. As EHRs continue to advance, therapy billing information could be used as a metric that predicts the complexity of a patient's needs.

Inappropriate use of billing codes can lead to an inaccurate picture of the profession and provide CMS and other payers with inaccurate data. If an intervention or evaluation is not billed accurately or integrated into the larger EHR network, then it cannot contribute to the goals and outcomes of the ACO. Practitioners must be knowledgeable and consistent in describing their services to meaningfully contribute to achieving ACO outcomes.

Discharge Planning and Transitions

Occupational therapy practitioners have a critical role in discharge planning and transitions because of their ability to conduct comprehensive evaluations of a person's functional independence, psychosocial factors, and cognition. Occupational therapy practitioners are able to determine whether a patient can safely return home or whether the patient requires further intensive rehabilitation. Occupational therapy practitioners also provide caregiver training, environmental adaptations, and other recommendations that facilitate a successful transition (AOTA, 2016). Occupational therapy practitioners must ensure that they appropriately document discharge plans, patient goals, and clinical reasoning in an accessible and understandable way for the attending clinician, who often makes the final discharge decision.

Interdisciplinary Team Member

Occupational therapy practitioners continue to play a critical role on the interdisciplinary team, where care coordination can happen daily. The effectiveness of an interdisciplinary team greatly relies on effective communication and collaboration. Effective communication can be facilitated by using a universal language to define function between professions and to integrate occupational therapy documentation with that of other professionals.

Practitioners must be equipped with the skills and resources to effectively communicate with other professionals and convey the importance of their findings in terms of function and transition planning. If occupational therapy notes are not located alongside notes from other professions, occupational therapy services will not fully contribute to the patient's *longitudinal care plan,* an action plan created by the medical team, patient, and family to plan for long-term disease prevention and treatment goals (Dykes et al., 2014). Communicating in the language of the team and ensuring that information such as notes is accessible to the care team is essential for occupational therapy's inclusion in new payment models and will promote an understanding of the goals and importance of the profession as a whole.

Chronic Disease Management

As the health care system continues to promote value-based care and capitated or bundled payments over traditional fee-for-service payment, occupational therapy practitioners must emphasize their role in longitudinal care, including as part of an interdisciplinary chronic disease management team. Longitudinal care plans are often holistic, dynamic, and integrated across the spectrum of care. Occupational therapy has much to offer in the development and implementation of such plans. Thus, these are fertile places to nurture new and expanded opportunities for occupational therapy.

As noted earlier, ACOs were established to improve care coordination and reduce wasteful duplications in services leading to improved outcomes for patients. Occupational therapy practitioners are often involved in every step of a patient's care both to prevent costly outpatient or home-based services and to prevent readmissions to hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health and outpatient care. At all stages of care, occupational therapy practitioners place a unique emphasis on a patient's psychosocial, socioeconomic, cognitive, physiological, and behavioral health needs (AOTA, 2016), which makes them the perfect contributors to a patient's longitudinal care plan. As the ACO model continues to be developed, the profession may see an opportunity for growth in these and other teams and in the underlying provision of coordinated, comprehensive, and continuous

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care that improves health and patient satisfaction (Metzler et al., 2012).

Behavioral Health

Behavioral health is an important component of ACOs and is included in the 31 quality metrics used to assess the success of an ACO (CMS, 2018c; refer to the metrics on identification of depression and on remission of depression). In many ways, occupational therapy practitioners are the perfect providers to bridge the gap between behavioral health and physical health and to achieve critical quality metrics (CMS, 2018c). Occupational therapy practitioners have an advanced understanding of how social determinants and behavioral health influence patients' overall function and health. This capacity, if used within an ACO, contributes not only to success in addressing the direct behavioral health depression metrics but also in achieving success on the tobacco use cessation and readmission metrics.

Again, to increase the presence of occupational therapy in behavioral health, each practitioner must be an everyday advocate. Clearly documenting the use of evidence-based behavioral health interventions and using the appropriate *Current Procedural Terminology*® codes can demonstrate the benefit of occupational therapy services in behavioral health beyond traditional mental health settings. Practitioners, however, must be aware of and responsive to sharing this information in ways in which other professionals, as well as managers and other decision makers, will be able to decipher and understand occupational therapy's contributions in behavioral health and throughout the health care system.

Reduction in Unplanned Admissions and Readmissions

Thirty-five percent of all Medicare Shared Savings Program quality losses came from unplanned admissions for heart failure, the percentage of primary care providers who qualified for EMR incentive payment, and unplanned admissions related to chronic obstructive pulmonary disorder (COPD) and asthma. Hervey and Muhlestein (2016) suggested that ACOs will likely dedicate larger resources to improve outpatient treatment of heart failure and COPD and asthma and to improve patient adherence to medications to reduce unexpected admissions. Occupational therapy practitioners who work with these populations may be the initial key to expanding the role and value of occupational therapy in ACOs. In one critical study, occupational therapy was deemed the "only spending category where additional spending has a statistically significant association with lower readmission rates" for heart failure, pneumonia, and acute myocardial infarction (Rogers et al., as cited in AOTA, 2016, p. 1). Alerting fellow direct care professionals in ACOs to the benefit of occupational therapy in reducing costly care and penalties will potentially make ACO management all the more willing to incorporate occupational therapy into their approach.

Potential Barriers to the Inclusion of Occupational Therapy

Additional challenges specifically hinder occupational therapy's advancement in the ACO model. These challenges are not necessarily exclusive to ACOs. As it currently stands, occupational therapy does not have a seat at the table. ACOs are primarily formed by physicians, hospitals, or other health systems usually with physician leadership and without a concerted effort to include nonphysician providers. CMS has only just begun to demonstrate an interest in expanding the role or presence of skilled therapy in alternative payment models. In addition, it is difficult for therapy providers to be involved in an ACO if they are unaware of its existence. If providers are unaware of their involvement in an ACO or their patient's enrollment in an ACO, they are unable to fully support the ACO model. To compound matters, such information can be challenging to locate and may not be indicated on patient charts. Nevertheless, practitioners must try to gain as much information about the systems in which they work, their goals, and the opportunities to promote the distinct value of occupational therapy. It is all the more important that occupational therapy practitioners demonstrate how they provide high-value care and reduce overall dollars spent while improving health and function.

Cost Efficiencies

As ACOs continue to mature, physicians and hospitals must continue to promote cost savings and maintain cost reductions. Although identifying redundancies or inefficiencies in therapy may be more difficult than in some areas of health care, it still must be done. Practitioners must identify which interventions and assessments are not best practice and yield poor outcomes. Efforts in the occupational therapy community have already begun, as demonstrated by AOTA joining the Choosing Wisely Campaign (AOTA, 2018). Practitioners not practicing at the top of their license, providing nonskilled services, or using non-evidence-based approaches risk conflation of their profession and practice with other therapies or even designation as an ancillary service. For the preservation of the profession, it is essential that occupational therapy practitioners demonstrate their distinct value on a daily basis. Doing otherwise risks the assumption that therapy costs more than it saves.

Future of Accountable Care Organizations and Value-Based Care

Reviews of ACOs and their benefits have been positive. The Medicare Payment Advisory Commission (2018) has expressed support for continuing this experiment. CMS continues to encourage ACOs to take on more risk and increase the use of capitated payment systems. Note, however, that CMS has rolled back some bundled payments aimed at improving efficiency within a defined episode, such as the Comprehensive Joint Replacement Model, even as it is expanding ACOs, which focus on improving population health and decreasing overall spending (Muhlestein et al., 2017).

Conclusion

Occupational therapy practitioners must be committed to providing evidence-based

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and client-centered care to facilitate the integration of optimum, creative, and beneficial therapy services into the ACO payment model and other future alternative payment models. All practitioners must continue to search for opportunities to advocate for occupational therapy services at the local, state, and federal levels in addition to participating in facility-level decisions. Ongoing debates about the future of the health care delivery system provide a unique opportunity to create change and grow the field of occupational therapy. Occupational therapy practitioners, educators, and researchers should investigate and expand into new and different roles. ACOs can be a fantastic testing ground for such new areas.

To conclude, occupational therapy practitioners have multiple opportunities to have a positive impact on ACOs and demonstrate the benefit of occupational therapy's inclusion in alternative payment models. If, however, practitioners wait to be approached by an ACO before advocating for a spot, the opportunity may never come. As CMS and other payers search for opportunities to reduce spending, it is vital that occupational therapy practitioners document medical necessity, meaningful outcomes, skilled occupation-based interventions, and the use of evidence-based practice for every patient in every note. This is a call to action for occupational therapy practitioners to influence the changing tides and not wait for a knock on the door. If we do not have a seat at the table, we will be on the menu. ▲

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