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ACO Model Fits Pediatrics Well

- Patient-centered/Family-centered focus
- Emphasis on care coordination
- Strong primary care base
- Quality measurement focus on improved outcomes
- Population health management

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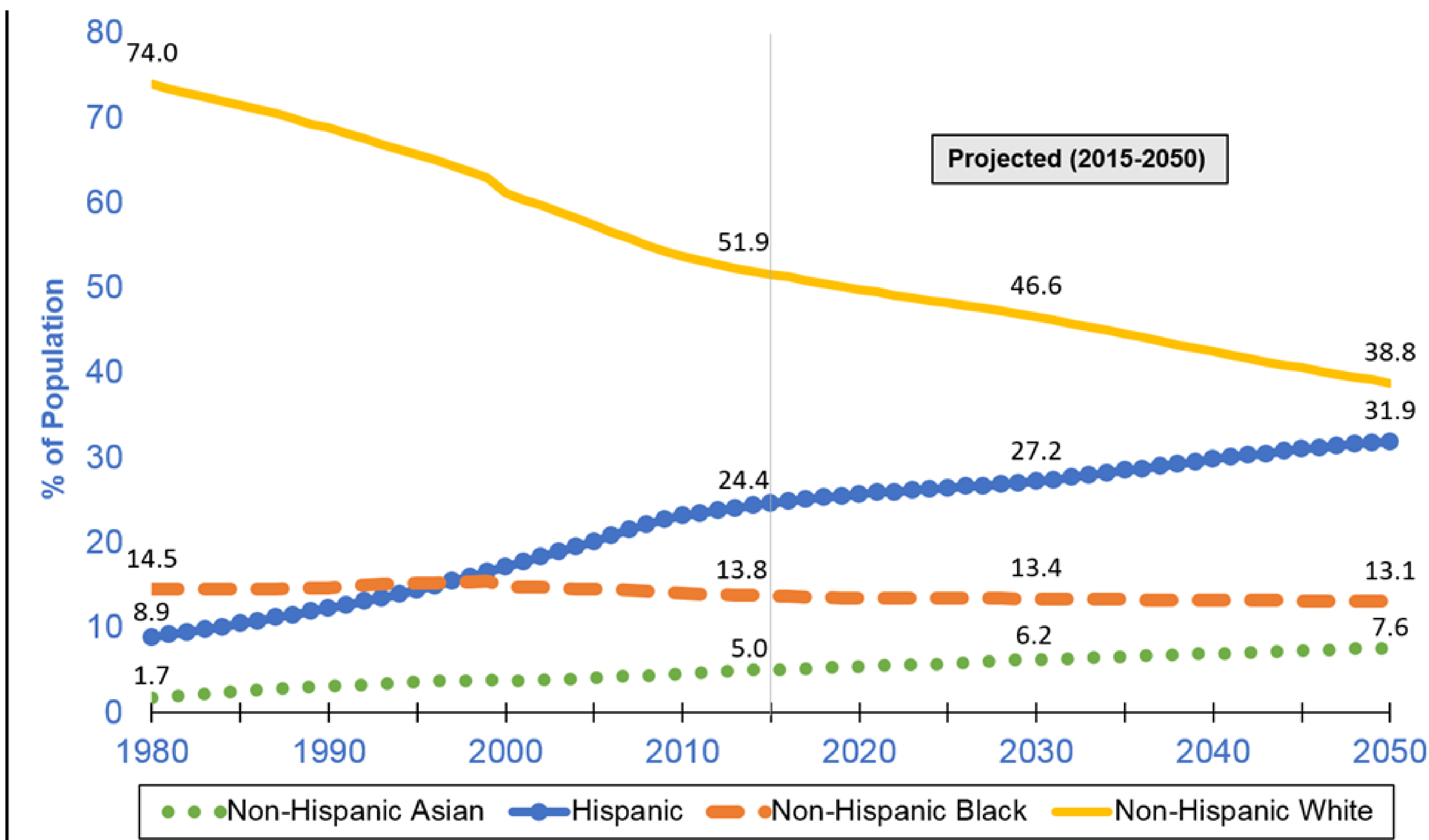
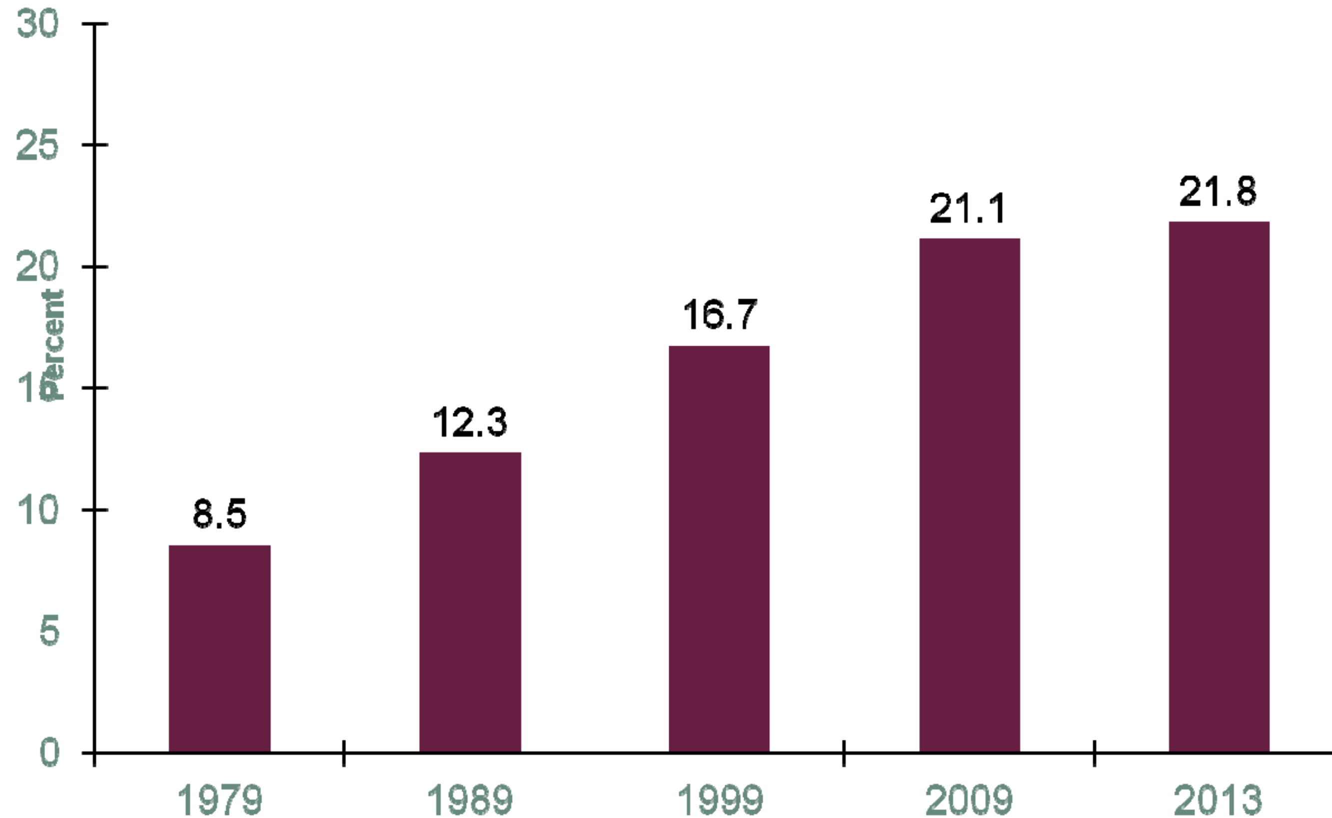
Population Characteristics Distinguish Pediatric from other ACOs

- Highly diverse pediatric population
- High rates of poverty
  - Some persistent over generations
- Emphasis on prevention
- Increasing prevalence of chronic conditions

Trends in Race/Ethnicity of U.S. Children (under 18) Recorded (1980-2014) and Projected (2015-2050)



Percentage of Children (ages 5-17) who Speak Language Other than English at Home: 1979-2013



Source: U.S. Census Bureau, Current Population Survey and American Community Survey

Portion of U.S. Population Living Below Federal Poverty Level by Age Group: 1980-2013

ELOW 100% OF FEDERAL POVERTY LEVEL

25
20
15
10
5
0

1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012

Children under 18
Adults 18-64
Adults 65 plus

Source: U.S. Census Bureau. Income and Poverty in the United States: 2013, Current Population Reports

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More Children have Chronic Conditions than Generally Thought

- High rates of obesity, asthma, mental/behavioral health and developmental conditions (6-8 million)
- Smaller but important group of rare conditions – typically requiring complex subspecialty involvement (2 million)
- Small number of highly complex, multi-system involved children (0.5 million)
  - Tracheostomy, G-tube, Mobility assistance, etc.
- Increasing rates of disability among young Americans of working age

80 million US children/youth <21yo

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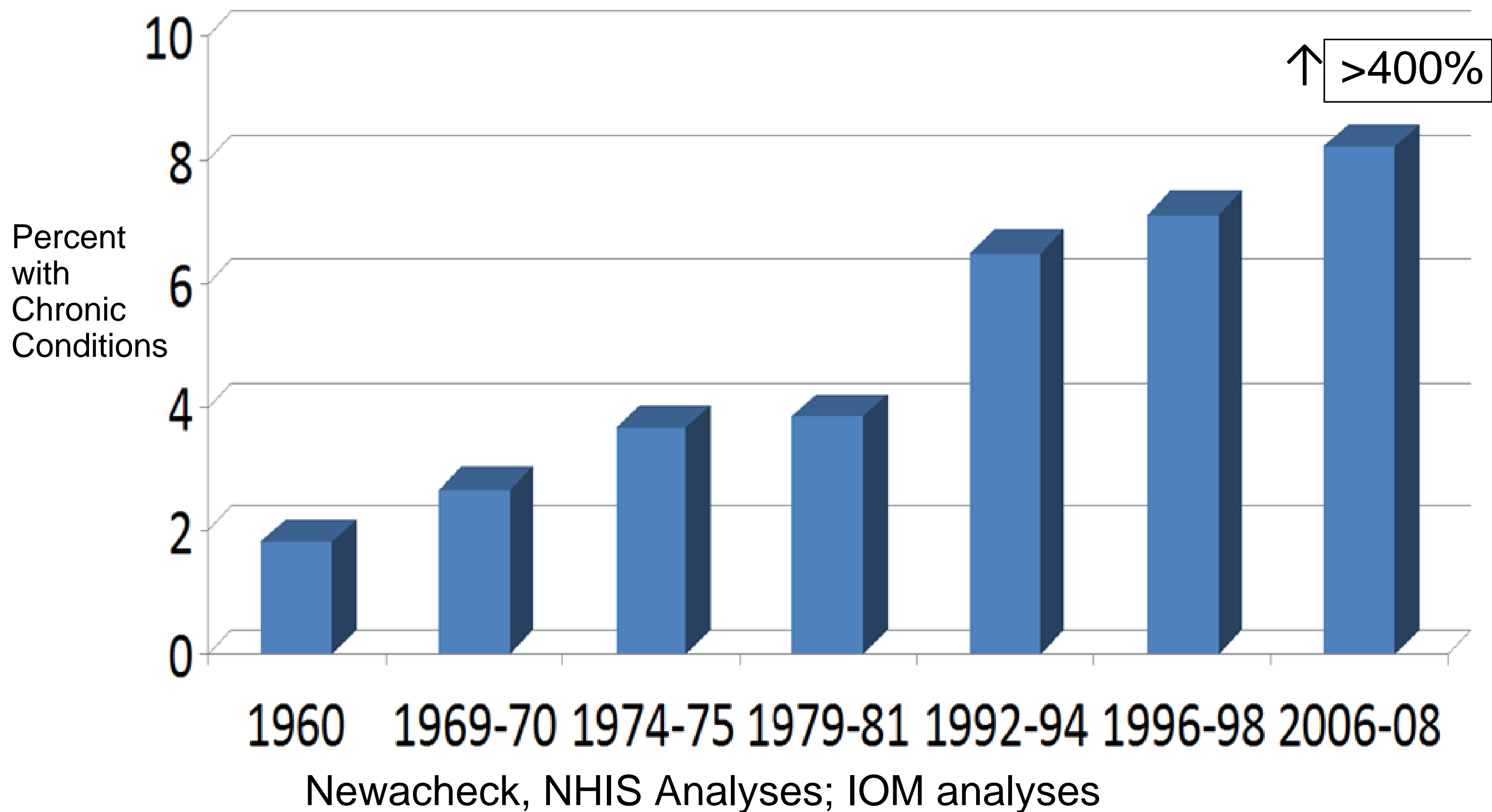
Activity-Limiting Chronic Conditions



Newacheck, NHIS Analyses; IOM analyses

ACO Growth Slower in Pediatrics

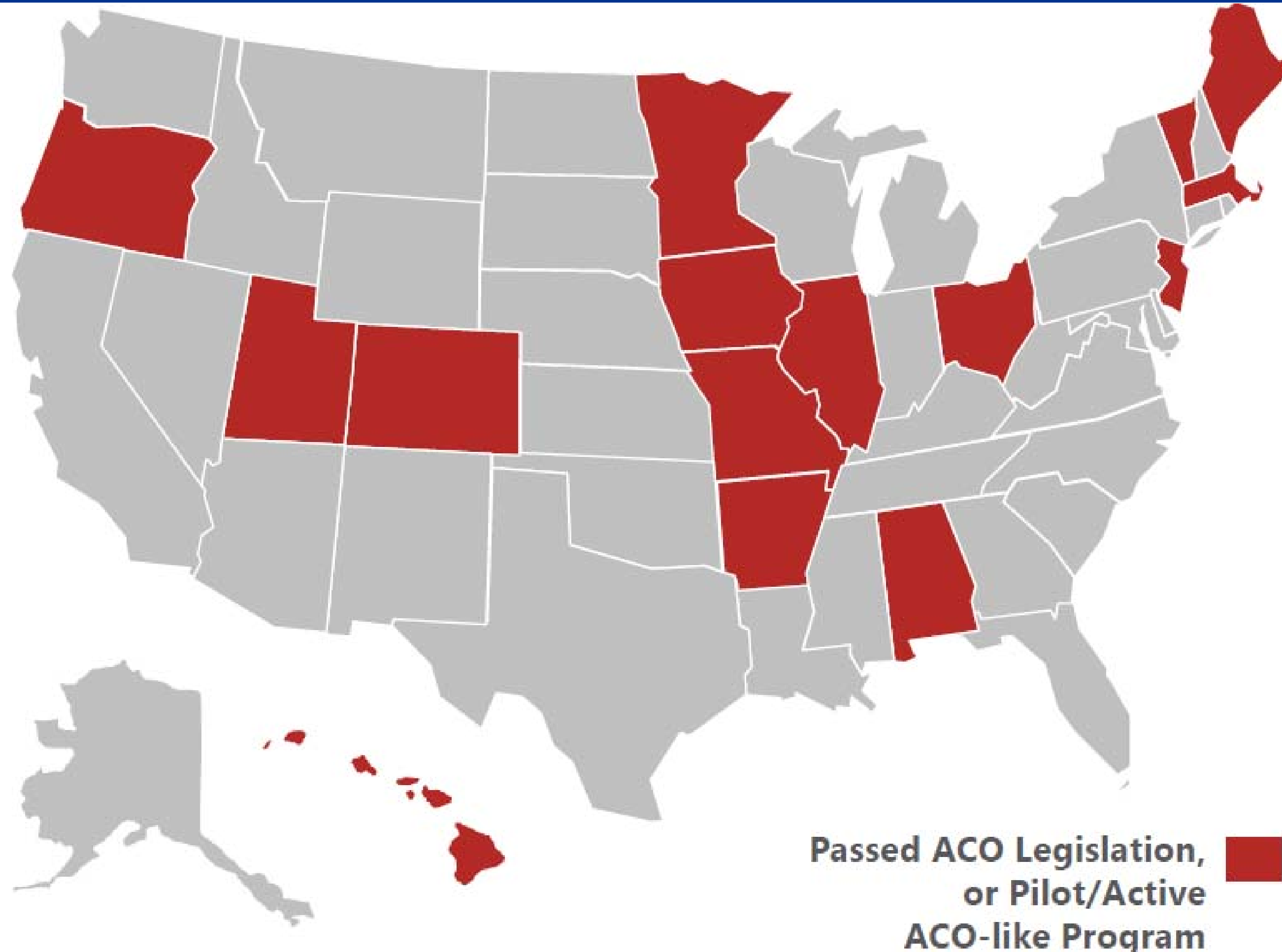
- ACA included language regarding pediatric ACO model development…

- …but project was never funded

Title II, Subtitle I, § 2706 (Pediatric ACO Demonstration Project)

The HHS Secretary shall establish a project that authorizes participating states to recognize pediatric providers that meet specified requirements as ACOs for the purpose of receiving incentive payments. The demonstration shall run from January 1, 2012 until December 31, 2016. States will apply to the Secretary in order to be included, although parameters of this application have yet to be determined.

State Medicaid Accountable Care Programs



Characteristics Common among Medicaid ACOs

- Payment models often include enhanced per member per month (PMPM) payments
- Some element of shared savings and/or global payments
- Increasingly looking to population health as component of reform activity
  - Shareable, meaningful data can be hard to come by
- State models could become models for nationwide reform

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Pediatric Case Studies – AAP/Leavitt Partners

Name	Market	Providers Involved	Year Est.	Payer Mix	Payment Arrangement	ACO Parti-cipants
UH Rainbow Care Connection	Cleveland	UH-employed + community physicians	2012	Medicaid (commercial)	Shared Savings	200k
Children's Mercy Pediatric Care Network	Kansas City	Children's Mercy Hospital-employed + community physicians	2012	Medicaid	Capitation, Shared Savings	100k
Advocate Accountable Care ACE	Chicago	Advocate Health System, Advocate Physician Partners	2014	Medicaid	Care Mgmt, SharedSavings	20k
Colorado Pediatric Collaborative	Denver	Colorado Pediatric Partners, Children's Hospital Colorado, Physician Health Partners	2012	Aetna, Anthem	Care Mgmt	200k
The Children's Care Network	Atlanta	Children's Healthcare of Atlanta, Kids Health First Pediatric Alliance	2015	N/A	N/A	N/A

Study strategy

- Organization diversity
  - Geographic
  - Represent variety of health care markets
  - Range of timing in creation and market entry
  - Differences in structure
    - E.g., clinically integrated network, Medicaid ACO, ACO-like models
- Willingness to participate/approval from AAP leadership
- Qualitative study of key clinical/administrative informant along with market analysis on patient demographics and market forces

Case Study #1: University Hospitals Rainbow Babies and Children's Hospital

- CMMI award ($12.5 million)
- Strategic Goals
  - Improve quality of care in primary care practices
  - Improve health and quality of care for medically complex children
  - Improve access, functionality of children with behavioral health problems
  - Decrease avoidable ED visits
  - Create sustainable model

Case Study #1: University Hospitals Rainbow Babies and Children's Hospital *(cont.)*

- Payment
  - Moving toward value-based payment
  - Contract with four of five Medicaid-managed care plans and four commercial plans
  - Medicaid includes dollars earned for reduced costs for ED, pharmacy and improved quality
  - Shared savings dollars received
- Community pharmacy kiosks

Case Study #2: Children's Mercy Integrated Care Solutions/Pediatric Care Network

- Background
  - Hospital sold Medicaid health plan
  - Formed "Integrated Pediatric Network"
  - Contracted with largest Medicaid MCO for all health care services for global capitation (65,000 lives)
  - Began building network of community and employed PCPs and specialists

Case Study #2: Children's Mercy Integrated Care Solutions/Pediatric Care Network *(cont.)*

- Strategic Goals
  - Volume to value
  - Create administrative efficiency, remove barriers to payment
  - Provision of corporate-based transformation team
  - Innovative technologies to support practices transformation efforts

    e.g., patient portals

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Case Study #3: Colorado Pediatric Collaborative

- Background
  - $1.5 million multi-year grant from Colorado Health Foundation
  - Commercial payer involvement essential to draw support from private practice pediatricians
  - Heavy emphasis on QI initiatives with direct support outreach to practices

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Case Study #3: Colorado Pediatric Collaborative *(cont.)*

- Strategic goals
  - Streamline data reporting by developing common IT platform for all practices/institutions
  - Focus on population health management
  - Evidence-based guidelines: asthma, immunizations, obesity, mental health, CYSHCN
- Payment
  - Working toward shared savings contracts
  - Current payment models based on PMPM care management fee and benefit bonus associated with meeting care metrics

Case Study #4: Children's Care Network Atlanta

- Background
  - Based on existing, well-defined clinically integrated network comprised of two pediatric health care systems
  - Rapid market changes in Atlanta region required new way of delivering pediatric care
  - Five-year funding commitment from Children's Healthcare of Atlanta ($25 million)
  - Proactive physician leadership key to success
  - Engaged vendors to build IT system and brand the entity

Case Study #4: Children's Care Network Atlanta *(cont.)*

- Strategic Goals
  - Aggressive QI program
    - Have developed seven PCP core measures; 57 specialty measures to date
  - Create clinical and financial environment to keep practices engaged in network operations
  - Emphasis on population health management
- Payment
  - Explore direct contracting with employer groups
  - Engage payers in adopting wrap-around P4P contracts
    - Physicians free to keep existing contracts but must agree to provide data to population health program
  - Evolve into value-based/risk-based contracting

Case Study #5: Advocate Accountable Care Entity (ACE)

- Background
  - Collaborative partnership between physicians, Advocate system
    - MSO operations, clinical integrated program, AdvocateCare programs -- outpatient, acute and post-acute
  - 11 PHOs; 4,900 employed and independent physicians
  - Joined Illinois Medicaid version of accountable care
  - Clinical integration driven by evidence-based guidelines, quality/utilization goals, data warehouse, QI commitment
  - Separate pediatric leadership structure tied to its children's hospitals and employed physician groups

Case Study #5: Advocate Accountable Care Entity *(cont.)*

- Strategic Goals
  - Emphasize PCMH, pediatric-specific QI metrics
  - Coordinated care for medically complex children
  - Outpatient pediatric care management model includes
    - Close relationship with specialty care
    - Use of telehealth services and community health workers
- Payment
  - Current physician payment based on FFS and PMPM care coordination fee
  - Goal is to gradually move to full-risk model; state mandates investment in infrastructure to support full-risk model

Key Findings from AAP-hosted ACO Summit

- Substantial capital investment needed; typically provided by hospital
- Data needed to evaluate clinical and practice performance; acquiring Medicaid data proving difficult
- Cost-saving emphasis resulted in initial focus on children with complex medical conditions
  - Key program intervention was support for care coordination to avoid unnecessary ED visits/hospital admissions

Key Findings from AAP-hosted ACO Summit *(cont.)*

- Urgent need to address behavioral health issues and integrate care into community-based pediatric care programs
- All ACOs provided incentives to encourage pediatricians to take active role in ACOs
  - QI Training
  - Support for PCMH certification
  - MOC opportunities through network
- All ACOs use pediatric-specific QI metrics
  - Adult measures inappropriate for pediatrics
  - Some incorporated metric related to social determinants of health
    - School readiness, use of childhood early education
- Some experimentation with innovations in telehealth technologies

Next Steps for Pediatric ACOs

- Characterize and disseminate best practices:
  - Data access and management
  - IT
- Special populations (CMC, behavioral health, social risk)
  - Develop robust pediatric-specific quality metrics that include long-term outcomes
- Building quality improvement programs
  - Defining value in pediatric care
- Harnessing new technologies

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