ACOs and Pediatrics

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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
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
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

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 <21y0
Activity-Limiting Chronic Conditions

Newacheck, NHIS Analyses; IOM analyses

Percent with Chronic Conditions

↑ >400%


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

Passed ACO Legislation, or Pilot/Active ACO-like Program
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
## Pediatric Case Studies – AAP/Leavitt Partners

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