The Pediatric ACO: When Things Go Bump in the Night

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Objectives

- Define an Accountable Care Organization (ACO) according to the 2010 Patient Protection and Affordable Care Act (PPACA).
- Describe the demonstration projects that support the potential value of using an ACO to improve the quality of health care delivered.
- Review the recommendations of major pediatric organizations related to Pediatric ACOs.
- Analyze the pro and con of adopting an ACO model to improve quality and reward PCPs for doing so.

Sunday Review
The New York Times
SUNDAY, AUGUST 14, 2011

The Elusive Big Idea

H. R. 3590

One Hundred Eleventh Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

906 pages as printed by US Government in 8 pt font

http://democrats.senate.gov/pdfs/reform/patient-protection-affordable-care-act-as-passed.pdf

Much Ado about ACOs

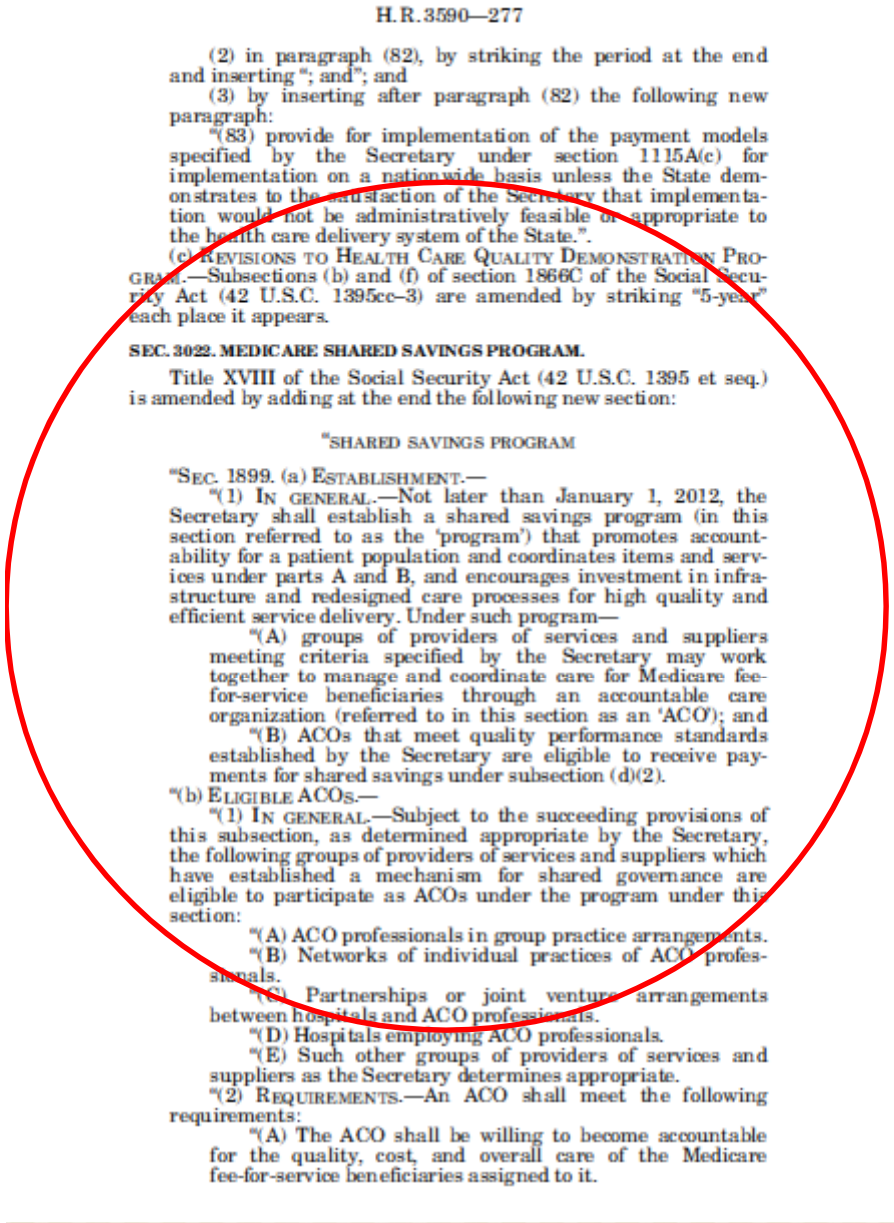
Background

- With the passage of the Patient Protection and Affordable Care Act (PPACA) , the Accountable Care Organization (ACO) concept is introduced and defined in the Medicare Shared Saving Program.

Accountable Care Organization (ACO)

→ an organization of healthcare providers that agrees to accept responsibility for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it. (PPACA §3022, 10307)

- The ACO model builds on the Medicare Physician Group Practice Demonstration Project.
- The ACO model clearly employs a number of the principles within the Patient-Centered Medical Home



H. R. 3590—277

(2) in paragraph (82), by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (82) the following new paragraph:

"(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.".

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking "5-year" each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"SHARED SAVINGS PROGRAM

"SEC. 1899. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

"(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

"(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

"(b) ELIGIBLE ACOS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

"(A) ACO professionals in group practice arrangements.

"(B) Networks of individual practices of ACO professionals.

"(C) Partnerships or joint ventures arrangements between hospitals and ACO professionals.

"(D) Hospitals employing ACO professionals.

"(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

"(2) REQUIREMENTS.—An ACO shall meet the following requirements:

"(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

Patient Protection and Affordable Care Act (PPACA) pages 277-281

Section 3022: Medicare Shared Savings Program

Background

Pediatric ACO Demonstration Project

- → a project … to recognize pediatric providers that meet specified requirements as an ACO … shall run from January 1, 2012 to December 31, 2016. States will apply to the Secretary in order to be included. (PPACA, §2706)

to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under

Patient Protection and Affordable Care Act (PPACA) pages 207-208 Section 207 Pediatric Accountable Care Organization Demonstration Project

Essential Characteristics of ACOs

1. The ability to provide a continuum of care across different institutional settings, including but not limited to ambulatory and inpatient hospital care.
2. The capability of prospectively planning budgets and resource needs
3. Sufficient size to support comprehensive, valid, and reliable performance measurement.

US Department of Health and Human Services. Pediatric Accountable Care Organization Demonstration Project. Section 2706.

http://dhhs.nv.gov/HealthCare/Docs/NVPolicyPapers/Section_2706_Pediatric_ACO.pdf

The Big Picture:

- "ACOs are not just a new way to pay for care but a new model for the organization and delivery of care."
- "An ACO will be rewarded for providing better care and investing in the health and lives of patients."

Donald Berwick, MD, CMS Administrator

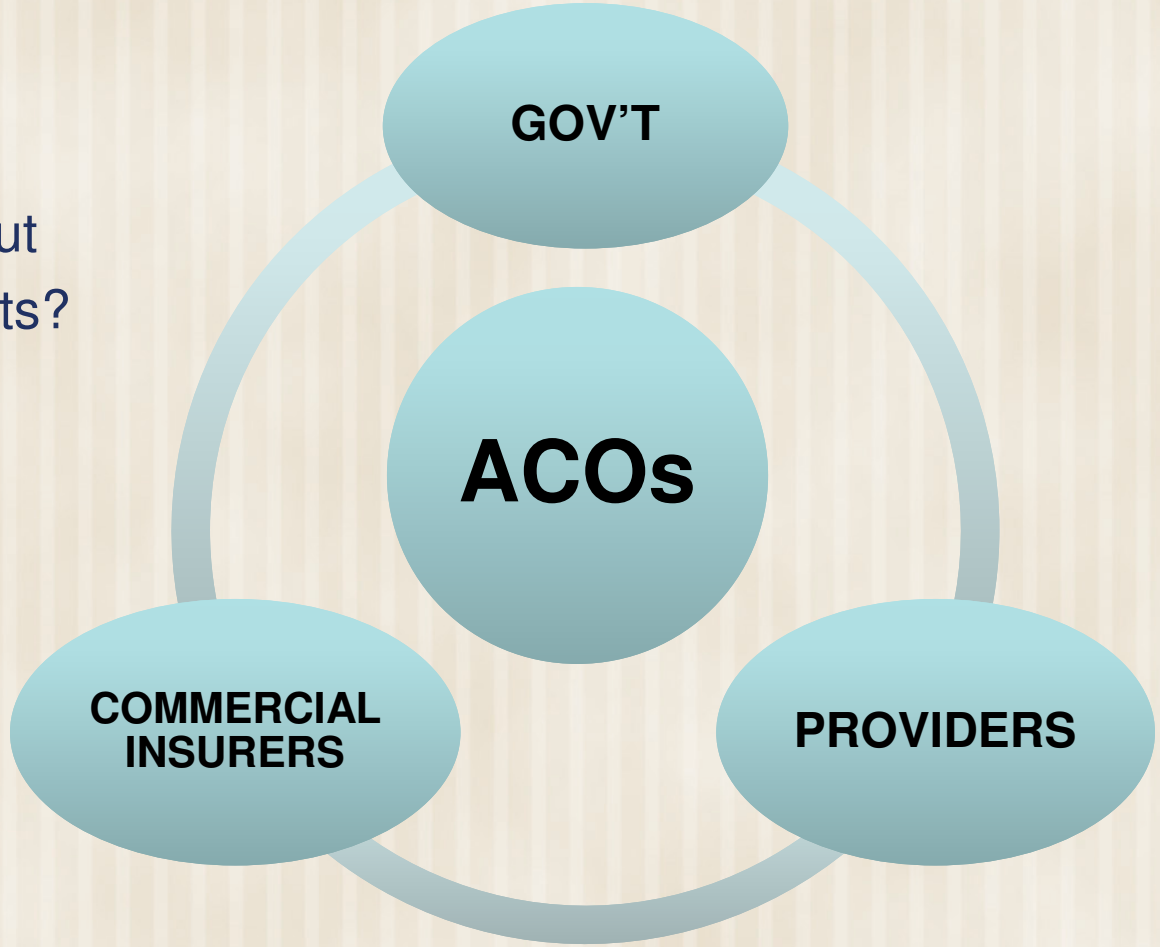
Ortolon, K. Failed Accountability? TMA, others criticize ACO rules. Texas Medicine. August 2011.

ACO Philosophical Underpinning

- 64% of Medicare patients' care delivered within "local referral network." (Dartmouth Institute)
- This local referral network of medical staff, hospital and related providers could be held accountable for the quality and cost of care.
- Patients don't need to enroll, just could be assigned based on PCP or where they receive most of their care.

ACO Development: Different Views and Definitions

What about the patients?



Harris, SF, McStay, RV. The Shifting Political and Policy Winds: Challenges Facing Children's Hospitals Under the Affordable Care Act. February, 2011.

ACO Development in the PPACA

Medicare Shared Savings Program (§ § 3022, 10307)

- Basic requirements
  - Accountability for the quality, cost and care of Medicare beneficiaries assigned to ACO
  - 3-year minimum participation commitment
  - Formal legal structure that allows for the receipt and distribution of shared savings payments
  - Sufficient number of primary care professionals to treat minimum of 5,000 Medicare beneficiaries

Harris, SF, McStay, RV. The Shifting Political and Policy Winds: Challenges Facing Children's Hospitals Under the Affordable Care Act. February, 2011.

ACO Development in the PPACA

Medicare Shared Savings Program (§ § 3022, 10307)

- Basic requirements (continued)
  - A leadership and management structure that includes clinical and administrative systems
  - Processes for evidenced-based, coordinated care management
  - Meet patient-centered criteria
  - Preference for multi-payer involvement

Harris, SF, McStay, RV. The Shifting Political and Policy Winds: Challenges Facing Children's Hospitals Under the Affordable Care Act. February, 2011.

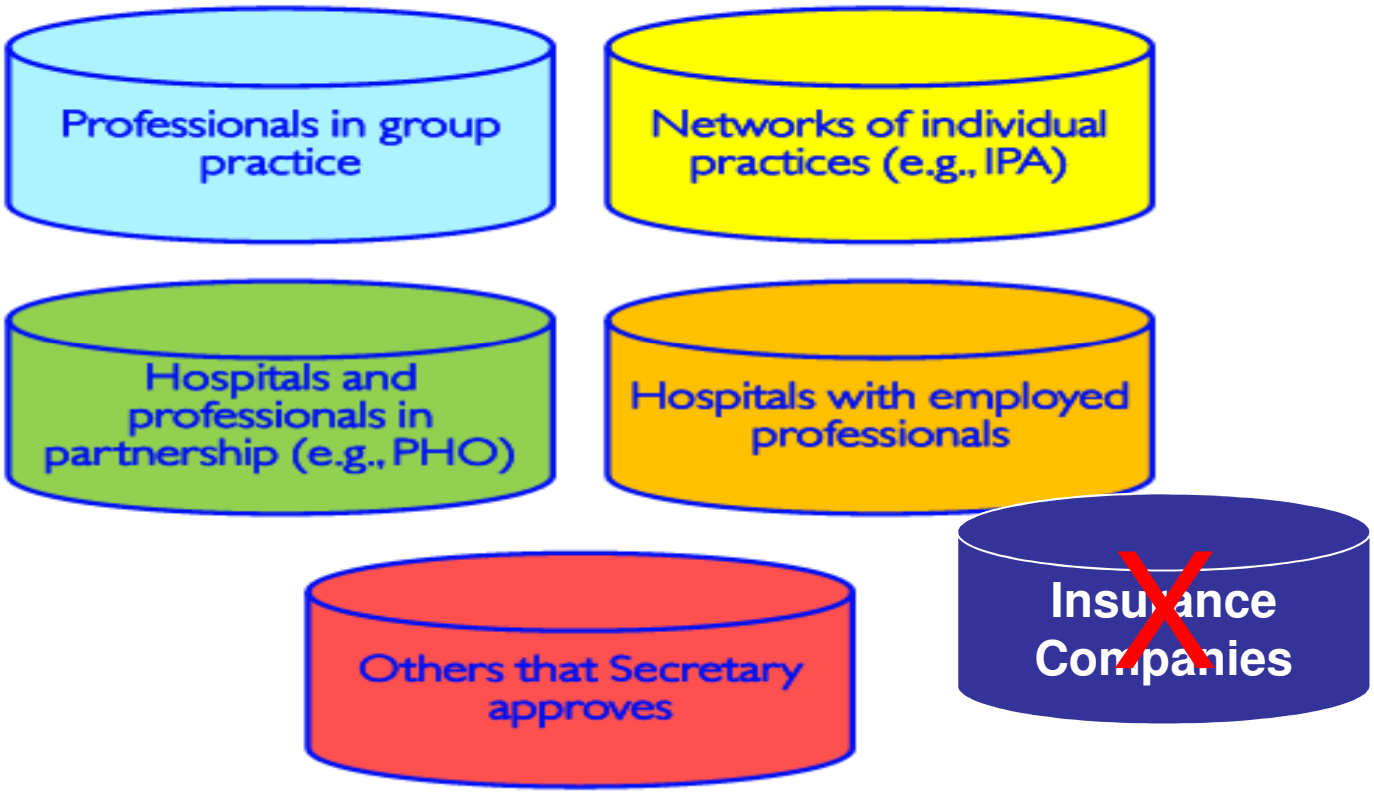
ACO Development Cont'd

Medicare Shared Savings Program (§ § 3022, 10307)

- Participation requirements
  - Demonstrated capacity to meet "patient-centeredness criteria" specified by HHS
    - "… such as the use of patient and caregiver assessments or the use of individualized care plans"
  - Preference will be given to ACOs
    - "… who are participating in similar arrangements with other payers"

Harris, SF, McStay, RV. The Shifting Political and Policy Winds: Challenges Facing Children's Hospitals Under the Affordable Care Act. February, 2011.

Who can be an ACO?



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DGAPARTNERS

Harris, J, Accountable Care Organizations-A Game-Changer. DGA Partners. AAIHDS Spring Manager Care Forum. April 22, 2010.

Figure 7: Three Shared Savings Models for ACOs

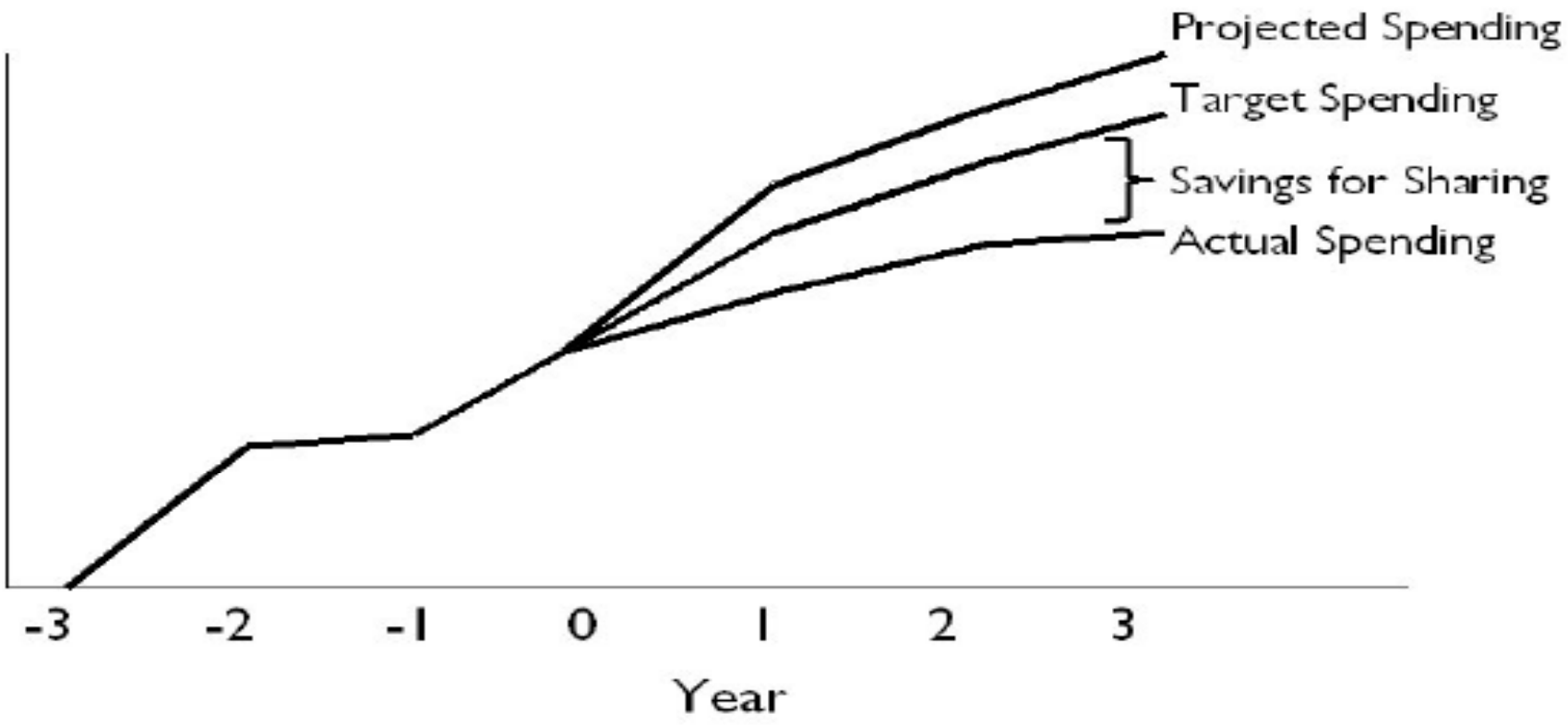
- ✔ Upside-only:
  - No penalty if costs exceed budget
  - ACO share of savings will be lower
- ✔ Full or partial risk
  - Upside and downside
  - ACO share of savings will be higher due to risk of loss
- ✔ Risk for part of care (e.g., only physician care)
- ✔ CMS will assess preparedness for particular contracting approach

(Taken from Pages 728-739 and 2186-2188 of PPACA)

Source: John M. Harris, DGA Partners

Harris, J, Karabatsos, L, Samitt, C, Shea, W, Valentine, ST. Essential Guide to Accountable Care Organizations: Challenges, Risks and Opportunities of the ACO Model. The Healthcare Intelligent Network. 2010

Figure 8: Upside-Only Shared Savings Model Over Time



Source: Dartmouth Institute for Health Policy and Clinical Practice

Source: John M. Harris, DGA Partners

Harris, J, Karabatsos, L, Samitt, C, Shea, W, Valentine, ST. Essential Guide to Accountable Care Organizations: Challenges, Risks and Opportunities of the ACO Model. The Healthcare Intelligent Network. 2010

CMS Physician Group Practices (PGP) Demonstration Project

Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.*

Physician Group Practice	Percentage of Quality Goals Attained				Shared Savings Payments ($)			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45	0	0	0	0
Dartmouth–Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34	0	6,689,879	3,570,173	328,798
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34	0	129,268	0	0
Forsyth Medical Group, Winston-Salem, NC	100.00	100.00	96.23	96.23	0	0	0	0
Geisinger Clinic, Danville, PA	72.73	100.00	100.00	100.00	0	0	1,950,649	1,788,196
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00	4,565,327	5,781,573	13,816,922	16,154,242
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34	0	0	0	0
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00	0	0	0	0
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11	0	0	3,143,044	8,185,757
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23	2,758,370	1,239,294	2,798,006	5,222,852

* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

Ingehart, John. Assessing an ACO Prototype – Medicare's Physician Group Practice Demonstration. The New England Journal of Medicine. 36;4(3):p 199.

Sebelius, K. Report to Congress. Physician Group Practice Demonstration Evaluation Report.. http://www.cms.gov/reports/downloads/RTC_Sebelius_09_2009.pdf

The Ideal:

Adapted from: Harris, J, Karabatsos, L, Samitt, C, Shea, W, Valentine, ST. Essential Guide to Accountable Care Organizations: Challenges, Risks and Opportunities of the ACO Model. The Healthcare Intelligent Network. 2010

Healthcare industry's response to ACOs:

(proposed Rules March 2011)

Mixed at best: concerned about the success of ACOs going forward…

- American Medical Association (AMA), American Medical Group Association (AMGA), American Hospital Association (AHA) & Medical Group Management Association (MGMA)
- American College of Physicians (ACP)

American College of Physicians (ACP) comments

- "…an ACO model has the potential of…enhancing quality, efficiency, integration, and patient-centeredness."
- "We are concerned, though that the current requirements proposed for acceptance as an ACO by Medicare under this program sets too high of a bar for participation by many internal medicine physicians, especially internal medicine specialists in primary and comprehensive care of adults who practice in smaller, independent physicians practices."

Hatton, D. Chair, Medical Practice and Quality Committee. American College of Physicians. Letter to Donald Berwick, MD, Administrator, Centers for Medicare and Medicaid Services, US Department of Health and Human Services.. June 2, 2011.

Joint Principles for Accountable Care Organizations

- American Academy of Pediatrics (AAP)
- American Academy of Family Practice (AAFP)
- American College of Physicians (ACP)
- American Osteopathic Associations (ACPAOS)

Twenty-one Recommendations!!

Healthcare industry's response to ACOs:
(Final Rules October 2011)

- Physician and hospital groups applauded the changes in the final ACO rule announced by officials at CMS.
- "We have been able to fine tune and improve the rules for a range of stakeholders, providers and patients, " said Donald Berwick, CMS Administrator.

Galewitz, P, Gold, J. HHS Releases Final Regulations for ACOs. Kaiser Health News. October 20, 2011.
http://www.kaiserhealthnews.org/stories/2011/october/20/accountable-care-organization-rules-regulations.aspx

ACP Applauds…

ACP concluded that the changes in the final rules will make it easier for:

- Primary care physicians to participate
- Many changes consistent with recommended suggestions

American College of Physicians. American College of Physicians Applauds CMS's Improved Shared Savings Program. Pressroom. October 20, 2011. http://www.acponline.org/pressroom/improved_shared_savings.htm

Final Rule Changes

- Less burdensome reporting
- Electronic medical records encouraged but not mandated
- Opportunity to avoid risk for losses
- Prospective patient attribution

American College of Physicians. American College of Physicians Applauds CMS's Improved Shared Savings Program. Pressroom. October 20, 2011. http://www.acponline.org/pressroom/improved_shared_savings.htm

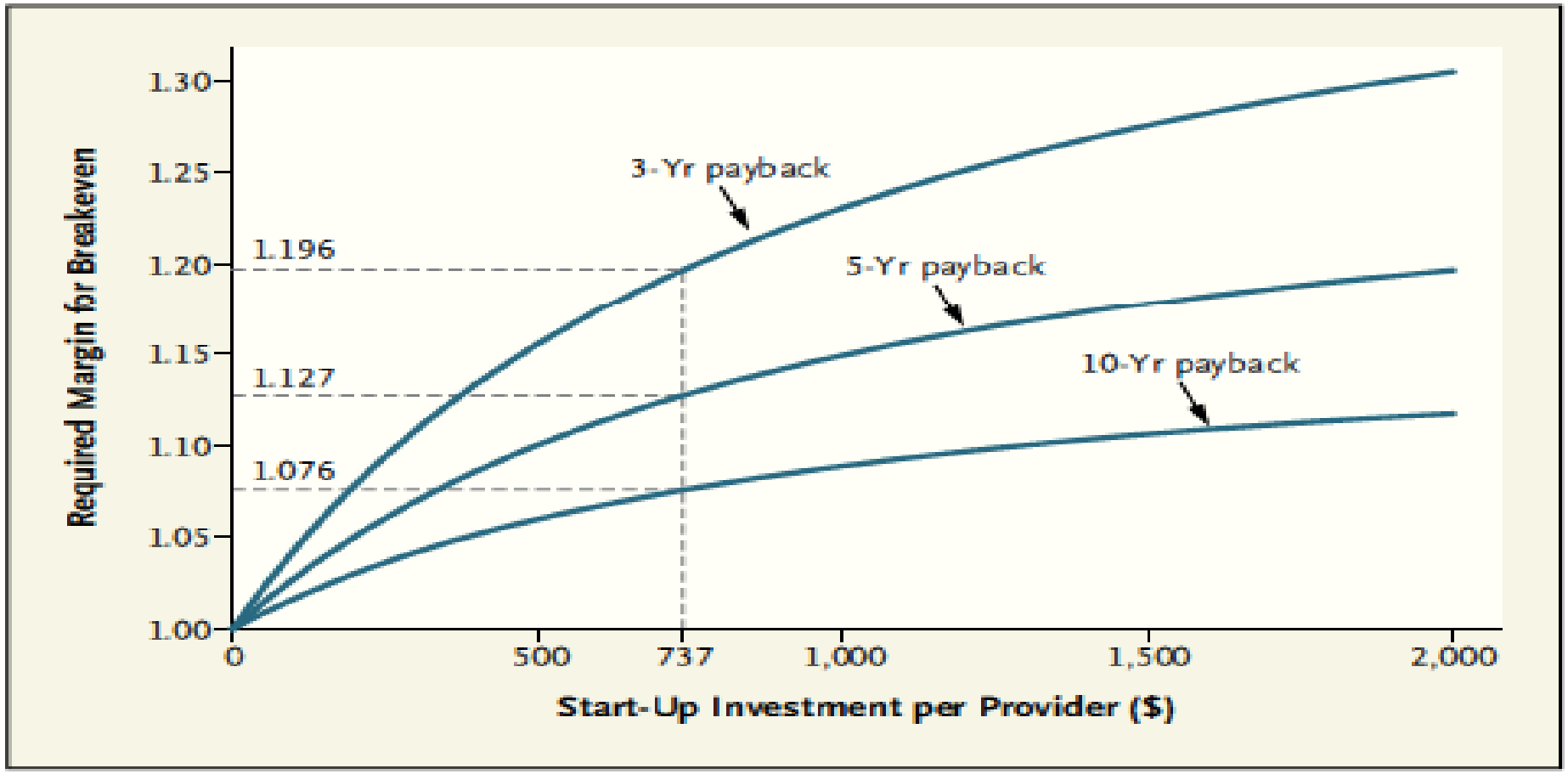
Estimate of ACO Investment

Average*

CMS (based on a range of an estimate of 75-150 ACPs	$ 1,800,000
AHA** (200-bed, single hospital system)	$11,600,000
AHA**(1200-beds, 5-hospital system)	$26,100,000

*Average amounts represent estimated costs for the start-up and ongoing costs for year 1.
**Draft estimates based on pending case studies. Includes start-up and ongoing costs for a typical year. Some costs may have already been incurred or be allocable to other budgets.

Necessary ACO Operating Margin



Required Operating Margin Needed for an ACO to Recover the Start-Up Investment.

Haywood, T.T., Kosel, K.C. The ACO Model – A three-Year Financial Loss? New England Journal of Medicine 2011;364:e27.

Patient Attribution

Prospective

Chooses

Patient

PCP

Attributed to ACO

Retrospective

Patient

Uses

PCPs

CMS looks at historical data

Attributed to ACO

The Quality Standards: Four Key Areas

1. Patient Satisfaction
2. Care Coordination
3. Preventive health
4. Care for chronic illness such as diabetes, hypertension and osteoporosis

CMS has decreased 65 separate quality standards that must be measured to 35.

American Academy of Family Physicians. Medicare Shared Savings Program: Accountable Care Organizations final rule. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/background/medicare-aco-summary.Par.0001.File.dat/AAFPFinalMedicareACO.pdf

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Pediatric ACOs

Pediatric ACO Demonstration Project

→ a project … to recognize pediatric providers that meet specified requirements as an ACO … shall run from January 1, 2012 to December 31, 2016. States will apply to the Secretary in order to be included. (PPACA, §2706)

TAKING HIS CUE: Houston software company CEO Doug Deitel has been racking up pool and billiard balls for years

H-TOWN/ PAGE 19A

HOUSTON BUSINESS JOURNAL
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Strictly Houston. Strictly Business.

MOVER & SHAKER: How Houston logistics company CEO Dean McKeely changed gears to grow his business

STRATEGIES/ PAGE 15A

Vol. 42 No. 34 Week of August 12-18, 2011 | [illegible]houstonbusinessjournal.com

68 Pages, 2 Sections | $2.95

Pediatrician Dr. Victoria Regan says doctors at her Houston practice are considering several physician networks, including accountable care organizations.

A new health care paradigm

Area physicians wary of local impact of ACOs

BY MELISSA MCIVER
HOUSTON BUSINESS JOURNAL

Like every busy primary-care doctor, Houston pediatrician Dr. Victoria Regan sees at least a few dozen patients every day.

She doesn't have much time to think about a comprehensive new health care model that will change the way her practice is managed. But she and other primary-care doctors will soon face a systemic business model revolution that may be a bitter pill for some to swallow.

The approaching revolution is what's known as an accountable care organization. Created as part of the Patient Protection and Affordable Care Act, doctors in an ACO will be required to collaborate to provide care and meet certain quality measurements in order to receive Medicare reimbursements. They also must keep costs down, and each doctors' group will have responsibility for 5,000 Medicare patients for at least three years.

Many doctors don't know much about ACOs, and some are stumped about how the regulations, which aren't yet finalized, might impact their practices, said Dr. Michael Speer, a Houston pediatrician and president-elect of the Texas Medical Association.

"We've [sent out] some educational materials, but probably the average primary-doctor doesn't know much," said Speer, who has served on TMA's ad hoc committee on accountable care organizations.

"And those that have heard the presentation are confused. If you look at the whole process even superficially, it will take a whole lot of organization and money to set it up — and where is that organization and money going to come from? Everyone is asking, 'Where on Earth?'"

SEE PHYSICIANS, PAGE 26A

A Case for Pediatric

Medical Home Evaluations – Children With Special Healthcare Needs (CSHCN)

Institution	Population Served	Areas of Savings	% of Savings (Reduction)
Arkansas Children's Hospital, Little Rock, Arkansas	CSHCN: 67.01% Medicaid 32.94% Commercial 0.06% Self Pay	Hospital Admissions	40%
		Per child cost	30%
Colorado Medical Homes for Children*	Medicaid/CHIP	Hospital Admissions	18%
		Savings per patient	$169-530
St. Joseph's Children's Hospital, Tampa, Florida	CSHCN: 85% Medicaid Commercial Self pay	Hospital Days	20%
		ER Visits	33%

* PCMH site

Fields, D, Leshen, E. Patel, K. Analysis & Commentary: Driving Quality Gains and Cost Savings Through Adoption of Medical Homes. Health Affairs. May 2010; 29:5.
Arkansas Children's Hospital. ACH Medical Home Program for Special Needs Children. November 2010.
National Association of Children's Hospitals. November 2010 presentation
U.S. Department of Health & Human Services. Medicaid Cost-Savings Opportunities. February 3, 2011. http://www.hhs.gov/news/press/2011pres/02/20110203tech.html

A Case for Pediatric ACOs

Patient-Centered Medical Home (PCMH) Evaluations

Institution	Population Served	Areas of Savings	% of Savings (Reduction)
Community Care of North Carolina	Medicaid SCHIP	Hospital Admissions	40%
		ER visits	16%
		Savings per patient	$516
Group Health Cooperative of Puget Sound	Commercial Medicaid Medicare Self Pay	Hospital Admissions	16%
		Ambulatory sensitive care Admissions	11%
		ER Visits	29%
Vermont BluePrint for Health	Commercial Medicaid Medicare Self Pay	Hospital Admissions	11%
		ER visits	12%
		Savings per patient	$215

Grumbach, K. & Grundy, P. Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States. Patient-Centered Primary Care Collaborative. Washington, DC. November 16, 2010.
Emdeon White Paper. The Case for Collaborative Care: A Health Plan Approach for Enabling Medical Home Concepts. Emdeon Business Services LLC. Nashville, TN. 2010.
Cassidy, A. Patient-Centered Medical Homes. Health Policy Briefs. Health Affairs. Robert Wood Johnson Foundation. September 14, 2010. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=25

Critical Success Factors for Pediatric ACOs [AAP]

- Organizational Structure Including Legal Considerations (11 recommendations)
- Structure of Critical & Financial Performance Metrics and Monitoring (8 recommendations)
- Payment Methodologies (5 recommendations)

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Organizational Structure Including Legal Considerations

1. The family-centered medical home anchors the ACO.
2. The governance and leadership of any ACO is physician-driven, and its design must encourage collaboration amongst physicians.
3. An explicit commitment to equal representation between primary care and specialty physicians.
4. Direct and indirect support to primary care practices that are committed to transforming to a family-centered medical home.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Organizational Structure Including Legal Considerations (cont)

5. ACOs should interface with all health-related operations in the state where they operate.
6. Medical management committees should be established and designed to assist the organization with analysis of clinical data to identify disease processes and interventions where value and cost can be affected to draw payer and employer support.
7. A family advisory council guides the ACO.
8. Strong linkages to key community resources to support care coordination and the delivery of primary and specialty care to all populations, in particular children with complex conditions.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Organizational Structure Including Legal Considerations (cont)

9. Legal structures to ensure compliance with existing state and federal laws.
10. Enable independent physicians to use existing or new organizational structures to participate as ACOs.
11. ACOs should be prohibited from imposing exclusive arrangements with pediatricians.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Structure of Clinical and Financial Performance Metrics and Monitoring

1. The ACO has the essential clinical and organizational elements in place to ensure the successful performance of all clinical care activities.
2. Quality-performance metrics that pertain to children should be developed and be evaluated by the AAP using its quality-improvement methodology.
3. Performance data shared with all members of the care team.
4. ACO can accommodate multiple methods of attributing patients that may be dictated by different payers.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Structure of Clinical and Financial Performance Metrics and Monitoring

5. Support for practice teams to support primary care pediatricians, including appropriate funding for other care professionals.
6. Provider satisfaction is monitored semi-annually for all members of the care teams.
7. Patient and family satisfaction measures should be elements of a performance metric portfolio for the ACO.
8. Interoperable health information technology and EMR.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Payment Methodologies

1. Compensation systems and incentives are aligned internally and externally.
2. Systems are in place to ensure appropriate payment methodologies that recognize the special elements of pediatric care.
3. A pediatric risk-adjustment methodology should be in place to ensure appropriate payment for delivery of care to children with special health care needs.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Payment Methodologies

4. The quality-performance standards must be consistent with AAP policy regarding the development of and reporting out of quality measures.
5. Savings and revenues from ACO operations are distributed in a fair manner.

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement. AAP News. January 2011; 32(1) http://aapnews.aappublications.org.

Principles for Pediatric ACOs [NACHRI]

- Pediatric ACO Structure and Design (12 recommendations)
- Role of Pediatric Providers (3 recommendations)
- Quality Measurement (2 recommendations)
- Focus on Access (3 recommendations)

Principles for Pediatric Accountable Care Organizations (N.A.C.H. comments) National Association of Children's Hospitals and Related Institutions. January 3, 2011.
http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087

Principles for Pediatric ACOs

NACHRI talking points:

- Children have unique needs (7 points)
- Medicaid is different from Medicaid (3 points)
- Role that children's hospitals can play (1 large point)

Principles for Pediatric Accountable Care Organizations (N.A.C.H. Fact Sheet) National Association of Children's Hospitals and Related Institutions. January 3, 2011.
http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088

Children have unique needs

1. While the highest rates of hospitalization for children are in the first year of life, for adults they occur at the end of life.
2. Children are hospitalized for different reasons than adults.
3. The majority of physician office visits in the first year of life are for well child and preventative care, while slightly over 10% of visits by persons 65 years and over were for preventative care in 2007
4. The needs associated with utilization and costs vary widely among children.

Principles for Pediatric Accountable Care Organizations (N.A.C.H. Fact Sheet) National Association of Children's Hospitals and Related Institutions. January 3, 2011.
http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088

Children have unique needs

5. While most adults receive outpatients care in doctor's offices, children often receive care in non-traditional settings, such as school, day care and community centers.
6. Additionally, measures of outcomes are different for children as compared to adults.
7. In contrast to the situation for adults, children face challenges in accessing specialty services due to a shortage in pediatric specialists.

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Medicaid is different from Medicaid

1. Beyond the obvious differences in the programs – one is a fully federal program and one is a federal-state program, and the difference is populations – the existing structures are not alike
2. Medicare has a national set of well-developed and tested quality measures, while the Medicaid program does not.
3. Medicaid is a significantly underfunded program relative to Medicare.

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Role that children's hospitals can play

Although they account for only 3.5% of hospitals in the United States, children's hospitals care for 45% of all children admitted to a hospital, including 47% of pediatric Medicaid admissions.

Principles for Pediatric Accountable Care Organizations (N.A.C.H. Fact Sheet) National Association of Children's Hospitals and Related Institutions. January 3, 2011.
http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088

Role that children's hospitals can play

- Children’s hospitals are regional centers for children’s health, providing care across greater geographic areas and often serving children across state lines.
- They provide physician practice support and often employ physicians to ensure availability of necessary pediatric specialties in their communities.
- Children’s hospitals provide transitional care to young adults with chronic conditions.

Principles for Pediatric Accountable Care Organizations (N.A.C.H. Fact Sheet) National Association of Children's Hospitals and Related Institutions. January 3, 2011.
http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088

Role that children's hospitals can play

- The average children's teaching hospital trains twice as many residents per bed as the average adult teaching hospital, and independent children's hospitals train almost 40% of all pediatricians and nearly half of all pediatric specialists.
- Children's hospitals and their affiliated pediatric departments conduct about 38% of all pediatric research sponsored by the National Institutes of Health.

Summary of Comments

In addition to being seeing as expensive to organize, ACOs

Administratively complex: "… an ACO model has the *potential* of… enhancing quality, efficiency, integration, and patient-centeredness." "The required administrative, infrastructure, service delivery, and financial resources and the need to accept risk will effectively limit participation…" (ACP letter to CMS; June 2, 2011)

Path to application to Pediatric Population not clear: "But many questions remain to be asked and answered. Does the model present an opportunity to create a fully integrated pediatric delivery system in some, or possibly all, markets? *AAP News* 2011;32;1

New ACO Initiatives: Announced by CMS

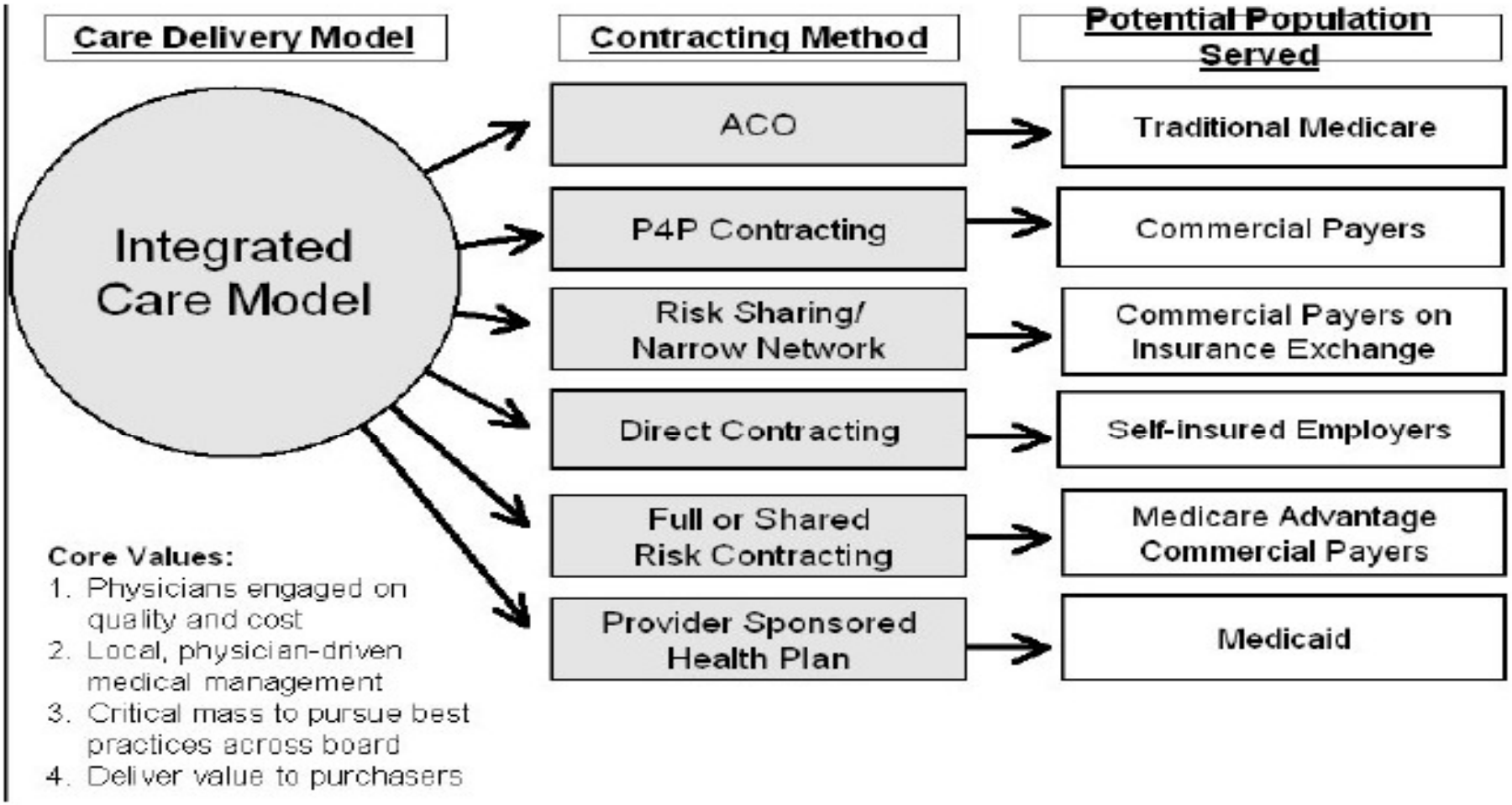
- **Pioneer ACO Model** – Designed for healthcare organizations and providers that are already experienced in coordinating care for patients across care setting
- **Advanced Payment Initiative** – Designed for those ACOs entering the Medicare Shared Saving Program to test whether and how pre-paying a portion of future shared saving could increase participation
- **Accelerated Development Learning Program** – Designed for providers who are interested in learning more about how to coordinate patient care through ACO

(ACP, Brief Summary of New ACO Initiatives through the CMS Innovations Center)

Sunday Review
The New York Times
SUNDAY, AUGUST 14, 2011

The Elusive Big Idea

Figure 12: Will Providers Reach Tipping Point with New Model?



Source: John M. Harris, DGA Partners

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