Regional Networks as a Basis for ACOs – Or, I am an ACO and I Don’t Even Know It.

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We have no relevant financial relationships with the manufacturers of any commercial products and/or provider of commercial services discussed in this CME activity.
Objectives

- Describe the evidence that ACOs improve the quality of health care delivery
- Demonstrate that regional networks have a role for promoting efficient, high quality care for children with special health care needs
- Describe the pros and cons of adopting an ACO model to improve quality and to reward PCPs for doing so
Overview

- ACO Basics
- ACO and Pediatrics I
- Case Studies #1
  - Columbus
- ACO and Pediatrics II
- Medical Home
  - Care Coordination
  - Population Health
- Case Studies #2
  - Wisconsin
  - Houston
- Looking to Future
  - Texas Efforts
  - National Perspective
Much Ado about ACOs
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:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Subpart II—Individual and Group Market Reforms

SUBPART II—IMPROVING COVERAGE

Sec. 2701. Guaranteed availability of coverage.

Sec. 2702. Guaranteed availability of coverage.

Sec. 2703. Offering health insurance to part-time employees.

Sec. 2704. Offering health insurance to non-employees.

Sec. 2705. Offering health insurance to employees.

Sec. 2706. Offering health insurance to full-time employees.

Sec. 2707. Offering health insurance to part-time employees.

Sec. 2708. Offering health insurance to non-employees.

Sec. 2709. Offering health insurance to employees.

Sec. 2710. Offering health insurance to full-time employees.

Sec. 2711. Offering health insurance to part-time employees.

Sec. 2712. Offering health insurance to non-employees.

Sec. 2713. Offering health insurance to employees.

Sec. 2714. Offering health insurance to full-time employees.

Sec. 2715. Offering health insurance to part-time employees.

Sec. 2716. Offering health insurance to non-employees.

Sec. 2717. Offering health insurance to employees.

Sec. 2718. Offering health insurance to full-time employees.

Sec. 2719. Offering health insurance to part-time employees.

Sec. 2720. Offering health insurance to non-employees.

Sec. 2721. Offering health insurance to employees.

Sec. 2722. Offering health insurance to full-time employees.

Sec. 2723. Offering health insurance to part-time employees.

Sec. 2724. Offering health insurance to non-employees.

Sec. 2725. Offering health insurance to employees.

Sec. 2726. Offering health insurance to full-time employees.

Sec. 2727. Offering health insurance to part-time employees.

Sec. 2728. Offering health insurance to non-employees.

Sec. 2729. Offering health insurance to employees.

Sec. 2730. Offering health insurance to full-time employees.

Sec. 2731. Offering health insurance to part-time employees.

Sec. 2732. Offering health insurance to non-employees.

Sec. 2733. Offering health insurance to employees.

Sec. 2734. Offering health insurance to full-time employees.

Sec. 2735. Offering health insurance to part-time employees.

Sec. 2736. Offering health insurance to non-employees.

Sec. 2737. Offering health insurance to employees.

Sec. 2738. Offering health insurance to full-time employees.

Sec. 2739. Offering health insurance to part-time employees.

Sec. 2740. Offering health insurance to non-employees.

Sec. 2741. Offering health insurance to employees.

Sec. 2742. Offering health insurance to full-time employees.

Sec. 2743. Offering health insurance to part-time employees.

Sec. 2744. Offering health insurance to non-employees.

Sec. 2745. Offering health insurance to employees.

Sec. 2746. Offering health insurance to full-time employees.

Sec. 2747. Offering health insurance to part-time employees.

Sec. 2748. Offering health insurance to non-employees.

Sec. 2749. Offering health insurance to employees.

Sec. 2750. Offering health insurance to full-time employees.

Sec. 2751. Offering health insurance to part-time employees.

Sec. 2752. Offering health insurance to non-employees.

Sec. 2753. Offering health insurance to employees.

Sec. 2754. Offering health insurance to full-time employees.

Sec. 2755. Offering health insurance to part-time employees.

Sec. 2756. Offering health insurance to non-employees.

Sec. 2757. Offering health insurance to employees.

Sec. 2758. Offering health insurance to full-time employees.

Sec. 2759. Offering health insurance to part-time employees.

Sec. 2760. Offering health insurance to non-employees.

Sec. 2761. Offering health insurance to employees.

Sec. 2762. Offering health insurance to full-time employees.

Sec. 2763. Offering health insurance to part-time employees.

Sec. 2764. Offering health insurance to non-employees.

Sec. 2765. Offering health insurance to employees.

Sec. 2766. Offering health insurance to full-time employees.

Sec. 2767. Offering health insurance to part-time employees.

Sec. 2768. Offering health insurance to non-employees.

Sec. 2769. Offering health insurance to employees.

Sec. 2770. Offering health insurance to full-time employees.

Sec. 2771. Offering health insurance to part-time employees.

Sec. 2772. Offering health insurance to non-employees.

Sec. 2773. Offering health insurance to employees.

Sec. 2774. Offering health insurance to full-time employees.

Sec. 2775. Offering health insurance to part-time employees.

Sec. 2776. Offering health insurance to non-employees.

Sec. 2777. Offering health insurance to employees.

Sec. 2778. Offering health insurance to full-time employees.

Sec. 2779. Offering health insurance to part-time employees.

Sec. 2780. Offering health insurance to non-employees.

Sec. 2781. Offering health insurance to employees.

Sec. 2782. Offering health insurance to full-time employees.

Sec. 2783. Offering health insurance to part-time employees.

Sec. 2784. Offering health insurance to non-employees.

Sec. 2785. Offering health insurance to employees.

Sec. 2786. Offering health insurance to full-time employees.

Sec. 2787. Offering health insurance to part-time employees.

Sec. 2788. Offering health insurance to non-employees.

Sec. 2789. Offering health insurance to employees.

Sec. 2790. Offering health insurance to full-time employees.

Sec. 2791. Offering health insurance to part-time employees.

Sec. 2792. Offering health insurance to non-employees.

Sec. 2793. Offering health insurance to employees.

Sec. 2794. Offering health insurance to full-time employees.

Sec. 2795. Offering health insurance to part-time employees.

Sec. 2796. Offering health insurance to non-employees.

Sec. 2797. Offering health insurance to employees.

Sec. 2798. Offering health insurance to full-time employees.

Sec. 2799. Offering health insurance to part-time employees.

Sec. 2800. Offering health insurance to non-employees.

Sec. 2801. Offering health insurance to employees.

Sec. 2802. Offering health insurance to full-time employees.

Sec. 2803. Offering health insurance to part-time employees.

Sec. 2804. Offering health insurance to non-employees.

Sec. 2805. Offering health insurance to employees.

Sec. 2806. Offering health insurance to full-time employees.

Sec. 2807. Offering health insurance to part-time employees.

Sec. 2808. Offering health insurance to non-employees.

Sec. 2809. Offering health insurance to employees.

Sec. 2810. Offering health insurance to full-time employees.

Sec. 2811. Offering health insurance to part-time employees.

Sec. 2812. Offering health insurance to non-employees.

Sec. 2813. Offering health insurance to employees.

Sec. 2814. Offering health insurance to full-time employees.

Sec. 2815. Offering health insurance to part-time employees.

Sec. 2816. Offering health insurance to non-employees.
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:

"(88) provide for implementation of the payment models specified by the Secretary under section 1115(a) 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:

"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 venture 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.
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
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.

"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
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?

ACOs

GOV’T

COMMERCIAL INSURERS

PROVIDERS

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?

- Professionals in group practice
- Networks of individual practices (e.g., IPA)
- Hospitals and professionals in partnership (e.g., PHO)
- Hospitals with employed professionals
- Others that Secretary approves

Insurance Company

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

The Ideal:

ACOs Deliver Better Care at Lower Cost

- Talent Acquisition
- Incentives
- Service
- Marketing & Business Development
- Leadership Development
- Defect Management
- Technology
- Metrics and Dashboards
- Outsourcing
- Process Re-Engineering
- Training

Figure 8: Upside-Only Shared Savings Model Over Time

Projected Spending
Target Spending
Savings for Sharing
Actual Spending

Year

Source: Dartmouth Institute for Health Policy and Clinical Practice

Source: John M. Harris, DGA Partners

# CMS Physician Group Practices (PGP) Demonstration Project

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

*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.*


Healthcare industry’s response to ACOs:

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)
### Estimate of ACO Investment

**Average*:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS (based on a range of an estimate of 75-150 ACPs)</td>
<td>$1,800,000</td>
</tr>
<tr>
<td>AHA** (200-bed, single hospital system)</td>
<td>$11,600,000</td>
</tr>
<tr>
<td>AHA**(1200-beds, 5-hospital system)</td>
<td>$26,100,000</td>
</tr>
</tbody>
</table>

*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.

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."

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!!
The Quality Standards: Five Key Areas

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

CMS quality standards that must be measured and reported on.

### Figure 10: Medicare ACO Timing

<table>
<thead>
<tr>
<th>Expected Timing</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Assume Regulations Issued</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assume Application Due</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assume Notified if Selected as ACO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begin Operation as ACO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assume Shared Savings Distributed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: John M. Harris, DGA Partners

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### Fast Facts - All Medicare Shared Savings Program ACOs (April 2012, July 2012, and January 2013 Starts) March 2013

#### Regional Data - ACOs and Assigned Beneficiaries (Note: An ACO may be in multiple regions)

<table>
<thead>
<tr>
<th>Region</th>
<th>ACOs</th>
<th>Assigned Beneficiaries</th>
<th>Percent Medicare Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Boston (CT, ME, MA, NH, RI, VT)</td>
<td>35</td>
<td>586,374</td>
<td>23.1%</td>
</tr>
<tr>
<td>2 - New York (NJ, NY, PR, VI)</td>
<td>30</td>
<td>421,900</td>
<td>8.0%</td>
</tr>
<tr>
<td>3 - Philadelphia (DE, DC, MD, PA, VA, WV)</td>
<td>22</td>
<td>217,195</td>
<td>4.3%</td>
</tr>
<tr>
<td>4 - Atlanta (AL, FL, GA, KY, MS, NC, SC, TN)</td>
<td>69</td>
<td>668,053</td>
<td>6.3%</td>
</tr>
<tr>
<td>5 - Chicago (IL, IN, MI, MN, OH, WI)</td>
<td>49</td>
<td>838,245</td>
<td>9.8%</td>
</tr>
<tr>
<td>6 - Dallas (AR, LA, NM, OK, TX)</td>
<td>24</td>
<td>259,411</td>
<td>4.7%</td>
</tr>
<tr>
<td>7 - Kansas City (IA, KS, MO, NE)</td>
<td>12</td>
<td>196,848</td>
<td>8.4%</td>
</tr>
<tr>
<td>8 - Denver (CO, MT, ND, SD, UT, WY)</td>
<td>5</td>
<td>53,751</td>
<td>3.6%</td>
</tr>
<tr>
<td>9 - San Francisco (AZ, CA, HI, NV)</td>
<td>34</td>
<td>485,533</td>
<td>7.3%</td>
</tr>
<tr>
<td>10 - Seattle (AK, ID, OR, WA)</td>
<td>4</td>
<td>64,816</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Counties with less than 1 percent of an ACO's assigned beneficiaries 295,702

**Total** 252 4,087,828 8.2%

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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)
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. 2708. 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
Critical Success Factors for Pediatric ACOs [AAP]

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

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)

AAP describes a Medical Home

A concept rather than a building:

- **Accessible** – location; time; payors
- **Family Centered** – family as expert partners
- **Continuous** – same providers; facilitated transitions
- **Comprehensive** – preventive, primary, consultative
- **Coordinated** – health care with school, community
- **Compassionate** – concern for child and family
- **Culturally Effective** – respectful of culture, religion.

Introduction

ACO Basics

ACO and Pediatrics I

Case Studies #1
  - Columbus

ACO and Pediatrics II

Medical Home
  - Care Coordination
  - Population Health

Case Studies #2
  - Wisconsin
  - Houston

Looking to Future
  - Texas Efforts
  - National Perspective
Nationwide Children’s

- ACO Partner’s for Kids
- Medicaid model for central and southeastern Ohio (37 counties)
- Jointly owned by Nationwide Children’s and pediatric physician group

http://www.partnersforkids.org/pfkexpansion/
<table>
<thead>
<tr>
<th>Population</th>
<th>285,000 pediatric Medicaid recipients (75,000 rural Appalachia, 210,000 urban).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting</td>
<td>Risk bearing contract to Physician Hospital Organization (Partners For Kids) for medical, dental, vision, psychiatric from all regional Medicaid MCOs.</td>
</tr>
<tr>
<td>Accountability</td>
<td>Shared incentives with MCOs, transparent outcome measures, regional pediatric report card.</td>
</tr>
<tr>
<td>Data</td>
<td>Pass through encounter data from MCOs, all specialist and some primary care data from Electronic Health Records (participating in national EHR pediatric pilot program).</td>
</tr>
<tr>
<td>Shared savings</td>
<td>Medicaid FFS rates plus incentive payments for non-employed PCPs with increased salaries for Hospital-employed clinicians.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Preterm birth, asthma, diabetes, immunization, health supervision and obesity outcomes with school, community and health department partners.</td>
</tr>
</tbody>
</table>
Health Care Innovation Award: Partners For Kids Geographic Expansion

The map below displays in turquoise the current coverage of Medicaid children in Ohio counties by Partners For Kids. The planned expansion of coverage will include disabled populations in the 12 additional Ohio counties displayed in green.

http://www.partnersforkids.org/pfkexpansion/
Children with Medical Complexity (CMC)

- Defined as a patient 18 and under with
  - One of about 60 qualifying neurologic diagnoses
  - A feeding tube in place
- Estimate 600 Patients at Nationwide Children’s Hospital and 200 Patients at Akron Children’s Hospital
- Should identify 90% of the kids

Personal communication: Garey Noritz, MD
Pediatric Academic Societies
May 3, 2013
# Program Aims: Complex Care

<table>
<thead>
<tr>
<th>Cost</th>
<th>Decrease hospital days per 10,000 member months for tube fed children at NCH from 20.8 to 18.7 days for 12-month period ending June 30, 2015.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Proactive care navigation will be provided for 85% of children with feeding impairment and neurodevelopment disorders from a baseline of 0% by June 30, 2015.</td>
</tr>
<tr>
<td>Health</td>
<td>Increase by the proportion of NCH tube fed children between the 5th percentile &amp; 95th percentile for weight on standard growth charts from a baseline of 60% to 80% for 12-month period ending June 30, 2015.</td>
</tr>
</tbody>
</table>

http://www.partnersforkids.org/hciainaction/
Primary Driver

Nutrition Management

Secondary Driver

RD involvement

Caregiver knowledge

Coordination of Nutrition Services across IP/OP/Home

Inaccurate/Outdated Weights

Staff Training

Aim

Increase the proportion of NCH tube fed kids with weights between the 5th and 95th percentile on a standard growth chart from 60% to 80% for the 12 month period ending 6/30/2015

Intervention

Assign clinical responsibilities (nutrition management) before tube insertion

Improve access to dietitian resources (for community PCP’s and NCH PCP’s)

Provide families with resources to effectively managing formula supply

Provide families with resources to ensure proper formula preparation

Maintain ongoing non-oral feeding plan in electronic medical record (nutrition management & therapy plan of care)

Engage families & community providers of tube fed kids who have not have weights in the electronic medical record in the past 6 months

Perform in-depth nutrition assessment for tube fed kids managed by PCP’s

Prioritize care coordination outreach efforts for tube fed kids with high nutrition needs

Clinical Nutrition & Lactation leading efforts to increase staff awareness (internal PSA’s, etc)

Personal communication: Garey Noritz, MD, Pediatric Academic Societies, May 3, 2013
Program Aim for June 30, 2015

Increase by 10% annually the proportion of NCH tube-fed kids between the 5th percentile & 95th percentile for weight on standard growth charts.

Baseline
60.1%

Results this Month
12 month average through Mar 2013:
62.4%
(0.4% ↑ from last month, 3.9% ↑ from baseline)

Goal
80.0%
(↑33% from baseline)

Personal communication: Garey Noritz, MD
Pediatric Academic Societies
May 3, 2013

Note:
1) Red line represents Jul 2011-Jun 2012 Baseline Average: 60.1% tube-fed population within 5th-95th weight percentile; however, beginning June 2012, the data as a group was statistically different from the Jul 2011-Jun 2012 baseline rate, signally a shift in the data around a new baseline. As a result, the average value of data for Jul 2012-Mar 2013 are centered around a new baseline of 63%.
2) Green dashed line represents June 2013 Goal: 80.0% tube-fed population within 5th-95th weight percentile

Updated: 4/15/2013
Lesson learned

- Go where the money is
- Leverage children’s hospitals as the network that provides the locus of care for complex pediatric patients
Overview

- ACO Basics
- ACO and Pediatrics I
- Case Studies #1
  - Columbus
- ACO and Pediatrics II
- Medical Home
  - Care Coordination
  - Population Health
- Case Studies #2
  - Wisconsin
  - Houston
- Looking to Future
  - Texas Efforts
  - National Perspective
Critical Success Factors for Pediatric ACOs [AAP]

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

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.

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.
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)
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.
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.
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.

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.

Principles for Pediatric ACOs [NACHRI/CHA]

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

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087
Pediatric ACO Structure and Design

1. The differences in health care needs/costs for children require flexibility in the design of the pediatric ACO.
2. Flexibility is required to allow states the ability to design the pediatric ACO with in its current Medicaid structure.
3. Funding should be made available for upfront capital and personnel expenditures, including IT, analytics and clinical support infrastructure.
4. The pediatric ACO demonstrations should allow a variety of payment structures to be tested.
5. Pediatric ACOs need special consideration when it comes to the number of patients required.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087
6. Pediatric ACOs should have the ability to exchange information through an EMR system.

7. Medical care and improvement initiatives for the pediatric population need to be family centered.

8. The transition of pediatric patients to adult providers needs to be a focus.

9. Special consideration needs to be given to newborns requiring intensive care.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087
10. Pediatric ACOs must be able to develop linkages with necessary entities in the community to influence the overall health of the child.

11. The regional nature of pediatric care needs to be addressed.

12. Pediatric ACOs should be structured to reflect the complexity of patients within the ACO.
Role of Pediatric Providers

1. The development of pediatric ACOs should recognize the unique leadership role of children's hospitals.
2. Pediatric ACOs must have the capacity to provide both primary and specialty services for children.
3. The issue of provider exclusivity in pediatric ACOs must be assessed.
4. Children with special health care needs should be allowed to designate their pediatric specialist as their primary care provider when appropriate.


http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087
Quality Measurement

1. Pediatric ACOs should be allowed to propose additional quality measures as part of the demonstration project.
2. In evaluation of the pediatric ACOs, impact should be assessed broadly.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087
Focus on Access

1. Access to care needs to be more significant focus within a pediatric ACO than a Medicare ACO because of the reliance of pediatrics on Medicaid as a payor.

2. The problem of children churning on and off the Medicaid program should be addressed.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55087
Principles for Pediatric ACOs

NACHRI (now CHA) 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)

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.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088
Children have unique needs

5. While most adults receive outpatient 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.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088
Medicaid is different from Medicare

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.


http://www.childrenshospitals.net/AM/Template.cfm?Section=Search3&template=/CM/HTMLDisplay.cfm&ContentID=55088
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.
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.
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.
# A Case for Pediatric ACOs

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

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

*PCMH site*

National Association of Children's Hospitals. November 2010 presentation
# A Case for Pediatric ACOs

## Patient-Centered Medical Home (PCMH) Evaluations

<table>
<thead>
<tr>
<th>Institution</th>
<th>Population Served</th>
<th>Areas of Savings</th>
<th>% of Savings (Reduction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care of North Carolina</td>
<td>Medicaid SCHIF</td>
<td>Hospital Admissions</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER visits</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings per patient</td>
<td>$ 516</td>
</tr>
<tr>
<td>Group Health Cooperative of Puget Sound</td>
<td>Commercial Medicaid Medicare Self Pay</td>
<td>Hospital Admissions</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ambulatory sensitive care Admissions</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Visits</td>
<td>29%</td>
</tr>
<tr>
<td>Vermont Blueprint for Health</td>
<td>Commercial Medicaid Medicare Self Pay</td>
<td>Hospital Admissions</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER visits</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings per patient</td>
<td>$ 215</td>
</tr>
</tbody>
</table>

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Summary Comments

Hopeful:

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)

But Concerned:

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
A new health care paradigm
Area physicians wary of local impact of ACOs

BY MELISSA McFARLAND

Like every other 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 solution that may be a better pill for some to swallow.

The approaching revolution is what is known as an accountable care organization. Created as part of the Patient Protection and Affordable Care Act, directors 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 ACO 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 fleshed out, might impact their practices, said Dr. Michael Spetz, a Houston pediatrician and president-elect of the Texas Medical Association.

“We’ve sent out some educational materials, but probably the average primary-care doctor doesn’t know much,” said Spetz, who has served on TMAs ad hoc committee on accountable care organizations.

And those that have heard the presentation are confused. If you look at the whole process over 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 is God?’”
Texas Legislative Comment

“One piece of the PPACA aiming to slow the growth of cost drivers and incentivize new delivery models looks to Accountable Care Organizations (ACO) as possible solution. From an outsider's view, Texas Children's Hospital (TCH) appears to be an institution that could potentially benefit from such a model with your existing hospitals, clinics and other ancillary facilities.

“As you and your staff at TCH continue to digest the coming changes in health delivery models, I encourage you to consider the proposed …"
Children on Medicaid - Not on SSI
Total Cost (Billions) and Cost Per Child per Month

- Total Non Disabled Children Cost (Billions)
- Cost Per Client Per Month

2007: $4.6 billion, $193/month
2008: $5.6 billion, $232/month
2009: $6.3 billion, $249/month
2010: $7.2 billion, $248/month

(0.4%)
Aged and Disability Related (adults and children)

Total Cost (Billions) and Cost Per Client Per Month

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Cost (Billions)</th>
<th>Cost Per Client Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$8.8</td>
<td>2.5%</td>
</tr>
<tr>
<td>2008</td>
<td>$9.7</td>
<td>7.0%</td>
</tr>
<tr>
<td>2009</td>
<td>$10.3</td>
<td>4.6%</td>
</tr>
<tr>
<td>2010</td>
<td>$11.3</td>
<td></td>
</tr>
</tbody>
</table>

2007: $1,138
2008: $1,218
2009: $1,249
2010: $1,306
## SSI Recipients Under 18

<table>
<thead>
<tr>
<th>Year</th>
<th>National</th>
<th>Regional</th>
<th>Texas</th>
<th>Texas Growth %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>1,121,017</td>
<td>181,218</td>
<td>105,084</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>1,153,844</td>
<td>193,209</td>
<td>112,875</td>
<td>7.4%</td>
</tr>
<tr>
<td>2009</td>
<td>1,199,788</td>
<td>205,919</td>
<td>120,467</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

As of 2013, HHSC estimates approximately 190,000 SSI recipients under 18

Target Population

- Roughly 4% of the Medicaid population in Texas consists of the Texas SSI (Disability Related – under age 21 category)
- In Houston/Harris County, 9% children on SSI select a STAR Plus plan and the remaining 91% select Fee For Service (FFS) Medicaid (aka, TMHP)


Texas Children’s Hospital. Texas SSI Medicaid Pediatric Accountable Care Organization Pilot Project. March 2, 2011.
Care Design Concepts

- "Network within a Network"
  - PCPs with an interest in chronic care (about 40%)
- Medical Home or Chronic Health Home Focus
  - Coordinated, comprehensive, family centered and accessible
- Inter-operable electronic medical records (EMR)
- Significant care coordination & use of Medical Home Index (MHI)
Medical Home

“The Medical Home is the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated, and family centered manner.”

Medical Home – *is* primary care

- It *is not* a primary care “*project*” *but*
  - the kind of care we all want for
    - Our families
    - Ourselves

Center for Medical Home Improvement, Crotched Mountain Foundation. [www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org)
Figure 12: Will Providers Reach Tipping Point with New Model?

Integrated Care Model

Core Values:
1. Physicians engaged on quality and cost
2. Local, physician-driven medical management
3. Critical mass to pursue best practices across board
4. Deliver value to purchasers

Source: John M. Harris, DGA Partners

Overview

- ACO Basics
- ACO and Pediatrics I
  - Case Studies #1
    - Columbus
  - ACO and Pediatrics II
  - Medical Home
    - Care Coordination
    - Population Health
  - Case Studies #2
    - Wisconsin
    - Houston
- Looking to Future
  - Texas Efforts
  - National Perspective
Who: CYSHCN
- Children with medical complexity = the sickest of the sick
  - Increased needs
  - Chronic condition
  - Functional limitation
  - Increased health care use

Who: CYSHCN

- 20% of children account for almost 70% of spending

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Chronic conditions</th>
<th>Complex &amp; chronic</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy kids with acute conditions</td>
<td>Single, low acuity condition</td>
<td>Complex and multiple conditions</td>
<td>Life-threatening</td>
</tr>
<tr>
<td>Pneumonia, UTI</td>
<td>Asthma, ADHD</td>
<td>Heart disease, cancer, cystic fibrosis</td>
<td>Vent-dependent, transplant</td>
</tr>
</tbody>
</table>
All children have a need for access to preventive care & developmental assessment

15-30% of all children have a chronic health condition

8% of children have condition limiting their activities

1% are technology dependent

Source: A Critical Analysis of Care Coordination Strategies for Children With Special Health Care Needs. Agency for Healthcare Research and Quality No. 290-02-0017
CLIN PEDIATR August 2012 vol. 51 no. 8 770-777
Why: CY SCHN

- Children with medical complexity are increasing
  - Annual increase in hospitalizations 3.6%
  - Increase in number 2004 – 2009 19.2%

- Percentage of children hospitalized 56.2%
- Percentage of hospital days 81.7%

- Percentage of hospital charges 86.1% ($14.9 billion)

From: Inpatient Growth and Resource Use in 28 Children’s Hospitals: A Longitudinal, Multi-institutional Study

### Table 3. Medical Care Use of Children With Special Health Care Needs by Complexitya

<table>
<thead>
<tr>
<th>Variable</th>
<th>Less Complex (n=9,897,116)</th>
<th>More Complexb (n=324,323)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s health care needs, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change all the time</td>
<td>5.4</td>
<td>32.0</td>
</tr>
<tr>
<td>Change sometimes</td>
<td>27.9</td>
<td>33.0</td>
</tr>
<tr>
<td>Are usually stable</td>
<td>66.9</td>
<td>35.0</td>
</tr>
<tr>
<td>No. in the last 12 mo. median (interquartile range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School days missed</td>
<td>3 (1-8)</td>
<td>10 (5 to 16-20)</td>
</tr>
<tr>
<td>Physician visits</td>
<td>4 (2-7)</td>
<td>11-15 (6-&gt;21)</td>
</tr>
<tr>
<td>Emergency department visits</td>
<td>0 (0-1)</td>
<td>1 (0-3)</td>
</tr>
<tr>
<td>Receipt of, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early intervention services at age &lt;3 y</td>
<td>19.0</td>
<td>82.2</td>
</tr>
<tr>
<td>Special education services at age range of 3-17 y</td>
<td>27.0</td>
<td>76.9</td>
</tr>
</tbody>
</table>

a All data are weighted. P<.001 for all variables (χ² test for proportions and Mann-Whitney test for nonparametric variables).

b More complex is defined as positive response to “need for more medical care” than usual item and 3 of the remaining 4 items on the complex children with special health care needs screener; medical equipment use; and seeing 2 or more specialists in the last 12 months.
Why: CYSHCN

- Properly caring for children with medical complexity lowers costs and improves utilization
- Canadian study n=81 high intensity children in specialized program
  - $255 pmpm → $131 pmpm

## Why: CYSHCN

<table>
<thead>
<tr>
<th>Author</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criscione et al (1995)</td>
<td>RCT NP case management</td>
<td>N=115 Over $200,000 savings in hospital charges</td>
</tr>
<tr>
<td>Liptak et al (1998)</td>
<td>Case management by 11 FTE for “wraparound” services</td>
<td>N=10, 715 $77.7 million savings</td>
</tr>
<tr>
<td>Antonelli et al (2008)</td>
<td>Care coordination measurement tool in primary care</td>
<td>N=3172 26% decr in ER visits</td>
</tr>
</tbody>
</table>
Wisconsin: CHW Special Needs Program

- Primary Care / Tertiary Care Partnership Model
  - Population
    - Medically complex and fragile children with chronic disease
  - Scope
    - Co-management / Consultant
  - Location
    - Inpatient throughout the hospital
    - Ambulatory (Clinics and ER)
    - Community

Personal communication: John B Gordon, MD. Pediatric Academic Societies. May 3, 2010
Tertiary Center Partner

- **Personnel**
  - SNP Nurse care coordinator for all patients
  - SNP Physician care coordinator for most
  - Family Advocate, Social Work, Psychologist as needed
  - Support staff includes AAs and Research Coordinator
  - Family, PCP, and Institutional Advisory Groups

- **Key Features**
  - 24/7 availability
  - Familiar with patients
  - Continuity of care (Home/Ambulatory/Inpatient)
  - Flexibility: respond to new needs/challenges

Personal communication: John B Gordon, MD. Pediatric Academic Societies. May 3, 2010
Aggregate Resource Use

equal pre / post enrollment periods of up to 3 years
mean = 425 days, n = 458

Personal communication: John B Gordon, MD
Pediatric Academic Societies
May 3, 2010
Paying for the SNP (FY 2009)

Expenses: $1,500,000
- Nurses (4.5 fte)
- Physicians (3)
- Other staff and operating costs

Revenues: $650,000
- Physician billing
- Medicaid reimbursement
- Grant support and philanthropy

Deficit Borne by Parent Institutions: $850,000
- Children’s Hospital of Wisconsin
- Medical College of Wisconsin
- Children’s Specialty Group

Personal communication: John B Gordon, MD
Pediatric Academic Societies
May 3, 2010
Lesson learned

- Tertiary centers, and some regional rural pediatric practices, by default assume responsibility for complex pediatric patients
Houston example
Why: Providers Response to Medical CSHCN Query

Repeat survey one year later 131 of 407 ‘Yes’ (32%).
Special Needs Primary Care Clinic

- Primary care and care coordination
- Over 700 patients
- Patient population
  - Technology-dependent
  - Intractable seizures
  - Terminal conditions
I. Organizational capacity (family feedback, regular visits, special rooms, in-person interpreters, regular education)

II. Chronic condition management (patient registry, strong community partnerships, co-management with specialists in the system, transition policy and partnership, 24/7 provider access)

III. Care coordination (care plans, expertise in community resources, advocacy)

IV. Community outreach (community public health and outreach, EMR support)
Case Management Time (faxes), week of 8/15 to 8/21/2010
School forms excluded
5. **Effective care.** Of triaged calls, 75-86% resulted in a clinic visit versus an ER visit. Of patients seen in the ER, 42—66% required admission (much greater than the average local ER admission rate).

<table>
<thead>
<tr>
<th></th>
<th>Jan-10</th>
<th>Feb-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triaged Calls</td>
<td>174.00</td>
<td>167.00</td>
</tr>
<tr>
<td>Patients Seen in ER</td>
<td>44.00</td>
<td>24.00</td>
</tr>
<tr>
<td>ER Avoided</td>
<td>130.00</td>
<td>143.00</td>
</tr>
<tr>
<td>Avoidance Rate</td>
<td>74.7%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Admitted</td>
<td>29.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Sent home from ER</td>
<td>15.00</td>
<td>14.00</td>
</tr>
<tr>
<td>ER admission rate</td>
<td>65.9%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>159</td>
<td>45</td>
</tr>
<tr>
<td>Average LOS</td>
<td>5.48</td>
<td>4.50</td>
</tr>
</tbody>
</table>
STAR KIDS (SB 7)

- Goals: Consolidate Medicaid waivers for I/DD population, improved health outcomes while reducing costs for children with disabilities
- Reduce or eliminate the waiting list
- MCOs assume the risk for providing acute and long-term services
Opportunities

- Current systems of care for children with disabilities are regionally based
- Opportunities with Medicaid reform to participate in trials
Goal

Improve care for better health and decrease cost with ↓ emergency department visits ↓ hospitalization and re-admission ↑ Experience of Care

Primary Drivers

Care Coordination

Patient and family engagement

Reducing Barrier to Care

Monitoring and improvement

Trained professional care team

Secondary Drivers

Streamlined and coordinated care using patient navigators, case managers and self management support, and care plans

Effective transition from hospital to home

Health Educators, patient portal,

Face to face support, Peer to peer support

Open Access with after hours and weekend care transportation support

ERM, registry system, e-prescribing

Risk stratification

Patient navigators, resource coordinators, trained
To improve emergency center/Urgent care visit for patient with asthma in the past 6 months by _____%
Improve behavioral health services of ADHD

**Aim**

- Reducing Barriers to Care
- Care Coordination
- Patient Education

**Primary Driver**

**Secondary Driver**

- Screening for ADHD symptoms
- Diagnosis Making appropriate diagnosis
- Patient and Family Education

**Intervention**

- Screen any child (4-18 years of age) who present with academic/behavioral problems and symptoms of inattention, hyperactivity, or impulsivity for ADHD
- DSM criteria must be met for diagnosis of ADHD
- Families will be given documentation which states the patient’s eligibility for school accommodation
- Using evidence-based guideline for medication and behavioral therapies and assessing for continued need of treatment or if symptoms have remitted treatment of ADHD
Estimated savings

- Take 18,000 children and reduce variability in hospitalization, ER, pharmacy, and DME

- **Yr 1** $22 million
Overview

- ACO Basics
- ACO and Pediatrics I
- Case Studies #1
  - Columbus
- ACO and Pediatrics II
- Medical Home
  - Care Coordination
  - Population Health
- Case Studies #2
  - Wisconsin
  - Houston
- Looking to Future
  - Texas Efforts
  - National Perspective
### Figure 12: Will Providers Reach Tipping Point with New Model?

<table>
<thead>
<tr>
<th>Care Delivery Model</th>
<th>Contracting Method</th>
<th>Potential Population Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care Model</td>
<td>ACO</td>
<td>Traditional Medicare</td>
</tr>
<tr>
<td></td>
<td>P4P Contracting</td>
<td>Commercial Payers</td>
</tr>
<tr>
<td></td>
<td>Risk Sharing/ Narrow Network</td>
<td>Commercial Payers on Insurance Exchange</td>
</tr>
<tr>
<td></td>
<td>Direct Contracting</td>
<td>Self-Insured Employers</td>
</tr>
<tr>
<td></td>
<td>Full or Shared Risk Contracting</td>
<td>Medicare Advantage Commercial Payers</td>
</tr>
<tr>
<td></td>
<td>Provider Sponsored Health Plan</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

**Core Values:**
1. Physicians engaged on quality and cost
2. Local, physician-driven medical management
3. Critical mass to pursue best practices across board
4. Deliver value to purchasers

*Source: John M. Harris, DGA Partners*

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Relationships between integrated delivery system and public health system.
The Elusive Big Idea
Improving Medicaid/Medicare accountability – and achieving meaningful savings – must have a robust physician network.

- Physicians are necessary for ACOs to work. Medical Homes vs. Health Homes.

- Texas: Only 42 percent of physicians report seeing all new Medicaid patients; in 2000, 67 percent reported same

- Medicaid payments average 73 percent of Medicare and 50 percent of commercial payments.

- Lack of competitive rates will discourage physicians from developing or participating in ACOs or other initiatives.

Speer, ME & Spangler, L. Accountable Care Organizations. TMA, 2013
Potential Opportunities

- ACO model is designed to be “physician centric” so it is a potential opportunity to increase physician prominence in the accountability discussion.

- Continued evolution of ACO model gives physicians opportunities to influence the future, but no time to dawdle.

- Antitrust Exemptions: May contribute to increased alignment and collaboration among physicians, making it easier for patients and physicians to navigate a complicated system.

Speer, ME & Spangler, L. Accountable Care Organizations. TMA, 2013
Potential Opportunities

- Increases focus on importance of primary care and prevention as well as use of evidence-based standards
- May bring practices new dollars to support investments in infrastructure, such as HIT.
- May allow direct contracting with employers, thereby removing insurers OR hospitals as an intermediary

Speer, ME & Spangler, L. Accountable Care Organizations. TMA, 2013
Potential Drawbacks

- Texas is predominantly organized around small and solo practices (72%), so most practices not primed for ACO 1.0 movement.
- Requires intensive capital to set up and maintain.
- Developing necessary physician culture to facilitate ACO model takes decades not months.
- Patients may view ACO as just another HMO.
- May result in a repeat of previous financial failures of provider-led organizations.

- IPA Failures: 1980s & 90s

Speer, ME & Spangler, L. Accountable Care Organizations. TMA, 2013
ACOs are here – PPACA provides for them and commands HHS to aid in their development.

How physicians approach the opportunity (leaders or mere participant) will have a fundamental impact on structure and focus.

Only the future will tell whether mistakes of the past are repeated or reformed.
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