



# Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement

As we enter the age of Accountable Care Organizations (ACOs), the Academy has produced guidance for members on factors to consider in evaluating an opportunity to participate in an ACO. Developed by the AAP ACO Workgroup, the following guidance has been reviewed and approved by the AAP Executive Committee.

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## Essential background

The Patient Protection and Affordable Care Act of 2010 (PPACA) included a number of provisions that establish accountable care organizations (ACOs) in Medicare and Medicaid/ Children's Health Insurance Program (CHIP). According to the Center for Medicare and Medicaid Services (CMS), an ACO is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of beneficiaries. In return, it will receive incentive payments based on quality and cost containment instead of volume and intensity. Eligible providers are likely to be individual and group practices, hospitals, integrated delivery systems, and others who create a legal entity with a management structure able to deliver and report on evidence-based and informed care to a defined population (likely a minimum of 5000 people), effectively engage patients, and receive and distribute shared savings.

The Pediatric Demonstration Project, scheduled to be implemented between 2012 and 2016, calls for participating state Medicaid programs to allow pediatric medical providers to form an ACO and receive incentive payments. The Department of Health and Human Services (DHHS) will develop quality guidelines that must be met, and the applicant state and ACO must meet certain level of savings or slow the rate of growth in health care costs to receive an incentive payment. The details of the Pediatric Demonstration Project have not been specified at the time this specific guidance was released from the American Academy of Pediatrics (AAP). However, it is anticipated that CMS will derive many of the ACO requirements on the basis of its Medicare Shared Savings Program, which will be implemented at the same time.

The growing interest in ACOs as a principal driver in the reconfiguration of the US health care delivery system is motivated by numerous factors, primarily the following: (1) need to limit the rate of increase in health care spending; (2) increased acknowledgment of the inadequacies inherent in fee-for-service payment; (3) growing interest in integrated systems of care; (4) physician awareness of the need for systemic changes and preferences for a medical home model of care; and (5) shortages in the primary care physician workforce.

The purpose of this AAP guidance is to provide background infor-

mation to help guide the design of this new pediatric delivery and financing model. It is organized in the following categories: organizational structure, clinical and financial performance metrics, and payment methodologies. CMS describes an ACO as "an organization of healthcare providers that agrees to be accountable 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." Successful physician participation will be strongly influenced by 3 elements within the ACO: organizational structure, clinical structure and payment considerations. From a structural perspective, ACOs must have strong and robust primary care infrastructure and robust electronic medical records/information technology systems to capture performance data and quality metrics. Health information technology (HIT) tools will be necessary both for sharing data and evidence-based and/or informed best practices with clinicians who are committed to ensuring that the family-centered medical home serves as the anchor of the ACO. This will promote the efficient and effective delivery of team-based integrative care. Medical homes can be accomplished within a variety of provider configurations, including integrated delivery systems, primary care medical groups, hospital-based systems, or virtual networks of providers, such as within independent practice associations. To achieve the savings championed by the ACO design, approaches other than the traditional fee-for-service system should be considered. Bundled payments, shared savings, quality performance payments, risk-based compensation, outcome-based reimbursement, and case-management fees are all currently under consideration. These schemes will certainly stimulate the provider network to focus on quality and cost performance goals and should align physician and hospital incentives. More importantly, within the legal framework of the ACO, the individual physician will need to be concerned about the governance structure to ensure the distribution of funds is adequate to support the medical home. The challenge of getting all of the players, not just physicians but hospitals and other ACO providers, to agree on changing payment mechanisms, mechanisms of distributing cost savings and changing values of different aspects of care will likely determine the success or failure of the ACO. An ACO will change the relationship between the primary care/cognitive care subspecialist pediatrician and those who have made their income based upon procedures in the volume/cost system that defines the business structure of the current health care delivery system.

## Critical success factors for pediatric ACOs

Much of the policy and analytical dialogue on ACOs has focused on population-based care systems, embracing pediatric and adult patients alike. There is risk in bundling the care of children and adults

into one organizational structure. The ACO may overwhelmingly focus on the adult population with marginal attention to the needs of children. Greater savings are found in managing care for adults and not children. This may skew the ACO's primary focus toward developing protocols and policies that govern the care for adults. Furthermore, health reform has given adults additional opportunities to enroll in Medicaid. There is the risk that the shift away from a concentration on children toward a greater influx of adults into the program could result in a potential short-change in the resources devoted to children. The Pediatric Demonstration Project outlined in health reform, although legislated but not funded, does give pause to critical thinking on the merits of a pediatric-specific ACO. In fact, the legislation also may empower state Medicaid programs to consider constructing a pediatric ACO. There are certain attributes of pediatric care that warrant serious consideration in support of a pediatric-only ACO. These include the long-standing importance the medical home plays in the delivery and coordination of children's health care services as well as the medical home's strong resonance with family and child-centered resources in the community. Emphasis on the medical home and its historic and strong commitment to providing quality care provides community pediatricians with a strong lever to support their independence in fostering arrangements with ACOs emerging in their markets. Many ACOs are emerging that balance their primary care workforce with both employed and independent community physicians. The need for strong and robust independent pediatrician participation is essential if the ACO is going to move away from an episodic, acute care-based model of care to one that focuses on prevention, wellness, and the care of children with special health care needs. Also, when compared with the adult model, the family plays a far more critical and central role in managing the child's care in the context of the medical home. Family experiences can provide a wealth of useful data and information in shaping some of the core elements of a pediatric ACO.

Along the same lines, important historical programs, such as Title V, Head Start, and childhood early intervention programs, and their strong connections with pediatric delivery organizations in the states also represent a strength that can buttress the cause for a pediatric-specific ACO. The pediatric community's vast experience with care coordination, not only in the management of children with complex conditions but also in the daily encounters with children who may need short-term and intermediate care coordination, also supports the concept of a pediatric ACO. In many parts of the country, tightly integrated relationships between children's hospitals, pediatricians, and specialty care pediatricians may be the foundation for a network that can be strengthened further within the architecture of a pediatric ACO. The explicit reference to *Bright Futures* as the axis for the design of a comprehensive set of infant, children, and adolescent preventive care services also serves as another stimulus for this model. Finally, a set of evidence-driven quality performance measures in the Medicaid program can be easily borrowed by pediatric ACOs to immediately put into play a set of performance metrics to critique the quality of care delivered in a pediatric ACO setting.

### **Key considerations in ensuring pediatric representation in an ACO**

The goal of an ACO is to increase access to care and improve the quality/outcomes of care while at the same time restraining the growth

in the cost of care, making the care more efficient. The following perspectives can be used by pediatricians in evaluating the organizational attributes of both a pediatric-specific and/or a pediatric-adult or mixed population-based ACO. Although the previous section briefly highlighted special elements in pediatrics that can stimulate serious consideration of a pediatric ACO, the points enumerated below can be used to measure the commitment of any ACO to a strong and enduring pediatric base.

### ***Organizational Structure Including Legal Considerations***

1. The family-centered medical home is the foundation of a primary care-driven integrated delivery system that is anchoring the ACO. There must be sufficient pediatric primary and specialty care pediatricians for the number of children managed by the ACO. In addition, the ACO should be required to understand, encourage, and support family-centered care, because a child's health is a family responsibility. Finally, integrating oral and mental health care into the ACO's delivery and payment structure is essential, because some of the most common major chronic care conditions children and adolescents experience are oral and mental health problems. Moreover, the future payment system should fully incorporate Behavioral Health into the ACOs by requiring that the ACO has sufficient providers of inpatient, outpatient and the entire array of services necessary to provide comprehensive services.

2. Although the ACO is an integrated system of care (eg, hospitals, physician practices), the governance and leadership of any ACO is physician-driven, and its design must encourage collaboration amongst physicians. Primary care physicians must occupy key positions in leadership during all formative stages of the development of an ACO, and they should be elected or chosen by the primary care physicians participating in the ACO.

3. There is an explicit commitment to equal representation on all governance and clinical committees between primary care and specialty physicians. Consideration also should be given to clinical professionals from the oral and mental health disciplines. This equity in representation also holds for physicians trained and boarded in pediatric primary care and pediatric medical subspecialty and pediatric surgical specialty care. More specifically, the following should be adopted:

- a. The ACO should be guided by a Board of Directors that is elected by the ACO physicians. Any physician entity (medical group, IPA) that contracts with the ACO should be physician (and not hospital) controlled and governed by an elected Board of Directors.
- b. ACO physicians should be licensed in the state in which an ACO operates and in the active practice of medicine in the ACO service area.
- c. Where a hospital is part of an ACO, the governing board of the ACO should be separate and independent of the hospital board.
4. The organization has systems in place to provide direct and indirect support to primary care practices that are committed to transforming to a family-centered medical home. This includes but is not limited to practice management support, technical assistance (including health information technology), and resources for clinical and nonclinical (community, social educational, etc) care. Practices should

be rewarded for achieving medical home recognition by agencies deemed to provide such recognition

5. ACOs should interface with all health-related operations in the state where they operate. This may include state Title V programs, early intervention programs, Head Start offices, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and public education entities as needed to ensure children receive optimal growth, development, and healthy outcomes.

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. All participants in an ACO should have ready access to real-time data to evaluate both care processes and support creative interventions that promote quality improvement.

7. A family advisory council is developed to help guide the ACO leadership.

8. The ACO has formed dedicated and 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 are in place to ensure all payment and managerial policies are in compliance with existing state and federal laws. Antitrust, federal and state anti-kickback and self-referral laws, and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow pediatricians and other physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (eg, so-called virtual integration) for purposes of participating in an ACO.

10. A full range of waivers and safe harbors should be promulgated that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicaid patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue. Also, rural providers face unique challenges in the design and operation of an ACO. Providers in rural communities should be granted additional flexibility to permit them to tailor ACOs to fit the special characteristics of their rural communities.

11. ACOs should be prohibited from imposing exclusive arrangements with pediatricians. Pediatricians should be able to exercise independence and align themselves with multiple ACOs.

## ***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. However, the primary responsibility for care coordination should be maintained jointly with the medical home and the ACO.

2. Quality-performance metrics that pertain to children should be developed with strong input from the primary care and subspecialty care physician disciplines and be evaluated by the AAP using its quality-improvement measurement methodology.

3. Systems are in place to permit the sharing of performance data with all members of the care team.

4. There is a method of attributing patients to providers for purposes of reporting, and the ACO can accommodate multiple methods that may be dictated by different payers.

5. There is leadership support for the development of practice teams to support primary care pediatricians, including appropriate funding for other health care professionals participating in their care.

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 electronic medical record systems are keys to ACO success. Pediatricians and hospitals must have effective communication processes in place to ensure information is shared on a timely basis and are designed to ensure effective and efficient coordination of care and reporting on all dimensions of quality improvement.

## ***Payment Methodologies***

1. Compensation systems and incentives are aligned internally and externally among providers and payers. The formula must be designed to ensure adequate supports for the primary care backbone of the ACO but should not compromise participation of subspecialty physicians. Values developed within the medical home, such as e-mail and telephone support and advice services, coordination of care, and teleconferencing, need to be recognized for the important contribution that they are in the efficient delivery of health care services.

2. Systems are in place to ensure appropriate payment methodologies (eg, bundled payments, full or partial capitation, shared savings, episodes of care payments, enhanced primary care coordination payments, etc) that recognize the special elements of pediatric care, including appropriate and fair payment for the administration of vaccines, and are distributed to participating providers of care in an equitable manner.

3. A pediatric risk-adjustment methodology should be in place to ensure adequate and appropriate payment for the delivery of care to children with special health care needs. Pediatric practices should be adequately paid for the additional effort required to involve family, community/educational resources, and other pertinent entities and activities in their care management/care coordination.

4. The quality-performance standards required to be established by the secretary must be consistent with AAP policy regarding the development of and reporting out of quality measures. The ACO quality-reporting program must meet the AAP principles for quality

reporting, including the use of clinically validated measures developed by leading organizations, such as the American Medical Association Physician Consortium for Performance Improvement; the inclusion of sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; and the right of pediatricians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

5. Savings and revenues from ACO operations should be retained for patient care services as well as to the participating pediatricians and other health care professionals in a fair and equitable manner.

## Conclusions

Although the concept of an ACO is a new paradigm, it builds on historical attempts to create integrated delivery systems to manage care more effectively and efficiently. Although not entirely new, this approach may set in motion another “evolution” in the design and configuration of the US health care delivery system. It appears so, because the model is evolving in numerous communities across the United States. The need for change is pressing. 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? Is the mixed population-based model the most viable approach? How can the organization strengthen its primary care infrastructure, yet meet the needs of the subspecialty physician community? There are additional questions, but the bottom line is that interest in ACOs is accelerating and the market will witness a growth in their numbers. Pediatricians must be in a position to assess

the ACO transition locally. More importantly, pediatricians are urged to actively engage in this process of change to best serve the needs of children and families and the pediatric health care delivery system.

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