More Pediatric ACOs Are Forming, but Challenges Loom With Narrower Focus

There may be only a half-dozen pediatric accountable care organizations in the country — and there’s as yet no federal template for that kind of delivery system, although Medicaid is planning one. But the pediatric ACOs that do exist, as well as similar entities that operate under different names, are making progress in lining up providers and attracting patients.

While some industry watchers note that a single-specialty ACO seems to run counter to the clinical and population inclusiveness that’s generally a hallmark of that type of delivery system, others note that a sharper focus and a better-defined patient population may actually make pediatric ACO development easier. Oncology is another specialty that has fostered single-specialty ACOs (see story, p. 8).

“The organizing entity will have less direct control over the spectrum of care, unless it employs specialist providers, which it usually doesn’t,” says Thomas Merrill, an analyst at Salt Lake City-based consulting firm Leavitt Partners LLC. On the other hand, “persons with specific conditions very often will receive the majority of their care from specialists rather than PCPs, and it makes sense for specialists to be the ‘directors’ of the patient’s care.” And when it comes to reimbursement, he adds, pediatric ACOs “are not necessarily different from other ACOs.”

Indirectly, says Erik Johnson, a consultant at Washington, D.C., consulting firm Avalere Health LLC, because the Medicare ACO model is fee-for-service, he expects “at least the first generation or two of pediatric ACOs will, at least initially, be FFS-based as well.” And the early pediatric ACOs will likely use similar reimbursement for both employed and independent providers. “There’s so much that’s hard about the pediatric ACO model anyway,” he points out, “and so much to invest to make it work, that reimbursement will likely be kept pretty uniform.”

What’s so hard about it? “Unless you’re a pediatric ACO based around a children’s hospital to set up a pediatric ACO with the expectation that one group of patients will be treated differently than another because of age, condition or payer.”

In addition, he says, “It’s very difficult to tell physicians, pharmacists and nurses to treat pediatric patients one way and others another way. But if the providers aren’t specialists, the ACO model will spread to the rest of the patient population. So it’s a tricky balance.” He notes as well that, “at some basic level, a pediatric ACO kind of violates the principle of ACOs, which are supposed to take a broad-based population health approach.”

There’s one additional difficulty that pediatric ACOs could face, Johnson adds. “It shouldn’t be hard to get parental consent, but it might be. And the issues around privacy and consent in the pediatric realm are huge.” For example, he says, “the rapid-fire information exchange that ACOs require could be severely inhibited if you have to solicit parental consent in each instance. It’s a unique factor that makes it difficult to envision how a pediatric ACO is going to operate smoothly.”

Rady Hospital Builds ACO Under Calif. Medicaid

So far, issues around privacy and consent haven’t bedeviled San Diego-based Rady Children’s Hospital, Merrill says. His firm is working with Rady to develop a pediatric ACO that will operate in Medi-Cal, the state’s Medicaid program, under the labyrinthine operational rules of the state’s Department of Health Care Services. “We haven’t seen any issues with that so far,” he tells ABN.

He adds that because Medi-Cal automatically enrolls kids with the certain conditions it’s contracted to care for under the demonstration project Rady is working with, opt-in isn’t really an issue. The California Children’s Services (CCS) program, as the demo is called, covers patients up to age 21 who have one of several serious conditions; a pediatric ACO structure is one option participating provider entities can use. At Rady, physicians are contracted, Merrill notes. “As far as direct physician incentives, they are working out the details in this area and haven’t concluded anything,” he says.
Another of the very few nascent pediatric ACOs, this one called Partners for Kids and run by Columbus, Ohio-based Nationwide Children’s Hospital, involves “mostly salaried physicians, along with some community physicians.” At Rady, Merrill adds, plans are in place to “open the PACO to commercial plans after it has had some time piloting the model. It will be easier for a hospital like Rady to make arrangements with commercial plans because the claims data won’t be from two different sources.”

Under the CCS program, he explains, Rady provides care for some patients who are also enrolled in Medi-Cal managed care plans. So providers end up working under two reimbursement models, one fee-for-service and the other capitation, at the same time. “If both were FFS, it would be easier,” he says. “Also, PACOs will want a profile for each patient and will need to get those data from claims data — and they aren’t getting them from Medi-Cal.”

He adds that two other pediatric ACOs are operating at Children’s Hospital of Orange County and at CS Mott Children’s Hospital, part of the University of Michigan Health System, which is a Pioneer ACO participant.

**Children’s Mercy Builds Provider Network**

Children’s Mercy Hospitals and Clinics is focusing on building an integrated pediatric network (IPN) (ABN 2/12, p. 1). The Kansas City, Mo.-based health system spent the first quarter of 2012 meeting with community providers to better understand their needs and help shape the “value proposition,” reports Bob Finuf, vice president at Children’s Mercy Hospitals and Clinics and executive director at Children’s Mercy Pediatric Care Network (CMPCN). The IPN expects formal contracting efforts to begin in the next 60 days.

Children’s Mercy already has 450 employed pediatricians, specialists and subspecialists. And “we have identified a significant number of community provider practices that will comprise the balance of CMPCN’s network. For now, CMPCN is focused solely on the Medicaid population enrolled in managed care, so we are specifically targeting those pediatricians and family practitioners who see a high volume of Medicaid kids and who would benefit from additional resources to better manage their patient populations.”

“From our perspective, there are not material differences between our IPN and a pediatric ACO,” Finuf says.

“Many of the features, functionality and infrastructure are the same.” For example, he says, “both the IPN and an ACO are aimed at delivering better population health management by integrating and coordinating care between a health system and, in our case, community pediatricians and family practitioners.”

However, he stresses, “because we are focused on pediatrics, and ACOs are so often associated with Medicare, we have chosen to differentiate ourselves from the technical ACO definition.” In addition, “While the IPN payment model will evolve and will eventually provide risk-sharing or shared-savings opportunities for network providers, early on the reimbursement model remains based on traditional FFS with supplemental payments tied to levels of engagement and performance.” Examples of engagement include access and data-sharing, he adds; performance issues include quality measures and appropriate use of services.

**Mass. Blues’ AQC Expands Into Pediatrics**

Blue Cross Blue Shield of Massachusetts used pediatric-specific performance measures when it recently added its first children’s hospital to its Alternative Quality Contract (ABN 3/12, p. 4), reports spokesperson Jenna McPhee. The deal with Children’s Hospital Boston “provided an opportunity to develop a first-in-the-nation set of measurements developed uniquely for a population entirely composed of children and adolescents and benchmarked with appropriate national comparators.”

For example, the hospital, specialists and pediatricians “will be measured on how well they help patients with cystic fibrosis maintain good lung function,” she explains, as well as “on preventing complications after appendectomies and on preventing bloodstream infections in patients in the cardiac, neonatal and medical/surgical intensive care units.”

The global payment system is “designed to encourage cost-effective, patient-centered care,” McPhee says. Providers can “earn significant performance incentives for adhering to nationally endorsed quality, health outcome and patient experience measures.”

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