ACO's, PCMH's and the Triple Aim: What They Mean for Infants and Toddlers

Child and Family Policy Center
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The latest efforts at health service delivery reform are Accountable Care Organizations (ACO's), designed to go a step beyond managed care organizations (MCO's) in controlling health care costs. Ostensibly, ACO's are designed to meet the "triple aim" of: (1) improving the quality of care provided to patients; (2) improving overall health at a population level; and (3) reducing per capita health care costs. At the macro-level, ACO's financial tools generally involve some form of capitated/global payment system that includes shared risk, shared savings, and pay-for-performance for those managing the ACO's. At the micro-level, these financing changes are designed to produce service reforms that include more integrated care through patient-centered medical homes (PCMH's), involving care coordination and access to and management of services and supports (both clinical and transmedical) that maintain health and, in particular, reduce the incidence of high cost episodic care health use (usually hospitalizations or emergency room care) from chronic health populations.

ACO's increasingly are being promoted for the Medicaid program, jointly financed by the federal government and state governments and serving low-income populations that include children and their parents, persons with disabilities, persons in intermediate care facilities/long-term care/nursing home care, and, now, at state discretion through the Affordable Care Act, low-income adults without health coverage.

Typically, ACO's seek to identify patients who are expected to be the highest cost users of health services, perhaps 2 to 5 percent of the population, usually those with chronic health conditions and medically complex conditions – for intensive and concerted PCHM's. While a small part of the overall Medicaid population, these patients consume a great share of current health costs – and are the most likely candidates for achieving the third goal of the triple aim. Generally, the global budgeting and shared savings within ACO's focus upon creating health cost reductions in the immediate clinical care and treatment of these patients, within an ACO's

contract period and through offsets in the use of high cost medical services. These 2-5 percent of the population are most actively managed by ACO's to achieve savings – as they constitute a good 20-30 percent of current health care expenditures.

Meanwhile, ACO's also generally have incentives to seek to manage the remaining 95 to 98 percent of the population to achieve savings. In order to achieve savings in current expenditures on this larger group, ACO's can involve more aggressive negotiation with providers on their payments and fees and additional efforts to reduce, often through additional monitoring, service disallowances, and limitations on service and prior approval protocols, the payment for services, particularly those a primary practitioner may prescribe. The financial incentives to ACO's for this population are to limit the use of services that do not have an immediate impact during the current contract period on health problems and expenditures.

Nationally, children are by far the largest age group being served by Medicaid programs across the country, although their share of Medicaid expenditures is quite small. Over half of all Medicaid recipients are children, but they account for about one-fifth of Medicaid costs. With the exception of children with special health care needs (often born at birth with very complex medical issues and constituting that 2-5 percent of the child population at risk of being highest cost users of health care), children are very low-cost users of health services.

Medicaid also serves a very large share of the child population in the United States. Over 35 percent of all children (0-17) are covered under Medicaid, and this rises to over 50 percent of children from birth to three. This 50 percent also includes the greatest share of all children most at risk for future physical, mental, social, and educational development problems (70 to 80 percent).

These infants and toddlers (0-2 year olds) represent about 12 percent of all Medicaid patients – although very few will be in the population likely to be a focus for PCMH's as current highest cost users.

That, however, is about today's health care costs and health care drivers and not about future health conditions and health cost drivers**. If ACO's are to better address this part of the Medicaid population and achieve the "triple aim" for them over the long-term, ACO's will have to be provided both incentives and requirements to do so – starting with enhancing the capacity and role of the primary health practitioner serving young children and defining a PCMH in broader terms as a family-centered health home and neighborhood (FCHH).**

It is in the first three years of life and the last three years of life that people see a health practitioner most often. What practitioners can do in the last three years typically can affect patient longevity and quality of life in terms of months. What practitioners can do in the first three years of life can affect patient longevity and quality of life in terms of decades. Current investments in health, however, are totally reversed. Half of all health care investments are in the last few years of life, while very young children are where society currently invests the very

least – across health, education, and development. At the same time, the rate of return on investments is greatest in the early years, setting the child's trajectory of health through life.

The Table on the following pages seeks to compare the driving dynamics within most ACO models being developed with what need to be driving dynamics to achieve the triple aim for young children.

ACOs and Infants and Toddlers		
Category	Current ACO Focus	Infants and Toddlers as Focus
Population of Most Interest	2-5 percent of population with health conditions/risks at highest likelihood of incurring major medical expenditures	Very young children with home environments that are not providing safety, consistency, and nurturing – e.g. 20-40 percent of infants and toddlers
Screening and Surveillance Needs	Health conditions requiring medical monitoring and management (often with complex treatment regimens across sub-specialties)	Family stress and home environment and any early signs of developmental/behavioral conditions in the child
Role of Primary Health Practitioner	PCMH that represents team leader for variety of other subspecialty providers and care coordinator, with PCMH as primary decision-maker with patient	FCHH where practitioner may serve as “first responder” and more primary contact and care with the child and family is through another entity
Role of Care Coordination	Under direction of practitioner and/or ACO and primarily involved in ensuring patient compliance with regimen of care and organizing responses from varied subspecialty medical providers.	Involving motivational interviewing and appreciative inquiry with family of infant and toddler and developing family-centered plans that include non-clinical supports to improve the safety, consistency, and nurturing within home health environment and reduce/mitigate stress and adversity.
Expected Outcomes	Improved health maintenance and reduced use of high cost episodic treatments, particularly related to hospitalizations, emergency room use, and iatrogenic disease.	Improved home health and learning environment through greater bonding, reduced stress, and more safety, consistency, and nurturing.

Locus of Cost Savings	Immediate reductions in overall medical system costs within current budgeting and contracting time-frames (generally real-time savings)	Long-term in terms of enhanced trajectory of health of child and gains in physical health, mental health, social health, and educational health outcomes – usually outside the general financial incentives through capitated payment structures.
Size of Cost Savings: ROI's and Rates of Return	Can be substantial for population targeted. Depending upon how the contract is established and budget set, the contractual goals in global budgeting may be relatively easily achievable through adopting evidenced-based protocols for specific presenting conditions (low hanging fruit). Some of the returns will accrue to the ACO and its managers and not to patients or the public system providing the financing. There is limited incentive to reduce the future demand for health services, however, which is a major element to meet the "triple aim."	Considered to be among the most important area for achieving high rates of return on investment – measured in terms of longer-term physical, mental, social, and educational health and well-being. Returns in the medical care sphere are very substantial in terms of improved population health and reduced life course morbidities (but over the long-term and beyond most contractual periods) – but there are also very substantial returns to patients and society outside the medical sphere in improved overall productivity and reduced social costs. The long-term benefits are in achieving the second goal of the triple aim – population health – which is ultimately very much connected to the third.

Financial Strategies	Global budgeting and shared savings primarily reward short-term reductions in medical costs through a focus upon health management that reduces costs among 2-5 percent of health patients and overall efforts to reduce other costs through more aggressive fee negotiation and greater management controls to reduce utilization in services which do not produce immediate health cost offsets.	Additional provisions to reward providers who identify the vulnerable population and provide services and supports that show evidence of improving the safety, consistency, and nurturing of the home health environment, with recognition that this requires investments that go beyond clinical services and that "savings" from such investments are longer-term and beyond contractual periods.
Decision-Maker Incentives	Primarily at the macro-level of the ACO management, with its own motives for securing its financial position as an additional/alternative layer of management in the health system.	Primarily at the practitioner-patient level in improving the healthy development of the child in the context of the child's family and community.
Societal Expectations	Contain or lesson the rise in current medical costs on a per capita basis and better manage the care for current high cost populations.	Improve the healthy development of children and reduce preventable morbidities that give rise to so great a share of health costs.
Champions and Their Motivation	Health management experts/technicians, who can secure continued employment and prestige by providing policy makers with sufficient evidence that they are meeting the triple aim (and at least doing no harm on the first two elements) and therefore reduce policy maker liability for improving the health system.	Primary practitioners and those working with and advocating for vulnerable families, motivated by improving results for the children with whom they connect and have taken an oath to serve.