Can Accountable Care Organizations "Disrupt" Our Fragmented Child Health System?

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An accountable care organization (ACO) is a hospital partnership with physicians (primary care and subspecialty/specialty care providers) that is accountable for both the cost and quality of providing care to a specified population. ACO agreements with a private health plan or public payer (Medicaid or Medicare) can be a full, partial, or no-risk arrangement with a negotiated allocation for any generated savings. ACOs should have a focus on a population, operate within an integrated system with shared physician and hospital control, and receive a capitated payment, all of which allow for a more innovative approach to providing care. Therefore, ACOs may be our best hope to "disrupt" the current fragmented pediatric health care system to achieve better child health as well as better care.

"Disruptive" Internet and mobile innovations have revolutionized many areas of our lives, and similarly, ACOs should be considered another great example of a potentially beneficial "disruptive innovation." ACOs will change our traditional ways of providing care, which are now based on individual face-to-face physician encounters. These innovations will alter the ways we monitor and manage patients as well as how we involve patients and families with shared decision-making. As a tool for influencing behavior, they will generate effective and less costly public health community-based interventions. For example, it will be much more cost-effective to put resources into community-based programs using these new mobile technologies to reduce prematurity then care for premature infants in NICUs.

To achieve dominance in the market, pediatric ACOs must show that they can improve quality while constraining costs. Kelleher and colleagues, in this issue of *Pediatrics*, describe the influence of Partners for Kids (PFK), an Ohio Medicaid pediatric ACO, on costs and quality from January 2008 through December 2013.[1] PFK is structured as a physician-hospital ACO that includes primary care and subspecialty pediatricians and the Nationwide Children's Hospital in Columbus, Ohio. Most pediatricians were employed by the hospital and salaried. Participating nonsalaried community-based pediatricians received enhanced Medicaid fee-for-service payments. PFK had a full-risk arrangement. The ACO had to cover any costs over Medicaid funds received from an adjusted per member per month (PMPM) capitation payment. It could keep all savings generated from spending less than the capitated amount received during the year. The PFK yearly cost increases in PMPM were smaller than the increases in Ohio's pediatric Medicaid population enrolled in traditional fee-for-service plans. The PFK yearly increases in PMPM were also lower than the Ohio Medicaid pediatric population enrolled in managed care plans for all the study years, but the differences did not reach statistical significance. The impact of PFK on quality, considered modest by the authors, included an increase in

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well-child visits, a decrease in NICU days, and modest improvements in the gastroenteritis admission rate, as well as acute and overall quality metrics. These modest effects on quality and costs are consistent with recent reports from nonpediatric ACOs.[2,3]

ACOs can do much more than restrain costs and improve quality. They need to have an expanded community mission focused on children, families, and health. This mission must address 4 domains:

1. The need to integrate ACOs into the community in ways that create strong public–private collaborations that invest in prevention. These collaborations must integrate the ACO with schools, Title V programs, Medicaid departments, foundations, and civic organizations in ways that address the social determinates of high-priority maternal and pediatric preventable conditions. Obvious prevention targets include prematurity, adolescent pregnancy, obesity, child abuse and neglect, smoking, school readiness, resiliency, and toxic stress.
2. The need to restructure health care processes away from traditional physician face-to-face encounters to more effective team models. Our health care delivery system must empower families and patients with the knowledge and education needed for a healthy lifestyle and for shared decision-making when a child or adolescent becomes ill. Intensive team-based care management and coordination that integrates mental health services is needed to reduce hospital care for children with complex and chronic conditions.
3. The need to develop, implement, and evaluate mobile smart-phone applications that influence behaviors and promote family/patient understanding of healthy lifestyles and specific conditions. These applications will provide needed tools to revolutionize how we home monitor a patient's condition by providing real-time clinical assessments as well as functional outcomes.
4. The need to strengthen advocacy efforts to reduce child poverty, which is a root cause of many of our preventable severe child health problems.

In the current environment, opposing financial incentives related to having both capitated and fee-for-service or bundled payments constrains efforts to "disrupt" our health care systems. Having the findings that a Medicaid pediatric ACO improves quality while constraining costs presented in this issue of *Pediatrics* should encourage the more widespread adoption of this model. Now is the time for bold leadership at all levels if pediatric ACOs are to become a transformative approach to better child health as well as better care.

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