Pediatric Healthcare Delivery – A System Undergoing Reform
Second of a Six-Part Series

March 15, 2012

Audience Reminders

- Submit a question by typing it into the Question and Answer pane at the right of your screen at any time.
- Respond to audience polls by clicking on the answer of your choice.
- Provide feedback through our electronic survey following the Webinar.
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Agenda

I. Pediatric Reform From Federal Perspective
II. Positioning for Success Under Healthcare Reform
III. PPACA and Health Reform: Pediatric and Children’s Healthcare
IV. Partners for Kids
V. Conclusions
I. Pediatric Reform From Federal Perspective
I. Pediatric Reform From Federal Perspective

Public Policy Priorities

- Improve Medicaid for Children and Families
- Raise Awareness About Importance of Children’s Hospitals
- Protect and Promote Policy Advances
- Advance Children’s Hospitals’ Education and Research

"It’s a reminder of what we can do when we all work together."
I. Pediatric Reform From Federal Perspective

Principles of Healthcare Reform

<table>
<thead>
<tr>
<th>Principles of Healthcare Reform</th>
<th>Enacted Package</th>
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<tbody>
<tr>
<td>All children must be covered from birth through age 21.</td>
<td>✔️</td>
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<tr>
<td>Coverage should be comprehensive.</td>
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<tr>
<td>Affordable coverage should be available.</td>
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<td>Coverage should provide access to appropriate care.</td>
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<tr>
<td>Coverage should be continuous.</td>
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<tr>
<td>Employer sponsored insurance and a market with multiple payers should be maintained.</td>
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<tr>
<td>System reform must be part of healthcare restructuring.</td>
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<tr>
<td>The federal government must play a leading role.</td>
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<tr>
<td>Medicaid will continue to have an indispensable role.</td>
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“This is not the end. It’s not even the beginning of the end. But it is, perhaps the end of the beginning.”

– Sir Winston Churchill
I. Pediatric Reform From Federal Perspective

Implementation Priorities

- Financing/Access
- Delivery System/Payment Reforms
- Children’s Coverage
- Workforce
- Quality

- Positively Impact Implementation
  - Influence policies proactively.
  - Review/analyze/respond to regulations.
  - Ensure pediatrics is part of innovations.

Use existing law to advance policy priorities.
I. Pediatric Reform From Federal Perspective

Innovative Solutions

- CHIPRA Pediatric Quality Measures
- Process for Waivers for State Innovation
- Non-payment for Healthcare Acquired Conditions
- Exchanges – Multiple Regulations
- IRS Notice Regarding Community Benefit
- Medicaid Conditions of Provider Participation
- Essential Benefits Guidance
- PCORI Research Agenda
- Stage 2 Meaningful Use

Coming Soon
- Medicaid Primary Care Services Increase
- Final Exchange Regs

- Center for Medicare and Medicaid Innovation and other demo opportunities.
  - Ensure that pediatrics is part of the delivery system/payment reforms.
- Pediatric Accountable Care Organizations (ACO).
  - Realign payments to support innovative models.
- Quality Transformation.
  - Children’s hospitals’ efforts to reduce infections.
  - Saved $115 million, 396 lives over 5 years.
- Medical Homes for Medically Complex Children.
  - Proven savings/improved quality from care coordination.
I. Pediatric Reform From Federal Perspective

Collaborative Change

Medical Home for Children With Complex Conditions

| Arkansas Children’s Hospital | Children’s Hospitals and Clinics of MN |
| Children’s Hospital of Colorado | Doerenbecher Children’s Hospital |
| Mattel Children’s Hospital UCLA | Nationwide Children’s Hospital |
| Rady Children’s Hospital | Children’s Hospital of Philadelphia |
| Seattle Children’s Hospital | Hasbro Children’s Hospital at RI Hospital |
| Children’s Healthcare of Atlanta | CHRISTUS Santa Rosa Children’s Hospital |
| Children’s Memorial Hospital | Texas Children’s Hospital |
| LaRabida’s Children’s Hospital | Primary Children’s Medical Center |
| Children’s Hospital Boston | |

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Request commitment to pediatric focused innovations.

Steve Larsen, Deputy
Administrator and Director
Center for Consumer Information and Insurance Oversight (CIIO)
Pediatric exchange issues – benefits, networks and quality measures.
I. Pediatric Reform From Federal Perspective

**Federal Policy Successes**

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<tr>
<th>Regulation</th>
<th>Impact</th>
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<tbody>
<tr>
<td>DSH Rule</td>
<td>Modifies insurance coverage for DSH.</td>
</tr>
<tr>
<td>Health Home 90% Match</td>
<td>Changed interpretation to allow children medical homes.</td>
</tr>
<tr>
<td>Development Medicare Code</td>
<td>Agreement to keep code for other payers.</td>
</tr>
<tr>
<td>Medicaid Rehabilitation Condition of Participation</td>
<td>CMS rescinded November policy.</td>
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II. Positioning for Success Under Healthcare Reform

Introduction

Our presentation will provide a framework for understanding how children’s hospitals should position themselves to be successful under healthcare payment reform.

- Government funding for the provision of healthcare is under tremendous pressure at the same time that access to public benefits is increasing.
- State Medicaid agencies are seeking to protect enrollment eligibility while also reducing the amount available to pay for healthcare services.
- Commercial insurance companies, employers offering health benefits, and Medicare have been focusing on value-based purchasing and accountable care as approaches to moving reimbursement away from traditional “pay for volume” into innovative approaches to “pay for value.”
- With a heavy reliance on Medicaid reimbursement, pediatric hospitals and other providers will need to understand how to prepare for the new paradigm.

Children’s hospital executives can learn from their peers in non-pediatric hospitals.

Trends and Issues - State Medicaid Challenges and Reform

- In fiscal year (FY) 2014, Medicaid will be expanded to include individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL.
- Managed Medicaid has already experienced major growth, with the percentage of Medicaid beneficiaries in managed care plans at 71%.
- Primary care payment increases are expected to move to 100% of the Medicare rates for 2013 and 2014, with 100% federal financing for the increase.
- DSH payments will be reduced in 2014, with reductions varying by state (CBO estimates this to be a savings of $14 billion over 10 years).
- In FY 2015, a 23 percentage point increase will be provided in the Children’s Health Insurance Program (CHIP) match rate, up to a cap of 100%.

Pediatric organizations are challenged by a payor mix that is heavily reliant on Medicaid, which typically accounts for half of their total revenue.

- The emphasis on managed Medicaid was mirrored by Medicare Advantage.
II. Positioning for Success Under Healthcare Reform
Trends and Issues - Cost Containment

Due to state budget crises, Medicaid cost-containment efforts are widespread. Eligibility for the programs is being protected because of federal incentives/mandates to do so.

The economy and national healthcare reform influences are impacting pediatric programs through state Medicaid changes that are focused on reducing cost.

State Actions – Medicaid Managed Care and ACOs

| Planning on Implementing Pediatric ACOs and/or Behavior Modification Grants in FY 2012 | 10 |
| Expanding Medicaid Managed Care in FY 2012 | 19 |
| Implemented or Planned to Expand Medicaid Managed Care in FY 2011 | 20 |
| Implementing or Had Implemented Disease Management/Care Coordination in 2010-2011 | 23 |


II. Positioning for Success Under Healthcare Reform

Trends and Issues - Subspecialty Physician/Hospital Alignment

The current environment is driving an increased need for alignment between children’s hospitals, SOMs, and faculty physicians.

Factors Driving Greater Alignment

- Downward pressure on professional fees.
- Physician shortages leading to escalating salaries.
- Increasing gap between professional fees and the cost of practice.
- Reliance on other sources of funding for the pediatric physician enterprise.
- Potential emergence of global payment systems.
- Care delivery reform (e.g., creation of ACOs, selected disease-specific care management efforts).

The Risk Continuum Associated With Existing and Proposed Reimbursement Structures

As reimbursement shifts from payments based on FFS (volume) to a more value-based system, risk will shift from payors to providers.

Reimbursement methodologies are inexorably moving to the right of this spectrum.

1 Medical homes that receive extra dollars for patient management.

II. Positioning for Success Under Healthcare Reform

Considering ACOs - Status of Children’s Hospitals

There has been little focus on innovative payment approaches for pediatric compared to non-pediatric providers.

- Innovative payment approaches are not being widely implemented.
  - Inpatient payments are made on a percentage-of-charges (POC) or per diem basis.
  - Outpatient payments are also based on POC, surgical case rates, or ambulatory surgery groupers.
- Bundled payments are not widely used.
- Those with Medicaid PCMHs have not explored or implemented payment methodologies with commercial payors.
- To date, most commercial payors have not yet put the pressure on children’s hospitals to move toward P4P arrangements.

Since little has happened to date with children’s hospitals, it is worth exploring what has happened in the non-pediatric world.

II. Positioning for Success Under Healthcare Reform

Considering ACOs - What Strategies Should Be Considered?

Medicare PCMH strategies provide an excellent analogy.

- Frail elderly and chronically ill children require similar coordination of care by teams of primary care and specialty providers and nonphysician professionals.
- Both populations are at risk of high emergency department utilization and inpatient admission rates.
- The PCMH needs to be able to identify, track, and care for that relatively small portion of the total population which has the greatest need for care and represents a disproportionately high cost.

A longitudinal approach from pediatric to non-pediatric ACOs may provide the best opportunity for the long-term control of healthcare cost and quality.
One client’s transformation to a value-based, integrated delivery system incorporated the six essential components illustrated in the framework below.

- Medical Home Construction
- Care Delivery Transformation
- Network Development
- Information Technology Infrastructure
- Payor Contract Restructuring
- Clinical Integration

II. Positioning for Success Under Healthcare Reform
Considering ACOs - Background Implementation

The MA PCMH infrastructure is an analogy for how a pediatric PCMH might be structured in an ACO.

- A 200-plus-physician multispecialty group developed a PCMH strategy with its largest MA payors.
- Each agreement met consistent overarching principles.
  - Enhanced FFS.
  - Grants or investments for infrastructure.
  - Quality and/or efficiency measures.
  - Per member per month (PMPM) medical management fee.
- Funding was based on shared savings from anticipated reductions in utilization and increased premiums due to appropriate risk adjustments from accurate hierarchical condition coding.
- While the details differed between plans, the incentives were consistent and in line with the group’s infrastructure and philosophy.

This approach begins to solve the problem of how to pay for a PCMH.
II. Positioning for Success Under Healthcare Reform
Assessing Strategic Options - Primary Care

ACOs are driven by primary care.

- Medicare ACOs are PCP driven, and we expect that Medicaid ACOs will be, as well.
- The decision to partner with or start an ACO may be informed by an understanding of the primary care market.
  - As other providers in the market join or form ACOs, they will have a vested interest in reducing cost. They may seek to move care away from children’s hospitals, where possible, especially if they are in a different or competing ACO.
  - ACOs’ enhanced focus on preventive care and case management could conceivably reduce the rates of premature births, putting increased pressure on NICUs.
- It is important to consider the status of physician alignment.
  - Strong or weak?
  - Relationship with independent physicians or employed?
  - Primary care and specialty network: are there shortages?
  - Who are the obstetricians aligned with?

It is critical to understand the pediatric primary care network.

II. Positioning for Success Under Healthcare Reform
Assessing Strategic Options - Other Market Factors

Other strategic factors that pediatric hospitals must consider include the following:

- Market-competitive situation?
  - Is the hospital freestanding or affiliated with an academic medical center, or is it a unit in a community hospital/health system?
  - Is it the only children’s hospital in the market, or are there competitors?
  - What is the hospital’s relationship with other hospitals, and what are their plans concerning ACO development?
- Relationship with commercial insurers?
  - All payors?
  - Limited participation?
- Financial circumstances?
- Technology?
  - EMR?
  - Integrated with physicians?

The final direction cannot be chosen without understanding the hospital’s strategic position.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare

The pediatric ACO (PACO) to begin 1/1/12 and end 12/31/16.

- But not funded.
- No regulations.

What might have been:

- Demonstration project for participating states.
- Pediatric medical providers to be ACOs for purposes of receiving incentive payments in the same manner as MSSP.

With:

- Performance guidelines to maintain quality.
- Required annual minimum level of savings.
- Minimum participation period of less than 3 years.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare
Section 2703

State option to provide health homes for enrollees with chronic conditions.
- To provide coordinated care requires an SPA.
- Eligible individuals with chronic conditions:
  - Must select a designated provider or health team.
  - As a “health home.”
- The health home.
  - Designated provider.
  - A team of healthcare professionals operating with a designated provider.
  - A health team.

Alternative models of payment, including capitation.
Eligible individual with chronic conditions.
- Eligible for Medicaid.
- Two chronic conditions or one-plus at risk or mental health.
- Chronic conditions: mental health issues, substance abuse, asthma, diabetes, heart disease, overweight.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare
Section 2703 (continued)

- Health home services.
  - Comprehensive care.
  - Comprehensive transitional care.
  - Referral services.
  - Care coordination and health promotion.
  - Patient and family support.
  - Use of IT to link services.

- Designated provider.
  - Physician.
  - Chronic.
  - HHA.
  - Community health center.
  - Community mental health center.
  - Other.

- Team of HCPs.
  - Includes physicians and other professionals (any state deems appropriate).
  - Freestanding, virtual, or faculty- or clinic-based.
  - AMC.
  - Other state-approved entities.

- Other opportunities.
  - Section 2704 – Demonstration Project to Evaluate Integrated Care Around a Hospitalization.
  - Section 2705 – Medicaid Global Payment System.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare
What We Are Watching

- Risk-based managed care contracting.
  - BCBSMA – Children’s Hospital Boston.
  - “AQC” contract.
    - 0% rate increase for 2012.
    - Manage growth in healthcare spending to a level tied to pediatric network coverage expense trend or face financial exposure.
  - Combination.
    - Per patient global budget.
    - Performance incentives based on agreed measures.
      - Quality.
      - Outcomes.
      - Patient experience.

Risk-based managed care contracting. (continued)

- Measures.
  - Helping children with cystic fibrosis maintain lung function.
  - Preventing complications (e.g., after appendectomies).
  - Infection rate – cardiac, neonatal, med/surg.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare

Consolidation of Pediatric and Children’s Services

- University of Missouri Children’s Hospital.
  - New clinic of larger size.
  - Telehealth capacity.
  - Laboratory capacity.
  - Specialists from 20 areas.
  - Thirty-five pediatric providers.

- Challenges.
  - Cohesive patient flow – clinical integration.
  - Compensation design with appropriate incentives.
  - Group structure – virtual group, employed, foundation.

Acquisition

- All Children’s Hospital – Johns Hopkins Health System (2010).
  - Financial integration vs. governance.
  - Managing diverse businesses.
  - Capital allocation.
  - “Creating a portal to Southern and Central America.”
  - Extending the brand.

  - A children’s hospital acquired a general acute care hospital.
  - Protecting market shares.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare
Collaboration and Comanagement

- A comanagement primer.
  - Agreement between hospital and specialty group.
  - Manages the operational and clinical activities.
  - Of a specialty service line.
  - Compensation – FMV.
  - Annual base fee.
  - Quality-based incentive fee.
    - Quality improvement.
    - Efficiency enhancement.

- Fees not based on value or volume of referrals.
  - Independent appraisal analysis.
- Monitor quality and patient mix.
  - Cost reductions where clinical quality maintained or improved.
- Term of 1 to 3 years (watch tax-exempt bond time limits).
- Counsel to avoid AKS, CMP, Stark exposure.
- Fit into Personal Services/Management Contracts safe harbor.
- Compensation – set in advance.
Lucile Packard Children’s Hospital-California Pacific Medical Center (Sutter Health) (2012).
- Create an entity to provide day-to-day oversight and support.
- Bring together pediatric specialty physicians from both hospitals.
- Manage units at CPMC.
- Collaboration – multispecialty historically.
  - Cardiology, cardiac surgery, GI, and liver transplant.

Children’s Hospital Boston – Southcoast Health System (2012).
- Coverage and medical directorship.
  - On-site medical director.
    - Medical oversight, development, and coordination of local hospital-based pediatric care.
    - Gastroenterology.
    - Cardiology.
    - Training and education.
  - Contract structure.
  - Avoid AKS, Stark issues.
  - Multihospital arrangements.
    - Maintain existing pediatricians or FP.
    - Referral network – recognition that competition may not be local.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare

The Power of Technology

- UCSD – Tri-City Medical Center (NICU) (2012).
  - Telemedicine “partnership.”
    - Live video feed.
    - Subspecialty consults.
    - “Present in the room.”
- Telemedicine statutes.
  - Licensing.
  - “Hands on” examination requirements.
    - Consults vs. direct patient responsibility.
    - State boundaries and licensing.

- Children’s Memorial Center at Bakersfield Memorial Hospital (2010).
  - Staffed by pediatric hospitalists of Children’s Hospital Los Angeles Medical Group.
    - Full-time staffing.
      - Infant, child, adolescent, teens.
      - ER consultation.
    - Hospitalists, intensivists, PICU.
  - Hospital within an existing hospital vs. “hospital within a hospital.”
    - 42 CFR 412.22.
      - Occupy spaces or located on some campus as another hospital.
      - Specific provisions for children’s hospitals at 412.23(e).
    - Separate governing body, CMO, medical staff, CEO.
    - Contracted services provisions.
III. PPACA and Health Reform: Pediatric and Children’s Healthcare

What’s the Right Approach?

- Market driven/opportunity driven.
- Front office – regional pediatric system – a consolidator.
- Back office – support for others.
- Hybrid.
- Expansion into complementary service lines.
  - Adult hospital alignment.
  - Women’s and children’s.
  - Market tension: internal growth vs. referral streams.
- Prognosis for children’s hospitals.
  - Inherent strengths (core pediatric specialty staffing, research, technology, infrastructure).
  - “Fortune favors the bold.”

IV. Partners for Kids
IV. Partners for Kids

Structure

- Ohio taxable, not-for-profit private entity.
- Joint venture between Nationwide Children’s Hospital, its employed physicians, and contracted community physicians.
- Approximately 80 employed and 230 community PCPs, 400 employed and 50 contracted community specialists.

Ohio Department of Insurance considers PFK to be an “intermediary organization.”

IV. Partners for Kids

Geography

Contracts with three Medicaid managed care organizations (currently) covering just under 300,000 lives in urban and rural Ohio (34 counties).
Ohio is a mandatory Medicaid managed care state – nearly all of the population in the Healthy Start; Healthy Family; and adult Aged, Blind and Disabled programs are enrolled in one of the eight health plans offered around the state.

ODJFS (Ohio’s Medicaid office) divided the state into eight regions – two or three health plans are offered in each region.

ODJFS is currently working on changes to the program as a result of the state budget:

- Adding pediatric Aged, Blind and Disabled to the Medicaid managed care plans.
- Adding financial responsibility for pharmacy.
- Changed regional structure to three regions; four plans to be offered in each one.
- Re-procuring – may result in new/different partner health plans.

### IV. Partners for Kids

#### Ohio Market

ODJFS pays the Medicaid managed care plans an age/sex-adjusted per member amount each month for all CFC members in their regions.

Plan passes the capitation for members 19 and under less a small amount for administration (reporting, member service, claims processing).

Nationwide Children’s Hospital is ultimately at risk.
IV. Partners for Kids
Financial Incentives

Primary Care pay-for-performance program.

Current PFK Physician Incentive Program

New PFK Physician Incentive Program

Access

Paying for Outcomes

Practice Improvement

IV. Partners for Kids
Evolutionary Growth

Patient Membership

Managed Care Strategy

Contracting Strategy

Accountable Care Organization (Population Health)
IV. Partners for Kids

Major Challenges

- Feeling comfortable with the risk when you don’t have a lot of control!
- Regulatory Issues.
- Maintaining managed care plan relationships.
- Competing priorities.
- Data management.

V. Conclusions
V. Conclusions

- The pressure on children’s hospitals to pursue integration strategies and to manage care on a population basis will increase.
- Financial and market analyses will be critical to understanding the impact of various options.
- Primary care networks will drive population-based reimbursement.
- As hospitals implement systems to be successful in Medicaid reform programs, the skills, infrastructure, and processes will be transferable to similar commercial arrangements.
- Developing a consistent approach to treating patients, regardless of payor, will be more efficient.
- A strategic approach will be important – children’s hospitals should not be complacent and wait to see what happens.

PEDiatric Business AND Healthcare DELIVERY SERIES

Questions & Answers

To submit a question for any of our presenters, type it into the Question and Answer pane at the right of your screen at any time.

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Thank you for participating in today’s session.

Please take a moment to complete the electronic survey upon exiting today’s program.

Future Programs

We hope you will join us for future programs in the Pediatric Business and Healthcare Delivery Series, which will feature the following topics:

- Physician/hospital alignment in pediatrics – Current trends and innovative structures.
- Fraud and abuse compliance.
- Information technology.
- Research and teaching.
- Subspecialty physician practice – Managing teaching, research, and clinical missions in the presence of shortages.