Children’s Hospital-Based Accountable Care: A National Survey

Naomi Makni, MHA
Grant Manager

Alex Rothenburger, MPA
Research Analyst
AGENDA

- Pediatric Accountable Care Organizations (PACOs)
- The PACO Study
- Results
- Final Thoughts
PEDIATRIC ACCOUNTABLE CARE ORGANIZATIONS
What is an **Accountable Care Organization**?

*For Adults, It’s Pretty Clear....*
ACO DEFINITION

- Integrated Group of Providers
- Partial or Comprehensive Services
- Defined Population
- Outcome Measurement
- Fiscal & Clinical Accountability
RESEARCH AIM

Describe the current Pediatric ACO (PACO) landscape and arm pediatric leaders with strategic knowledge of PACO development.
THE PACO STUDY
TIMELINE

2013

- Outreach
- Interviews
- Analysis
- Presentation
DATA COLLECTION

60-90 Minute Phone Interviews

67 Questions
6 Categories
Medicare ACO Standards

Excel Database
SAMPLE INTERVIEW QUESTIONS

**General**
- Why did your organization decide to pursue an ACO?

**Structure**
- Is there a physician dedicated to being the full time medical director?

**Providers**
- Are the ACO’s primary care physicians capitated?

**Shared Savings**
- How is shared savings calculated?

**Data and Quality**
- Does the ACO have direct access to claims for the entire defined population?

**Path**
- What are the top lessons learned from ACO Implementation?
DATA ANALYSIS

PACO Trait Spectrums

Model Diagrams

Shortell Framework (Modified)
STUDY SAMPLE

affiliated with a Children’s Hospital

bearing some Financial Risk*

utilizing Incentive Payments
STUDY SAMPLE

n=13

3 Provider-Sponsored MCOs

2 Shared Savings Only Models

5* Integrated Health Networks

1* Employee ACO

1 CH in Adult ACO

1 Specialty Risk Arrangement

*One or more ACO(s) in planning stage

n=13
STUDY SAMPLE

PACO Target Populations as Named by Participants

- Employee*: 1
- Commercial: 1
- TANF, CHIP: 1
- Medically Complex*: 1
- ABD, TANF, CHIP*: 4
- Commercial and Medicaid: 1
- Medicaid and CHIP: 2
- Medicaid: 2

*One or more ACO(s) in planning stage
RESULTS
Question 1 of 7

What is **greatest number of lives** covered by any one of the 13 PACOs?

- 175,000
- Just over 300,000
- Exactly 150,036
- 97,000
Answer: Just over 300,000 lives—wow! And these lives are attributed to a fully capitated ACO—NOT a health plan.
ACO Pediatric PCP to Pediatric Lives Ratio (n=9)

Average Ratio of Cluster = 1:475
ACO Pediatric Specialists to Pediatric Lives Ratio (n=8)
Question 2 of 7

The majority of our 13 PACOs had a ______________ arrangement with one or more payers.

• Shared Savings
• Quality Incentive
• Risk Corridor
• Fully Capitated
Answer: Fully Capitated
## (Modified) Shortell Framework for ACOs

<table>
<thead>
<tr>
<th>Delivery System Model</th>
<th>Shared Savings ONLY</th>
<th>Risk Corridor</th>
<th>Full Capitation</th>
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</thead>
<tbody>
<tr>
<td>(1) Hospital Medical Staff Organization</td>
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<td></td>
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</tr>
<tr>
<td>(2) Physician Hospital Organization</td>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>(3) Health Plan Provider Organization/Network</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>(4) System-Based Pediatric Contracts</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
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2014 Annual Leadership Conference and Meeting of the Membership

ACO Risk Methodology: Full Capitation

- Target MLR
- ACO Keeps 100% of Savings
- ACO Bears 100% of Overages

% Difference between Target and Actual Medical Spend:
- <5%
- <3%
- <1%
- 0%
- >1%
- >3%
- >5%
Sample Payment Models: Full Risk Capitation

- **Payer**
  - **CAPITATED PAYMENT**
  - **Pediatric ACO**
    - **HOSPITAL SUB-CAPITATION**
    - **NETWORK PROVIDER INCENTIVE**
ACO Risk Methodology: Risk Corridor

% Difference between Target and Actual Medical Spend

Target MLR

<table>
<thead>
<tr>
<th>Corridor 3</th>
<th>Corridor 2</th>
<th>Corridor 1</th>
<th>Corridor 1</th>
<th>Corridor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO 60%</td>
<td>ACO Keeps 50%</td>
<td>ACO Keeps 100%</td>
<td>ACO Bears 50%</td>
<td>ACO 25%</td>
</tr>
<tr>
<td>Payer 40%</td>
<td>Payer Keeps 50%</td>
<td>Savings</td>
<td>Overage</td>
<td>Payer 75%</td>
</tr>
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<td></td>
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</tr>
</tbody>
</table>

<5% <3% <1% 0% >1% >3% >5%
Sample Payment Models: Risk Corridor

- Payer
- FFS Budget Over/Under
- Pediatric ACO

HOSPITAL/PROVIDER FEE FOR SERVICE

NETWORK PROVIDER INCENTIVE
ACO Risk Methodology: Shared Savings

ACO Keeps 60% of Savings

Payer Keeps 40% of Savings

Payer Bears 100% of Overages

% Difference between Target and Actual Medical Spend

Target MLR
Sample Payment Models: Shared Savings Only

Payer

| HOSPITAL/ PROVIDER FEE FOR SERVICE |

SHARED SAVINGS PAYMENT*

*based on PMPM and Quality goals

Pediatric ACO

| NETWORK PROVIDER INCENTIVE |
Question 3 of 7

Out of 7 PACOs, what percent had a shared savings agreement, based on cost AND quality?

- 0-25%
- 25-50%
- 50-75%
- 75-100%
Answer: 23%
ACO Payment Mechanism

1. Payer-to-ACO

2. ACO-to-Provider

3. Independent

4. ACO

5. Independent

6. Reinvested

7. None
Payer-to-ACO Payment

Cost Targets

ACO

5

Cost & Quality Targets

ACO

2
ACO Savings Overview

- **Payer-to-ACO**
- **ACO-to-Provider**
- **ACO**
  - **INDEPENDENT**
  - **INDEPENDENT & EMPLOYED**

- **PAYER**
  - None
  - Reinvested

Numbers:
- 7
- 6
- 5
- 2
- 3
- 2
Shared Savings: ACO-to-Provider

ACO 2

Cost Targets

ACO 3

Cost & Quality Targets

2014 Annual Leadership Conference and Meeting of the Membership
Out of 13 PACOs, what percent used a **pay-for-performance** incentive program for their providers?

- 0-25%
- 25-50%
- 50-75%
- 75-100%
Answer: 30%
Pay for Performance: ACO-to-Provider
The majority of our 13 PACOs had a __________ overseeing the ACO’s activities.

- CEO
- Separate Board
- Medical Director
- Legal Department
Answer: Separate Board
ACO Oversight Models

1. HOSPITAL
   - Operations
   - Finance
   - Strategy
   - ACO Oversight

2. HOSPITAL
   - Board
   - ACO Subcommittee

3. HOSPITAL
   - Board
   - ACO Board
Question 6 of 7

What was the most commonly named set of metrics used to evaluate ACO outcomes?

- Relative Resource Use
- CHIPRA Core Set Measures
- Effectiveness of Care
- HEDIS
Answer: HEDIS
ACO Evaluation Metrics

HEDIS
- Ten ACOs Utilize HEDIS for Performance

HEDIS +
- Four ACOs added Additional Measures: CLABSI, Low Birth Weight, Quality of Life, Infant Mortality, Next Available Appt., Readmissions, Unnecessary ED visits; ED for ASC Conditions; NICU Admissions; Net. Adequacy Requirements and AAP periodicity; Parent Satisfaction*
Question 7 of 7

When sharing their lessons learned, executives most frequently named the need for this **vital ACO component**.

- Data & Analytics
- Gin and Tonic
- >75% Pediatric Market
- Dedicated Case Management
Answer: Data & Analytics
Data Analytic Capabilities are Required for...

Under/Over Utilization
Case Management
ACO Outcomes
Financial Performance
Care Coordination
Risk!
Population Health
Spectral View of PACO Investment

Investment in Infrastructure

<table>
<thead>
<tr>
<th>SHARE HOSPITAL INFRASTRUCTURE</th>
<th>STAFF, SOFTWARE/IT, OR ANALYTICS</th>
<th>2+ INVESTMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
</tbody>
</table>

- Level 1
- Level 2
- Level 3

- K
- L
- M

- D
- G
- B
- J
- E
- A
- I
- C
- H
- F
Recommendations for D&A

1. ACO Should Eventually Own Analytic Staff—Not Share Hospital Staff
   • Ensure quality of data received from payers
   • Examine data for cost savings and quality improvement opportunities
   • Determine and Negotiate the specs or data elements that the ACO will need from health plan/vendor
   • Financial and Risk Analysts determine risk level

2. Utilize Vendors When Necessary
   • Vendor may help facilitate the data acquisition/cleaning process
   • Prevent system drags at early onset

3. Realistic Expectations
   • PLAN, PLAN…PLAN!
Lessons Learned from PACO Executives
Lessons Learned from PACO Executives

“We've really included the providers. They are on every subcommittee, on every board. They are shaping decisions about how things are structured, we've been very transparent.”
“...take caution with carving out certain service lines because there may be overlap that helps your population’s overall health...”
“Keeping the IT infrastructure is a seven-figure chunk to bite off. It was a huge investment and a hard argument to win. Now that we have it, we have a better value proposition for the doctors we want to work with.”
Lessons Learned from PACO Executives

“...an understanding of adverse selection and its relationship to capitation rates...”
### Payer Negotiation
- An effective data analyst who can drive discussions with payers
- Knowledge regarding your technology capabilities, limitations, requirements and support
- Negotiated data elements from health plan
- Education for payers on pediatric metrics as part of the negotiation process
- Provisions against cherry-picking rates if the at-risk population can see out-of-network providers

### Provider Network
- A solid understanding of the needs of your network
- Strategic intent driving the design of the networks and decision-making
- Willingness to drop a payer if it does not contract with a desired provider
- Caution in carving out certain service lines because there may be overlap that helps your population’s overall health
- Focus on contracting with the right network to keep from getting lost in financials and PMPM

### Physician Engagement
- A solid understanding of the needs of your network
- Early and constant physician engagement
- Physicians on all boards and subcommittees driving discussions

### Org Development
- An executive director on board early in the planning process
- Sufficient time to develop a legal structure
- Knowledge about taking on both commercial and Medicaid risk
- An external consultant if merging entities
- Realistic expectations about potential savings
- An understanding of adverse selection and its relationship to capitation rates
- Knowledge of your population, market and cost drivers to create solutions

### Data and Analytics
- A vendor for claims processing to avoid system drag
- Population data to make the population healthier
- Knowledge regarding acquiring and managing big data with analytics
- An understanding that IT investments are the largest and most useful
- An early look at state data processes because they can be cumbersome to handle
FINAL THOUGHTS
1. PACO Quality Conundrum
2. More PACO Research

Continued Studies
• Beyond the 13
• Component-Focused

Federal and State Policy
• State Medicaid Interactions
• Federal Research

Get Involved!
• Study Participants
• Children’s Hospital Association
3. Adult & Pediatric ACO Expansion

Total Accountable Care Organizations; Source: Leavitt Partners Center for Accountable Care Intelligence
Questions?

"Can you repeat the part of the stuff where you said all about the things?"
Thank You!

Naomi Makni, MHA
naomi.makni@nationwidechildrens.org

Alex Rothenburger, MPA
alex.rothenburger@childrenshospitals.org
UnityPoint Health Partners
(PKA Iowa Health Sys.)
• Owner of all ACO activities in UPHP
• 15 Hospitals across 2 states

UPH: Fort Dodge
hosts a Medicare Pioneer ACO between 4 UPH locations (2 hospitals, 1 clinic, 1 home health)

UnityPoint Health: Des Moines
• Owns the System’s ACO
• Consists of 5 hospitals, 1 clinic, 1 home health
• Performing some Case Management and Utilization Review
• 200 Employed MDs (50 PCP + 150 specialists)

Blank Children’s Hospital
• 88-bed UPH: Des Moines hospital
• 90 Employed MDs
  • 40 PCPs (Pediatricians)
  • 50 Specialists

UnityPoint Health: Des Moines
• At risk for Commercially insured
  Iowa lives
  • 46,000 pediatric
  • 174,000 adult

40 Independent Pediatricians and Ancillary Providers
• Provide services at UPH: Des Moines hospitals

Claims
• Analytics team
• 4-5 month delay
• No Rx or part D

EMR
• All visits within the UPHP multi-state system
• 85% of at-risk pop’n.

Board
• 90% ACO MDs
• President
• 2 PT Med Dirs.

Subcommittees
Pediatric reps on Network, Finance, Quality

FFS Claims (All Payors)

FS Claims (All Payors)

CLAIMS DATA

CLAIMS DATA

CLAIMS DATA

CLAIMS DATA

PMPM
QUALITY

EMR

SYSTEM

FFS Reimbursement

FFS Reimbursement

SHARED SAVINGS AGREEMENT

PAYBACK DUE:
If above PMPM target by >2%

10% to Admin

PMPM
QUALITY

Tier 1=Employed/PCP
Tier 2=Specialty

90% to MDs

SHARED SAVINGS:
If below PMPM target by >2% AND quality threshold score met

Lives

(Providers)

(Data)

(Hospital)

(ACO)

(Payor)

(Hospital)

(Payor)

(Hospital)

(Payor)
**Cook Children's Health Plan**
- Owned by Health Foundation
- Not-for-Profit
- 50% Medical Director (supports C4CH)*
- 42% of Medicaid market
- UR and CP; shared CM with other providers
- PROFIT >3% is rebated to Texas Medicaid

**Cook Children's Health System**
- Not-for-profit system
- Includes 8 entities (2 are hospitals)

**Board**
- Appointed by Foundation Board
- 41% Practicing CCPN MDs and community practices
- 59% Community volunteers

**Center for Child Health**
- Population Health planning & research
- 50% Medical Director*

**Claims Data**
- PCMH RESOURCES
- CLAIMS DATA
- COST, VOLUME, UTILIZATION DATA

**EMR**
- Primary Care for 20% of at-risk children (22k)
- Specialty Care for 60% of at-risk children (57k)
- Inpatient Care for 95% of at-risk children

**Texas Medicaid**
- FFS BILLING
- FFS REIMBURSEMENT
- HEDIS & STATE REPORTING METRICS
- PROFIT MARGIN >3%
- CAPITATION

**CCHP enrollees (CHIP and STAR)**
- 120,000 (adults/kids) in CHIP (22k) and STAR (98k) in 6 counties
  - 10,000 Adults
  - 110,000 Kids

**SOE**
- FFS BILLING
- FFS REIMBURSEMENT
- HEDIS & STATE REPORTING METRICS
- PROFIT MARGIN >3%
- CAPITATION

**Contracted by Health Plan**
- 677 Primary Care
- 1430 Specialists
- Both substantially adult providers

**Data**
- CLAIMS DATA
- COST, VOLUME, UTILIZATION DATA
- PCMH RESOURCES

**Provider-sponsored MCO**
- Cook Children's Health Plan

**Out-of-system Providers**
- Cook Children's Medical Center
- Cook Children’s North East Hospital
- Cook Children’s Physician Network
- Cook Children’s Home Health

**System-based Providers**
- Cook Children’s Medical Center
- Cook Children’s North East Hospital
- Cook Children’s Physician Network
- Cook Children’s Home Health
Children’s Hospital & Health System
- Independent not-for-profit system consisting of:
  - Medicaid Health Plan
  - 2 hospitals, many primary/specialty clinics
  - Children’s Medical Group
    - 80 Employed PCPs

Children’s Community Health Plan
- Owned by CHHS
- 10,500 provider network
- Primary care, specialty, home health medical equipment, mental health, dental (in 6 counties)
- Case Management
- Utilization Review
- Data Analytics
  - HEDIS and PMPM
  - Quality and Financial Reports generated for board

Board - Separate from System board

Contracted Providers & Health Systems
- Health Plan network providers across the 13 county service area
  - 2494 Primary Care
  - 6876 Specialists

Dean Health Plan
- Claims Processing
- Customer and Provider Service

BadgerCare (SCHIP) enrollees
- 13 Wisconsin counties
  - 90,000 children
  - 46,000 adults (mothers)
- 6 Wisconsin counties
  - Foster Kids (non-risk arrangement for now)
- ABD not included

Medical College of Wisconsin
- Children’s Specialty Group = 482 Pediatric Specialists
- 37 Primary Care Pediatricians
- 207 Adult Primary Care
- 1204 Adult Specialists

Wisconsin Medicaid
- Claims Processing
- Customer and Provider Service

*2.5% of PMPM contingent upon satisfactory HEDIS performance

EMR
- All patients’ activity within CHHS hospitals and clinics
- NO PHARMACY

Claims

READ-ONLY ACCESS (Disease Mgmt)