Housekeeping Details

- All lines are muted throughout the webinar.
- Have a question?
  - Use the available pods and we will facilitate a discussion at the end of the presentation.
- This meeting will be recorded.
- The recording and presentation slides will be posted to the CHA website a few days following the presentation.

CHILDREN'S HOSPITAL ASSOCIATION

Value Based Care: Two Member Experiences

Member Highlights

April 27, 2017

Welcome

Aimee Ossman

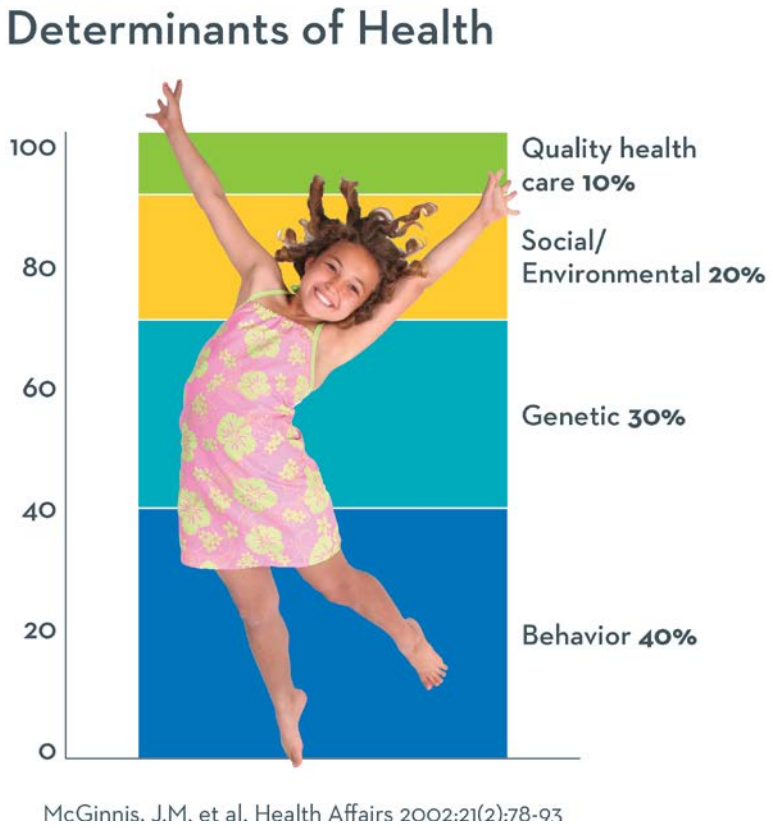
Vice President,

Policy Analysis and Implementation

Children's Hospital Association

Children's Hospitals: Creating Health

- Commodity-driven health care system is not generating the optimum health for children.
- Much of health care is *not* curing factors that decrease life quality/expectancy. Majority of spend treats symptoms.
- Need to understand populations, subpops and what drives cost and health



McGinnis, J.M. et al. Health Affairs 2002;21(2):78-93

ESSENTIALS IN

POPULATION HEALTH

An educational series to support your child health priorities

Value Based Care: Anchor of the New Health Care Landscape

David B. Nash, MD, MBA
Dean, Jefferson College of Population Health

Value encompasses:

- Quality of care
  - Safety
  - Care coordination
  - Social determinants of health
- Patient-Centeredness
- Cost-Effectiveness

Payment Reform

- Tying payment to evidence and health outcomes rather than units of service via pay-for-performance models
- Reimbursing providers for coordination of care in patient centered medical homes (PCMHs)
- Bundling payments for physician and hospital services by episode or condition
- Basing compensation on accountability for managing patients across care settings via accountable care organizations

Today’s Presenters

Scott Wilkerson
Executive Director
Lurie Children's Health Partners
Chicago, IL

Michael Murphy
Vice President of Accountable Care
Seattle Children's

Lurie Children's Health Partners
Clinically Integrated Network

Pursuing Risk Based Models

Scott Wilkerson, Executive Director
April 27, 2017

The Chicago Market is Evolving

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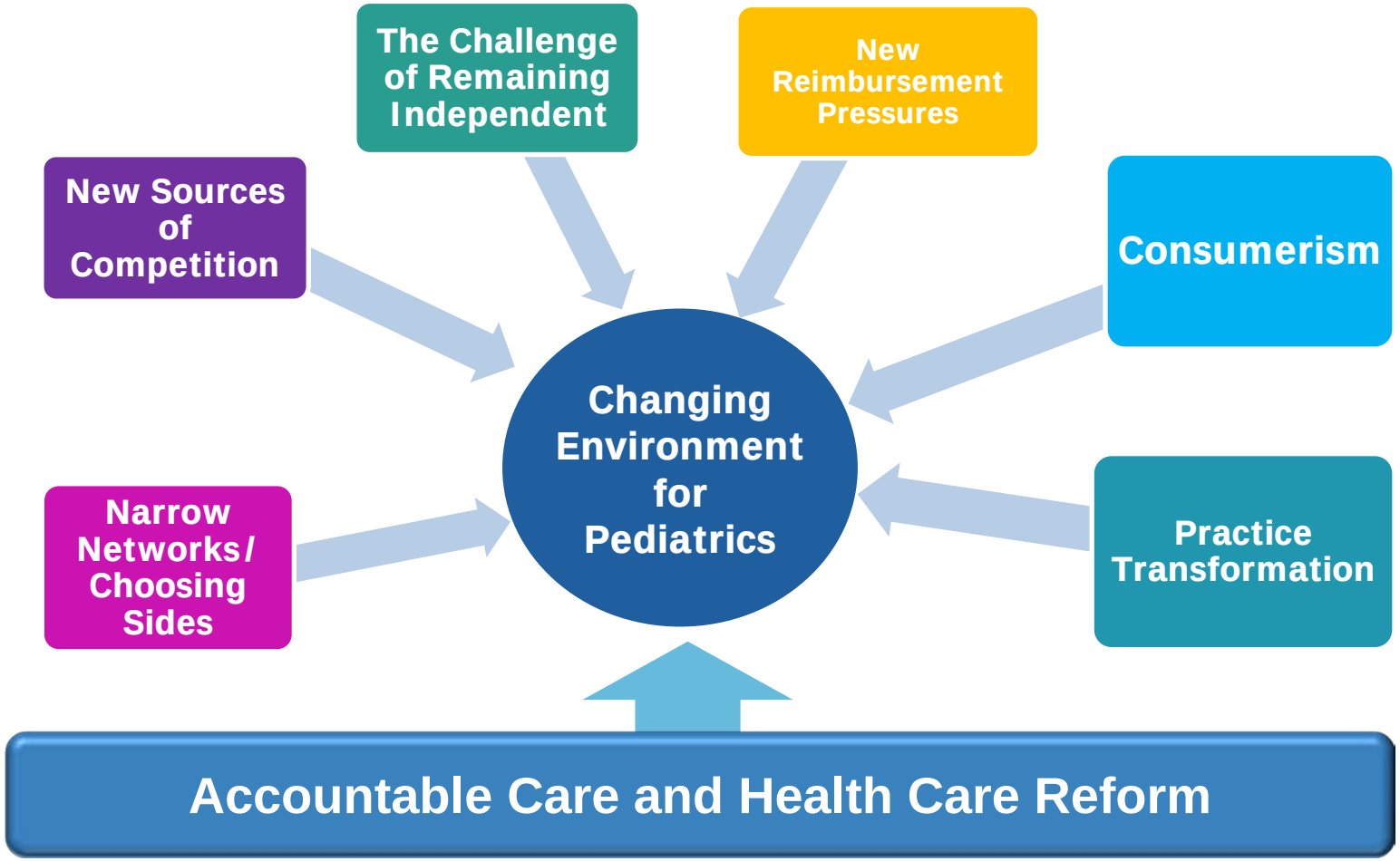

Goals of Integration

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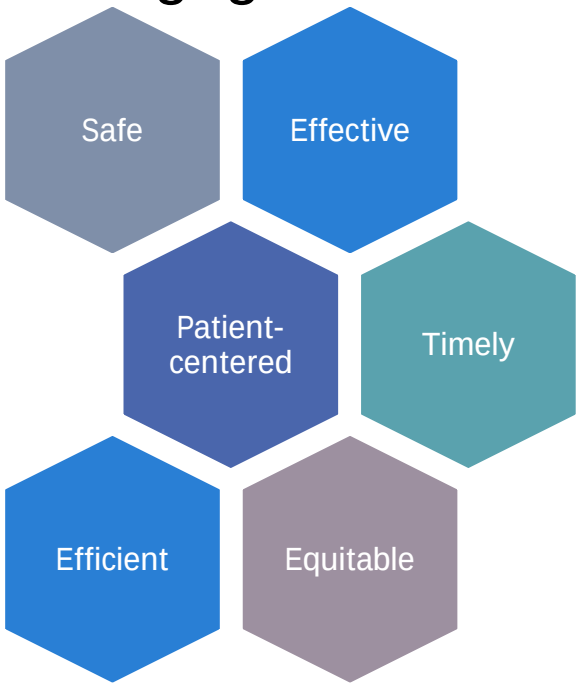
Clinically Integrated Network

Improve Quality and Patient Engagement



Manage Resources

Financial Rewards

CIN Structure – Physician Led

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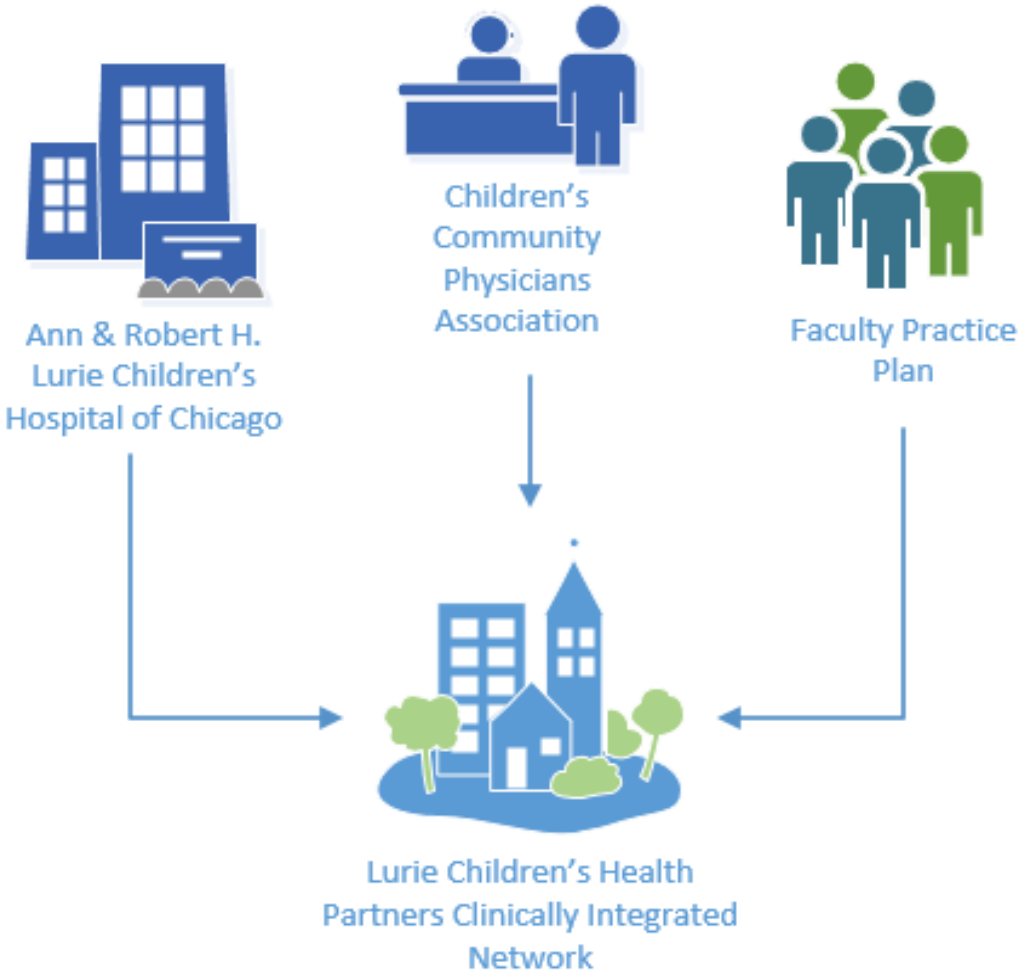
Clinically Integrated Network

LCHPCIN serves Chicago and the surrounding region

950 providers



The CIN has a separate 12 member board, of which 11 are physicians.
CCPA appoints 6 members, FPP appoints 4 members and the hospital appoints 2 members.

Fiscal Year 2017 Plan

Lurie Children's Health Partners
Clinically Integrated Network

Value-Based Contracting

- Implement Shared Risk Contract
- Implement Other Contracts

Improve Integration and Access; Reduce Network Leakage

- Improve Access to Specialists
- Improve integration within Network

Continue Implementation of the CIN Quality Plan

- Implement Performance Management System
- Continue Practice Transformation Efforts
- Continue Quality Measure Initiatives
- Improve Patient-Family Experience

Expand Network

- Membership
- Partnerships with other CINs

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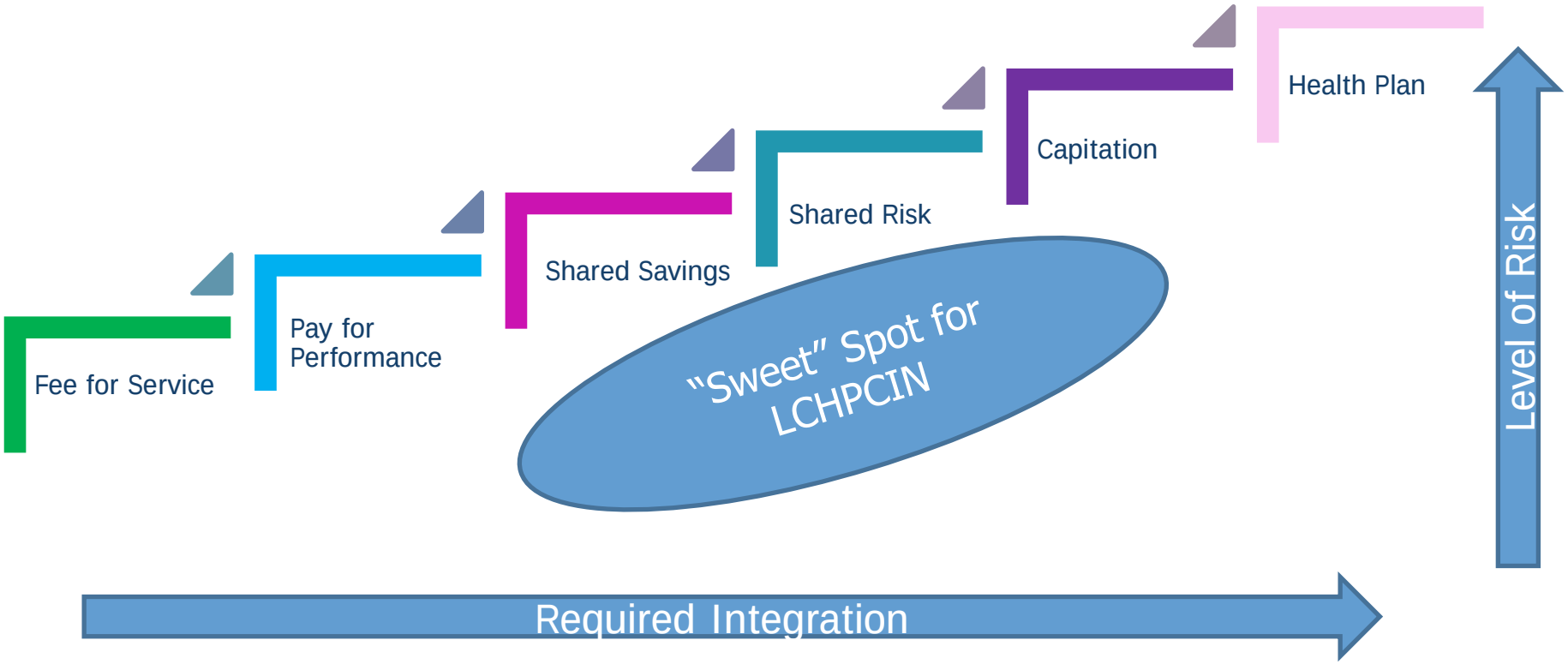
We are on track with the original CIN business plan



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Beginning January 2017

Commercial Payer A

Shared Risk arrangement:

- Covering 85,000 kids
- Approximately $250 million in medical spend
- Includes quality bonus opportunity
- No change in reimbursement rates
- Responsible for care coordination

Commercial Payer B

First combined fee schedule for CIN

- Includes quality and cost incentives
- Focus on episodes of care
- Commitment to reduce leakage within network

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Current Contracts

Medicaid Payer A

Medicaid contract

- Covers 7,000 kids
- Pediatrician contract only
- Includes quality bonus program
- Shared savings opportunity

Medicaid Payer B

Medicaid contract

- Covers 5,000 kids
- Covers all CIN providers
- Includes quality bonus program

Commercial Payer C

Narrow Network

- National employers
- Move to value over long-term

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Key Features of Our Risk Contract

- There are caps on upside and downside risk
  - Limited to +/- a percentage within a corridor
  - Pharmacy excluded from risk arrangement
  - Single member costs capped
- Savings/loss **generally** calculated on actual baseline costs plus agreed upon trend over baseline year
- Quality metrics can provide an additional opportunity of eligible savings pool (prior to sharing)
- Reconciliation will occur nine months after year end with final payments made thereafter
  - First year reconciliation Sept 2018 (cash settlement within 30 days)
  - First potential distribution to CIN providers late fall 2018

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Clinically Integrated Network

Key Features of Our Risk Contract, cont'd

- Requires significantly higher insurance limits than we currently have for general liability, managed care liability, D&O, cyber liability and crime policy
- Requires commitment to work on other "initiatives"
- Most administrative functions maintained by payer; however, we are doing care coordination for high-risk kids
  - We will use various data sources, in coordination with pediatricians to identify appropriate children
  - Factors will include medical, behavioral, and social issues
  - Care coordination utilizes a team based approach centered around a care plan. The model is focused on face to face interaction
- We get a full claims file each month and load into our business intelligence tools

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Quality Measures (All Contracts)

A portion of earnings will be based on quality measures

- Immunizations
- Well Child Visit
- Diabetic control – HbA1c
- Other quality measures
- All Cause Readmissions
- Episodes of care cost index
- Patient Experience - CAHPS

Note - Must stick with desire for pediatric-focused measures

Sample Cost PMPM Breakdown

Lurie Children's Health Partners
Clinically Integrated Network

Cost Distribution - Illustrative	PMPM	% of Total
Cost Category		
Facility inpatient	46.20	22%
Facility outpatient	48.30	23%
Professional	96.60	46%
Ancillary	18.90	9%
Total	210.00	100%
Rx	19.40	
Grand total	229.40	

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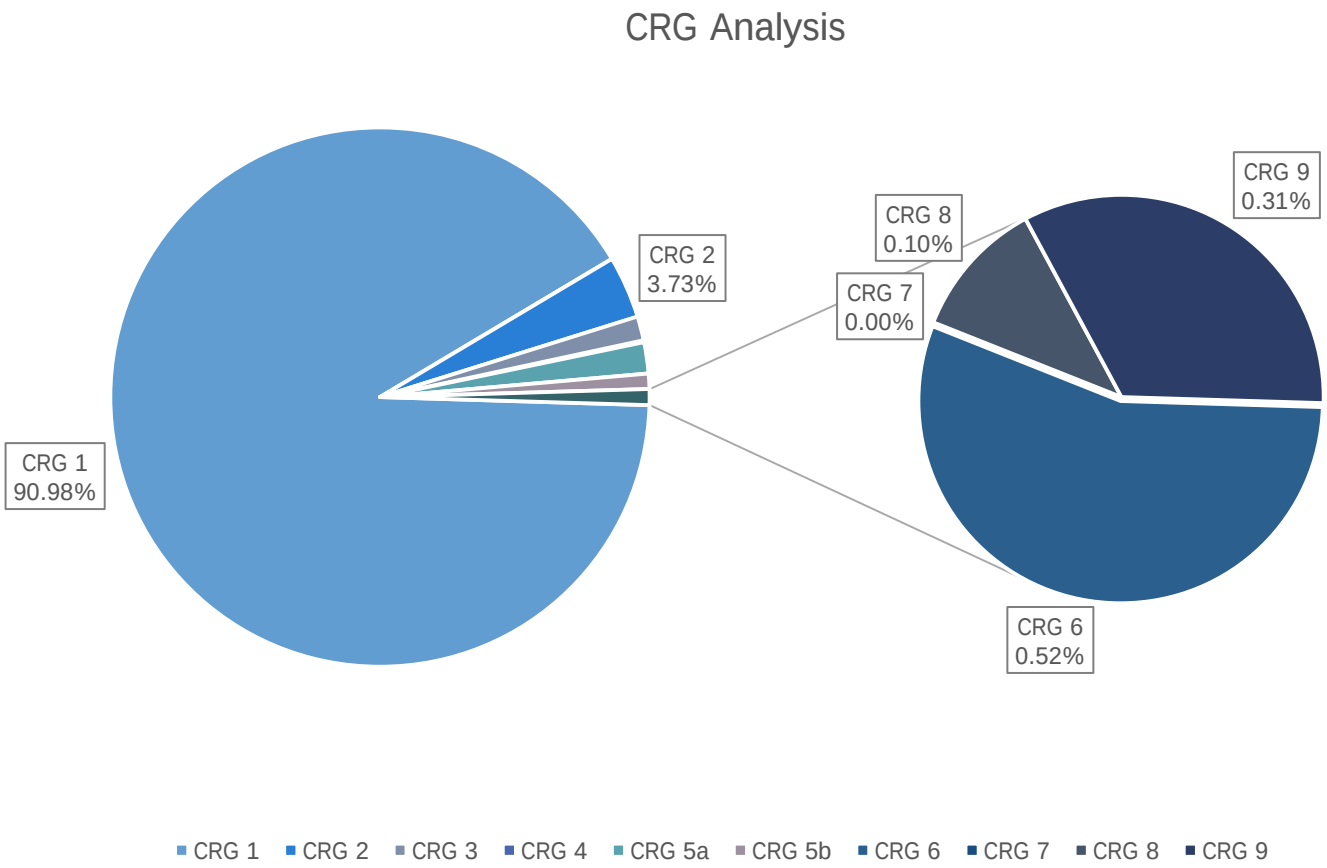
Distribution of Population

Must Develop plan to focus on children with chronic conditions



Risk Status - PMPM Distribution

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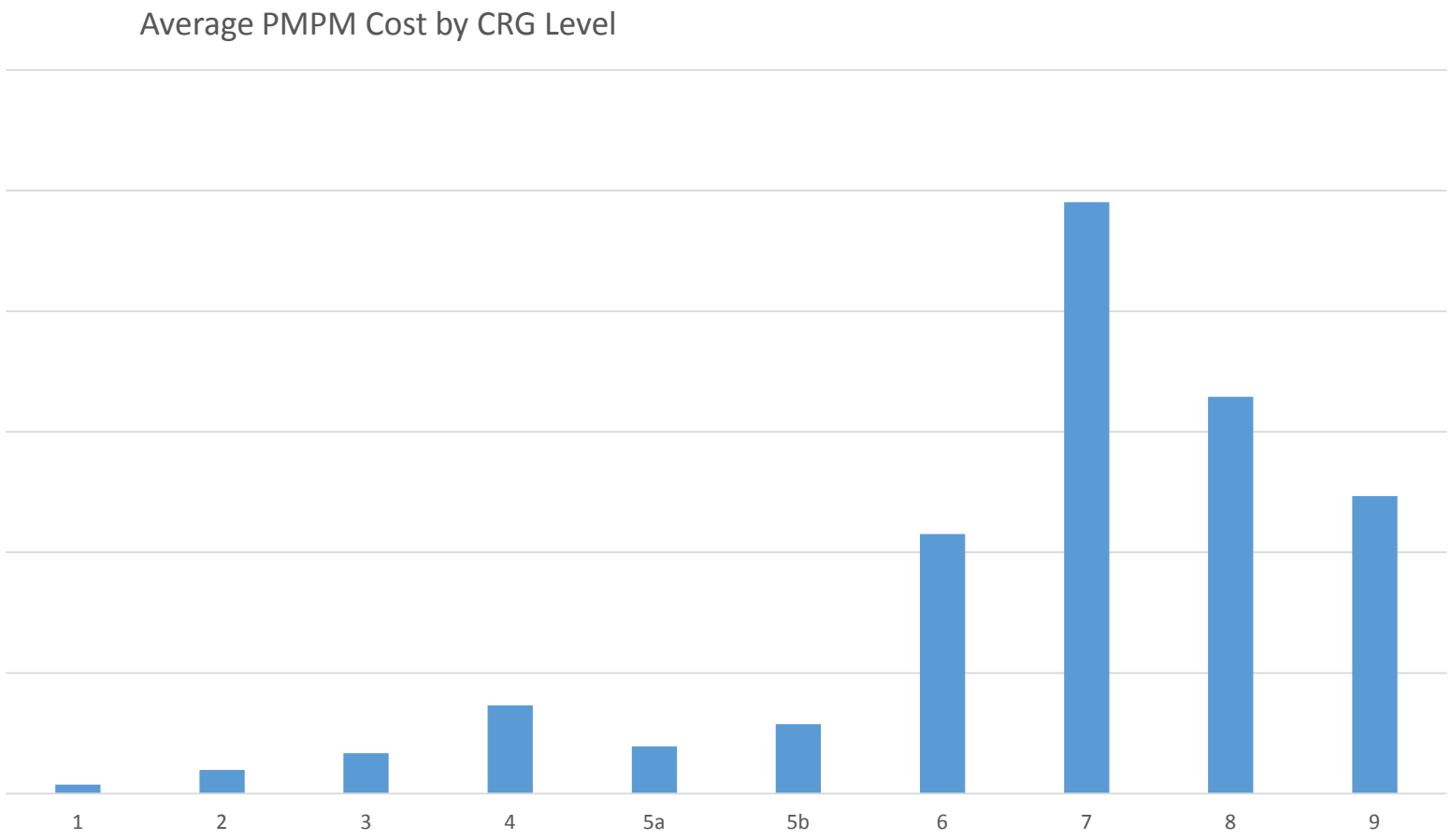

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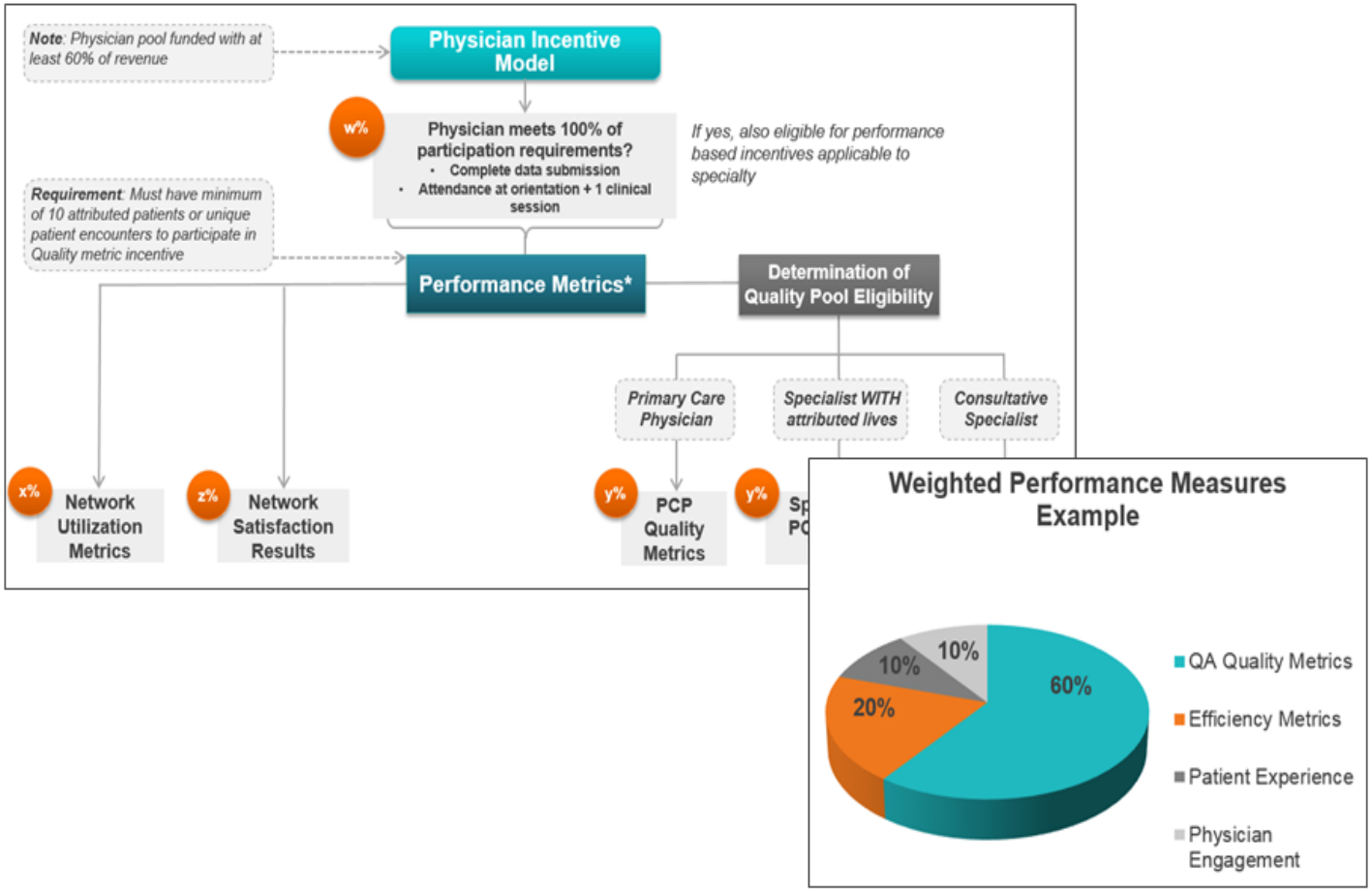
Incentive Distribution Model

Work is underway to determine how incentives will be shared within CIN



Value-Based Strategies

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- Contracting strategy emphasizes a direct relationship with payers
  - Create pediatric only contracts first
  - Partner with adult network next
- Engage board and committees in planning early
- Develop strong relationship and communication with hospital leadership
- Understand how much risk the organization can/should take and the nature of the risks
  - What's in/out of risk model?
  - Is stop loss included?
  - How will changes in population risk be handled?
- Spend time to carefully understand responsibilities and assess internal capabilities
  - Who's paying claims
  - Who's performing utilization review and medical management

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Strategies, cont.

- Review the payer attribution model and understand how dual claimed providers will be managed
- Obtain as much data as possible on the cost and use in the market to develop models
  - Medicaid can be helpful but understand use trends and cost are different
- Develop model of CIN investments necessary to maximize financial opportunities
  - Be careful not to invest more than the financial opportunity
- Involve physicians early and often in evaluating medical spend
- Ensure involvement of financial team throughout process
- Share easy win opportunities for PCPs
- Must have comprehensive claims data if taking risk
  - Understand the frequency and granularity of the data to be shared
- Must have risk scoring capabilities
- Develop care coordination roles and functions
- Develop incentive distribution model before contract starts (or very early on)

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Improving Flow of Care

What Is Causing "Leakage"?

- Access challenges
- Primary care communication gaps
- Quality concerns
- Clinical capabilities
- Prohibitive cost or restrictive payer network
- Lack of convenience for the patient

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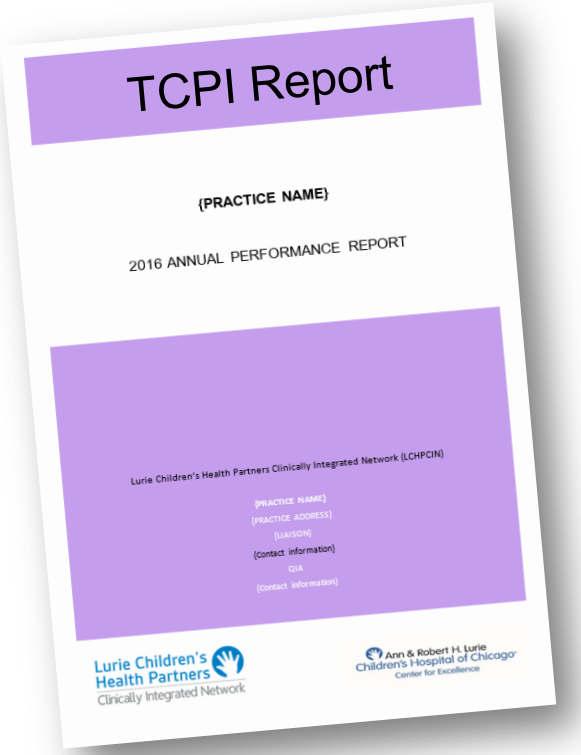
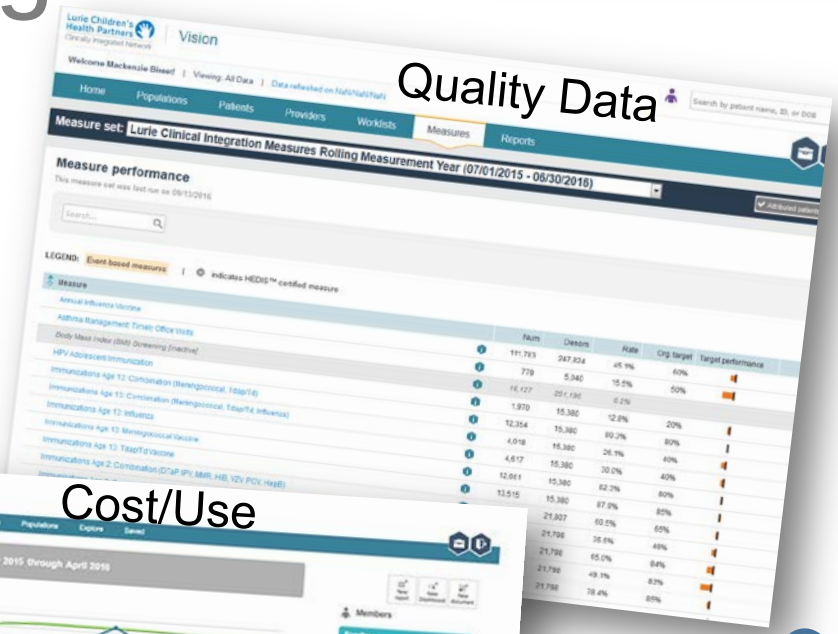
Performance Management





Give us the data!

Continue Implementation of the CIN Quality Plan

Transformation Model

Volume → Value

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Clinically Integrated Network

Goals

(1) Improve Quality

(2) Reduce Cost

(3) Position Providers for Changes in Health Care
- Increase Accountability
- Decrease Utilization
- Focus on Population Health

Drivers

1. Patient-Centered Care

- Patient Engagement
- Managing Populations (risk stratification, registries, care gaps)
- Care Coordination (transitions, referrals)
- Access
- Practicing Evidence-Based Care

2. Quality Improvement

- Leadership
- Transparency (measures)
- Health Information Technology (HIT)

3. Business Operations

- Revenue Strategy
- Ensuring Fulfillment at Work
- Operational Efficiency

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Continue to Explore Opportunities

Pediatricians

- We are hopeful that more practices will join given the new value-based contracts

Adult Partners

- We must find a fit that works for all

Almost Home Kids
Share the Care

- A partnership with AHK provides an opportunity to reduce inpatient costs under value-based arrangements

Key Takeaways

Lurie Children's Health Partners
Clinically Integrated Network

- Engage physicians in all aspects of the business
- Take risk – don't wait
- Develop deep analytic capabilities
- Everything comes back to quality
- Be flexible and open minded

Contact Info:

Lurie Children's Health Partners
Clinically Integrated Network

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Lurie Children's Health Partners
Chicago, IL
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A Children's Hospital CIN Journey to value based contracting

Mike Murphy FACHE, CMPE,
Executive Director of SCCN and
Vice President of Accountable Care

April 2017

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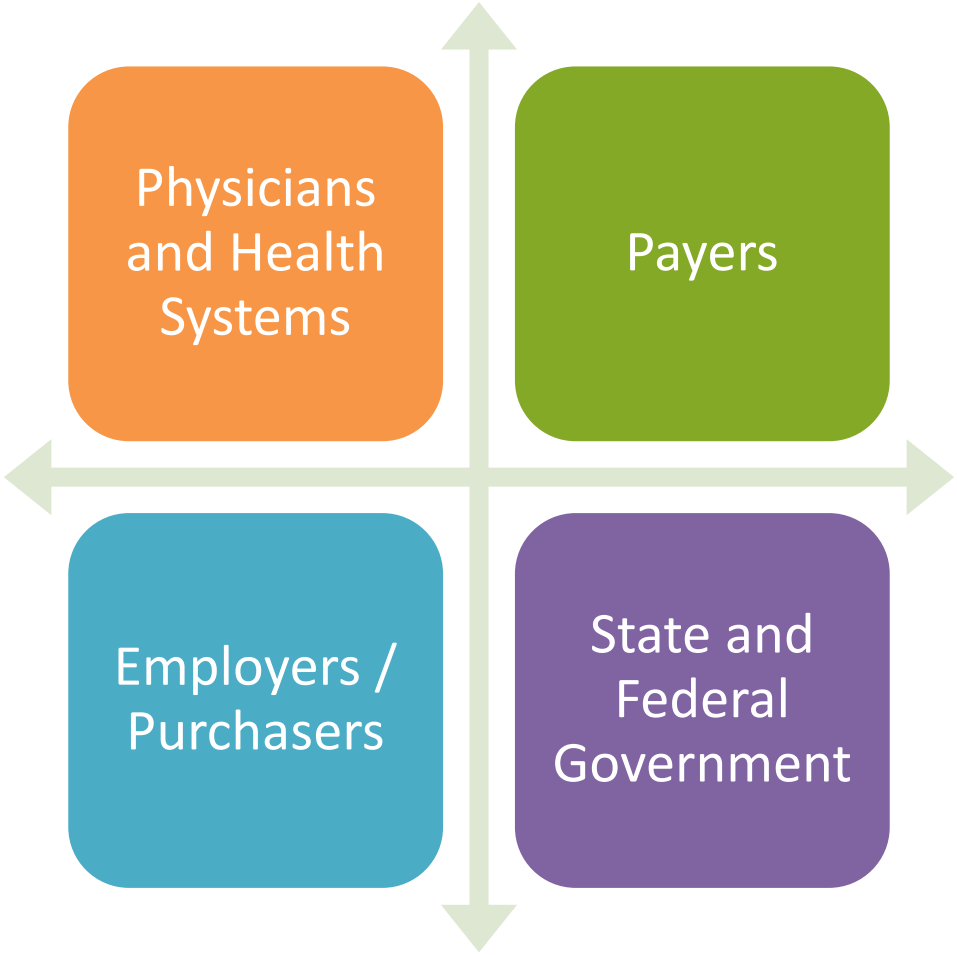
Seattle Children's Care Network

Seattle Children's Care Network: Journey Towards Accountable Care

- Background and market drivers for accountable care
- Our journey to establish our Clinically Integrated Network (CIN)
- SCCN today
  - Governance and Leadership
  - Role of advanced IT
  - Patient Centered Care
  - Developing Capacity to assume risk
- Global Outcomes Contract (GOC): Total Cost of Care
- Lessons Learned

2012-2015: Local market drivers lay the foundation for accountable care

- Rapid health system consolidation
- Emerging accountable care networks (ACNs) with new capabilities for population health and risk



- Downward pricing pressures
- Narrow and "high value" networks for state exchange and beyond
- New insurance products

- Boeing and WA State healthcare benefit model drives dramatic shift in employer sponsored purchasing
- Others likely to follow once demonstrated savings occur

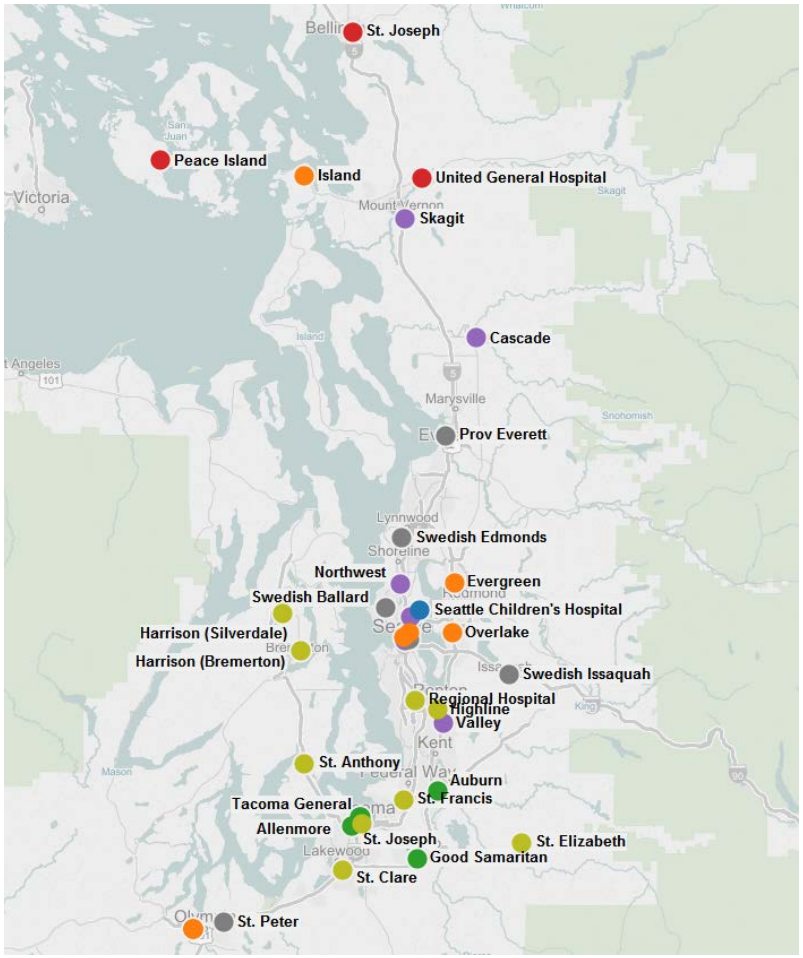
- Opened exchange and expanded coverage to nearly 400,000 adults
- State to consolidate purchasing model for its 2 million insured

The path to building the Seattle Children's Care Network began in 2012

- In late 2012, looking at changing market trends, SCH began planning its CIN
- Initial goals
  - Contract with adult ACO
  - Contract with commercial payors to provide 'pediatrics only' care including risk arrangements
- Engage large, loyal and un-aligned community primary care pediatric groups
- Retained legal counsel
- Started community, faculty and board communication plan
- Began planning IT infrastructure to support CIN
- Created interim 'Board of Managers'
  - Divided into work groups staffed by planning department
- Established CIN in August 2014 – Seattle Children's Care Network

Role of market consolidation

- Over a 3-year period, 20+ community hospitals consolidated into 6 systems in Puget Sound area
- Rising costs prompted changes in employer sponsored health care and contracts with new consolidated systems
- Commercial and Medicaid payers became interested in new risk arrangements for both ACO and PPO products



Pushing Back: Legal Strategy

The Seattle Times

"Left off many networks, Seattle Children's sues"

"People buying insurance through the exchange may not realize that the pediatric hospital is not in the health plan's network of providers, Children's officials say…

Seattle Children's filed suit Friday over the state Office of the Insurance Commissioner's "failure to ensure adequate network coverage" in several health plans being sold through the state's new online insurance marketplace...

Most exchange plans….do not include Children's among their in-network providers, which hospital officials say could significantly disrupt and delay care for children in need of the hospital's services"

Seattle Children's Care Network

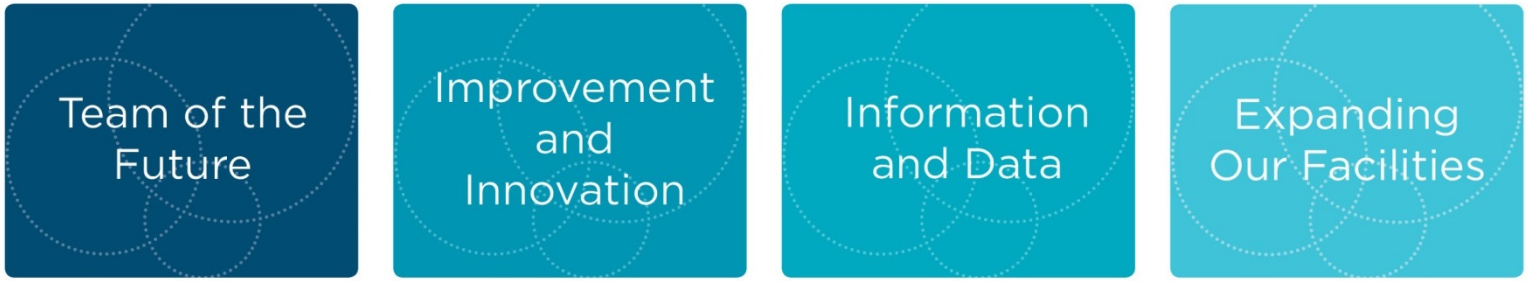
Exchange exclusion increased sense of urgency for CIN development

- Dramatic consolidation raised anxiety among community pediatricians
  - Concerns of being ‘locked out’ of newborn referrals
  - Exclusion from narrow networks or concern about being restricted from referring patients to Seattle Children’s Hospital
  - Real and perceived contracting disadvantages
  - Inability to participate in direct-to-employer contracts
  - Highlighted weaknesses in IT capabilities
  - Difficulty demonstrating quality or unique value

- National trend facing children’s hospitals from emerging ‘mega-systems’
  - Leading to ‘make or buy decisions’
  - Prospect of dramatic increases in competitive forces from large systems

Strategic Choices: A Plan for the Future

Strategic Enablers: How We'll Achieve Our Goals



Philanthropy: A Key Driver

Seattle Children's Care Network

SCCN is a key component of our Population Health Strategy

SCCN is a pediatric organized system of care that is a collaboration between physicians, other providers and administrators who share a commitment to quality, cost, and patient and provider experience, across the care continuum.

OUR VISION

To be the best **"manager of pediatric lives"** in the Pacific Northwest with superior clinical outcomes, and exceptional patient and provider experience, while reducing the cost trends

Seattle Children's Care Network

SCCN Goals

Build a clinically integrated network where members share a commitment to patients across the care continuum

Collect data from members and other important data sources to drive population health management

Analyze and report on that data to address gaps in care and measure improved health outcomes

Facilitate patient-provider collaboration and accountability by implementing capabilities key to accountable care

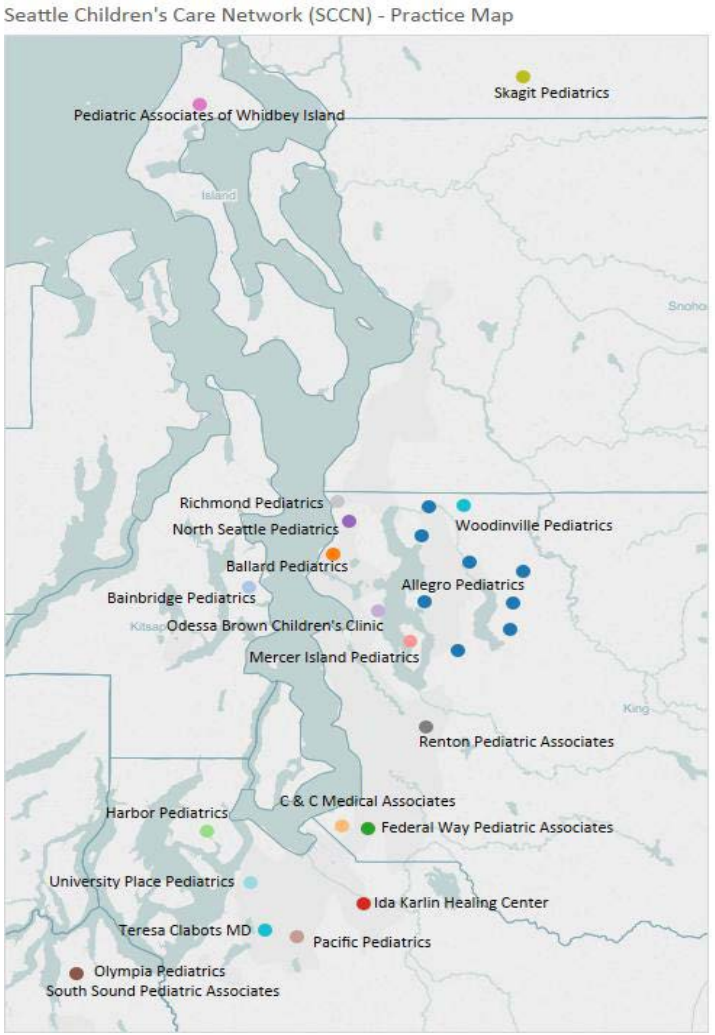
In 2017, SCCN includes nearly 1,000 primary care and specialty physicians over a wide area

SCCN Membership

- **21** community primary care practices
- Children's University Medical Group (CUMG)
- Seattle Children's Hospital

SCCN extends across six counties, from Olympia to Skagit

- Island, King, Kitsap, Pierce, Skagit and Thurston



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Seattle Children's Care Network

Our Timing

2015: Standup the "governance" structure for Seattle Children's Care Network (SCCN)

- Seattle Children's Hospital
- CUMG: 605+ pediatric specialists
- 21 Primary Care Pediatric Clinics: with 200+ pediatricians

2016: Develop our "capabilities" in primary care to manage populations

- Metrics / measures
- Technology: WellCentive
- Care management
- Completed a GOC with commercial #1

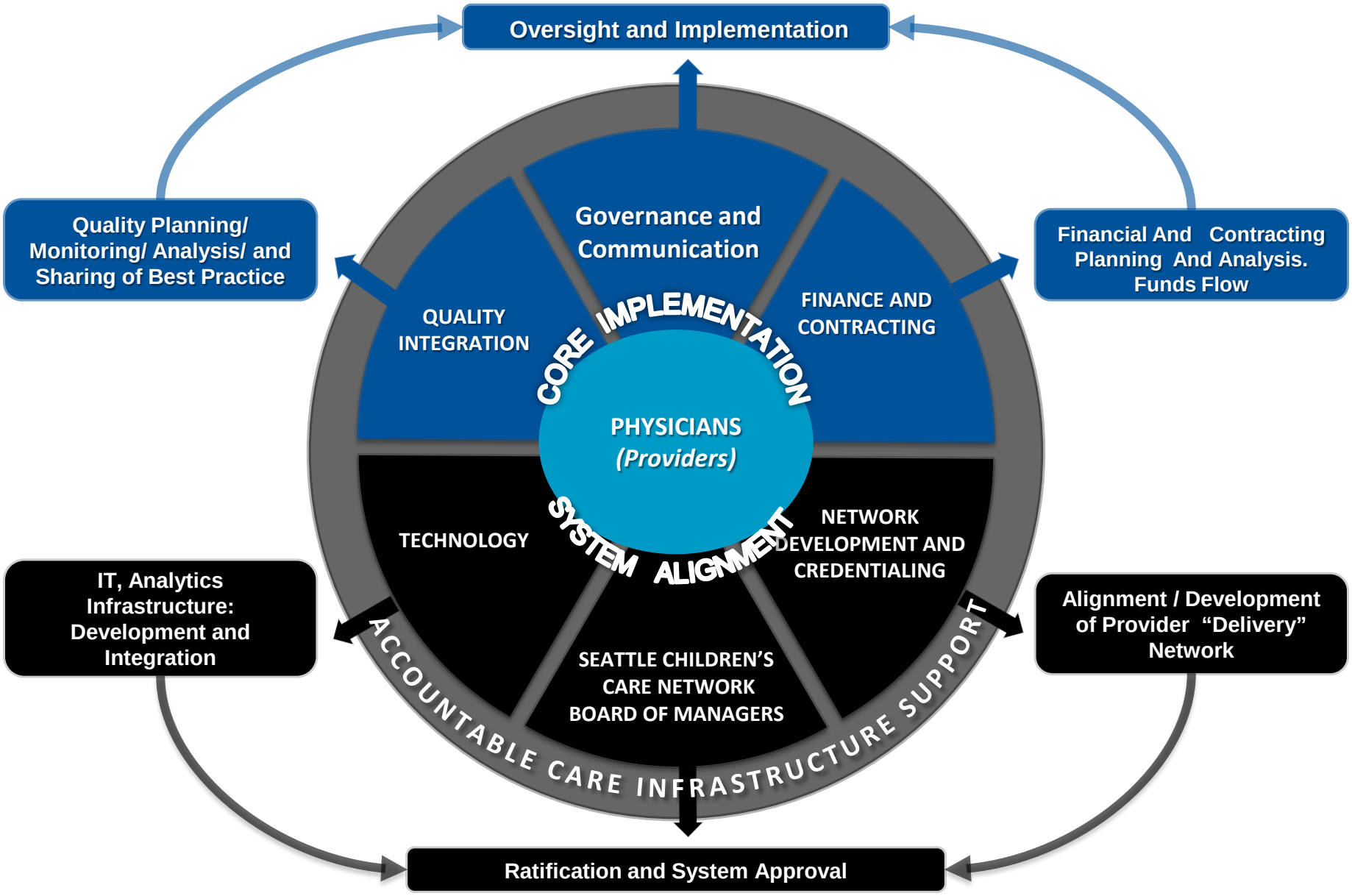
2017: Engage CUMG in specialty care capabilities to manage populations

- Metrics / measures
- Co-management pilots
- Complete GOC w/ commercial #2
- Complete a GOC w/ commercial #3
- Funds Flow

2018: Implement our "accountable care capabilities" for the Medicaid populations

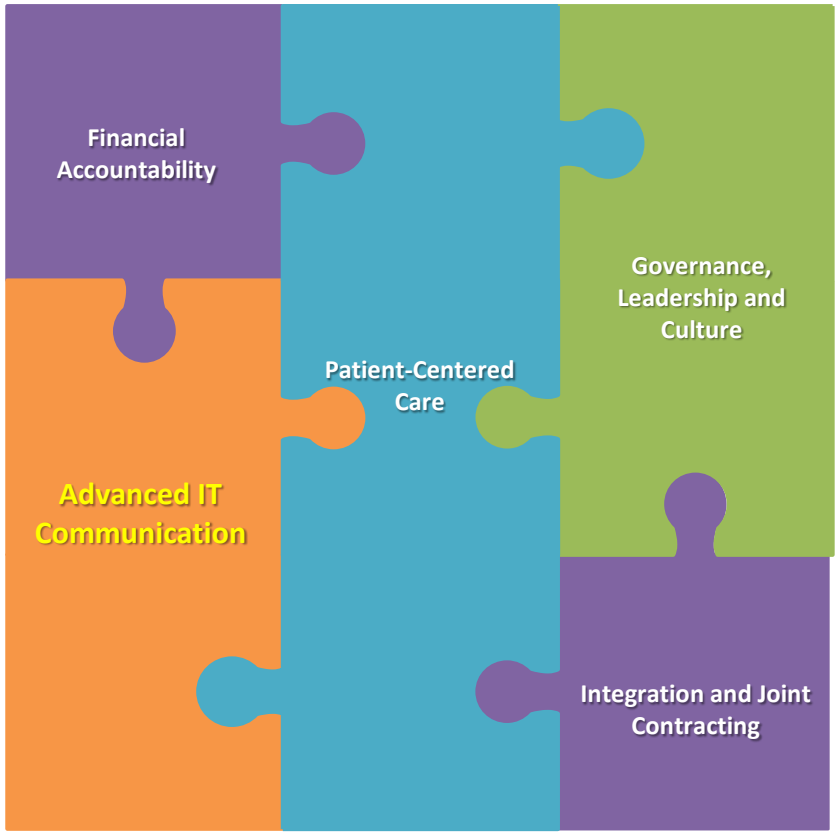
- Complete TCOC contract w/ Medicaid payor

SCCN: Foundational Capability Sets


Oversight and Implementation
Quality Planning/ Monitoring/ Analysis/ and Sharing of Best Practice
Financial And Contracting Planning And Analysis. Funds Flow
Governance and Communication
QUALITY INTEGRATION
FINANCE AND CONTRACTING
CORE IMPLEMENTATION
PHYSICIANS (Providers)
TECHNOLOGY
NETWORK DEVELOPMENT AND CREDENTIALING
SYSTEM ALIGNMENT
SEATTLE CHILDREN'S CARE NETWORK BOARD OF MANAGERS
ACCOUNTABLE CARE INFRASTRUCTURE SUPPORT
IT, Analytics Infrastructure: Development and Integration
Alignment / Development of Provider "Delivery" Network
Ratification and System Approval

Advanced IT and shared communications are a critical part of our population health toolkit

- Patient Registry
- Online, evidence-based protocols (MOC)
- Ability to provide data security & information privacy
- Ability to collect & measure performance data
- Ability to aggregate & share data from multiple EHRs
- IT system capable of receiving & distributing incentive dollars
- Patient Portal
- Electronic Prescribing
- Practice EHR Enhancements
- Pediatric HIE
- Data Warehouse



Population Health Technology

- The **aggregation** of patient data cross multiple health information technology sources
- The **analysis** of patient data into a single, actionable patient record
- The **actions** through which care providers can track and improve patient outcomes

Aggregation:

Combining patient data from disparate sources

Analytics:

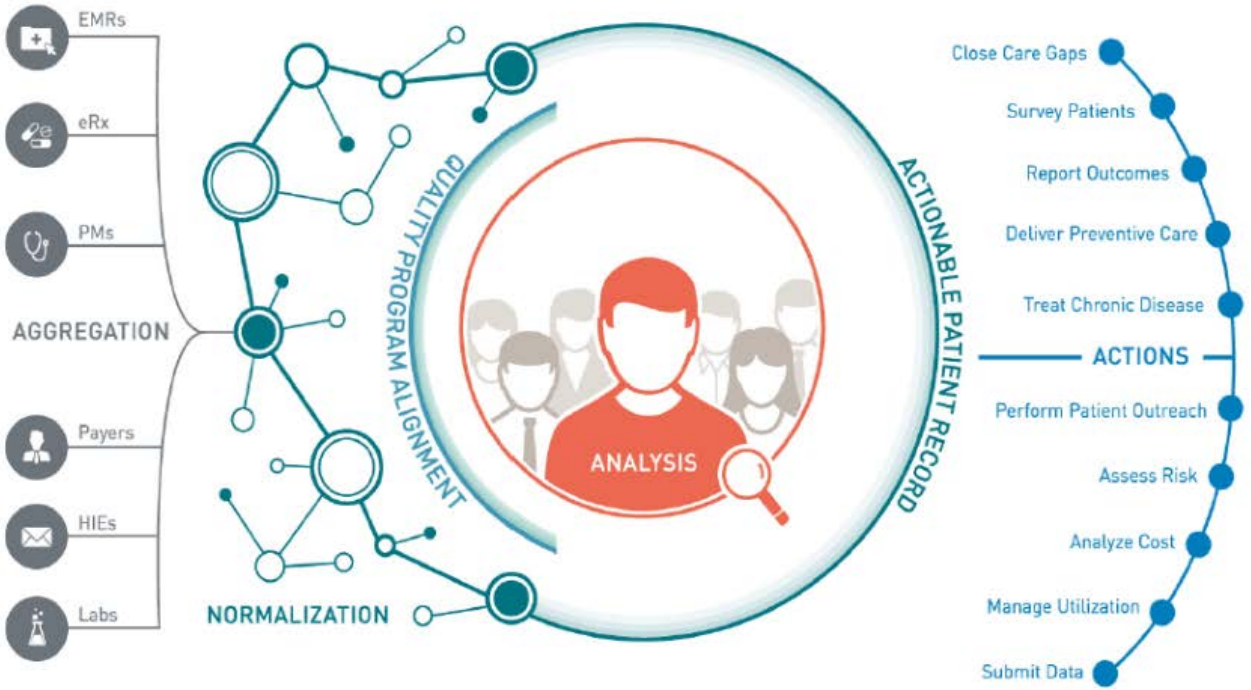
Segmenting populations to prioritize risk & interventions

Action:

Care Coordination:
Directing care providers' efforts

Patient Outreach:
Engaging patients in their care

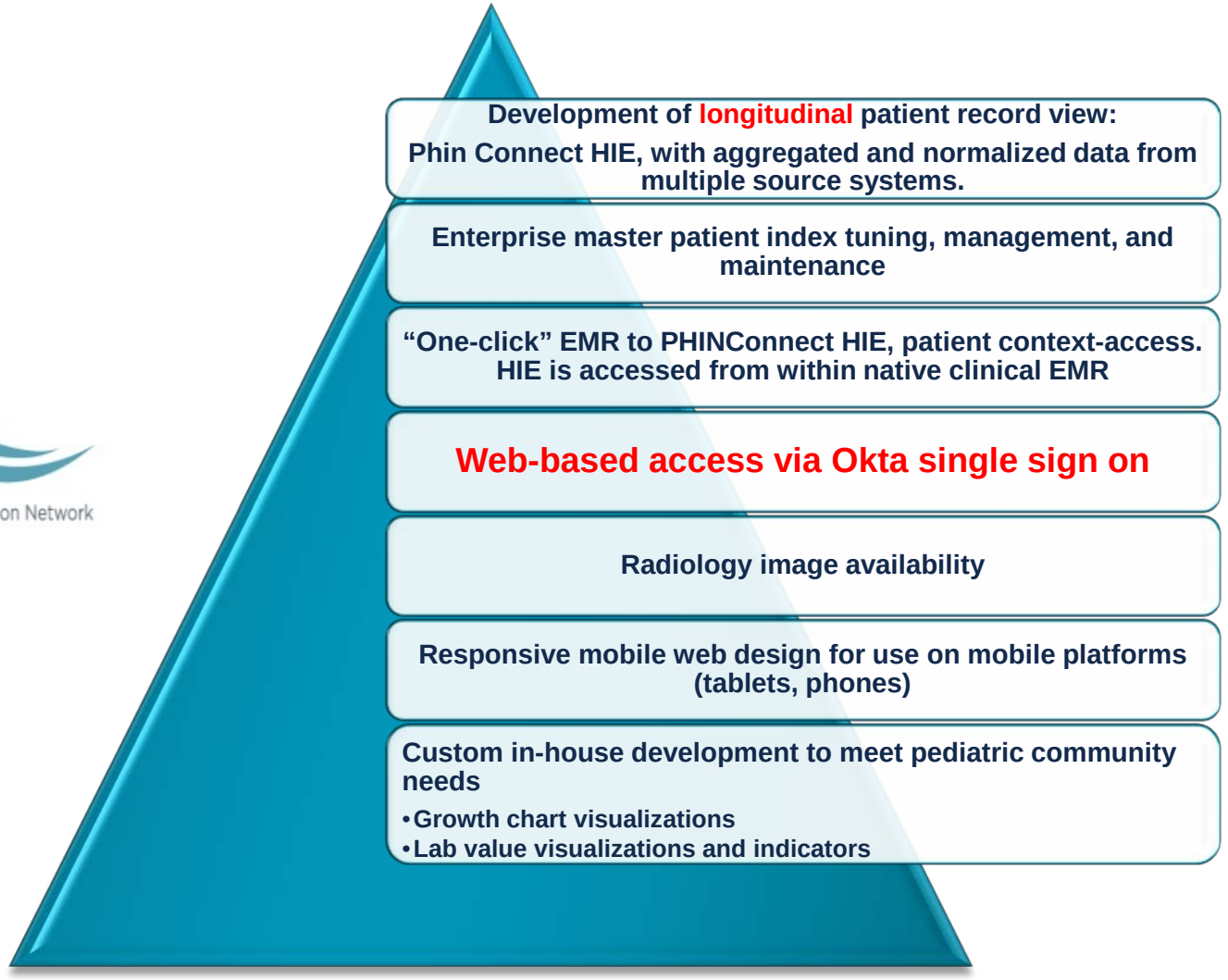
Payer Collaboration
Quality reporting & incentives



wellcentive

Pediatric Health Information Network (PHIN Connect) – Health Information Exchange

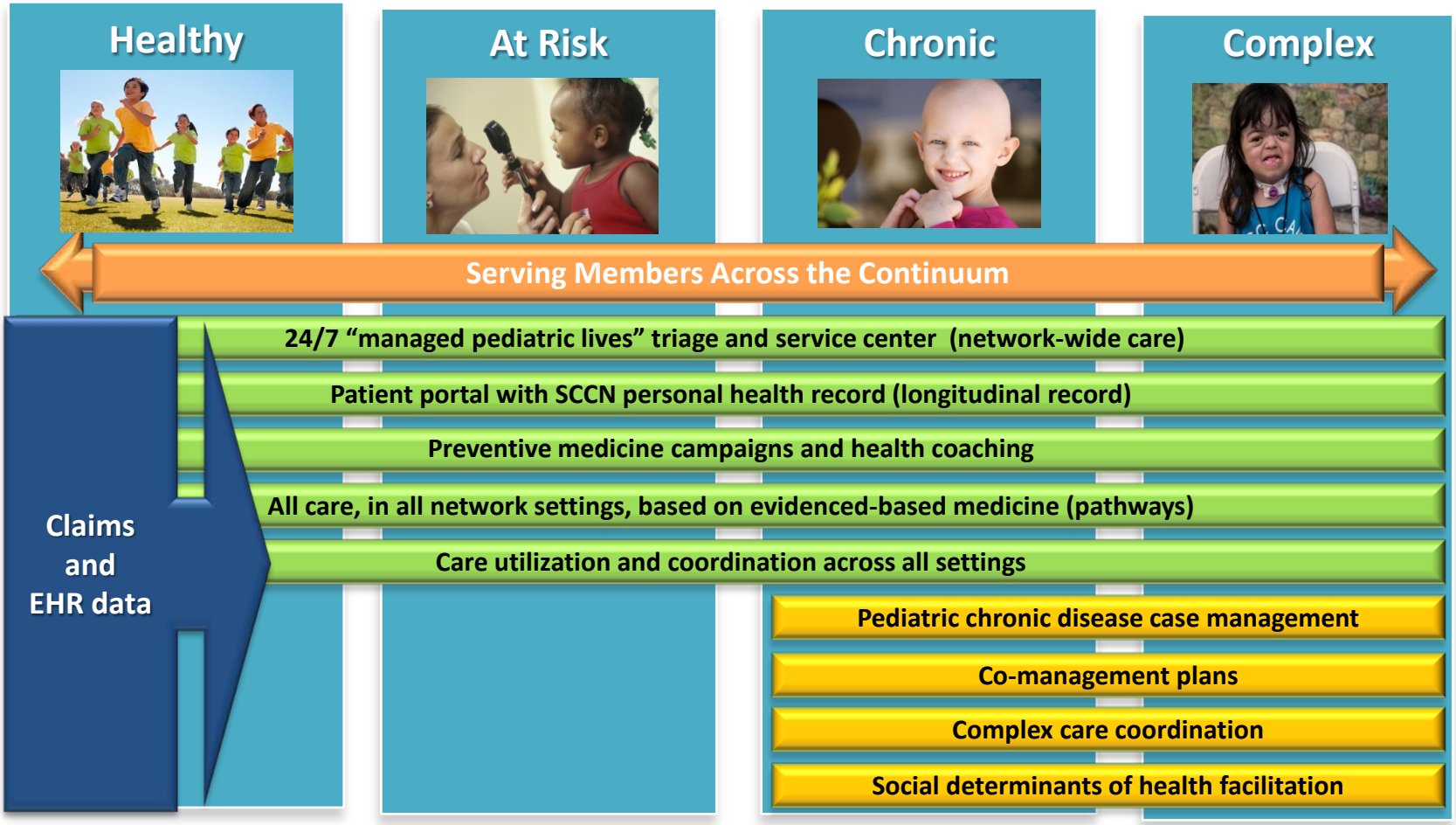
Pediatric Health Information Network



We are focusing on developing “patient centered care” capabilities

- Performance measurement systems
- Reporting across the continuum of care (acute to community)
- PCMH recognition (primary and specialty care)
- Care management
  - ✓ Complex patient identification and stratification
  - ✓ Care coordination
  - ✓ Health Homes
  - ✓ Co-management plans
  - ✓ Transitions of care

Care Management Approach



Leveraging Our Learnings: Pediatric Partners in Care (PPIC)

What it is

- Pediatric Partners in Care (PPIC) is a collaborative, community-based care management model targeted to improve the health care and health outcomes for children with disabling conditions who receive Supplemental Security Income (SSI) and are covered by Medicaid

Eligible population

- Approximately 4,000 SSI children and adolescents in King and Snohomish counties under the age of 18. Payer participants agree to carve out these patients for care management.

Goals

- Improve the health outcomes of disabled children covered by SSI
- Reduce medical costs by eliminating unnecessary, redundant, and ineffective treatments, and substituting more effective, patient-centered, and less costly care
- Develop a scalable, community-based care management model that supports and optimizes the existing care delivery infrastructure

Award

- Estimated $5.6M for three years by CMS, with 9/1/14 grant period start date

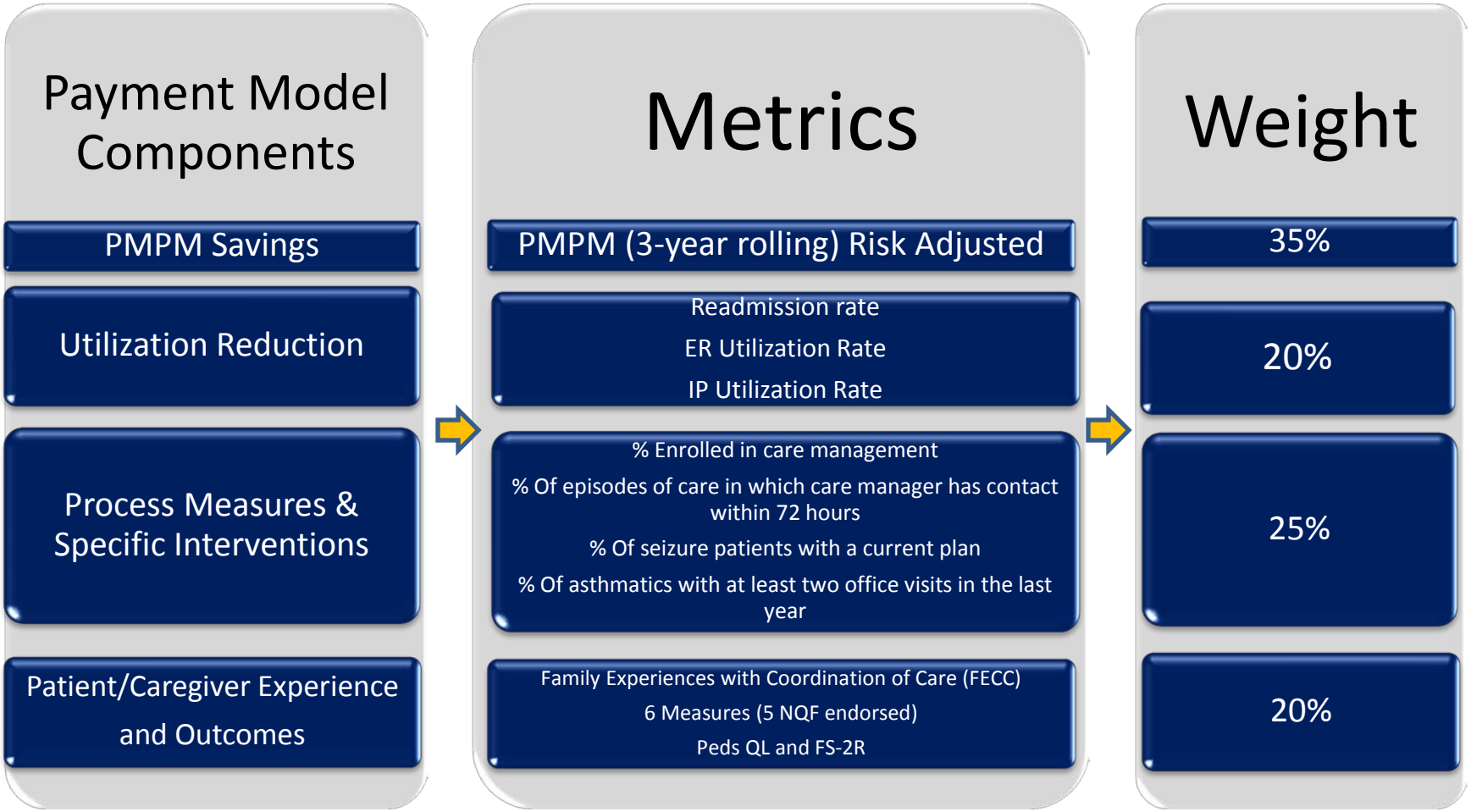
Payer partners

- Molina,
- Community of Health Plan of Washington
- Coordinated Care
- Amerigroup

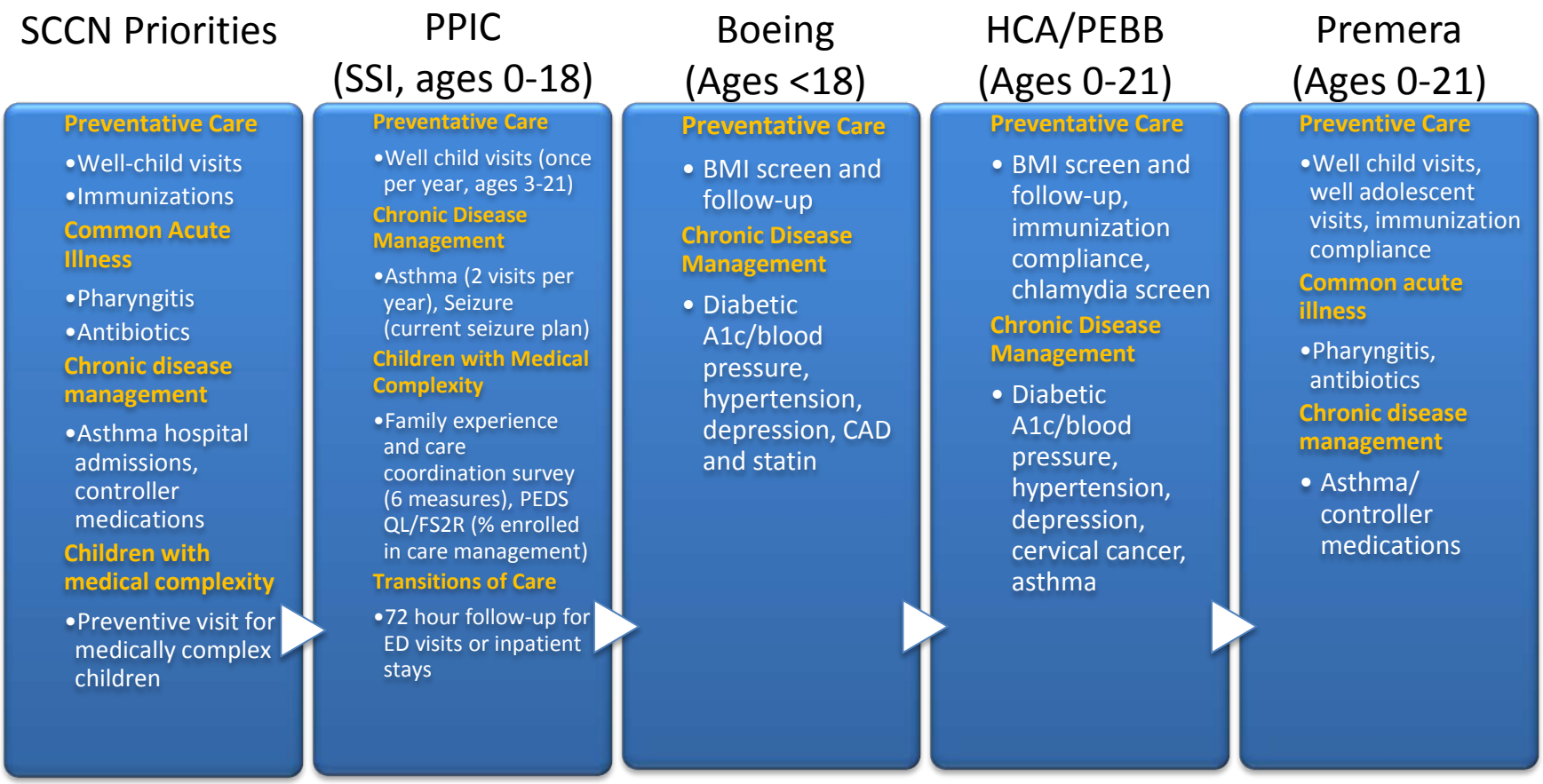
Care team

- 4 RN Care Managers
- 4 Care Coordinators
- 1 Program Coordinator
- 1 Data Analyst

Assuming Risk: The PPIC Payment Model



Alignment of Quality / Care Measures and Metrics

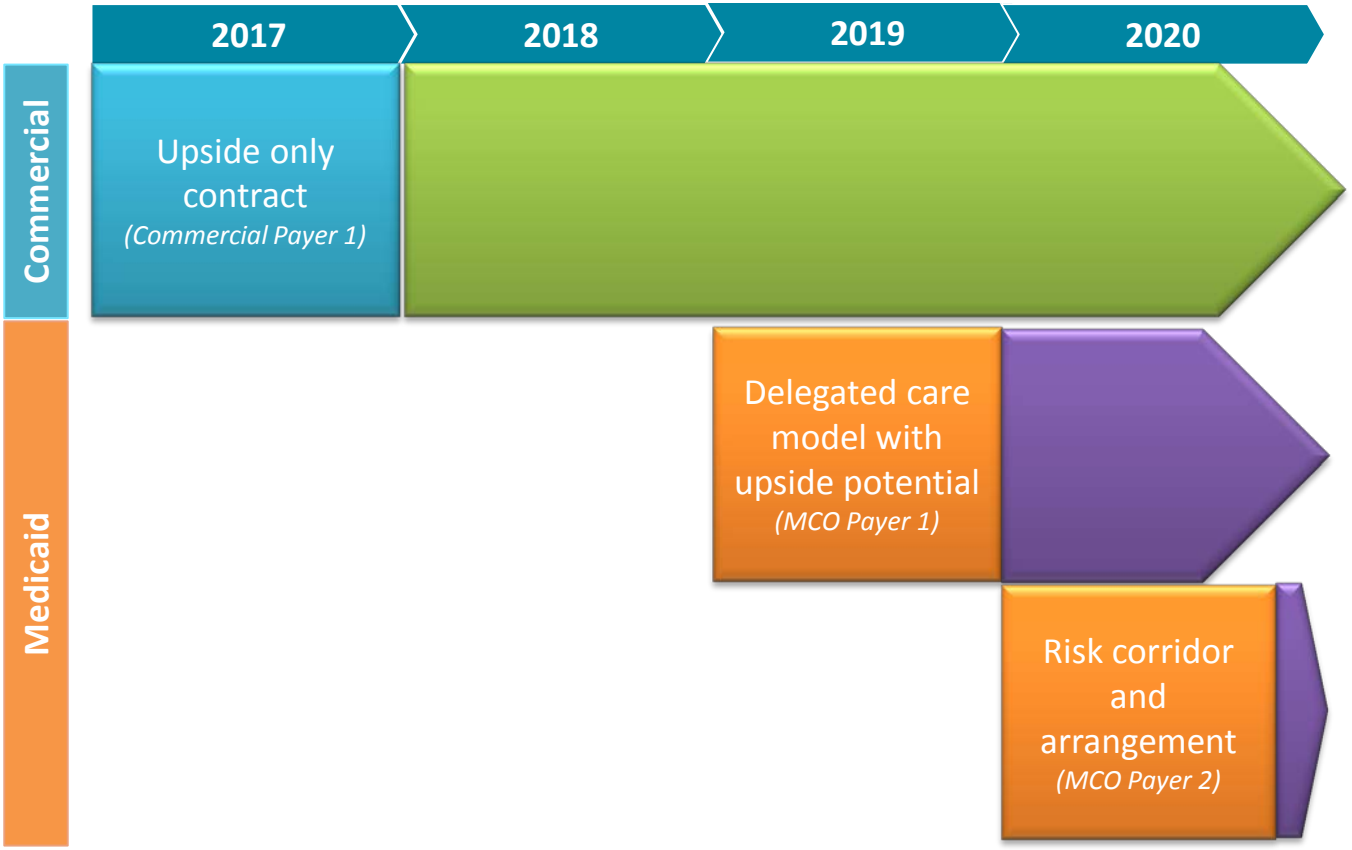


"Show Me the Money"
Developing Capability to Assume Financial Risk

- Developing capability to set rates, receive and distribute payments (single signature)
- URAC accredited as a CIN
- Financial risk modeling and actuarial analysis
- Ability to manage risk
- Value based performance management systems

Our roadmap for progressive risk over time

We will participate in three types of value-based contracts



- Upside potential for reducing cost of care
- Pay-for-performance based on certain outcomes
- Level of risk in contract could increase over time

- Carve out high-risk children
- Upfront PMPM payment + upside potential for lower cost of care

- SCH takes on limited upside potential and downside risk

Timeline illustrative – subject to change depending on negotiations and market conditions

Value-base commercial contracting: Global Outcomes Contract (GOC)

General Terms

Term & Termination

- Upside only gain-sharing
- Initial Term: 3 years

Measurement Periods

- Baseline: 2016
- Contract Year 1: 2017
- Contract Year 2: 2018
- Contract Year 3: 2019

Plan Exclusions

- Contract covers all products aside from those specifically excluded

Attribution

- 18 years and younger, using 24 months of claims experience

Financial Terms

Outlier Adjustments

- Risk Corridors: annualized claims costs not included in the calculation of overall PMPM.
- Certain diagnosis removed from the calculation of overall PMPM (e.g. organ transplant).

Risk Score & Risk Adjusted PMPM

- The Outlier Adjusted PMPM adjusted for risk using the DxCGs risk score.

Calculation of Trend Outcome

- Comparison of the PMPM trend from Baseline Period to Performance Period for the Provider versus the Control Group used to calculate Total PMPM savings.

Shared Savings Calculation

- Shared Savings Distribution split 50/50 between Payer and SCCN of the Total PMPM Savings
- Shared Savings Distribution capped
- SCCN's shared savings portion: 50% based on costs and 50% adjusted based on a quality scale

2017 Quality Metrics

Metric	Measure Description	Threshold	
AWC – Adolescent well care visits	Percentage of members 12-18 years of age who had at least one comprehensive well-care visit with a PCP or an OB GYN during the measurement year	75th Percentile (NCQA)	
CIS10 – Combo 10	Percentage of children 2 years of age who have completed the vaccination schedule	75th Percentile (NCQA)	
CWP – Appropriate Testing for Children with Pharyngitis	Children 2-18 years of age who were diagnosed with pharyngitis dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	75th Percentile (NCQA)	
IMA – Immunizations for Adolescents	Adolescents 13 years of age who had one dose of each: Meningococcal MC (between 11th and 13 birthday) and Tdap or TD (between 10th and 13th birthday)	75th Percentile (NCQA)	
MMA – Medication Mgmt for people with Asthma	Percentage of members 5-11 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	75th Percentile (NCQA)	
MMA – Medication Mgmt for people with Asthma	Percentage of members 12-18 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	75th Percentile (NCQA)	
W15 – Well child visits in first 15 months of life	Percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits.	75th Percentile (NCQA)	
W34 – Well child visits ages 3-6	Percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.	75th Percentile (NCQA)	

Financial Terms (continued)

Quality Score and Shared Savings Distribution

Aggregate Quality Score	Percent of Quality Portion of Share Savings	Percent of Total Shared Savings
>= 90%	100.0%	100.0%
>= 85% and < 90%	75.0%	87.5%
>= 80% and < 85%	50.0%	75.0%
< 80%	0.0%	50.0%

Payment

- Funds flow paid at the TIN level (each TIN controls distribution within its group)

Bringing all the Pieces Together
Seattle Children's Care Network: Pediatric Population Health

GLOBAL CONTRACTING PLATFORM

Focus: Defined / Distinct Populations

VALUE-BASED CONTRACTS

- Provider-based Narrow Network
- Commercial: Premera (current), Aetna, Regence (future)
- Employer Direct: Boeing, HCA
- Medicaid: CMS Grant - PPIC
- Self-Insured Plan: SCH
- Managed Medicaid

Seattle Children's Clinically Integrated Network (CIN)

A pediatric organized system of care that is a collaboration between physicians, other providers and administrators who share a commitment for the quality, cost, and patient experience across the care continuum.

- Clinics: Primary Care
- Clinics: Specialty
- Hospitals: SCH
- Community school based services
- Home Care
- Transitional & Long Term Care
- Mental Health
- Public Health
- FQHCs

VALUE-BASED CARE CAPABILITY SETS

- Advanced IT Tools
- Care Management Across the Continuum
- Chronic Disease Co-Management
- Facilitation of New Collaborations
- Total Cost of Care Reporting
- Analytics: Predictive Risk Modeling and Stratification
- Quality Outcomes Monitoring & Reporting
- Value-Based Contracting
- Patient Experience Reporting

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Seattle Children's Care Network

Lessons Learned

- The health care market is moving quickly
- CIN provides a way for (a) the children's hospital system to participate in longitudinal value based arrangements and (b) community pediatricians to have an alternative to acquisition by the emerging mega-systems
- CIN leadership very dependent on trust between entities, which is improved with a shared sense of mission and a physician led governance structure
- Sharing data and standardizing clinical practice is harder than it sounds!
- Need a dedicated operations team to move CIN development forward and will need to grow as VBC increases.
- Sharing risk and funds are very complex and have to be handled with a great deal of sensitivity to each parties' interests. Build trust first.
- We can be a voice for pediatrics and kids health in a world dominated by adult care and systems! The CIN offers a path to accomplish this.

Contact Info

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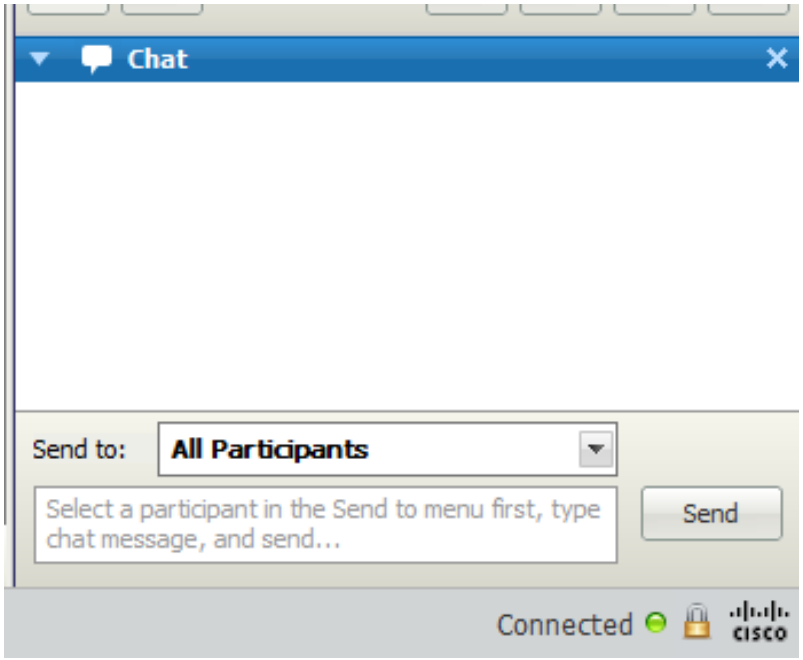
Discussion

Pose questions to "All Participants" using the chat box on the right side of your screen, or simply use the Q/A pod.



ESSENTIALS IN

2017

POPULATION HEALTH

An educational series to support your child health priorities

Engaging Communities to Optimize Outcomes and Care Coordination **May 9 | 2:00 pm ET**

Rosemary Frasso, PhD, MSc, CPH | Program Director, Public Health Program

Jillian L. Baker, DrPH | Assistant Professor, Jefferson College of Population Health

Member Highlights

Engaging Communities to Optimize Outcomes and Care Coordination

June 6 | 2:00 pm ET

Hospital Collaborations with Schools

June 19 | 2:00 pm ET

Thank You; Provide Feedback

- It’s brief!
- When you exit the webinar, the survey will launch on your screen.
- Please take a few minutes to give us feedback.

CHILDREN'S HOSPITAL ASSOCIATION

Photo by Tine Hoffman
Cincinnati Children's Hospital

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