ACO UPDATE
from Child Health Corporation of America

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Unique Perspectives

We hope you enjoyed last month's premier issue and found the contents valuable for discussing future plans and strategies with your leadership team. Our goal is to bring you a new perspective from one of our children's hospitals in each issue as well as a state overview. This time we've interviewed representatives from Massachusetts—a state who has been on the frontline and a model of reform for several years, as well as California—a state in financial flux with innovative approaches to reform. You will also find some key information about California's lessons learned and how two constituency groups, the National Committee for Quality Assurance (NCQA) and several united physician groups, are identifying their role and standards in the development of ACOs.

I welcome your comments and suggestions as well as your questions. Please feel free to contact me directly.

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What is happening at Boston Children's?

With the Federal Healthcare Reform legislation reportedly having been heavily modeled after that passed by the Massachusetts legislature about two years ago, CHCA *ACO Update* thought it would be helpful to learn about what is happening at Children's Hospital Boston. Wendy Warring, Senior Vice President, Network Development and Strategic Partnerships, spoke with us. What we learned follows.

State leaders have suggested that they plan to introduce legislation proposing substantial payment reform, and it is likely to be in the form of global or bundled payments. While there has been considerable activity by way of hearings on various aspects of payment reform, no policies have been issued, nor have any specific proposals been passed. The Hospital has, nevertheless, taken on a number of initiatives in anticipation of the move to a more value-based purchasing approach by both the State's Medicaid program as well as commercial payers, to help further improve the cost and quality effectiveness of programs, and to establish and further enhance relationships with referring physician

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groups, many of whom have taken on risk based arrangements with private payers. Some of the initiatives are structural/operational and some are strategic.

From an operational standpoint, the Hospital is working with several primary care practices on shared savings projects to lower the cost of care for their patients in risk-based products. The practices with which it is working vary in size and the scope of their connection to the Hospital and its physicians, but the shared savings approach is currently driven most aggressively by practices that have accepted risk on at least 50% of the pediatric populations they serve. There is no shared governance structure in place yet, nor is there joint liability for patient care, but affiliation agreements between the Hospital, its physicians and the practices are targeting defined savings and devising management incentives to complete the projects. Not only is the amount of savings achievable a strong factor in the selection of a shared savings project, but the extent to which the project builds a culture of joint accountability is also weighed heavily. Projects in process and under consideration include those that seek to reduce episode of care costs in connection with conditions such as asthma, scoliosis, lipid control, diabetes and appendicitis. More generally, joint projects will continue to pursue reduced ED demand and utilization, as well as inpatient admissions and readmissions.

Work with primary care practices is also focused on developing joint clinical protocols and processes (collaborative care models) and on enhancing connections with established medical homes to evaluate opportunities to improve population health through more advanced use of information systems and joint proactive outreach to specific populations of children. In the area of developing joint clinical protocols and processes, the Hospital is piloting various initiatives that seek to better target (and reduce) the need for subspecialty support (in neurology, cardiology and imaging, for example). In enhancing connectivity, the Hospital has established various mechanisms for electronically pushing information to its referring providers (discharge summaries, ED encounter information and ambulatory subspecialty visit note) and is providing easier access to clinical data through a provider portal and automated link known as the “magic button.” The Hospital and its physicians have also begun to address the plans of certain community based hospitals to form Accountable Care Organizations that accept substantial risk in their payer relationships. It is in discussions with one regarding management of its pediatric programs under some form of sub-capitation, although this is quite preliminary. Concretely, as a benefit to all referring providers who have accepted risk, as of December 1, the Hospital has moved to differential pricing for its community-based satellites, lowering its prices for radiological and ambulatory surgical services by as much as 20%.

On the Medicaid side, the Hospital is working with several managed care plans to improve care coordination and efficiency of care for their predominantly Medicaid membership; the background is agreement that lowering the cost of caring for Medicaid members is essential to sustainable reductions in rates and prices. Based on shared data analysis, the plans and Hospital are likewise focused on

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projects that target areas of significant expenditure with feasible alternative care strategies—e.g., the reduction of emergency department visits, including improved management of asthma-related ED visits and the cost of care for high-risk asthma patients. They are also pursuing administrative simplifications to remove these costs. Specific savings targets have been set in association with each project. More strategically, the Hospital is planning, in concert with at least one Medicaid managed care plan, to present the MassHealth (Medicaid) program with options to move fee for service pediatric patients, including high risk patients, into the managed care plans. Not only would this simplify the program administratively, but it will allow the Hospital, its physicians, and the health plans to introduce complex care management protocols that target a segment of the Medicaid pediatric populations with the highest medical expenditures. In accepting the management of some risk, it will also align financial incentives among the health plans, physicians and the Hospital.

The following are among some of the additional structural initiatives that are under way:

- Building a data warehouse – Blue Cross claims data have already been loaded. The Hospital is in the process of loading claims data from other payers and network partners.
- Exploration of methodologies for managing high risk populations.
- Study of and experimentation with bundled payments – the Hospital is evaluating the time and cost involved with craniofacial treatments covering the period from initial assessment to the end of treatment. Further, the Hospital has experience with global payments for care provided to international patients and is evaluating if it is adequately accounting for costs and risks associated with caring for such patients.
- Creation of a team to evaluate innovative payment models.
- Installation of shared savings programs with primary care physicians that incentivize them to redirect care to community hospitals when appropriate (this falls under both the structural/operational and strategic categories).

Editor's Note: We plan to continue visiting with other hospitals over the coming months to inform you about what they are doing to prepare for and assume leadership in the emerging pay-for-performance environment. Based on all of the initiatives under way at Children's Hospital Boston, we plan to talk with them again in a few months to learn of and report on what we know will be good progress on the initiatives outlined above.

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What is it like in California?

It is like being the hood ornament on a storm chaser's car about to catch a tornado based on our interview with Steven Peiser, Associate Vice President, Contracting, Children's Hospital Los Angeles and Children's Hospital Los Angeles Medical Group. So, what has Children's Hospital of Los Angeles done and what is it doing now? Here is what he told us. Hold onto your seat as we take a "ride" with Steve.

According to Steve, many believe that the California health care delivery system is what the federal health care reform legislation will eventually lead to nationally. Health care in California can be conceptualized as an 'ACO ecosystem.' California has 285 physician organizations, both integrated medical groups and Independent Practice Associations (IPAs), which have many of the characteristics described in the current national policy debate. These include primary and specialty care physicians who care for defined populations of patients, provide or arrange for hospital services, and publicly report data on their clinical and financial performance. California's provider organizations vary in their conformity with the parameters discussed in the national debate, but many go beyond the minimum set of ACO activities to include preventive care, chronic care management and complex case management, often supported by clinical information technology and financed through partial or global capitation payment.

In California, a range of relationships exists between physician organizations and hospitals. Alignment of incentives between physician organizations and hospitals has and will continue to offer important opportunities for performance improvements across the entire continuum of care. Capitation has been vital to encouraging coordinated care by California's providers, as it has forced financial discipline, and allowed for investment in the infrastructure necessary to manage care across the continuum of providers. Fee-for-service (FFS) payments do not offer the same incentives for providers. As a method of payment, capitation can be effective at encouraging coordinated care, but payment methods should vary across ACOs depending on an organization's ability to assume risk. California health care providers, outside of capitation arrangements, also experience increased case rate formation and bundled payments for hospital and professional services. Case rate or bundled payments are often found in contracts for transplant, cardiac and orthopedic services.

Health plans have played a key role in the historical development of California's provider organizations. In the early days of medical group formation, plans often acted in concert and adopted similar capitation payment parameters, which lessened the administrative burden on groups, and allowed providers to focus on delivering high quality care to enrollees. Health plans must be ready and willing to foster ACO formation along similar lines, as a critical mass of payers will be pivotal to their success. California's experience with pay-for-performance (P4P) also highlights the benefits to ACOs of health plans working

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together. California has the largest non-government P4P program in the country; it includes seven health plans paying performance bonuses to 221 physician organizations based on uniform measures and results aggregated across plans. The aggregation of data across plans enhances data reliability and validity, and has engendered increased provider trust in performance measurement, as well as collaboration between health plans and physician organizations.

Health care reform has opened opportunities for significant collaborative discussions between hospitals, medical groups and health plans. "We are talking with everyone and looking under every stone for potential partner opportunities," Steve said. The Hospital has taken a multi-pronged approach. It also has chosen to attempt to work cooperatively, rather than compete, with provider/medical group partners and health plans. Steps taken to date include:

- Preliminary development of a Children's Hospital health care network. The goal is to build an infrastructure to support health care reform initiatives and to further align hospital and physician incentives. The focus is on the building of a pediatric primary care base in partnership with existing groups and practices to offer the full continuum of care for comprehensive pediatric services within the community and regionally.
- Working with two high profile medical groups (which employ or contract with both primary care and specialty physicians) focused on development of an exclusive pediatric referral relationship for approximately 100,000 commercial pediatric lives throughout the LA market. This will move the medical center and its medical group from potentially being commodity based providers into a relationship that is built on partnership and alignment. It will also promote the development of alternative reimbursement mechanisms for hospital inpatient and outpatient services.
- Developing a capability and gaining experience with different payment methodologies such as capitation, bundled payment, case rate and others.
- Creation of community-based ambulatory care centers located more conveniently for the families and referring pediatricians.
- Expansion of the hospital and medical group laboratory outreach programs. Currently the hospital has three laboratory outreach centers in the community.
- Partnering with community hospitals to manage their pediatric programs under CHLA's license. This is better known as the "hospital within a hospital" concept.
- Our affiliated medical group (CHLAMG) has recently entered into an at-risk arrangement with a Federally Qualified Health Center (FQHC) located on the hospital campus to manage 8,000 MediCal lives.
- An increase in the robustness of the Hospital's analytic and information technology capabilities to better focus on outcomes, quality measurement and development of an outpatient electronic medical record (EMR).
- Strategic discussions with managed care companies about options for collaboration.
- Investigating the potential of developing new partnerships with other children's hospitals in the region.

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California has a special program for children with chronic illnesses called California Children's Services (CCS). CCS pays for care on a fee-for-service basis. The Hospital submitted an application to CCS to take on some form of risk for this population. The Hospital submitted its application jointly with a medical group. In the application, the Hospital included plans to form an ACO, create a specialty health network, and operate primary care programs in conjunction with medical group partners. The state reportedly has been vague about what they have in mind, but they are expected to make their final recommendations in February 2011.

Strategically, the Hospital's approach is to work with, and to talk with many potential partners. They perceive that time is of the essence and are moving as quickly as possible. That is why they are devoting lots of attention to and pursuing many activities even while preparing to also open a brand new patient care tower this coming July.

MediCal accounts for 75% of the Hospital's business. While managed care is generally more advanced in California than most other places, interestingly, MediCal managed care accounts for only 6.3% of the Hospital's revenue; commercial managed care accounts for 19%. But the Hospital anticipates these percentages will grow, and recent changes in activity prove that belief is probably correct. MediCal managed care admissions and patient days have increased a lot in recent months, probably due to the state's efforts to increase the percent of MediCal beneficiaries enrolled in managed care programs.

Editor's Note: And, of course, the federal Patient Protection and Affordable Care Act (PPACA) is likely to spur even more managed care or managed care-like activity not only in the Medicaid and Medicare markets, but in the commercial markets also. That is because changes in Medicare payment arrangements have usually been adopted by commercial payers as well.

Lessons Learned from California Accountable Care Organizations

ACO-type organizations have existed in California for about thirty years. With 285 ACO or "ACO-like" physician organizations currently serving 15.7 million of California's roughly 37 million people, there would seem to be lots of lessons to be learned from California's experience. In "Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform," published by the Integrated Healthcare Association, six lessons seem most germane to CHCA's membership.

- **A variety of organizational structures are effective at delivering high quality, coordinated care; at least equally important are the organization's capabilities, culture and infrastructure and the degree of goal alignment between the organization and individual physicians.** There needs to be strong leadership, a clear purpose, shared goals, availability and use of data to help

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reach the goals (supported by a robust health information technology infrastructure), performance feedback and accountability for individual providers, participation in external quality improvement incentive programs, advanced care coordination capabilities, use of coordinated chronic care teams, provider acceptance and use of evidence-based guidelines, and strong market incentives to provide value.

- **In California a range of relationships exist between physician organizations and hospitals. Alignment of incentives between physician organizations and hospitals are important keys to performance improvements across the entire care continuum.** While many California ACOs do not include a hospital as a member, with hospitals being the highest-cost element of the delivery system, including them in the initiatives to control costs and increase value is essential.
- **While capitation is one payment method that can be successful, payment methods should vary across ACOs depending on each organization's ability to assume risk.** The authors say it is unclear if shared savings programs (versus capitation), as proposed for Medicare, will be enough to incentivize providers to transition from volume to value, or to invest in the infrastructure needed to provide effective care management.
- **Most California ACOs have focused on commercial, Medicare/Medicaid HMO plans for their patients.** But mechanisms need to be found to encourage PPO and traditional Medicare and Medicaid patients to use ACOs as well. Benefit designs should reward patients for choosing higher value ACOs. The current California market does not incentivize purchasers or consumers to choose lower cost, more efficient providers. Laws and policies must allow for innovative provider payment arrangements regardless of insurance type.
- **Balancing patient choice with the desire to decrease costs and effectively coordinate care is difficult.** It is much tougher to coordinate care in unrestricted provider choice environments.
- **Special attention must be given to establishing ACOs in areas with social and economic challenges.** Lower performing organizations were clustered in socio-demographic and health system challenged areas. Low payment rates means less capital for structural and process improvements. Even in integrated medical groups, Medicaid patients tend to be grouped due to low payment rates and the difficulty of providing a single standard of care where payment rates are so different among the various payers. While the Patient Protection and Affordable Care Act (PPACA) will provide more coverage in these areas, there will be a need to pay special attention to the quality gaps (and presumably to provide incentives to obtain and utilize the resources needed to address them).

Seventy-eight percent of California ACOs serve fewer than 50,000 patients with some small medical groups and IPAs being successful with fewer than 5,000 patients. The largest ACOs benefit from economies of scale but can also suffer from diseconomies of scale (e.g., loss of culture and sense of

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ownership by individual doctors). The authors also express concern about market consolidation and clout enabling very large organizations without competition to charge higher prices and be more lackadaisical about cost containment. Smaller ACOs can succeed via use of outside management service organizations and benefit from larger scale in information technology, contract negotiation and other administrative functions, which is especially important because most regions lack the population density necessary to support multiple, large ACOs. ACO expansion via mergers and acquisitions and across regions has been difficult.

The authors describe a new pilot in the Sacramento region involving Hill Physicians Medical Group, the California Public Employees' Retirement System (CalPERS), Blue Shield of California, and Catholic Healthcare West (a hospital system). These organizations have formed a virtual integrated model and agreed to keep CalPERS' costs at or below what they were in the Sacramento area in 2009.

For a link to the white paper visit:
http://acowatch.wordpress.com/2010/10/25/integrated-healthcare-association-white-paper-accountable-care-organizations-in-california-lessons-for-the-national-debate-on-delivery-system-reform/.

NCQA's Proposed Accountable Care Organization Standards

On October 19, the National Committee for Quality Assurance (NCQA) issued for public comment eighty pages of proposed ACO standards with a November 19, 2010 comment deadline. The Washington, D.C. –based, twenty-year-old NCQA accredits and certifies a variety of health care organizations. Its Healthcare Effectiveness Data and Information Set (HEDIS) is probably the most widely used healthcare performance measurement tool.

NCQA began the process in April by appointing a sixteen member ACO task force including representatives from Healthcare Partners, Kaiser Permanente, Geisinger Health Plan and others.

NCQA recognizes and supports that how providers organize themselves as accountable care entities is likely to vary based on existing practice structures in a region, population needs, or local environmental factors. They also note that ACOs are likely to vary widely with respect to the components of care delivery included directly. In other words, some may include a full range of services, including primary care, sub-specialists, hospitals, home care agencies, insurance products, etc. Others may be more narrowly constructed but maintain active relationships and/or formal contracts with providers across the spectrum of care.

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As a minimum, NCQA is proposing that the ACO include a group of physicians with a strong primary care base and a sufficient number of other specialists to support the care needs of a defined population. The ACO would have to align providers' clinical and financial incentives, ensure that they are clinically integrated and work seamlessly to coordinate care. The ACO would need an administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals. They also would expect the ACO to have the potential to simplify the care process for patients, enhance quality and reduce costs. Those achieving certification would then have to undergo reviews every two or three years.

The proposed standards are built on five guiding principles:

- A strong primary care foundation – a core of Primary Care Physicians (PCPs) with medical home capabilities.
- Reporting of reliable measures to support quality improvement and waste/inefficiency elimination to reduce cost.
- Commitment to improving quality, the patient experience and reducing cost – this includes establishing shared goals for improvement across providers, continually monitoring and analyzing clinical quality, patient experience, and cost data and application of findings via benchmarking, best practices, and peer review.
- Cooperation with stakeholders in a community or region such as by linking providers in the ACO with other delivery system components (e.g., hospitals, social service agencies and county health departments), and help with managing the full continuum of the patients' care (e.g., from preventive services to hospital-based and nursing home care).
- Creation and support of a sustainable work force, noting that likely increased PCP demand coupled with a shrinking PCP supply calls for creating a system that supports both providers and patients.

The proposed guidelines contain one reference to pediatric practices in "Element D: Guidelines for Important Conditions." This element requires clinicians to systematically identify patients for whom they will proactively plan and manage care. Under this provision, the guidelines call for the physician practice to implement evidence-based guidelines through point of care reminders. One of the factors (number 3 of 4 listed) subject to identification is unhealthy behaviors such as substance abuse; obesity; smoking or other tobacco use; risky sexual behavior; overuse of illegal drugs, alcohol or prescription drugs. Mental health issues may include depression. The proposed guidelines characterize conditions such as well-child care, asthma, obesity, ADHD, eczema and allergic rhinitis as among those meeting Factor 3. Another

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factor (number 4 of the 4) is patients with complex medical or high risk medical conditions. Relevant conditions listed as potentially meeting Factor 4 with regard to pediatric practices include children and youths with special health care needs such as sickle cell disease.

For more insight, read the proposed standards in their entirety:
(http://www.ncqa.org/tabid/1266/Default.aspx).

Physician Groups Issue ACO Principles

Four physician groups—the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association—announced November 19 that they had developed and released "Joint Principles for Accountable Care Organizations (ACOs)." The groups represent 350,000 physicians. The 21 principles address ACO administrative structures and how payment should be facilitated. They strongly support that primary care should be the foundation for an ACO and that patient and/or family-centered medical homes should be the basic structures within the ACO. The four physician groups have sent the principles to the Centers for Medicaid and Medicare Services (CMS) for their consideration as CMS develops their rules for ACO certification.

The joint principles can be found at:
http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/private/healthplans/payment/acos/20101117.Par.0001.File.tmp/AAFP-ACO-Principles-2010.pdf.

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