Emerging Practices Profile

Developing Community-Based Pediatric Health Services By Tackling Financials First

Children’s Mercy Hospitals and Clinics (Kansas City) Case Study

Fall 2012
Profile Snapshot

Children’s Mercy’s approach to developing an accountable care-like model for pediatric patients is dramatically different from what most organizations are doing today. The organization has tackled the details of the financial structure first by determining the steps for sharing risk across the network of care. Next, it will move rapidly to develop the model for care management. Learn more about the organization’s strategy for aligning incentives across the primary care network and how it will impact children in the community, particularly the Medicaid population.

About This Series

The Emerging Practices series of case studies showcases thought leaders, innovation practices and technologies from children’s hospitals. By gathering information from leading organizations, we hope to inform and inspire the adoption of great ideas among children’s hospitals for better patient and operational outcomes. This publication was developed through the Research and Development program of the Children’s Hospital Association.

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Executive Summary

Children’s Mercy Hospitals and Clinics’ (Children’s Mercy) approach to developing an accountable care-like model for pediatric patients is dramatically different from what most organizations are doing today. Children’s Mercy has tackled the details of the financial structure first and is moving rapidly to develop its model for care delivery. Drawing upon 15 years’ experience running a health plan for low-income families, organizational executives started researching new payment and care models in spring 2010, shortly after the Affordable Care Act (ACA) passed.

They determined that the status quo was unsustainable and wanted to create a value-based option with a revenue stream. The organization made a bold move by selling its Medicaid managed care organization (MCO) and developing an integrated pediatric network (IPN), a non-profit entity called the Children’s Mercy Pediatric Care Network (CMPCN), in January 2012. This change enables the hospital to have a greater impact on the pediatric community in the Kansas City Metro area, particularly with the Medicaid population.

CMPCN Executive Director Bob Finuf and Children’s Mercy’s Chief Financial Officer Sandra Lawrence sat down with Children’s Hospital Association staff to discuss the organization’s strategy for addressing community-based pediatric services. They shared how the organization is leading the wave of accountability and health reform by focusing on the alignment of incentives, coordinating care, and promoting quality across the primary care community. With the IPN strategy, Children’s Mercy can maintain its focus on pediatric patients, avoiding a potentially significant increase in adult enrollment as part of the ACA via ownership of the Medicaid MCO.

The Opportune Confluence

Finuf outlined three factors that enabled Children’s Mercy to make the move to the IPN strategy:

1. The hospital is the single dominant provider of specialty pediatric services with 70 to 85 percent market share in the Kansas City metropolitan area and surrounding rural communities.

2. The hospital has 15 years’ experience owning and operating a 210,000-member health plan spanning the Medicaid program across two states.

3. The hospital employs specialty physicians.
“In our due diligence efforts, the organization focused first on participation in the revenue stream, changing the payment model and aligning incentives. By doing this, we uncovered opportunities, and the economic model began to fall into place,” said Lawrence. This strategy is intended to help Children’s Mercy avoid some of the hazards of health reform including falling margins. Under the health plan it previously owned, Children’s Mercy received the entire premium for adults and children and was financially responsible for the entire population.

“Subsequently, we are developing the care delivery model, shifting away from admits and days to community-based population health, primary care medical homes and wellness,” said Finuf. This approach contrasts with the other forward-leaning organizations that first seek to understand the underlying cost structure, then transform cultural expectations about resource use and, ultimately, plan to sell a new product to payers.

But challenges do exist for Children’s Mercy as it moves down this alternate route. While the organization may not yet understand the true cost structure or the level of potential capacity with specialty versus primary care, access remains a problematic issue. “If no action is taken, potentially pieces and parts of the business will be taken away,” said Finuf. But by removing the payment barrier early in the process, Children’s Mercy can:

• More easily support technologies and processes such as telehealth and medical homes which enable accountable care;
• Over time, improve transportation issues for families; and
• Move care to the most appropriate delivery setting such as the primary care office or the home.

Pediatric Data and Expertise Inform the Payment Model

“Although we sold the health plan, we kept the infrastructure including the data and medical management systems. With the advantage of understanding historical payment trends through the health plan, we can take previous analyses and trend the data forward to begin to build risk models including capitation for the hospital,” said Lawrence.

With the sale of the MCO and retention of the pediatric population via an ongoing risk contract, Children’s Mercy can put all efforts on pediatrics only. CMPCN will continue to receive a percentage of the premium and will reimburse the hospital and its employed physicians on a capitated basis. “By keeping the managed care infrastructure capabilities, we can provide better care management while monitoring performance relative to traditional fee-for-service (FFS) payment methodologies. The payments to the community providers will continue to be on a FFS basis with supplemental per member per month (PMPM) payments based on level of engagement and performance,” said Finuf.

“It was important to create an interchangeable and comprehensive model for payers, and scale was a key factor. Many community providers and a high percentage of practices would provide the underpinnings needed for both care coordination and a viable pediatric product. Payers can delegate pediatric care solely to CMPCN, which possesses the knowledge to manage utilization and appropriateness of care for children. This provides payers with a more global frame of reference versus envisioning the organization as all high-cost. The organization wants to partner with payers, not be adversarial, and share in revenue stream fluctuation,” said Lawrence.

“Payers can delegate pediatric care solely to our integrated pediatric network, which possesses the knowledge to manage utilization and appropriateness of care for children.”

—Sandra Lawrence, Chief Financial Officer Children’s Mercy Hospitals and Clinics
The Expanded Target Population

Beginning in January 2012, CMPCN assumed risk under global capitation for about 112,000 Kansas City area children in Missouri and Kansas who are enrolled in the Medicaid and CHIP programs in those states through a risk contract with an MCO. Beginning in January 2013, children with complex, chronic conditions in Kansas are scheduled for inclusion in MCO contracts pending the approval of a CMS waiver application. CMPCN intends to contract with the Medicaid MCOs under multiple compensation models including global capitation and shared savings. In some cases, the shared savings approach is necessary to allow the MCOs that are new to the market sufficient time to become more familiar with historic cost/use data and to enable CMPCN and the MCOs to develop a more defined pathway toward prospective payment. In this manner, capitation revenue can be matched against FFS billing.

Unique Challenges

One of the challenges faced by CMPCN was how to address the medical management for patients up to 21 years of age for whom it assumes risk and who become pregnant. It would be complicated to carve out the risk only for obstetrical (OB) services and achieve the coordinated care desired for the population being managed. CMPCN retained the staff (OB case managers) with health plan experience to enable it to continue its outreach and care management program. CMPCN’s OB case managers work with patients and their providers to coordinate prenatal and post-discharge care.

In addition, CMPCN intends to evaluate geographic variation to understand whether medically complex patients migrate to the urban core. It may be that rural children are less complex or have different care coordination needs than those in the urban area. Medical management programs will be adjusted as needed to address any unique geographical needs that may be identified.

Primary Care Physician Support

CMPCN will offer support services to the primary care physicians (PCP) to help them build the capacity to better manage patients as a patient-centered medical home. The current system does not allow for physicians to optimize care coordination or disease management. Primary care physician support includes:

1. Administrative simplification; working with the organization replaces the need for the PCP office to work directly with five to six managed care organizations and will facilitate a consistent payment model and standardized medical management processes.

2. Resources including health information technology, education programs, clinical practice guidelines, medical home support, web hosting, patient registries and business office support.

3. Pediatric-focused disease management programs that include in-office training and patient education tools. The use of one common set of disease management programs reduces redundancy and improves efficiency.

CMPCN can provide better management support on the front end to produce better quality and lower cost overall for patients. It is dedicated to reducing the fragmented care that many providers and patients experience by gathering, analyzing and sharing information and providing the resources needed to make the information actionable.
New Payment Model Phases

To reach greater alignment in coordination of care across hospital and primary care, a phased approach will be instituted for payments to primary care physicians. This begins with fee-for-service and a per member per month fee based on levels of engagement and performance (e.g., access measures, emergency department visit avoidance, call coverage, data sharing and quality measures such as HEDIS measures). The split may be 70 percent FFS and 30 percent PMPM payments, and then migrate to more performance emphasis over time.

In addition to its work with community providers through CMPCN, Children’s Mercy is putting in a cost accounting system, and its physicians continue to develop evidence-based guidelines. The physicians are taking the lead on standardization, and the organization believes as a whole that costs will come down with standardization.

State Medicaid Program Compensation Model

The compensation model for CMPCN is based on a percent of premium (global capitation) received by the MCOs that contract with the state Medicaid programs in Kansas and Missouri. CMPCN receives global capitation for all pediatric patients assigned to a PCP within its designated service area. All medical management functions are delegated to CMPCN by the MCOs. By participating in the revenue stream and performing the delegated medical management functions, CMPCN can reduce the friction that so often occurs between the provider and the MCO. In addition, Children’s Mercy and the MCOs no longer conduct unit cost negotiations or have disputes over appropriate levels of utilization.

A New Conversation

“More” is not always better in the current health care environment, and with this belief begins the evolutionary process with both the hospital and the physicians. Into the future, CMPCN could expand its focus to the commercial population. Adult system interactions garner a wait-and-see approach as well as those with family practice physicians that provide little pediatric care.

Ultimate Benefit

With its IPN strategy, Children’s Mercy can maintain its focus on pediatric patients and avoid a potentially significant increase in enrollment of adults as part of the ACA via ownership of a Medicaid MCO. Trade-offs may include more distant relationships with the states and a level of dependence on others (like contracting MCOs) to provide payment for care. However, this alternate approach ultimately helps Medicaid children gain access to the specialized care they need and allows them to build direct relationships with their pediatric providers. CMPCN also has relationships with those providers, and the incentives are aligned for providing the best quality care at the lowest cost.

“Our integrated pediatric network is dedicated to reducing the fragmented care that many providers and patients experience. We are gathering, analyzing and sharing information, and providing the resources needed to make the information actionable.”

-Bob Finuf, Executive Director, Children’s Mercy Pediatric Care Network
The Children’s Mercy Pediatric Care Network Plan
September 2012

I. Background

Shortly after the Affordable Care Act (ACA) passed in March 2010, Children’s Mercy Hospital (CMH) and Children’s Mercy Family Health Partners (FHP) began researching strategies relating to payment and care delivery model reform in the Medicaid market that would better align and integrate CMH and FHP resources in order to create a new model meant to deliver lower-cost high-quality health care, in the most efficient setting. The ACA contemplates Pediatric Accountable Care Organizations (ACOs) as one such vehicle. While ACOs in the ACA are mainly focused on Medicare, the concept of an “ACO-like” structure combined with a number of environmental factors motivated CMH to sell its Medicaid HMO (FHP) and launch a new “ACO-like” payment and care delivery model called an Integrated Pediatric Network (IPN). CMH formed a new non-profit entity called Children’s Mercy Pediatric Care Network (CMPCN) as the vehicle to operate the IPN. The sale of FHP and the launch of CMPCN occurred on January 1, 2012.

II. IPN Development

The IPN is an alternative to owning a Medicaid MCO that enables CMH to impact the pediatric community in the greater Kansas City Metro area and specifically (at least initially) in the Medicaid population. As part of the sale of FHP to Coventry Health Care (CHC) and its Missouri Medicaid MCO Healthcare USA (HCUSA), CMPCN entered into a long term risk-based global capitation agreement with CHC/HCUSA. At its core, payment model reform of this nature is aimed at increased risk and accountability for the provider(s) participating in the CMPCN network. See Figure 1 for an illustration of what the levels of risk might
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...look like with partial or no risk at the base and greater levels of risk occurring up the pyramid ending in a full capitation payment at the top. Looking at this illustration, CMH via CMPCN would be in the “Cap” section of the pyramid under its agreement with CHC and other MCOs. As CMPCN contracts with community pediatricians and family practice physicians not affiliated with or employed by CMH, those CMPCN network physicians will be in an ‘incentive-based fee for service’ model, with the goal of moving those community physicians to a fuller risk sharing contract. It is envisioned that the full development and implementation of CMPCN will occur over a series of “Phases” with each phase of development lasting approximately 6-12 months. An outline of the first three phases is presented below.

A. IPN Phase I

CMPCN entered into contracts with CHC/HCUSA on January 1, 2012 under a global capitation methodology for the legacy FHP pediatric lives as well as the HCUSA pediatric lives Missouri in CMPCN’s geographic service area (SA). Initially CMPCN manages approximately 112,000 lives under these agreements. The SA (see Figure 2) is a nineteen county area that essentially mirrors CMH’s primary catchment area. The three largest counties in CMPCN’s SA include Jackson, Johnson and Wyandotte. CMPCN’s SA includes Wyandotte and Johnson Counties, and every contiguous county thereto in Kansas; as well as the entire Western Region of the MO HealthNet

Managed Care program. This SA for CMPCN represents counties in which there is a significant enough pediatric population as well as pediatricians (both PCP and specialists) to be able to influence behavior so that real change in pediatric population health can be achieved.

Fig. 2: CMPCN Service Area

CMPCN Overview - September 2012
The age definition for ‘pediatric’ lives under the contracts are 21 years old and under in Kansas, and 20 years old and under in Missouri. This definition is consistent with the current rate cell breakdown in each state Medicaid contract. Members are assigned to CMPCN according to the location of the member’s PCP, i.e. all members assigned to PCPs in CMPCN’s SA make up CMPCN’s membership.

As mentioned above, it takes resources and infrastructure to actively manage 110,000 pediatric lives in CMPCN’s SA. Since CMPCN is at risk for all medical care provided, the bulk of the administrative services CMPCN performs center around the medical management and care coordination functions that are typically provided by the MCO. The attached CMPCN “Medicaid Managed Care Administrative Services” table (see Appendix 3) illustrates the administrative services provided by CMPCN, those services provided by the MCO, and those services that are shared between CMPCN and MCO.

The attached “Provider Flow of Funds/Data” diagram (see Appendix 2) depicts the flow of funds, reports and data between the MCOs, CMPCN and providers.

The MCO pays part of the global capitation payment to CMPCN for the administrative services performed and for sub-capitation payments for CMH, its employed physicians and other CMPCN network providers. The balance of the global capitation is deposited into a separate bank account designated as a network FFS account which will make FFS payments directly to MCO network providers. CMH submits claims to the MCO, but will receive remits without pay because the claims have been prepaid through the capitation from CMPCN to CMH. Any surplus or deficit in the FFS accounts will be the responsibility of CMPCN, that is, any surplus paid to CMPCN and any deficit funded by CMPCN.

Staffing levels for CMPCN include deploying personnel to work more closely with PCP practices that care for CMPCN members. CMPCN will assign a team to each PCP office that will include a Resource Nurse, Care Manager and Educator/Health Coach for asthma/diabetes. These teams meet with high volume PCP offices on a regular basis to review key metric reports and determine future initiatives. Such a team will be a component of what makes a PCP office a medical home. In other words, CMPCN will bring resources to community pediatricians and family practice physicians to transform their practices to patient centered medical homes which will produce better health outcomes at lower costs.
B. IPN Phase II

Phase II of the IPN development includes building a network of community pediatricians and family practice physicians to better align payment incentives in order to improve the care coordination and overall health of CMPCN’s population. While CMPCN assumed risk for its assigned population (as described in Phase I) on January 1, 2012, it did not initially have its own network of community pediatricians and family physicians in place (beyond those physicians that are employed by CMH) to coordinate care and services.

CMPCN expects to bring significant value to a community physician’s office, including creating shared significance that facilitates efficiencies and improvements in care delivery and use of resources. The following is a list of features that CMPCN offers community PCPs to enhance their practice:

1. Simplified administration and reduced fragmentation with too many Medicaid MCOs by creating standardized:
   • Payment policies
   • Utilization management policies - e.g., precertification requirements
   • Credentialing process

2. Better population-based clinical tools and medical home support tools:
   • Uniform model that doesn’t force the community pediatrician to conform to multiple MCO models

![Fig. 3: Data Sources Feed into CMPCN Data Warehouse](image-url)
• Tools and resources for care coordination at the practice level
• Health Information Technology tools (EMR, HIE)
• Data Warehouse with aggregated data for the pediatric population in the IPN SA which will drive the following:
  - Figures 3 & 4 are depictions of what data and reports may be available to IPN network providers
  - Patient registries
  - Peer to peer best practices
  - Preventive care/patient outreach
  - Chronic disease management
  - Targeted high cost/high use interventions
• Social services support

3. Payment System Reform:
• Transition from “volume based” payment with constant pressure on unit cost and volume of services to “value based” payment through common structure
• Opportunities for at-risk contracting, sharing savings, and other creative payment models
• Aligned incentives with the hospital and other providers

C. IPN Phase III

Phase III of the IPN development includes the full development of the network of providers and the movement of those providers into greater degrees of engagement in shared savings and/or shared risk/capitation.
Appendix 2

Provider Funds / Data Flow
Children’s Mercy Pediatric Care Network (CMPCN) Provider Flow of Funds / Data

State Medicaid Agency

Premium / Capitation

Medicaid MCOs

Capitalion

CMPCN

Claims Data

PMPM Payments

Clinical Data

Population / Practice, Quality and Outcomes Measures

Medical Home Resources and Support

Children’s Mercy Hospitals & Clinics & Other
CMPCN Network Providers

Medicaid MCO Network Providers

MCO / CMPCN Fee-For-Service Claims Account

Surplus

Deficit Funding

Fee-For-Service Payments / Remittance Advice

Fee-For-Service Payments / Remittance Advice
Health Plan vs. Network Roles
## Children’s Mercy Pediatric Care Network (CMPCN)

### Medicaid Managed Care Administrative Services

<table>
<thead>
<tr>
<th>Shared Services CMPCN/Health Plans</th>
<th>CMPCN</th>
<th>Health Plans</th>
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| “Shared Services” are performed separately by CMPCN and Health Plans but not necessarily with the same allocation of resources by each. | • Appeals (first level for network providers)  
• Care Management (high use / high cost)  
• Data Analytics  
• Disease Management (Asthma, Diabetes)  
• HEDIS Data Collection Support  
• Inpatient Transition  
• Medical Home Support  
• Payer Contracting/Relations  
• Payment Model Determination  
• Prescription Drug Management (if applicable)  
• Prior Authorization  
• Performance Reporting and Analysis  
• Utilization Management  
• 24-Hour Nurse Advice Line | • Appeals (except first level for network providers)  
• Benefits Administration  
• Claims Administration  
• Community & Member Outreach  
• Compliance  
• Customer Service  
• HEDIS Data Collection & Reporting  
• Enrollment  
• Marketing  
• Non-Medical Services (transportation, dental)  
• Pharmacy Benefits Management Services  
• Pharmacy Network  
• Quality Improvement  
• State Contracts  
• Underwriting |
Network Marketing Materials
Our Mission
The mission of Children’s Mercy Pediatric Care Network is to improve the health and well-being of children through an integrated pediatric network in the greater Kansas City area that is value-based, community-focused, patient-centric, and accountable for the quality and cost of care.

Who We Are
Children’s Mercy Pediatric Care Network (CMPCN) is an integrated pediatric network that coordinates the medical care of pediatric patients enrolled in various managed care organizations (MCOs). CMPCN is comprised of Children’s Mercy Hospital and its employed physicians, community pediatricians and other health care providers in the Kansas City area. CMPCN contracts with MCOs to provide all medical services for one global fee.

CMPCN uses a team-based approach to reduce barriers, export resources and expertise from Children’s Mercy Hospitals and Clinics, and support patient-centered medical homes for the providers in our network.

Ultimately we are focused on better alignment of the payment model and the care delivery model so that the focus can truly be on the right care, at the right time, in the right setting.

What We Do
Improve health care delivery by offering:
Simplified administration and reduced fragmentation, including standardized claim submission requirements, payment policies, and credentialing processes.

Better population-based clinical tools and medical home support tools such as Health Information Technology and aggregated data for the pediatric population in the Kansas City area.

Payment system reform: “value based” payment, opportunities for at-risk contracting, sharing savings, and other creative payment models.

Delegated health plan administration, including medical management, provider credentialing, and disease management programs.