THE BUSINESS OF PEDIATRICS:
BETTER CARE = BETTER PAYMENT

19th CNHN Pediatric Practice Management Seminar
Thursday, December 6, 2016
SMALLER vs BIGGER?
WHAT PRACTICE SIZE IS JUST RIGHT?

Mark Weissman, MD
Looking ahead—what’s best for pediatric practice?
Shift from FFS to value-based payment
ACA driving new payment models

Health Care Reform

“Triple Aim”

Improve individual experience

Improve population health

The best care

For the whole population

At the lowest cost

Control inflation of per capita costs

D. Teliock, Institute of Healthcare Improvement, 2016
HHS: CMS Timetable for Value Based Payment

• “Triple Aim” ⇔ “Better, Smarter, Healthier”
• January 2015: HHS sets clear goals & timeline for shifting Medicare reimbursements from volume to value
  - Shift Medicare payments to physicians and hospitals through alternative payment models such as medical homes and accountable care organizations (ACOs)
  - 30% by 2016; 50% by 2018
  - In addition, HHS has set a goal of tying 85% of all fee-for-service (FFS) payments to quality and cost measures by 2016, and 90% by 2018.
• AMA, AAFP: We’re “on board”
MACRA: MIPS & APM’s

• Beginning 2017, Medicare providers will be required to participate (incrementally) in Merit-Based Incentive Payment System (MIPS) or Alternative Payment Model (APM) (eg ACO with risk-based payment)

• Higher performing practitioners will receive increased payments-funded by reduced payments to lower performers

• Public reporting of performance

• Applies to Medicare but potential to extend to Medicaid and commercial insurance (adult care initially- pediatrics?)
MACRA (Medicare Access and CHIP Reauthorization Act of 2015) (BIPARTISAN APPROVAL)
Merit-Based Incentive Payment System (+/-)

MIPS Score
Four categories, one composite score and report

Quality + Resource Use + Clinical Practice Improvement Activities + Meaningful Use of Certified EHR Technology = MIPS Composite Performance Score

MIPS (Merit-Based Incentive Payment System)
Adjustment to provider’s base rate of Medicare Part B payment

Maximum Adjustments:
- 2019: +4%
- 2020: +5%
- 2021: +7%
- 2022: +9%

Business of Pediatrics 2016
MIPS: Merit-based Incentive Payment System
What about pediatrics?
The future is not so clear…

ACA Repeal?

Pediatric Payment
I have a plan...

I support health care for people. I want people well taken care of. But I also want health care that we can afford as a country. I have people and friends closing down their businesses because of Obamacare.

(Donald Trump)
Implications for children, families & pediatricians

Priorities & timeline?

- ACA repeal vs replace
- HHS (Tom Price) & CMS (Seema Verma) appointees & priorities
  - Medicaid block grants to states
  - CHIP (Children’s Health Insurance Program) reauthorization (thru 2017)
  - Coverage of children and preventive services
    - Reduced coverage?
    - Lower premium vs more out of pocket expense?
Shift from FFS to value-based payment continuing
Current payment incentive trends will continue

- Pediatric practices will be increasingly accountable for meeting both care quality (eg HEDIS, EPSDT) and cost measures
  - Not just for patients you see in your practice - but all patients attributed to you as PCP/medical home/panel
  - Not just the cost of care in your practice (what you charge) but the total utilization and total spend of all patients attributed to you across the care continuum
- Payment adjusted on top of base payment through withhold or incentives
Think differently about care delivery and payment models
Expand focus beyond individual patient
Manage care & expense for ALL patients
What’s a pediatric practice to do?

• Most pediatric practices are good at “small practice” business- but business is changing…
• Most pediatric practices lack the infrastructure & resources for managing care and cost outside their practice- particularly for attributed patients who are not actively engaged in primary care medical home
• Larger payer and health systems have potentially more resources- but often not focused on needs of children, families & small pediatric practices
• **2016 Future of Pediatrics practice survey:** >60% pediatric practice respondents preferred practice independence- and also interested in exploring clinically integrated network (CIN) option for pediatrics
Smaller vs bigger- or maybe both?

• “Smaller is better”
  • Maximize personalized care and small business productivity model (Chip Hart presentation to follow)

• “Bigger is better”
  • Explore and develop models where small practices can align and share/profit from resources targeted to pediatric population health delivery and payment
FFS Medicine: Entrepreneurial Silos
FFS Medicine: Incentivizes volume

- Primary Care Practice
- Specialty Care
- Hospital Care

- Competing cost centers within hospitals or health systems or across communities
- Poor communication or coordination across silos
- Total care: fragmented and expensive
Not designed for value-based care
CareFirst: PCP’s Opportunity is with the Entire Healthcare System

Distribution of Medical Spending is Changing

- Spending on prescription drugs has become the largest share of the medical dollar (including spending in the Pharmacy and Medical benefits)
- This key change causes increased focus on pharmacy care coordination

Primary Care Physician, 5.7%
Pharmacy, 28.8%
Specialists, 22.7%
Outpatient, 19.5%
Inpatient, 19.7%

Source: CareFirst HealthCare Analytics – Medical spending is based on claims paid in 2014 for the CareFirst Book of Business Excluding Medicare Primary Members. The Pharmacy % is adjusted to represent typical spend for members with CareFirst’s pharmacy benefit.
PCP’s challenged to control total spend unless aligned with specialists & hospital - need to align care model & payment incentives - for all

CareFirst Sample Pediatric PCMH Expense
Need to develop integrated care networks
Value-based Care & Payment: Requires new infrastructure to manage care of populations

- Payer and provider contracting
- Network development and management
- Identifying and managing populations by risk
  - Population health analytics
  - Care coordination & case management
- Driving & improving quality & safety performance
- Managing population health payment, shared savings & risk
- Limited pediatric experience & expertise—particularly in adult-centric systems
Children’s Hospitals now partnering with community pediatricians in care and contracting networks (Medicaid → Commercial)
Pediatric Clinically Integrated Networks

- CIN video:
- The Children’s Care Network (TCCN) from CHOA (Children’s Healthcare of Atlanta)
- http://www.tccn-choa.org/
Getting bigger: building an integrated pediatric network

- Children’s Hospitals typically underwrite network development
  - Physician-led; shared governance models
- New value-based payment models typically blend FFS payments to practitioners with added payments for care coordination and meeting quality performance measures (clinical, engagement & cost)
  - Models for sharing savings of total cost of care across network/stakeholders
- Networks designed to meet FTC requirements for “clinically integrated network” (CIN) and/or to accept risk incrementally
- Children’s Hospitals typically outsource managed care infrastructure (business); leverage pediatric focus & expertise, provider networks & working relationships
Children’s National moving forward on CIN

- Children’s National will be partnering with community-based pediatricians to develop a pediatric Clinically Integrated Network (CIN)
  - CIN permits pediatric practices to remain independent but be part of aligned regional system focused on care of children- and improving quality and cost outcomes and value-based payments for all in CIN.

- Successful CIN’s are physician-developed and led.
  - CNHN will convene regular CIN planning sessions (February – May 2017) – looking for community pediatrician champions and leaders to participate.
  - Goal- present CIN model at June 2017 Future of Pediatrics

- Interested? Contact: Mark Weissman
  - mweissma@childrensnational.org 202-476-3524
Pediatric CIN: Why now?

- Continued local market evolution to value-based payment models
  - Driven by states or payers; not by providers
  - Adult health system focus and consolidation
  - Limited at-risk dollars and focus on children (vs adults)
- Opportunity to develop pediatric physician-led organization that leverages value & promotes success of community practice participants
  - Self-organizing local provider activities underway- not likely to reach sufficient scale to influence payers
- Leverage Children’s National resources & brand to advance model focused on children, quality & appropriate payment
- Pediatric CIN likely not the end-game- aligns & strengthens community pediatric providers and Children’s National to address appropriate pediatric care and payment with future adult partners
Questions & discussion