

## Living in Both a Fee-for-Service and a Value-Based Purchasing World- Barbara Spivak, Mt. Auburn Cambridge IPA

### Notes from the Presentation

- MACIPA takes full risk capitation from three major health plans since mid 90's
  - BCBSMA
  - Tufts Health Plan and Tufts Medicare Preferred
  - Harvard Pilgrim Health Care
- Value-Based Purchasing
  - Consumers hold providers of health care accountable for both cost and quality
- Types
  - Budgeted Cap-MACIPA
  - Bundled Payment-single payment for episode
  - Capitation-fixed monthly payment for all services
- MACIPA Settlement for PCPs
  - 70% based on # of patients assigned to the PCP
  - 15% based on # of pod meetings attended
  - 15% based on improvement in specified quality measures
- MACIPA Settlement for Specialists
  - 85% based on payment volume for services provided during the surplus year
  - 15% on development of specialty-specific quality measures
- Focus on education and quality
- Check on variation in procedures, show data to doctors- consistently have them evaluate why there's variation
- Data driven
- Physician leaders practice medicine at least 50% of the time
- All PCPs grouped into pods (have to go to 8/11 meetings): Topics:
  - New physicians and services
  - Pharmacy management and reconciliation
  - Data and reports
  - New programs and initiatives
  - Meetings attended by MACIPA case managers, other staff
  - Quality improvement programs, focus on preventive care
- Need population management-big picture
- People need support to keep them out of the hospital
- Challenges:
  - Huge culture shift
  - Need to build reserves, re-insurance
  - Years before rewards are seen
  - Getting to win/win with less funds available
  - Difficulty evaluating program efficiency, planning services, and developing programs

### Session #1 Q&A

Q: Are post-acute services part of savings?

A: We have a budgeted cap and take care of almost all parts of savings. We share with hospitals and physicians, but opt-out of post-acute services.

Q: How do incentives interact with both a budgeted cap, and a day-to-day fee-for-service payment?

A: We reconcile all expenses against the budget and monitor any high-volume or variation from specialists or primary care doctors. We actually encourage more primary care visits.

Q: What kind of tools do you use for data management?

A: We use both in-house and outside data tools. Claims data is very messy and we do a lot of scrubbing of the data so that it's accurate.

Q: Describe case manager practices, including population management.

A: Pod teams are made up of doctors and disseminate information to the Primary Care Physicians. Each Pod has a case manager who works with the team on how to deal with data, quality improvement programs, variation management, etc. We also perform surveys on out-patient care to monitor what's going on and enforce better communication. We want specialists to know what services can be offered here, so they don't unnecessarily send patients out.

Q: Why did you move towards an ACO?

A: We were one of the first organizations to do this; we thought it was the right thing. Sometimes we have to pay the health plans at the end of the year, and sometimes we get bonuses. The Alternative Quality Contract's (AQC) budget is based on prior years' experience; it pays a percentage for meeting quality benchmarks. We believe it's not enough to know if something is done, we want to know if there are outcomes, and want those to be weighted more heavily.

Q: What proportions of contracts are value-based? What will get the doctors attention?

A: Don't know what the minimum is to get doctors attention. We want 50% of care to be at risk, but we need the data.

Q: How do you evaluate AQC and other contracts?

A: That's a big obstacle for us. We need to know how to model it, look at historical experience, look at what's coming, and have talented workers.

Q: Do you have re-insurance?

A: We buy from outside market, it's very expensive.

## **Session #2 Q&A**

Q: How do patients receive this type of care?

A: Most patients just want to feel better, not have more surgeries or tests performed. You need to teach people what they actually need and what the criteria are for tests/MRIs- better communication.

Q: How many docs are in a pod?

A: It varies from 6-12. We try to stay small to promote discussion.

Q: How do you monitor physicians?

A: We mostly monitor visits, it's not practical yet to monitor every touch.

Q: Have you thought of experimenting with Registered Nurse led pods to see if the discussion changes?

A: I want a team of mid-levels working with me; I think it's effective, but most of the practices don't work with mid-levels. I think that will change soon, but it's hard to get the board's permission.

Q: Have you found a need to evolve talent to recruit to board?

A: Right now it's all physicians on the board, but we will need to change to the ACO governance structure regulations and put consumer representation.

Q: Are quality projects adopted at the practice level? Are lessons learned from one practice to the next?

A: We have practices come to pod meetings to discuss best practices and lessons learned and they're sometimes adopted. We are firm about people doing their quality projects, and when specialists don't, they don't get paid. We want the QP to become institutionalized; we need written results and proof they did it.

Q: Can physicians sustain previous years' quality projects, or do they need entirely new ones?

A: Needs to be a new one.

Dr. Spivak: I don't like bundled payments. I would rather care for the whole patient, than slice off pieces.

Dr. Spivak: We don't pay claims like most IPAs. I don't see it adding value to the HC world.

Q: Do you have anything related to Behavioral Health, physician hospital integration?

A: Haven't done enough with ER to home, but the 1<sup>st</sup> meeting I have with the pioneer ACO is with behavioral health. We don't do well with that because the health plan doesn't pay therapists well. Most therapists don't take insurance. In 2012 we will implement a behavioral health model and social managers.

Q: What allowed you to continue to effectively be an HMO?

A: We are mostly small practices and we made a decision to really partner with practices. We had stable leadership.