Issue Brief #5

Total Care for a Sub-Population

Definition

Total Care for a Sub-Population is similar to the concept of "global payment" or "population-based payment" described in the CNYCC Issue Brief on Total Care for the Total Population. It is a model where one or more providers receives a fixed dollar amount to manage the health of an attributed subpopulation of patients. The New York State Roadmap defines subpopulations as individuals living with HIV/AIDS, individuals included in the MLTC/FIDA, HARP and DISCO populations

In this payment model, if the provider effectively manages costs and measures well on performance indicators, then the provider gets to keep a portion of the saved dollars. However, if the provider manages care inefficiently, it may be responsible for covering a portion of the additional costs incurred.

Example in Use[1]

Massachusetts-based Commonwealth Care Alliance provides services to seniors and those with physical and mental disabled under a population-based payment model by offering a full spectrum of services, including individualized primary care, care coordination, behavioral health, and home and community-based care. It receives a risk-adjusted capitated payment from Medicaid and Medicare and operates similar to an integrated health care system. Services are provided through its own provider network which includes FQHCs, independent physicians and academic medical centers. Its umbrella organization provides wrap-around services in support of primary care providers.

Despite challenges in maintaining adequate financial reserves, integrating capitated payments from its payers, and recruiting multilingual staff who can respond to the cultural and language needs of the population served, it has experienced success in cost savings by reducing nursing home stays and effective multi-disciplinary care coordination. It has excelled at quality measures ranking at or above the national 90th percentile on HEDIS measures.

NY DOH Approach

One approach to taking on Total Care for a Sub-Population being discussed in New York is the development of an ACO specifically for HIV/AIDS patients. The ACO would be comprised of different providers who typically care for this subpopulation and would be held responsible for the total cost and quality of all HIV/AIDS patients attributed to the provider group.

Payment Mechanism & Risk Models

Population-based payments can be administered on a fee-for-service basis with a retrospective reconciliation to a total budget, or they can be paid prospectively on a PMPM basis. Budgets are typically built considering historical provider experience and adding a trend factor to account for cost growth. Budgets are risk adjusted prospectively based on historical claims and then retrospectively risk adjusted to reflect the profile of the actual attributed population. DOH will classify arrangements for total care for the sub-population administered on a fee-for-service basis in VBP Levels 0-2.[2] Prospectively-administered "global capitation" payments (with financial consequences for quality performance) will be considered VBP Level 3 by DOH.

The options for risk models associated with total care for a subpopulation are the same as for a total population. See CNYCC Issue Brief on Total Care for the Total Population for more detail.

Quality Measures

Quality measures are important to population-based payment models to help ensure that providers are focused on population health outcomes, not just on the cost of care. Quality measures for subpopulations might include measures specific to the population (e.g., HIV viral load suppression) and include measures that are also applicable to a more general population, such as prevention measures, chronic illness care measures, etc.

Operational Implications

The operational implications for participating in a payment model for a subpopulation are the same for participating in a payment model for a total population. (See CNYCC Issue Brief on Total Care for a Total Population for more detail.)

However, **care coordination and integration of care** across providers might be more relevant when caring for a subpopulation that inherently has greater health care needs than a more general Medicaid population. For example, if the subpopulation includes those in the HARP population who have co-occurring substance use and mental health conditions, behavioral health care services will need to be well coordinated with medical services.

While real-time analytical resources are important in managing populations of patients, for certain subpopulations (e.g., those with behavioral health conditions), it will be important for providers to have **access to the clinical records of individuals from outside of their discipline** (e.g., behavioral health provider accessing medical health provider's documentation) in order to effectively manage care. Where behavioral health care is concerned, interested providers need to be aware of data privacy laws within New York and how that may help or hinder coordination.

References

1. Meyer, H. "A new care paradigm slashes hospital use and nursing home stays for the elderly and the physically and mentally disabled." *Health Affairs,* 30, no. 3 (2011): 412-415 http://content.healthaffairs.org/content/30/3/412.full

2. For more information on New York State's VBP Levels see the CNYCC Issue Brief on Value-Based Payment Reform.