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Total Care for the Total Population

Definition

Total Care for the Total Population, sometimes called "population-based payment" or "global payment," is a model where one or more providers (e.g., the PPS or integrated providers within the PPS) receives a fixed dollar amount to manage the health of an attributed population of patients. 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. This payment model is typically used with Accountable Care Organizations.

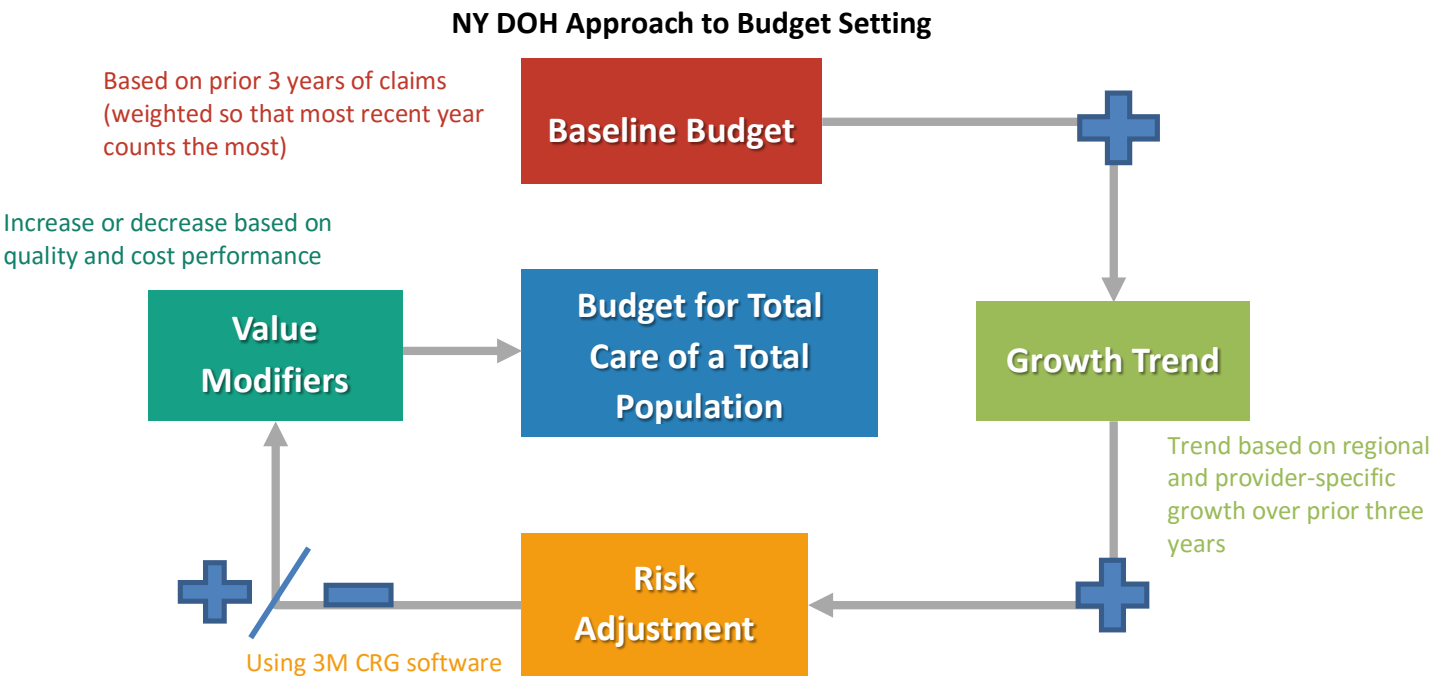
Note that Total Care for the Total Population is often a misnomer. Many population-based payment models do not actually include all health care services in a population, and typically "carve-out" long-term supports and services, and may sometimes exclude pharmacy and behavioral health services. There is also usually provider protection against high-cost outliers and for changes in population risk.

Examples in Use

Blue Cross Blue Shield of Massachusetts[1] has instituted population-based payment models with 85 percent of physicians and hospitals in its HMO network. Providers contracting under the "Alternative Quality Contract" are held to a risk-adjusted budget that covers all medical expenses (including behavioral health) for the attributed population. The budget is based on historical spending and adjusted annually during the contract period to account for inflation and health status changes in the attributed population. During the year, the providers continue to receive fee-for-service payments. The budget is reconciled against the actual expenses at the end of the year.

Providers that deliver cost efficient care are eligible to keep a portion of savings, and those who do not risk owing the health plan money.

Providers are also held accountable to quality of care outcomes and can receive an increase of up to 10 percent above their global budget for excellent performance.



NY DOH Approach

In New York, the guidelines for patient attribution include a prospectively-administered approach based on the MCO-assigned PCP. For example, if a PPS contracted for the total care for the total population, the patients assigned to the primary care physicians by the MCO within the PPS would be attributed to the PPS.[3] However, since MCOs are free to design their own VBP methodologies, other attribution approaches may be used.

Payment Mechanism

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 total 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.

Quality Measures

Quality measures are important to population-based payment models to help ensure that providers are focused on population health outcomes, and not just on the cost of care. Quality measures typically focus on prevention, chronic illness care, preventable acute utilization (e.g., for ambulatory care-sensitive conditions, access and patient experience. They may also include measures of patient safety and health status. Data sources can include claims, clinical data and patients.

According to DOH's VBP Roadmap, the recommended model would include a positive adjustment to the budget for a high performance on quality scores in 2016 and 2017 for providers in VBP Levels 2 or 3. In 2018, downward adjustments may be introduced to the recommended model design.

Benefits

Studies of population-based payment models have shown a decrease in overall health care costs and an improvement in quality. In addition, in many programs, providers are successful and able to share in savings – but provider success varies by program and by provider.

References

1. www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf
2. For more information on New York State's VBP Levels see the CNYCC Issue Brief on Value-Based Payment Reform.
3. Technical Design I Subcommittee meeting presentation October 1, 2015.
4. Burns MB and Bailit MH. "Alternative Payment Models and the Case of Safety-Net Providers in Massachusetts." *Blue Cross Blue Shield of Massachusetts Foundation.* March 2015.

Risk Models

Most often, providers engaged in population-based payment arrangements share in a percentage of savings when costs are below the budget and carry responsibility for a percentage of costs incurred above budget. In New York, and in many population-based contracts, MCOs use "stop loss" and "risk corridors" to limit the amount of loss a provider may be subject to.

Stop Loss: A dollar amount or percentile (above budget) for which a provider is no longer responsible for the costs of an individual patient, or a total population.

Risk Corridor: The percentage above and below budget for which a provider can share in savings or be held responsible for losses. Risk corridors do not have to be symmetrical (e.g., 50% savings and 50% loss).

New York may choose in the future to set a limit through regulation on how much risk a provider can accept.

Operational Implications

In order to successfully engage in population-based payments, providers need to ensure **financial readiness.** This means the ability to make needed investments to develop capacity and eventually when a contract may begin to involve shared risk, a financial strategy to cover any losses that may be incurred.

Providers also need a **sufficient population size** in order to gain statistical confidence that any savings or spending above budget is not due to random variation. While there is no industry standard population size, minimum population sizes vary from as few as 2,000 to upwards of 10,000,[4] and some believe populations need to be much larger than 10,000.

It is important to have **real-time analytical resources** and population-based management tools, like **patient disease registries** so that patients most likely to need to care are identified and potentially-avoidable acute care averted. Health plans contracting may often offer providers reports, case management support, data file sharing, consultation, and in some cases, share patient disease registries.

Like with many alternative payment models, it is helpful for providers to have undergone a process of **care redesign** prior to implementing a population-based payment method to ensure that care across the continuum is evidence-based and coordinated. While this is a very important tool for success, it will be important in health plan negotiations to understand how much cost savings may have already occurred as the result of care redesign so that budgets can be set appropriately, without penalizing providers for having already gained efficiencies.