CATALYST FOR PAYMENT REFORM

Implementing Global Payment

Action Brief

WHAT IS GLOBAL PAYMENT?

A global payment is a comprehensive payment to a group of providers that is intended to account for most or all of the expected cost of care for a group of patients for a defined time period. While generally synonymous with the term "capitation," advocates of the concept use the term "global payment" to distinguish its design and application from early capitation models under which some providers suffered financial losses.

WHAT PROBLEM DOES GLOBAL PAYMENT TRY TO SOLVE?

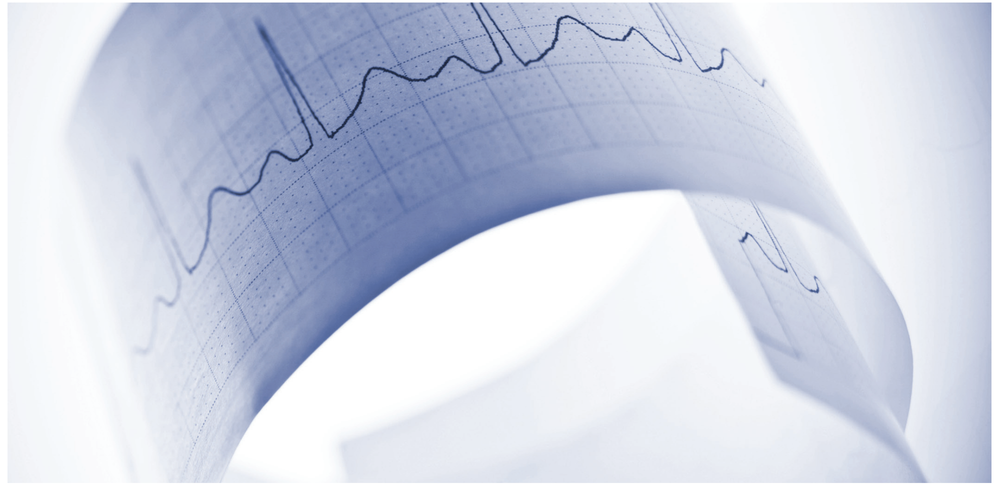
Global payment seeks to address the many adverse consequences of the current predominantly fee-for-service (FFS) payment.

Global payment removes the economic incentive for providers to deliver more services, or more expensive services. By giving a contracted provider entity a budget, it creates the incentive to invest in lower cost services such as primary care, to direct care provision to lower cost and higher quality settings, and to coordinate care delivery to prevent avoidable acute and costly service needs for patients with chronic conditions such as heart disease and diabetes.

WEAKNESSES OF FFS

While fee-for-service payment promotes access to services, and protects to some degree against undertreatment, it has significant weaknesses that make it a prime target for reform. Fee-for-service…

- is inherently inflationary. It creates a strong financial incentive to deliver more care.
- creates a financial incentive to deliver *more costly* care, even if the services are of no or marginal benefit to the patient.
- does not create incentives for, or reward, superior care delivery or outcomes, nor does it incent or reward efficient resource use or care coordination across providers or settings.
- has produced shortages of certain services, including primary care, by offering much greater financial rewards for interventional specialty services (e.g., surgery, imaging, testing) than for non-interventional, primarily cognitive services



Global payments are generally made to provider entities with the financial and operational wherewithal to assume responsibility for managing the health of a population of patients. The entity, if large, can assume clinical and financial responsibility itself, or alternatively, can choose to contract with other providers

HOW DOES GLOBAL PAYMENT WORK?

There are a variety of applications of global payment. Most adjust payments for the clinical risk of the covered population, removing a possible economic incentive to serve only healthy patients.

Global payment terms tie payment in some fashion to performance on access, consumer experience and/or clinical quality measures. Linkages to quality measures include bonus arrangements and making the percentage of earned savings contingent on the level of quality.

Global payment arrangements often require that the provider entity be reinsured and/or purchase "stop loss" insurance in the event that it faces an adverse financial situation. The insurer can offer the reinsurance or it can be purchased by the provider from another reinsurer.

Global payment arrangements vary in the degree of risk held by the provider. Some of the most common arrangements are described below.

FULL RISK Full-risk global payment entails a complete or nearly complete transfer of financial or performance risk from the payer to the provider entity. The payer in most cases is an insurer contracting on behalf of fully insured groups, but could also be an insurer or TPA doing so for self-insured groups. A provider entity assuming full risk typically must be licensed pursuant to state law to satisfy solvency tests. California and Minnesota are two states that have created specific licensing requirements for such provider entities.[1]

FULL RISK WITH RISK CORRIDORS Many payer-provider arrangements choose not to transfer full risk to the provider entity because of a desire to keep the provider from becoming subject to state regulation as a risk-bearing entity, and because of a desire to protect the provider from excessive adverse financial risk.

Risk corridors are usually, but not always symmetrical. For example, the provider entity could be at risk for plus and minus 5% of the value of the global payment, with the payer assuming responsibility for any savings or excessive spending outside of the corridor.

PARTIAL RISK A partial-risk global payment places the provider entity at risk for only a portion of the covered services. The balance of the services can be subject to a shared-savings arrangement, whereby the provider entity is able to share savings if expenditures and (typically) quality are superior to a benchmark, but have no financial risk if they do not. The non-risk services can, alternatively, lie completely outside of any risk arrangement between the payer and provider.

The risk-assuming entity can take many organizational forms, including but not limited to:

- a medical group (primary care or multi-specialty);
- an independent physician association (IPA); and,
- an integrated delivery system comprised of doctors, a hospital(s) and potentially other service providers.

There are a number of examples of global payment strategies that have been successfully implemented.

Most formal evaluation of capitation/global payment was performed in the late 1980s and early 1990s and did not distinguish payment strategy from delivery system design. Some of the research indicated that global payment resulted in lower inpatient utilization than among patients cared for by providers with a comparable quality of outpatient care but who were reimbursed fee-for-service.[23] However, providers reimbursed by global payment sometimes believed their ability to provide high-quality care was diminished.[4]

HAS GLOBAL PAYMENT BEEN TRIED BEFORE?

- **CMS (Medicare)** is conducting a five-year demonstration with 10 physician groups. By year 3:
    - all 10 had improved quality scores; scores improved by 6-11% on each of four of the five assessed conditions; and,
    - 5 had reduced spending by 2% or more relative to non-participating practices.[5]

(Note: the participating physician groups in the CMS demonstration are large organizations that are *not* representative of physician organizations in the U.S.)

- **Blue Cross Blue Shield of Massachusetts** has implemented global payment arrangements with nine provider groups, representing 25% of network physicians. An evaluation of first-year experience for 2009 revealed:
    - every group met its budget in 2009;
    - all groups significantly improved quality, including those who were already comparatively high performers; and,
    - quality improvement in the AQC medical groups occurred at a faster pace than among those not participating.[6]
- **The California Public Employees' Retirement System (CalPERS)** contracted for 2010 on an insured basis with Blue Shield of CA to offer a limited-network HMO comprised of a large physician group and a multi-hospital system, with a promise of no cost increase, and an insurer/ provider target of a $32PMPM *cost decrease*. The insurer and two provider groups agreed to accept the global payment risk jointly, and to share in any savings. Over 41,000 employees and dependents enrolled and, as of July 2010, costs had decreased $31PMPM.

There are many challenges and potential problems that the application of global payment could produce.

WHAT PROBLEMS COULD GLOBAL PAYMENT PRODUCE?

- When providers organize into large corporate entities to accept global payment and manage risk, this could further consolidate the provider marketplace and increase pressure on price, perhaps offsetting the incentive global payments produce for improved efficiency.[7]
- Despite a recent flurry of hospitals acquiring practices, and small practices joining groups, most American physicians continue to operate in small practices and independently are unable to contract under global payment terms.
- Providers accepting global payments will seek to constrain patient choice of provider to maximize their ability to manage to their global payment budget. Consumers have consistently demonstrated an aversion to such a constraint.
- Even if provider networks are not limited, consumers may be distrustful if they know that their providers are managing within a budget.
- Providers may avoid serving expensive patients if payments are not adequately risk-adjusted.
- There can be complexities to consider with the use of global payment with self-insured employers. Health care providers may be unable to bear full risk or to find financing instruments (stop-loss or reinsurance) to help them bear risk.
- State insurance agencies may view providers who bear financial risk from self-insured employers as engaging in the business of insurance, and regulate them as such (e.g., require them to hold financial reserves).

Advocates of global payment distinguish it from early capitation arrangements in the following fashion:

- payments are linked to measures of access and quality, protecting against incentives to underserve;
- risk-adjustment models are far improved from what existed 20 years ago;
- provider organizations have much better health information technology than they did, allowing them to target and monitor their efforts to improve quality and reduce cost;
- some states have created robust regulatory systems to protect against excessive risk assumption by provider organizations; and,
- years of experience with capitated payment in specific markets in the U.S. has produced a pool of organizations and individuals with expertise in how to administer such programs from both the provider and payer positions.

Global payment holds significant promise for contributing to arresting the growth of health care costs.

What steps can a purchaser take?

- ENCOURAGE your insurer or TPA to enter global payment arrangements that have the following characteristics:
  - make provider financial success contingent, in part, on performance on access and quality measures to protect against an incentive to undertreat;
  - protect providers against catastrophic financial loss through risk-adjustment of payment and other means;
  - support broad network products (if desired by the employer in response to a consumer preference for broad choice of provider); and,
  - allow for participation by self-insured employers.
- SUPPORT employer coalition and insurer efforts to obtain state support for anti-trust protection and other means to ensure competitive health care markets, since provider consolidation to contract on a global risk basis may result in monopoly pricing.
- CONSIDER offering an HMO with a network of a provider entity(ies) receiving global payment as an employee option, as such a network will have significant capability to influence cost and quality, as evidenced by the CalPERS experience in 2010.
- ANTICIPATE a multi-year transition, and encourage state government and insurers to jointly monitor the development, implementation and operation of ACOs to identify opportunities for improvement and unanticipated consequences

1. California SB 260 regulations can be found at www.hmohelp.ca.gov/aboutthedmhc/hpp/reporting/gen_reporting.aspx. See also Minnesota Integrated Services Network Act, Minn. Stat. Ann. sec. 62N.309.
2. Hillman AL, Pauly MV and Kerstein JJ. “How do financial incentives affect physicians’ clinical decisions and the financial performance of health maintenance organizations?” *New England Journal of Medicine*, 1989; 321:86-92.
3. Udavarhelyi IS, Jennison K, Phillips RS, Epstein AM. “Comparison of the Quality of Ambulatory Care for Fee-for-Service and Prepaid Patients” *Annals of Internal Medicine*, September 1, 1991 vol. 115 no. 5 394-400.
4. Reschovsky JD, Hadley J and Landon BE. “Effects of Compensation Methods and Physician Group Structure on Physicians’ Perceived Incentives to Alter Services to Patients” *Health Services Research*, 2006, Volume 41 Issue 4p1, Pages 1200 – 1220.
5. www.cms.gov/apps/media/press/release.asp?Counter=3495&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date
6. Personal communication with Deborah Devaux, BCBSMA.
7. Abbleby J. “As more hospital systems consolidate, experts say health-care prices will jump” *Kaiser Health News*, September 25, 2010.