catalyst FOR PAYMENT REFORM

Action Brief
Implementing Global Payment

WHAT IS GLOBAL PAYMENT?

A global payment is a comprehensive payment to a group of providers intended to account for most or all of the expected cost of care for a group of patients for a defined time period. While "global payment" is 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 and patients may have suffered from a lack of focus on quality.

WHAT PROBLEMS DOES GLOBAL PAYMENT TRY TO SOLVE?

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

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 provisions 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 a 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 delivery *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, primary cognitive services.

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 case it faces an adverse financial situation. The insurer can offer the reinsurance or it can be purchased by the provider from another reinsurer.

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.

GLOBAL PAYMENT ARRANGEMENTS VARY IN THE DEGREE OF RISK HELD BY THE PROVIDER.

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 third-party administrator doing so for self-insured customers. A provider entity assuming full risk typically must be licensed pursuant to state law to satisfy a solvency test. California and Minnesota are two states that have created specific licensing requirements for 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 financial risk.

Risk corridors are usually, but not always, symmetrical. For example, the provider entity could be at risk for plus and minus five percent 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.

EXAMPLES OF GLOBAL PAYMENT STRATEGIES THAT HAVE BEEN IMPLEMENTED SUCCESSFULLY

- **In collaboration with CMS (Medicare),** Maryland initiated an all-payer, global budget program for hospitals in 2014. The program included 36 hospitals, 10 of which were in rural areas. After the pilot's first 2 years of operation, there were mixed results:[5]
    - Total expenditures and total hospital expenditures decreased for Medicare. beneficiaries, without redistributing costs to other areas of the health care system.
    - Inpatient hospital admissions declined but led to no direct savings.
    - Hospitals reduced unnecessary utilization among Medicare beneficiaries.
    - Global budget operations have not led to any adverse effects for financial status of participating hospitals.
    - Evaluations of the program are largely mixed because hospitals have widely varied in their adaptation of the model.
    - As of 2018, CMS and Maryland have contracted to extend the pilot through 2023. The expansion will include additional care settings within the all-payer, global budget model.

- **Blue Cross Blue Shield of Massachusetts** implemented a global payment arrangement and has expanded the program's reach to include 90% of network physicians and hospitals. As of 2014, the BCBS of MA Alternative Quality Contract (AQC) had improved the quality of patient care and lowered costs

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

- 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 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.

- In the pilot's first year, the AQC saved approximately two percent compared to the control group.
- After year four, savings were up to 10 percent.
- The majority of savings were concentrated in outpatient care, best explained by reduced utilization and emphasizing lower cost care delivery.[6] Starting in 2015, the ACQ placed greater priority on quality measures evaluating both patient-reported outcomes and clinical data.

- **The California Public Employee's Retirement System (CalPERS)** contracted with Blue Shield of CA, Dignity Health, and Hill Physicians Medical Group in the greater Sacramento Area in 2010 to launch a pilot Accountable Care Organization (ACO) program supported by global payment for 41,000 members.[7] The pilot aimed to deliver cost savings to CalPERS by reducing the growth in health care costs to 0 percent in the first year, to grow membership, to maintain or improve quality of health care, and to create a model sustainable for geographic expansion.
  - After the first year, the pilot saw positive results - savings were $15.5 million; per member costs were 10 percent lower than for members not in the pilot; inpatient hospital days decreased 12.1 percent; average length-of-stay decreased by 15 percent and hospital readmissions decreased by 15 percent.
  - The second year continued to show positive results; pilot savings totaled $37 million for CalPERS and readmission and length-of-stay rates continued to decline.
  - Based on these positive results, Blue Shield of CA extended global budgets to at least eight ACOs, covering 130,000 members in CA.

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 who were paid fee-for-service.[2,3] However, providers reimbursed by global payment sometimes believed their ability to provide high-quality care was diminished.[4]

CHALLENGES AND POTENTIAL PROBLEMS THAT THE APPLICATION OF GLOBAL PAYMENT COULD PRODUCE

WHAT PROBLEMS DOES GLOBAL PAYMENT PRODUCE?

- When providers organize into large corporate entities to accept global payment and manage risk, it can further consolidate the provider marketplace and increase pressure on price, perhaps offsetting the incentive global payments produce for

improved efficiency.[8]

- Despite a recent flurry of hospitals acquiring practices, and small practices joining larger physician groups, nearly 70% of American physicians continue to operate in small practices or independently and are thus unable to contract under global payment terms.[9]
- Providers accepting global payments will seek to constrain patient choice of providers to maximize their ability to manage their global payment budget. A narrow network benefit design can be paired well with a global payment strategy. Consumers have historically had an aversion to such constraint, though this is changing as they look for more affordable health care options and as purchasers use best practices to communicate high-value health plan options to their members.
- 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).

WHAT STEPS CAN A PURCHASER TAKE?

- ENCOURAGE your insurer or TPA to enter global payment arrangements that:
  - 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;
  - Allow for participation by self-insured employers.
- CONSIDER offering an HMO with a network of provider entity(ies) receiving global payment as an employee health benefits plan option, as such a network will have significant capability to influence cost and quality. Be sure to evaluate the quality of providers before implementing such a program.
- DESIGN benefits so that employees have incentives to utilize in-network providers, though consider whether any particular frequent, high-cost or complex services would be better delivered by providers outside of the network. If so, support these with appropriate provider network and benefit designs.
- 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.

ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

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