Health Cost Containment and Efficiencies
NCSL Briefs for State Legislators
No. 2 May 2010

Global Payments to Health Providers

Cost Containment Strategy and Logic

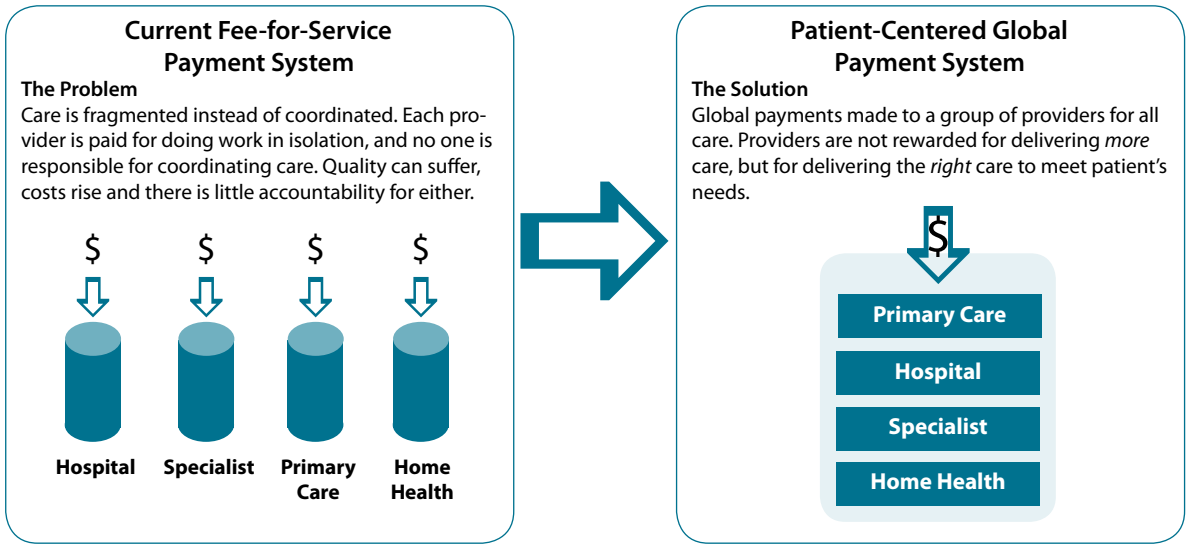
A global payment—a fixed prepayment made to a group of providers or a health care system (as opposed to a health care plan)—covers most or all of a patient's care during a specified time period. Global payments are usually paid monthly per patient over a year, unlike fee-for service, which pays separately for each service (Figure 1). In most cases, a global payment encompasses physician and hospital services, diagnostic tests, prescription drugs and often other services, such as hospice and home health care. Under a global fee arrangement, a large multispecialty physician practice or hospital-physician system receives a global payment from a payer (e.g., health plan, Medicare or Medicaid) for a group of enrollees. It is then responsible for ensuring that enrollees receive all required health services. Global payments usually are adjusted to reflect the health status of the group on whose behalf the payments are made. Entities that receive global payments sometimes are known as accountable care organizations (discussed in a separate brief) and can include both formally and loosely organized health care systems. Global payment provides an incentive for providers to coordinate and deliver care efficiently and effectively to hold down expenses.

Where providers are organized and have the data and systems to manage global payments, research indicates such payments can lower costs without affecting quality or access.

Some similarities exist between global and episode-of-care payments (discussed in a separate brief). In both cases, payment is bundled instead of made separately for each service. The major difference is that global payments are made on behalf of a group of patients (e.g., enrollees in a health plan) and cover all care for all conditions covered by the health plan. Episode-based payments cover an episode of illness or medical condition, such as a heart attack, hip replacement or diabetes.

The term global payment includes capitation, most frequently used to pay health maintenance organizations (HMOs) on a per-member, per-month basis for all care covered by the HMO plan. Some important differences exist between the current concept of global payments and traditional capitation, however. Today's global payments include incentives for patient access and quality improvement. They also include better ways to adjust payment for the overall health and specific chronic conditions (i.e., risk level) of patients covered by global payments. Further, they use more sophisticated, often electronic, systems to manage care.

Figure 1. Fee-for-Service versus Global Payment Incentives



Source: Massachusetts Special Commission on the Health Care Payment System, "Recommendations of the Special Commission on the Health Care Payment System," PowerPoint (Boston: SPHCP, July 16, 2009).

Global payments also are known as risk-adjusted capitation and bundled global payments.

Health economists and others are increasingly promoting global payments as an important strategy to slow growth of health care expenditures. A 2008 *New England Journal of Medicine* article examining health care cost control options concluded, "The most potent version of payment reform is budget-based capitation, or a global payment to cover all health care needs of a population of patients."[1]

Target of Cost Containment

Global payments are designed to:

- promote cost-effective prevention and early intervention;
- eliminate services of questionable value;
- reduce excess health care system capacity; and
- reverse the current incentive providers have under fee-for-service to provide more services to earn a higher income.

These goals are accomplished by holding multiple providers in multiple settings jointly accountable for the total cost of care through shared payments. In the current payment system, no incentive exists for providers to hold down total costs. With global payments, providers have greater net income when they hold down costs for their shared fixed global payments. They also have an incentive to maintain or improve a patient's health, prevent hospital admissions and coordinate care; their net income will be higher if they can lower care costs for a fixed payment. Global payments encourage formation of organized provider systems that can accept global payments and provide comprehensive care.

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Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, requires the secretary of Health and Human Services to establish the Medical Global Payment System Demonstration Project in up to five states, effective 2010 (section 2705). Under the project, participating states must use global capitation rather than fee-for-service to pay large safety net hospital systems. The pilot program period is FY 2010 through FY 2012. The act also authorizes tests of innovative Medicare and Medicaid payment and service delivery models "to reduce program expenditures while preserving or enhancing patient quality of care, effective Jan. 1, 2011" (section 3021). The secretary can select several models for testing, including direct contracting with groups of providers using "risk-based comprehensive payments" (i.e., global payments).

State Examples

- A 2008 Massachusetts law required creation of a Special Commission on the Health Care Payment System.[2] In July 2009, the commission recommended that all payers—both public and private—move to a system of global payments for providers no later than 2014. The Massachusetts Health Care Cost and Quality Council made a similar recommendation in October. In November, the Massachusetts Medicaid Policy Institute proposed testing global Medicaid payments "with a defined set of providers that includes high-volume Medicaid providers and providers currently participating in a global fee initiative with a commercial insurer."[3]

- In 2009, Maine passed "An Act to Protect Consumers and Small Business Owners from Rising Health Care Costs."[4] The act directed the Advisory Council on Health Systems Development to recommend payment reforms. A November 2009 draft of the council's report to the Legislature recommends pursuing several strategies, given the diversity of Maine's delivery system and needs, and highlights global payments as a key payment reform strategy.[5]

- Many states have Programs for All-Inclusive Care for the Elderly (PACE). These programs are paid a capitated rate to provide total care for frail patients who are eligible for both Medicare and Medicaid. Patients must have a disability and be eligible for nursing home care. PACE provider organizations are responsible for coordinating a wide range of services, including comprehensive primary medical care, prescription drugs, adult day care, meals and nutritional counseling, home health care, and hospital and nursing home care. According to the Centers for Medicare and Medicaid Services, 30 states have one or more PACE sites.[6]

- Several states require that, if a group of providers accepts risk (i.e., global payments) to ensure that a population of patients obtains all or most of their required care over a defined period of time, the group must be licensed. This is especially true for provider-sponsored organizations that accept capitation. A 1997 study found some states require HMO licensure if the organization, rather than an insurance plan, is the ultimate bearer of risk or assumes risk beyond that which its providers are themselves licensed to provide (e.g., California, Illinois and Pennsylvania).[7] Others require a special license or certificate (e.g., a limited service license in Colorado, a nonprofit health corporation license in Texas, and a community integrated service network license in Minnesota).

Non-State Examples

- Patient Choice is a program for self-funded employers in Minnesota, North Dakota and South Dakota. Created by Buyers Health Care Action Group in 1988, it currently is operated by Medica, a large HMO. The Patient Choice Care System Program works with groups of providers (including both hospitals and physicians) called care systems. Care systems submit bids based on the expected total (global) cost of care for a defined population of patients with the same health plan benefits. Reimbursement rates are driven by performance on quality measures and total care costs—also called "virtual capitation" or "capitation in drag."[8] Care systems' incentive to hold down

costs is competition for consumers who select among competing care systems based on total price and market share. Consumers pay the difference in the bid price if they select a care system in a higher cost tier.

■ Blue Cross Blue Shield of Massachusetts offers providers an Alternative Quality Contract. Under this voluntary contract, providers can accept a condition-adjusted, fixed annual payment for each Blue Cross Blue Shield patient. The payment, which covers all care delivered by the provider, also includes incentives for quality, effectiveness and patient satisfaction.

■ Some programs use partial capitation or partial global payments, for instance for primary care. One example is a pilot program of the Massachusetts Coalition for Primary Care Reform, a nonprofit organization comprised of health policy experts, leading primary care practices, payers, patient advocacy groups and government. Under the program, each participating primary care medical home practice[9] receives a global fee for all primary care services for each patient. Although the fee does not include hospitalization, lab tests or other services, participating practices are eligible for performance-based incentives based in part on reduced use of those services. Cost targets for the incentives include less use of high-cost imaging procedures; pharmacy use; and ambulatory-sensitive emergency room visits, admissions and readmissions. Thus, although they receive a global payment for primary care services only, practices have an incentive to hold down total patient care costs.

Evidence of Effectiveness

Research indicates global payments can result in lower costs without affecting quality or access. Existing evidence comes from experience with traditional capitation, which is a form of global payment.

■ Several studies have shown that fully integrated health care systems that provide the full range of health care services and directly employ most or all their physicians have significantly lower spending and use through capitated managed care.[10] Examples of integrated health care systems are Cleveland Clinic in Ohio and Kaiser Permanente, based in California and operating in Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington and the District of Columbia.

■ A 2004 report prepared by The Lewin Group reviewed 14 studies of savings achieved from Medicaid managed care programs using capitated payments.[11] It found clear evidence of cost savings, mainly from less use of inpatient services. Savings ranged from 2 percent to 19 percent compared to fee-for-service. Michigan's capitated, managed care program savings were 9 percent in 2001, 14 percent in 2002, 16 percent in 2003 and 19 percent in 2004. Kentucky's Region 3 Partnership program savings were 2.8 percent in FY 1999, 5.4 percent in FY 2000, 9.5 percent in FY 2001, 9.5 percent in FY 2002 and 4.1 percent in FY 2003. In FY 2002, inpatient costs decreased by 27 percent under Ohio's Medicaid managed care program, Premier Care. Many state Medicaid programs in the Lewin report used a global capitation fee that covered physical but not behavioral or long-term care services. Programs often excluded special populations such as people with disabilities. Based on evidence from the states that included some or all special populations and other types of care in their capitated contracts, Lewin concluded, "Real opportunities exist for states to benefit from expanding the Medicaid managed care model to eligibility categories and services heretofore largely excluded from managed care."

■ Mathematica Inc., a policy research firm, conducted a comprehensive review of the evidence and found that "Payment approaches involving risk-sharing with providers—including global payment or capitation—are associated with lower service use and cost, compared with fee-for-service arrangements."[12] A 2008 article in *The New England Journal of Medicine* reported, "Experiments with capitation in commercially insured populations demonstrate reductions in cost."[13]

■ Experience with Patient Choice (described previously) indicates the program "... has encouraged patients to select more cost-effective providers and has spurred providers to reduce their costs while maintaining or improving quality to attract more consumers."[14] Reimbursement rates under Patient Choice, which are driven in part by the total cost of care (although not the only factor accounting for these findings), appear to be a significant contributor.

■ Not all researchers agree that the evidence shows clear cost savings from capitation. Some find the evidence inconclusive and have noted some problems provider-sponsored organizations have problems sufficiently integrating care among physicians, hospitals and other health professionals to control costs.[15] Others have found that, although capitation may lower cost growth, it is difficult to maintain the effectiveness.[16]

Challenges

A number of challenges are involved in implementing global payments on a broader scale than traditional managed care capitation arrangements. The types of care covered by a global payment must be clearly defined. The patient population must be stable because, as one payment reform expert notes, "If you don't have them long enough, you can't effectively manage and hold down the cost of care."[17] Risk adjustment is an important factor in ensuring global payments are high enough to manage the level of risk assumed by providers. However, risk-adjustment methodologies are imperfect and must be continually refined. Most providers are not organized to accept global fees. Where a global payment is made to loosely—rather than formally—integrated networks of providers, a system must be developed to handle receipts and payments (e.g., the local independent practice association or the hospital). States may want to regulate which entities can accept global payments and the types of clinical and/or insurance risks global payments can include.

Complementary Strategies

Global payments often are used with other methods of payment and health care programs. Examples include performance-based pay, medical homes and accountable care organizations. Using global payments in conjunction with these payment and program strategies (see other briefs in this series), may offer a greater level of cost containment than could be achieved by implementing a single strategy.

For More Information

Heit, Mark, and Kip Piper. *Global Payments to Improve Quality and Efficiency in Medicaid: Concepts and Consideration*. Boston: Massachusetts Medicaid Policy Institute, November 2009; http://www.massmedicaid.org/~/media/MMPI/Files/20091116_GlobalPayments.pdf.

Massachusetts Special Commission on the Health Care Payment System. *Recommendations of the Special Commission on the Health Care Payment System*. Boston: SPHCPS, July 16, 2009; http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf.

Mathematica Inc. *Summary: Global Payments*. Princeton, N.J.: Mathematica, May 2, 2009; http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_02_13_Global_Payment-C2.pdf

NCSL has posted supplemental materials and 2010 updates on this topic online at http://www.ncsl.org/?tabid=19931.

Notes

1. James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, "Options for Slowing the Growth of Health Care Costs," *New England Journal of Medicine* 358, no.14 (April 3, 2008); http://content.nejm.org/cgi/content/full/358/14/1509?ijkey=Vxj69c62UL9ec&keytype=ref&siteid=nejm.

2. 2008 Mass. Acts, Chap. 305.

3. Mark Heit and Kip Piper, *Global Payments to Improve Quality and Efficiency in Medicaid: Concepts and Consideration* (Boston: Massachusetts Medicaid Policy Institute, November 2009) 3; http://www.massmedicaid.org/~/media/MMPI/Files/20091116_GlobalPayments.pdf.

4. 2009 Me, Laws, Chap. 350 (Laws of Maine).

5. Advisory Council on Health Systems Development, "Proposed Report to Legislature to Advance Payment Reform in Maine," draft (Augusta, Maine: Governor's Office of Health Policy and Finance, Nov. 19, 2009); http://www.mainemed.com/spotlight/2009/Advance_Payment_Reform_in_Maine_Proposed_Report.pdf.

6. The states are Arkansas, California, Colorado, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington and Wisconsin.

7. The Lewin Group Inc., *State Regulatory Experience with Provider-Sponsored Organizations* (Falls Church, Va.: TLG, June 27, 1997); http://aspe.hhs.gov/health/pso-6.htm.

8. Ann Robinow, "Patient Choice Health Care Payment Model," PowerPoint presentation, Network for Regional Healthcare Improvement Payment Reform Summit, July 31, 2008, slide 3; http://www.nrhi.org/downloads/RobinowPresentation2008NRHISummit.pdf.

9. Medical homes are discussed in another brief in this series.

10. F.J. Hellinger, "The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence," *Medical Care Research and Review* 53, no. 3 (1996).

11. The Lewin Group Inc., *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies* (Falls Church, Va.: TLG, July 2004); http://www.ahipresearch.org/pdfs/MedicaidCostSavings.pdf.

12. Mathematica Inc., *Summary: Global Payments* (Princeton, N.J.: Mathematica, May 2, 2009); http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_02_13_Global_Payment-C2.pdf.

13. James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, "Options for Slowing the Growth of Health Care Costs."

14. Harold D. Miller, "From Volume to Value: Better Ways to Pay for Health Care, *Health Affairs* 28, no. 5 (Sept. Oct. 2009); http://content.healthaffairs.org/cgi/content/full/28/5/1418.

15. Massachusetts Special Commission on the Health Care Payment System, "Overview of Global Payments: Presentation by Deborah Chollet" (Boston: SCHCPS minutes, March 13, 2009); http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_03_13_minutes.pdf.

16. Michael Chernew, "Health Care Cost Containment Incentives and Value-Based Insurance Design," PowerPoint presentation, Cost Management Meeting, The Heller School for Social Policy and Management, Jan. 18, 2008; http://heller.brandeis.edu/costmanagement/meeting-material/011808/Chernew_Presentation.pdf.

17. Personal email correspondence by Barbara Yondorf with Donna Marshall, executive director, Colorado Business Group on Health, March 1, 2010.

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

NCSL gratefully acknowledges the financial support for this publication series from The Colorado Health Foundation and Rose Community Foundation of Denver, Colorado.

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