

Transitioning to Comprehensive Care Payment

One option for improving healthcare quality and controlling costs is to use some form of population-based payment instead of Fee-for-Service payments. There are a variety of different names for this – “Comprehensive Care Payment,” “Condition-Adjusted Capitation,” or “Risk-Adjusted Global Fee” – but the core element is paying a single price for all of the healthcare services needed by a specific group of people for a fixed period of time (e.g., all of the care needed during the course of a year by the people who work for a particular employer or by a group of people who have chronic diseases). The goal of a Comprehensive Care Payment is to encourage the healthcare provider receiving it to keep patients well and out of the hospital (i.e., to reduce the number of episodes of care they need) as well as to avoid providing unnecessary services within any particular episode of care. Moreover, Comprehensive Care Payment gives healthcare providers the flexibility to decide what services should be delivered and the upfront resources to deliver them, rather than being constrained by fee codes and amounts, or waiting for uncertain, after-the-fact shared savings payments to be made.

(For more information on different healthcare payment methods, see *Better Ways to Pay for Health Care: A Primer on Healthcare Payment Reform*.)

However, since Comprehensive Care Payment represents a dramatic change in the way most healthcare providers are paid, it is unclear how many providers could manage under such a payment system. Also, since any type of population-based payment method sounds to many people like the capitation payment systems that caused so many problems during the 1990s, there are concerns about whether a Comprehensive Care Payment system can work successfully without causing financial difficulties for providers and resistance from patients.

Fixing What Was Wrong With Traditional Capitation

Details matter, and a good Comprehensive Care Payment system should be structured to avoid the problems that traditional capitation systems experienced. In particular:

- **The amount of the payment must be adjusted based on the types of conditions, severity of conditions, and other characteristics of the patients being cared for.** Traditional capitation systems paid a provider a fixed amount per patient, regardless of how sick or well the patients were, which penalized providers for treating sicker patients.
- **Payments need to be set at adequate levels to provide good-quality care.** In traditional capitation systems, payments were often arbitrarily set at levels far below the average cost of care experienced prior to institution of the capitation system, or were not increased adequately over time to reflect inflation.
- **Special provisions are needed for unusually high-cost cases**, such as outlier payments, reinsurance, etc., to avoid having a few expensive cases cause financial problems for providers who are doing a good job of managing typical cases.
- **Providers should not be required to establish claims-payment systems.** A provider contracting for a Comprehensive Care Payment should be expected to manage the total cost and quality of care, not necessarily to directly pay other providers delivering care. The payer can still process claims from other providers using its existing claims-processing system, essentially treating the Comprehensive Care Payment as a debit account.
- **Providers should be expected to collect and publicly report measures of quality of care**, in order to assure both patients and payers that there is no inappropriate stinting on care.
- **Patients must be given the flexibility to choose high quality providers, but patients must also be encouraged to use a consistent medical home** to help them manage their health and healthcare services effectively.

There are payment systems in several regions that are making population-based payments in ways that meet many of these criteria. For example, in Minnesota, Medica’s Patient Choice system pays providers the equivalent of a Comprehensive Care Payment by using the standard fee-for-service claims payment system and adjusting fee levels based on the severity-adjusted total cost of care. In Massachusetts, the Alternative Quality Contract offered by Blue Cross Blue Shield of Massachusetts is paying providers a severity-adjusted capitation payment combined with quality incentives.

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Creating Partial Comprehensive Care Payment Options

Many large physician practices and healthcare systems could immediately participate in a Comprehensive Care Payment system. Smaller practices probably would be unable to participate immediately, but could evolve to do so over time. *Partial Comprehensive Care Payment* systems would help them to make this transition. Similar to partial capitation, a healthcare provider would receive the Partial Comprehensive Care Payment to cover the costs of a pre-defined set of services when they were needed by patients, but other services would continue to be paid by the patients' health insurance plan (or Medicare or other payer) on a fee-for-service or other basis. For example, a small physician practice might be able to take responsibility for managing the costs of all outpatient services, but not the costs of hospitalization; a Partial Comprehensive Care Payment could replace fee-for-service payment for all outpatient services, but hospitalizations would continue to be paid directly under the DRG, per diem, or other system currently used by the payer.

Since a Partial Comprehensive Care Payment would give the provider a financial incentive to substitute services that are not covered by the Payment for those which are covered, a pay-for-performance system could be used to maintain some level of financial risk for the provider for the costs of *all* services the patient receives.

For example, two different levels of Partial Comprehensive Care Payment could be defined in addition to (Total) Comprehensive Care Payment, as follows:

Level 1: Practice-Cost Comprehensive Care Payment, with P4P on Outpatient and Inpatient Costs.

A physician practice (or health system) would receive a single (severity-adjusted) payment per patient to cover all of the services provided *within the practice* that would previously have been billed under individual fee codes, e.g., E&M codes, immunizations, etc. Other outpatient services (e.g., lab tests) and inpatient care (hospitalizations) would continue to be paid separately, but the physician practice would receive a pay-for-performance (P4P)-style bonus/penalty payment based on the level of utilization of those services (on a severity-adjusted basis). For example, the Massachusetts Coalition for Primary Care Reform is testing this type of approach in several small primary care practices.

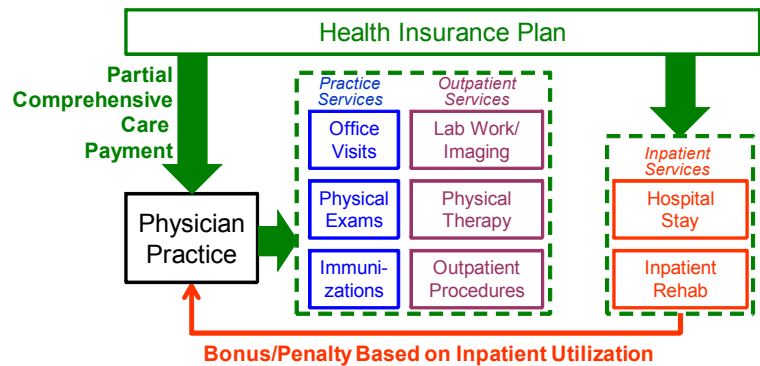
Level 2: Outpatient Comprehensive Care Payment, with P4P on Inpatient Costs. The physician practice or health system would receive a single payment to cover all *outpatient costs*, but inpatient care would still be paid separately. The practice would receive a bonus/penalty payment based on the rate of utilization of inpatient services.

Level 3: (Total) Comprehensive Care Payment. All costs – practice-based, outpatient, and inpatient – would be included in a single payment. The payer could still pay the actual claims, but the physician practice or health system would be responsible for keeping total costs within the Comprehensive Care Payment amount, except for outlier cases. Bonus/penalty payments based on outcomes and quality measures could be included as an incentive to ensure patients receive high-quality care.

Small physician practices and those with no experience in any kind of capitation or risk-based payment could start at Level 1, then move to Level 2, and finally advance to Level 3 at some point in the future. But providers could enter at any level they wished, and many providers would likely choose to enter directly at Level 2 or Level 3.

As part of the transition process, small physician practices could also be encouraged and assisted to join together in virtual organizations that would enable them to better measure and improve their quality and cost performance and share costly care management resources (such as nurse care managers, electronic health records, patient registries, etc.). For example, Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP) encourages small physician practices to form multi-practice organizational structures that focus on quality improvement and enable sharing of quality improvement resources the practices could not individually afford to support.

LEVEL 2: OUTPATIENT COMPREHENSIVE CARE PAYMENT



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