



# HCCI Payment Reform:

## Aligning Clinical and Financial Incentives

# Reimbursement Mechanisms

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- **Fee-for-service** rewards service volume
  - Reduction in inpatient/high cost care results in reduced revenue (no incentives for cost containment)
- **Capitation** rewards efficiency and cost containment
  - Dollars saved through reduction in high cost care can be re-invested in program enhancements (case management, remote monitoring, etc.)

**Note: Neither mechanism explicitly rewards quality!**

# Proposed Program Elements Under Capitation Model

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- Move from episode-based care to panel management
- Case management / navigators for high utilizers
- Remote monitoring for patients with selected chronic conditions
- Group visits
- Health Information Exchange and other IT enhancements

# Capitation Caveats

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- Capitation rates must be risk-adjusted and actuarially sound
  - Sickest patients are referred to public system while healthy patients remain in private sector  
(e.g., nearly all OB patients in LACDHS are high-risk)
- Need to account for patients moving in and out of system
  - Less opportunity to influence utilization and health outcomes with a transient population
- Must ensure that under-use does not become a problem
  - Solution: require quality/outcome measures such as HEDIS

# More Capitation Caveats

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- Best-case scenario is still much less than 100% reimbursement
  - Currently tied to FMAP without any State funds
- Utilization reductions in one population are back-filled by another (usually uninsured)
  - Unmet demand is great