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Payment Systems to Improve Quality, Efficiency, and Care Coordination for Chronically Ill Patients

Experience from six countries (Australia, England, France, Germany, the Netherlands and the United States)

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European Observatory on Health Systems and Policies

Introduction

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- Care for people with chronic conditions is an issue with increasing importance in all industrialized countries

- Countries have been experimenting and working towards care models in response to the fact that chronic diseases can rarely be treated in isolation

- These models try
  - to coordinate and potentially integrate care
  - with the aim of providing higher quality of care
  - while also being efficient

- Challenge: to pay providers in a way that incentivizes these objectives

Basic forms of payment mechanisms and their expected incentives in regard to selected objectives

Payment mechan-ism	Risk selection	Activity		Expenditure control	Technical efficiency	Quality of outcomes
		Number of services/ case	Number of cases			
Fee-for-service	+	++	+	— —	0	0
Salary	0	—	—	+	0	0
Capitation	— — (if not risk-adjusted)	— —	+	+	+	0
Global budget	0	— —	—	+	0	0
DRG based case payment	— (if insufficient consideration of severity and provided services)	— —	++	0	+	— (if compli-cation = comorbidity)

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Salary	0	—	—	+	0	0
Capitation	— — (if not risk-adjusted)	— —	+	+	+	0
Global budget	0	— —	—	+	0	0
DRG based case payment	— (if insufficient consideration of severity and provided services)	— —	++	0	+	— (if compli-cation = comorbidity)

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		Number of services/ case	Number of cases			
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Salary	0	–	–	+	0	0
Capitation	– – (if not risk-adjusted)	– –	+	+	+	0
Global budget	0	– –	–	+	0	0
DRG based case payment	– (if insufficient consideration of severity and provided services)	– –	++	0	+	– (if compli-cation = comorbidity)

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Fee-for-service					0
Salary					0
Capitation					0
Global budget					0
DRG based case payment	… provided services)				– (if compli-cation = comorbidity)

Three observations stand out:

1) all payment mechanisms provide conflicting incentives for "activity" and "expenditure control", with capitation and DRGs best for efficiency;

2) <u>none</u> provide incentives <u>for producing high quality outcomes</u>;

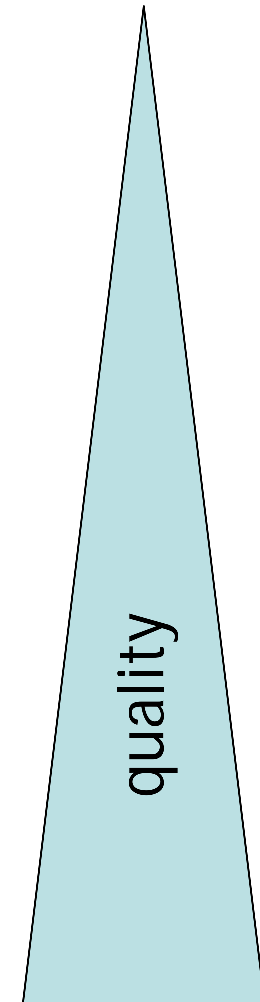
3) <u>none</u> provide incentives <u>for care coordination</u>.

First strategy: Paying for quality of care *(cf. CF Int. Symp. 2010)*

for Structure, e.g. access time, provider's function as a gatekeeper or for including patients in registers

for Processes, i.e. for treating chronically ill according to established practice, e.g. adherence to guidelines

for Outcome of care, i.e. short- or long-term clinical outcomes or patient satisfaction



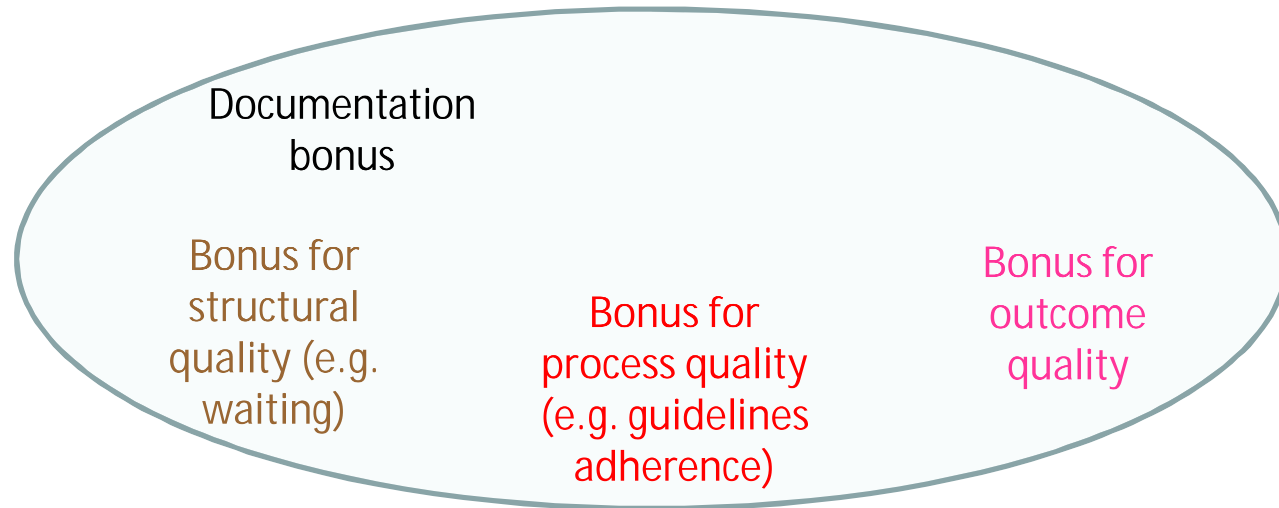
Framework I

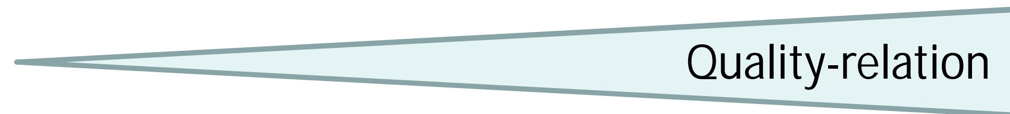
Capitation

or

Case-based

and





Structure Process Outcome

Paying for quality

Financial incentives to (primarily) improve quality of care

... targeting structures of care	... targeting processes of care	... targeting outcomes of care
Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols or providing patient education (FR)	Points for reaching process targets (UK: QOF; FR: CAPI; AUS: PIP)	Points for reaching outcome targets (UK: QOF)
Bonus for DMP / PIP recruitment and documentation (GER; AUS)	P4P (mainly hospitals, US)	P4P (mainly hospitals, US)
Points for reaching structural targets (UK: QOF; FR: CAPI)		

Second Strategy: Paying for care coordination

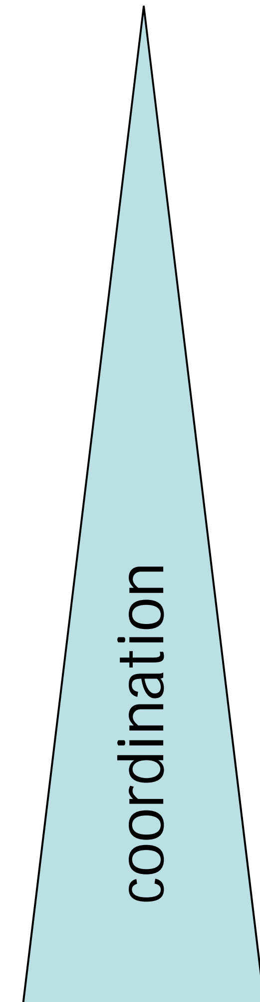
1st level: separate payment for coordination or extra effort

2nd level: bundled payment across services (for one provider but incl. referrals/ prescriptions)

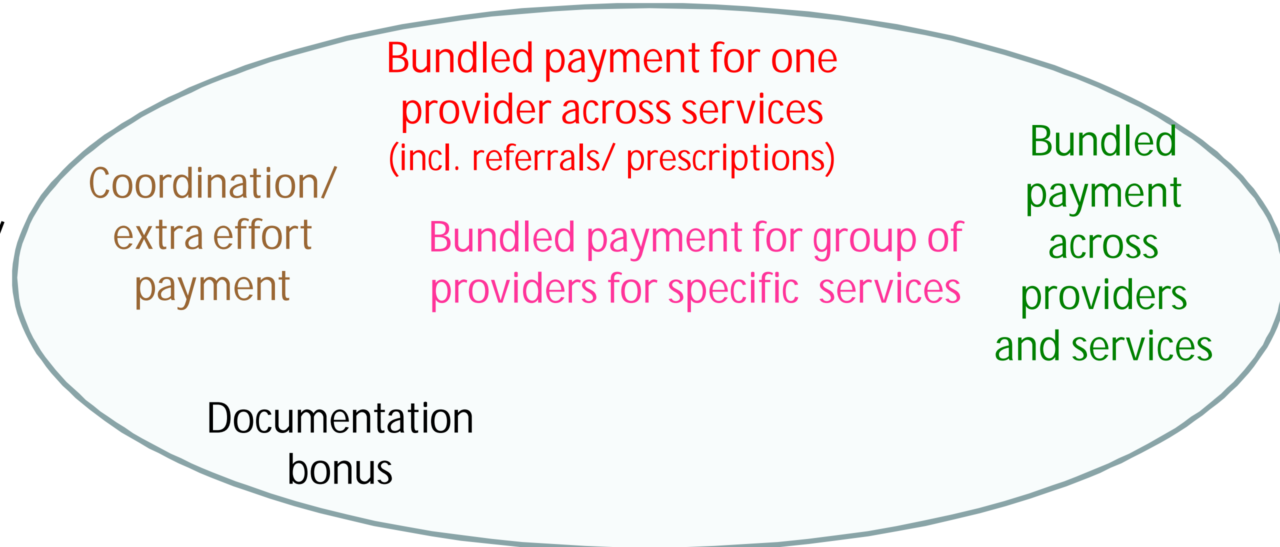
3rd level: bundled payment across providers (but restricted to a set of activities, e.g. only those related to one disease)

4th level: bundled payment across services and providers

Main incentive: be efficient and keep savings!



Framework II



Capitation

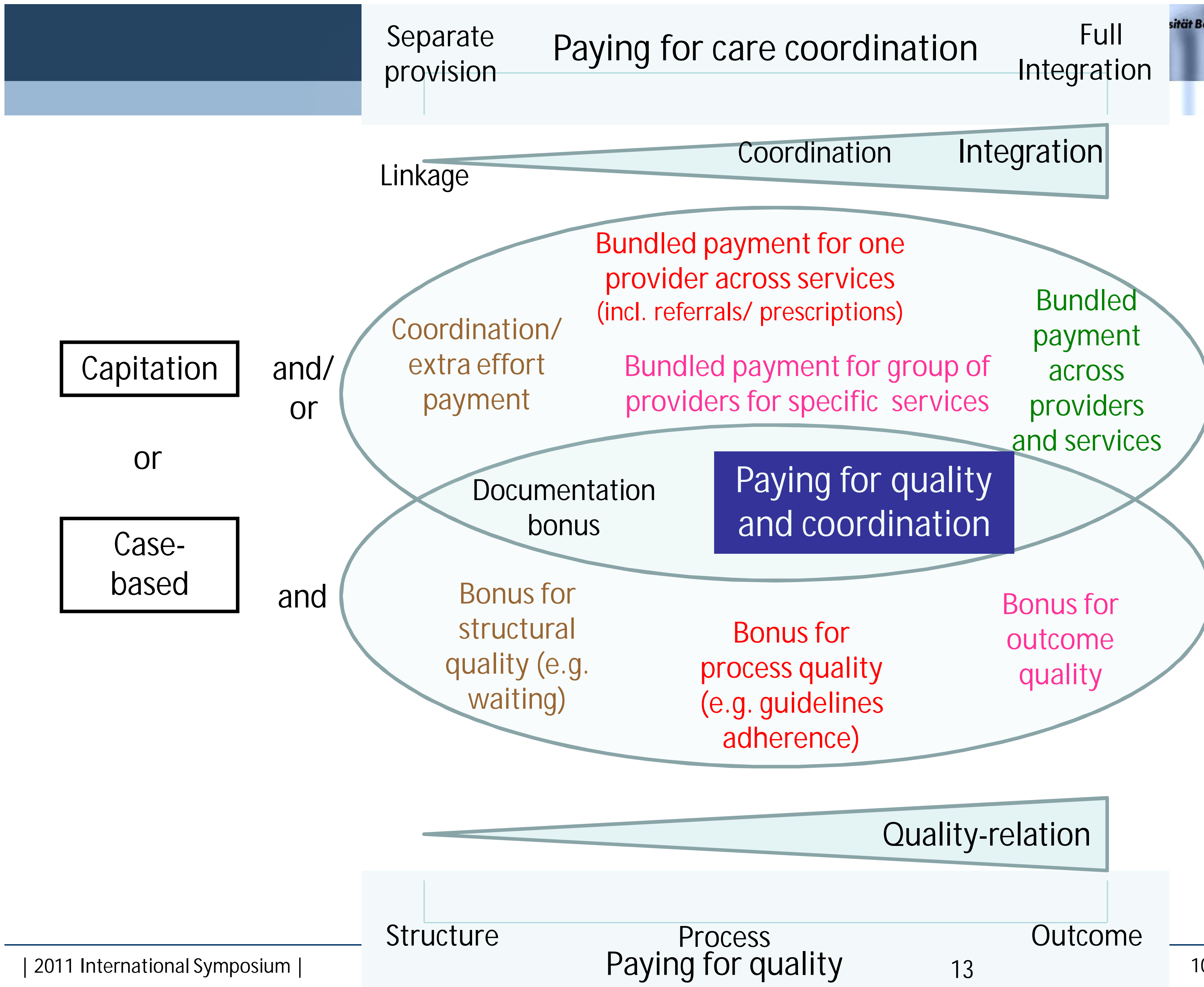
and/ or

or

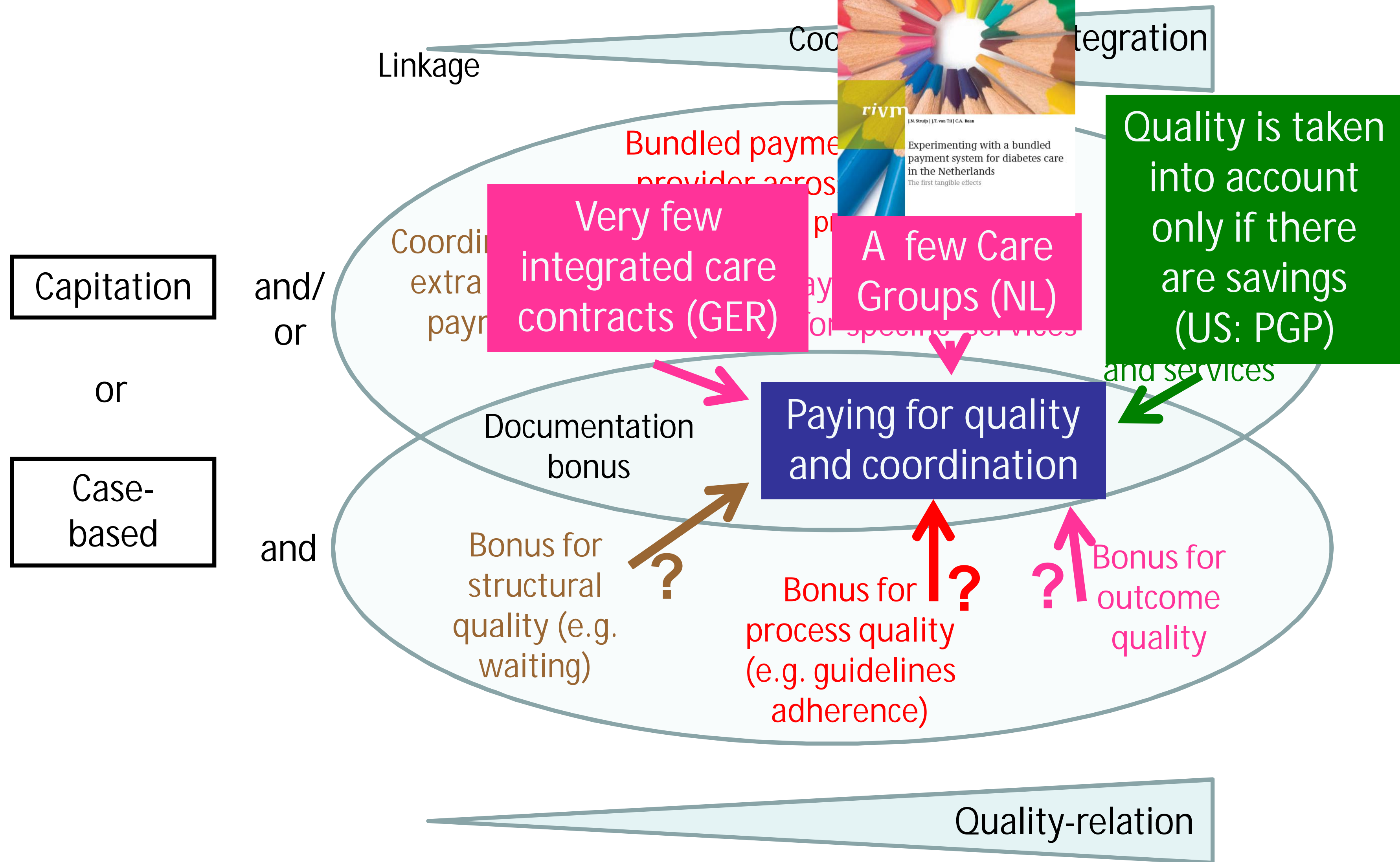
Case-based

Financial incentives used to (primarily) improve care coordination

… for coordination/ extra effort	… for bundling across services	… for bundling across providers	… for bundling across services and providers
"Year of care" payment for the complete package of chronic disease management (UK) or service incentives (AUS)	GP "fundholding" (UK)	1% of overall health budget available for integrated care → majority of integrated care (GER)	1% overall health budget available for integrated care → population-based integrated care (Kinzigtal; GER)
Per patient bonus for physicians acting as gatekeepers for chronic patients/ for setting care protocols/ providing patient education (FR)		Payment for professional cooperation and diagnostic-related bundled payment (FR)	Shared savings for Accountable Care Groups ; tested in Physician Group Practice demonstration (US)
Bonus for DMP recruitment and documentation (GER) or initial payments (AUS)		Integrated Care Groups (NL)	
Service outcome payments (AUS)		Bundled payment for acute-care episodes (US)	



Separate provision
Paying for care coordination
Full Integration
Linkage
Coordination
Integration
Bundled payment for one provider across services (incl. referrals/ prescriptions)
Coordination/ extra effort payment
Bundled payment for group of providers for specific services
Bundled payment across providers and services
Capitation
and/ or
or
Case-based
and
Documentation bonus
Paying for quality and coordination
Bonus for structural quality (e.g. waiting)
Bonus for process quality (e.g. guidelines adherence)
Bonus for outcome quality
Quality-relation
Structure
Process
Outcome
Paying for quality



Linkage
Coo
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Capitation
and/
or
or
Case-
based
and
Bundled payme
provider acros
Coordi
extra
payr
Very few
integrated care
contracts (GER)
rivm
Experimenting with a bundled
payment system for diabetes care
in the Netherlands
The first tangible effects
A few Care
Groups (NL)
Quality is taken
into account
only if there
are savings
(US: PGP)
and services
Documentation
bonus
Paying for quality
and coordination
Bonus for
structural
quality (e.g.
waiting)
?
Bonus for
process quality
(e.g. guidelines
adherence)
?
?
Bonus for
outcome
quality
Quality-relation

Conclusions

- A shift from incentives which simply take into account the presence of chronically ill towards incentives designed to improve structural and process indicators
  - Although a trend towards more quality-related payment can be observed, financial incentives for the delivery of quality outcomes are still limited
  - A separate trend towards more bundling of payments across providers, services or both ("integrated care") can be observed (main incentive: profit-sharing for efficiency)
- The challenge – paying for successful coordination AND quality (rather than just efficiency) – still remains
  - The current rare approaches need to be evaluated
  - Further models need to be developed