Economic incentives for health care integration

Prof Igor Sheiman,
National Research University – High School of Economics

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Structure

- Typology of integrated payment methods – methods to encourage integration
- Brief overview of methods – design, evidence, implementation problems
- Pre-conditions for global payment implementation
- Comparative analysis of integrated payment methods

The starting point of new methods discussion: FFS encourages fragmentation

-selling *units of care* rather than a *total package of care* that can be designed to avoid aggravations of chronic diseases and hospital admissions

-costly provision of care

Typology of integrated payment methods

1) **Pay-for performance (P4P) that reward:**
- general integration activities (teamwork, coordination, etc.)
- disease specific integration activities (structure, process and outcome)

2) **Episode-based bundled payment for:**
- outpatient care
- outpatient and inpatient care
- readmission
- multi-morbidity case

3) **Global payment** with major risk bearers:
- PHC providers (fundholding)
- hospitals
- all providers in integrated networks

4) **Mixed methods**
- episode-based bundled payment + P4P
- global payment + P4P
- global payment + episode-based bundled payment for specific diseases +P4P

Three major distinctions between global and episode based bundled payment

- global payment is related to general medical activities, while bundled payment is the reimbursement of disease-specific activities
- global payment always implies enrollment of patients with a specific integrated network and capitation payment, while bundled payment sometimes does not (eg Geisinger Health System in the USA)
- global payment is always made for a specific period of time, while bundled payment is usually related to an episode of care that does not have clear cut time dimension

Pay-for-performance: design

Bonuses are paid to promote:

- ***teamwork of GPs and specialists with the use of electronic cards*** -projects in Australia, Canada
- ***efficient management of chronic cases*** -Quality and Outcome Framework (QOF) in the UK
- ***telephone and e-mail patients' consultations -*** *Denmark*
- ***continuity of care of chronic cases -*** indicators for PHC providers: frequency of emergency calls and re-admissions in Russia

P4P: major concerns about impact on integration

- QOF can potentially result in the neglect of non-incentivized areas (Ham et al, 2011)
- does not provide incentives to develop new ways of delivering care for people with co-morbidities and long-term conditions (Maresso 2013)
- special scheme for teamwork is not enough to ensure collaborative models of provision. In Russia - multispecialty polyclinic (presumes teamwork), however, poor evidence of poor collaboration between GPs and specialists (Sheiman et al, 2014)

P4P is usually used together with other payment methods (FFS, capitation or bundled payment), therefore is dependent on the incentives they provide

Episode-based bundled payment: Geisinger Health System (US)

Offers 40 specific clinical processes related to managing patients after coronary artery bypass surgery. Integrated rate includes: surgery, tests and post discharge follow-up of patients within 90 days

-readmissions are not reimbursed

-the rate is based on the assumption that historic frequency of complications is reduced by half

First 18 months (Mechanic and Altman, 2009):

-promotes integrated delivery with electronic tracking of patients after discharge

-44 percent readmissions reduction, shorter LOS, and reduced hospital charges

The major problems of episode-based bundled payment:

- narrow scope of bundled payment, its limited impact on integration. The scheme is designed for the specific diseases management programs and doesn't create incentives for providers in other clinical areas
- there is potential for providers to skew their activity to most "rewardable" schemes.
- related issue – the possibility of double billing a payer for the same services – through traditional FFS and bundled payment (Dutch diabetes group care). When more chronic diseases are added to the bundled payment schemes it will be difficult to determine under which bundle certain services should be billed (Liano, 2013).

Global payment: Alternative Quality Contract in Massachusetts

-covers all services under 5-year global budget

-enrollees are registered with the specific PC group

-providers are risk bearers

-plus bonuses for reaching performance measures

Evidence (Song et al for 2005-2009):

-small savings

- improvement in measures of quality of management of chronic conditions for adults and pediatric care, but not for adult preventive care

Global payment: PHC–fundholding in Russia

- Polyclinics (big multispecialty outpatient care settings) - are capitated for both outpatient and inpatient care and pay for referrals to hospitals and other providers
- The range of services differs in the regional schemes from small scale global budgets (e.g. in Kaluga region - only for outpatient care) to all-inclusive payment, incl. tertiary care and emergency calls (in Kaliningrad region)
- Polyclinics can keep savings. This creates incentives to:

- plan jointly with hospitals the necessary tests, volumes and structure of inpatient care
- communicate with hospitals on their patients (policlinics control LOS)
- expand activities to avoid aggravations of chronic cases (so that to reduce hospital admissions and emergency care calls)

Fundholding evidence in Russia

- fundholders set-up physician-nurses teams for home visits in case of emergency or expected aggravation of health status (the case of Perm)
- set up “schools of diabetes” and “schools of asthma”
- lower utilization and high outcomes in 10 regions with fundholding vs. 73 without it (Sheiman, 2011)

But:

-incentives are not enough to compensate for the lack of organizational integration activities and the low GP coordinating role

-conflicting incentives for integration on the part of polyclinics and hospitals. The former are interested in more cooperation with hospitals to avoid aggravations of chronic cases, while the latter are not

Global payment: the problem of excessive risk bearing

- some integrated networks *in the US* hospitals agree to pay out physicians from pre-capitized accounts after procedure before receiving reimbursement from payer (Rice, 2012)
- *In Russia* polyclinics as fundholders are supposed to pay for hospital care even when the revenue is not enough to cover all cost or when capitation rate is not risk-adjusted enough

Excessive risk bearing may lead to:

-unwillingness to be involved in networks (USA) and even growing tension between providers (Russia)

-opportunistic behaviour of providers - underprovision

Pre-conditions for global payment as integration instrument

1) Risk bearing in integrated networks. Provider or group of providers that act as integrators are financially accountable not only for the savings but also for the deficits of revenue

2) A set of activities to mitigate excessive risk bearing. E.g. in Russia:

- *Savings of polyclinics-fundholders can be kept by them only when performance targets are met.* Targets are designed to 'capture" potential opportunistic behavior of fundholders. For example, frequency of deaths at home or the number of the reveled cancer cases at terminal stage are heavily weighted indicators

- *Financial penalties are used for patients that have not been timely referred to hospital.* Health insurers are responsible for revealing such cases and penalizing polyclinics. They are interested in this kind of control, since receive 10% of the financial penalty size.

- Some regions (for example, Kemerovo region) use the scheme of *risk sharing between health insurers and polyclinics.* The latter have the limit of their financial responsibility.

Pre-conditions for global payment as integration instrument-2

3) Shared savings schemes in integrated networks

-*i*f PHC group acts as the major risk bearer, then hospitals must be encouraged to work in such networks and meet their objectives

4) ***Performance transparency system*** – constant monitoring of each provider performance

5) ***Infrastructure for coordination and collaboration*** - major organizational changes should precede the adoption of global budget to make new incentives work

Evaluation of integrated payment methods based on key criteria

	Promoting provider integration	Controlling unnecessary utilization	Encouraging high quality care	Operational feasibility	Degree of excessive financial risks of providers
Pay-for-performance	*	-	*	***	-
Episode-based payment	**	**	**	**	*
Global Payment	***	***	**	*	***

Concluding remarks

- More comprehensive methods of payment create stronger economic incentives for integration but at the same time they are hard to implement and make integrated networks more vulnerable
- There is a dilemma of strong economic incentives with serious implementation problems and low economic incentives with no or few implementation problems
- Global payment is the example of the first, while episode based bundled payment – of the second