

Payment Reform

Gerald F. Anderson PhD.

**Johns Hopkins Bloomberg School of
Public Health**

Provider Payment

- Payment reform should create incentives for cost-savings, improved access to care, and quality improvement in the treatment of each patient.
- A combination of approaches is often most effective.
- Each type of provider may require a different payment system.

Provider Payment (cont.)

- Most countries will have to move step-wise toward these goals while *management, expertise, and information systems* improve.
- Ease of implementation is critical
- Incentives for ‘gaming’ need to be considered.

Provider Payment Mechanisms and Provider Behavior

Mechanisms	Retrospective/ Prospective	Incentives for Provider Behavior			
		Prevention	Delivery	Cost	Quality
Line item budget	Prospective	+/-	--	+++	--
Global budget	Prospective	++	--	+++	--
Capitation	Retrospective	+++	--	+++	++
Per case	Either	+/-	++	++	++
Fee-for-service	Retrospective	+/-	+++	---	++

Different Providers

Different Payment Methods

- Primary Care
- Outpatient Specialist Care
- Hospital Inpatient

Primary Care

- Primary method - capitation
- Capitation
 - fixed amount per person/per year
 - may be adjusted for health status
- Possible adjustments
 - Health Status of Enrollees
 - Preventive Services
 - Poor Working Conditions
 - Qualifications of Physician
 - Length of Waiting Lists

Primary Care - Capitation

- Major Concern – Excessive Referral to Specialists

Paying Primary Care Providers

Country	Payment Mechanisms	Possible Incentives
Bulgaria	Capitation	Bonus for poor working conditions; bonus per patients for management of priority health problems.
Czech Republic	Capitation	Bonus for cost-containment; fee-for-service for preventive care..
Estonia	Capitation (70% of income)	Fee-for-Service for immunizations; allowances for location, rent, transport, investment costs. Fund holding for diagnostic tests (25% of capitation payment, reduced if over budget).
Hungary	Capitation	Extra payments depending on practice size and location; higher rates for better qualifications. Decreasing payment above practice list cap.
Latvia	Capitation Fundholding	Rural bonus GP certification bonus; Fundholding for fees of upward referrals (with exception of direct access specialties).

Paying Primary Care Providers (cont)

Country	Payment Mechanisms	Possible Incentives
Lithuania	Capitation	Bonus for rural location, fee-for-service for selected services.
Poland	Capitation	Fundholding of payments for specialists.
Romania	Capitation (70% of income)	Fee-for Service for immunizations; preventive and health promotion services (30%); fixed allowance to cover administrative expenses; 2006 laws-create disincentive to referral.
Slovakia	Capitation	Fee-for-service for preventive care.
Slovenia	Capitation and fee-for-service with national cap	Receive full payment only if preventive care is given; no long waiting list; referrals don't deviate from contract.

Outpatient Specialist Care

- Primary Method – Fee-For-Service
- Fee-For-Service – Payment for each service the MD provides
- Possible adjustments
 - Limits on number of visits
 - Regional or national limits on total spending
 - Payments reduced if limits exceeded

Paying Outpatient Specialists

Country	Payment Mechanisms	Requirements for Referral?
Bulgaria	Fee per visit; service fee-for-diagnosis	Yes. No payment without referral except in emergency.
Czech Republic	Capped fee-for-service	No.
Estonia	Capped fee-for-service	Yes. No payment without referral except in emergency. (Exceptions for direct access specialists.) Can pay full rates and by pass waiting lists.
Hungary	Capped fee-for-service	Yes. Small copayment if no referral. (Exceptions for long list of direct access specialists.) Frequently by passed.
Latvia	Salary and points system	Yes. No payment without referral except in emergency (exceptions for direct access specialties – psychiatry, gynecology and others).

Paying Outpatient Specialists (cont)

Country	Payment Mechanisms	Requirements for Referral?
Lithuania	The Specialist is paid a salary by the clinic which receives fee-for-service payment	Yes. No payment without referral.
Poland	Capped fee-for-service	Yes, but increasing list of direct access providers.
Romania	Capped fee-for-service	Yes.
Slovakia	Capped fee-for-service for private providers; Points-related salary for public providers	Yes, but frequently by passed.
Slovenia	Salary for SHI contractors; Fee-for-service for private providers	No payment without referral except in emergency.

Hospital Care

Dominant Service of Expenditures

Reasons for high expenditures include:

- high numbers of admissions
- long length of stay
- too many beds
- crumbling infrastructure

Hospital Payment Systems

- Old Method – line item budgets
- Current Methods:
 - per diem
 - per case
 - global spending limits

Per Diem

- Amount per day
 - May adjust for difference in case mix
- Major problems
 - Length of stay increases because hospitals can make money on last days of hospital stay

Per Case

- Amount per visit
- Need to adjust for differences in case mix
- Major problems
 - Developing adequate case mix adjuster
 - Need to monitor perverse hospital behavior

Global budget

- Total amount for all hospitals
- Set limits for each hospital
- Major problems
 - How to set total amount
 - How to allocate to specific hospitals

Hospital Payment Systems

Country	Per Diem	Per Case	Global Budget	Notes
Bulgaria		X	Developing	Global Budget more frequently being employed and DRGs are being explored
Czech Republic		X	X	Global Budget negotiated between SHI funds and each hospital based on previous year and inflation. In addition, a flat fee based on number of cases. Reimbursements include depreciation allowance to finance capital expenditures. A DRG plan is being prepared.
Estonia	X	Partially implemented		Per-diem rates cover cost of examination, diagnosis, treatment, simple procedures, test, drugs and capital costs. Varies by specialty. Cap on number of days a per diem rate is paid. Fee-for-service for: surgical procedures, lab tests with an annual cap per provider contract. Case-based payments with 50 complex prices already in place but still a small % of total payments. DRGs will replace all FFS in time.

Hospital Payment Systems (cont)

Country	Per Diem	Per Case	Global Budget	Notes
Hungary	X			DRG (758 categories). Volume caps result in trading of allowed capacities among hospitals; and incentives to limit production with regressive payments beyond caps. Floating point values for DRGs.
Latvia	X	Developing		Case-based depending n diagnosis; bed-day free; point-system
Lithuania		X		Case-based with 4 broad case-mix/price categories, including incentives to discourage unnecessary hospitalization. Reimbursement based on service, not location of delivery. Municipal and county budgets are the main source of capital financing
Poland		X		Per-Admission payment according to 2400 point categories. Movement toward a DRG-system is possible by 2008

Hospital Payment Systems (cont)

Country	Per Diem	Per Case	Global Budget	Notes
Romania		X	X	Hospitals are paid according to global budgets negotiated with the National Health Insurance House. Payments to 276 of the largest hospitals are based on DRGs using a revised version of the Australian classification model.
Slovakia	X		Developing	DRG-like system with broader categories.
Slovenia		X		Moving toward DRGs from case-based payment based on broader categories.

Recommendations – Primary Care

- Capitation
- Issues to decide
 - Gate Keeping
 - Risk adjustments
 - Extra payments for prevention

Recommendations: Outpatient Specialist Care

- Salaried if motivated to work
- Capped Fee-For-Service if need financial incentives to work
- Consider
 - Motivations of primary care physicians to over refer to specialist
 - Who to cap
 - Ability to self refer

Recommendations: Hospital Inpatient

- Diagnosis-related payment subject to global cap
- Consider:
 - Mechanism to monitor quality of care
 - How to create diagnosis related groups (DRGs)
 - Information systems need to set payment and monitor behavior
 - Capital needs