Universität St.Gallen

School of Medicine

Qualitätsorientierte Vergütung – Möglichkeiten und Erfahrungen aus dem Ausland

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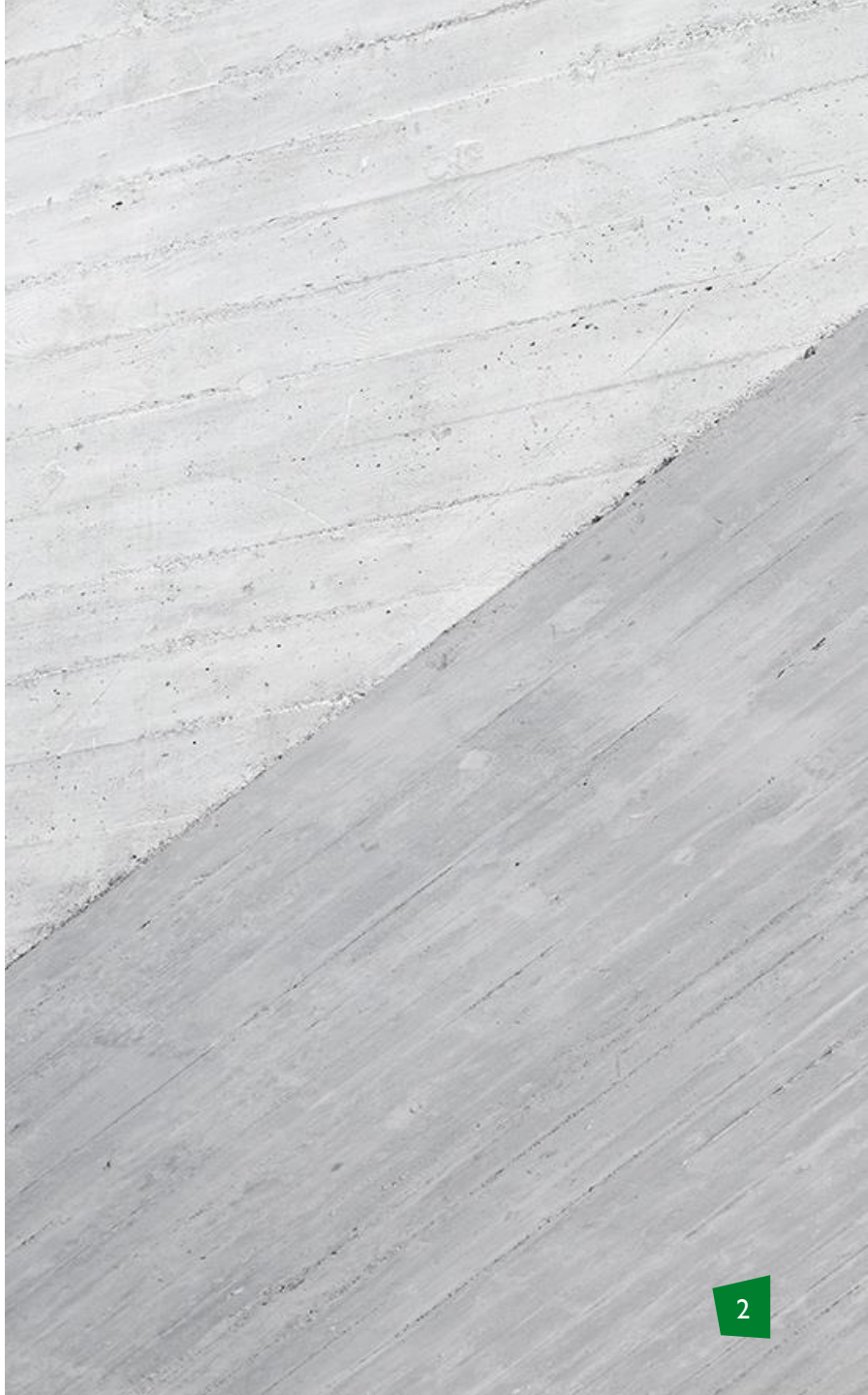
From insight to impact.

Content

1. Payment systems
2. Inpatient payments
3. Ambulatory payments



Aims of provider payment: What do we want providers to do? That…

- they care for patients when they need care … and do not risk-select …
- they provide services … and are not idle …
- services are provided only if indicated/appropriate … and not unnecessarily …
- provided services are of high quality … and do not endanger patient safety …
- expenditure is well controlled … and not sky-rocketing …
- services are efficiently provided … and money not wasted …
- service provision is transparent … and not opaque …

How can providers be paid?

1. **Reimbursement of costs**

2. **Budget** (mainly input-oriented, i.e. depending on personnell, beds, technical equipment) or **Salary** (dending on qualification/ experience)

3. **Unit of service** (prozess-/time-oriented):
   (a) Fee-for-service (Einzelleistung),
   (b) Service complex fee (e.g. operation),
   (c) Per diem (Tagespflegesatz),
   (d) Per case/ diagnosis related group (Fallpauschale),
   (e) Capitation (full or partial)

4. **Outcome** ("Pay-for-performance")
   (a) at time of discharge – e.g. in form of quality-bonus/ malus
   (b) mid- to long-term -> creation of health ("value-based payment")

Advantages and disadvantages of different payment mechanisms

Payment mechanism	Patient needs (risk selection)	Activity		Expendi-ture control	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services per case				
Fee-for-service	+	+	+	–	0	N/A	–
DRGs	0	+	–	0	+	N/A	–
Global budget	–	–	–	+	–	N/A	+
Salary	0	–	–	+	–	N/A	+
Capitation	–	+	–	+	–	N/A	0

Source: adapted from Geissler A, Quentin W, Scheller-Kreinsen D, Busse R (2011) Introduction to DRGs in Europe: Common objectives across different hospital systems. In: Busse R, Geissler A, Quentin W, Wiley M (Hrsg) Diagnosis-related groups in Europe. Moving towards transparency, efficiency and quality in hospitals. Open University Press

Qualitätsorientierte Vergütung – aber wie?

Bisher hat die erzielte Qualität einer Behandlung *keine Auswirkungen* auf die Vergütung (z.T. sogar gegensätzlich: Komplikationen ↑ → Vergütung ↑).

Die Vergütung sollte qualitätsfördernde Maßnahmen (z.B. leitliniengerechte Prozesse) unterstützen und nicht konterkarieren.

- Zu P4P existieren einerseits Studien, die hohe Zuwächse der Effektivität aufzeigen, andere Studien hingegen finden keine Effekte → *keine eindeutige Evidenz*
- Es zeigt sich jedoch positive Honorierung effektiver ist als eine negative Sanktionierung
- Zunehmend erscheinen (Meta) Reviews hinsichtlich der Effekte von int. P4P-Initiativen

Beispiel 1

Review

Pay for performance in the inpatient sector: A review of 34 P4P programs in 14 OECD countries☆

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ABSTRACT

Across the member countries of the Organisation for Economic Co-operation and Development (OECD), pay-for-performance (P4P) programs have been implemented in the inpatient sector to improve the quality of care provided by hospitals. This paper provides an overview of 34 existing P4P programs in the inpatient sector in 14 OECD countries based on a structured literature search in five databases to identify relevant sources in Danish, English, French, German, Hebrew, Italian, Japanese, Korean, Norwegian, Spanish, Swedish and Turkish. It assembles information on the design and effects of these P4P systems and discusses whether evaluations of such programs allow preliminary conclusions to be drawn about the effects of P4P. The programs are very heterogeneous in their aim, the selection of indicators and the design of financial rewards. The impact of P4P is unclear and it may be that the moderately positive effects seen for some programs can be attributed to side effects, such as public reporting and increased awareness of data recording. Policy makers must decide whether the potential benefits of introducing a P4P program outweigh the potential risks within their particular national or regional context, and should be aware that P4P programs have yet not lived up to expectations.

R. Milstein, J. Schreyoegg/ Health Policy 120 (2016) 1125–1140

Beispiel 2

Pay-for-performance and patient safety in acute care: A systematic review

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A B S T R A C T

Pay-for-performance (p4p) has been tried in all healthcare settings to address ongoing deficiencies in the quality and outcomes of care. The evidence for the effect of these policies has been inconclusive, especially in acute care. This systematic review focused on patient safety p4p in the hospital setting. Using the PRISMA guidelines, we searched five biomedical databases for quantitative studies using at least one outcome metric from database inception to March 2023, supplemented by reference tracking and internet searches. We identified 6,122 potential titles of which 53 were included: 39 original investigations, eight literature reviews and six grey literature reports. Only five system-wide p4p policies have been implemented, and the quality of evidence was low overall. Just over half of the studies (52 %) included failed to observe improvement in outcomes, with positive findings heavily skewed towards poor quality evaluations. The exception was the Fragility Hip Fracture Best Practice Tariff (BPT) in England, where sustained improvement was observed across various evaluations. All policies had a miniscule impact on total hospital revenue. Our findings underscore the importance of simple and transparent design, involvement of the clinical community, explicit links to other quality improvement initiatives, and gradual implementation of p4p initatives. We also propose a research agenda to lift the quality of evidence in this field.

Slawomirski L, Hensher M, Campbell J, deGraaff B. Pay-for-performance and patient safety in acute care: A systematic review. Health Policy. 2024 May;143:105051.

Possible P4P (P4Q) options in inpatient settings

	Single case	All cases with same diagnosis/ DRG	All cases within one hospital
Indication Quality	No payment if no indication or unindicated length of stay	Deduction per DRG and share on cases without indication; no payment if minimum quantity for specific treatments is not reached	
Structural Quality	Unverified procedure codes are neglected by grouping algorithm	Certain DRGs are not billable if specific structures are not in place (e.g. Stroke Unit)	Budget deduction if deviation on structural requirements
Process Quality	Hospital acquired infections are neglected by grouping algorithm	„Best practice“ DRG-weights if costs for better quality are proven to be higher	
Outcome	Payment rules for unplanned readmissions or never-events	Surcharge for significant above average quality	
Reporting of Quality	No payment if quality data is not available or submitted	Deductions if quality data is not available for numerous cases	Base rate deduction if quality data is wrong or incomplete

Source: adapted from Busse, R., Eckhardt, H., Geraedts, M. (2020). Vergütung und Qualität: Ziele, Anreizwirkungen, internationale Erfahrungen und Vorschläge für Deutschland. In: Klauber, J., Geraedts, M., Friedrich, J., Wasem, J., Beivers, A. (eds) Krankenhaus-Report 2020.

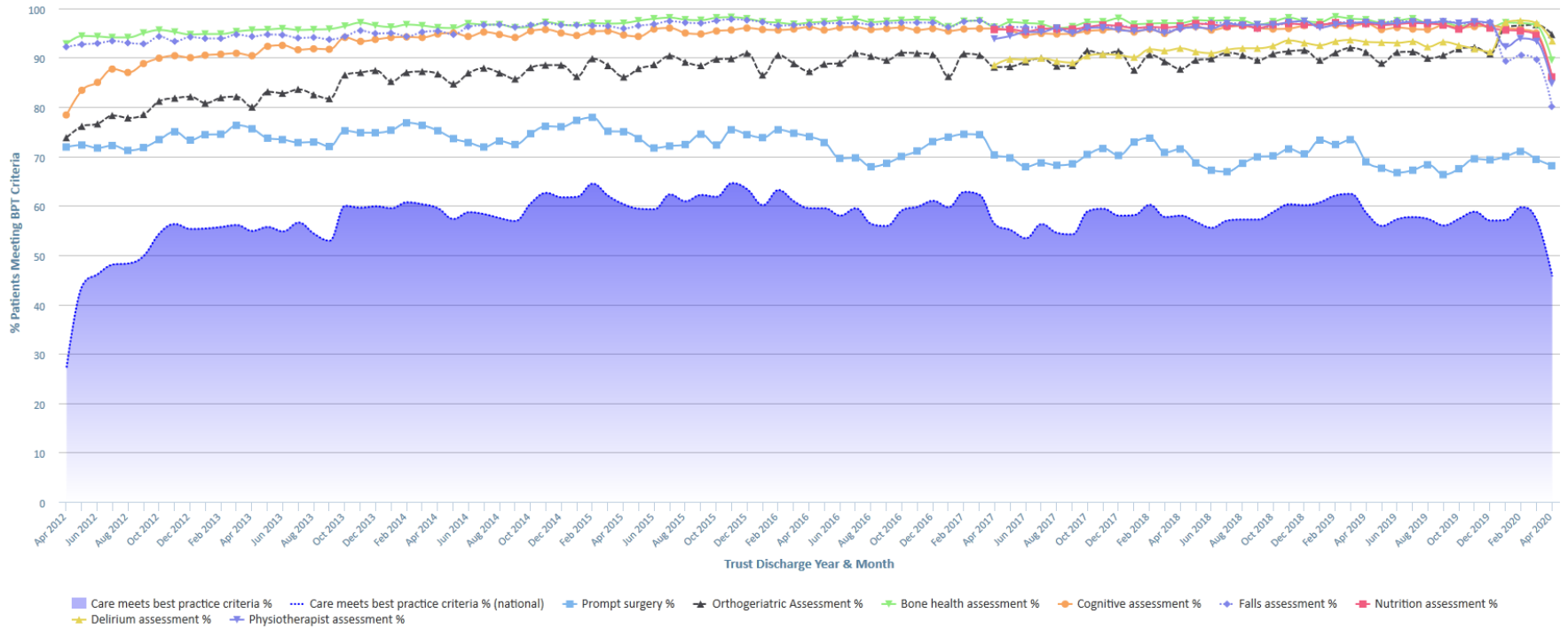
Beispiel 1: England - best practice tariffs

- 2010 wurden 4 „best practice tariffs“ eingeführt, mittlerweile sind es 22 Leistungsbereiche
- „Best practice tariffs“ orientieren sich überwiegend an Parametern für die Prozessqualität, u.a. aus klinischen Leitlinien
- Spitäler, die für bestimmte Leistungsbereiche vom Referenzwert positiv abweichen, erhalten andere Vergütung als üblich
- Die Vergütung beruht auf den Kosten von Spitälern mit guter Prozessqualität und effizienter Leistungserbringung
- Fachgesellschaften können Vorschläge für „best practice tariffs“ einbringen
- Evaluation zeigt unterschiedliche Ergebnisse je nach Leistungsbereichen

Best practice tariff: Hip fracture

Requirements:

- surgery within 36 hours of admission
- shared care by orthopaedic surgeon and orthogeriatrician
- admission using a care protocol agreed by orthogeriatrician, orthopaedic surgeon and anaesthetist
- assessment by orthogeriatrician within 72 hours of admission
- pre-and postoperative abbreviated mental test score (AMTS) assessment
- orthogeriatrician-led multidisciplinary rehabilitation
- secondary prevention of falls
- bone health assessment



Beispiel 2: USA – Medicare Hospital Value-Based Purchasing

- Eingeführt 2010 mit dem Affordable Care Act: Start in 2013
- 2% der Gesamtausgaben für DRGs werden einbehalten und nach Qualitätsaspekten neu verteilt:
  - Clinical Care (25%) →Outcomes (20 %) Process (5 %)
    - 3 Outcome-Indikatoren und 3 Prozess-Indikatoren
  - Patient and Caregiver Centered Experience of Care/Care Coordination (25%)
    - 8 Dimensionen aus standardisierter Patientenbefragung
  - Safety (25 %)
    - 5 Infektions-Indikatoren und 1 AHRQ-Patientensicherheitsmaß
  - Efficiency and Cost Reduction (25 %)
    - 1 Indikator: Ausgaben pro Fall von 3 Tagen vor bis 30 Tage nach KH-Aufenthalt
- Jährliche Anpassung der Dimensionen und Indikatoren

Beispiel 3: USA – Medicare Hospital-Acquired Conditions (HAC)

Spitäler erhalten keine zusätzlichen Zahlungen für Fälle bei denen ausgewählte Konditionen nicht bei Aufnahme vorhanden waren. Die Zahlung mit und ohne Nebendiagnose ist demnach gleich.

Eingeführt Anfang 2006, aktiviert Oktober 2008 für Konditionen die:

(a) hohe Kosten /Volumen oder beides aufweisen,

(b) zur Eingruppierung in eine höher bewertete DRG führen wenn sie als Nebendiagnose kodiert werden

(c) und angemessen unter Einhaltung von Leitlinien verhindert werden können.

Original Investigation

Effect of Medicare's Nonpayment for Hospital-Acquired Conditions
Lessons for Future Policy

CLABSIs: central line–associated bloodstream infections
CAUTIs: catheter-associated urinary tract infections
HAPUs: hospital-acquired pressure ulcers

Teresa M. Waters, PhD; Michael J. Daniels, ScD; Gloria J. Bazzoli, PhD; Eli Perencevich, MD; Nancy Dunton, PhD; Vincent S. Staggs, PhD; Catima Potter, MPH; Naleef Fareed, PhD; Minzhao Liu, MS, PhD; Ronald I. Shorr, MD, MS

RESULTS Medicare's nonpayment policy was associated with an 11% reduction in the rate of change in CLABSIs (incidence rate ratio [IRR], 0.89; 95% CI, 0.83-0.95) and a 10% reduction in the rate of change in CAUTIs (IRR, 0.90; 95% CI, 0.85-0.95), but was not associated with a significant change in injurious falls (IRR, 0.99; 95% CI, 0.99-1.00) or HAPUs (odds ratio, 0.98; 95% CI, 0.96-1.01). Consideration of unit-, hospital-, and market-level factors did not significantly alter our findings.

CONCLUSIONS AND RELEVANCE The HACs Initiative was associated with improvements in CLABSI and CAUTI trends, conditions for which there is strong evidence that better hospital processes yield better outcomes. However, the HACs Initiative was not associated with improvements in HAPU or injurious fall trends, conditions for which there is less evidence that changing hospital processes leads to significantly better outcomes.

JAMA Intern Med. 2015 Mar;175(3):347-54.

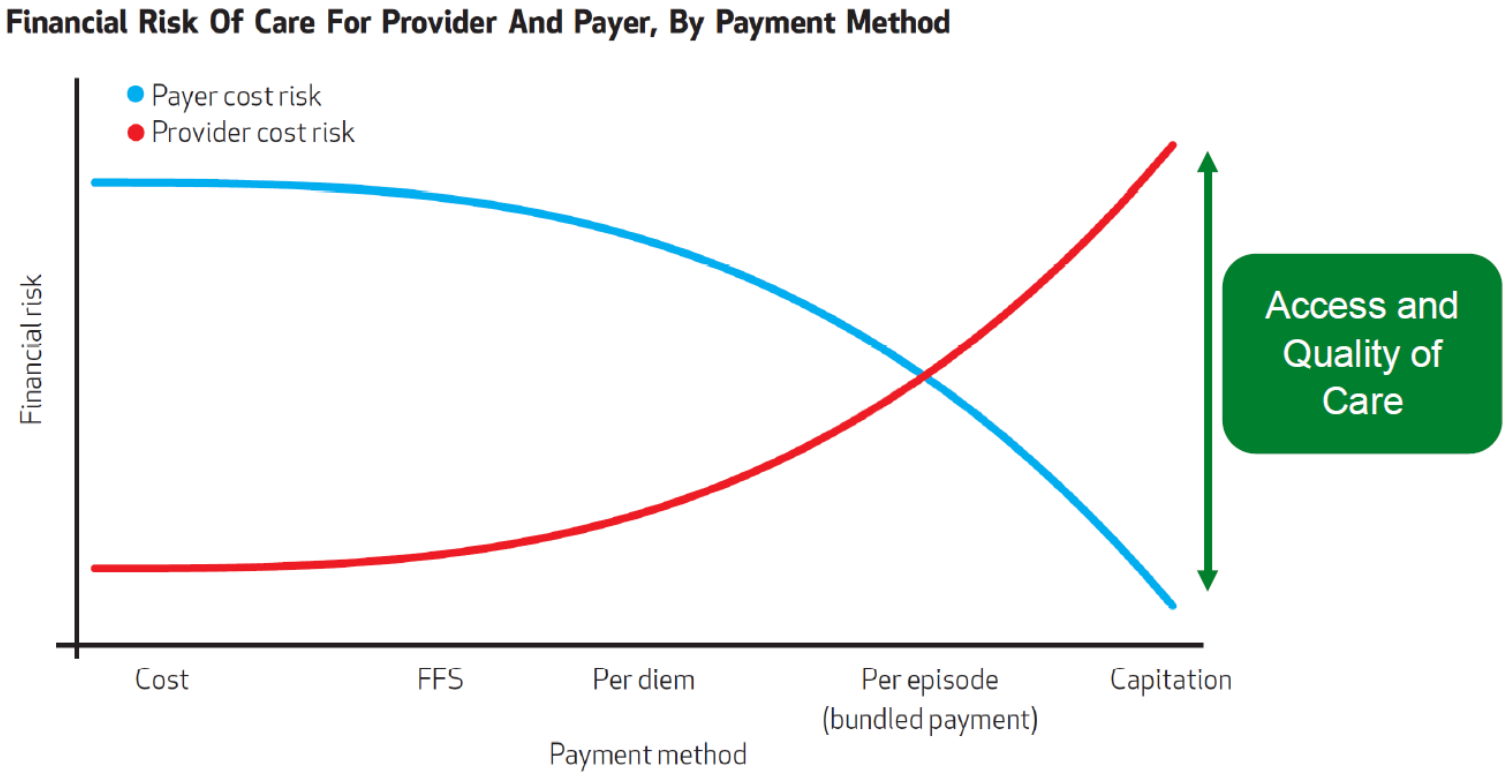
Capitation pays healthcare providers a fixed amount per patient and period, while fee-for-service pays per individual service

"Capitation is a way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period of time."

Source: Capitation and Pre-payment | CMS

The primary goal of capitation is to control healthcare costs while encouraging providers to deliver efficient care through financial incentives

With capitation, the financial risk shifts from payer to provider

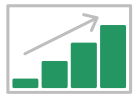


Source (with modification): Frakt AB, Mayes R. Beyond capitation: How new payment experiments seek to find the 'sweet spot' in amount of risk providers and payers bear. Health Aff. 2012;31(9):1951–1958. doi: 10.1377/hlthaff.2012.0344.

There are different advantages and risks linked to capitation models

Advantages

Cost Control



Long-term Health Management rather than episodic care

Incentive for Preventive Care

Simplified Administration for payers and (partially) providers

Risks

Quality reduction of health services to save costs

Risk of less patient choice regarding providers and services

Patient Selection Risk

Financial loss for providers if the cost of care exceeds the capitation payment

Complexity in Rate Setting

There are two main types of capitation models, differing in provider and payer responsibility, and suitability

Full Capitation

Definition: A payment model where the provider (group) receives a set fee for each enrolled patient (person) per specified time period, covering all needed medical services.

Risk for provider: incurring costs that exceed the fixed payment

Risk for payer: underutilization of services or compromised care quality

Suitability: best for providers with a broad range of services, e. g. primary care and single payer systems

Partial Capitation

Definition: A model where the capitation payment only covers a specific set of services or patient groups/needs.

Risk for provider: potentially higher costs on the non-capitated services.

Risk for payer: they remain responsible for some of the patient care expenses outside the capitated arrangement.

Suitability: best for providers specializing in certain service areas, e. g. cardiology clinic within a hospital or GP services

An important challenge in implementing capitation models is setting capitation rates

Factors to be considered

Patient demographics

Health status of insured population

Local healthcare costs

Utilization patterns (how often patients use medical services)

Adjustment and incentive mechanisms

- **Risk Adjustment:** Adjusting capitation rates to account for patients with higher expected medical costs
- **Quality Incentives:** Incorporating performance metrics to incentivize high-quality care
- **Profit-and-loss sharing:** Extent to which risks for deficits and profits are shared between providers and insurers

Periodic review and update

- **Regular Assessments:** Continual evaluation of capitation rates based on updated health and cost data
- **Adjustment for Changes:** Modifying rates to reflect changes in healthcare delivery, technology, and patient population

New initiatives of capitation models recently discussed and to be implemented in Switzerland – example of Reseau de l'Arc

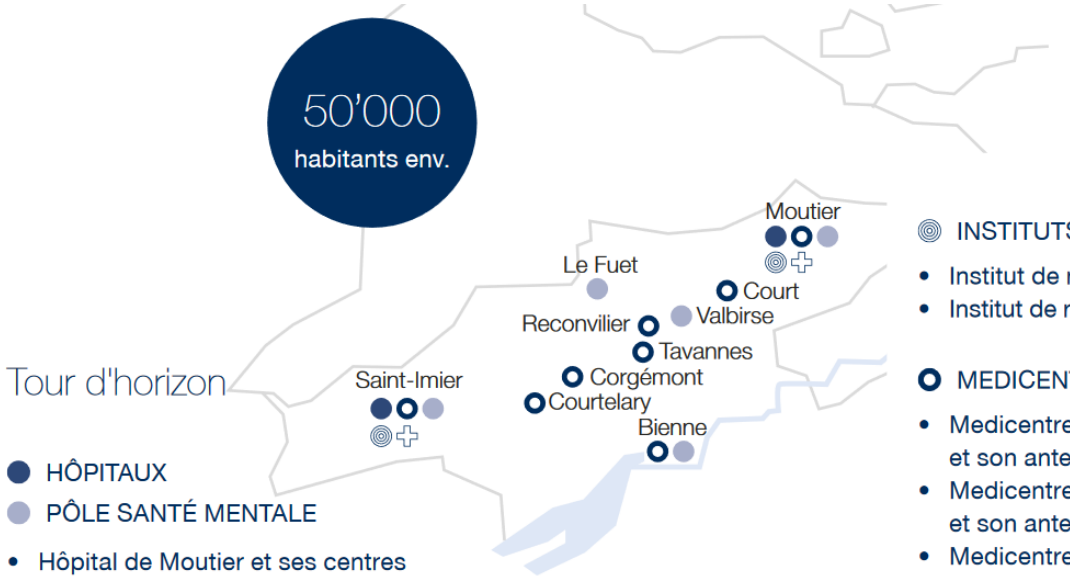
The Swiss Medical Network (SMN), the Canton of Bern and Visana (Atusana) health insurance will develop the "Réseau de l'Arc", Switzerland's first **fully integrated healthcare organization**, and launch it on 1.1.2024. A **full-capitation insurance model** is to be used that transfers budget responsibility to the Réseau de l'Arc healthcare organization, i.e. the above partners.

1. Increasing **medical quality** in the context of value-based healthcare

2. **Cost containment** in the provision of medical services

3. **Medical care security** and access to adequate medical care

Swiss Medical Network takes on the provider role in the Réseau de l'Arc initiative



Tour d'horizon

HÔPITAUX

PÔLE SANTÉ MENTALE

- Hôpital de Moutier et ses centres en ville de Moutier ainsi qu'à Valbirse et à Le Fuet
  - Centre médical Pôle Femme-mère-enfant
  - Consultation ambulatoire du Pôle santé mentale
  - Clinique de jour (Valbirse)
  - Unité thérapeutique des dépendances (Le Fuet)
- Hôpital de Saint-Imier et ses centres en ville de Saint-Imier
  - Centre de physiothérapie ambulatoire
  - Consultation ambulatoire du Pôle Femme-mère-enfant
  - Consultation ambulatoire en médecine générale
  - Unité stationnaire de réhabilitation psycho-sociale

INSTITUTS DE RADIOLOGIE

- Institut de radiologie de Moutier
- Institut de radiologie de Saint-Imier

MEDICENTRES

- Medicentre Moutier et son antenne de Court
- Medicentre Tavannes et son antenne de Reconvilier
- Medicentre Corgémont
- Medicentre Courtelary
- Centre de thérapies multidisciplinaires de Tavannes
- Medicentre Biel-Bienne et ses deux cliniques de jour
- Centre Médical Bienne (CMB)/ Medizinisches Zentrum Biel (MZB)

PHARMACIE

- Pharmacie interjurassienne (en collaboration avec l'Hôpital du Jura)

Summary

- All payment systems include incentives to jeopardise quality
- However, the payment of hospital cases should support other quality-enhancing measures
- The existing payment models could be modified by bonuses, reductions up to non-remuneration, withholdings and "shared savings"
- Pay-for-quality programs in other countries provide inspiration and (some) evidence
- Hospital payments should consist of multiple components, rather than being narrowed down to programs that reward or punish hospitals for individual process or outcome parameters
- Capitation models (full or partial) provide incentives for keeping a population healthy
- However, they must be monitored extensively to avoid decreasing access and withholding of services

Vielen Dank!

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