E²CM: WHAT'S NEXT?

World Bank Group

October 2017

Eesti Haigekassa

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e^2cm = Estonian Enhanced Care Management

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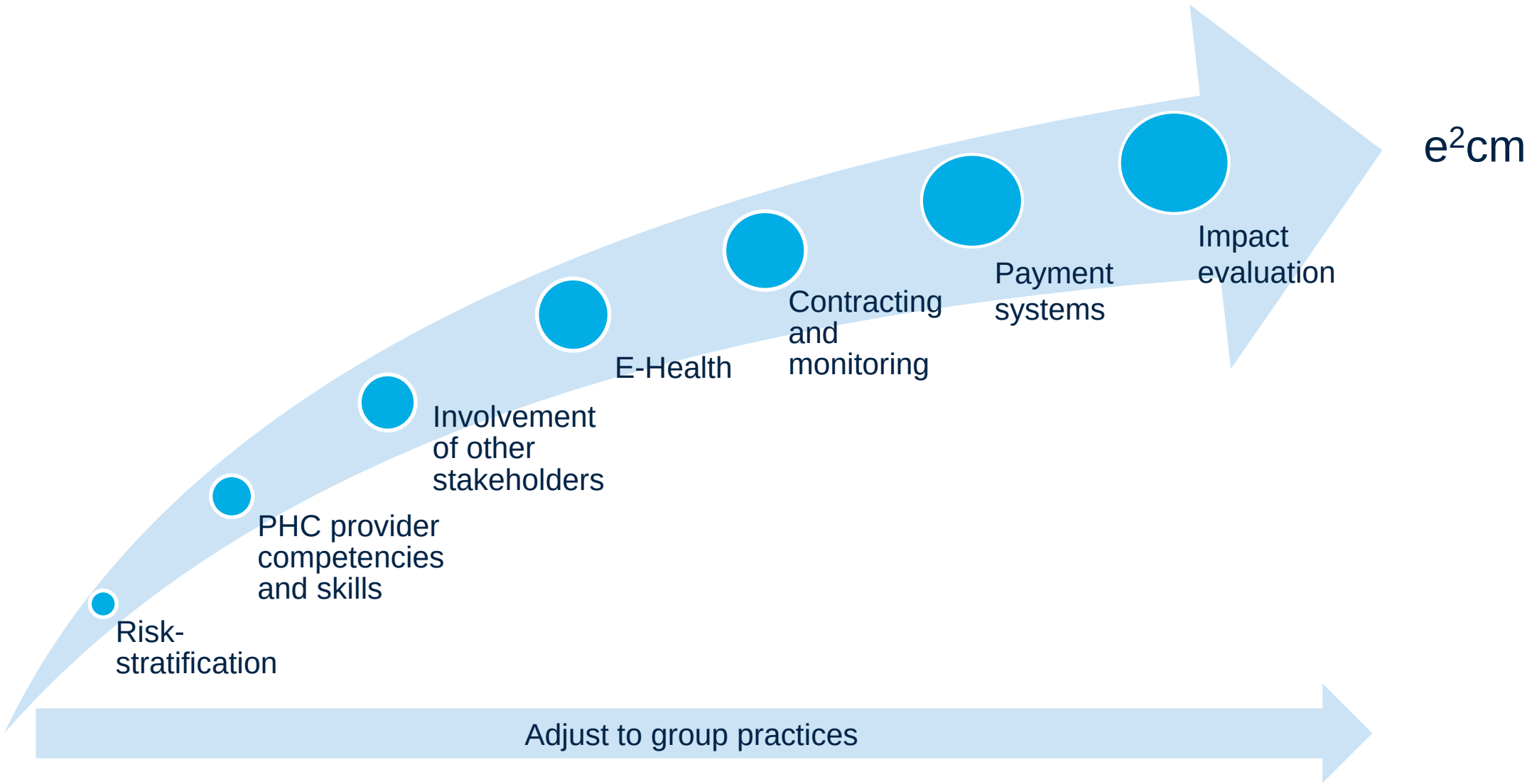
Areas of further work



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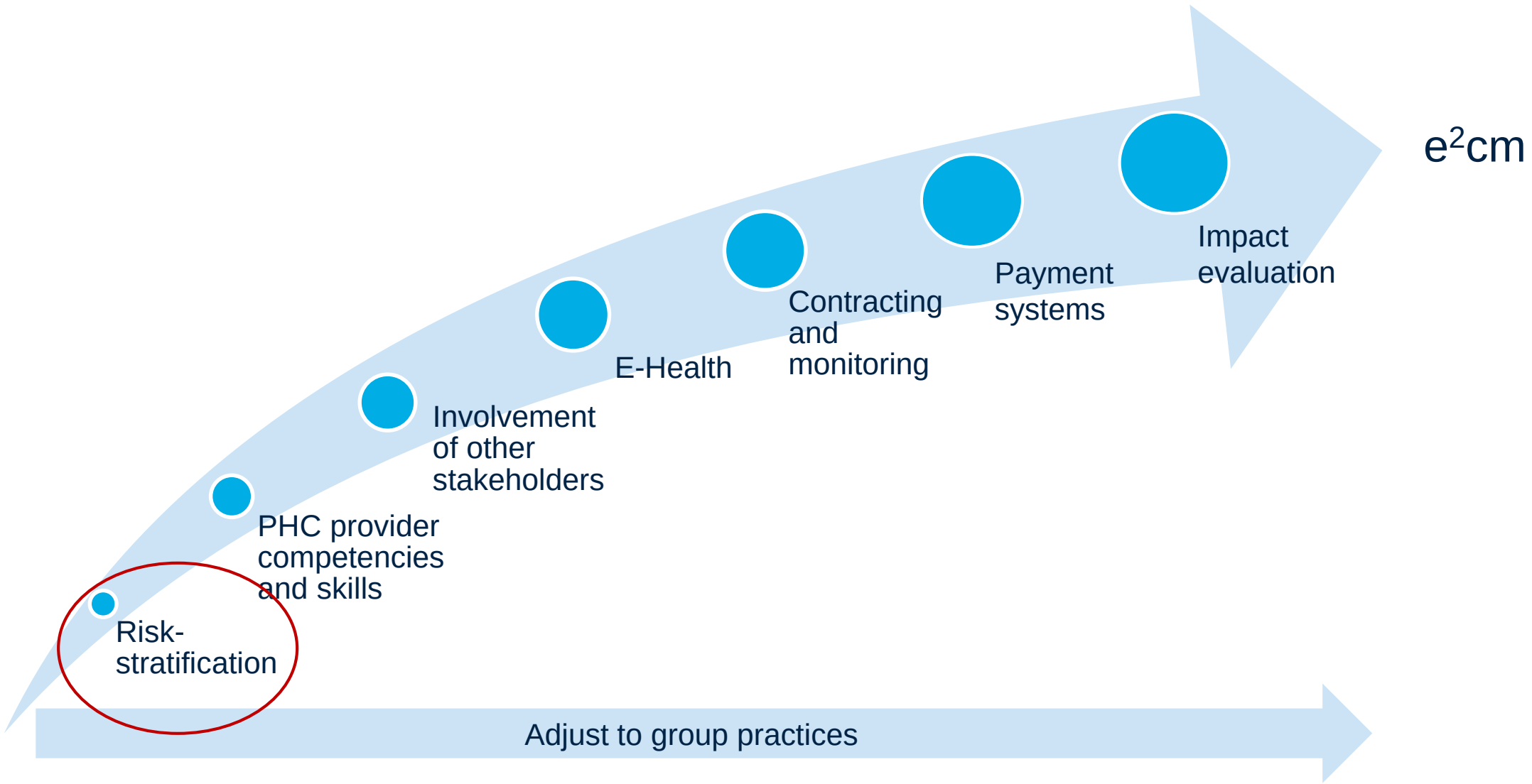

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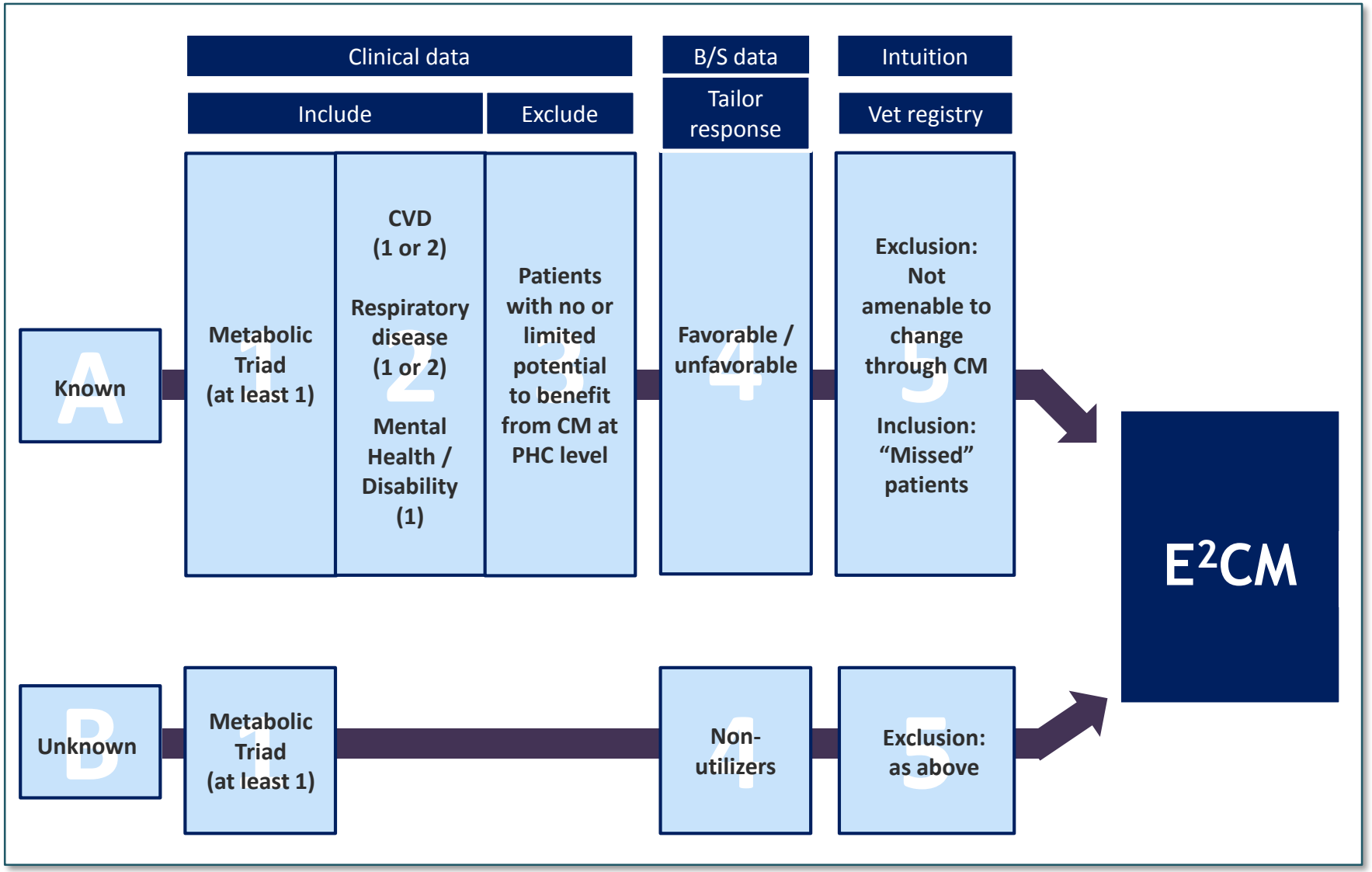
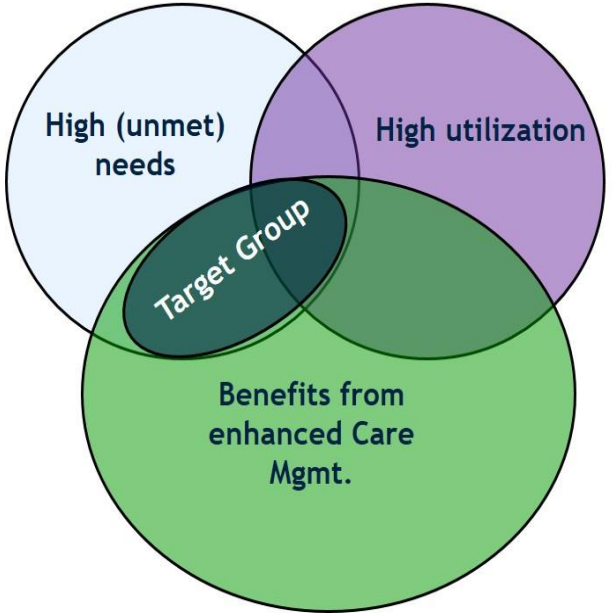
Risk-Stratification Model for EECM



Design principles of the risk-stratification approach

- Health maximization / potential to benefit from EECM

Archetypes



- Dynamic
- KISS (Keep It Simple, Stupid) at the beginning

Modular structure

- Mixed approach
  - (Data and intuition-based)
  - Data: Clinical, behavioral, social

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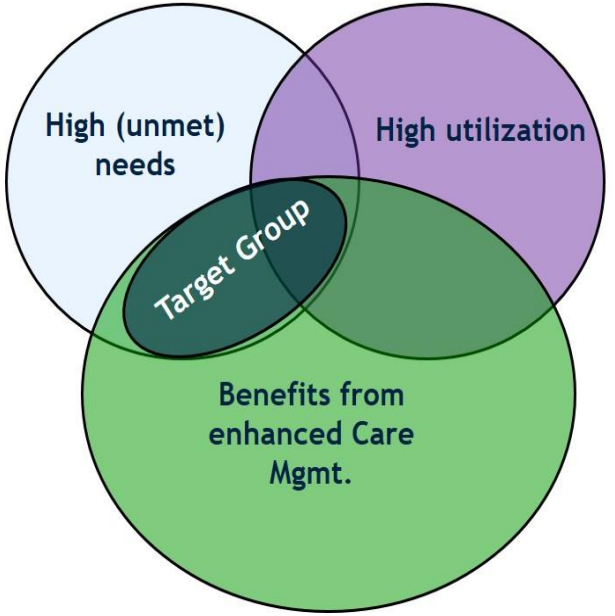
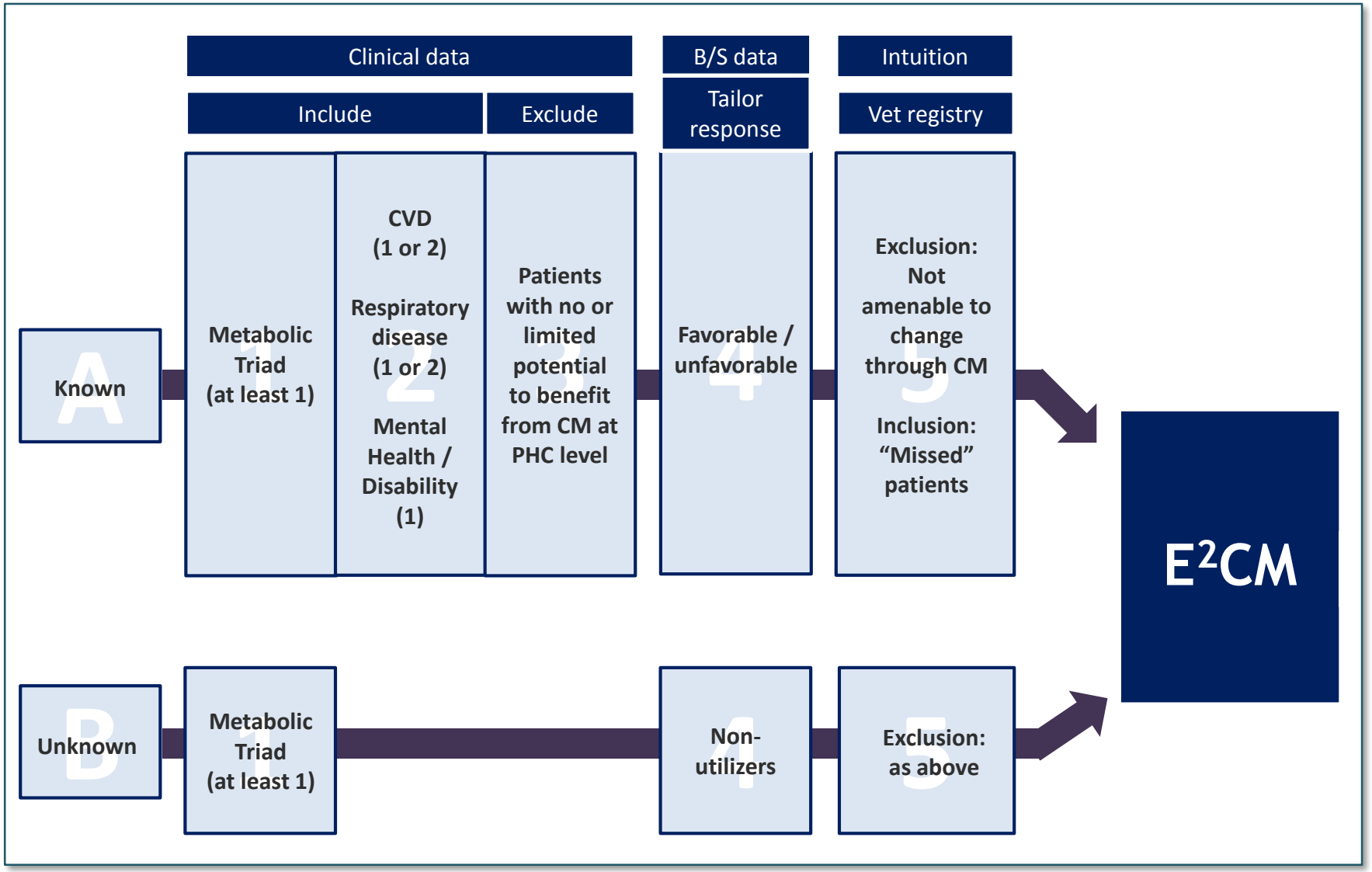


Risk-Stratification - areas for further development

- Two tracks of patients
- Disease severity and amenability to EECM
- Sources of behavioral & social data
- National variations in the disease burden
- Dynamic risk-stratification

Two tracks of patients

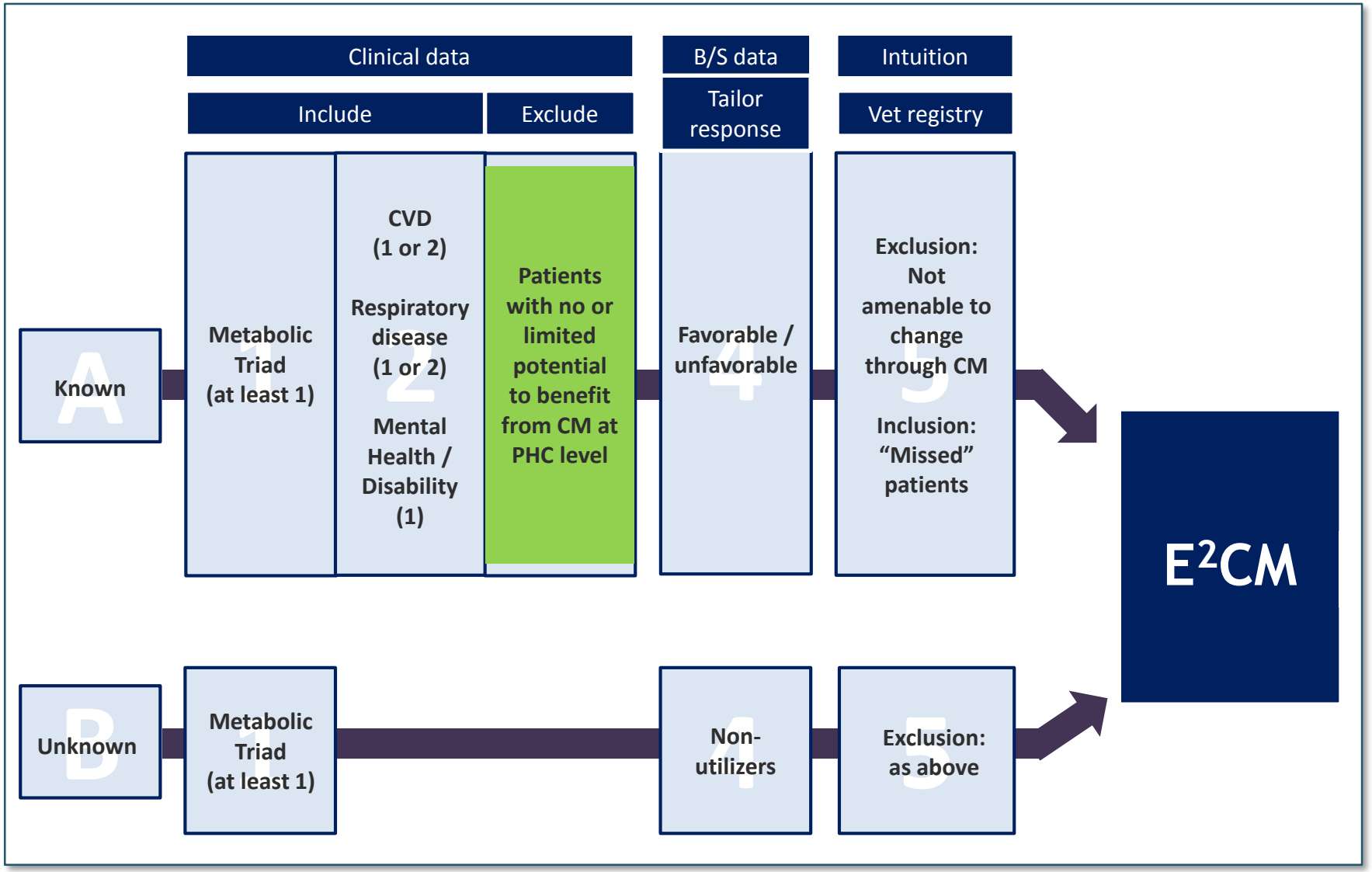


Two tracks of patients

Different risk profiles for the same objective

- *Example 1*: Elderly patients, multiple a/o unstable chronic conditions
- *Example 2:* Relatively young patients, some chronic condition

Disease severity and amenability to EECM



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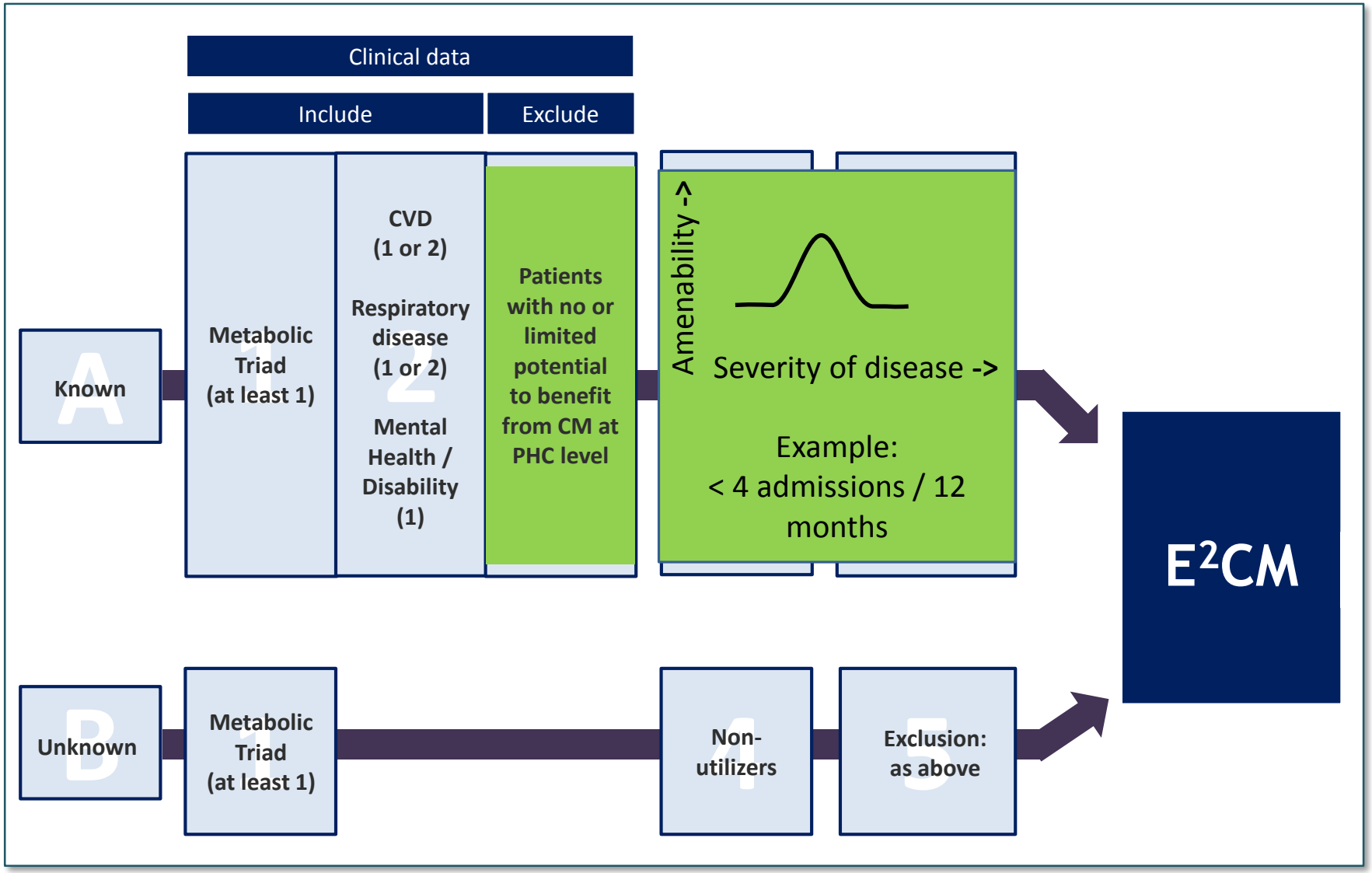
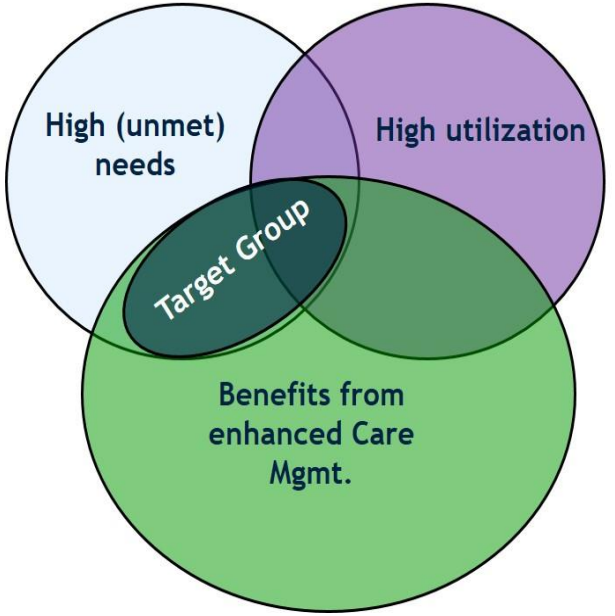


Importance of Behavioral and Social Data

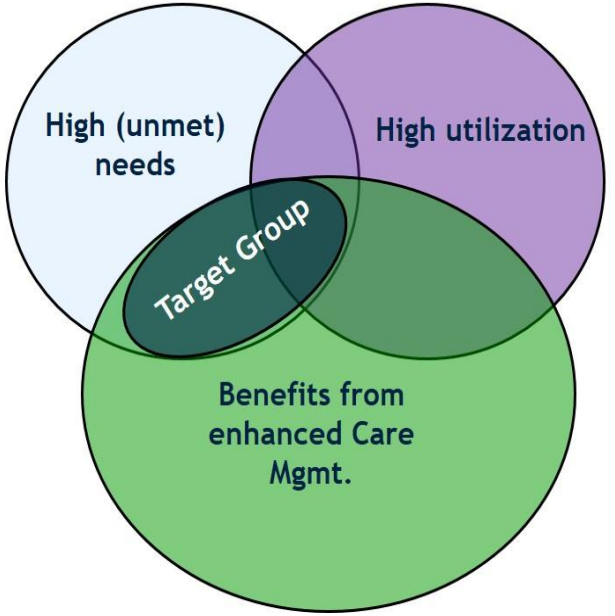
Who are the high-need patients that are amenable to EECM?



Importance of Behavioral and Social Data

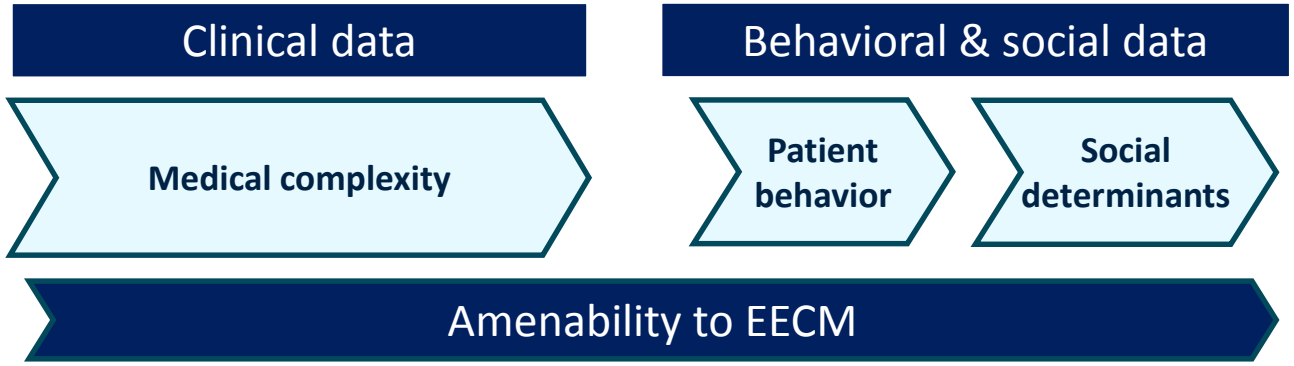
Who are the high-need patients that are amenable to EECM?

- Social and behavioral factors are as important as actual medical needs
- Behavioral/mental illnesses impact how well patients can handle their other chronic conditions
- Social needs (loneliness, financial worries, etc.) critically define a patient's health condition



Behavioral	Social
x/✓	x/✓

Behavioral & social data - Tapping the great data existing data sources



Behavioral

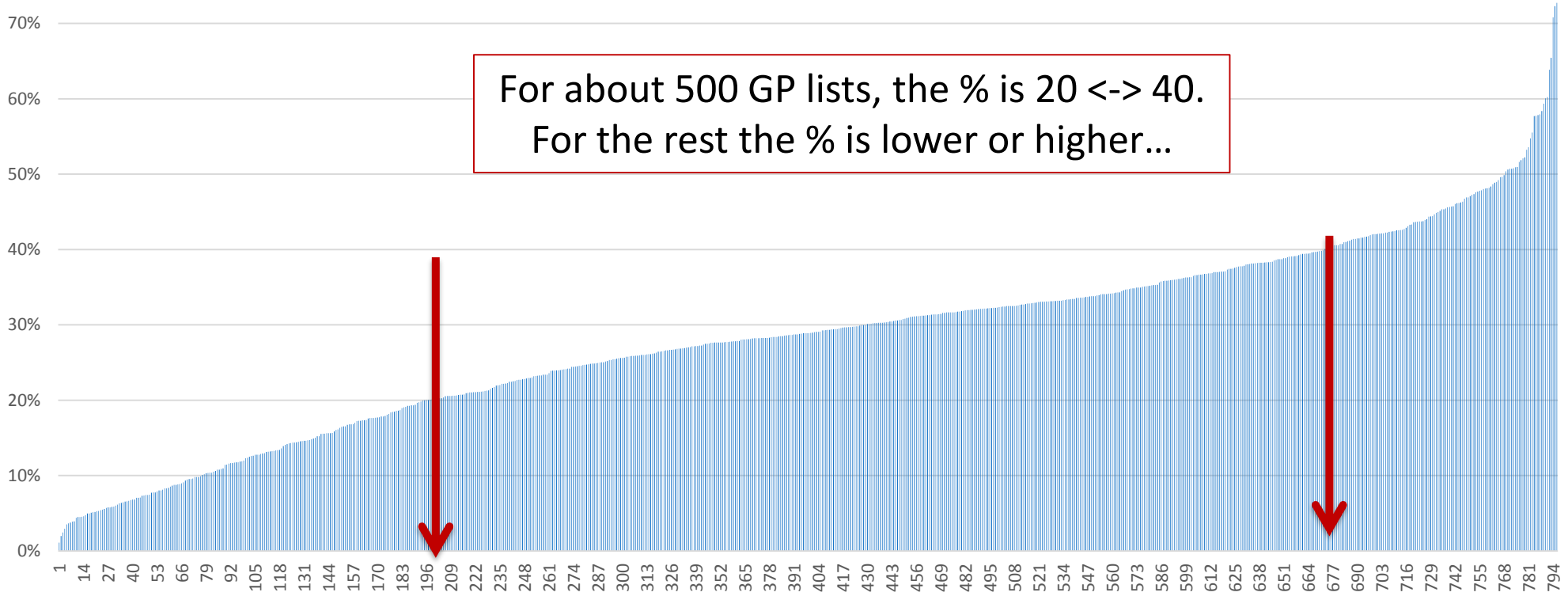
- Info on missed visits (to become available)
- Number of medications/number of medications picked up
- Emergency visits
- Avoidable specialist visits

Social

- Living alone
- Mother tongue & knowledge of Estonian
- Socio-economic status (household income)
- Education level
- Employment status
- Place of residence

National variations in the disease burden

% of patients with >= 1 condition(s) from metabolic triad (DM/HTN/Hyperlipidemia)



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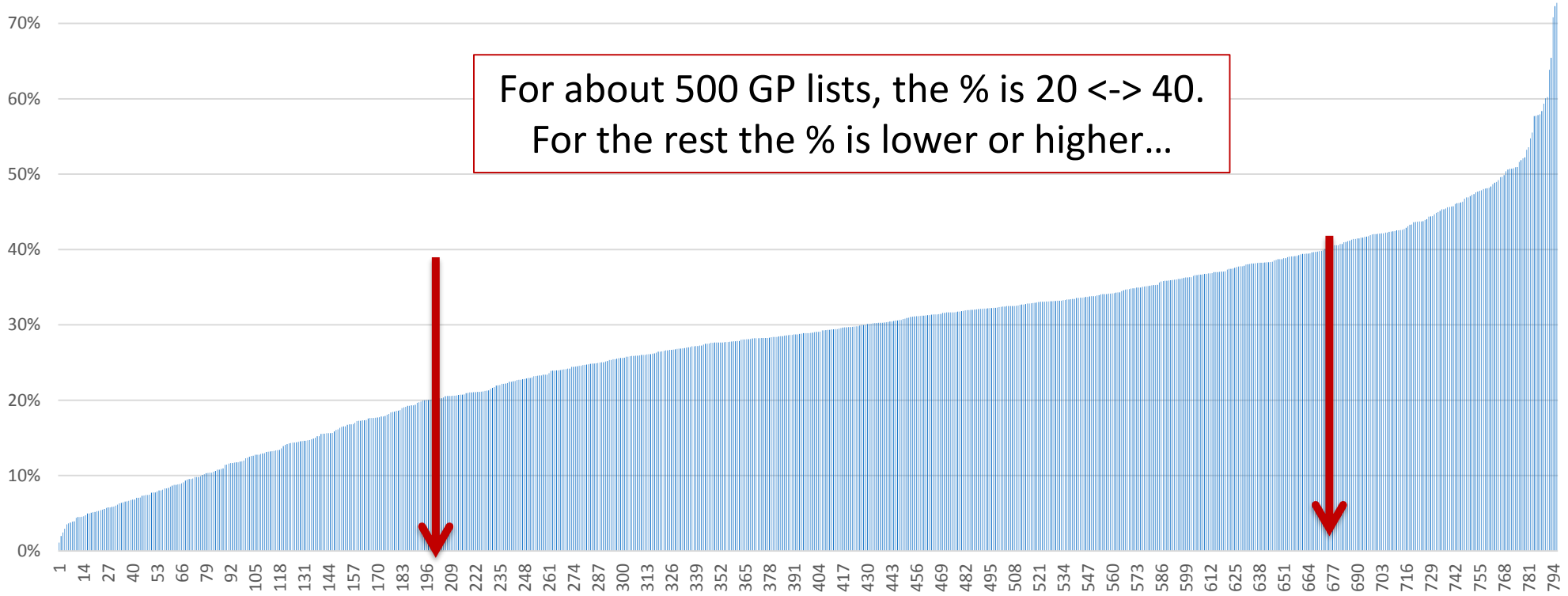
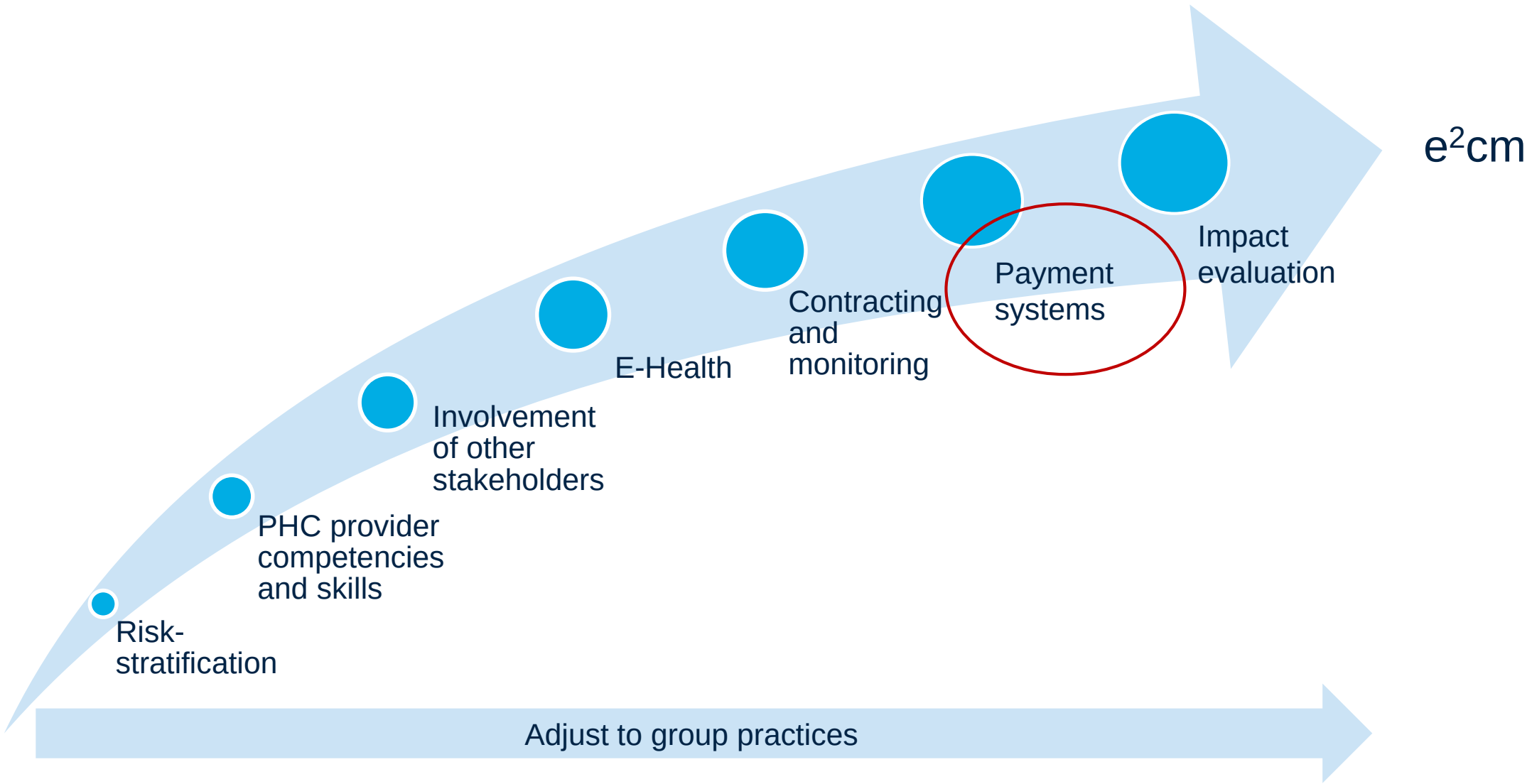


- Homogeneity or heterogeneity of patients across FP practices
- Balancing the size/risk-profile of patient lists across FP practices

The goal - dynamic risk-stratification

- Dynamics of risk profiles
  - Changes in risk profiles over time (short-term acute vs. longer-term risk), need for graduation of people from the registry according to rules
- Graduation/discharge rules:
  - How to balance the influx vs. outflow of patients through the right graduation/discharge criteria?
  - How to determine whether someone stays in the CM program?
- Updates of the risk-stratification algorithms
  - Gradual but constant improvements to target the right patients

Areas of further work



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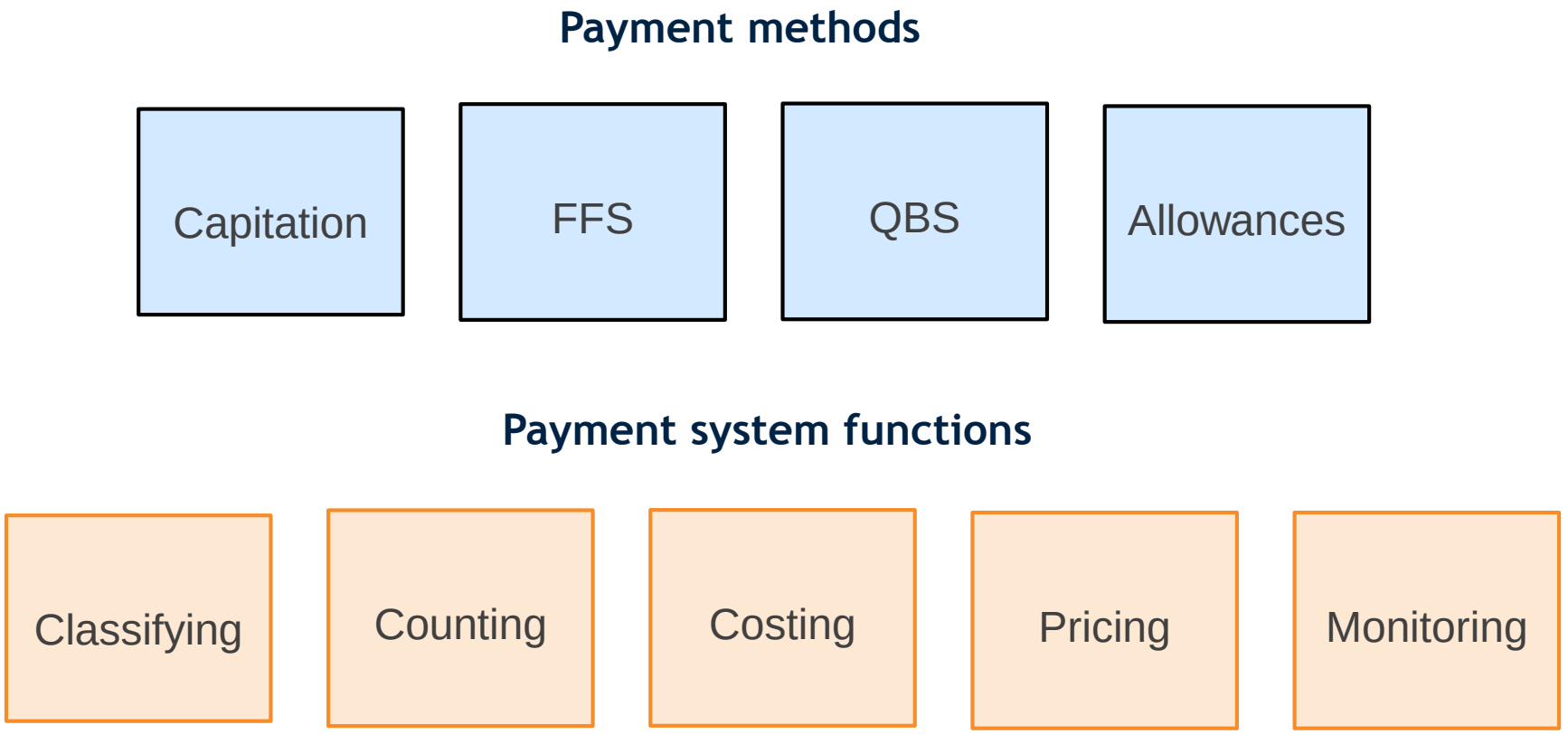
Introduction to payment systems



Challenges of paying for E²CM:

- Activities are not considered under traditional payment methods (e.g. capitation, FFS, allowances, pay for performance)

- Since they are historically not expected from primary health care providers, e.g.:
  - Comprehensive assessment of care needs, considering patient's social and contextual environment
  - Development of comprehensive care plans (dual-facing, anticipatory)
  - Coordination of care transitions (beyond referrals, including follow-up care)
  - Coordination of social care services

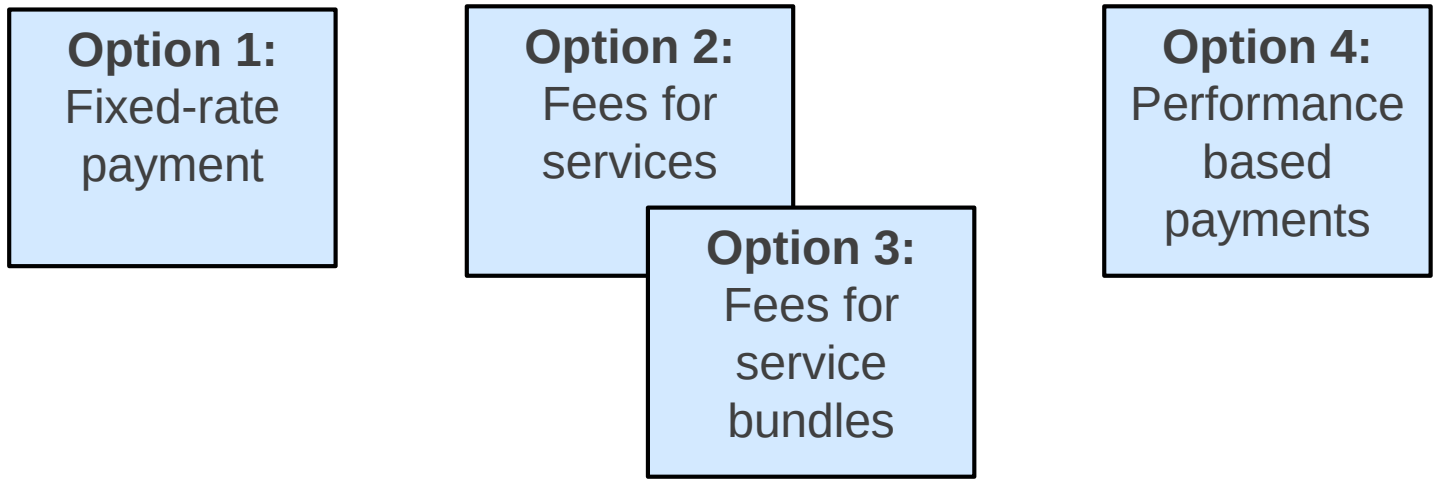
Key principles of payment method design

- Payments can be made before services are delivered (ex-ante) or after (ex-post)
  - Ex-ante payments tend to encourage efficiency, but may result in “skimping” or “cream-skimming”
  - Ex-post payments encourage the delivery of priority services, but may result in unnecessary care

- Payment recipients include either:
  - Structures/facilities (e.g. primary care practice) or
  - Individual health care professionals (e.g. primary care physicians, nurses, primary and/or secondary care specialists, etc.)

- Payment rates may vary based on patient severity level

Principle options for enhanced care management payment



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Option 1: Fixed-rate payment

- **Key features:**
  - Single payment covering costs of all program services for an average patient during a business cycle
  - Flat or risk-adjusted payment
  - Ex-ante

- **Example:** “Experimentation of New Modes of Remuneration (ENMR)” in France

➢ ***Payer:*** National Health Insurance Fund - scheme for salaried workers

➢ ***Design:***
  - ➢ Separate flat, fixed-rate payments for three domains
    - Care coordination
    - Patient education
    - Multidisciplinary approach
  - ➢ Payments to the facilities not professionals
  - 3 types of multidisciplinary primary care facilities with different governance structures and contracting arrangements

➢ Combined payments constituted approx. 5% of facility revenue

Option 2: Fees for services

- **Key features:**
  - Fee-for-service
  - Ex-post

- **Example:** “Chronic Care Management (CCM) Services” in the United States

➢ ***Payer:*** Medicare

➢ ***Design:***

  ➢ Fees for two types of services:

    i. initial assessment and care planning, and

    ii. care coordination activities per month, including ongoing, non-face to face oversight, direction and management

  ➢ Fees vary depending on complexity of patient

  ➢ Payments to primary care physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners or physicians assistants

Option 3: Fees for service bundles

- **Key features:**
  - Fees for bundles of services
  - Ex-post

- **Example:** “Cardio-Integral” program in Germany

➢ ***Payer:*** AOK Plus - statutory sickness fund of Saxony and Thuringia

➢ ***Design:***

  ➢ Three service bundles:
    - Enrollment of patients, compliance monitoring (visits, treatment), adherence to clinical pathways
    - Coordination of invasive diagnostic and therapeutic procedures
    - Compliance with treatment guidelines, including drug lists

  ➢ Tariffs and billing frequencies dependent on care needs of patients with different cardiovascular conditions

  ➢ Payments to structures – GP practices and cardiac department in University Hospital Dresden

Option 4: Performance-based payment

- **Key features:**
  - Single payment, with amount contingent on provider performance
  - Process or outcome indicators
  - Ex-post or mixed

- **Example:** Second phase of “ENMR” program in France

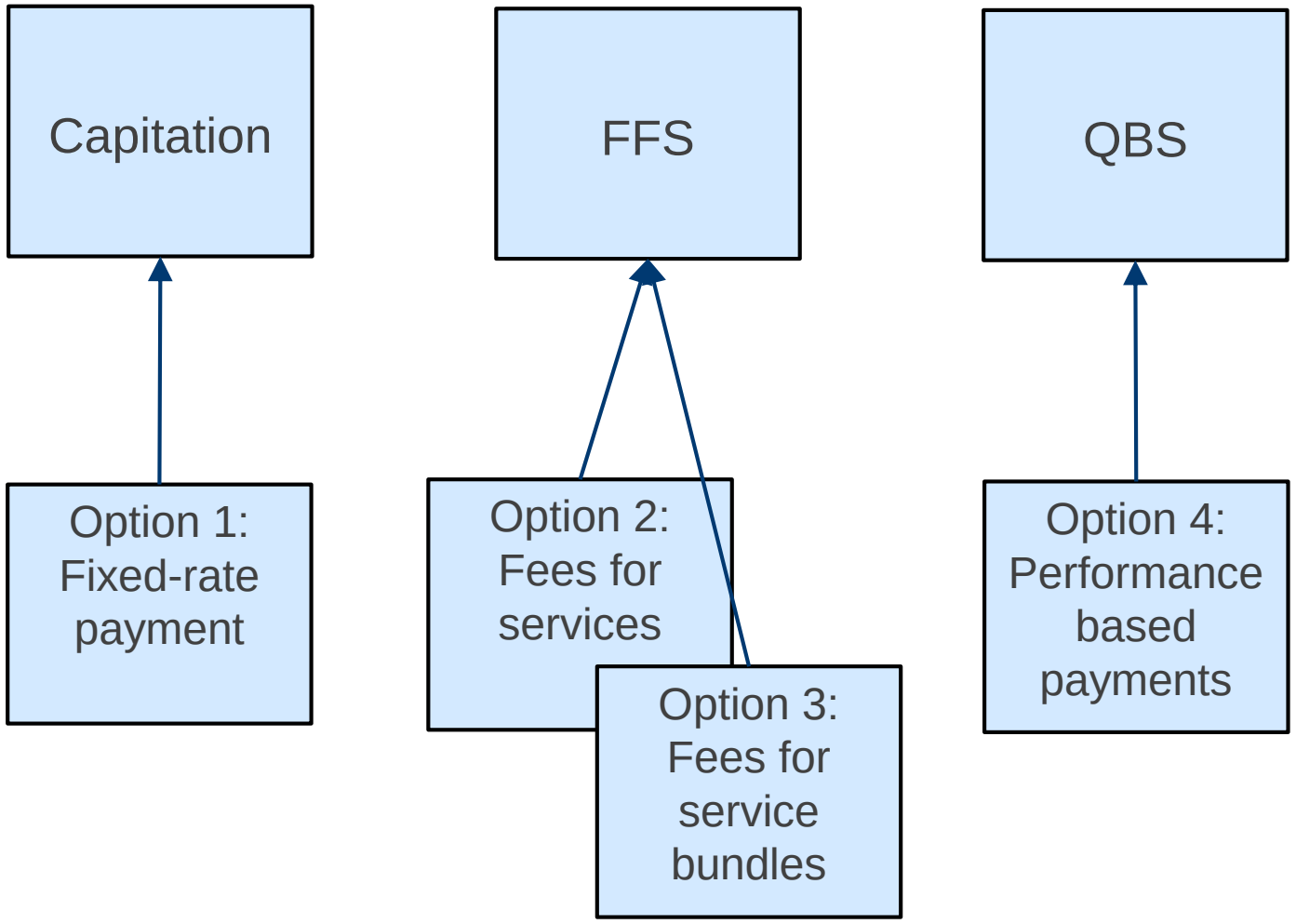
➢ ***Payer:*** National Health Insurance Fund - scheme for salaried workers

➢ ***Design:***
  - ➢ Performance-based payment for care coordination domain only
  - ➢ Distinguishes sub-domains of mandatory and optional services
  - ➢ For each of these sub-domains, fixed and variable payments
    - Fixed payments based on number of patients
    - Variable component reflects improvement in care coordination processes (24 key indicators, three dimensions: (i) quality of care, (ii) coordination and continuity and care, (iii) efficiency)
  - ➢ Mixed: providers receive 60% of expected payment in advance with the remaining share paid at the end of the year.

Some lessons

- Payment methods for enhanced care management can create strong incentives for providers to enhance care management
- Focus is on improvements in processes rather than outcomes
- Typically constitute small share of provider revenue, however independent of the payment method combined with close provider monitoring
- Administrative burden depends on overall payment system design

Potential integration with current payment methods



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Likely best design fit for Estonia

- Fixed-rate payment covering costs of all program services for an average patient during a business cycle (Option 1)
  - Reflects the comprehensive approach to enhanced care management
  - Supports focus on coaching and supervision rather than billing and reporting in early stage of program
  - Keeps administrative burden low (prior to a comprehensive e-health solution)
- Payment to structures (both solo and group practices)
  - Facilitates shift from solo to group practices
- Eventually risk-adjusted dependent on improvements to risk-stratification
- Combined with development of contracting and provider monitoring model


KEEP
GOING