Development of a payment model for chronic care in primary care

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▢ Introduction

Burden of chronic diseases has increased due to aging in South Korea. But chronic care has faced many challenges. Primary care should be strengthened for effective chronic care. In addition to fee-for-service (FFS), new payment methods should be applied to improve quality of chronic care. This study aimed to develop a payment model for chronic care in primary care and calculate a fee for initial assessment and planning (initial assessment fee) which will be applied in the second year of Community-Based Primary Care (CBPC) project.

▢ Theoretical considerations for chronic care payment models

Payment models are theoretically underpinned by principal-agent relationship in economics. It can contribute to make an agent maximize its principal's benefit by paying providers fairly and helping improve care quality under uncertain conditions of medical care.

Prototypes of payment methods encompass FFS, case payment, capitation, global budget and salary. Additionally, there are ancillary payment methods, such as pay-for-performance (P4P) and shared savings. Each payment method has its own advantages and disadvantages, so a mixed payment approach has been popular around the world because it can compensate for the weakness of each payment model.

▢ Foreign experiences of chronic care payment models

The U.S. Comprehensive Primary Care Initiative is a 4-year demonstration project where primary care providers are paid a monthly non-visit-based care management fee and shared savings for strengthening 5 primary care core functions and improving care efficiency. Interim evaluation of the project revealed that there were some improvements in primary care quality, but whether medical cost was contained was uncertain.

The British Quality and Outcomes Framework (QOF) was a typical P4P applied to primary care, which provided financial incentives to general practice according to the level of care quality. The first year of the QOF introduction saw an increase of 25% in general practitioners' income. There were prominent improvements in blood sugar and pressure control while mortality rate did not decrease.

The Australian Practice Incentive Program was an incentive program aiming to help provide comprehensive primary care. It included incentives for chronic care and service infra-structure. Its evaluation showed that there were some improvements in care process with little favorable outcome improvements.

The German Disease Management Programs (DMPs) was introduced to tackle care fragmentation. It was based on Chronic Care Model of which strategies include the use of evidence-based practice guidelines, patient education, etc. DMPs employed a combination of per-member, per-quarter payment and FFS. Care process was improved and cost containment was achieved, but outcome improvement was uncertain.

▢ Current status and challenges of chronic care in primary care

The standardized mortality rates of major chronic disease and avoidable mortality has been continuously decreasing, but international comparison showed that higher mortality was observed in South Korea than in other OECD countries. A so-called 'Korean paradox' implies chronic care's weakness.

There were some challenges to chronic care in South Korea: making sure access to non-visit services; ensuring comprehensive primary care; establishing vertical and horizontal patient referral system.

The government of South Korea has implemented quality and payment initiatives: reducing user charge of people with chronic disease at primary care, community-based hypertension and diabetes registration program, chronic care fee schedule for care continuity and comprehensiveness; paying providers patient referral fee for care coordination; public disclosure of patient outcomes and P4P for care quality; financial incentives for efficient drug prescribing and dispensing.

Although it is currently just for people with hypertension and/or diabetes, chronic care should embrace those with other chronic diseases in the future. Using FFS as a basis of payment model can make a chronic care payment model acceptable and feasible. Feedback and financial incentives will be beneficial.

▢ Development of a payment model for chronic care in primary care

Principles of developing a payment model are strengthening primary care, value investing for health system sustainability, and incentivising people and providers to voluntarily participate in chronic care. A framework of the payment model consists of FFS for additional services, per-patient payment for chronic care, quality incentives, and shared savings with established FFS scheme.

A step-by-step approach is proposed for payment model reform: in the 1st step, FFS for additional services and per-patient payment for chronic care will be introduced; P4P in the 2nd phase; shared savings in the 3rd phase. Additional medical cost in the 1st phase will be about 835 billion won, 9.8% of costs covered by the National Health Insurance Service (NHIS) at primary care or 2.0% of total costs covered by the NHIS under health coverage when the number of people with hypertension and/or diabetes is 10 million and service utilization rate is 50%.

▢ Initial assessment fee in the 2nd year of CBPC project

Initial assessment fee was calculated by measuring consultation time and using a ratio of initial assessment time to usual consultation time. Initial assessment is composed of two consultations, one for comprehensive patient assessment and laboratory test order and the other for interpreting test results and making care a plan with a patient. The fee was calculated to be 65,799 won, 2.28 times of the two-time new patient consultation fee, 28,818 won.

Keywords

: primary care, chronic care, payment model