Hospital financing in France: Introducing casemix-based payment

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RÉPUBLIQUE FRANÇAISE
Ministère de la santé et de la protection sociale

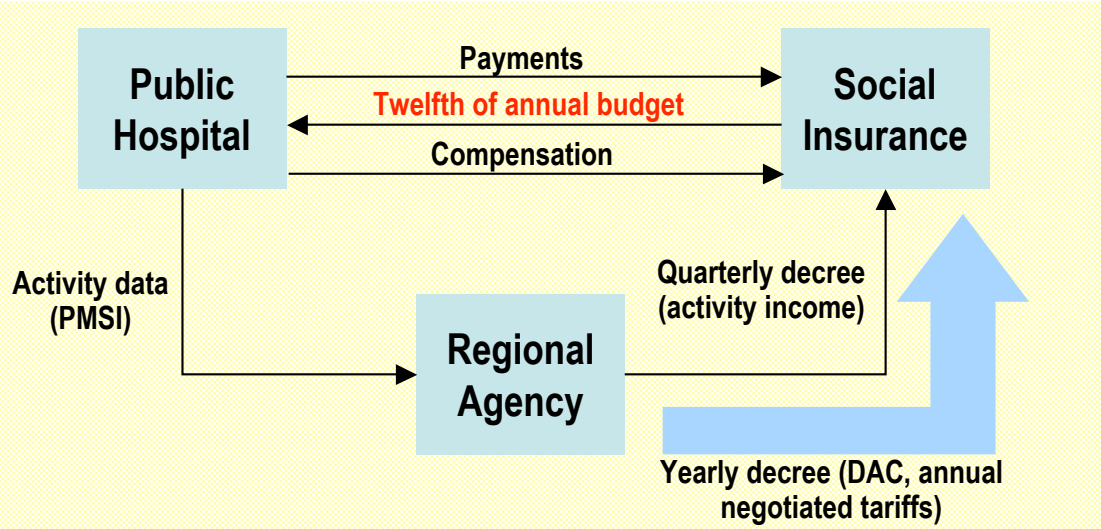
HOPITAL 2007 T2A

Agenda

1. The current French hospital financing system
   - ➔ Description
   - ➔ Problems
2. Moving towards casemix-based financing
   - ➔ Basic idea, main objectives and principles of the reform
   - ➔ Technical aspects of the reform
3. Impact of the new system and future perspectives
   - ➔ Expected impact on healthcare management
   - ➔ Future development

Description of the current financing system for French public hospitals

French public hospitals are financed through a global budget system managed by the hospitals, the funds providers (the social insurance fund) and a regulator (the ARH)



Monthly payment of a twelfth of the global budget to the hospitals by the social insurance funds

- Allocation of the regional envelopes to the hospitals according to expected activity growth, based on former statistical data (PMSI)
- Possible adjustment based on a system called “points ISA”

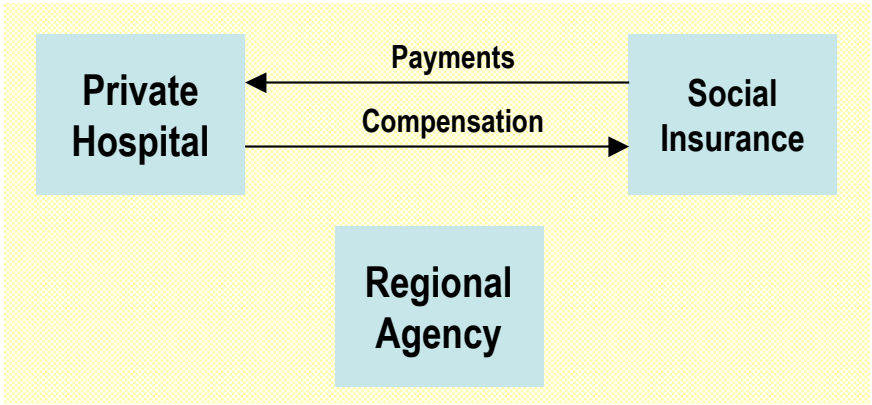
- Determination of the National Objective for Healthcare Expenditure (ONDAM)
- Splitting of the ONDAM in several envelopes, one of which affected to hospital care
- Allocation of this envelope to the Regional Hospital care Agencies (ARH)

Description of the current financing system for French private hospitals

Negotiated fee-for-service tariffs constitute the main source of financing for French for-profit hospitals

Separate billing of:

- medical services (each delivered service reimbursed separately according to the negotiated tariff)
- housing expenses (i.e. laundry, catering, etc.) through a negotiated tariff per daybed
- additional payment of a number of expensive drugs or devices



Negotiation with private hospitals professional unions on the services provided and their tariffs

Allocation of the regional envelopes to the hospitals according to the expenses growth rates negotiated with the professional unions

- Determination of the National Objective for Healthcare Expenditure (ONDAM)
- Splitting of the ONDAM in several envelopes, one of which affected to hospital care
- Allocation of this envelope to the Regional Hospital care Agencies (ARH)

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Problems generated by the current system

Teaching, Research, Recourse and Innovation lump sums are composed of a fixed and a variable share

Inequity within public sector

- ➔ Increasing inequity in the share of resources between dynamic and less dynamic hosp.
- ➔ No incentive to better quality nor greater quantity
- ➔ Rigidifying of the distribution of activities among hospitals

Inequity within private sector

- ➔ Very strong disparities of tariffs per procedure among hospitals and regions, depending on each hospital's and each Regional Agency's ability to negotiate
- ➔ Great complexity of the system, making it hard to pilot for the State

Inequity between public and private sector

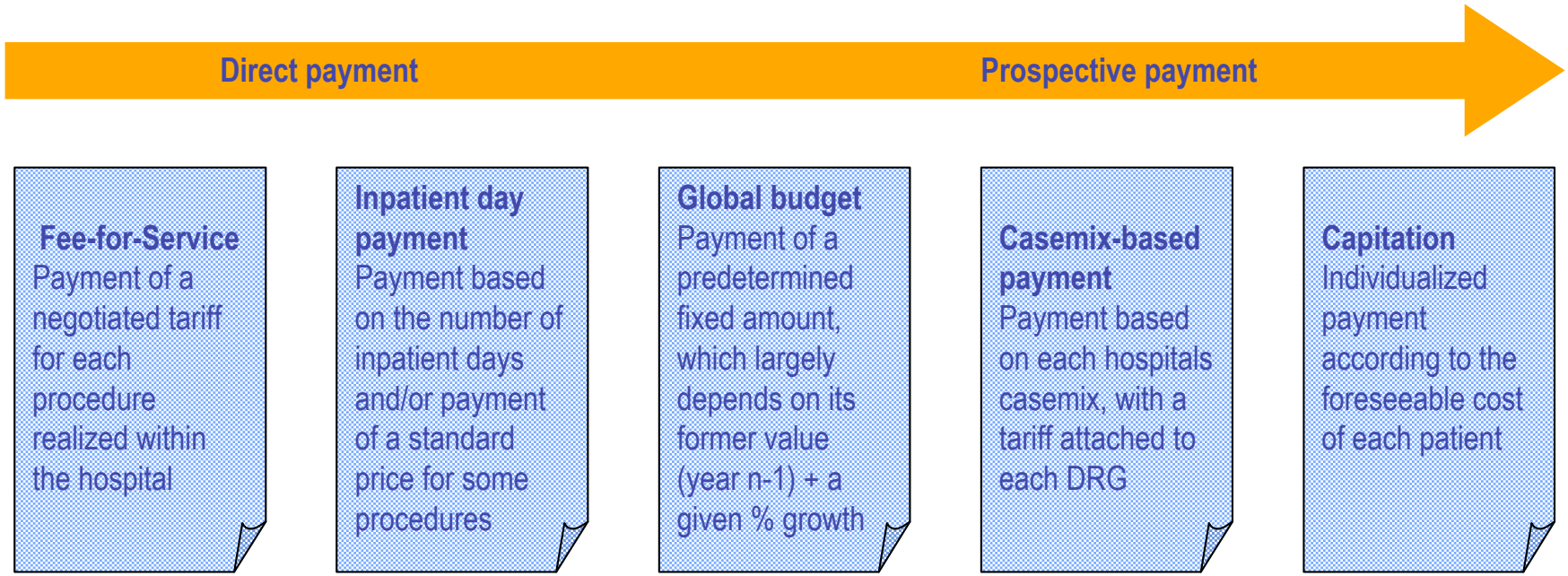
- ➔ Stronger incentive for private for-profit hospitals to management optimization, costs cutting and maximization of activity volumes

Failure of casemix-based adjustment

- ➔ Creation in 1996 along with the Regional Agencies of the 'point ISA'
- ➔ Failure of many regions to use it as a budget adjustment tool
- ➔ Increase in interregional inequalities as a result

Evolving towards casemix-based financing

Following a classic pathway, France is thus moving from global budget to casemix-based hospital financing



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The Casemix-Based Hospital Payment Project: Main objectives and principles

The objectives of the reform and the principles it follows directly result from the flaws of the current system

Objectives:

- ➔ Link financing to the actual level of activity of the hospitals
- ➔ Establish a common financing system for public and private hospitals
- ➔ Create incentives for hospital managers and medical staff to analyze their casemix, medical practices and costs structure
- ➔ Promote the development of some activities (e.g. ambulatory surgery) and hinder the growth of others

Principles:

Field: hospital activity in medicine, surgery and obstetric (thus excluding psychiatry, rehab, etc.)
A gradual implementation with many transition adjustments
A global price-volume regulation (i.e. if the global hospital activity grows on year n, the tariffs will be lowered on year n+1 to make sure the hospital budget is not exceeded)
Convergence of the tariffs scales applied to the public and private sector
Within each sector, convergence of the tariffs and conditions between hospitals

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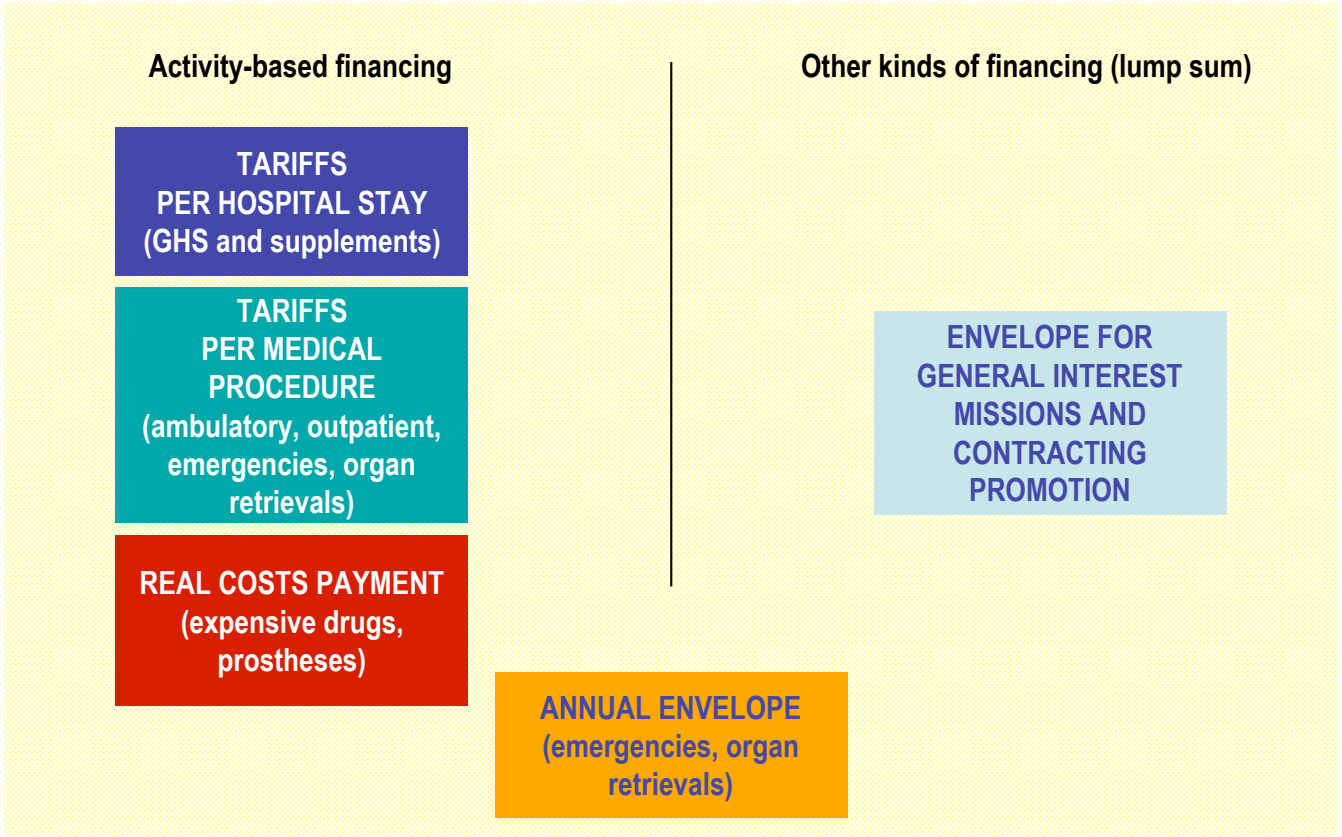
The Casemix-Based Hospital Payment Project: Technical aspects

A mixed system is being implemented in France for both public and private hospitals, with five different modes of financing



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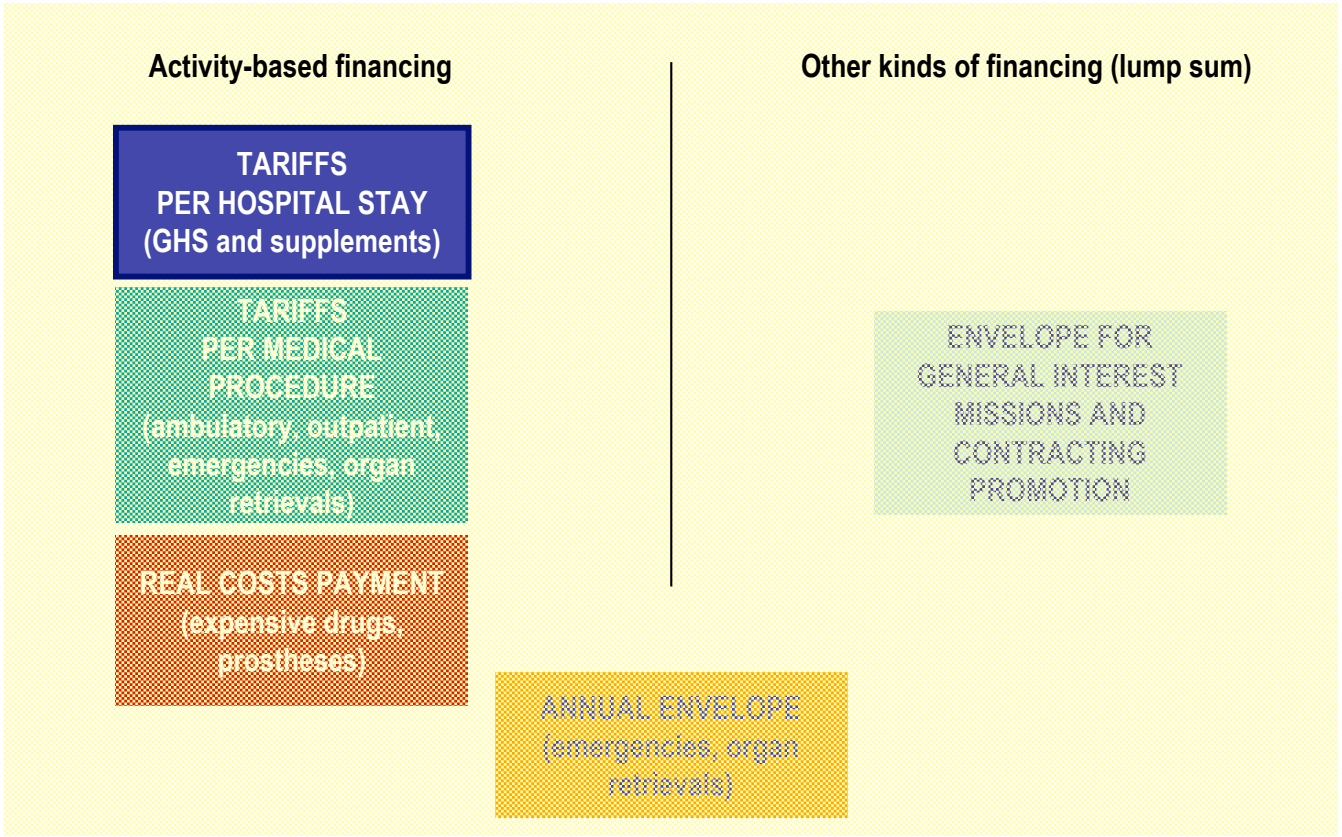


Casemix-based financing (1/5)

Developed based on the third version of the American HCFA-DRG, the French GHM have then been enriched with elements from the AP-DRG classification

PMSI:

- ➔ the French patients classification tool
- ➔ based on the GHM classification (580 groups)
- ➔ managed by a public agency, the ATIH (http://www.atih.sante.gouv.fr)

French GHM (*"Groupes Homogènes de Malades"*) classification:

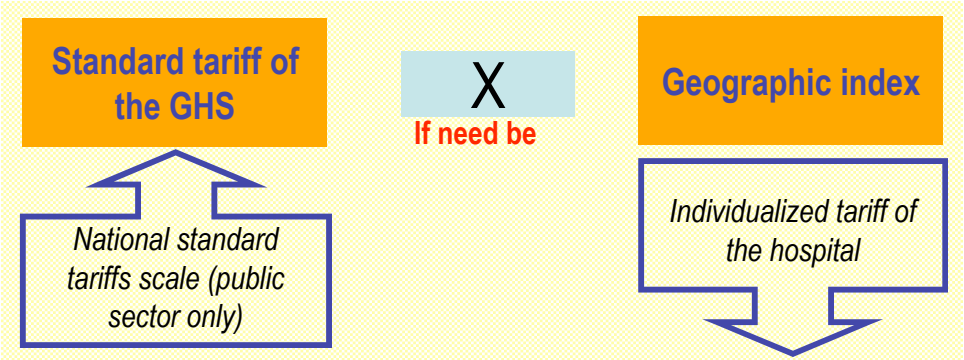
- ➔ first developed based on the third version of the HCFA-DRG classification
- ➔ enriched with elements from the AP-DRG classification
- ➔ now on its 9th version

Coding based on:

- ➔ ICD-10-CM for the coding of diagnoses
- ➔ the French classification of medical procedures (CdAM, soon to be replaced by the CCAM) for the coding of procedures

Casemix-based financing (3/5)

The tariffs linked to each GHS will be adjusted by applying specific indexes

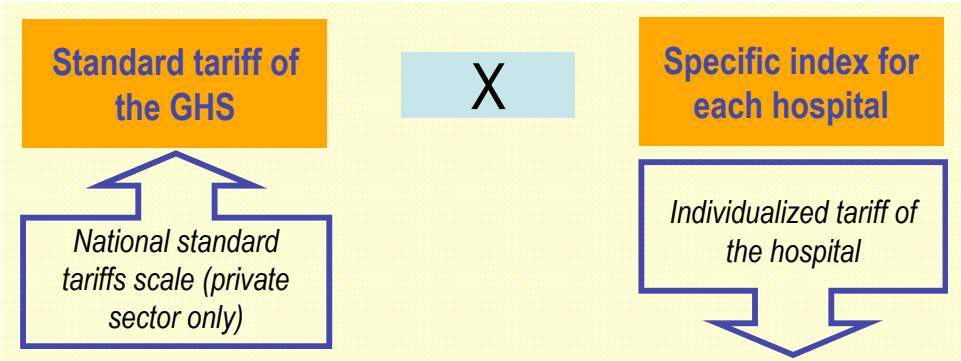


Publics hospitals and private hospitals PSPH:

The national tariff is uniformly applied, with the exception of some specific areas where an index is used to take geographic disparities of costs into account

Private hospitals non-PSPH:

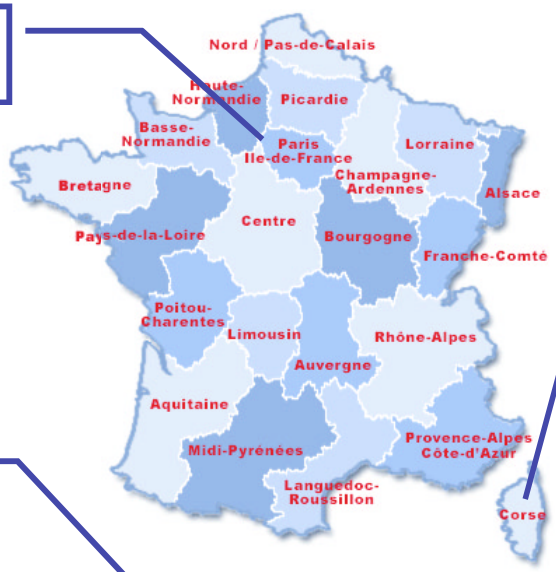
An individualized and composite index is applied for each hospital to the national tariffs



Casemix-based financing (4/5)

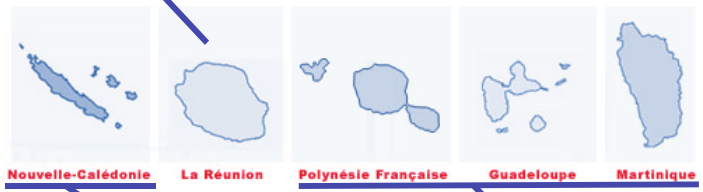
The geographic index applied to the GHS tariffs of public hospitals is very rough at this stage of the reform and should remain marginal as a means of adjustment

Paris and its surroundings: 7%



Corsica: 5%

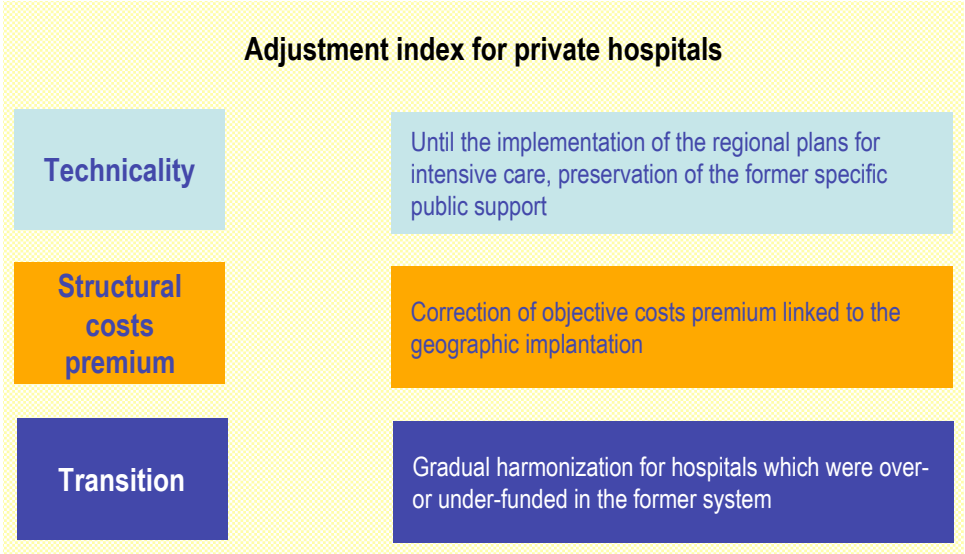
La Réunion: 30%



Other overseas territories: 25%

Casemix-based financing (5/5)

While the geographic index created for public hospitals is to be used marginally, the adjustment index applied to the tariffs in private hospitals is systematic and complex

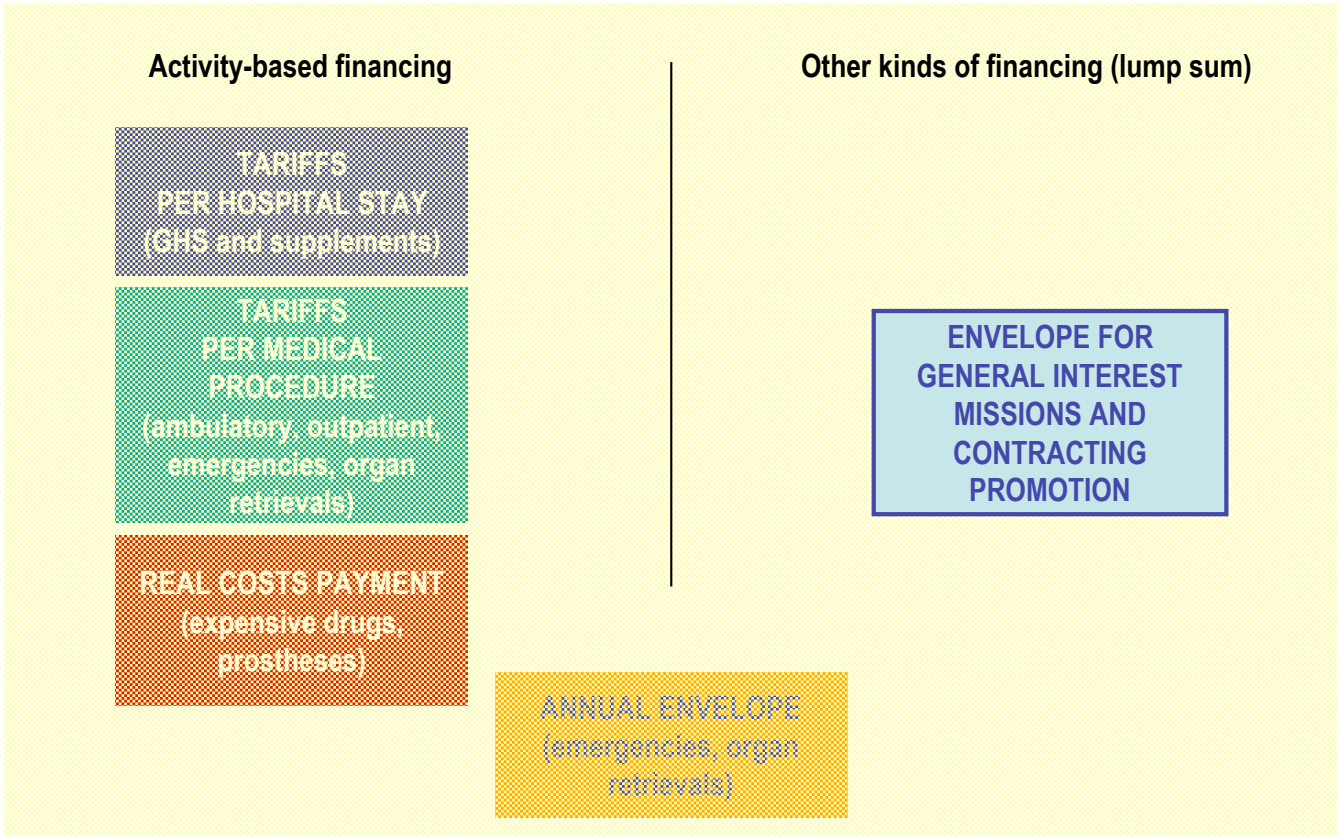


Other possible minor adjustments practicable (as regards fixed costs):

- As a general rule, fixed costs (i.e. committed costs such as real estate amortization, interest expenses, wages) are integrated to the standard tariffs fixed on a national scale for each GHS
- However, the Regional Agencies for Hospitalization (ARH) can allocate some of the MIGAC envelope to cover some of the fixed costs of a given hospital

The Casemix-Based Hospital Payment Project: Technical aspects

A mixed system is being implemented in France for both public and private hospitals, with five different modes of financing



Financing of public interest missions (1/2)

Public interest missions, insofar as they induce special charges for the hospitals which support them, are financed on a lump sum basis

Teaching, research, recourse and innovation	•Allocated based on the special costs supported by some hospitals for their teaching and research activities or due to their recourse function •Should not remain restricted to statutory teaching hospitals only (see next slide)
Other public interest missions	•Public interest activities which are currently excluded from the field of Medicine, Surgery and Obstetrics by hospitals accounting rules, but must be protected •Ex.: organs banks, care to specific populations, mobile medical teams, therapeutic screening, etc.
Contracting promotion	•Allocated by the Regional Agencies for Hospitalization based on regionally-defined criteria and regional capacity planning •Cannot be used to support the hospitals in the implementation of the reform

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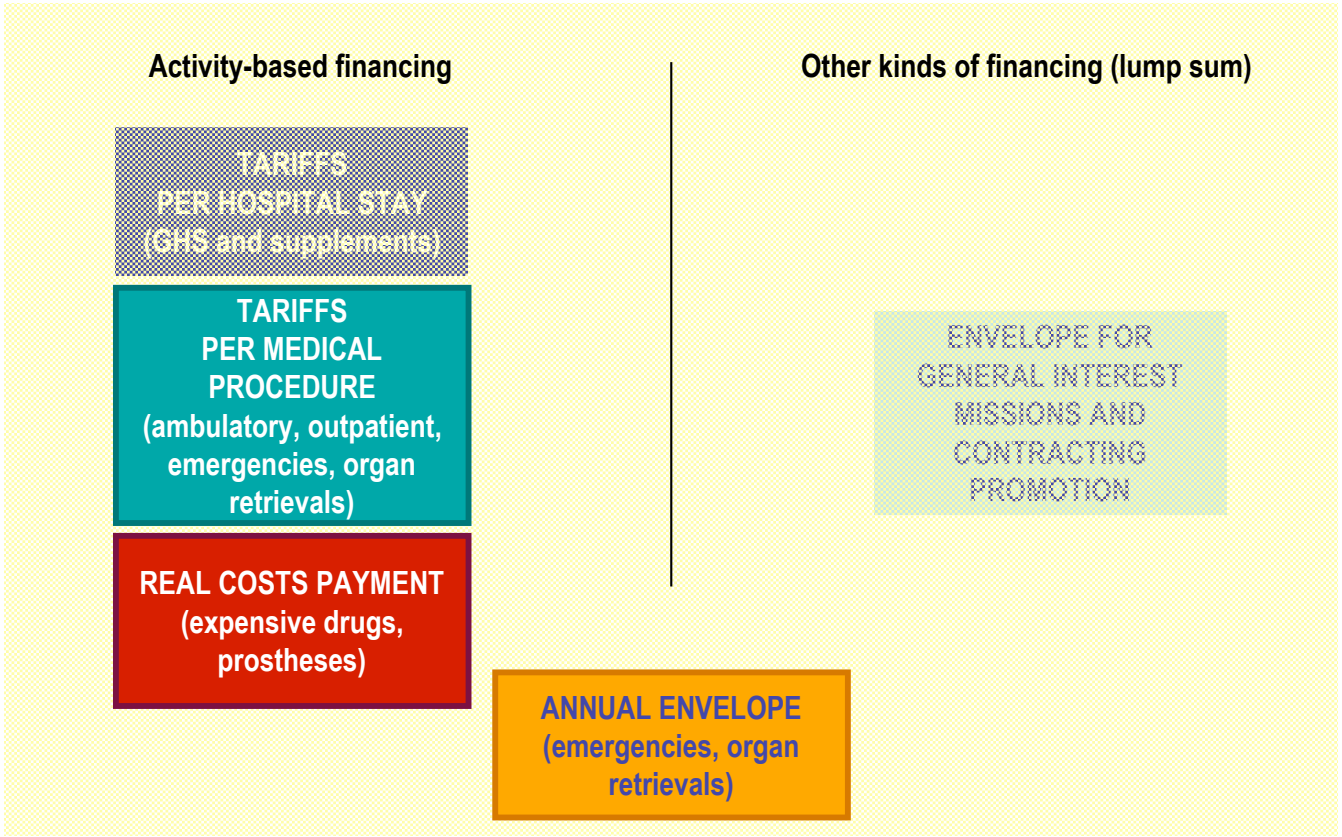


Other types of adaptations (2/4)

Emergencies and Organs retrievals and transplants benefit from a twofold financing with a fixed and a variable share

Emergencies

- annual lump sum payment to each hospital who has an emergency unit to cover fixed costs (single tariff up to a certain number of annual venues, which is majored by a standard tariff for each additional 5000 yearly venues)
- payment of one unique national tariff for each patient's transit through an emergency unit, provided it is not followed by a hospitalization (which would imply the billing of a GHS)

Organs retrievals and transplants

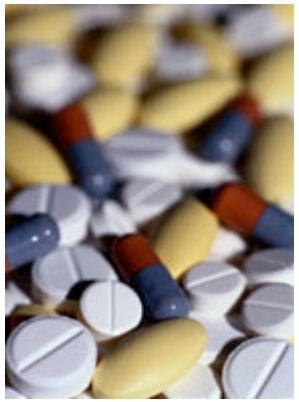
- annual lump sum payment to cover the costs linked to hospitals' coordination of organ retrievals and transplants (8 levels)
- national tariffs paid to the hospital where an organ is retrieved (5 tariffs)

Other types of adaptations (3/4)

Some particularly expensive drugs and implants are excluded from the GHS tariffs perimeter and reimbursed additionally based on hospitals' real costs

Additional reimbursement based on the price the hospital pays only if three criteria are fulfilled:

- ➔ high cost ;
- ➔ introducing heterogeneity within the GHM costs ;
- ➔ inscription on a list published every year



Two-folded regulation:

- ➔ maximum price: if the price paid by the hospitals is above it he is not reimbursed for what exceeds the maximum price; if it is under it he gets a margin (fraction of the difference)
- ➔ hospitals / regional agencies contracting for good usage (i.e. according to nationally or internationally acknowledged medical standards)

Reminder: drugs + implants are included within the GHS tariffs in principle

Other types of adaptations (4/4)

Specific rules apply to outliers and to transfers between hospitals

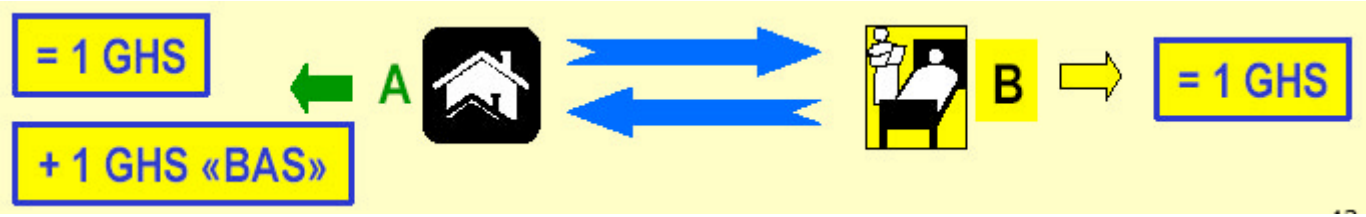
Concerning outliers:

- If the length of the stay is inferior to a certain limit, a minorating index is applied to the tariff of the GHS (0,5)
- If the length of the stay is superior to a certain limit, each additional daybed is paid individually but at an inferior tariff through the application of another index (0,75)

Concerning transfers:

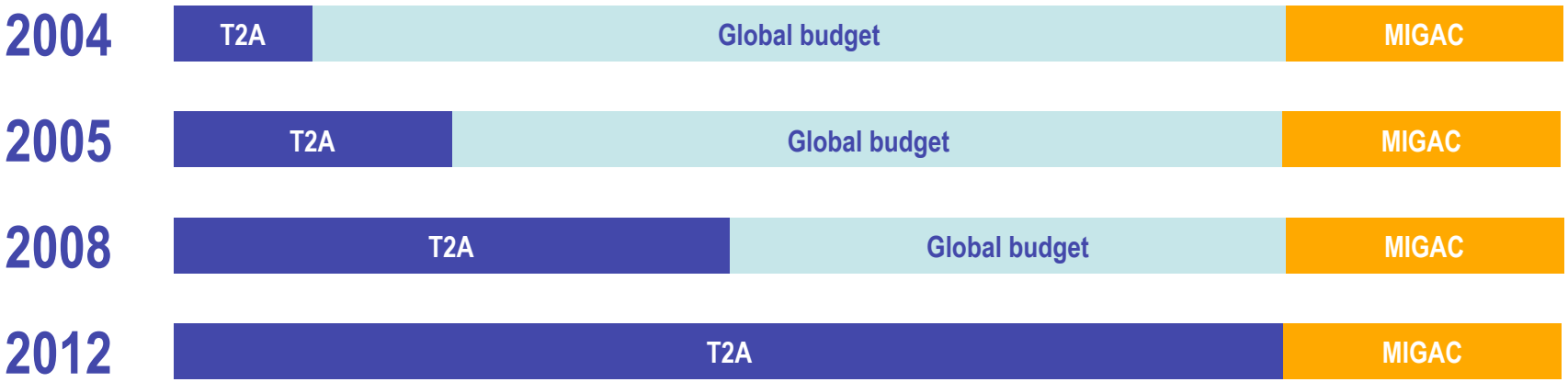
- Transfer < 48 hours: Only one GHS can be billed

- Transfer > 48 hours: Two identical GHS are billed, one of which is composed of two separate entities, except in the case of iterative treatments where still only one GHS can be billed



Organization of the transition in the public hospital sector (1/3)

In public hospitals, casemix-based financing started in 2004, representing 10% of the budgets in 2004 and 25% in 2005



Organization of the transition in the private hospital sector

In private hospitals, casemix-based financing started on the 1st of March 2005 with a transition period of 7 years

- ➔ 100% casemix-based financing from 1. March 2005
- ➔ Transition made progressive through the transition part of the adjustment index, which should equal 1 in 2012

Tariffs calculation

no cost knowledge per GHM for the private hospital sector, but only fee-for-service charges

current tariffs calculation system: for each GHM, addition of all the fee-for-service charges which result from the billing of all patients stays within this GHM, then calculation of a national average cost for each GHM

a national study is being launched for the years 2004 and 2005 based on the same methods as in the public sector

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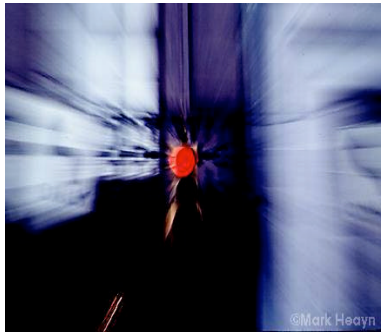
Expected impact of the reform

There are strong reasons to believe that the new system can actually led to an improvement in the quality of healthcare



The potential negative effects are well-known:

➔DRG creep

➔lower quality of care through excessive cost cutting or reduction of the ALOS

➔patients selection

➔delay to the adoption of new technologies or procedures when they are more costly or less profitable than the existing ones

But impact on quality of care can also be positive:

➔coding becomes essential, thus coding quality will get better (aside from the DRG creep risk)

➔indirect incentive is provided to justify diagnoses through coding of complexity levels

➔incentive to the development of certain activities possible either within the tariffs (e.g. ambulatory surgery, palliative care) or aside from them (e.g. development of post-hospital care)

➔conversely, possible disincentive through low payment for undesirable behaviors (e.g. waiting zones within the emergency wards)

➔better tracing and protection of certain expenses (e.g. organ transplants, continuous and intensive care, reanimation, emergencies, expensive drugs, MIGAC)

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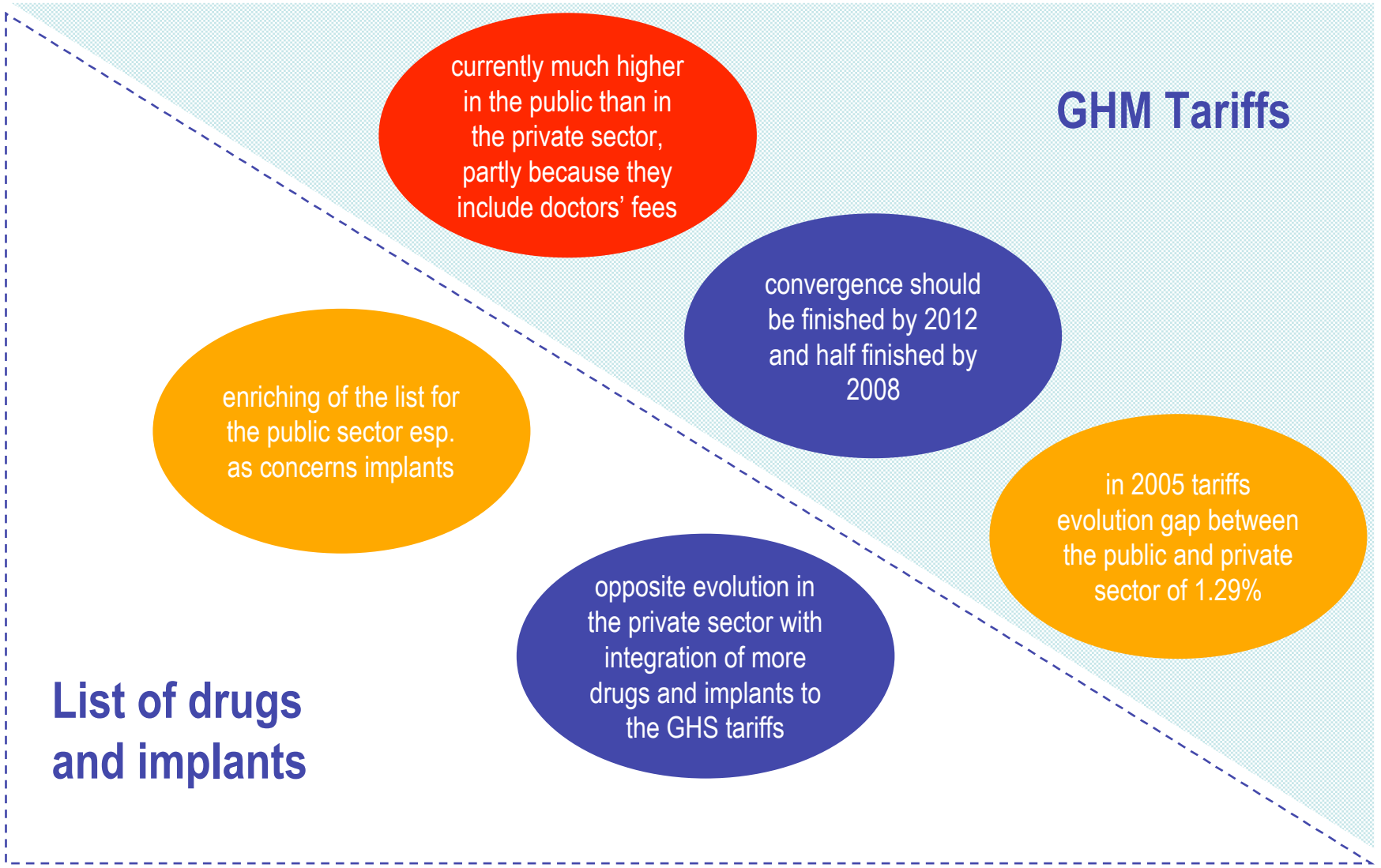
Future developments: Public/private sector convergence



Future developments: extension to new areas of care

Now that the system has been defined for the medical-surgery-obstetric inpatient sector, its extension to new areas of care is under way

Psychiatry:

- ➔ experimentation of a patients classification system since 2001
- ➔ classification based on hospital days
- ➔ reflection on the payment system in 2005:
  - ➔ casemix-based financing on a per day- or per procedure- basis
  - ➔ with special lump sum budgets for general interest duties and expensive drugs
  - ➔ a special budget proportional to the population in the covered area

Rehabilitation:

experimentation of a patient classification system since 1993:

- weekly collection of patient data (age, morbidity, medical procedures supported, dependence, and intensity of rehab activities)
- classification in homogenous day-groups called GHJ

launch of a national costs studies in 2003

important remaining problems remain (coding quality, appropriateness of classification for financing, reliability of the costs study) before a financing model can be chosen

THANK YOU