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Aligning pricing with overall policy goals

6.1 Adjustments and add-ons to ensure payment adequacy and fairness

Price adjustments and add-on payments are common when prices are set unilaterally or negotiated collectively, to ensure that specific services or caring for specific populations are covered, particularly where there are additional costs of providing care or it is considered unprofitable.

Geographical price adjustments are common to ensure that health facilities are adequately reimbursed and compensated for factors outside their control. For example, Thailand and Australia adjust prices for remote or rural facilities to ensure adequate funding of operations. In England and the USA (Medicare), adjustments are made for variations in input costs across geographic regions, which are expected to be higher in urban areas (Figure 17). Germany uses geographical add-on payments for hospitals in financial deficit that provide basic surgery for inhabitants of low-density areas.

Prices are also adjusted to promote greater coverage of specific services or access for specific populations. In 2003, Australia introduced financial incentives for general practitioners to provide greater access to services through lower copayments for specific patient groups. Australia, England and the USA (Medicare) adjust for long-term or costly patient stays or specialized services. In addition, adjustments are made for goods that broadly benefit society and communities, such as medical education (USA Medicare) and public health activities (Australia and England). In France, regulated prices are modified for activities related to education, research, and innovation as well as national priorities including cancer treatment and palliative care.

Pricing policies in Japan provide incentives to physicians to deliver services in line with policy goals such as providing end-of-life care at the patient's home, and LTC and community care. This is primarily done by establishing the conditions of billing that set forth human resource and facility standards as a condition of the payment. Bonus payments are also made to provide additional incentives, for example, to nursing homes for delivering end-of-life care within the facility rather than transferring residents to hospitals.

Germany uses financial penalties. For example, hospitals receive a deduction if they refuse to provide emergency care (EUR 60 per case), if they fail to submit requested data, or if the data are of insufficient quality. However, the effect of these deductions is limited because the financial penalties are lower than implementation costs, i.e., hiring additional staff for submitting data.

Figure 17
Adjustments to ensure payment adequacy and fairness

Setting	Geographic adjustments	Outlier payments	Public health goods
Australia	Adjustments are made for approximately 400 hospitals serving small, rural or remote populations based on size, location and type of services.	Adjustments are made for long-stays receiving a per diem rate.	For population based services that are not described in terms of activity, block funding is directed to states and territories to allocate to hospitals.
England	Costs are multiplied by nationally determined market forces factor (MFF), which is unique to each provider and reflects relative costs of care across the country. Providers in London attract the highest MFF.	Adjustments are made for long or short stays and specialised services.	Adjustments are made to support specific policy goals, such as providing care that is compliant with best practices.
France	Geographic adjustments are made only for the Parisian area (Ile-de-France) and for overseas territories.	Adjustments are made both for long and very short stays and specialised services.	Add-on payments are made for medical education, research, and investments for improving quality of care. Add-on payments are also made for local public policy goals, such as prevention, out-reach to populations in need, etc.
Germany	Recently, the government has initiated add-on payments to hospitals if they are located in financially unattractive regions but are vital to providing medical services to the region.	Since 2018, 205 add-on payments were made for patients with high needs for nursing care, or the provision of additional services and pharmaceuticals, which are not included in the DRG system yet.	Add-on payments are made for medical education, specialised units and medical centres, and the delivery of care to medically demanding patients.
Japan	None.	Adjustments are made for long stays.	None. Public health goods are funded from different sources (i.e., screening is funded by health plans directly contracting providers, and public health and immunizations while funded directly by government and through user charges).
Republic of Korea	None.	Adjustments are made for long stays.	Information not available.
Thailand (UCS)	Adjustments are made for districts having higher unit costs due to sparse populations such as mountainous areas or island districts to ensure adequate funding for operations.	No adjustment for outliers are made.	No adjustments are made. Such services are mostly funded by the Ministry of Public Health.
USA (Medicare)	The Medicare Wage Index accounts for local market conditions, by adjusting national base payment rates to reflect the relative input-price level in the local market.	Outlier payments are added for cases that are extraordinarily costly.	Operating and capital payment rates are increased for facilities that operate an approved resident training program (on the basis of hospital's teaching intensity), or that treat a disproportionate share of low-income patients.

Sources: case studies (see annexes). Note: UCS: Universal coverage scheme.

6.2 Expenditure control mechanisms

Ultimately, the amount of money that the government spends on health care is determined by the amount available to spend (Getzen, 2006). While costing exercises are useful in understanding the cost structure, particularly where the sample sizes are sufficiently large, prices are also influenced by the budget envelope representing the available funds. Therefore, expenditure ceilings have been used to link prices to the overall available budget, primarily to control costs. Moreover, regulated prices can be combined with additional instruments to control volumes. As illustrated previously, in settings that have adopted DRGs as the main method of payment method for inpatient care, they have also used DRGs with global budgets as an overall volume constraint (Busse et al., 2011).

In France, ONDAM (National Goal of Health Insurance Spending) is used to control overall hospital expenditure (with price volume adjustments) and in negotiations for controlling prices in the ambulatory sector. The growth in activity volumes are not regulated at the individual hospital level but at the aggregate level (separately for the public and private sectors). National-level expenditure targets for acute care are set by the Parliament each year to contain hospital expenditures. If the actual growth in total hospital volume exceeds the target, prices are reduced the following year. In practice, the activity level has been higher than the targets, and prices have been adjusted downwards regularly since 2006. The French Ministry of Health also introduced a volume-price control mechanism at the individual hospital level. For high volume and fast growing DRGs (including knee prosthesis and cataract surgery), the Ministry sets a threshold based on the growth rate for that activity nationally. If the hospital's caseload grows faster than the threshold, the price is reduced by 20%. The impact of this pricing policy is being monitored.

In Germany, hospitals face financial pressures to increase the volumes of care provided beyond what is medically necessary to finance infrastructure costs that are only partially covered by the states. Some one-half of the total number of DRGs are driven by one or more medical procedures, which provide strong incentives for volume and surgical interventions. Deductions are therefore used to incentivize hospitals not to deviate from the negotiated budget. If a hospital performs more services than agreed upon, it receives only 35% of the reimbursement price; if a hospital performs fewer services than negotiated, it receives a reimbursement of 20% for the services it should have theoretically performed. Since 2017, hospitals also face a 35% deduction on DRGs that are subject to economies of scale, such as hip and knee replacements. This deduction applies to additional negotiated services between the individual hospital and its sickness funds and aims to discourage hospitals to request budget increases.

In Japan, the Prime Minister establishes the global revision rate, or the de facto global budget for health expenditures, based on an evaluation of the political and economic situation. Factors considered include information from the survey of pharmaceutical prices and data about the revenues and expenditures in health care facilities. Subsequently a line-by-line revision of the fee schedule is undertaken based on the global budget constraint and changes in volume and prices. The government contains expenditure increases by lowering the fees of items that have had rapid increases in volume and/or can be delivered at lower costs by providers. For example, physician FFS payment for an initial visit is four-times higher than for a repeat visit.

In the Republic of Korea, copayments are used to decrease demand. Copayments for outpatient care range from 30% to 60% depending on the level of the system (from primary to tertiary level). This is done to prevent patients from overusing services at private hospitals. In the Republic of Korea, for LTC hospitals, the national health insurance reduces its price by 5% for stays over six months and by 10% for stays over one year to encourage hospitals not to keep patients for long stays. The impact of these policies has yet to be evaluated. In Thailand, the base for payment varies based on the total number of cases to keep within the budget framework.

Under the Maryland all-payer model, an annual global budget is established during a base period (2013) and adjusted for subsequent years factors such as hospital cost inflation rates, approved changes in the hospital volume based on changes in population demographics and market share, rising costs of new outpatient drugs, and additional adjustments related to reductions in potentially avoidable utilization and quality performance (Health Services Cost Review Commission (HSCRC), 2018). The global budget establishes a ceiling on hospital revenues. This provides hospitals have an incentive to ensure that revenues do not fall short of or exceed their budgets.

The HSCRC sets an agreement with each hospital in Maryland following the Global Budget Revenue model. This model is a revenue constraint and quality improvement system to provide hospitals with strong financial incentives to manage their resources efficiently and effectively and to slow growth in health care costs. Hospitals that adopt the model receive a fixed amount of revenue each year (Approved Regulated Revenue) –regardless of the number of Maryland residents they treat or the amount of services they deliver – provided that they also meet their obligations to serve the health care needs of their communities in an efficient, high quality manner on a continuous basis.

6.3 Balance billing limitations and financial protection

Where balance billing is permitted, some groups of patients may face additional out-of-pocket fees.

A key question for pricing policy is whether the prices are binding for providers or whether the providers are permitted to charge patients more than the regulated price for covered services. In the case of balance billing, health care providers can charge patients for amounts higher than the amount reimbursed based on the fixed or negotiated prices. In this case, the patient should pay the difference. Where balance billing is permitted, some groups of patients may be excluded from the prices determined and face additional out-of-pocket fees. The policy of fully reimbursing regulated prices influences the affordability of health care services to individuals.

Among the settings in this study, several prohibit balance billing, including Malaysia, Japan, the Republic of Korea, Germany, Thailand, and the USA Medicare program and state of Maryland for preferred providers. Thailand strictly enforces laws to prohibit balance billing and hospitals are legally required to return the amount to patients should any cases occur.

Under the USA Medicare program, balance billing is generally prohibited for preferred providers within the insurance network. Similarly, in Maryland, preferred providers are not permitted to balance bill. Additional protections apply to low-income beneficiaries enrolled in the Qualified Medicare Beneficiary program. Enrollees do not pay cost sharing (i.e., deductibles, copayments, and coinsurance), which is covered by the Medicaid program in the beneficiary's state. Out-of-network providers can balance bill patients, but they are limited to the Health Services Cost Review Commission-approved hospital rate in Maryland.

The Republic of Korea does not permit balance billing for covered services; however, physicians can provide both insured and uninsured services in one episode and bill for uninsured services to compensate for lower payments for covered services. In Japan, physicians are prohibited from balance billing. The exception is nursing care facilities, where the rules restricting balance billing are more relaxed because equity is considered less problematic in LTC. A separate practice of extra billing can occur, in which services and pharmaceuticals not listed in the Japanese Fee Schedule are billed together with those listed in certain conditions. This practice is mainly limited to new technology under development by hospitals. Before being permitted to extra bill, hospitals must submit a request to the Ministry of Health, Labour, and Welfare to carry out clinical trials on efficacy and safety, with the objective of including the technology in the revision of the fee schedule.

Figure 18
Conditions of balance billing in Australia, England, France, and the USA

Setting	Conditions of balance billing
Australia	Doctors can charge any fee to any patient at any time with the gap between the regulated fee and the actual price paid by the patient. In most cases, the fees charged by general practitioners are equal to the established fees and the patient incurs no out-of-pocket payments. For specialists, fees are higher than regulated prices for 59% of services.
England	Published mandated prices for hospital-based care must be used unless providers have agreed to an alternative price, payment approach, or to a different service delivery model. In very exceptional circumstances, providers can make an application to National Health Service Improvement for an increase to a nationally determined price. Only one application has been approved to date.
France	Physicians and dentists working as sector 2 contractors can balance bill or charge higher than the regulated fees based on their level and experience. In some cases (but not all) the amount above the regulated price can be covered by private complementary health insurance. Balance billing is prohibited for emergency care and low-income patients.
USA	Health providers participating in Medicare cannot balance-bill. Non-participating providers are allowed to balance-bill beneficiaries, but the amount cannot exceed 15% of the Medicare-approved payment amount for non-participating providers for each service (95% of the Medicare fee schedule amount). For privately insured individuals, in 29 states and the District of Columbia, there are no state laws or regulations that protect individuals from balance billing by out-of-network providers in emergency departments or in-network hospitals.

Source: case studies (see annexes)

In other settings, balance billing is permitted (Figure 18). In Australia, doctors can charge any fee to any patient at any time with the gap being paid by the patient. If the doctor charges a fee equal to the reimbursement level, the patient faces no copayment. Although doctors have full discretion over their fees, in practice, the fees charged by doctors tend to be equal to the regulated fee ("bulk-billing"). In 2017/18, 86% of all primary care consultations were bulk-billed, indicating that the fee schedule acts as a floor price. The high rate of bulk billing was the result of a major reform in incentive payments to doctors. General practitioners were given bonus payments if they bulk-billed (charged zero copayments to) patients who hold a concession card (for low-income families and pensioners) or are 16 years or younger. The payment amounted to an extra AUS \$5 for metropolitan areas, and AUS \$7.50 for rural, remote, and some outer metropolitan areas. Whereas bulk billing is not routine in practice and concession-card holders are more likely to have zero copayment, other types of patients are more likely to experience an increase in their copayment. Such price discrimination, where an identical service can be

purchased by different payers at different prices, became more of a problem with primary care (Wong et al., 2016). Government control over specialist prices is more limited. For specialists, fees are higher than regulated prices for 59% of services.

In England, prices paid can exceed the schedule in certain extenuating circumstances. Published mandated prices for hospital-based care must be paid by commissioners unless providers have agreed to an alternative price or payment approach, or to a different service delivery model. In very exceptional circumstances, providers can make an application to NHS Improvement for an increase to a nationally determined price when it cannot be locally agreed. Only one such application has been approved. Patients are not financially impacted by such decisions.

France permits balance billing for a certain category of health workers (sector two). In the 1980s, sector two contractors were allowed to reduce the cost of social contributions for the social health insurance fund. Those physicians and dentists allowed to work in sector two can charge prices higher than the regulated fees based on their level and experience. Prices set by sector two providers above the regulated fees may or may not be covered by private complementary health insurance. Patients without private complementary insurance can face high out-of-pocket payments, which raises concerns on equity of access to care. This practice may also drive growth in total health expenditures since unregulated prices could be highly inflationary. Regulations prohibit balance billing for emergency care and low-income patients and, where applied, must be "reasonable," which is defined as less than three to four times the regulated fee.

In the USA, balance billing may be permitted where the patient selects an out-of-network provider. Six states provide comprehensive consumer protection, including prohibiting balance billing and protecting patients from financial liability.⁸ In contrast, no state laws or regulations exist in 29 states and the District of Columbia that protect privately insured consumers from balance billing by out-of-network providers in emergency departments or in-network hospitals (Lucia et al., 2017). One survey comparing charges billed by out-of-network providers to Medicare fees reported that members were routinely billed 10 to 20 times Medicare rates for out-of-network care (NASI, 2015). Given that many insurance plans have very minimal or no out-of-network coverage, exposure to balance billing in the USA is a major concern for financial protection (Hempstead, 2018). Recently, federal legislation has been proposed that prohibits balance billing completely or allows it only under consent (Dekhne et al., 2019).

8 Comprehensive protection was defined as applying consumer protection to both emergency department and in-network hospitals settings, as well as to health maintenance organization and preferred provider organizations. It also includes protecting consumers by "holding them harmless" from liability of extra provider charges; prohibiting balance billing; and adopting adequate payment standards or dispute resolution processes between providers and insurers (Lucia et al., 2017).

6.4 Bundled payments

A bundled payment method involves combining the payments for physicians, hospitals, and other health care provider services into a single amount. Bundled payments can refer to clinical pathways (i.e., maternity), to clinical episodes or to blending inpatient and outpatient care.

A persistent challenge with the Medicare program in the USA is that the payments are fragmented, focusing on a category of care or provider. This allows providers to shift costs to another part of the care system in response to cost containment pressures (Frankford and Rosenbaum, 2017). To address this challenge, Medicare is testing a new voluntary episode payment model, the Bundled Payments for Care Improvement Advanced (BPCI Advanced). It generates a single retrospective bundled payment for 32 clinical episodes (29 inpatient and three outpatient clinical episodes), which begins at inpatient stay or outpatient procedure for 90 days starting on the day of discharge or the completion of the outpatient procedure. Payment is tied to performance on quality measures, and payments based on target prices are provided in advance. Retrospective reconciliation is done with actual Medicare FFS expenditures for a clinical episode, which results in a positive or a negative balance based on the target price and adjusted for quality. Positive balances are returned to the participating facilities, and negative balances must be repaid. The first cohort of participants started their participation on October 2018, and the initiative will run through the end of 2023.

The Maternity Pathway Payment System was first introduced in 2012-13 by NHS England and replaced FFS arrangements for birth and block grants for community midwifery services. The scheme involves a single prospective national price (tariff) provided to a NHS commissioner, which pays providers for an integrated package of care offered to all pregnant women and their newborns. The pathway consists of three integrated packages of care covering the antenatal, birth, and postnatal phases (Department of Health, 2016). The purpose of the scheme is to give providers the financial flexibility to focus on providing high quality, coordinated care. A new patient level activity data set for maternity care was also introduced. The tariff is based on the average cost of a stage of care and allows for different levels of payment depending on the risk and complexity profile of the woman. Her risk and complexity profile is determined prospectively within the first few booking appointments. The tariff for the antenatal and postnatal phase is split into standard, intermediate, and intensive pathways, while the tariff for the birth episode has seven payment levels, six related to clinical complexity, and one specifically for home births (NHS Improvement and NHS England, 2019).

England adjusts regulated prices to encourage health care providers to comply with best practices. Best practice tariffs focus on 50 procedures with the greatest potential impact on outcome.

6.5 Incentives for quality

Any of the payment methods can be combined with explicit specific performance-based rewards or penalties (results-based financing or pay for performance) to promote quality and performance.

England adjusts regulated prices to encourage health care providers to comply with best practices (Best Practice Tariffs (BPTs)). BPTs focus on 50 procedures with the greatest potential impact (i.e., high volume care, significant unexplained variation in practice, or significant clinical impact of best practice on outcomes), strong evidence base, and clinical consensus. Regulated prices are adjusted upwards or downwards based on national average costs. The price differential between best practice and usual care is calculated to ensure that the anticipated costs of undertaking best practice are reimbursed while creating an incentive for providers to shift from usual care to best practice. BPTs apply to all providers of NHS-funded care for hospital admissions related to hip fracture, stroke, cholecystectomy, and cataract surgery. Early evidence suggests that the impact was positive for some conditions. Among participating hospitals, two-fifths of episodes receive the BPT for hip fracture. Those receiving BPT reported a larger decrease in mortality rate (by 0.7%) and a 2.1 % higher increase in the share of patients discharged within 56 days (Marshall et al., 2014). Evaluators also noted the importance of the conditions of payment, differences in quality trends, and ongoing quality improvement initiatives (McDonald et al., 2012).

In Australia from June 2017, the pricing authority has been working with another independent body, the Australian Commission on Health Care Safety and Quality, to adjust prices with the objective of promoting safety and quality. For example, hospital admissions that include a sentinel event (i.e., serious medical errors or hospital-acquired infections) are not paid. Prices are adjusted downward for hospital-acquired complications after adjusting for patient characteristics. Discussions are underway about how to adjust prices for avoidable hospital admissions. In the USA, all states have non-payment policies for health care-acquired conditions such as retaining a foreign object surgery, stage III and IV pressure ulcers, and surgical or other invasive procedures performed on the wrong body part. Evaluations of zero reimbursement for sentinel events in the USA did not demonstrate an impact on their incidence (Lee et al., 2012). Instead, such policies resulted in perverse incentives for coding practices –implying that such events would more likely go unreported (Kawai et al., 2015).

In the USA, the Quality Payment Program mandates incentives for value and outcomes for eligible health care providers through a Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs). Under MIPS, the performance of eligible clinicians is scored in four areas:

quality (six measures of performance that reflect the scope of practice); improvement activities (activities appropriate to each practice related to enhancing care coordination, shared clinical decision-making, and expansion of practice access); promoting interoperability (sharing information with other clinicians or the patient); and total cost of care (CMS, 2019b). In 2019, final scores above a fixed threshold receive a 7% positive payment adjustment, while those below the threshold receive a 7% negative payment adjustment. APMs give bonus payments to provide high quality and cost-efficient care for specific clinical conditions, care episodes, or populations.

In 2019, Maryland implemented the 10-year Total Cost of Care Model to promote better coordination across hospital and non-hospital settings, including mental health and LTC. The model sets a per capita limit on Medicare total cost of care. All-payer hospital cost growth will be limited to 3.6% per capita, a limit set in 2014 based on long-term economic growth. Each hospital receives a population-based payment amount to cover all hospital services provided during the year. Hospitals can make incentive payments to non-hospital health care providers who perform care redesign activities to improve quality. A participating hospital may only make incentive payments if it has attained certain savings under its fixed global budget, and the total incentive payments cannot exceed such savings. In addition, primary care providers receive an additional per beneficiary per month payment directly. These performance-based incentives are intended to reduce hospitalizations and improve quality (CMS, 2019a, 2019b, 2019c).