

Prepaid coordinated care for patients with diabetes: practices and patients bear the risks

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Until recently, the Australian Government was planning to ask general practices to register patients with diabetes from July 2012.¹ This initiative, designed to yield better health outcomes using consumer-orientated coordinated care, has been delayed for piloting.² This provides an opportunity to reconsider the proposal.

Under the coordinated care initiative, practices were to receive \$1200 for each registered patient — \$250 for purchase of allied health care services and \$950 for a year of services from the practice of registration. Practices were to manage the funds and provide services and not bill Medicare.

This article contrasts the prepaid method of funding with the way practices currently generate income and discusses how, in other settings, the prepaid method has produced change. Challenges for practices taking on coordinated care are presented in terms of managing funds, complexity of practice consultations and cost allocation, risks of practice overspend, timing of payments and patient satisfaction. Finally, potential changes to the initiative are considered. The \$250 for allied health care is not discussed as this may be managed by Medicare Locals.¹

How will prepaid care change general practice?

Currently, general practices earn by providing services, such as consultations, or by extending these services (eg, opening out-of-hours, employing nurses, using information technology). The emphasis of practice activity is on contact with individual patients, and practices do not receive funds for services yet to be provided. With prepaid funding, practices do receive funds for services yet to be provided. Such models have been implemented in the United Kingdom, initially with fund holding in the 1990s^{3,4} and now in practice-based commissioning,⁵ in New Zealand's primary health organisations (PHOs),^{6,7} and in Australia's coordinated care trials.⁸ While each setting has its unique characteristics, funding for all is for services yet to be provided, in anticipation of more cost-effective government spending than under fee-for-service.

Prepaid funding can be used to direct patient care resources towards activities such as improving access to health care, providing preventive care and coordinated team care, and implementing public health measures, in the hope of yielding better health outcomes. In many countries, including Australia, investment in coordinated care has led to improved health outcomes for patients with chronic diseases, including diabetes.⁸⁻¹⁰ In keeping with health reform strategy goals, New Zealand's PHOs have looked beyond the clinical consultation to focus on improving public health and access to primary health care.^{6,7} In the UK, when practices managed a budget for patient care in the original fund-holding initiative, beneficial changes occurred. Patients appreciated the quality of practice organisation and valued access to the increased number of allied and other health professionals.¹¹ Admissions to hospitals decreased¹² and shorter waiting times for elective treatment were achieved.¹³ Furthermore, in both New Zealand and the UK, prepaid funding has led a cadre of doctors to develop skills and interests in managing funds.⁶

ABSTRACT

- The Australian Government is planning to pilot a model of prepaid funding for coordinated care of patients with diabetes in general practice.
- Patients will register with a practice that undertakes to coordinate their care, and practices will manage pre-allocated funds to provide services instead of billing Medicare.
- Systems to manage prepaid funds in Australian general practice have not yet been developed.
- In the model that has been proposed, practices with a small register of patients will be at risk of overspending, which may threaten practice viability and patient services.
- If the initiative is to have integrity, all patient services should be paid from the prepaid funds and patients should only attend the practice with which they have registered.
- Risks should be delineated and contingency plans made explicit before practices and patients commit to the initiative.

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In the Australian Government's plan for prepaid coordinated care, practices would be freed from the fee-for-service model and the restrictive regulations of the Medicare Benefits Schedule (at least for patients with diabetes) and would thus be able to use a wider range of methods for providing the services recommended in evidence-based care guidelines to meet a range of outcome measures.^{14,15} For example, practices could develop practice teams, engage patients in care, design individual management programs, provide group education and set up local support groups. New models of health care, such as supported self-management, could be offered to interested patients.¹⁶ Doctors could take a major role in implementing these methods, as the prepaid model permits health care delivery outside the consultation.

What are the challenges for general practice?

The need for resources

General practices in Australia have no experience of, and no infrastructure for, managing prepaid funds for patient care. In the UK, the original fund-holding initiative was supported by a great deal of information and resources.^{3,4} In the United States, demonstration projects for patient-centred medical homes have clearly shown that additional resources should be paid, by capitation or other means, to enable practices to transform into centres for patient care coordination.^{17,18} This is necessary to give physicians time to coordinate care, and is akin to Medicare items for GP Management Plans and Team Care Arrangements (although these Medicare items do not assist with establishment and management costs). In New Zealand, prepaid funding has often been inadequate in terms of covering PHOs' increased management costs. Supple-

mentary funding has been required and, in some cases, PHOs have increased patient copayments to meet the increased costs.⁷ Although Australian health care services and delivery differ from those provided in these other settings, careful consideration must be given to the costs associated with managing prepaid funds and changing practice processes. The planned pilot projects need to determine the costs of implementing and operating the coordination of care for patients with diabetes.

Complexity of clinical care and allocating costs

The proposal appears to assume that the \$950 paid to the registering practice is to provide all the health care services for the patient, not just for diabetes. If this is not the case, doctors will have to separate diabetes care from non-diabetes care. In general practice, where more than one problem is managed in a consultation,¹⁹ it is not realistic to expect a general practitioner to deal with the reasons for the encounter, partition the relative time and effort involved in each, bill Medicare for the non-diabetes portion, and assign the diabetes portion to the prepaid funds. Perhaps the prepaid funds are expected to pay only for a guideline-based set of specific services?¹⁴ This would imply that any extra services for diabetes, outside those specified in guidelines, could be billed to Medicare, possibly shifting costs back to Medicare and undermining the initiative. In both cases, justifying cost allocation across uncertain boundaries will add work and increase bureaucratic surveillance.

General practice's *raison d'être* is whole-patient care. Diabetes may reach beyond the medical complications to, among other things, employment, relationships and psychiatric morbidity. GPs will find it difficult to determine where the health implications of diabetes end. For these reasons, prepaid funding should cover whole-patient care. This would make the accounting a simpler task, but would increase the likelihood of spending more than \$950 per patient and create the risk of a reverse moral hazard, as practices may have to reduce services for needy patients if funding is inadequate.²⁰ With the small amount of prepaid funding due to the relatively low number of patients registering in any one practice, this is a strong possibility.

Risks of overspend

As a basis for a fund to provide diabetes care, the payment of \$950 is a blunt capitation measure. It is not sensitive to individual patient variation but relies on an average that might compensate a practice for servicing costs. The sum of registered patient payments will constitute a fund administered by the practice. A fund's resilience depends on there being enough low usage patients to compensate for the fewer high usage patients. An indication of this risk has been provided by research on the probability of matching expenditure to fund size in the UK primary care setting. Using a sophisticated indexed capitation formula that is sensitive to local health indicators and therefore to likely expenditure, the probability of being 10% off target is nearly zero for a population of 500 000, but reducing the population to 10 000 increases the probability of the same outcome to 0.35.^{21,22}

For a practice with a cohort of 300 registered diabetic patients and a resultant prepaid fund of \$285 000, there may not be a sufficient reserve of low usage patients to compensate for the few patients who may require an unexpectedly high amount of care. The risk of being more than 10% off target is too high. A 10% overspend would bring a loss of \$28 500, which could be enough to threaten the practice's viability and patient services.

Lag time between service provision and payment of funds

Practices will need to develop a process that enables patients to register voluntarily and may have to counter unrealistic patient expectations (related to costs) that have been engendered by the government's promotion of the initiative.¹ The latter is particularly important in view of the New Zealand experience, where increased patient copayments have been required in some PHOs.⁷ Building the register will take time, whether carried out opportunistically when patients attend or by using a recall system. It will also take time to build numbers of patients for alternative service delivery, such as group work. Practices will be faced with costs of registration, setting up alternative methods of service delivery and establishing systems for managing funds while waiting for funds to arrive.

Patient satisfaction

A small decrease in patient satisfaction with UK fund-holding practices has been shown, which was partly related to the perception that doctors were concerned about keeping costs down.¹¹ Levels of patient satisfaction with patient-centred medical homes in the US are not yet clear.¹⁸ Satisfaction was not studied in the Australian coordinated care trials.²³ There is little information on patient satisfaction with New Zealand's PHOs, although a national patient satisfaction survey has been developed for inpatient and outpatient services.²⁴ Patient satisfaction is important to measure as it will be a patient's own, and limited, health funding that his or her practice will spend.

Can the proposed initiative work?

With these challenges, does the initiative have merit from a general practice's perspective? Coordinated diabetes care services can already be supplied, using existing Medicare items, to earn a practice \$665 a year to manage a patient with diabetes over a 2-year cycle of care, without the risk and cost of managing funds. This is based on bulk-billing using the November 2009 Medicare Benefits Schedule and provides quarterly reviews, as recommended by the Australian guidelines for diabetes management,¹⁴ and four extra consultations for intercurrent issues. It includes these items:

- eight level B consultation claims;
- two Service Incentive Payment claims;
- one Item 721 claim for a GP Management Plan and three reviews, plus one Item 723 claim for a Team Care Arrangement and three reviews; and
- ten Item 10991 claims for nursing care.

Providing these items also requires organisation, additional staff and resources that, if given funding, could be more acceptable to practices and patients than the prepaid initiative.

GPs in the UK responded to the empowerment that fund holding gave vis-a-vis specialist and hospital services and the capacity to retain savings to improve clinical services. In New Zealand, where fee-for-service was the model for remuneration before the government introduced prepaid funding, doctors have seen advantages in organising themselves to maintain very strong control of most PHOs.⁷ In Australia, the pilot program could help organise practices to amalgamate registers of patients with diabetes, as a way of spreading risk and management overheads across larger patient groups. This would test the organisational capacity of doctors, but managing the coordinated care of patients with complex health care needs without fee-for-service payments already resonates with a substantial minority of doctors in Australia.²⁵

Although the initiative is designed to improve health outcomes, practices would risk financial loss. Practices that commit to registering patients should be supported to manage set-up costs associated with registering patients and managing funds. The government should carry some of the risk. Extra funding for unexpected increases in demand for services should be negotiable if practices are to be confident of continuing to meet service obligations. If a patient requires services that extend substantially beyond the prepaid amount, Medicare should carry the extra cost.

Patients who register also carry some of the risk. Registration should be the first step of engaging patients in this new way of health care delivery. For the period of registration, the patient needs to take the risk of attending only the registering practice for all health care, except for agreed contingencies. As the sole providers for registered patients, accountable for all costs and outcomes, practices will be keen to improve their cost-effectiveness. Registration should, therefore, include informed consent to give patients a full understanding of the initiative and its aims. The services to be provided and the means of access need to be clarified. Alternatives to prepaid care will have to be offered if a patient declines registration. Patients will need to understand that the practice will pool the prepaid funds for use as it deems most effective, and potential out-of-pocket costs should be discussed. Patients will have to understand that registration separates them from those without diabetes and, in seeking better health outcomes, places a potential limit on what a practice can provide. Finally, patients must be engaged in the coordinated care process and the ongoing services that are developed. Consequently, registration must be sensitive to health literacy, socioeconomic disadvantage and each patient's capacity and willingness to participate.

The bottom line

Piloting of the coordinated care initiative for patients with diabetes will need to clarify the risks of the initiative and develop contingency plans for risk management. This is essential before practices and patients can commit to a prepaid funding model.

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Competing interests

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