Prospective payment for inpatient psychiatric care

Country: Germany
Partner Institute: University of Technology, Berlin
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Health Policy Issues: Remuneration / Payment

Current Process Stages

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<th>Change</th>
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1. Abstract

The 2009 Hospital Financing Reform Act (KHRG) mandated the German self-governing bodies to develop a prospective payment system (PPS) for psychiatric and psychosomatic facilities. The process of developing the system mirrors the introduction of DRGs for other hospitals prior 2004. However, the future psychiatric PPS will be based on per diem payments adjusted for patient characteristics and procedures in order to introduce performance incentives to this part of the German hospital sector.

2. Purpose of health policy or idea

The 2009 KHRG fundamentally reforms the old payment system for psychiatric and psychosomatic facilities, which is still based on budgets with per diem charges as the unit for reimbursement. The KHRG will introduce prospective payment that will apply to all hospitals - irrespective of ownership status - and to all psychiatric and psychosomatic patients (including day cases), regardless of whether or not they are members of the SHI system, private health insurance (PHI), or self-funding patients. The primary motive of the reform is to achieve a more appropriate and performance-based allocation of resources since the old system is perceived to provide insufficient reimbursement and does not reflect new scientific developments in the treatment of psychiatric patients (Fritze 2010). Related goals of the reform are to facilitate precise and transparent measurement of the casemix and the level of services delivered in psychiatric and psychosomatic facilities. Moreover, PPS are assumed to increase efficiency and quality of services due to the improved documentation of internal processes and increased managerial capacity (Scheller-Kreinsen et al. 2009).

The general features of the new PPS for psychiatric and psychosomatic facilities are outlined by the 2009 KHRG. Similar to the old system, the new system is supposed to be based on per diem payments but, in contrast to the old system, these payments are to be adjusted for characteristics of patients and for treatment efforts of facilities in order to introduce performance-related incentives. Patients are to be classified into medically disparate groups and reimbursement is supposed to follow a cost weight approach, where payments are calculated on the basis of the relative resource intensity of the different groups. The existing system of global budgets determining total resources available to psychiatric facilities is transferred on to the new system in a slightly modified way.

Mirroring the process of introducing DRG-type hospital payment in Germany, the self-governing bodies at the federal level (i.e. the Federal Associations of Sickness Funds, the Association of Private Health Insurances, and the German Hospital Federation) are mandated to develop and introduce the new psychiatric PPS themselves by the year 2013. The Institute for the Hospital Remuneration System (InEK), which is controlled by the self-governing bodies, and which updates the German DRG system annually, is charged with identifying medically meaningful and cost
Developing the new psychiatric patient classification system will start from the existing “treatment areas” of the psychiatry personnel directive (Psych-PV), which used to be the basis for determining personnel requirements of psychiatric facilities. Since 2010, facilities are supposed to classify all patients using the Psych-PV classification system and to code diagnoses and procedures based on newly developed coding guidelines. The generated data will be used to develop the new classification system. The InEK will calculate per diem cost weights for the identified groups of patients. Hospital reimbursement under the new system will be determined by multiplying a (per diem) base rate with calculated cost weights. The base rate will be calculated as the sum of psychiatric care costs divided by the sum of psychiatric inpatient care days.

Additionally, the KHRG authorizes contracting parties in the German system of self-governance to negotiate reimbursement for services that are not covered by the PPS. In the existing G-DRG system this takes the form of supplementary fees for certain complex or cost-intensive services, and/or for very expensive drugs. The supplementary fees are used due to a lack of sufficient data for calculating certain DRGs, and the limited appropriateness (in terms of reflecting actual costs incurred) of the current cost weights. The psychiatric PPS is likely to employ similar measures for reimbursement of certain services. Furthermore, the KHRG mandates the self-governing bodies to explore possibilities of introducing alternative reimbursement systems for certain areas of care in which integration of services across sectoral borders needs to be encouraged.

Main objectives

- Reforming the old reimbursement system for psychiatric and psychosomatic facilities.
- Achieving appropriate and performance-related allocation of resources.
- Measuring the psychiatric case-mix.
- Increasing efficiency and quality of service delivery.

Type of incentives

- PPS provide financial incentives that are supposed to encourage hospitals to make efficient use of resources (Berki 1985).
- Payment to hospitals will be determined by patient length of stay, patient characteristics, and treatment intensity.
- Measuring the psychiatric case-mix will facilitate performance comparisons between facilities.

Groups affected

1. Facilities providing psychiatric and psychosomatic medicine services; 2. Sickness funds; 3. Self-governing bodies at the federal level; 4. Institute for the Hospital Remuneration System (InEK); 5. Patients with mental disorders, psychiatric patients

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
</tr>
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<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
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</table>
4. Political and economic background

In 2004, when the German DRG system was introduced, facilities providing psychiatric and psychosomatic services were exempted in order to avoid negative consequences for their patients. Prospective payment systems are, generally, thought to encourage efficiency in the provision of hospital inpatient care. However, DRG-type hospital payment requires classifying patients into cost homogenous groups based on diagnoses and procedures, and hospitals are reimbursed on the basis of calculated average costs of patients in these groups. Studies of patients with mental disorders have shown that length of stay and treatment modalities vary widely even for patients with the same diagnosis (Burgmer et al. 2003). Therefore, DRG-type hospital payment for psychiatric and psychosomatic medicine facilities is seen to be inadequate.

Over the last 30 years, DRG-type hospital payment systems have become the main method of hospital payment in most high-income countries. Consequently, attempts have been made to introduce similar prospective payment systems for psychiatric facilities. The U.S. introduced prospective payment for inpatient psychiatric facilities in 2005. Various European countries are working on or have introduced PPS for inpatient psychiatric care.

5. Purpose and process analysis

 Origins of health policy idea

Introducing the PPS for psychiatric and psychosomatic facilities can be seen as both, a fundamental change of the existing remuneration system for these facilities and an extension of the PPS for somatic hospitals (the G-DRG system).

On the one hand, introducing PPS for psychiatric and psychosomatic facilities changes the incentive structure for psychiatric and psychosomatic facilities. The future system will take into account patient characteristics and treatment intensity in order to determine per diem payments to hospitals. It will require providers to generate information on diagnoses and procedures of patients treated in their facilities and will, thus, facilitate performance comparisons.

On the other hand, introducing PPS for psychiatric and psychosomatic facilities builds on infrastructure and processes developed as a result of the introduction of the G-DRG system to the German somatic hospital sector. The InEK will play a key role in developing the new system and the established process of consultations with professional medical associations and the system of annual updates to the payment system will be adopted by the new psychiatric PPS.

Initiators of idea/main actors

- Government: The 2009 KHRG authorises the Ministry of Health to enact all necessary regulations to introduce the psychiatric PPS if the self-governing bodies fail to develop the system on their own.

- Providers: The German Hospital Federation (DKG) is supportive of the policy as it hopes for increased payments to psychiatric facilities. Professional medical associations are critical as they fear increasing bureaucracy related to coding and documentation.
• Payers: The Federal Associations of Sickness Funds and the Association of Private Insurances are involved in the development of the PPS. Together with the DKG, they control the InEK.

• Patients, Consumers: Action Patients with Mental Illness (Aktion Psychisch Krank e.V.) is an association joining parliamentarians from all parties and professional associations. It is rather critical of the new system.

Approach of idea
The approach of the idea is described as: new: Introducing prospective payment will be a fundamental change to the remuneration system for psychiatric facilities. amended: The new PPS builds on infrastructure of the G-DRG system. It will be managed by the Institute for Hospital Remuneration Systems (InEK) and follows the procedures developed for the G-DRG system.

Stakeholder positions
Mirroring the process of introducing the G-DRG system, the 2009 KHRG outlines only the general idea of the payment system and leaves the development of the specific features to the self-governing bodies. The main stakeholders in the process of developing and introducing the PPS for psychiatric and psychosomatic facilities are, therefore, the Federal Associations of Sickness Funds, the Association of Private Health Insurances, and the German Hospital Federation.

Also, patterns of support and opposition for the new payment system are similar to the situation prior to the introduction of G-DRGs. The self-governing bodies are rather supportive as they can influence the design features of the payment system. In addition, the German Hospital Federation expects increases in total reimbursement in order to fulfil staffing requirements as stipulated by the psychiatry personnel directive (Psych-PV), which was reinforced through the KHRG.

On the other hand, professional medical associations are, in general, critical of the new system as they fear overburdening bureaucracy related to the patient classification system and increasing economic pressures and interference in clinical decision making by hospital managers.

Actors and positions
Description of actors and their positions

Government
Federal Ministry of Health very supportive strongly opposed

Providers
German Hospital Federation (DKG) very supportive strongly opposed
German Society for Psychiatry, Psychotherapy and Neurology very supportive strongly opposed

Payers
Federal Association of Sickness Funds very supportive strongly opposed
Association of Private Insurances very supportive strongly opposed

Patients, Consumers
Aktion Psychisch Kranke very supportive strongly opposed

Influences in policy making and legislation
During the legislative process prior to the adoption of the KHRG, the "Action Patients with Mental Illness" (Aktion Psychisch Kranke e.V.) lobbied for increased funding for psychiatric facilities to ensure that staffing requirements can be fulfilled as stipulated by the Psych-PV.

In general, since specific features are to be developed by the self-governing bodies, the passage of the bill in
parliament was the origin rather than the end point of the reform.

Legislative outcome

major changes

**Actors and influence**

Description of actors and their influence

**Government**

- Federal Ministry of Health
  - very strong
  - none

**Providers**

- German Hospital Federation (DKG)
  - very strong
  - none

- German Society for Psychiatry, Psychotherapy and Neurology
  - very strong
  - none

**Payers**

- Federal Association of Sickness Funds
  - very strong
  - none

- Association of Private Insurances
  - very strong
  - none

**Patients, Consumers**

- Aktion Psychisch Kranke
  - very strong
  - none

**Positions and Influences at a glance**

<table>
<thead>
<tr>
<th>Influence</th>
<th>Federal Association of Sickness Funds</th>
<th>German Hospital Federation (DKG), Association of Private Insurances</th>
<th>Federal Ministry of Health</th>
<th>German Society for Psychiatry, Psychotherapy and Neurology, Aktion Psychisch Kranke</th>
</tr>
</thead>
<tbody>
<tr>
<td>strongly opposed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>very strong</td>
<td>none</td>
<td>very strong</td>
<td>none</td>
<td>very strong</td>
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**Adoption and implementation**

The schedule for the implementation of the PPS for psychiatric and psychosomatic facilities envisages the following steps:
2010: All psychiatric and psychosomatic facilities classify their patients according to the Psych-PV and code diagnoses and procedures. All data are transmitted to the InEK as the basis for developing the classification system.

2011: In a sample of hospitals complying with certain cost accounting standards, per diem costs are calculated for patients. The InEK creates a patient classification system with medically meaningful and cost-homogenous groups of patients.

2012: A preliminary version of the new payment system is presented to psychiatric facilities for training and testing.

2013: The new system is introduced in all psychiatric and psychosomatic facilities on a budget-neutral basis.

**Monitoring and evaluation**

The 2009 KHRG stipulates that the new psychiatric PPS is to be updated annually in order to reflect new developments in medical knowledge, changes in infrastructure and increases in costs. This is similar to the process developed for the G-DRG system, which has been updated annually since its introduction in 2004.

The self-governing bodies are obliged by law to ensure adequate research is undertaken to evaluate the impact of the PPS on the provision and the quality of care. However, the same obligation was part of the G-DRG introduction process, and it took about seven years until the first results of the evaluation were published. Researchers demand that the evaluation should start already during the implementation of the system and should rely on patient level data (Fritze 2010).

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**6. Expected outcome**

In general, it is difficult to forecast the likely effect of the reform on costs and quality. Whether or not the reform will achieve its objective is likely to depend on a number of points:

1. Is it possible to develop a patient classification system with a manageable number of sufficiently cost homogenous groups?
2. Will the new payment system develop mechanisms or parallel systems to encourage the integration of care across sectoral borders?
3. Are hospital managers and insurance funds able to make use of the generated information in order to improve care processes and increase quality?
4. Are enough resources available to fulfill expectations of the German Hospital Federation, which is expecting increased payments?
5. Will the payment system be accepted by providers? Will it introduce economic considerations into clinical decision making?

It will be possible to evaluate most of these points only after implementation of the system in 2013.

**Quality of Health Care Services**

- marginal
- fundamental

**Level of Equity**

- system less equitable
- system more equitable

**Cost Efficiency**

- very low
- very high

Difficult to predict at this point in time.
7. References

Sources of Information


Author/s and/or contributors to this survey
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