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Blended Payments

Lessons for the National Disability Insurance Scheme

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Following a meeting of the National Cabinet on 28 April 2023, the ***NDIS Financial Sustainability Framework*** was announced aiming to 'reboot' the National Disability Insurance Scheme. Alongside significant investment in the NDIA to lift capability, capacity and systems to better support participants, there will be an annual growth target on total costs of the scheme of 8 per cent by 1 July 2026.

As part of the $732.9 million investment in the NDIS, the 2023-24 Federal Budget announced a commitment of $24.6 million over four years from 2023-24 to work with participants and providers to trial blended payment models. This investment is predicated on the basis that it should 'increase incentives for providers to innovate service delivery and improve outcomes' (p. 197). There is a substantial evidence base, largely within the health sector, relating to different payment mechanism and their impacts on factors such as effectiveness, efficiency, evidence, and quality. However, this does not find that blended payments necessarily deliver improvements in cost containment, improved quality or innovation in service delivery. What this literature tells us is that blended payments mechanisms can be complex and tricky to set up and without careful consideration these can lead to a series of unintended or perverse consequences for providers and service users. The literature can be difficult to draw lesson from because blended payments are not one distinct model and can involve the use of a variety of different types of payment mechanisms. The research evidence suggests that if these payment mechanisms are to be used the following considerations are important to ensure their success:

- No single blended payment approach will work across all NDIS services, these need to be tailored to specific services.
- Trial in smaller programmes with defined services and invest in evaluating these.
- Be clear about why blended payments are the most appropriate payment mechanism within those specific services.
- While blended payments can transfer some risk to providers, the NDIA should be aware of the risk that it retains.
- Invest significant time and ensure the appropriate skills are present in the teams designing and implementing blended payment approaches; underinvesting or rushing these processes can have negative consequences.
- Be clear about what outcomes are being sought and have a range of measures that will be able to demonstrate when these are being met.
- Consider the timescales over which we would expect to see particular performance levels met. Some outcomes may have a longer lead time.
- Anticipate the potential for perverse incentives for providers that may result in undesirable behaviours that could have equity impacts (e.g., underserving those with the most complex needs).
- There needs to be significant investment in data and monitoring capacity and capability to ensure that blended payment systems have their intended impact.
- Quality baseline data is important to ensure that appropriate targets can be set for providers. Without this there will be a lack of certainty over the impact providers have had.
- Co-design different payment measures and incentives with providers and NDIS participants to ensure they are appropriate.
- Ensure there are not any other forces present that might confound the efforts of different payment mechanisms.
- Consider the use of other activities that can reinforce the impact of blended payment mechanisms (e.g., information, training).
- Use of blended payment models may suit larger organisations more than smaller ones given their administrative burden, so there is a need to consider how smaller sized organisations can be supported.

Different payment methods

Prior to the establishment of the NDIS, disability providers were predominantly funded on a ***block*** basis (Fisher et al., 2010). Under this system providers were allocated grants tied to particular conditions of service delivery. The positive of this sort of arrangement is that it gave providers certainty and stability in terms of income. But this system was seen as limited as it gave people with disability restricted choice or control over the services that they receive (National People with Disabilities and Carer Council, 2009). A number of the organisations funded to deliver these services also expressed concern that the funding blocks were not always reflective of the true costs involved in delivering these services being more based on historical funding (Baines et al., 2022).

Within the advent of the NDIS, disability services are now largely funded through the scheme moved to being paid for on a ***fee-for-service*** basis (Productivity Commission, 2017). Individuals are allocated a budget according to their level of need and self-defined goals to purchase services and supports for providers under a range of conditions. Typically, providers are paid an amount per delivery of a service in line with the NDIS Pricing Arrangements and Price Limits guidance. Within this system payment is tied to the delivery of a service, but no account is given to quality of service or whether particular outcomes are achieved. Fee-for-Service approaches to funding typically incentivise providers to increase their activity and as a result their associated costs, but this is not necessarily tied to high quality or improved outcomes. Such funding models may have negative consequences for expenditure control and encourage overuse of inappropriate services (Cashin et al., 2014). Moreover, they are not always sufficient to meet the requirements of individuals who have complex needs, who require multiple services or where a team-based approach is required (Medicare Benefits Schedule Review Taskforce, 2020).

Outside of the NDIS, ***capitation payment*** approaches have been used for some social welfare services. These give providers a fixed amount per individual to cover some (partial capitation) or all (full capitation) of the needs of a specified group of individuals for a specified period of time. These funding arrangements can be adjusted according to the number and mix of individuals to be serviced or other population characteristics (Deber et al., 2008). This payment is not linked to providing volumes of specific services, which gives providers flexibility to spend funds on activities that they believe will achieve the best outcomes (Wranik and Durier-Copp, 2009). However, this system can put the provider at significant financial risk (particularly smaller organisations), should the care needed cost more than the capitation payment then the difference has to be met by the provider (Deber et al., 2008). In full capitation systems there may not be an incentive to improve quality of services. Partial capitation systems might encourage a narrow focus on services meaning providers need to refer individuals to other providers thereby shifting the costs to others.

In recognition of the limitations of more traditional methods of payment methods, a number of social insurance systems internationally have experimented with a range of alternative modes to address quality gaps and other aspects of performance. A number of these actively seek to focus not just on the activities being delivered or the population being serviced but also the outcomes or performance being achieved.

Pay for performance (P4P) approaches attach payment to defined metrics focusing on particular processes, structures or outcomes (Eijkenaar, 2011). There are a variety of ways that this type of approach might be set up depending on the types of activities and outcomes that are sought. These programmes can be difficult to evaluate because targets,

payment size and payment mechanisms can be hard to define. They require regular review and improvement of incentives to support adaptation and keep the number of targets manageable (van Gool and Hall, 2016). There can be uncertainty within these systems as to what to reward, should this be absolute against a pre-determined performance threshold or relative to an improvement from baseline measurement (Charlesworth et al., 2012). To date, most reviews demonstrate only rather modest improvements and that their impacts are generally stronger when implemented alongside broader policies (e.g. information feedback, training, development of new technologies) (Cashin et al., 2014). The design of these systems is crucial and can be highly complex, but too narrow a focus can also result in distorted activities (Veen et al., 2022).

Outcomes based payments (also known as ***payment by results***) seek to make payments contingent on agreed outcomes. Such approaches focus less on the activities being delivered and more on the results that this achieves, based on the idea that this should encourage providers to innovate, and this transfers risk to the provider (National Audit Office, 2015). Such approaches are thought to encourage services that are high-value and focus on the recipient to ensure that what is delivered works for that person (Moloney et al., 2021). These models are not without limitations though. Typically they operate under a deferred payment model, which can favour providers with access to capital over those who do not (Fox and Morris, 2021). Outcome measures must also be chosen carefully. Where outcomes may be impacted by a range of other factors or may not occur until years after the intervention they can be difficult to identify and measure (Fox and Morris, 2021, Veen et al., 2022). There are also significant data requirements to evaluate performance, which can be a particular challenge for smaller organisations (Deber et al., 2008). Finally, these models can encourage perverse behaviours from providers whereby they engage in 'creaming' and/or 'parking' behaviours (Considine et al., 2011). We have seen these emerge in Australian employment services where 'creaming' refers to providers focusing their effort on those individuals most likely to achieve payable outcomes. 'Parking' refers to creating artificial situations that can maximise payments, without actually achieving the outcome, for example by providing clients with low employment probabilities with temporary roles and then rotating people through these.

What are blended payments and what does the evidence say?

Given that none of these different payment methods are without limitations, different systems have experimented with blending different forms of payments. Blended payment models use multiple mechanisms concurrently to balance the limitations of any one approach. For example, capitation might be blended with fee-for-service payments or payment for performance. The OECD reports that in European primary health care services, most countries adopt a blended approach (OECD, 2016) and such approaches are also being currently trialled in Australian General Practice. Much of the published academic literature on these different types of approaches comes from the health sector and it is important to note that disability services often have different sets of drivers and incentives. It can also be difficult to be definitive about these types of payments mechanisms as they are not one model and there are a variety of different ways that these incentive structures can be mixed.

Context is important in terms of payment mechanisms. Wranik and Durier-Copp (2009) identify data from a wide range of studies where various payment mechanisms have been used in different health services. What this shows is that while different methods can have their intended impact on various goals (e.g., quantity of service, prevention, quality, acceptance to service recipient), there is also evidence to suggest that these impacts have not been found in some contexts where the same payment mechanisms have been used. They conclude that the precise blend is important and this needs to be appropriate to the local context. For example, in rural and remote areas where there is a low population density, the most appropriate blend for funding of General Practitioners would combine a salary for a specific set of services, with a small capitation component to ensure that all individuals are accepted into a practice with additional fee for service for all activities that fall outside of the specified services. However, the blend needed for a more populous area might look quite different depending on the aims being sought through the development of the payment mechanisms.

As these observations suggest, most reviews on blended payments provide mixed evidence of their effect on quality, typically because it is difficult to summarise and synthesise effects on quality as there is significant variation in the types of outcomes and the mix of payment methods (Eriksson et al., 2020). A structured review on mixed provider payment systems in health care (Feldhaus and Mathaeuer, 2018) found that 'Blended payment models generally reported moderate to no substantive reductions in expenditure growth, but increases in health system efficiency' (pg. 1). Typically, these increases in efficiency related to blended capitation and performance payments around preventative services, screening and following guidelines-based care for individuals with chronic health conditions that reduced the number of admissions to hospital and where hospital admissions did occur these were for shorter lengths of time.

Considerations in implementing blended payments within an NDIS context

As outlined in the introduction, the approach to using blended payments in the NDIS context is to be initially trialled as a way of incentivising providers to focus on quality and outcomes and not simply focus on activity. Such an approach may incentivise providers to not simply increase activity (and thereby costs to the NDIS) and instead to focus on delivering better results. As outlined above, the evidence base suggests that there are a broad category of payment types that do not necessarily work to reduce expenditure growth, but there may be potential to improve other aspects of system performance.

Minister Shorten has suggested that blended payments will be trialled in School Leavers Employment Services and in relation to moving young people out of residential care settings. Trialling this approach in targeted areas is appropriate to ensure that the approaches are appropriately developed. Fox and Morris (2021) suggest that if an outcomes component is being considered in payment mechanisms, then the focus should be on smaller programmes for tightly defined services, accompanied by detailed, holistic, impact evaluations. The literature is clear that these sorts of contracts are often difficult to get right (National Audit Office, 2015), which could make them risky and costly for the NDIA. If blended payments are to be used then the risks and costs may be worthwhile, provided there is credible evidence that they are appropriate to the purposes. No one single model of blended payments will work for all services across the NDIS and so these will need to be developed in a way that is appropriate to the services and the process and outcomes sought.

Blended payment systems can be highly technically challenging to contract for, particularly when they include a performance or outcome element, and this is often underestimated (National Audit Office, 2015). Such approaches are more likely to be successful if results can be measures and attributed to the efforts of the provider, indicating the importance of data baselining (see below for more on this). It is also important that it is possible to forecast the level of performance that would have occurred without the intervention. It can take considerable time and skills to design and manage blended payment mechanisms and underinvesting in this can have negative consequences. While blended payment mechanisms, particularly those with a performance or outcomes component, may transfer some risk to providers the NDIS needs to be aware of the risks that they retain should providers fail to meet the objectives of the initiative. Pilots can be very useful in testing planned approaches for both the particular service area they are introduced

to and also learning more generally about the impacts of different payment mechanisms.

The pay for performance literature suggests that effective design focuses on not just a few measures pertaining to one specific performance aspect. If such an approach is taken then this may result in providers disproportionately focusing on one specific behaviour (Eijkenaar, 2011). However, if there are too many measures developed relating to a number of performance dimensions then the contract may be too complex, and providers struggle to understand these incentives. It is also important to combine objective measures (e.g., placement in a job) with subjective measures (e.g. appropriateness of job or supports). This points to the importance of co-designing any payment and incentive structures with both providers and NDIS participants. If the payment incentives do not relate to what participants value this can encourage the wrong sorts of activities. In more complex contracting arrangements, it should be ensured that all providers are included. For example, if a prime provider subcontracts with a series of sub-providers, all providers in the delivery chain need to be involved in this process. These types of payment mechanisms can create a high administrative burden, and this may be difficult for smaller providers to comply with. Ultimately, it is important that what is described as good performance is appropriate to the context. Timing is also a crucial consideration here. Some outcomes may have a longer lead time to see effect and so carefully designing for these is an important consideration.

If not well designed, blended payment mechanisms can create the conditions for providers to behave in unintended ways (e.g., creaming and parking behaviours). The NDIA needs to consider in advance some of these potentially perverse incentives and ensure there are measures in place to counter these. An important part of this process is to understand provider costs. If payment mechanisms are too high this may lead to inefficient services, but if too low then providers may not be able to deliver an effective service, and this may lead to perverse incentives. Differential payments for different groups can be one way to avoid these, although setting the right levels for different groups can be a challenge. Having good knowledge of baseline performance can help to set attainable but also stretching expectations of performance. Data baselining is a key activity in making these payment mechanisms effective and underinvesting in this can undermine efforts to incentivise providers.

In order to develop and monitor the impact of blended payment mechanisms there needs to be significant investment in the capacity and capability to measure and assess service performance. The NDIA has not always been focused on measuring participant outcomes (although the development on the new wellbeing measure may help this) and there will need to be an uplift in the modes of assessing these and the infrastructure to facilitate this. This will be a challenge to blended payment systems as these are most effective where there is strong data on baseline performance levels. Alongside this, there will need to be investment in the capability of staff within the agency and providers to undertake these activities. Data needs to be reported in a timely way so that the credibility of these systems of payment is maintained. These skills should not just be located in localities, but there needs to be a central repository of knowledge and expertise in terms of what works in blended payment approaches so this can be drawn on and these are not reinvented for every new initiative that is undertaken. Publication of data around these service areas could provide meaningful data for NDIS participants to better understand provider performance. Currently there is very little data on provider quality available to NDIS participants and this could be a positive for some in making decisions about services.

It is important to be aware of the range of drivers and different initiatives that may have an impact on providers. It is crucial to ensure that other forces are not present that may confound the efforts of different payment mechanisms. Financial incentives are not the only mechanisms that drive provider performance. Blended payment mechanisms can be more effective when they are reinforced by a range of other activities (for example, information, training, capacity building).

References

BAINES, D., CUNNINGHAM, I., JAMES, P. & ROY, C. 2022. Privatizing the sacrifice: individualized funding, austerity and precarity in the voluntary sector in Australia and Scotland. In: MCBRIDE, S., EVANS, B. & PLEHWE, D. (eds.) The chaging politics and policy of austerity. Cambridge: Cambridge University Press.

CASHIN, C., CHI, Y., SMITH, P., BOROWITZ, M. & THOMSON, S. 2014. Paying for peformance in health care: Implications for health system performance and accountability. Berhshire: Open University Press.

CHARLESWORTH, A., DAVIES, A. & DIXON, J. 2012. Reforming payment for health care in Europe to achieve better value. London: Nuffield Trust.

CONSIDINE, M., LEWIS, J. M. & O'SULLIVAN, S. 2011. Quasi-markets and service delivery flexibility following a decade of emoloyment assistance reform in Australia. Journal of Social Policy, 40, 811-833.

DEBER, R., HOLLANDER, M. J. & JACOBS, P. 2008. Models of funding and reimbursement in health care: A conceptual framework. Canadian Public Administration, 51, 381-405.

EIJKENAAR, F. 2011. Key issues in the design of pay for performance programs. The European Journal of Health Economics, 14, 117-131.

ERIKSSON, T., TROPP, H., WIRÉHN, A. & LEVIN, L. 2020. A pain relieving reimbursement program? Effects of value-based reimbursement program on patient reported outcome measures. BMC Health Services Research, 20.

FELDHAUS, I. & MATHAEUER, I. 2018. Effects of mixed provider payment systems and aligned cost sharing practices on expenditure growth management, efficiency, and equity: a structured review of the literature. BMC Health Services Research, 18.

FISHER, K., GLEESON, R., EDWARDS, R., PURCAL, C., SITEK, T., DINNING, B., LARAGY, C., D'AEGHER, L. & THOMPSON, D. 2010. Effectiveness of individual funding approaches for disability support. Occasional Paper 29. Canberra: Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

FOX, C. & MORRIS, S. 2021. Evaluating outcome-based payment programmes: challenges for evidence-based policy. Journal of Economic Policy Reform, 24, 61-77.

MEDICARE BENEFITS SCHEDULE REVIEW TASKFORCE 2020. An MBS for the 21st century: Recommendations, learnings and ideas for the future. Canberra: Department of Health.

MOLONEY, R. M., MESSNER, D. A., WESSLER, Z. & TUNIS, S. R. 2021. Proposed framework for patient-centred outcomes-based measures in alternative payment models. The American Journal of Managed Care, 27, 80-84.

NATIONAL AUDIT OFFICE 2015. Outcomes-based payment schemes: government's use of payments by results. London: National Audit Office.

NATIONAL PEOPLE WITH DISABILITIES AND CARER COUNCIL 2009. Shut out: the experience of people with disabilities and their families in Australia. Canberra: The National People with Disabilities and Carer Council.

OECD 2016. Better ways to pay for health care https://www.oecd.org/els/health-systems/Better-ways-to-pay-for-health-care-FOCUS.pdf: OECD.

PRODUCTIVITY COMMISSION 2017. National Disability Insurance Scheme (NDIS) costs. Canberra: Australian Government.

VAN GOOL, K. & HALL, J. 2016. REFinE PHC Report on Primary Health Care in Australia: Towards a more sustainable and equitable health system. Sydney: CHERE, University of Technology Sydney

VEEN, A., BARTRAM, T. & COOKE, F. L. 2022. Potential, challenges and pitfalls of pay-for-performance schemes: a narrative review evaluating the merits for the Australian home care sector. Journal of Health Organization and Management, 36, 38-50.

WRANIK, D. W. & DURIER-COPP, M. 2009. Physician remuneration methods for family physicians in Canada: Expected outcomes and lessons learned. Health Care Analysis, 18, 35-59.

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