EXPLORING ALTERNATIVE PAYMENT MECHANISMS

In 2016/17, Bermuda spent $723M on healthcare, up from $707M the year before; and when compared to other similarly affluent jurisdictions, we are lagging behind in some measureable health outcomes[1].

In line with our strategic goal to enhance collaboration and care integration, and our vision of creating value through the promotion of an equitable and sustainable health system, we have reviewed options for enhancing the current system structure, one of which being the way payment for services are made.

Currently the majority of our private providers are paid via a fee-for-service model, public providers are paid according to available budgets and the hospital is funded through a hybrid of fee-for-service and available budget. Although the payment mechanisms differ between provider types, the funds originate from the same four sources (see diagram below).

HERE IS A SIMPLIFIED REPRESENTATION OF HOW FUNDS MOVE INTO AND AROUND BERMUDA'S HEALTH SYSTEM

TYPES OF PAYMENT MECHANISMS[2]

The goal of health system payment mechanisms should be to ensure that patients' care needs are met and providers are fairly and appropriately reimbursed for managing that care. The right payment mechanism encourages providers to offer necessary, cost effective care without compromising quality.

The Health Council continuously reviews Bermuda's health system and its financing. To improve outcomes, we recommend shifting from a volume-based health system to a value-based one. This document provides details of the pros and cons of volume-based payment, and the pros, cons and implications of implementing transitional performance-based mechanisms and value-based payment mechanisms.

VOLUME-BASED *(CURRENT)*

Providers are paid for each unit of service they provide to their patients according to the charges determined by their individual practice.

PERFORMANCE-BASED *(TRANSITION)*

Payors adjust fee-for-service payments and use budgeted funds to incentivise providers to achieve certain targets.

VALUE-BASED *(GOAL)*

Providers are rewarded based on securing good outcomes that matter to the patient or consumer. Payment typically has conditions attached based on data collected.

VOLUME BASED[2,3-5]

FEE-FOR-SERVICE

Providers are reimbursed for each service provided to each patient.

PROS

» allows for changes to treatment plans with no impact to anticipated associated revenue
» provider autonomy as the goals and costs of care are independently set

CONS

» encourages unecessary treatment and testing
» providers are incentivized to treat more often and at a higher cost rather than in the safest most cost-effective way
» success can be measured on how much money a provider can earn rather than the health outcomes of those receiving care
» reduces collaboration among providers

PERFORMANCE BASED[2,3,6,7]

BONUSES

Payors adjust reimbursement to providers and pool those funds to be used later as single bonus payments for providers who achieve certain goals.

PENALTIES

Payors reduce reimbursement to providers for sub-par performance. The penalties can be added to the pool of bonus funds or be reflected as savings to the payor.

PROS

» encourages transparency and accountability for care provision
» promotes positive health outcomes and reduction in unecessary spending
» stresses quality over quantity and enables redirection of funds toward achieving positive health outcomes
» provides the same goals as value-based reimbursement but can be used in conjunction with volume-based reimbursement to allow for a smoother transition

CONS

» may erode intrinsic motivation and instead encourage financial motivation
» could encourage neglect of unmeasured indicators, ie those not associated with payments
» increased administrative costs associated with monitoring achievement of performance measures
» may reduce access for high risk populations as providers avoid patient loads that make it harder to achieve targeted health outcomes
» difficult to manage patient outcomes for patients who seek care from multiple providers

IMPLICATIONS OF IMPLEMENTATION

» identificiation of achievable quality indicators that align with payor expectations
» clearly defined, relevant and realistic goals that also consider social determinants of health
» a clear plan of action for all providers involved

VALUE BASED[2,8-11]

CAPITATION

Providers are paid a set fee per patient to provide all necessary services to that patient for a defined period of time - month, year etc.

PROS

» limits use of unecessary health services
» encourages lowering of the cost of care
» reduced administrative costs associated with claims generation and processing
» simplifies provider ability to budget

CONS

» may restrict patient choice to provider networks
» health risk of the population shifts to the provider rather than the insurer
» may encourage “upcoding” where providers claim the risk of their population to be high in order to justify higher capitated payments
» may increase unecessary referrals to secondary providers to reduce the expense on the primary provider receiving the capitated payment

IMPLICATIONS OF IMPLEMENTATION

» relies on buy-in from providers of all levels and classifications of care
» requires set reimbursement for participating providers and agreement on the expectations associated with that payment

BUNDLED

Providers are paid a set fee per patient to provide all necessary care associated with a specific condition or target outcome such as reduced pain.

PROS

» payment contract considers risk
» goal is to heal patient or achieve maximum possible positive outcome for target condition
» outcome driven, therefore encourages good care that is in the patient’s best interest
» payment is intended to cover full spectrum of related care
» typically includes a stop-loss to protect providers from unexpected unusually high costs
» greater coordination among medical teams

CONS

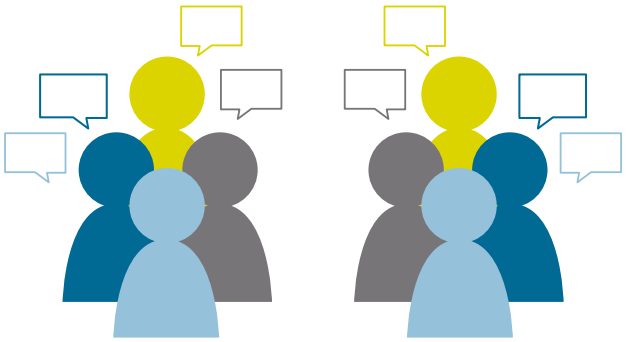
» encourages use of emergency services for non-emergency situation when a problem outside of a budgeted care plan arises
» complicated to design and implement due to complex care needs
» limited data available to assess the true cost of care needed to achieve treatment goals

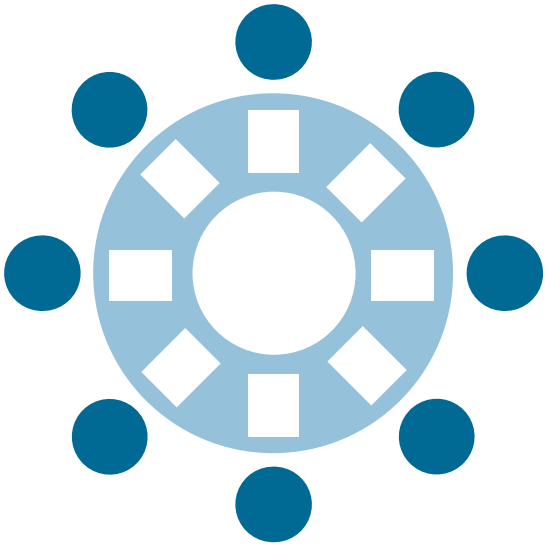
IMPLICATIONS OF IMPLEMENTATION

» requires buy-in from all providers involved
» requires a clear understanding of each patient’s clinical needs and the treatment plan necesary to achieve the agreed on goal
» requires more accurate and reliable patient records and health system data collection

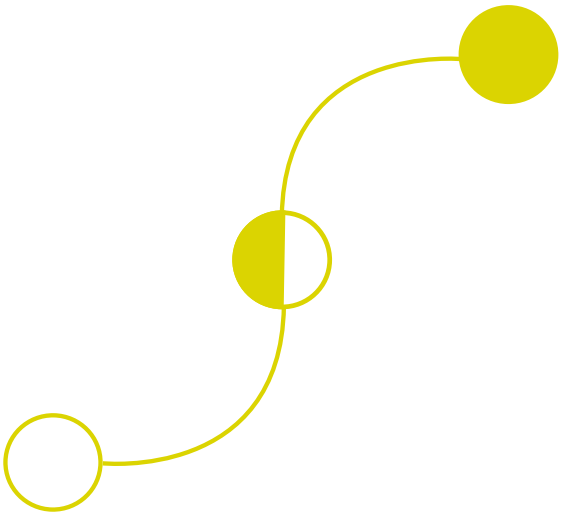
WHAT NEXT?

While it is genarally agreed that change is necessary, disagreement tends to be around the intended goals of change, the way change is achieved and how different groups are impacted by the change.





Health system goals should be clear, achievable and for the greater good. Collaboration meetings have begun to address some of the concerns with the system structure by identifying areas of improvement and potential solutions.



The Health Council is committed to facilitating the identification of the appropriate phases of the required system enhancements and working collaboratively with health system partners to execute the most suitable transition from our unsustainable volume-based system to a more cost-effective and integrated value-based system.

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