Reimbursement Models in Healthcare

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Introduction

Reimbursement models in the healthcare sector are different ways of paying care providers for the services they deliver to their patients. These models are transitioning the healthcare sector from a payment system that emphasizes the number of services delivered to a system that focuses on the value of the service provided. In the present case, the patient visited the ER with alarming symptoms of blurred vision and tingling sensation diagnosed with an epileptic seizure event yet was discharged 24 hours later. In this patient's case, they need to reconcile the payment as there appear some quality issues that influence the payment. As he returned the next day, he was diagnosed with an ischemic stroke. This paper explores reimbursement models that have been used in the healthcare field for varying effectiveness and provides a deeper grasp of traditional reimbursement approaches.

Traditional Payment Models

Traditional reimbursement models for professionals who render care services include Fee-For-Service (FFS), Capitation, and Episode-Based Payment (EBP) models. The primary reimbursement approach, Fee-For-Service (FFS), is the most popular form of payment that pays healthcare professionals for the quantity and volume of the services offered to the patients based on schedule and codes of fees that are used to regulate payment for care services regardless of the treatment outcome. In this reimbursement model, benefits are paid for individually as this approach was implemented in order to increase utilization of the service but also to increase costs (Lockner & Walcker, 2018). The EBP reimbursement method is a method that pays healthcare providers a single time for all services provided to treat a specific episode of care. This reimbursement approach rendered for the care service is also known as a "bundled" payment model. Lastly, the capitation model to reimburse services refers to the set sum that is provided to healthcare professionals based on the number of patients assigned to each care provider.

Current Trends in Healthcare Payment

Before the implementation of reimbursement models, the healthcare sector was solely focused on volume and quantity rather than the value of the service rendered which led to arising a problem because the number of services a healthcare facility provides overshadows the standard of the care offered. This way, healthcare institutions and care professionals tend to make more income and profits causing no significant improvement in patient outcomes while causing expenditures of the healthcare sector to rise. Initially, a volume-based payment method was put in place to provide

healthcare professionals compensation and increase the service's cost. This method was used to penalize providers financially for reducing medical errors, saving someone's life, and avoiding services that were needed. The healthcare sector transitioned from volume-based to value-based for both the physicians' and patients benefits. These new payment models encourage unhealthy populations and clinicians to focus on maintaining health and increasing health variable awareness (Casto & Forrestal, 2013).

How Quality Outcomes Are Rewarded

Quality outcomes are rewarded in the healthcare sector through reimbursement models that link the payment for care services to the results they deliver for their patients as these models aim to improve quality and patient experience by using financial incentives. These models encourage healthcare providers to follow best practices and achieve desired outcomes. Episode Based Payment (EBP) rewards providers to receive a single payment for all the services rendered to care for a specific medical problem. Providers who are rewarded through EBP can share the savings, benefits, or losses depending on how well clinicians or physicians manage the episodes of care.

Quality Concerns Affecting Reimbursement

Quality concerns can affect reimbursement in healthcare to discuss whether higher spending on healthcare leads to better care outcomes for patients or whether payers and stakeholders should penalize or reward healthcare providers based on their performance related to services they render on quality measures. It is also a quality concern that there might be little or no correlation between quality of care and spending on healthcare as some care providers in some regions may offer inefficient care that does not improve patient care outcomes. Another challenge related to exploring the relationship between quantity or volume and quality or value is measuring the quality and value of the care services rendered to the patients. Care quality in this regard can be measured through various indicators including outcome measures, process measures, and patient-centered measures that may capture different aspects of quality care that may not always align with spending levels (Mosadeghrad, 2014). For instance, a healthcare facility may have higher outcome measures but low patient satisfaction measures which vary by setting, condition, provider, and patient characteristics. However, high-intensity care can also improve patient outcomes and reduce spending which may harm the quality of the care. Moreover, different reimbursement approaches and payment models have been implemented to align incentives for care professionals to deliver cost-effective care such as capitation, pay-for-performance, and value-based purchasing which have different effects on care quality, clinicians, and patients, but there is no one-size-fits-all solution to determine which reimburse model is optimal.

Conclusion

Reimbursement models in the healthcare system refer to how services provided by healthcare providers are compensated since these models determine and evaluate how much amount healthcare providers receive, influence the quality and quantity of the care rendered, and affect cost-efficiency measures to significantly shape the healthcare environment. Healthcare professionals inform care priorities so that they not only provide high-quality care but also understand the financial implications of the clinical decisions.

References

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