

Agenda



Background

Alternative Reimbursement Models

Contracting on Value

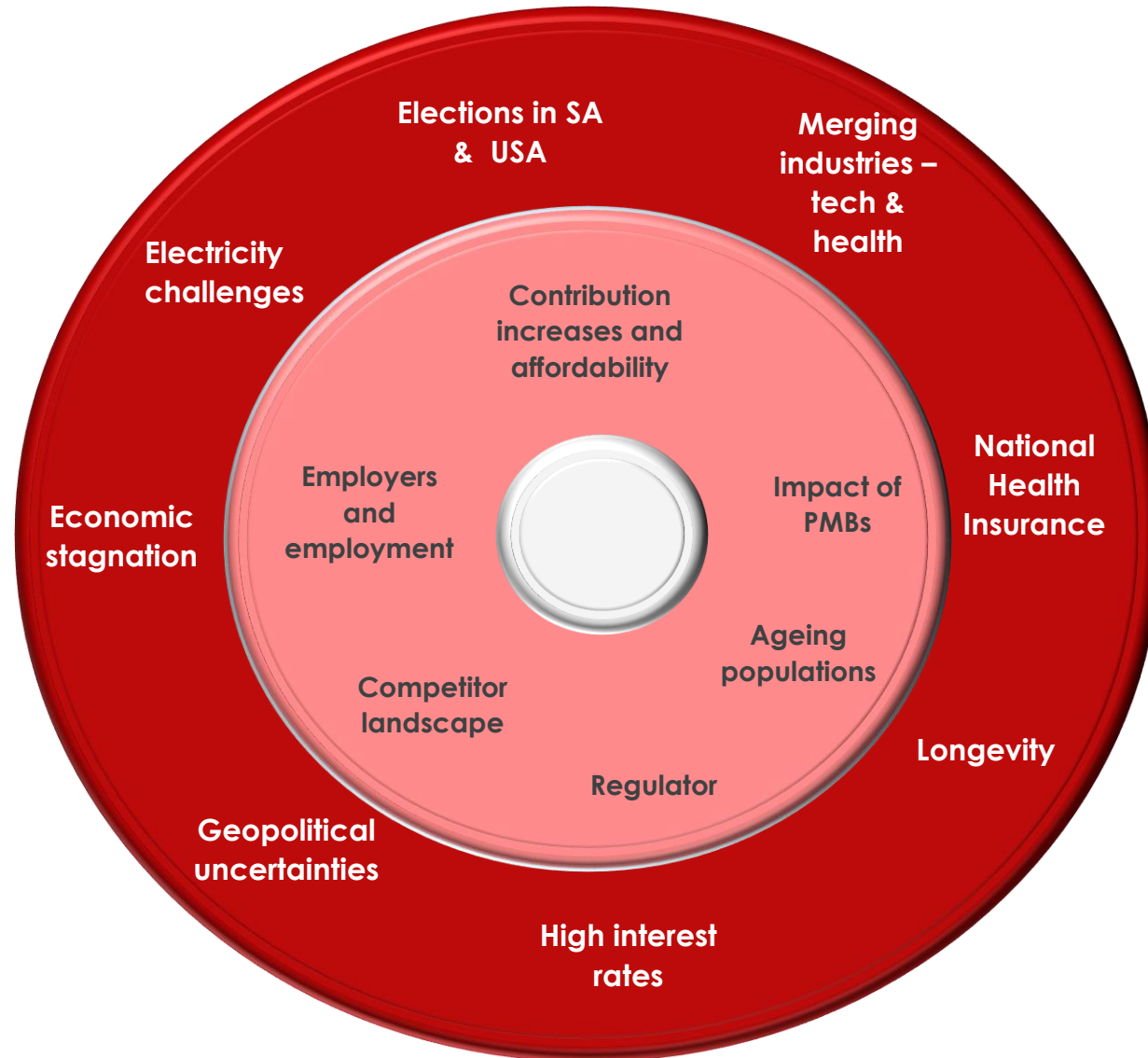
HPCSA Ethical Rules Amendments

Opportunities for Multi-Disciplinary Team and Case Studies

Actuarial Considerations



Factors influencing Healthcare landscape

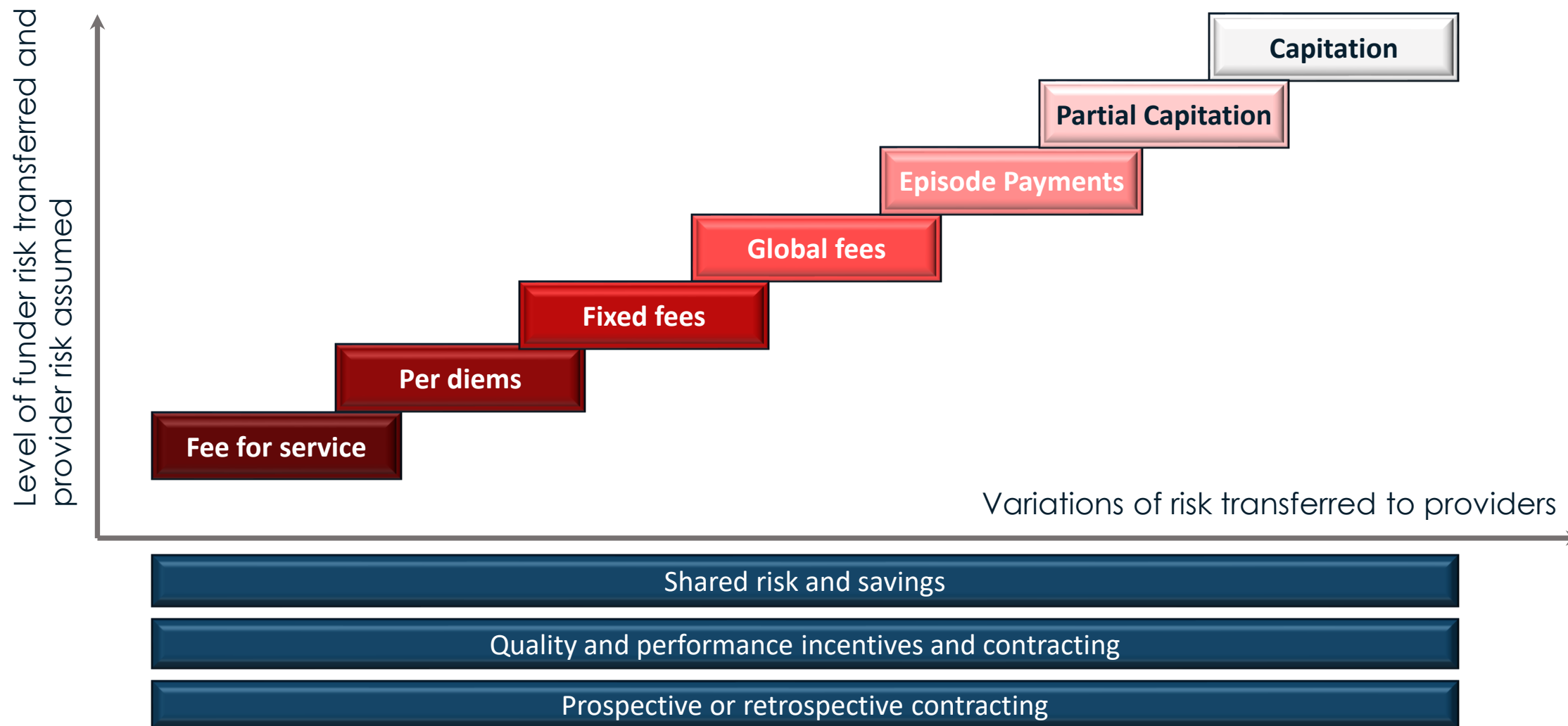




Alternative Reimbursement Models



What do we mean by Alternative Reimbursement Models



Fee for service



Most common form of reimbursement in private healthcare in SA in recent years

Fee is paid to a provider each time a service is rendered

Insurers may negotiate a maximum fee per service / create networks or preferred providers



Simple and transparent

Granular **data** received

Doctor treatment autonomy

Aligns with activity and drives productivity



Risk of **overservicing** to increase revenue

May have **preference for profit maximizing patients**

Reflects **activity not outcomes**

Can lead to **escalating costs for funders**

Disincentives collaboration across the patient care pathway

Administrative burden of billing and coding

Bundled Payments- Fixed fee, Global fee



Price set on specific services (with low-cost variation) or across the care continuum for a specific condition

Fixed fee includes associated with single provider's bill (normally hospital), global fee includes all professionals

Transfers elements of intensity and severity risk within an event, but not frequency risk



Simpler to administer than fee for service

More **cost predictability** for funder and **income predictability** for provider at an admission level

Coordination of care incentivized in a global fee



Risk of **under-servicing** leading to poor quality outcomes, e.g. readmissions

Carve outs

Requires **underlying fee for service data to track performance, risk sharing repricing**

Hard to determine who bears the risk in global fee structures

Capitation



Payment of a fixed amount per beneficiary (population level) for a particular service regardless of whether the service is used

Can be full capitation or partial capitation

Price, intensity, severity, frequency risks transferred



Costs are predictable for funder and **steady stream of income for the provider**

Incentivises coordination and holistic care



Quality of care may be compromised

Incentive to **underservice**

Queues, waiting times

Underlying **granular data might not be retained**
Potential loss of experience making it difficult to evaluate

Provider requires infrastructure and financial capability to take on and manage risk

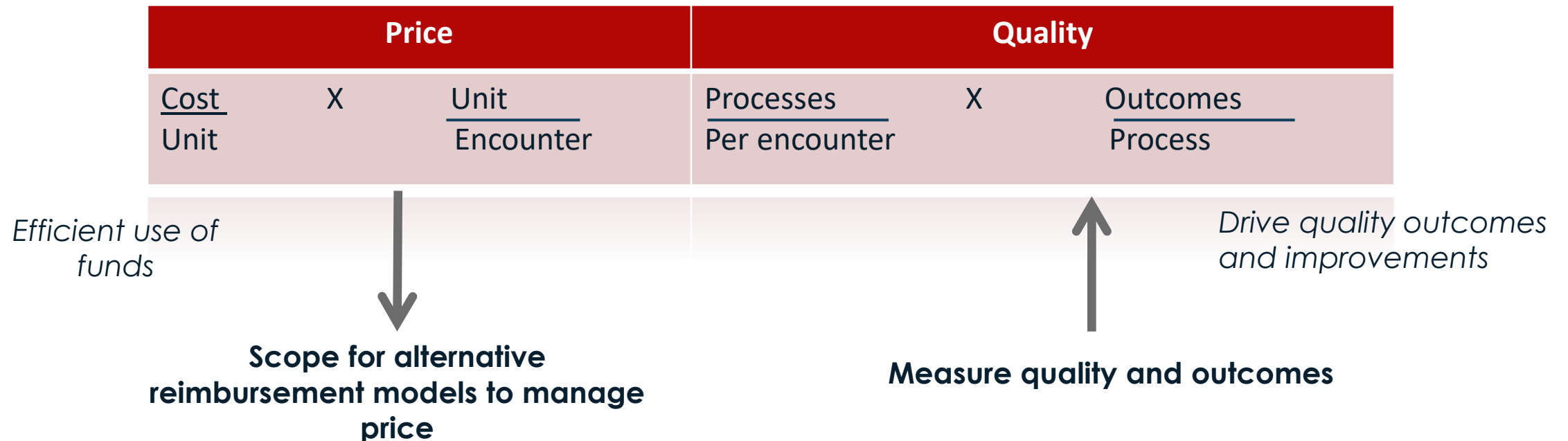


Contracting on Value





$$\text{Value based care} = f(\text{Price}, \text{Quality})$$





The use of ARMs are limited in the current environment

Push from HMI to move to ARMs:

“Inquiry...would like to promote stakeholders to engage in effective ARMs with real risk sharing and commitment to providing better value for money”

Regulatory restrictions may have hindered widespread adoption of innovative payment models due to a restriction on:

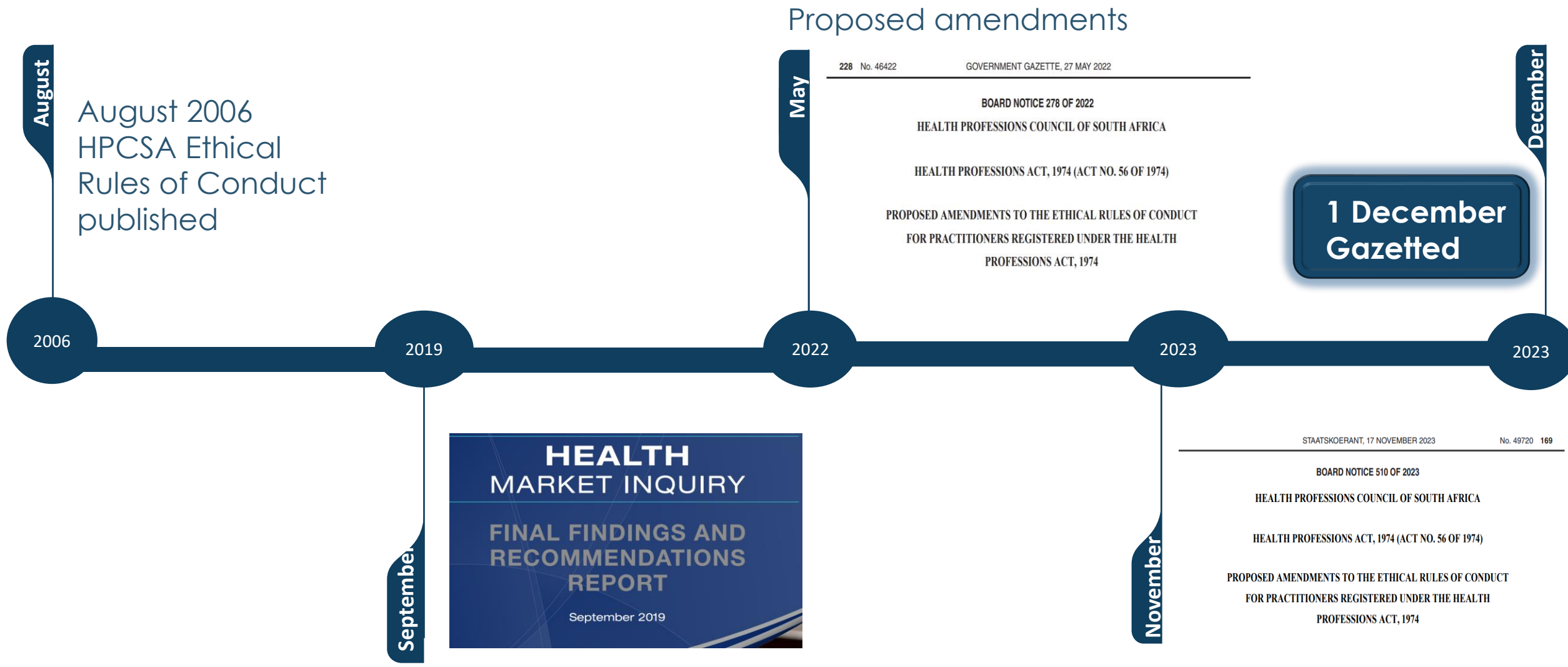
1. Multidisciplinary practices and global fees
2. The HPCSA's ethical rules on sharing of fees (ethical rule 7), business models (ethical rule 8) and sub-contracting (ethical rule 18).



HPCSA Ethical Rules Amendments



Timeline: Amendments to the HPCSA Ethical Rules of Conduct





Health Market Inquiry

“More needs be done to shift the focus from FFS towards meaningful risk-sharing and contracting on **value-based** metrics.”

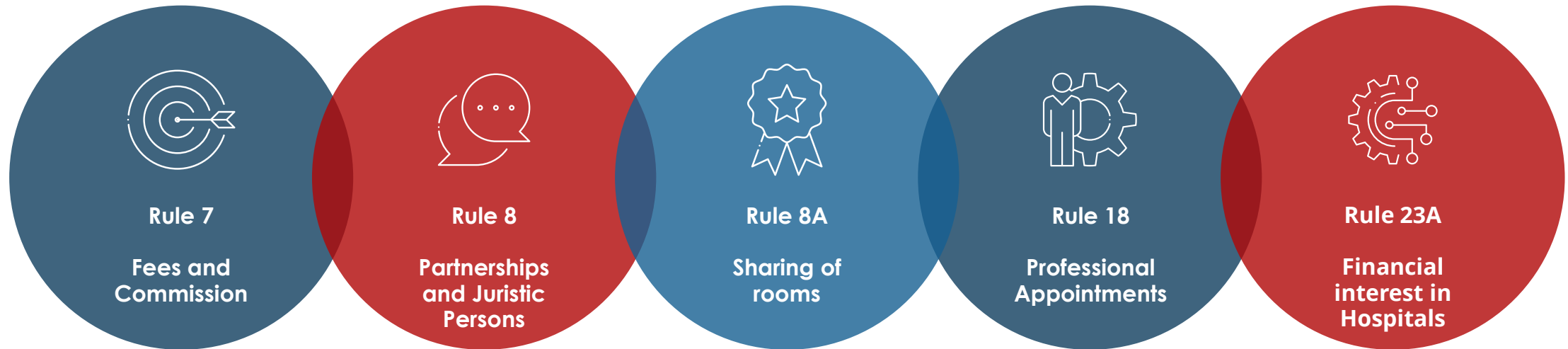
“Our recommendations to foster competition (standardised benefit package), create **outcomes measurements** (OMRO)”

“The Inquiry wishes to encourage a variety of alternative forms of practice and methods of payment and stakeholders to engage in **effective ARMs with real risk-sharing** and a commitment to **providing better value** for money”

Amendments to HPCSA Ethical Rules of Conduct



Amendments allow for multidisciplinary teams and employment aiming to lead to more collaboration



Multi Disciplinary
healthcare



Appropriate
healthcare



Quality healthcare
services



Collaborative
practices

Fee sharing between provider types allowed



Based amendments to Rule 7, further opportunities available to practitioners to extend the how they collaborate and consequently bill for healthcare services.



Rule 7 before amendments: practitioners may only receive fees for services personally rendered

The Rule can be interpreted as restricting alternative reimbursement models, such as global fee agreements.

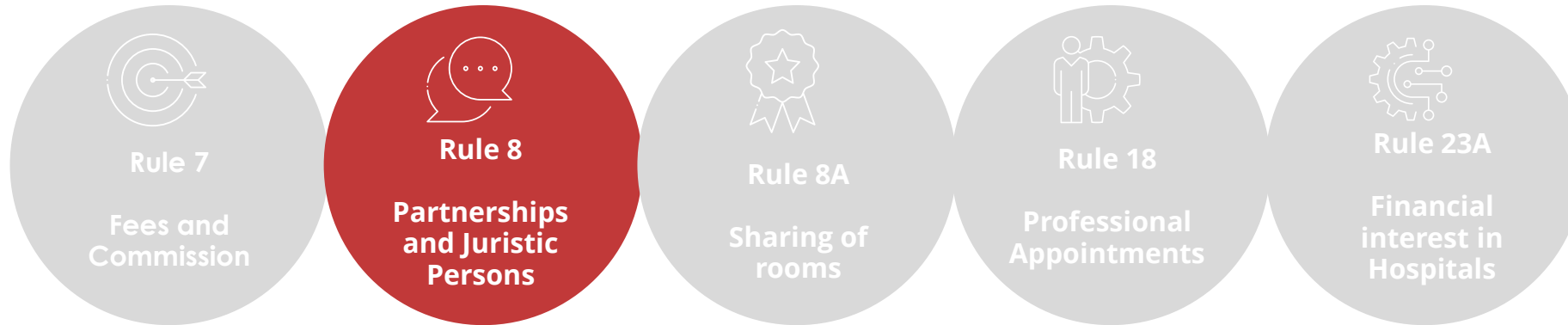
Amendment: "7(6) Notwithstanding anything contained in sub-rules (4) and (5) above, a practitioner may share, charge or receive fees from another practitioner: Provided that in such an instance, there is an express agreement, arrangement or model of rendering multi-disciplinary based health-care services to patients which is structured, which provides high quality health-care services or products, contain costs of rendering health-care services, and enhance access to appropriate healthcare".

Multidisciplinary Practices Allowed



Previously, Rule 8 restricted practitioners to practicing only in partnerships with each other

The amendments to Rule 8, now allow collaboration between practitioners in different registration categories



Except for specific allowances for radiologists or pathologists, practitioners are only permitted to form practices with persons who practice within the same registration categories.

Partnerships enabled & practitioners should maintain professional autonomy and independence

Amendment: "Notwithstanding anything contained in [Rule 8], a practitioner may provide health-care services with other registered practitioners, persons registered in terms of the [Health Professions Act No. No. 56 of 1974 ('HPA')], or in terms of any other legislation regulating health professions: Provided that the primary aim will be to enhance the quality of health-care services to patients, and further that there is an express agreement, arrangement or model of rendering multi-disciplinary based health-care services to patients..."

Multidisciplinary practices supported by sharing of rooms



The Ethical Rule read:

“8A A practitioner shall not share his or her rooms with a person or entity not registered in terms of the Act.”

Rule 8A, read with Rule 8, inhibited the establishment of multidisciplinary practices

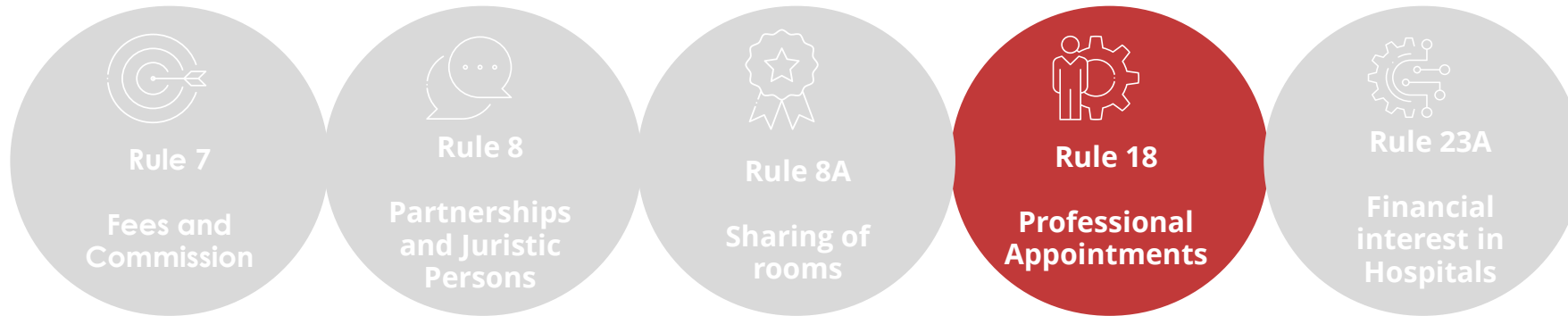
Newly inserted Rule 8A appears to support the establishment of multidisciplinary practices, that may now operate together in the same establishment.

Amendment: *"practitioner may share his or her rooms with a person registered in terms of the Act, or in terms of any other legislation regulating health professions".*

Professional Appointments allowed, quality of care focus



Generally, the employment of practitioners by persons not registered in terms of the Act is not permitted, unless special exception has been granted by the HPCSA.



The effect of Rule 18 is that a practitioner is required to obtain permission from the HPCSA to be employed by a non-registered person. Presently the HPCSA's Policy on Business Practices does not permit the employment of healthcare practitioners by private hospital groups.

Amendment: "A practitioner shall accept a professional appointment or employment from employers [approved by the council only] in accordance with a written contract of appointment or employment which is drawn up on a basis which is in the interest of the public and the profession: Provided that, the health practitioner ensures that the employment contract has as its primary aim the enhancement of the quality of health-care services to patients, is structured to contain costs, enhance access to appropriate, high quality health-care services or products to patients, and is not designed to extract profit for the benefit of the practitioner or their employer to the detriment of patients".



Opportunities for Multi-Disciplinary teams and Case studies



Example of Multi-Disciplinary Teams in Surgical Settings



AIM: To provide access to a high-quality surgical network for a specific episode with excellent clinical care



Pre & Post Surgery Education

Clinical Outcome Measures

Peer Review & Mentoring

Patient Reported Outcome Measures

Full cover benefit

Incentivise commitment to the highest standards of quality of care

Reimbursement alignment to share savings

Case Studies: Multidisciplinary teams & Reimbursement



Total Joint Arthroplasty



Effect of Bundled Payments and Health Care Reform as Alternative Payment Models in Total Joint Arthroplasty: A Clinical Review

Ahmed Siddiqi DO^a, Peter B. White BA^b, Jaydev B. Mistry MD^c, Chukwuweike U. Gwam MD^c, James Nace DO, MPT^c, Michael A. Mont MD^d, Ronald E. Delanois MD^c 

- Reduced costs in total joint arthroplasty
- largely by reducing hospital length of stay, decreasing readmission rates,
- reducing the number of patients sent to in-patient rehabilitation facilities...

[Effect of Bundled Payments and Health Care Reform as Alternative Payment Models in Total Joint Arthroplasty: A Clinical Review - ScienceDirect](#)

Primary Care



Dutch shared savings program targeted at primary care: Reduced expenditures in its first year

- Participating GPs lowered total medical spending by 2% in the first year
- Savings realized predominantly by lowering volumes of hospital care
- Almost all GPs displayed cost-saving behavior.

<https://www.sciencedirect.com/science/article/pii/S0168851021000300>

Maternity Care



Blue Cross VT Recognizes Rutland Regional Medical Center for High-Quality, Lower-Cost Maternity Care

- 26% lower episiotomies
- 17% lower cesarean births

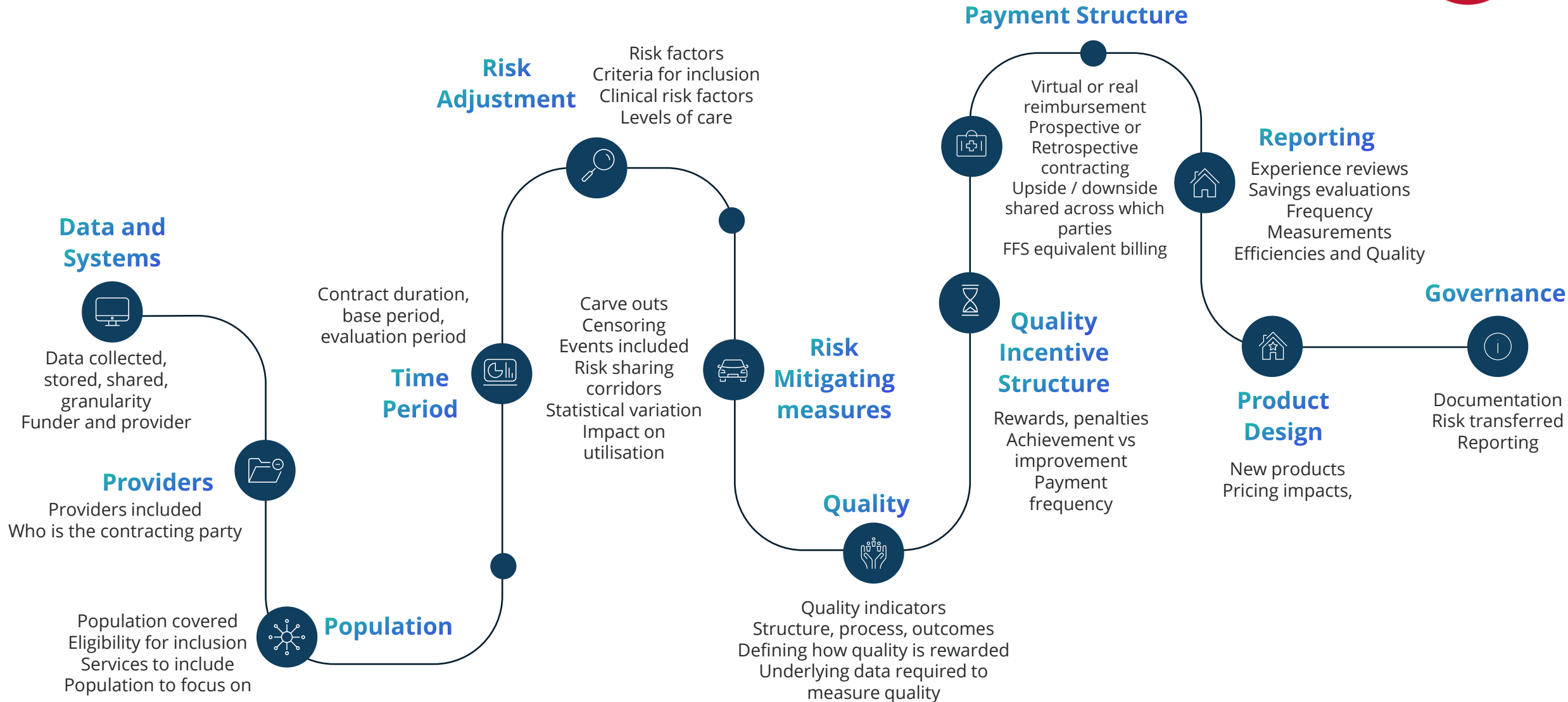
[Blue Cross VT Recognizes Rutland Regional Medical Center for High-Quality, Lower-Cost Maternity Care | Blue Cross VT](#)



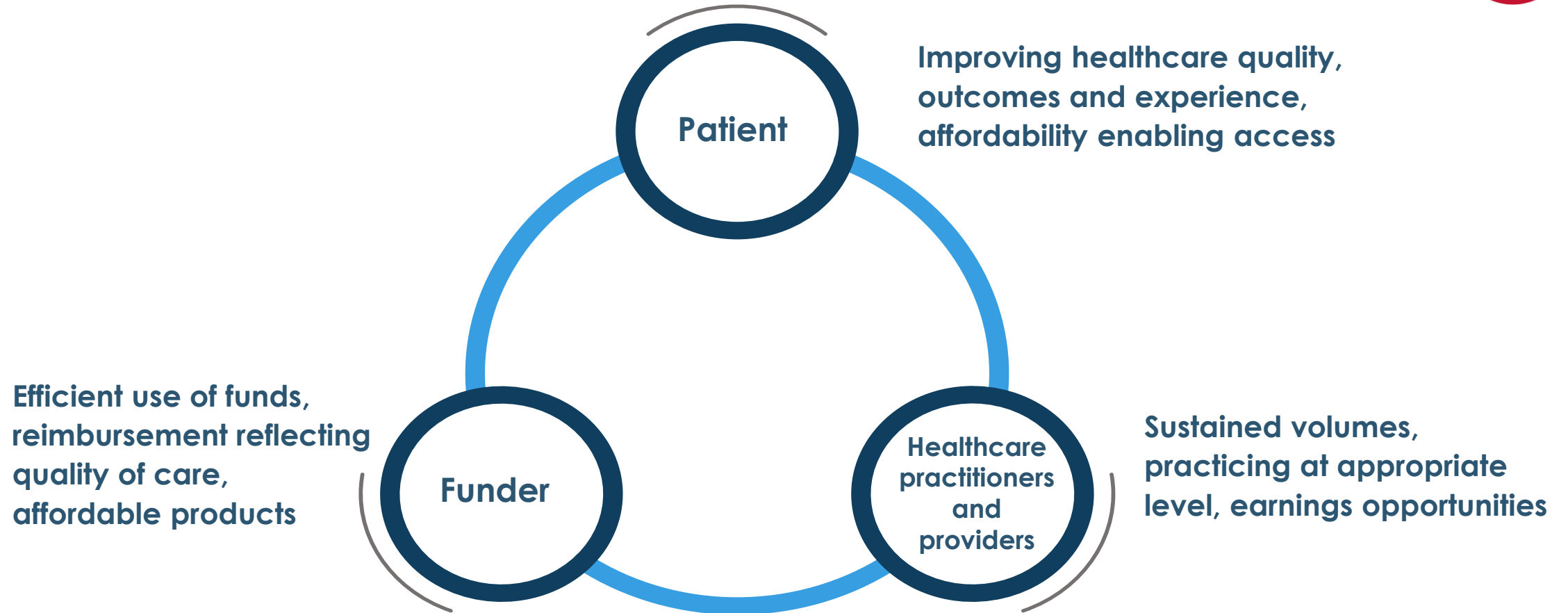
Actuarial Considerations



Actuarial considerations



Striving for Win-Win-in outcomes



Working harder – versus working smarter and together
Patient volumes opportunity

Conclusion



ARMs and value based contracting

- Current environment predominantly fee for service reimbursement
- ARMs exist but are largely focused on cost containment
- To contract effectively, cost efficiency needs to be combined with quality outcomes

HPCSA Ethical Rules Amendments

- Amendments aligned with HMI recommendations to move toward “ARMs *with real risk-sharing and a commitment to providing better value for money*”
- Allow providers to be salaried and promote multi-disciplinary teams

Opportunities for Multi-Disciplinary Team and Case Studies

- Multi-disciplinary teams promote collaboration between providers
- International case studies on multi-disciplinary teams have demonstrated improved outcomes:
 - Multiple Joint Replacement
 - Primary care setting
 - Maternity

Actuarial considerations

- Actuaries can assist in designing ARMs to promote multidisciplinary teams taking into consideration data, design, risk sharing, monitoring
- Ultimate goal is to achieve a win-win-win for patient, provider and funder



Thank you

