B·H·F
BOARD OF HEALTHCARE FUNDERS

SPECIAL REPORT

BOTTOM-UP APPROACH

Developing Alternative Reimbursement Models for Hospital Admissions related to COVID-19

AUTHORS

Shivani Ranchod,
Martin Coxon, Aphiwe Baleni

Table of Contents

1. Introduction

This is the second part of a report released by the Board of Healthcare Funders (BHF) on the work done by the Industry Technical Advisory Team (ITAC). The group was tasked with exploring the feasibility of creating a global fee for COVID-related admissions. The first report was from the 'top-down' team: it analysed the variation in COVID admissions and assessed the possibility of a global fee.

The second team in the ITAC group explored the same question but using a 'bottom-up' approach. We held a series of interviews with hospital groups and this paper is a summary of the learnings from our discussions with the hospital executives, analysts and clinicians interviewed. Hospital executives spanned clinical risk management and funder relations.

To maintain confidentiality, the hospital groups and individuals who were interviewed will not be identified by name.

2. Methodology

The questions and rationale behind the questions that we asked are below:

Questions	Rationale
Can you summarise for us the hospital group's appetite for alternative reimbursement mechanisms (ARMs) for COVID-related admissions?	For an ARM to work, we would need buy-in from several stakeholders. This question gave us an indication of interviewees' openness to exploring a global fee or any other ARM.
What have you observed in terms of variations in clinical practice for COVID patients, both over time and between hospitals and doctors?	Variation in clinical practice likely translates to variation in the total cost of an admission, and variation between doctors and hospitals would make it more difficult to have a fee that would be agreed to by the industry. Variation in clinical practice can also point to the need for an ARM – ultimately to incentivise and drive more consistent clinical practice. The question about variation over time relates to the novel nature of COVID-19 and hence the viability of imposing a more rigid financing structure on top of dynamic clinical practice.
What are the factors that influence patient length of stay for COVID admissions?	To ensure fairness of the global fee, the ARM would need to account for the factors influencing length of stay.

Questions	Rationale
What are the factors that influence patient level of care for COVID admissions?	These factors would help explain the observed variation in COVID admissions. The factors that are not in the control of providers should be considered when setting the global fee.
Have you observed any trends in level of care for COVID admissions over time?	This relates to the frequency with which the global fee would need to be adjusted. If trends are easily identified and justified, then the ARM can take this into account.
Can you comment on the extent of clinical teamwork required for COVID admissions as compared to business as usual?	The ARM that includes professional fees would need to consider the mix of doctors involved in COVID admissions. This can explain part of the variation between hospitals. An ARM can also be used to support teamwork.
Would a global professional fee for COVID admissions better reflect the clinical delivery model than fee-for- service arrangements?	This gives a view of any additional factors impacting the suitability of an ARM.
Are there interesting fee models that have been negotiated with schemes for COVID admissions?	The existence of ARMs or lack thereof in the industry would provide useful learnings

3. Findings

The findings below explore the key themes emerging from the interviews rather than directly sharing the answers.

3.1. Concerns about competition principles

A concern was raised about the role of the BHF in assembling a technical team, given that the BHF represents member schemes. The concern is that the BHF is pooling technical skills across the funding industry, and this could be perceived as schemes combining resources and working on a project that could influence scheme-provider negotiations. This could be interpreted as uncompetitive.

It is important for ITAC to address this concern directly in terms of intention, independence and impact. Firstly, from the perspective of intention: ITAC was created by the BHF to serve the wider healthcare industry.

Secondly, ITAC members act in their professional capacity. The majority of the members in the task team are not representing particular medical schemes but are volunteering their technical competencies. The role played by the BHF was one of initiating the project and facilitating the work done for the benefit of the wider industry. Many of the members of ITAC are actuarial consultants with both funder and provider clients.

In terms of impact, the work done will be shared publicly and it is envisioned that it can empower and be used by different healthcare stakeholders towards creating alternative reimbursement arrangements that can improve the resilience of our healthcare system in the fight against COVID. The work done will also provide a useful framework that the industry can build on when creating ARMs for other conditions.

It is also useful to distinguish between reimbursement structures and the prices associated with those structures. The focus of ITAC has been to consider questions relating to reimbursement structure. It is in the interests of both funders and providers to have coherent reimbursement structures that reflect underlying clinical dynamics. Reimbursement fragmentation creates system complexity and cost, and undermines the likelihood of funders and providers aligning incentives.

3.2. Variation in experience between COVID waves

COVID-19 is a novel illness, and much is still being learned about its symptoms, its long-term health implications and the appropriate treatment protocols. As our understanding evolves, the solutions proposed must match the latest clinical research. This is complicated by the emergence of new strains.

Caution must be taken when trying to understand the two waves. There are (at least) three dynamics to consider:

- The first is more understanding/experience when clinicians were dealing with the second wave;
- The second is that the available treatment options had expanded by the time of the second wave;
- The second wave was associated with overwhelming volumes.

It is still largely unknown to what extent the new variant impacted on clinical presentation.

One interviewee cited, as an example, that there were cases where paediatricians had to step up and treat adult patients. There was also an indication that there was greater deviation from standard clinical protocols in the attempts to treat patients quickly to create capacity (for example, greater use of antibiotics to manage down the risk of secondary infections).

We learned that hospitals experienced shorter lengths of stay in the second wave, but this could have been influenced by the higher volumes and more pressure to discharge as early as possible.

A consequence of the above is that there is a non-negligible risk that the clinical behaviour during any upcoming waves might be materially different from what we have experienced so far; a global fee arrangement defined using our past experience might fail to fairly account for any future difference in the clinical presentation of the virus, the treatment options available (and prevailing wisdom on treatment choices) and the extent of the pressure on the system.

Providers would be concerned, for example, about fees being too low to account for longer lengths of stay, more expensive clinical interventions and a higher acuity of care than reflected in the historical data.

3.3. Variation in clinical practice between doctors, hospitals and over time

Some hospitals have created protocols on the standard drugs that must be used by clinicians, but standard treatment differed between the two waves and this would create hesitancy from a hospital to commit to a fixed fee arrangement.

Another source of variation would be patient behaviour. We learned that there was an element of patients relying more on home remedies during the second wave and delaying admission, which can impact the level of care ultimately required.

Some of the treatments involved the use of experimental drugs, which are expensive, and there is variation in treatment between and within hospitals groups. Part of the treatment variation arises from how teams are comprised; in some situations, the team is led by a physician and in others by an anaesthetist; a multi-organ failure patient would be attended by a larger team.

3.4. The suitability of a global fee for COVID-19 admission

In principle, our interviewees expressed openness to ARMs but did not think that COVID-19 admissions would be the clinical area best suited to an ARM (for reasons of novelty, emergent clinical practice and clinical variation).

One of the main rationales for a global fee is to align incentives between funders and providers. In this instance, our interviewees thought that incentives are already aligned in that there is a reduced likelihood that providers would over-utilise already limited resources. In other words, the short-term pressured nature of the waves of infection creates a natural incentive to discharge patients and to manage limited high care and ICU capacity.

On the question of existing ARMs, none of the hospital groups interviewed had any existing ARMs currently in place for COVID-19 admissions. The main reason cited was that there is currently no clear clinical pathway for COVID admissions.

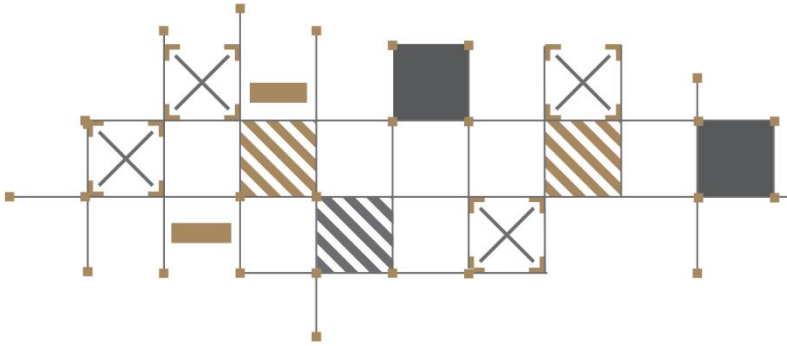
One of the advantages of a global fee is the reduced billing activity, which can be strenuous for doctors. This was accentuated by the nature of the teamwork required by COVID-19 patients (both due to limited resources and clinical need). The lack of familiarity across the system with fee structures that support teamwork (in part as a result of HPCSA regulations) was noted as a constraint that was highlighted by COVID-19.

There is a view that a global professional fee (*per diem*) would benefit doctors and that they are more likely to buy into it than hospitals. A fixed or decaying *per diem* might make sense; risk adjusted to allow for a higher fee for more complicated admissions.

4. Conclusion

The anecdotal evidence shared above showed that there is variation in COVID admissions between hospitals, doctors/teams, treatment protocols. In addition, the experience was different between the two waves.

There seems to be little appetite for a global fee at a hospital level owing to the variation, but a *per diem* fee is perhaps a viable alternative for doctors and teams; this has the added benefit of creating incentives for teamwork and might result in the creation of standard protocols that can evolve over time and reduce variation.



CONTACT DETAILS

Charlton Murove

Head: Research

T: +27 11 537 0256

M: +27 76 812 2780

CharltonM@bhfglobal.com

Board of Healthcare Funders

http://www.bhfglobal.com

South Tower, 160 Jan Smuts Ave,
Rosebank, 2196

B·H·F

Board of Healthcare Funders