Title page

Health management capstone

The three common reimbursement models used by the organizations and healthcare providers include; free-for-service, value-based system and patient-centered medical care. Free-for-service method focuses on paying the money based on the volume of the service provided. This a traditional method of payment in which doctors and the physicians are paid by the government and insurance companies. The number of service and procedures ordered, impacts the payment. According to this model, a higher price is paid for high volume and vice versa. Bundled payment method is used in this model which means separate bills are used for payment (Ogundeji & Bland, 2015). The clients are allowed to choose their physicians, hospitals and services while the payments are made by government agencies and insurance companies. The coverage is offered for the hospitalization, admission to the nursing facility or hospice care, payment for surgical processes, medical equipment and outpatient care.

The value-based system of reimbursement allows customers to pay according to the quality of care and the value received by them. This method adopts the strategy of assessing client’s experiences and satisfaction. Payment is based on patients’ feedbacks which decline with the negative feedback of customers. The central focus of this model is to come up to client’s expectations. This is a practical method which encourages nurses and physicians to improve their performance level. The payment is purely based on individual performance of the staff. Rewards in the form of better pays encourage healthcare providers to work with dedication and help patients in attaining health. Patient-centered method emphasizes on meeting customers’ expectations. Patient experience and responses are used for evaluating the payment for healthcare services.

The best healthcare facility proposed to the hospital is value-based system because this is the most practical method. This is the most effective method because it adopts the practical way of charging customers according to the service. The value portion is aimed at measuring outcomes related to patient specific services in response to the cost of providing services. According to this model, the healthcare provider will not receive any payment if the patient doesn’t show any signs of improvement (Cashin et al., 2014). Similarly, the provider will receive little payment when patient shows little signs of improvement.

Value-based model offers many benefits such as increased likelihood of improved health and wellness of the patient. It also lowers pocket costs because evaluation of services quality is essential. This model is of significant benefit for thee payers as they are the controlling entity. This reduces the risks and leads to greater profits for the payers. Another benefit of the value-based reimbursement model is that it enhances the efficiency of the healthcare providers. Doctors, nurses and the entire staff is motivated to improve their service quality for attaining maximum value in the form of money. This model also gives a larger margin of profit generation to the healthcare organizations and institutes. By offering enhanced care, the organization is more likely to receive positive customers feedback and satisfaction level. This ultimately increases profit margin for the organizations. Improved safety and reduced harm are also prominent benefits of the value-based model (Counte, Howard, Chang, & Aaronson, 2018). Healthcare providers can assist patients and coordinate with care efforts which improves the reputation of organization.

There are also some cons of value-based model including inappropriate accountability of the physicians and staff. The model can be successful only if reliable measures are used for evaluating performance. It is difficult to provide actionable information to the hospital about the physicians, doctors and other staff. Patients lacking information will expect cost reduction.

References

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