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Hospital Funding Policy in Canada

An Update

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Hospital Funding Policy in Canada

- **Responsibility for health care funding, delivery and policy is a provincial issue**
- **Re-distribution of income between provinces for equity of funding**
- **Over $55 billion per year on hospitals (excl physicians)**

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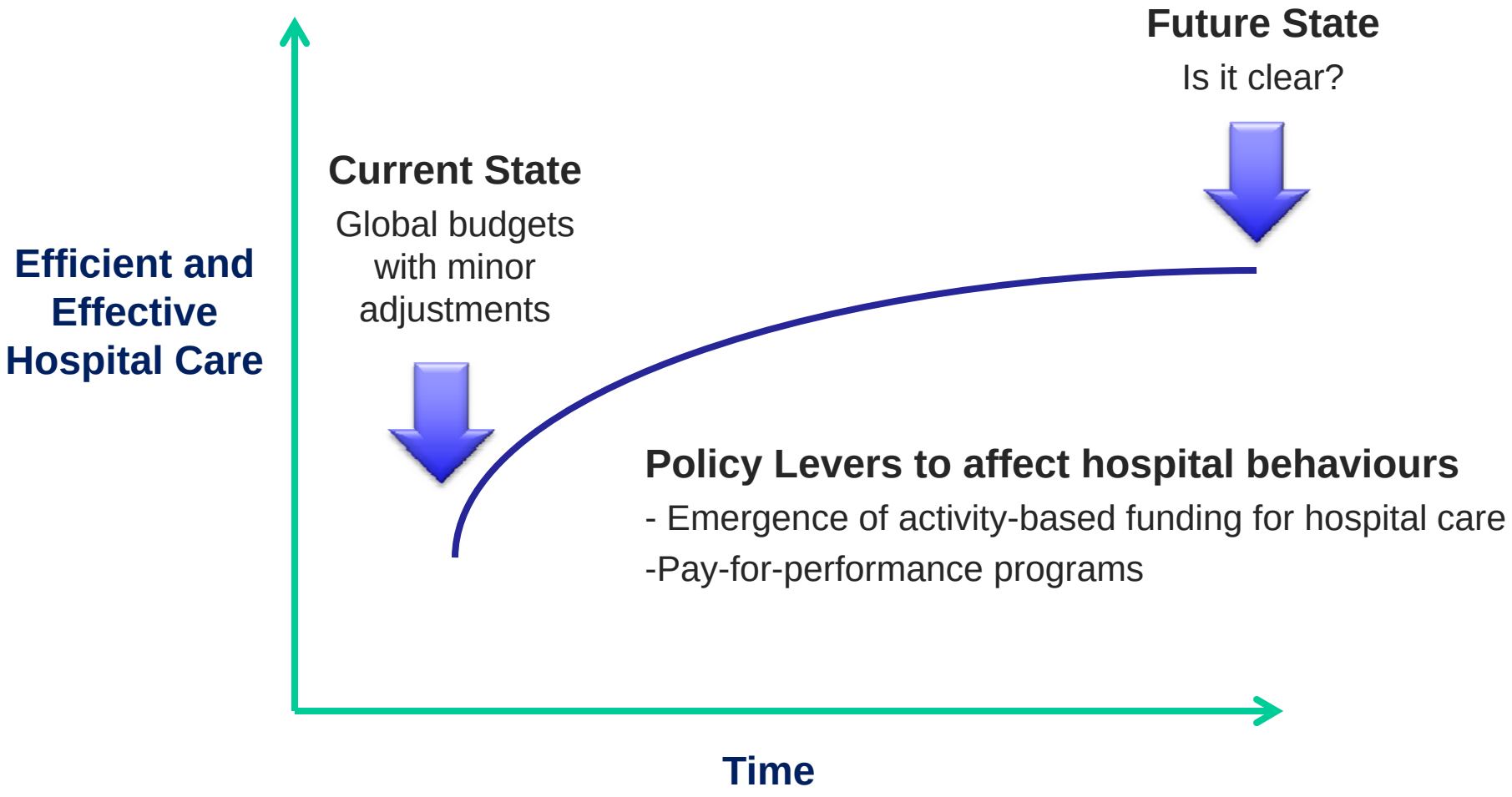

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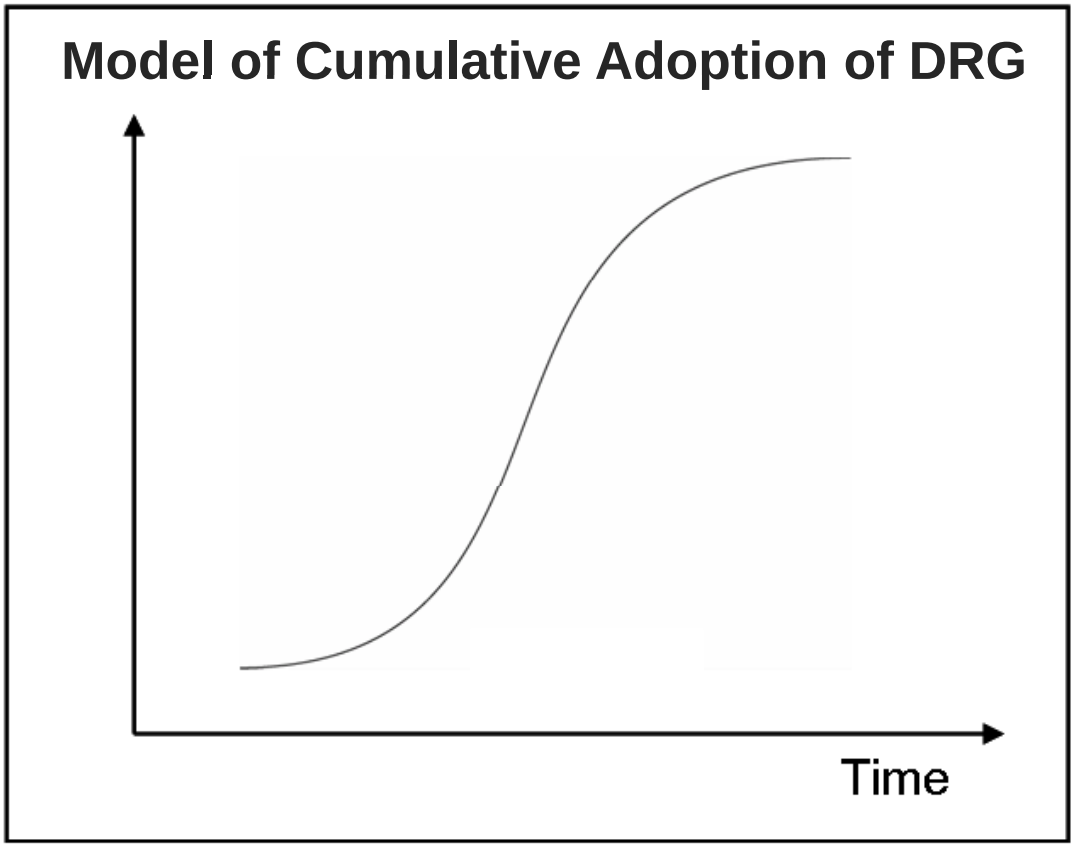
- Canadian provinces movement from global budgets to activity-based funding
- Heterogeneity between provincial responses and activity



Rogers, Everett M. (2003). *Diffusion of Innovations*, 5th ed.. New York, NY: Free Press.

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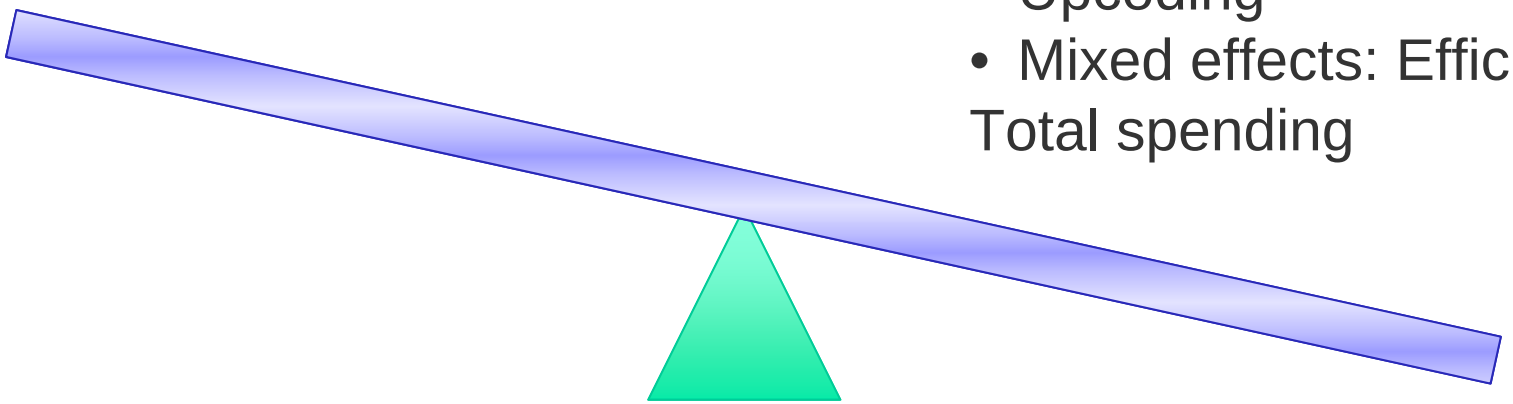
Attractiveness of ABF

Using funding as a 'lever' to increase technical efficiency

- Economic incentives
- Political incentives

Challenges of ABF

- No incentive to coordinate care, fragmented care
- Over-provide profitable services
- Upcoding
- Mixed effects: Efficiency, Total spending



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- **'Unique' issues regarding activity-based funding in Canadian provinces:**
  - Geographic access
  - Equity of access

- **Stakeholders concerns**
  - Health human resource implications
  - Quality
  - Hospital financial performance
  - Patient satisfaction
  - Impact on other sectors (home care, long term care)

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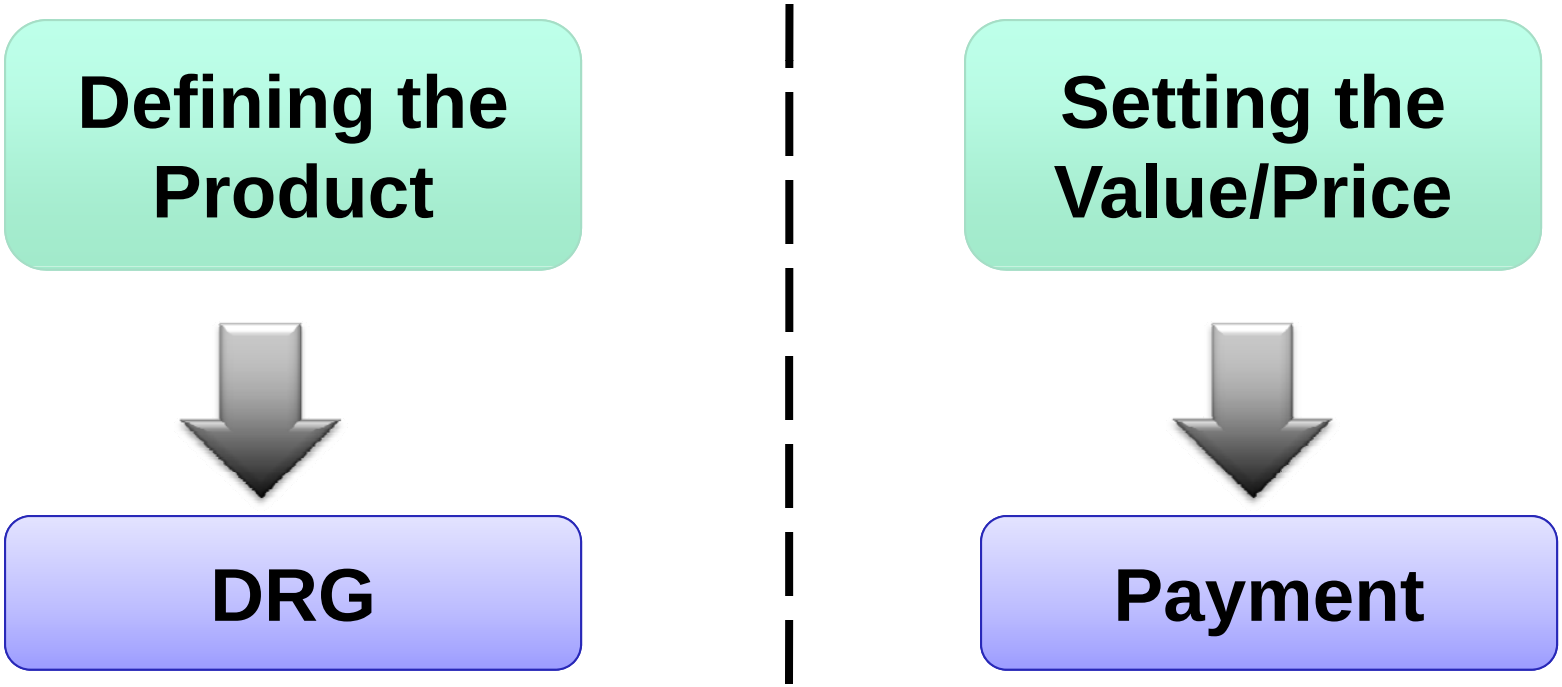
Before widespread activity-based funding

- Mutually agreed upon hospital ‘products’
- Deriving a ‘value’ for hospital products



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Discontinuity

- Currently, the funder (provincial governments) does not define the products or prices
- Canadian Institute for Health Information

Should each province/funder define it's own products and prices?

- Implementation and transaction costs

Setting the payment amount is really hard to balance incentives

- 'best practice price', 'fair and achievable' or average

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What happens when the price is not right?

Expanded Use Of Imaging Technology And The Challenge Of Measuring Value

The benefits of expanded imaging might not b patients' disease outcomes.

by Laurence C. Baker, Scott W. Atlas, and Chris

ABSTRAC ing (MRI) s document tentially in dressed if be valuabl though evi thus, a par be quantifi

Getting The Price Right: Medicare Payment Rates For Cardiovascular Services

prices is necessary to ensuring disabled.

Jeffrey Stensland

hospitals have grown rapidly. Physicians diovascular diagnostic services in their of- in Medicare's prices for hospital care and he accuracy of those prices. We find that

When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care

If payment rates are not made more accurate, another powerful driver of health cost trends could be created.

by Paul B. Ginsburg and Joy M. Grossman

ABSTRACT: Unintended overpayment of some services, in combination with other market factors, is driving increased use of expensive care, which in turn could be an important driver of health care cost trends. Reimbursement systems are highly dependent on provider charge data that rarely provide accurate and up-to-date indicators of relative costs. As a result, newer services, in which productivity is increasing over time, tend to be more lucrative. As the largest payer, and one whose reimbursement policies are followed by private insurers and Medicaid programs, Medicare can address this issue by taking steps to make its prospective payment rates reflect relative costs more accurately.

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Costing Methods

THE IMPACT OF USING DIFFERENT COSTING METHODS ON THE RESULTS OF AN ECONOMIC EVALUATION OF CARDIAC CARE: MICROCOSTING VS GROSS-COSTING APPROACHES

ORIGINAL PAPER

ELSEVIER Health Policy 56 (2001) 149–163

www.elsevier.com/locate/healthpol

Comparing methodologies for the cost services

S. S. Tan · F. F. H. Rutten · B. M. van Ineveld · W. K. Redekop · L. Hakkaart-van Roijen

Received: © Springer

Abstract the total when the replaced or gross represent appendec dial infa

Cost Weight Compressio and C

Charles K. Botz, Ph.D., Jaso

This study was designed to quantitati assess the impact of deficiencies in compi ness and precision of hospital case cost on cost weight compression. For the nurs per diem model versus the nursing workl model the average compression was 19.6 percent (for the 25.9 percent of cases that

Using computerised patient-level costing data for setting DRG weights: the Victorian (Australia) cost weight studies

Terri Jackson

Monash University Health Economics Unit, Hospital Services Research Group, P.O. Box 477, W. Heidelberg VIC 3081, Australia

Received 8 April 2000; accepted 16 November 2000

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Abstract

Casemix-funding systems for hospital inpatient care require a set of resource weights which will not inadvertently distort patterns of patient care. Few health systems have very good sources of cost information, and specific studies to derive empirical cost relativities are themselves costly. This paper reports a 5 year program of research into the use of data from

Carter and Farley, 1992; Benoit, Skea, and Mitchell, 2000), still represented only a

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- **Can activity-based funding be credibly executed in Canada?**

- **Technical Challenges**
  - Data availability
    - Clinical
    - Financial
    - Patient level costing
  - Coding quality
    - Framework for non-adherence to standards
  - Increased demands for timeliness

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- **Clear evidence that hospital respond to case mix incentives**
  - Multiple perspectives on how to address
    - Education, Monitoring, Compliance measurement

Detecting Medicare abuse

David Becker[a], Daniel Kessler[b,*], Mark McClel

[a] University of California, Berkeley, CA 94720, USA

[b] Graduate School of Business, Stanford University, Hoover Institution, and NBER, Stanf

[c]

Abstract

This paper
responsive to

PbR Data Assurance Framework 2007/08

Findings from the first year of the national clinical coding audit programme

Medicare upcoding and hospital ownership

Elaine Silverman[a,b], Jonathan Skinner[b,c,*]

[a] Dartmouth Medical School, Hanover, NH 03755, USA

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[c] National Bureau of Economic Research, Cambridge, MA 03755, USA

Received 1 July 2003; accepted 1 September 2003

Abstract

Coding Response to a Case-Mix Measurement System Based on Multiple Diagnoses

Colin Preyra

Objective. To examine the hospital coding response to a payment model using a case-mix measurement system based on multiple diagnoses and the resulting impact on a hospital cost model.

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Implementation challenges

- Vision and Leadership
- Political issues related to changing hospital case mix
- Understanding the effects of natural geographic monopolies
- Threshold for applicability in less-populated provinces and territories
- Understanding demand and supply on post-hospital services

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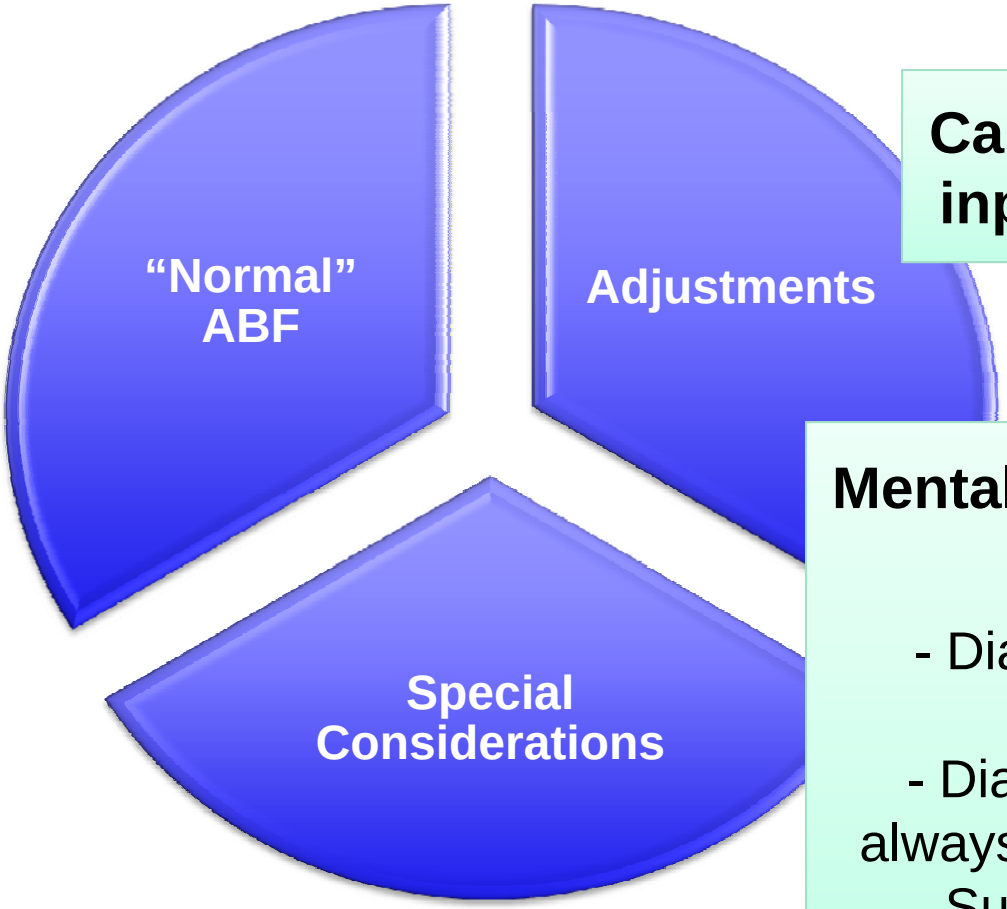
Strategies for ABF Pricing



Capital, teaching, rural, input price differences

Mental health, geriatric, palliative, rehabilitation

- Diagnosis explains a very small portion of episode cost
- Diagnosis and symptoms do not always align with treatment strategies
- Substitutability between sectors

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Preparing for changes related to ABF

- Change within hospitals
  - Profile of clinical activity
  - Hospital financial performance
  - Management changes
- Change in other sectors
  - Increased acuity in long-term care, home care
- Increase in volume of the most profitable patients rather than those most in need

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Open Questions - Implementation

- What are the desirable levels of activity?
- Should there be spending ‘caps’ to limit growth of activity?
  - Payment for marginal cost?
- How long does the commitment to ABF need to be for hospitals to respond to incentives?
- How quickly can ABF be phased in and implemented?
- What percentage of funding should be ABF?
- How do we measure and monitor quality?

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- **In addition to ABF**
  - Designing incentives
    - Improve evidence-based care
    - Improve effectiveness
    - Improve safe, coordinated care between sectors
- **Key issues of P4P**
  - Few hospital measures of quality
    - Lack of process measures in Canada – 'silos' of data
  - Formal evaluations of hospital-based P4P's effectiveness and efficacy are few
  - Integration of P4P with activity based funding

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Takeaways

- Hospital funding policies in Canada are changing… but slowly
- Technical challenges to ABF implementation not as large as political challenges
- ABF is a framework that needs continuous attention
- ABF is ‘One tool in the toolkit’, but becoming increasingly important

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