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HEALTH SERVICES AND POLICY RESEARCH

Healthcare Financing, Innovation and Transformation

Hospital Payment Mechanisms: Options for Canada

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Hospitals = $50 billion in expenditures per year

Seeking strategies for limitations of Global Budgets?

- Transparency
- Perceived inefficiencies
- Wait times
- Unexplained variation in utilization/cost
- No reward for innovation
- Emergency Departments
- Alternative Level of Care
- No incentive to improve quality

Drivers of hospital funding reform: ABF

- Stimulating productivity and efficiency
- Reducing lengths of stay
- Reducing hospital waiting lists
- Increasing competition between hospitals to improve quality
- Encouraging monitoring and benchmarking
- Reducing excess capacity, increasing transparency in hospital funding
- Facilitating patient choice
- Harmonizing payment mechanisms between public and private providers

Activity-Based Funding 'Rushing In'

- BC, AB, ON; incremental funding in SK, NL
- CMA, BCMA, OMA, OHA, Kirby Commission (v.6)
- International norm
- Much more complex to administer

Major Motivating Factors

Pluses and Minuses of Activity-Based Funding

Opportunities

Using funding as a 'lever' to increase technical efficiency

- Economic incentives: retain surpluses
- Political incentives

Challenges

Problems well known: Rewards Volume….

- No incentive to coordinate care, fragmented care
- Over-provide profitable services
- Upcoding ….

Decades of Research and Application

Evidence

- Tends to shorten lengths of stay
- Tends to increase the volume of hospitalizations
- Tends to increase spending
- Little evidence of effect on hospital quality

Mixed effects

- Efficiency

Other potential impacts

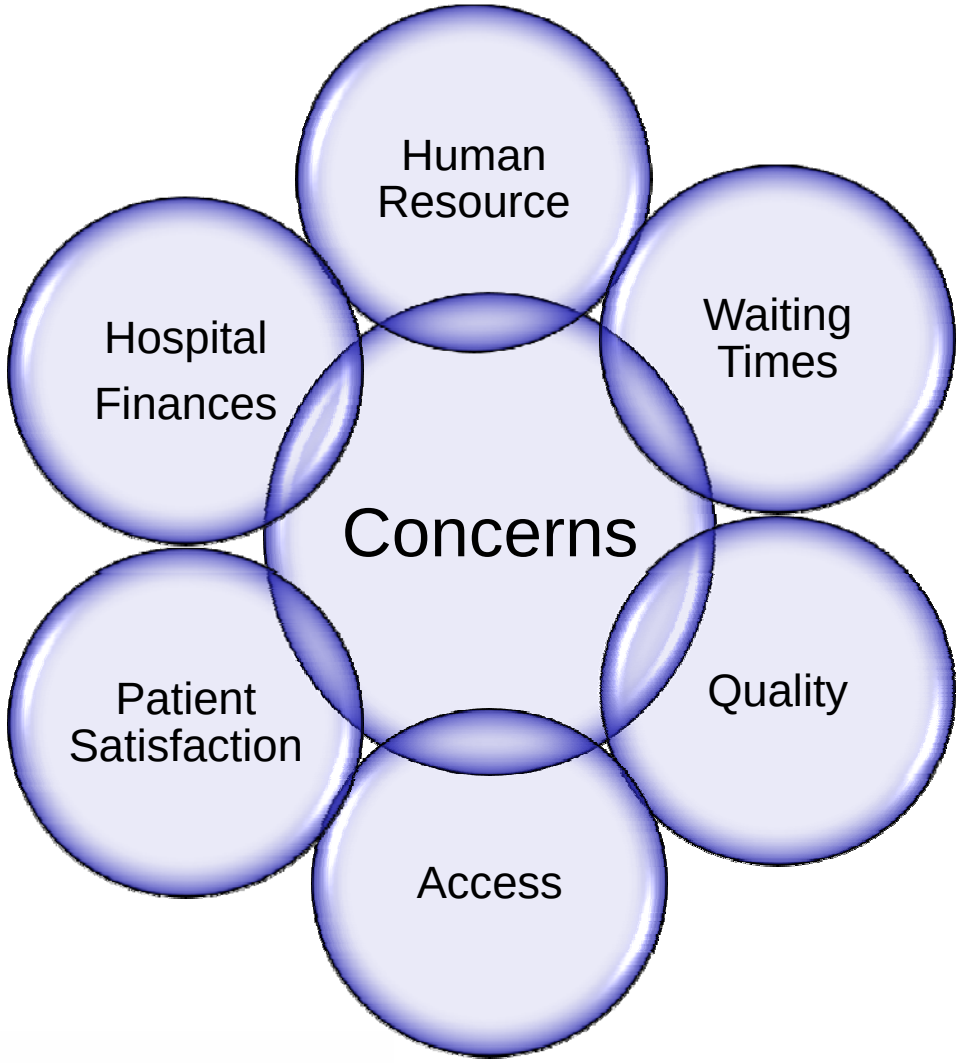
- Geographic access
- Equity of access

No Evidence

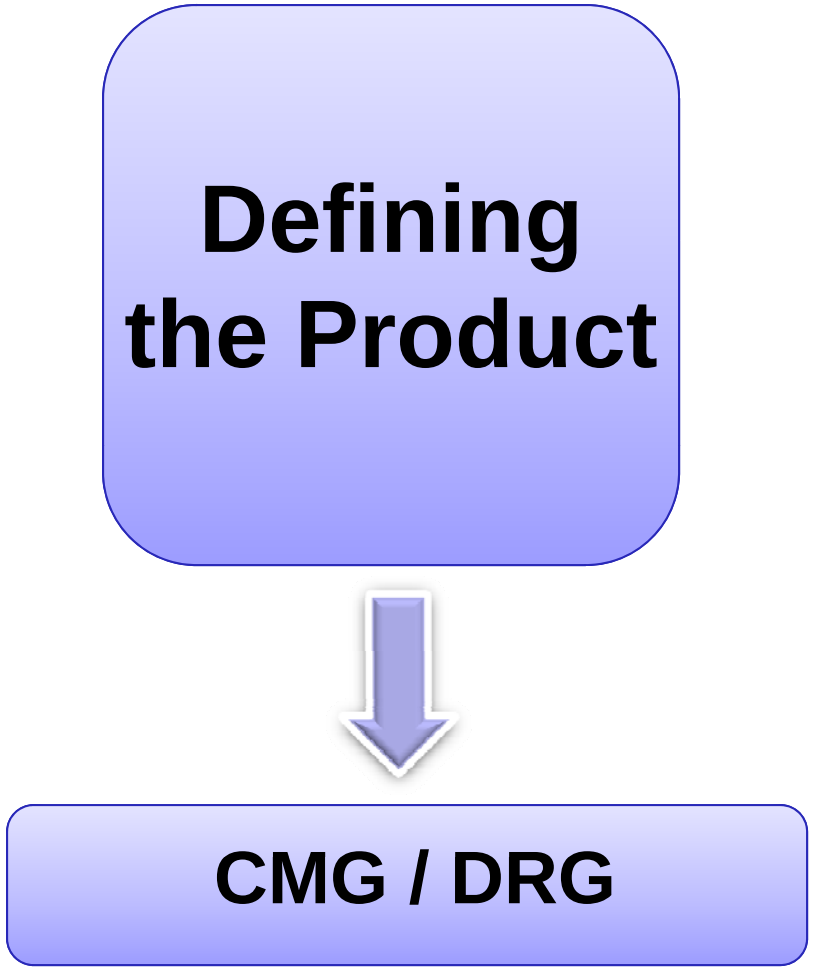
- Improves evidence-based care
- Improves effectiveness or appropriateness
- Impact on other sectors
- Provider engagement

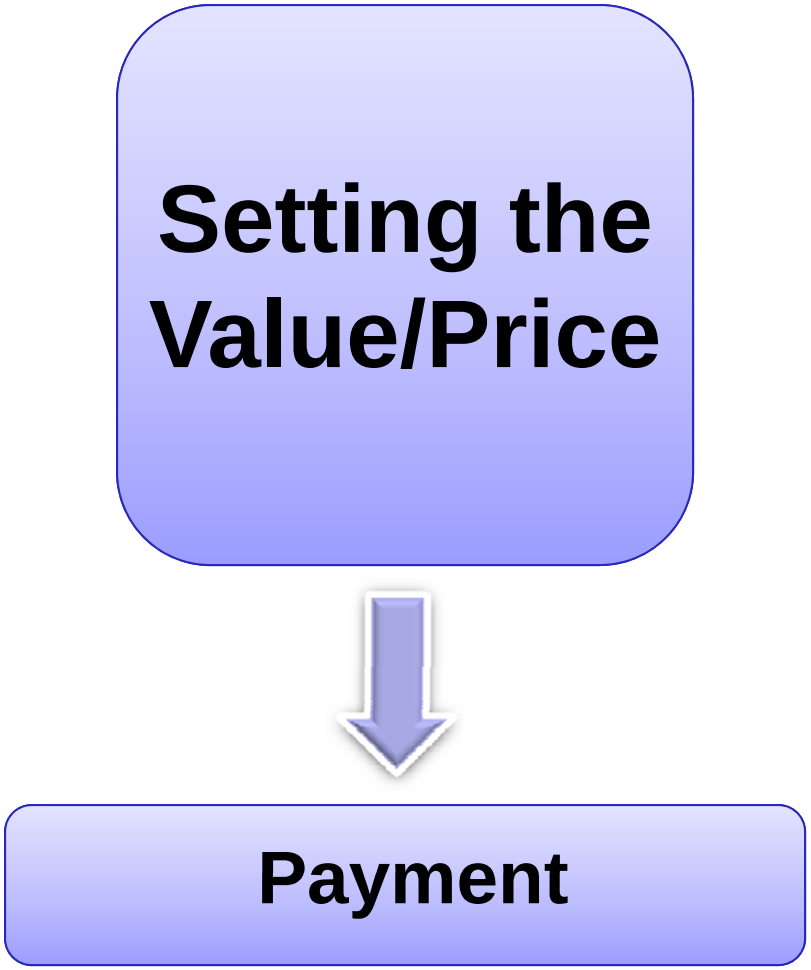
….but, neither does global budgeting

Addressing Common Stakeholder Concerns



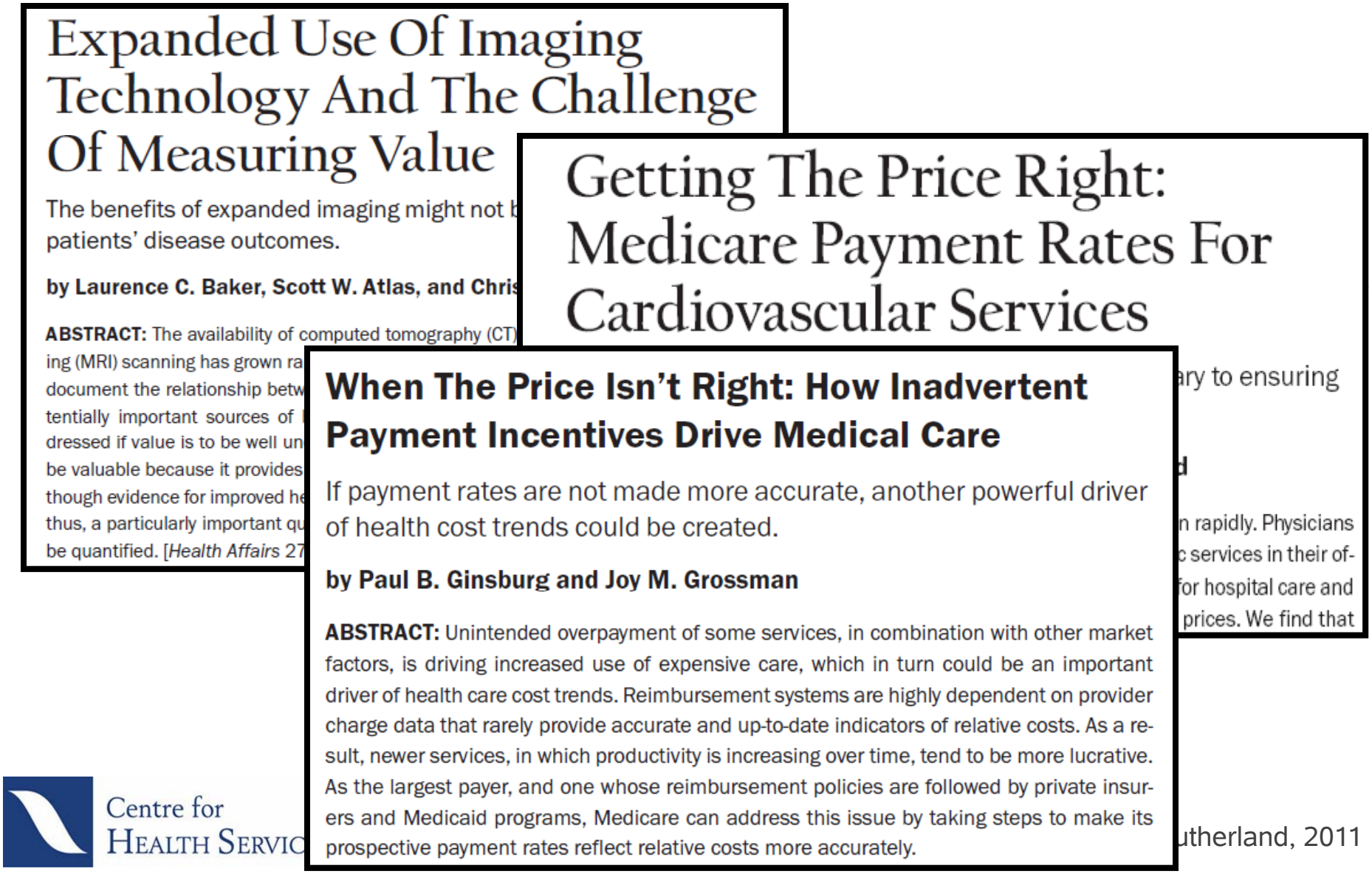
- Generally, the payer defines the product groups it is willing to pay for
  - Medicare (DRG)
  - Department of Health, UK (HRG)
  - Department of Health and Ageing, Australia (AR-DRG)





- Cost data is used to set the value (price)
  - Ontario Case Costing Initiative, Alberta costing
  - Charge data (DRG)
  - Micro-costing studies, Australia (AR-DRG)
  - Hospital financial data (UK, HRG)
- What components are in?

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

ABSTRACT: The availability of computed tomography (CT)
ing (MRI) scanning has grown ra
document the relationship betw
tentially important sources of
dressed if value is to be well un
be valuable because it provides
though evidence for improved he
thus, a particularly important qu
be quantified. [*Health Affairs* 27

Getting The Price Right: Medicare Payment Rates For Cardiovascular Services

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n rapidly. Physicians
c services in their of-
for hospital care and
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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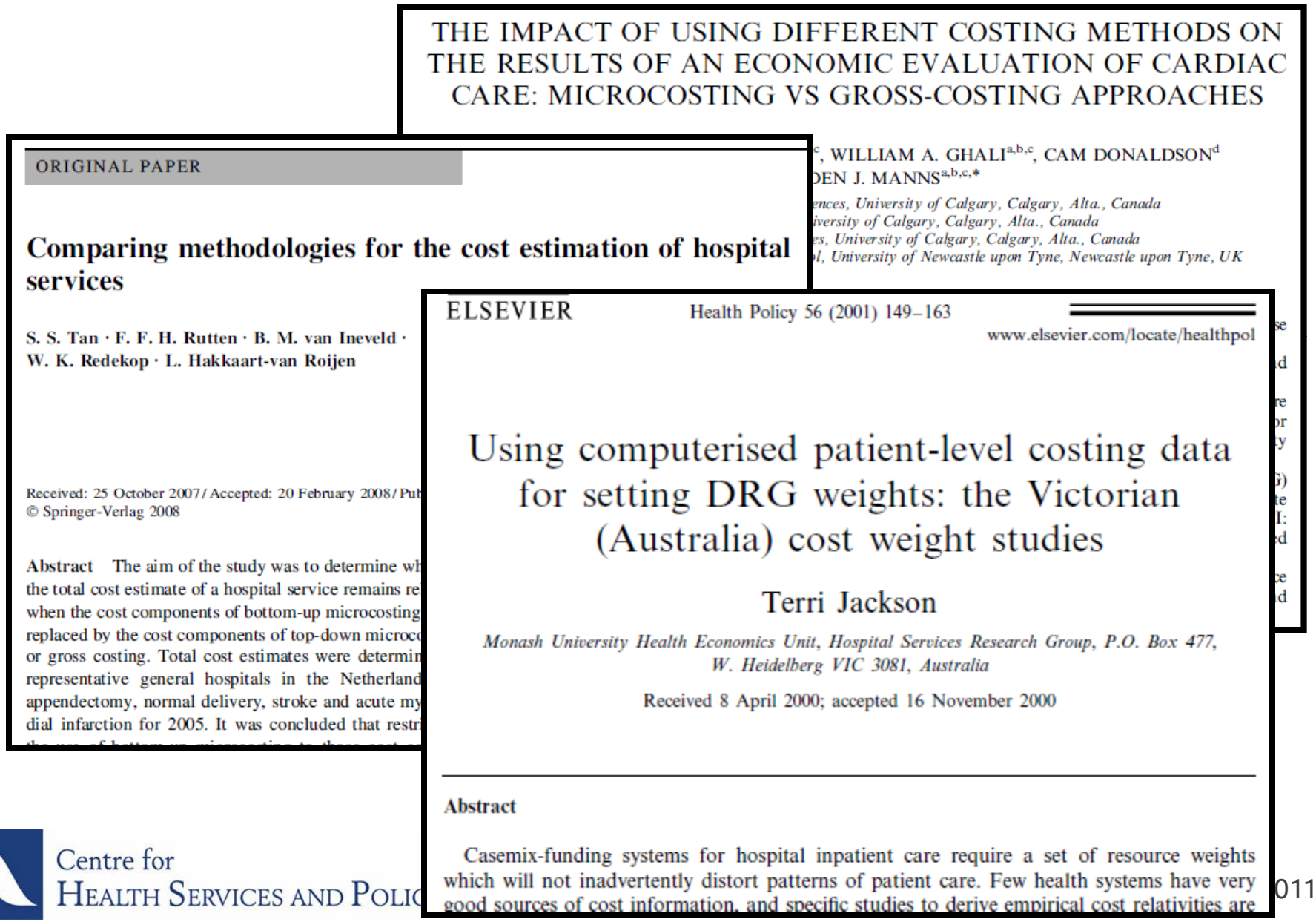
Costing Methods



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

, WILLIAM A. GHALI[a,b,c], CAM DONALDSON[d]
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ORIGINAL PAPER

Comparing methodologies for the cost estimation of hospital services

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

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Abstract The aim of the study was to determine wh
the total cost estimate of a hospital service remains re
when the cost components of bottom-up microcosting
replaced by the cost components of top-down microc
or gross costing. Total cost estimates were determin
representative general hospitals in the Netherland
appendectomy, normal delivery, stroke and acute my
dial infarction for 2005. It was concluded that restri

ELSEVIER Health Policy 56 (2001) 149–163

www.elsevier.com/locate/healthpol

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

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

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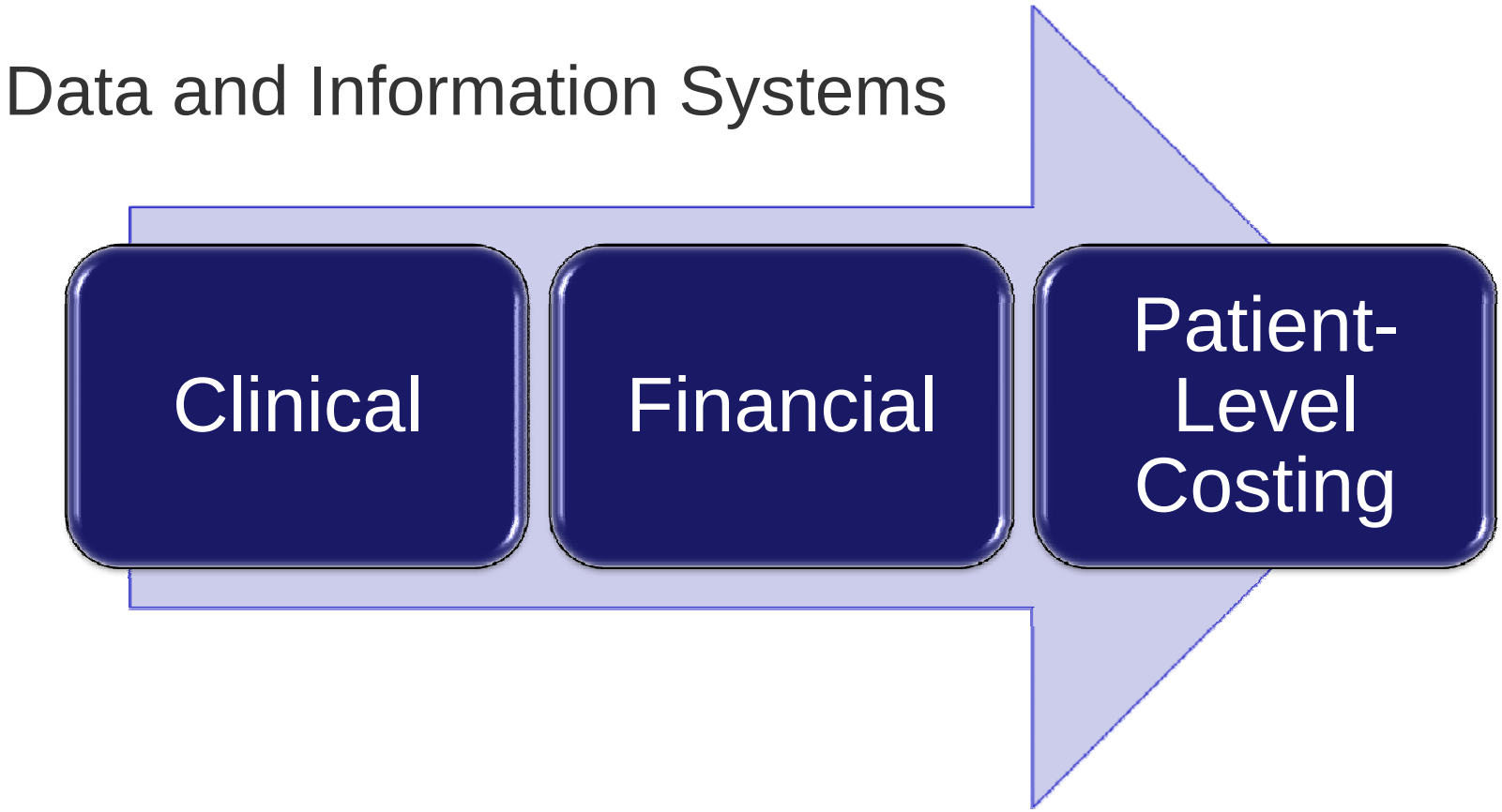
Can ABF be credibly executed in Canada?



What are key implementation challenges?

- Determining desirable levels of activity
- Spending ‘caps’ to limit growth of activity
- Long-term commitment needed for hospitals to respond to incentives
- Phased implementation (How quickly and to what level)
- Adjust payment amounts away from ‘average’
- Quality

What are the known risks?

- **Preparing for change within hospitals**
  - Activity
  - Hospital financial performance
  - Management changes
- **Changes in other sectors**
  - Greater reliance on post-acute care settings
- **Pricing**
  - Increase in volume of most profitable patients

Important success factors?

- Vision and leadership
- Political risk related to changing hospital activity and capacity
- Understanding the effects of natural geographic monopolies
- Applicability in less-populated provinces/regions
- Understanding demand and supply of post-hospital services

Maintaining credibility

Coding Quality

- Surveillance efforts should be aligned with funding incentives
- Framework for non-adherence to standards
  - Attribution of responsibilities

Continuous Attention

- Quality
- Access
- Prices and Volumes

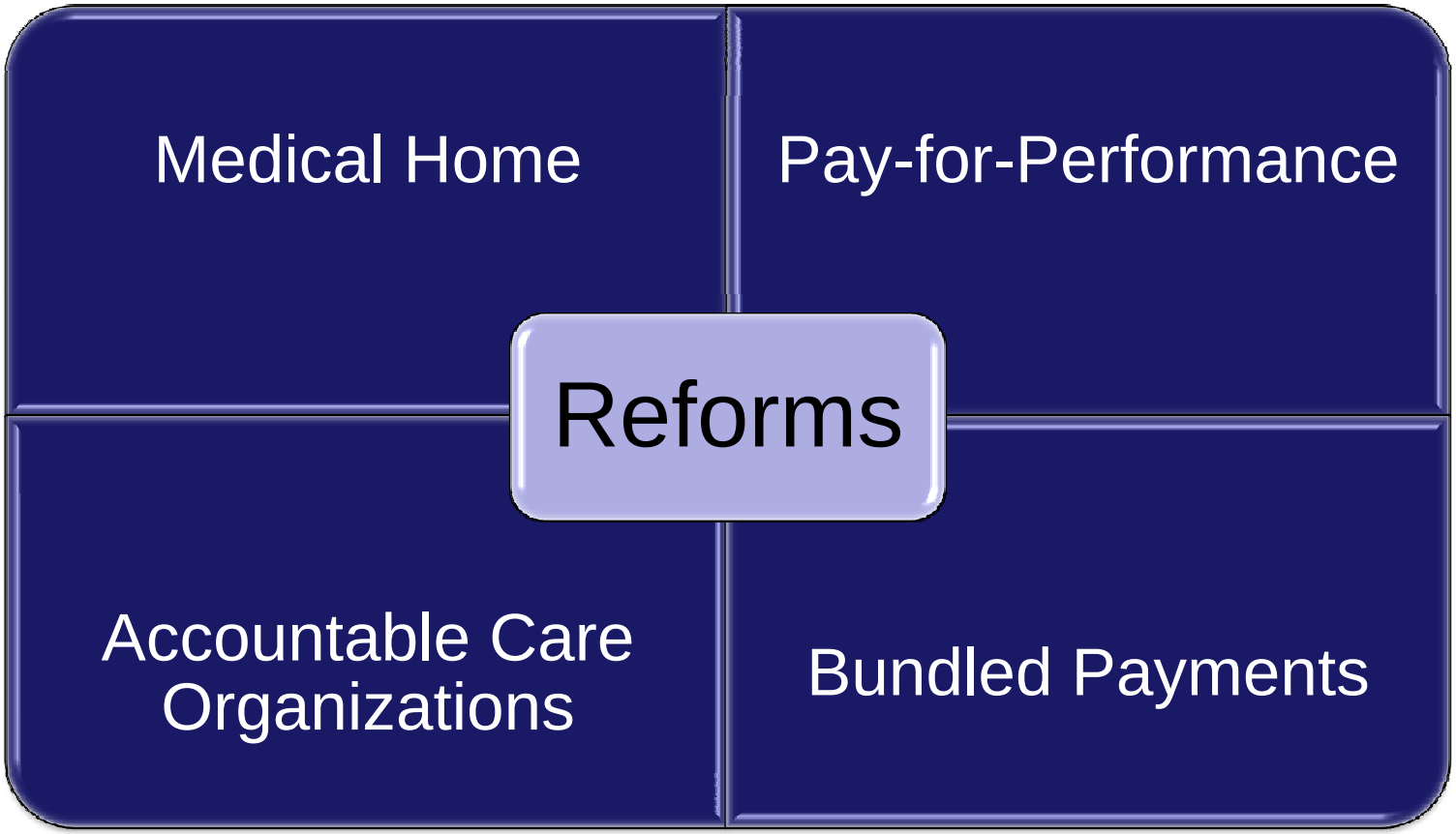
International 'Lessons Learned'

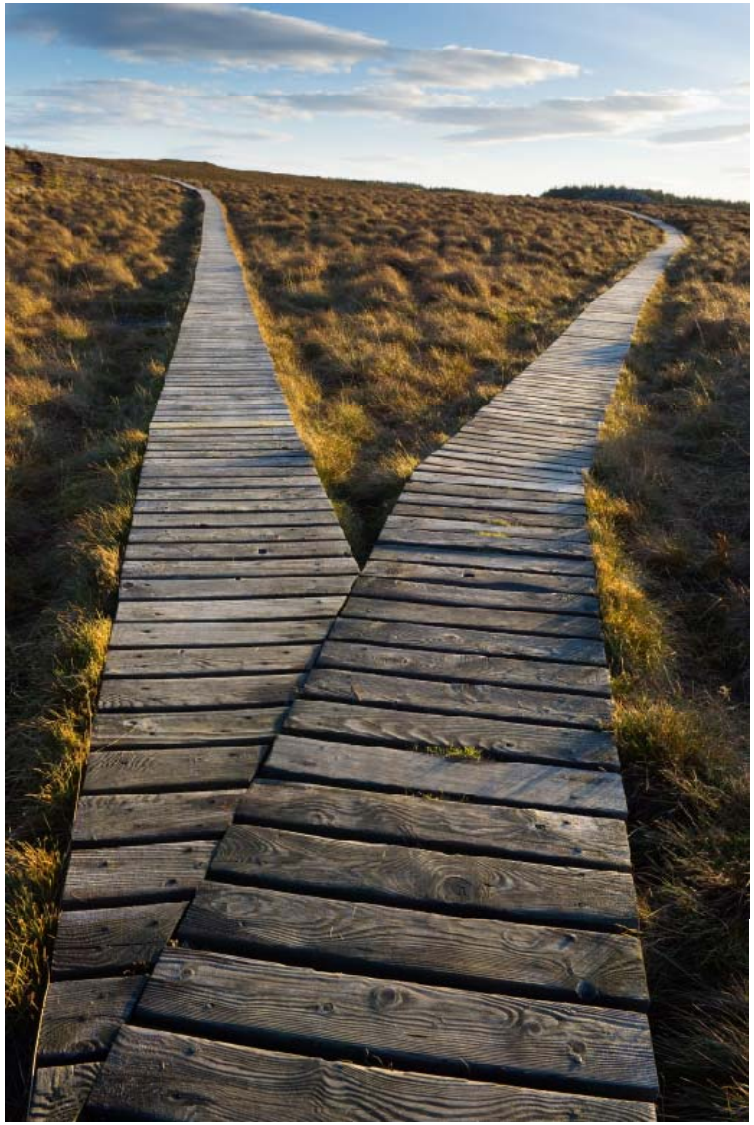
- ABF is one tool in the toolkit
- Remove some components
  - Capital, teaching, rural, EDs
- Setting the payment amount is really hard to balance incentives
  - 'best practice price', 'fair and achievable' or average
  - Mental health, pediatrics, palliative
- Funding for growth in cost and volume
- Episode splitting

Hospital Funding: Options for Canada

- Health care systems most like our own: mix of fixed/ABF
- Long term commitment with phased implementation
- Spending increases are NOT equal to improvements in health
  - Cap overall spending when using ABF
  - Growth and policy adjustments
- Payments shouldn't be 'average'
  - Target 'value' or health gain
- CMG+ is cost-based reimbursement

Other initiatives in the environment





Thank you!

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Incentives

- ABF creates incentives for hospital 'volume'
  - Salaried physicians
  - Fee-for-service physicians
  - Other incentives
  - Role of purchasing groups

- Aligning hospital and physician incentives: But for what?
  - Rewarding volumes
  - Rewarding quality