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Episode-based Payments for Health Care and Shared Objectives

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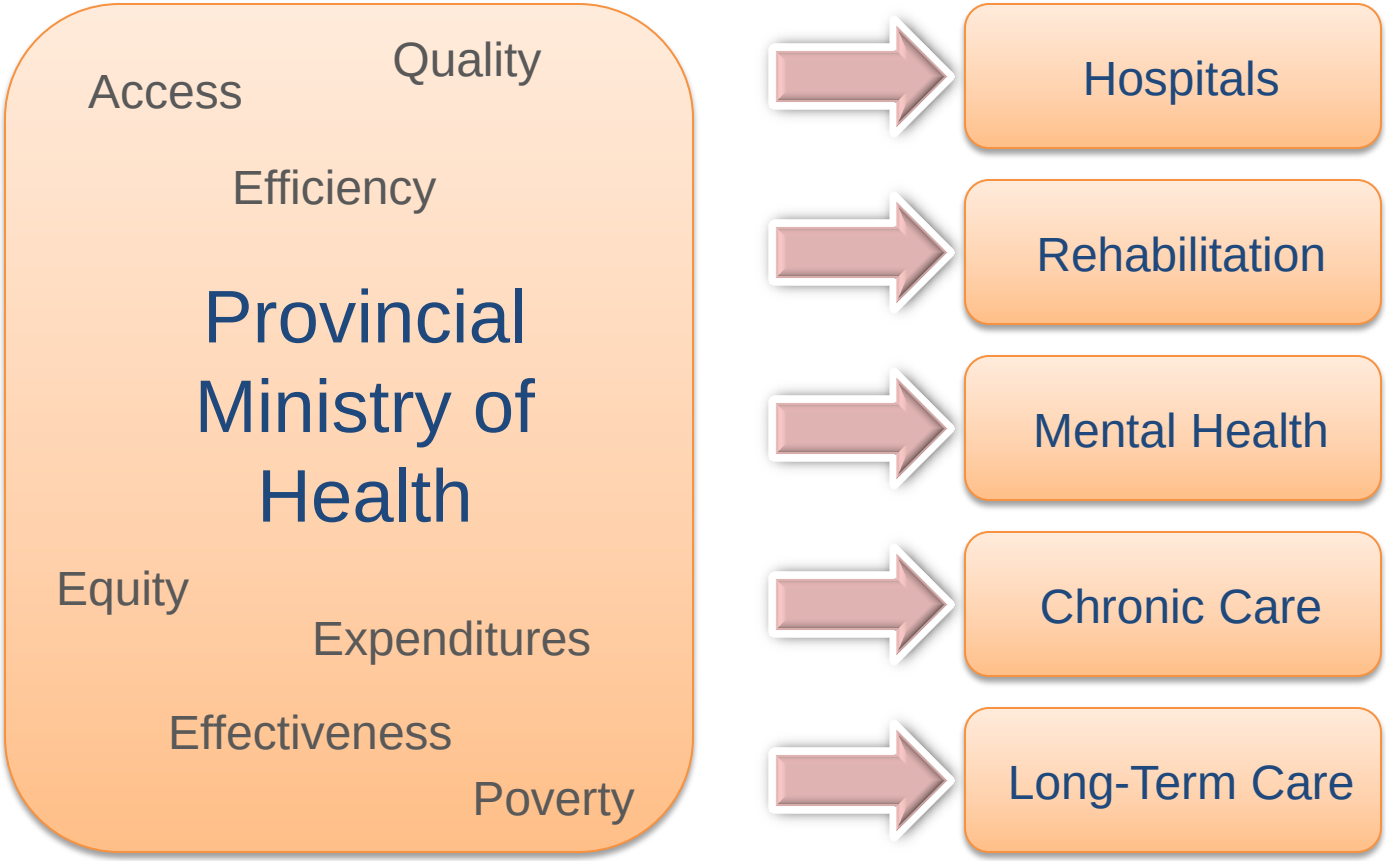
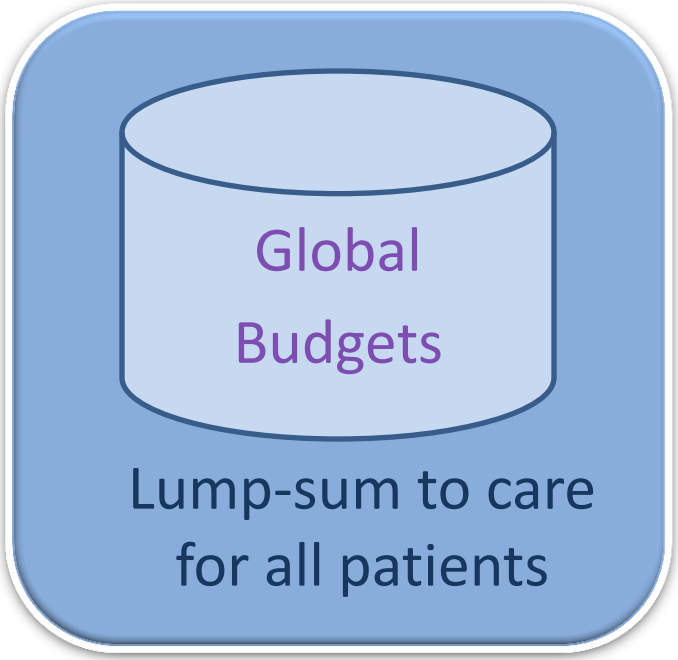
Funding Healthcare in Canada: A Story of Institutions



Drivers of Funding Reform

Goals?	Problems?
Efficiency	Over-use
Expenditure Control	Under-use
Access	Mis-use
Quality	Alternative Level of Care (ALC)



Canada is unique!

Many high-profile supporters of activity-based funding:

- CMA, OMA, BCMA
- Castonguay Report
- Kirby Report

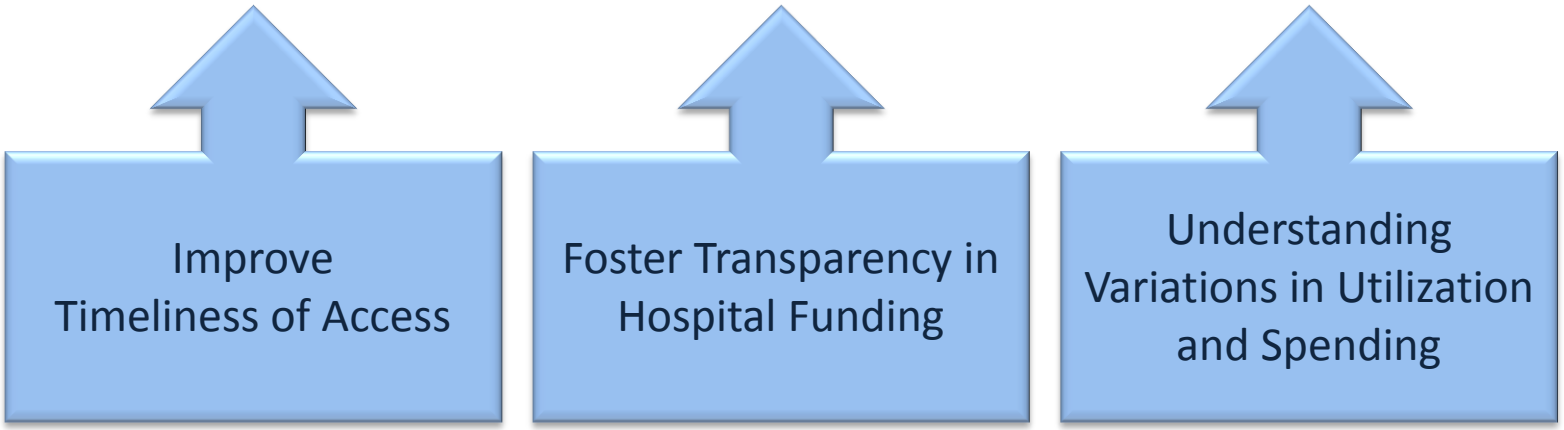
Doubts exist:

- Canadian Doctors for Medicare
- Canadian Centre for Policy Alternatives
- Many healthcare employee unions

- Most countries have transitioned to activity-based funding:
  - Transparency
  - Wait times
  - Inequities in funding
  - Lack of incentives for:
    - Improved Quality
    - Innovative Practices
  - Efficient bed use

Activity-based Funding is 'Rushing' in

Major Motivating Factors in Canada



More Complex to Administer

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The Power of Incentives: When the Price is Not Right

Expanded Use Of Imaging Technology And The Chall Of Measuring Value

The benefits of expanded imaging might not be directly re patients' disease outcomes.

by Laurence C. Baker, Scott W. Atlas, and Christopher C. Af

ABSTRACT: The ava ing (MRI) scanning ha document the relatio tentially important s dressed if value is to be valuable because though evidence for i thus, a particularly in be quantified. [*Healt*

Getting The Price Right: Medicare Payment Rates For Cardiovascular Services

Improving the accuracy of Medicare's prices is necessary to ensuring rly and disabled.

ll, and Jeffrey Stensland

d cardiac hospitals have grown rapidly. Physicians vide cardiovascular diagnostic services in their of- f errors in Medicare's prices for hospital care and nprove the 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.

The Evolving Picture of ABF: P4P and Overlays

Value-based Purchasing

- 'Clawbacks' to establish bonus pool
- ~2% of Medicare acute inpatient spending
- Quality measures:
  - Related, unplanned, readmissions

Quality Initiatives

- Non-payment for poor quality
  - Related, unplanned, readmissions
  - Hospital-acquired infections
  - Surgical mis-adventures

Where does this get us?

Link btwn evidence and funding

- Some parallel to VBP and P4P
- Little evidence on incentives for longitudinal management of chronic disease

Macro-level initiatives to change providers behaviours:

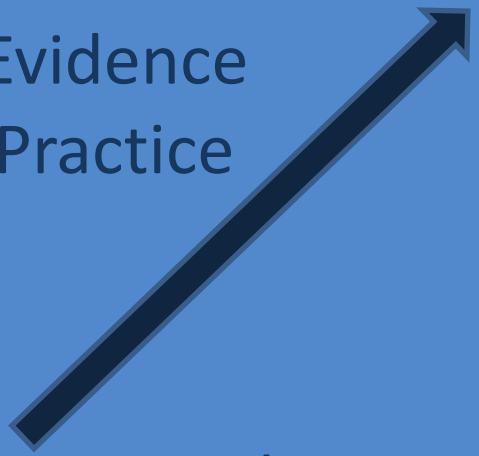
- Medical Home
- Accountable Care Organizations

Ontario's Initiatives

- Global Budget
- HBAM
- QBP
  - No clear analogue elsewhere
  - Draws of elements used for P4P and ABF

Where are Opportunities to Integrate 'Evidence' with Funding?

Evidence
Practice



Care Pathways
Clinical Teams

Funding:
- Effective Practice
- Efficient
- High Quality
- Outcomes

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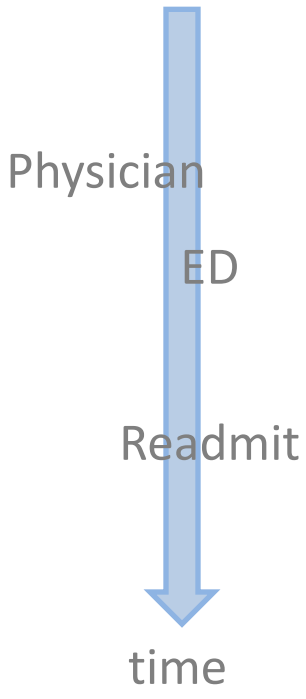
What is a 'Bundled Payment'?



Collective Accountability for Medical Care — Toward Bundled Medicare Payments

Glenn Hackbarth, J.D., Robert Reischauer, Ph.D., and Anne Mutti, M.P.A.

Medicare's projected spend
growth is unsustainable.
program already strains the
sources of beneficiaries and
payers alike and will some
crowd out other public- and
vate-sector priorities, given
Medicare spending as a perc

Payment Reform Options: Episode Payment Is A Good Place To Start

yment system must be
very of care.

Episode-Based Performance Measurement And Payment: Making It A Reality

Moving toward episode-based approaches for payment and performance

by Peter S. Hus
and Cheryl L. D

ABSTRACT: Prop
measurement are
in applied settings
key issues that wi

growth are urgently needed. Al-
ervice (FFS) payments will hurt
restructure the delivery system

Medicare Payments for Common Inpatient Procedures: Implications for Episode-Based Payment Bundling

John D. Birkmeyer, Cathryn Gust, Onur Baser, Justin B. Dimick, Jason M. Sutherland, and Jonathan S. Skinner

Background. Aiming to align provider incentives toward improving quality and efficiency, the Center for Medicare and Medicaid Services is considering broader bundling of hospital and physician payments around episodes of inpatient surgery. Decisions about bundled payments would benefit from better information about how payments are currently distributed among providers of different perioperative services and how payments vary across hospitals.

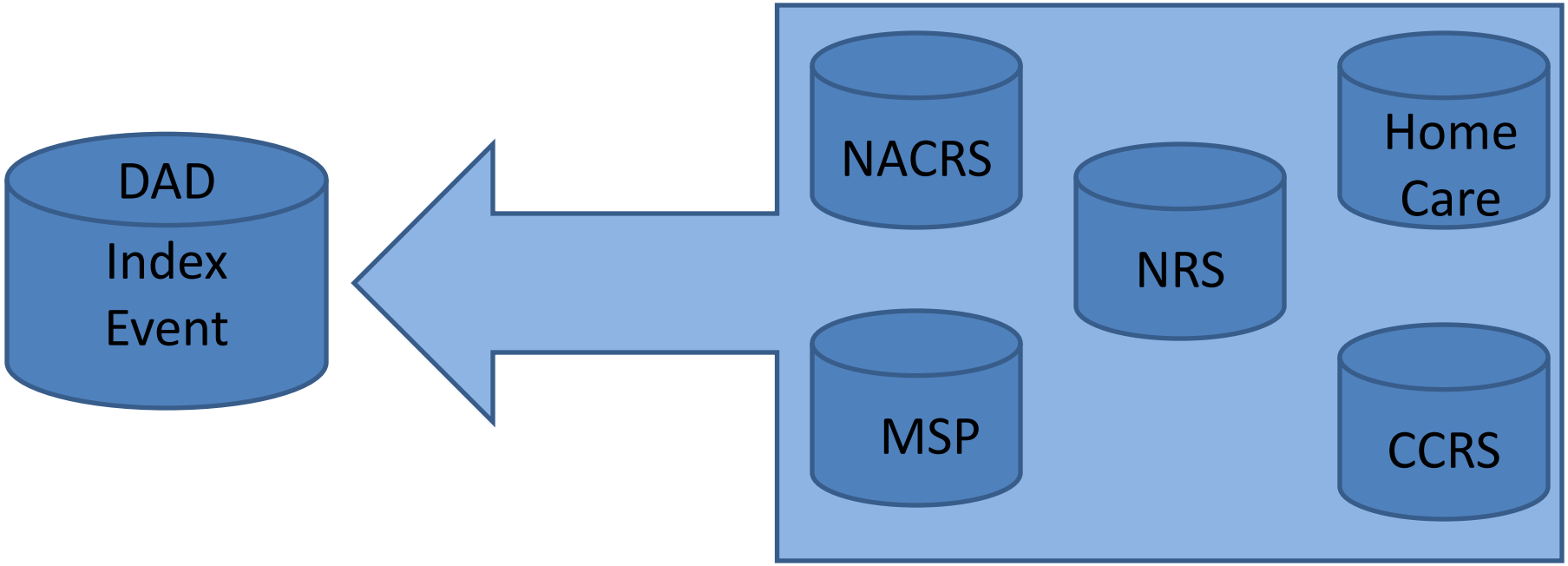
The 'Why?'

- Limits of global budgets, activity-based funding and P4P
  - 'Silo-based' services and funding
  - No relation between care and outcomes
  - Unexplainable, and wide, variation in patterns and costs of care
- Shared accountability for efficiency and poor clinical outcomes
- Expanded opportunity for quality measurement

- Ongoing:
  - Medicare/CCMI pilots of bundles
  - Financial responsibility between providers
- Bundle 1:
  - Retrospective, acute
- Bundle 2:
  - Post-acute care provider event
- Bundle 3:
  - Acute and post-acute care providers

What does the data say?

Linking the data: Hip and Knee Replacement



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What does the data say?

- 30 day post-discharge
  Remarkable variation in LHIN practice and cost!

LHIN	Number of cases	Acute hospitalization				Post-acute care	
		Average acute inpatient cost	Average physician claims	Average inpatient & physician cost	% Rehospitalized within 30 days (cost)	% Discharged to inpatient rehabilitation (cost)	% Discharged to home with home care (cost)
Ontario overall	26,538	$10,125	$2409	$12,535	3.6% ($11,040)	28.6% ($5637)	47.8% ($977)
1	1537	$10,244	$2305	$12,549	4.7% ($16,205)	17.8% ($5503)	56.8% ($975)
2	2706	$9773	$2049	$11,822	4.4% ($7590)	6.6% ($7994)	71.7% ($909)
3	1523	$10,177	$2213	$12,390	3.3% ($10,450)	9.8% ($6384)	73.3% ($1057)
4	3578	$10,488	$2477	$12,966	3.3% ($10,910)	11.5% ($7864)	62.7% ($1007)
5	850	$10,508	$2731	$13,239	3.9% ($12,444)	59.0% ($5757)	17.3% ($1026)
6	1711	$10,031	$2631	$12,662	3.7% ($10,221)	35.0% ($6736)	34.5% ($973)
7	1836	$10,321	$2637	$12,958	3.6% ($14,498)	45.9% ($6174)	32.3% ($988)
8	2409	$10,035	$2866	$12,900	3.7% ($13,245)	56.3% ($5934)	23.2% ($1012)
9	2919	$9935	$2477	$12,412	4.5% ($11,471)	44.4% ($4854)	35.7% ($944)
10	1430	$10,294	$2129	$12,423	4.1% ($11,865)	9.0% ($7349)	68.0% ($1044)
11	2698	$9950	$2363	$12,313	3.9% ($10,970)	45.0% ($3580)	22.9% ($820)
12	1105	$10,181	$2262	$12,442	3.9% ($11,356)	17.5% ($5520)	64.5% ($986)
13	1559	$10,106	$2251	$12,358	8.1% ($8164)	13.0% ($5683)	57.6% ($969)
14	546	$9857	$1929	$11,786	8.8% ($9402)	33.5% ($6964)	59.9% (1143)

Summation

Nobody has sorted out the ‘best’ way to fund healthcare for:

appropriateness, efficiency, and quality

Care pathways might be a helpful starting point – if they can build off of existing, and validated, data

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