Health System Funding Reform

Memorandum#19, December 19, 2014

Re: Update on Cataract Quality-Based Procedure

Health System Funding Reform (HSFR) was introduced three years ago as a key enabler of the Ontario Action Plan for Healthcare and as a catalyst to providing the right care in the right place at the right time. Key goals of HSFR include improving the quality of care provided and ensuring sustainability of the system. As you know, HSFR is comprised of two funding streams one of which is for Quality Based Procedures (QBPs) and the other, Health Based Allocation Methodology (HBAM).

Cataract Surgery was one of the first QBPs introduced following consultation with a clinical expert panel that defined the appropriate clinical pathway and a technical panel that determined the appropriate funding approach. In 2012-13 the first year of the QBP, cataract surgeries were defined broadly and the cataract price and carve-out from global was based on direct cost per case. This approach did not recognize the higher complexity of some of the cataract procedures captured in the cohort.

The ministry received feedback on this approach and in 2013-14 (year 2) changed the pricing approach to reflect the acuity by using direct cost per weighted case. Higher complexity procedures, such as bilateral cataract received a higher weight and a higher price. Due to this new way of pricing, the most transparent approach to implementation was to credit hospitals global budgets for any carve-out that happened in the first year before re-carving using this new direct cost per weighted case approach.

In 2014-15 (year 3), the Cataract Surgery Clinical Handbook specifications were updated to focus on routine cataract day surgery. Complex cataract surgery, bilateral cataract surgery and surgeries under general anesthetic were identified as exclusions to the Cataract QBP. This resulted in a reduction in QBP volumes provided to hospitals and the individual hospital QBP funding was also adjusted to reflect a lower acuity and costs since the non-routine cases had been removed.

For all hospitals, this means that funding associated with complex, bilateral and cataracts under general anesthetic are in the hospital's non-QBP base funding allocation for 2014-15.

These changes are summarized in Tables 1 and 2 below. In addition, we have provided QA's regarding the frequently asked questions we have received on the Cataract QBP.

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The ministry has recently heard about challenges with implementing the Cataract QBP with these non-complex cases outside the cohort and looks forward to receiving recommendations from the Cataract Clinical Expert Panel on how this should be addressed. The Panel will begin its deliberations in December and recommended revisions are expected to be available for 2015-16.

We look forward to working together to accelerate the successful implementation of HSFR.

For enquiries, please contact our Helpline:

- Email: HSF@ontario.ca
- Phone: 416-327-8379

Sincerely,

Original signed by:

Michael Stewart
Director, Quality Based Procedures Branch
Health System Delivery and Implementation Division

Original signed by:

Brian Pollard
A/ Director, Health System Funding Policy Branch
Health System Delivery and Implementation Division

Table #1: Cataract Carve-Out and Funding Methodological Changes from Y1 to Y3

Background Information:

- Y2 HSFR: Due to major changes with cataract carve-out and funding approaches, Y1 cataract QBP funding was re-credited to the hospital's base funding so that a new cycle could be started for Y2.
- Y3 HSFR: The cataract definition is narrowed to routine (or unilateral) cataract only. Y2 non-routine cataract QBP funding is switched to global. There is not a re-carve process since routine (or unilateral) cataract related carve-out was already completed during Y2.

Category	Y1 HSFR	Y2 HSFR	Y3 HSFR
Cataract Coverage	Routine and Non-Routine	Routine and Non-Routine	Only Routine
Carve-Out Unit Cost	Hospital-Specific, OCDM/OCCI-Based Direct Cost per CASE	Hospital-Specific, OCDM-Based Direct Cost per WEIGHTED CASE	N/A (Carve-Out Completed during Y2)
Carve-Out Volume: Primary Data Source	2010-11YE NACRS*	2011-12YE NACRS	N/A (Carve-Out Completed during Y2)
Funding Rate	Provincial 40th Percentile, OCCI-Based Direct Cost per CASE	Provincial Avg. OCCI-Based, HBAM-Adjusted Direct Cost per WEIGHTED CASE	Y2 Funding Rate Maintained for Y3
Funded Volume: Primary Data Source	3-Year Average Share	2011-12YE NACRS	2011-12YE NACRS & Wait Time Report
QBP Funding	One-Time**	BASE	BASE
Additional One-Time	Yes for Bilateral Cataract	Yes for Bilateral Cataract	No

*Y1 cataract volume for carve-out and funding was later updated with 2011-12YE actual. 3-Year average share was based on 2008-09YE to 2010-11YE actual. The share was multiplied with forecast provincial total volume to get the hospital's funded volume.

**Y1 cataract funding which was allocated as one-time was re-credited base in Y2.

Table #2: An Example for Change with Cataract Carve-Out and Funding from Y2 to Y3

Row No.	Category	Y2 Cataract (Routine and Non-Routine)			Y3 Cataract (Routine)	Change from Y2 to Y3 (Routine)
		Total Cases (A)	Non-Routine Cases (B)	**Routine Cases (C)**	**Routine Cases (D)**	Change (E) = (D) – (C)
A	Case Volume	100	5	**95**	**99**	4
B	Weighted Cases	17	1.3	**15.7**	**16.0**	0.3
c=b/a	Case Mix Index	0.170	0.260	**0.165**	**0.162**	0.004 (due to decimals)
D	Carve-Out Unit Cost	$5,000	$5,000	**$5,000**		
e = b*d	Carve-Out Amount	$85,000	$6,500	**$78,500**		
F	Funding Rate (Direct CWPC)	$6,000	$6,000	**$6,000**	**$6,000**	$0
g=b*f	Total BASE Funding	$102,000	**$7,800**	**$94,200**	**$96,000**	$1,800

2014-15 Cataract Grand Total BASE Funding $103,800

Frequently Asked Questions

1. **Complex Cataracts can have disparate costs. How is this accounted for in the HBAM funding formula?**

   For 2014-15, complex cataract surgery is excluded from the Cataract QBP. As a result, the procedure is funded through non-QBP base funding which includes HBAM funding and global funding.

   For HBAM funding, the complex cataract related HBAM expected expense remains in the calculations of the hospital's HBAM share and HBAM funding.

2. **Bilateral cataracts received special one- time funding last year. Why are additional funds not required this year?**

   In 2012-13, the cataract price was based on direct cost per case. To recognize the higher complexity of bilateral procedures, the ministry provided additional one-time funding. However, in 2013-14, the cataract price was based on direct cost per WEIGHTED case. A patient with bilateral procedure has a higher weight to recognize higher complexity. This approach recognized higher complexity of bilateral cataracts. However, the one-time funding for bilateral procedures was continued as adjustments were still being made to cataract definitions.

   For 2014-15, the one-time funding is not being put back into the base for the following reasons:
   - This one-time funding has never been in the base.
   - The new definition of cataracts results in a lower CMI for 2014-15; the difference with the funding will be given back to hospitals as NON-QBP base funding (please see table 2).

3. **How can hospitals identify exactly how much HBAM funding is earmarked for non- routine cataract cases (such as complex cataracts or bilateral cataracts or cataracts under general anesthesia)?**

   Hospitals can ROUGHLY identify non-routine cataract cases related HBAM funding by calculating the difference between:
   a) The original HBAM funding amount which covers non–routine cataracts
   b) The revised HBAM funding amount which EXCLUDES non-routine cataracts.

   The revised HBAM funding can be calculated in the following steps:
   - Calculating the percentage of non-routine cataract related service volume among the hospital's total service volume
   - Removing this percentage from the calculations of the hospital's HBAM expected expense, HBAM share, and HBAM funding. The details of HBAM funding calculation are available in the 2014-15 HSFR funding workbook.

4. **Was the amount of funds for non-routine cataracts that were transferred from the hospitals QBP at the same volume of complex and bilateral and cataract surgery under general anesthesia performed last year (13-14)?**

2014-15 HBAM funding calculation was based on 2012-13YE actual service volumes (e.g. non-routine cataracts), which was the most recent clinical data available at the time.

5. **If the hospital does more routine cataract volumes than the QBP funded volumes, will the hospital receive additional 14-15 QBP funding? What happens if the volume of non-routine cataracts increases, will the hospital receive additional funding for these?**

   The ministry will shortly be releasing volume management instructions that provide flexibility for providers that may be exceeding their QBP allocation. Further detail will be provided in the actual instructions, but the approach will be to allow hospitals to net over- and under-performance of QBPs against each other within the broad categories of elective and urgent/non-urgent procedures. If the hospital's total performance for the CATEGORY is over, it will not be compensated for the over portion.

6. **Will complex and bilateral cataract cases be included in Cataract QBP Clinical Handbook and QBP funding for 15-16?**

   The Cataract QBP Clinical Advisory Panel will be reviewing the issues that have been identified and more specifically whether complex cataracts, bilateral cataracts and day surgery cataracts done under general anesthesia should be included in the QBP methodology. Included with this work, will be review of new performance and quality indicators that would be appropriate for these types of patients for a QBP.

7. **Will the ministry be redoing the hospital carve out for cataracts each year?**

   No. The carve-out for QBPs is completed during the year when the QBP is introduced.

8. **How will we know that the Cataract QBP process has improved clinical care?**

   The ministry, working in partnership with the Provincial Vision Task Force, has released the report, "Quality Indicators for Cataract QBP-- Baseline Results", October 2014. This report provides data on Cataract QBP quality indicators at the LHIN Level and can be found at (https://hsimi.on.ca/hdbportal/node/605)

   In addition, specific hospital level results have been shared with each hospital and LHIN CEO for the cataract QBP. This will allow both the Hospital and the LHIN to work together to improve quality and clinical care for cataract patients.

9. **Who can hospital contact if they have further questions about Cataract QBP funding that they received?**

The hospital should contact their local LHIN if they have further questions about Cataract QBP funding.