Managing and Regulating Contracted Medicare Services in Non-Hospital Facilities

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Introduction

- The number of for-profit, free-standing, non-hospital facilities (NHFs), providing advanced diagnostic and surgical services has grown in recent decades.
- There is much debate about the appropriate role of such facilities in provincial health systems, yet there is limited empirical evidence or even thorough comparison of current practice to inform policy decisions.

Objectives:

1. Compare the mechanisms used by provincial governments to hold NHFs accountable for the quality and cost of publicly funded advanced diagnostic (e.g. MRI, CT Scans) and surgical services under Canada Health Act (or Medicare) rules, considering three levers of accountability; and
2. Compare the volumes and level of spending on surgical services in NHFs within provincial health coverage programs.

Three Levers of Accountability[1]

1. **Regulation**: governments use regulations (e.g., legislation or bylaws) to require providers to behave in a certain way. They may also delegate this authority to professions (e.g., provincial regulatory colleges).
2. **Financial Incentives**: governments adjust payment mechanisms to induce providers to behave in a certain way (e.g., pay-for-performance).
3. **Information**: an indirect approach to accountability whereby governments direct performance information towards users in order to help them make choices about how to get the best care.

Defining terms

A **non-hospital surgical or diagnostics facility** is a facility or clinic outside of a hospital where licensed medical professionals provide surgical or diagnostics services to patients.

The terminology for these facilities varies across jurisdictions in Canada. We use the following:

1) **non-hospital surgical facility (NHSF); and**
2) **non-hospital advanced diagnostics facility (NHADF).**

Alberta, British Columbia, and Saskatchewan - non-hospital surgical facilities (NHSF) or non-hospital medical and surgical facilities (NHMSF), Ontario - independent health facilities (IHF), and Québec -medicaux spécialisés (CMS).

We did not include outpatient treatment facilities that do not provide advanced diagnostic nor surgical services (examples include radiation therapy and dialysis).

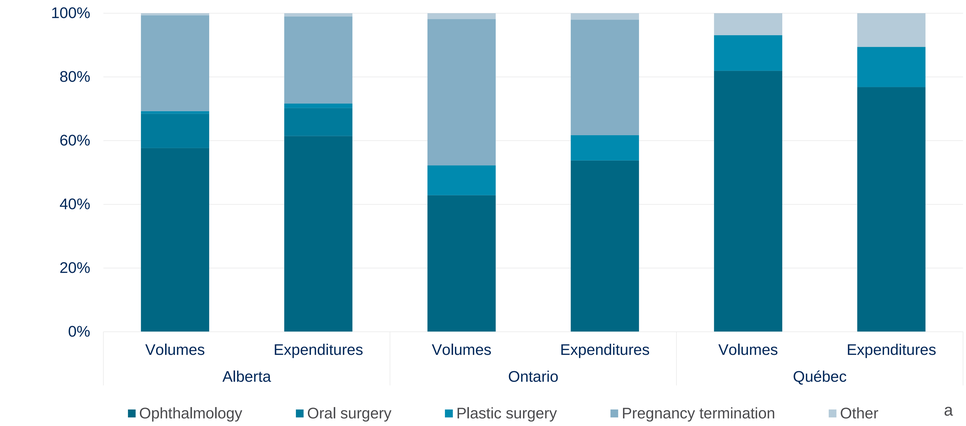
Approach

- To capture a diversity of regulatory and contracting models, we selected five provinces with evidence of some activity of out-of-hospital surgical and diagnostic services: British Columbia (BC), Alberta (AB), Saskatchewan (SK), Ontario (ON), and Québec (QC).
- A structured data collection template was used to capture relevant information from literature and consultations with local experts (and ministry of health/health authorities where possible) in the two sectors (diagnostic and surgical) of each province.

Results

We collected provincial estimates of surgical volume and expenditure for three of the five provinces (Figure 1). These costs do not include physician fees which are paid separately through the billing system. Canadian Institute for Health Information (CIHI) data could identify fewer than 10 NHSFs in the country, so these could not be used to estimate provincial volumes or expenditure.

Figure 1 – Breakdown of Surgeries in NHFs, by Province, by Category[b]



a: Dermatology, ENT/Otolaryngology, Gynecology, Orthopaedics, Urology, or Vascular surgery

b: Categorization comes from the data provided by provinces, with the exception of Saskatchewan, which provided a list of procedures the authors assigned to the relevant category. Although provinces used similar labeling, there is no assurance the definitions are comparable. For example, the list of procedures categorized as plastics by Ontario contains many procedures which may be classified as orthopaedic (e.g., bunions), otolaryngologic (e.g., adenoidectomy), or ophthalmologic (e.g., ptosis).[2]

The extent to which NHFs are included in provincial health coverage programs, as well as the approaches to regulate and hold NHFs accountable vary across the five provinces. Figure 2 shows the purchaser of surgeries in each province.

Figure 2 – Public Purchaser for NHSF Services

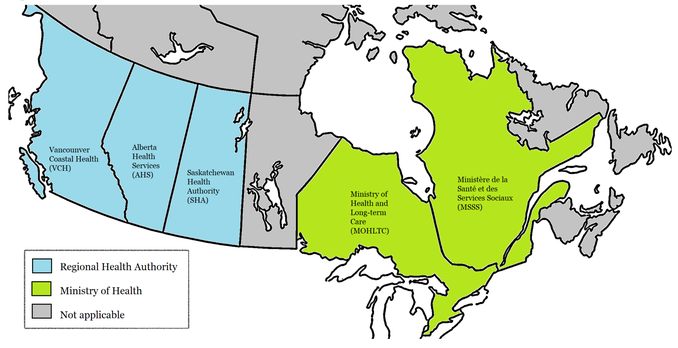


Table 1 – NHADF (Diagnostics) selective findings

	BC	AB	SK	ON	QC
Accreditation Body	Professional regulatory body: CPSBC.	Professional regulatory body: CPSA.	Professional regulatory body: CPSS.	MOH; and the professional regulatory body: CPSO.	Professional regulatory body: OTIMROEPMQ.
Insured NHADF (in provincial health coverage programs)	Yes, but there is limited to no use within public system.	Yes. Although these are delisted, the AHS does contract with NHADFs.	Yes	Yes, since 2003 the ministry has contracted with 7 non-hospital providers	No. All NHADFs are privately financed.
Direct patient billing allowed?	Yes, but only from physicians opted-out of medicare	Yes	Yes, with the 'One for One' policy, all privately funded scans must include a public scan at no cost to the system	No, the province of Ontario does not allow private payment	Yes, patients may pay privately for any delisted service

Table 2 – NHSF (Surgical) selective findings

	BC	AB	SK	ON	QC
Unit of purchase	Surgical/ operating theatre time	Specific procedures	Specific procedures	Service provision at facilities	Specific procedures
Purchaser	Regional health authorities (Vancouver Coastal Health)	Alberta Health Services (AHS)	Saskatchewan Health Authority (SHA)	Ministry of Health and Long-term Care (MOHLTC)	Ministère de la Santé et des Services sociaux (MSSS)
Details of purchase	Contracts provide an amount for a surgical day's worth of OR hours	Each practitioner/ clinic is contracted for specific services at a specific rate	Specific rates are provided for specific procedures with capacity allocated by the region	Facilities are provided with global budgets	MSSS has established a pilot project with 3 clinics

College of Physicians and Surgeons of British Columbia (CPSBC); College of Physicians and Surgeons of Alberta (CPSA); College of Physicians and Surgeons of Saskatchewan (CPSS); College of Physicians and Surgeons of Ontario (CPSO); Ordre professionnel des technologies en imagerie médicale, en radio-oncologie et en électrophysiologie médicale du Québec (OTIMROEPMQ)

There are significant limitations that we face in comparing the use and spending on surgeries performed in NHSFs for a number of reasons, including:

1. **Spending and utilization data are not publicly available, nor identifiable in CIHI administrative datasets**
2. **Lack of data on prices**: for most provinces we are not able to obtain actual prices (all except SK) for services provided in NHFs, but we can estimate average price by dividing total expenditure by volumes. We were able to obtain *projected* spending and volumes for surgical services (ON), while for others we have information on *actual* spending and volumes (QC). For AB we collected actual volumes but estimated (upper limit) spending, and for SK, we were able to collect prices of individual services (from 2011) but no validated estimates of total volumes or expenditures.
3. **Differences in surgical categorization:** the types and classifications of surgeries provided vary between provinces. Our categorization is described in *note a* in figure 1.

Conclusions

- There is considerable variation in the approaches taken by these five provincial governments to regulate and contract with non-hospital facilities that provide surgical and advanced diagnostic services.
- The challenge facing government is not necessarily one of ownership per se, but about ensuring that the rules of Medicare are applied (i.e., that medically necessary services are accessed based on need and not ability to pay).
- Among the three broad approaches to accountability, the five provinces rely primarily on of regulatory approaches, with very little use of financial incentives and information.
- We identify some overarching challenges that provincial governments continue to grapple with. These include ensuring the cost effectiveness of the care the facilities provide in the absence of comparable measures across sectors; addressing the limited empirical evidence about the effect facilities have on provincial surgical and diagnostic wait times; and improving measuring and reporting on performance.

Questions for Future Work

- **Preferential access and queue jumping -** To what extent does use of out-of-pocket payments for diagnostic services, where these are permitted, grant preferential access to medically necessary surgical and other specialized services?
- **Optimizing the use of contracting to ensure value for money -** What is the optimal time period for contracts, how should prices be set, and how might the payments be tied to outcomes (since currently these are not)?
- **Improving appropriate use of services -** To what extent do profit-maximization goals of corporate-owned facilities lead to inappropriate use services?
- **Ensuring quality-of-care -** What are the best practices for quality assurance/outcome measurement to ensure quality-of-care standards are being met? Who should assume the risk in the event of complications?
- **Strengthen public reporting -** How can information (e.g., public reporting) be used better to hold facilities accountable for cost, quality, and outcomes?

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