Funding model design and casemix classification development in aged care

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Funding model design and casemix development in aged care
Background

Main characteristics of casemix systems in acute inpatient care

- Main cost drivers are diagnoses and procedures

- Established annual data collections (cost and activity)

- Care is episodic in nature (clear start and end)

- Inlier and outlier adjustments to cost weights

- Typically, casemix-based funding of a hospital is based on its the sum of all cost weights

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Background

Points of difference

- Cost drivers

  - Physical function

  - Cognitive function

  - Falls risk

- Data collection limited, not fit for a casemix system

- Care is often ongoing

- Dis-economies of scale

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Service capacity and individual care

Capacity component

- To cover the costs of being ready to deliver the aged care services contracted for:

  - Management & administration

  - Office/building, IT, equipment

  - Maintenance & depreciation

- Examples:

  - Night & meal room supervision

  - Fleet

  - Kitchen

Individual component

- To cover the costs of delivering aged care services to individuals:

  - Staff (time)

  - Consumables

- Examples:

  - Nurses & care staff

  - Drivers or cooks

  - Fuel or Ingredients

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Consultation – stakeholder involvement

Audience

- People with clinical expertise

- People with expertise in management of services

- Main stakeholders in the sector

Purpose

- Main source of information

- To fill potential gaps in the data

- Increase buy-in and acceptance

- Education of the sector

  - Casemix concepts are hard

  - Distinction between cost and price

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Consultation – stakeholder involvement

Outcomes

- Answers to the following questions:

  - What types of cost are in the capacity vs individual component?

  - Which service characteristics drive capacity costs?

  - Which characteristics drive individual activity costs?

  - Ideally, draft classification with cost relativities

  - Which data is available?

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Data collections and analysis

Types of data required

- (Audited) financial reports incl. service characteristics – normally available

  - For capacity component

- Individual service use data incl. client characteristics

  - Extracted from booking or scheduling system

  - Individual care time

  - For individual component

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Data collections and analysis

Other considerations

- Depending on the circumstances, primary data collection may not be required or feasible

- Data analysis and consultations are an iterative process

- Data analysis to support the outcomes of the consultation

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Funding model considerations

Several options exist

- At its core, funding based on sum of cost weights of capacity and individual component multiplied by a monetary value (base rate)

- May be paid in advance or in arrears

- May be paid monthly, quarterly or annually

- Paid per service delivered or service contracted (e.g. occupied or contracted bed day)

- May be designed as price-volume contract with 10% bands

  - No funding adjustment if activity is within 10% of target

  - Adjustments can be retrospective or prospective

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Considerations for future steps

- Design regular data collection, integrated in IT/reporting systems

- Regular update mechanism

- Transition arrangement, e.g. shadow implementation

- Calibrate and update cost weights

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Summary

Outcomes

- A funding system that creates transparency and accountability for providers and funders

- Incentive to manage what is manageable

- Casemix-based tools become available for casemix adjusted comparisons/benchmarking

  - Inputs (e.g. staffing levels)

  - Outputs (more transparent and equitable pricing)

  - Outcomes (e.g. casemix adjustment) e.g. mortality rates

Limitations

- First version cannot solve all issues

- 50%-70% of cost in the capacity component

Thank you

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