CONSULTATION PAPER ON THE ABF PRICING FRAMEWORK FOR THE 2024 PRICE LIST

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ABBREVIATIONS AND ACRONYMS

ABF	Activity based funding
AR-DRGs	Australian Refined Diagnosis Related Groups (also referred to generally as DRGs)
BRG	Benchmarking Review Group
COVID-19	Coronavirus disease 2019
ED	Emergency Department
HIPE	Hospital In-Patient Enquiry Scheme
HPO	Healthcare Pricing Office
HSE	Health Service Executive
OCG	Outpatient Clinic Groups
OPD	Outpatient Department
PLC	Patient-Level Costing
QBF	Quality Based Funding

1. INTRODUCTION

This is the first consultation paper on the Pricing Framework produced by the Healthcare Pricing Office (HPO) and relates to the Pricing Framework for the ABF Price List for 2024. This document and the consultation process aims to support, in the first instance, the focus in the ABF Implementation Plan 2021-2023 on the system-wide responsibilities for ABF and in the second instance on the operating principles of Engagement and Responsiveness outlined in that plan.

The aim of this consultation paper are:

1. To inform ABF stakeholders about the methodological and policy changes that the HPO are considering for the 2024 price setting cycle.
2. To set out the process for making submissions on the 2024 price setting cycle

The decisions resulting from this process will be outlined in the ABF Pricing Framework for the 2024 Price List.

2. TOPICS FOR CONSULTATION

2.1 ABF DRG PRICES FOR 2023

The HPO works to generate annual DRG prices which primarily reflect the patient level costs returned to the HPO by participating hospitals. The price list sets out up to 5 separate payments (day case, same-day, one-day, multi-low per-diem, inlier, multi-high per diem) for each of the 807 AR-DRGs which results in approximately 3,300 individual prices being set each year. The HPO closely monitors the evolution of DRG prices over time and seeks to understand those changes through the examination of the underlying PLC data. It is however, beyond the scope of operation of the HPO to forensically examine and each and every DRG price that is set and therefore this consultation provides a means by which those stakeholders, hospital or otherwise, who have intimate knowledge of particular clinical areas and/ or costs can feed back to the HPO on DRG prices which they feel may not reflect the underlying costs.

When considering submissions relating to individual DRG prices, the HPO will consider PLC data as being the gold standard in terms of supporting data and will make any determination on a DRG price submission based primarily on PLC returns. It should also be noted that capital and depreciation are outside of the scope of ABF and should not be considered when assessing a DRG price.

The 2023 ABF price list for admitted patients is available on www.hpo.ie.

2.2 ADOPTION OF A COMMON WEIGHTED UNIT OF ACTIVITY

Historically, the National Casemix Programme and more recently the ABF Programme have largely treated inpatient and day cases activity completely separately. This approach was driven mainly by the fact that the scope of the National Casemix Programme initially only covered inpatient activity while day case activity was included at a later stage. This separation of the two treatment settings, meant that for Casemix and ABF purposes we had two distinct modes of treatment with two distinct base prices and two distinct definitions of a weighted unit. In particular, the weighted units for inpatients and day case cannot be directly combined to get an overall weighted measure of admitted patient activity.

As the scope of ABF expands beyond the admitted patient setting and into the Emergency Department (ED), Outpatient (OPD) and eventually the community settings it will become increasingly important that a common unit of weighted activity is adopted to gain a holistic picture of healthcare provision regardless of setting and to support the shift-left of healthcare provision.

For the 2024 price setting cycle, the HPO are proposing to adopt a single definition of a weighted unit which will be applicable to all care settings. The proposed weighted unit will be based on all admitted patient activity (i.e. inpatients and day cases) and the base price will be based on the average cost of providing an admitted patient episode of care (inpatient or day case). The proposed change would result in:

- an activity measurement that can be combined directly across treatment settings
- a base price which can be applied across treatment settings
- a more holistic measure of relative efficiency in our healthcare system.

This single weighted unit and base price has been used previously by the HPO as input to efficiency papers and the progression of the single base price was presented in the ABF Implementation Plan 2021-2023 to provide an overall view of admitted patient unit costs. The proposed change would make this combined picture the standard view of healthcare activity with the separate pictures still derivable as required as opposed to the current situation whereby the separate views are the standard and the combined view must be derived.

As the scope of ABF widens to include ED and outpatients it is proposed that the admitted patient weighted unit and base price remain the units of measure and the weighted units associated with ED and OPD activity will be converted to these measures based on the relative costliness of an episode of care in each setting.

2.3 FUNDING MODEL CALIBRATION

Calibration is a key concept in the ABF price setting process. It ensures that at each step of the process the estimated value of activity at the national level is equal to the actual cost of carrying out that activity. Section 6.1 of the HPO ABF Pricing Framework 2023 details this process step and sets out the rationale for it.

In recent years, the HPO have noted an issue in the main calibration step where the average DRG costs derived from plc returns are calibrated to match the total inpatient and day case activity and costs for all ABF hospitals. In this step the inpatient activity and costs are treated completely separately to the day case activity and costs. Due to some differences in the allocation methods between PLC and SC, this calibration step results in a significant increase in the day case DRG estimates caused by a relative over allocation of costs to day case areas in SC compared to PLC. The effect of this is also noticeable in the ABF benchmarking results where hospitals who are not in PLC can make significant wins based on some high volume day case DRGs with prices that are too high.

In 2022, the HPO examined the effect of calibrating plc to SC at the total cost level rather than for inpatients and day cases separately and found that the resulting model was a better fit to the cost data. i.e. calibrating to total costs reduced the average the average ABF adjustment level.

The HPO are considering adopting this total cost calibration approach for the 2024 pricing cycle and invite the input from stakeholders on this change.

2.4 ROADMAP FOR REDUCTION OF TRANSITION ADJUSTMENTS

When introducing an ABF model it is common practice to bridge the gap between what hospitals are spending and what the model says they should be spending for a period of time. This transition period allows both the funder and the funded institutions to examine and fully understand the operation of the model and the implications of that model for hospital management. Typically, this transition period is phased. It usually starts with a shadow funding period where the output of the model is used solely for learning and preparation purposes. In subsequent periods the amount of exposure a hospital has to the model is gradually increased so that allocation of funding moves towards the model and away from historical block amounts.

ABF funding in Ireland has been on hiatus since the impact of the global Covid-19 pandemic in 2020. At that point the level of transition adjustment was 87.5% (i.e. 87.5% the gap between actual expenditure and the model was funded). ABF will recommence in Ireland in 2024 and the proposed roadmap for the reduction of transition adjustments is outlined below. T22his roadmap will be reviewed periodically in the context of the work of the ABF Benchmarking Review Group and the roadmap beyond 2026 will be agreed and communicated in collaboration with relevant stakeholders e.g. CFO, ND Acute Operations.

Calendar Year	Basis of ABF Benchmarking	Funding Year Impacted	Transition Adjustment
2023	Actual 2022 Cost and Activity	2024	85%
2024	Actual 2023 Cost and Activity	2025	80%
2025	Actual 2024 Cost and Activity	2026	75%

2.5 ICU FUNDING IN THE ABF MODEL

The implementation of ABF and the Australian AR-DRG system in Ireland can be described as a “bundled” approach when it comes to ICU patients. This means that there is no additional payment made in the model for ICU stays which are significantly more costly than stays in a general ward. The model therefore relies on there being a similar proportion of ICU-based care across all hospitals for funding to be appropriately directed. It is known that the proportion of ICU care is not the same across all hospitals and therefore work was carried out to see how best to address this in the mode.

The HPO, in conjunction with Dr Fiona Kiernan have carried out a micro-costing study on activity from two ICUs in Ireland and the final report on this work entitled “Use of existing data sources to refine the funding in ABF for ICU patients” can be found on http://www.hpo.ie. It is intended that this micro-costing work will form the basis of a complexity adjusted per-diem payment for patients who spend some or all of their

hospital stay in an ICU. The intention is that patients who spend time in a level 3 or 3s ICU will have that portion of their stay funded based on the complexity-adjusted ICU length of stay. The remainder of their stay (i.e. the non-ICU period) will be funded through the DRG as per normal. This will have a number of effects on the model.

In general, DRG payments will exclude any component of ICU funding which will reduce the DRG price for those DRGs where there is a significant proportion of days sent in ICU.

1. DRG lengths of stay and therefore the inlier boundaries will reduce due to the ICU portion of stays being removed. Note that, the full length of stay will still be available so this move will not affect LOS based metrics beyond ABF.
2. The complexity adjusted ICU per-diem payment will be made only to those hospitals who have a level 3 or 3s ICU.
3. In order to support the proposed model, the HPO are working with NOCA to develop a data flow from the INICUA audit database to the HPO which will allow for the application of complexity adjustment for each day a patient stays in ICU.
4. The resulting model will direct funding more accurately to hospitals with level 3 and 3s ICUs and will no longer rely on averaging effects.

2.6 MODEL BASED HOSPITAL ADJUSTMENTS

Under the National Casemix Programme, which operated until 2013, a separate base cost was generated for each of the 4 groups of hospitals included in the model. The 4 groups were, tertiary referral hospitals, dedicated maternity hospitals, dedicated paediatric hospitals and others. When ABF was established in 2016 it was done so on the “single base price” principle. In recent years, it has become apparent that a single base price based system imposes constraints that does not allow for differential cost growth in different settings.

For instance, the Covid-19 pandemic dramatically reduced the level of activity in our hospitals in the years 202-2022 while at the same time dramatically increasing the cost of providing that activity. The exception to this trend was in maternity care where the activity levels were largely unaffected by the Covid-19 pandemic. The result of this, is that provision of maternity care seems to be much more efficient in ABF terms in these years and therefore dedicated maternity hospitals would be rewarded in ABF budget allocations due to factors which are largely beyond the control of the acute hospital system.

Another related phenomenon, is the fact that despite playing a crucial role in the alleviating the pressure on tertiary referral hospitals and providing a suitable clinical environment providing less complex care, model 2 hospitals tend to struggle in an ABF environment. This is largely a result of their relatively small size and relatively lack of clinical complexity compared to the staffing and overhead costs of operating these hospitals.

In both of these instances, the ability to fund the activity at a differential rate for different groups could significantly reduce the large “wins and losses” that we can see in the ABF model.

The HPO are therefore proposing to investigate the introduction of group based indexing to the ABF model. The idea here is that a single base price would be produced as usual, but individual adjusters would be created for identified types of hospitals so that the cost to value within those hospital types would be 1. In real terms this would mean that hospitals are only competing with similar type hospitals for resources. This type of idea has been in place in the ABF model in operation in 2016 where both the tertiary referral adjustment and the paediatric hospital adjustment essentially perform this role all-be-it under a slightly different name.

3. MAKING A SUBMISSION

3.1 CONSULTATION SUBMISSION PERIOD

The 2023 consultation period will be from 01 July 2023 until 31 August 2023 inclusive. The HPO will endeavour to assess and respond to all submissions received within that time frame. It is proposed that as well as responding directly to the submission originator, the HPO will also collate the submissions and include them, along with the HPO response, in a consultation log so that repeat submissions can be avoided. This log will be updated and released in line with the publication of the consultation paper in the following year.

3.2 CONSULTATION CONTACT DETAILS

All submissions arising from this consultation process should be made through ABFConsultation@hse.ie. Please do not send consultation submissions directly to HPO staff members as they could get overlooked when reviewing the annual submissions.

3.3 SUBMISSION GUIDELINES

In order to ensure that consultation submissions can be received and considered appropriately the following guidelines should be adhered to.

1. Submissions should be made through ABFConsultation@hse.ie. Submissions which are made through a different channel may not be considered for the upcoming ABF cycle.

2. Submissions must be received during the official consultation period. The consultation mailbox will not be monitored on a year-round basis and submissions received outside of the official consultation period may not be considered for the upcoming ABF cycle.

3. Submissions will only be accepted on the topics set out for consideration in the annual Consultation Paper on the ABF Pricing Framework. Submissions on unrelated topics may be considered in future consultations cycles.

4. All submissions should contain
    a. A clear and concise description of the position of the submitter.

    b. Substantive back-up material (costs, activity, papers etc.) which back up the position.

    c. Where applicable, reference should be made to particular concrete examples preferably based on existing ABF data (i.e. HIPE, PLC, specialty costs)

    d. References to any previous related submissions whether from the same or a different requester.

5. The following **important** items should be noted **before making** a submission.

    a. The scope of ABF process covers revenue costs only. Capital and depreciation are not within the scope of ABF, are not captured in the costing processes and are not intended to be cover by the DRG price. If your intended submission relates to capital items, it will be considered to be out of scope for this consultation process and will not be considered by the HPO.

    b. Neither the HPO nor the ABF process sets the amount of budget available for acute hospitals. The job of the HPO is to distribute the available funding to hospitals based on relative efficiency as measured through the annual benchmarking exercise, target activity levels as set out in the NSP and DRG pricing. Although submissions can be made in relation to individual DRG prices, submissions on overall price levels will not be accepted.

    c. The HPO does not hold budget beyond that which is required for the running of its own operation. Submissions requesting funding from the HPO will not be consider as part of the annual consultation process.

4. RELATED ABF COMMUNICATION ROUTES

There are a number of other ABF processes which seek to gather feedback from ABF stakeholders and it is important to understand the differences between them and any areas of potential overlap.

4.1 BENCHMARKING REVIEW GROUP (BRG)

The benchmarking review group is being established by the HPO in 2023 and will comprise representatives from the HPO costing, coding and pricing sections, ABF group accountants, Acute Finance and Acute Operations. The aim of this group is to dissect the annual ABF benchmarking results in order to understand the factors leading to those results and identify legitimate and unavoidable costs which may not be appropriately accounted for in the current model. The group will also review current ABF data throughout the year to help identify and rectify any issues which may impact on the following years benchmarking results.

The findings and recommendations of that group may be reported in a manner deemed suitable by that group, but any proposed changes to the ABF funding model will be flagged in a future ABF Pricing Framework consultation paper and any changes adopted will be detailed in the ABF Pricing Framework document.

Benchmarking Review Group Topics - Broad Characteristics

- Identified by Benchmarking Review Group
- Affects more than a single hospital / hospital agnostic
- Issue likely to be permanent rather than temporary
- Can relate to any aspect of the ABF process (costs, activity, ABF adjustments, prices etc.)

Submissions made through BRG representatives

4.2 UNIQUE ISSUES SUBMISSIONS

As part of the annual specialty costing exercise, hospitals are asked to make detailed submissions on any costs which they feel are not appropriate for ABF funding or may not be adequately funded in the ABF model. The HPO for their part, must review these submissions each year and make a judgement on whether a cost adjustment should be made in the benchmarking exercise in respect of that unique issue.

Unique Issues Submission - Broad Characteristics

- Specifically related to costs
- Identified by individual hospitals
- Hospital specific issue
- Can be a temporary or more permanent issue

Submission made through the annual specialty costing submission process.

4.3 QUALITY BASED FUNDING FRAMEWORK

The purpose of the Quality Based Funding Framework is to describe the guidelines, processes and minimum requirements for making an application for creating and implementing a quality based ABF funding initiative. Such QBF initiatives should be considered to be separate to the baseline ABF funding model which essentially seeks to set prices that match the underlying costs rather than explicitly incentivise any particular clinical practices, pathway or mode of treatment delivery.

Quality Based Funding Framework - Broad Characteristics

- Related to Quality Based Funding Initiative
- Typically identified by clinical programmes, audit groups etc.
- Submission based on Quality Based Funding Framework

Submissions made through QBF@hse.ie