The ABC of ABF
(Activity Based Funding)

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Agenda

- Irish Healthcare – Some Facts an Figures
- History of Casemix and ABF in Ireland
- What is ABF?
- Components of ABF
- ABF Policy Context
- ABF and Quality
Ireland – Some facts and figures
Ireland: Some facts and Figures

- Population: 4.5 m
- Total Area: 68,895 km²
- No. of Acute Beds: 13,500
- No. of ABF hospitals: 38
- No. of Hospital Discharges: 1.6m
- No. of Outpatient attendances: 3.6m
- No. of ED attendances: 1.3m
- Public Health Budget: circa €13 billion
Health spending as % of GDP, 2010

% GDP

Note:
1. In the Netherlands, it is not possible to distinguish clearly the public and private share for the part of health expenditures related to investments.
2. Total expenditure excluding investments.
3. Information on data for Israel: [http://dx.doi.org/10.1787/888932315602](http://dx.doi.org/10.1787/888932315602)

Source: OECD Health Data 2012
Ireland’s Economic Woes!!!!

Average OECD health expenditure growth rates in real terms

Note:
Growth rates for 2009/10 are not available for Australia, Japan, Luxembourg, Israel, Spain and Turkey. Growth rates for Chile calculated using the Consumer Price Index (CPI).

Source: OECD Health Data 2012.
The Picture Since 2008

Change in Allocated Budget and Activity Levels

-25.0% -20.0% -15.0% -10.0% -5.0% 0.0% 5.0% 10.0% 15.0%

2008 2009 2010 2011 2012 2013

Acute Hospitals Budget  Inpatients and Day Cases
History of Casemix and ABF in Ireland
Casemix in Ireland

- Up to 2012 Casemix data was used to make an efficiency based adjustment to hospitals budgets based on data from the previous year
  - Single line item in hospital allocation

- In 2012 this process was halted in preparation for the introduction of ABF in Ireland

- Under ABF Casemix data will form the basis of the hospital’s funding
In 2004 Ireland adopted
- ICD–10–AM & ACHI classification systems
- AR–DRG system

Long standing relationship between Australia and Ireland in terms of Casemix
- States of Victoria and NSW

Much of the Casemix development in Ireland has been informed by Australian experts
What is ABF?
Activity based funding (ABF) is the provision of funding to healthcare providers based on the quantity and quality of services they deliver to patients.

Funding patient care rather than hospitals
Clinical information + Financial information

Bed sheeters + Spreadsheeeters
ABF Components

- Activity Information
  - HIPE

- Costing Information

- Price Setting

![Diagram showing the interrelation of Activity Information, Costing Information, and Price Setting with terms like HIPE, Pricing, and Activity Costs.](image-url)
Activity Information (HIPE)
Activity Information

- Each admitted discharge coded to HIPE
  - Administrative, demographic and clinical data
  - HIPE must reflect the Chart
  - Capture information relevant to episode of care
    - Principal diagnosis
    - All relevant secondary diagnoses
    - Principal procedure
    - All relevant secondary procedures
    - In accordance with coding standards and guidelines

All discharges are assigned to one and only one DRG
## Case Study: B70 Strokes

### B70A – Stroke with catastrophic complication

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>Price</th>
<th>2014 cases</th>
<th>2014 %</th>
<th>ABF hosp %</th>
</tr>
</thead>
<tbody>
<tr>
<td>B70A</td>
<td>Stroke and other cerebral disorder with catastrophic complications/co-morbidities</td>
<td>€23,261</td>
<td>15</td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>B70B</td>
<td>Stroke and other cerebral disorder with serious complications/co-morbidities</td>
<td>€9,410</td>
<td>79</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>B70C</td>
<td>Stroke and other cerebral disorder without catastrophic or severe complications/co-morbidities</td>
<td>€5,159</td>
<td>226</td>
<td>62%</td>
<td>47%</td>
</tr>
<tr>
<td>B70D</td>
<td>Stroke and other cerebral disorder died/transferred within 5 days</td>
<td>€1,707</td>
<td>46</td>
<td>13%</td>
<td>10%</td>
</tr>
</tbody>
</table>

| Highest DATH | 366 | 100% |

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**Note:**
- DRG: Diagnosis Related Group
- ABF: Average Burden of Illness
Key Issues re HIPE Coding and ABF

- Coverage
  - Code every chart: No coding = no funding

- Complexity
  - Ensure that all diagnosis are captured: Incomplete coding = incomplete funding

- Deadlines
  - Coded late – funded late = gap between costs and funding

- Guidelines
  - HPO Irish coding standards
  - Activity is subject to audit

- If it is not on the chart it did not happen
Costing Information
**Allocation of Costs**

**Gross Costs €200m**

**IP €120m**
- **IP Cardiology**
  - Cost: €36m
  - Discharges: 4,000
  - Cost per discharge: €9,000
  - Weighted units: 7,500
  - Cost per WU: €4,800

**DC €30m**
- **DC Cardiology**
  - Cost: €10m
  - Discharges: 8,000
  - Cost per discharge: €1,250
  - Weighted units: 10,000
  - Cost per WU: €1,000

**OPD €20m**
- **Chest pain**
  - Cost: €3m
  - Attendances: 30,000
  - Cost per attendance: €100
  - Weighted units: 20,000
  - Cost per WU: €150

**ED €10m**
- **Hypertension**
  - Cost: €10m
  - Attendances: 40,000
  - Cost per attendance: €250

**Extern €20m**
- **What**
  - Labs: €10m
  - X-ray: €7m
  - Medical pay: €3m
- **Where**
  - GPs: €14m
  - Other hosps: €5m
  - Comm care: €1m

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**Healthcare Pricing Office**
# Patients are different

<table>
<thead>
<tr>
<th></th>
<th>ED</th>
<th>Ward</th>
<th>ICU</th>
<th>Labs</th>
<th>Radiology</th>
<th>Theatre</th>
<th>Physio</th>
<th>Procedure Room</th>
<th>Overheads</th>
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<tbody>
<tr>
<td>Leg fracture</td>
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<td>Car crash multiple trauma</td>
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<td>Stroke without complications</td>
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<td>Heart transplant</td>
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<td>Hip replacement</td>
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<td>Colonoscopy</td>
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<td>GP referral</td>
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Costing requires connecting

HIPE
Types of patients

Cost per patient

GL
Expenditure on patients

Hosp systems
What happened to patients
Healthcare Reform and Activity Based Funding Policy Context
4 Pillars of Reform

1. Health and Wellbeing
2. Service Reform
3. Structural Reform
4. Financial Reform (ABF)
Policy Objectives

- To support the move to an equitable single-tier system
- To have a fairer system of resource allocation
- To drive efficiency in the provision of hospital services
- To increase transparency in the provision of hospital services
- Any ‘ABF’ system must support and reinforce the delivery of quality care in the most appropriate setting
ABF Governance Structures

- Department of Health
  - Healthcare Pricing Office
  - Healthcare Commissioning Agency
    - Hospital Group
    - Hospital Group
    - Hospital Group
ABF Process

- Pricing Office sets national price list using cost and activity data
- Minister sets global hospital budget and national service targets and priorities
- Healthcare Commissioning Agency agrees performance contracts with Hospital Groups – capped cost and volume contracts
- Additional activity must be pre-approved and can be paid at different rates
- Payment based on submission of claims for agreed activity
Currently restricted to acute admitted care
  ◦ Covers daycase and inpatient activity
  ◦ All other activity funded in block grant

- All other hospital costs funded in the block budget
What ABF is not?

- Not about increasing the level of funding available to acute hospital system

- Not about carrying out additional unapproved activity to increase size of hospital budget

- Not panacea for all ills in the health system
  - It is essentially about the *distribution* of the pie rather than the *size* of the pie
ABF - Quality
ABF and Quality of Care

- Aim to improve patient access to care together with the overall quality and safety of care they receive.

- The funding mechanisms should encourage quality care in the most appropriate setting.

- This will involve working closely with the clinical programmes to align pricing with clinical objectives.

- How can we use DRG payments to incentivise prevention, hospital avoidance, quality and safety, care pathways and appropriate patient outcomes?
Coding of Sepsis – New Codes

- Jan 2015 = 8\textsuperscript{th} edition ICD-10-AM/ACHI/ACS
- New category for SIRS including
  - R65.1 Systemic inflammatory response syndrome [SIRS] of infectious origin with acute organ failure
    - includes Severe sepsis
- New code for Septic shock
  - R57.2 Septic shock
- Revised Sepsis Coding Guideline for HIPE Coders
There are two specific DRG’s for Sepsis within the Australian DRG system:

- T60 A  Septicaemia + CCC
- T60 B  Septicaemia – CCC

Sepsis can also appear as a Secondary Diagnosis in other DRG’s which can cause an impact on DRG assignment.

Obvious question is should you pay the additional cost of a more complicated DRG caused by the Sepsis?

Should you pay if it is Hospital Acquired?

Can you determine if it was hospital acquired?
Funding of Sepsis – Some Issues

- Should there be an additional payment for following an agreed clinical pathway?
- Should there be a reduction for not following the pathway?
- How do you collect the information to determine whether an agreed pathway has been adhered to?
- Is this administratively feasible?
- Is the data verifiable and auditable?
- Do you have a sliding scale i.e., if 70% of pathway adhered to you get 70% of additional payment?
- Is it 100% adherence or nothing?
Thank You

Any Questions?