Money Follows the Patient
Policy Paper on Hospital Financing

Frequently Asked Questions

- Fairness
- Efficiency
- Transparency
- Quality

Money Follows the Patient

Tús Áite do Shábháilteacht
Patient Safety First
An Roinn Sláinte
Department of Health
Money Follows the Patient
Frequently Asked Questions

Overview of the ‘Money Follows the Patient’ System

Q1. What is ‘Money Follows the Patient’?
‘Money Follows the Patient’ (MFTP) is a new model for funding public hospital care. It involves moving away from inefficient block grant budgets to a new system where hospitals are paid for the actual level of activity undertaken. Hospitals will be funded based on the quantity and quality of the services they deliver to patients - money will follow the patient!

Q2. Why is the Government introducing this new system?
The new MFTP model will offer a number of important benefits. Firstly, it is a fairer and more transparent way of funding hospital services with payments linked to the treatment delivered. Secondly, the new model will encourage greater efficiency and productivity in the delivery of hospital services. Under MFTP providers will be paid for the needs they address, the quantity and quality of the services they provide and the outcomes they deliver, rather than being in receipt of a historical block grant allocation. They will be liberated, subject to overall budgetary ceilings, to pursue the most cost-effective means of achieving this standard of performance.

Finally, MFTP is also an important building block for universal health insurance under which every patient will be insured and have their care financed on the same, transparent basis.

Q3. How will MFTP work?
In summary, the new funding model involves three main stages as follows:

- **Stage 1:** Setting national prices for services and determining an overall budget
- **Stage 2:** Agreeing performance contracts with Hospital Groups which set out the quantity and quality of services to be delivered
- **Stage 3:** Making payments to hospitals based on national prices and based on confirmation that agreed services have been provided

In order to deliver on each of these stages new structures will be required.

Firstly, a new National Information and Pricing Office will be established. The Office will use cost and activity data to set national prices for ratification and publication by the Minister. The Minister will publish these prices alongside details of the overall MFTP budget and the national service targets and priorities to be delivered from within that budget (stage 1). A separate Healthcare Commissioning Agency (HCA) will be grown from within the HSE and will be responsible for agreeing performance contracts and making payments to Hospital Groups (stages 2 and 3). This process is summarised in the diagram below:
More detail on the MFTP process, including the roles of the National Information and Pricing Office and the Healthcare Commissioning Agency can be found in questions 23 and 24.

Q.4 Why can’t the Healthcare Commissioning Agency set prices as well as purchasing services from Hospital Groups?
It is best practice to separate price-setting from purchasing. This is consistent with international practice and it is important in safeguarding the integrity of the MFTP process.

However, it is also important to note that the new National Information and Pricing Office and the Healthcare Commissioning Agency will be developed using existing organisational structures as well as existing staffing and resources (e.g. the staff of the National Casemix Office). Moreover, the new structures are consistent with the wider health reform agenda. Future Health already commits to the creation of the Healthcare Commissioning Agency which will subsume HSE Directorate management teams involved in the performance contracting and financing of services.

Q5. What will MFTP mean for patients?
From the patient’s perspective, the new funding model won’t involve any change in how they obtain hospital services and interact with professionals. However, as already stated, MFTP is about improving the efficiency and effectiveness of the delivery of hospital care. In line with these aims, the new model should enhance value for money and improve overall patient experience. By boosting productivity, the model should reinforce the important work of the Special Delivery Unit in improving access for public patients.

Q6. Could the funding model affect quality of care?
A recent pilot project, which implemented a MFTP model in the orthopaedic speciality, demonstrated positive productivity gains. There was a two day reduction in average length of stay and a 45% increase in day of surgery admission rates, while not raising any quality concerns.

In developing policy and implementation plans for full introduction of the funding model, the issue of quality has been considered and built-in at each stage of the process. Indeed, the policy explicitly
links payment to the achievement of quality and safety measures through the use of an integrated performance contracting approach. This approach means that contracts agreed between Hospital Groups and the Healthcare Commissioning Agency will incorporate quality performance targets as well as agreed cost and volume information. Therefore, instead of diverting focus away from quality, the new payment system will be used as a lever to drive better quality and patient safety.

The quality agenda under MFTP will be further enhanced as the system is developed to incorporate best practice prices. Best practice prices will build on the vital work of the National Clinical Programmes by calculating prices based on the costs associated with agreed principles of best clinical practice. As such, they will further underpin and encourage delivery of a better quality of service, a better patient experience and optimal efficiency.

Additional safeguards such as a robust auditing function, strong performance management and structured consultation will be built into the system so as to guard against the unintended consequences which can be associated with MFTP-type systems such as upcoding or inappropriate early discharge/under treatment.

**Q.7 Is ‘Money Follows the Patient’ not just a crude tool for cutting hospital budgets?**
No. The new funding model does not seek to reduce budgets, rather it will encourage hospitals to use the resources at their disposal more efficiently. It provides a more transparent funding mechanism and it more fairly rewards hospitals for the activity that they undertake.

**Q.8 Why does the MFTP model only apply to hospitals? Will it really enable money to follow the patient out of the hospital setting?**
While MFTP begins with hospital services, the payment system is designed to evolve so that money will follow the patient out of the hospital when appropriate to support treatment in primary care services. The work of the National Clinical Programmes will be central to the future development of the payment model so that care can be financed as a bundle/package across a variety of settings.

The Programme for Government notes the commitment to deliver a MFTP model in the hospital sector. While the policy paper explicitly focuses on the hospital sector in the first instance, it also sets out a clear vision for how policy should continually evolve so as to support integrated care across settings. As such, it actively seeks to design a payment system that is flexible, responsive and can be used as a lever to encourage the delivery of care in the most appropriate setting and at the lowest level of complexity that is safe, timely and efficient.

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**Implementation of the ‘Money Follows the Patient’ System**

**Q.9 What is the implementation timescale for MFTP?**
The policy proposes that MFTP will be introduced on a shadow funding basis in 2013 and will apply to the major or ‘hub’ hospitals of each Hospital Group. This will mean that hospitals continue to receive their existing base budget but a shadow funding process will be put in place to examine the potential impacts of the new model. Thus, no changes will actually be made in 2013 to hospital budgets on foot of this exercise. Full phased implementation will then begin in 2014.

This approach offers a safe and sustainable transition to the new model as it provides time to develop the necessary expertise and IT requirements before full implementation. Furthermore, focusing on hub hospitals allows space for the establishment of Hospital Groups while still facilitating shared learning across all hospitals in a Group and across all Hospital Groups.
Q.10 What are the Hub Hospitals to be involved in the first instance?
The hub hospitals will be announced in the context of overall Government announcements in relation to Hospital Groups. The Government intends to make a decision shortly on the composition of Hospital Groups informed by the Report on the Establishment of Hospital Groups.

Q.11 How can you ensure that MFTP is implemented in a safe and sustainable way which does not destabilise the hospital sector?
As noted in the policy paper, a comprehensive financial management plan will be developed to underpin the safe and sustainable introduction of MFTP. This plan will ensure that the new funding model is phased in over an appropriate timeframe which takes account of the need for hospitals to tackle areas of inefficiency so that they can operate at the nationally agreed price. It will also identify the systems which need to be in place to support robust cashflow management at hospital level, will provide for rigorous ongoing monitoring of hospital expenditure and activity levels, and will establish escalation mechanisms to ensure early intervention and effective resolution of potential budget overruns.

Q.12 How can you ensure that the system doesn’t drive activity and result in severe cost escalation and budgetary overruns?
It is certainly the case that uncapped MFTP funding models can drive excess activity and the international literature cautions that an uncapped system is simply not an option in times of financial crisis. It is, therefore, imperative that a strict budgetary discipline is retained within the new funding model. Accordingly, MFTP will be introduced within a fixed budget envelope. In addition, hospitals will agree capped cost, volume and quality contracts with the Healthcare Commissioning Agency. As noted above, a comprehensive management plan will establish escalation mechanisms to ensure early resolution of potential budgetary overruns.

Q.13 What will the introduction of MFTP mean for smaller hospitals or hospitals in rural areas? Will it lead to their closure?
The new funding model is not about reducing services or closing hospitals. It is about ensuring a fairer and more transparent resource allocation system for all hospitals.

The Healthcare Commissioning Agency will agree performance contracts with Hospital Groups rather than with individual hospitals. This approach, whereby the Hospital Group is the contracting entity, offers a number of very important benefits. It ensures that all hospitals, by virtue of being part of a Group, are operating on a fair and level playing field. It ensures that all hospitals can benefit from the economies of scale and management expertise which will be provided through the Group structure. Linked with this, it ensures that provider entities are of a sufficient scale in financial terms to effectively spread and manage risk. Finally, and most importantly, it reinforces a key objective of moving to Hospital Groups, namely to configure services across a Group structure so as to optimise quality and efficiency while simultaneously securing and developing the role of smaller hospitals within that Group.

However, if particular Hospital Groups incur unique or additional costs due to issues such as geographical location, this factor may be incorporated into the MFTP pricing mechanism provided that robust evidence of these legitimate, additional costs is offered.
Q.14  Why does this policy only focus on public patients in public hospitals – What are the plans for private patients in public hospitals?
The policy paper focuses on the implementation of MFTP for public patients. As such, it represents an important starting point and the immediate next step must be to develop a corresponding charging regime for private patients in public hospitals as was recommended in the *Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals*. This work will be undertaken in 2013.

Q.15  What are the aims of the consultation process for MFTP?
The Minister recognises that successful implementation of MFTP will require the active support and co-operation of all stakeholders. The Department will shortly undertake a consultation process which will: build awareness of the MFTP policy among the key stakeholders; get feedback from the stakeholders on the policy so as to allow consideration of changes to the detail of the new funding model; secure commitment to the policy aims; and ensure that key consistent messages on MFTP are delivered.

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**Detailed/ Technical Questions on the System**

Q.16  What type of MFTP model is being introduced? Is it case-based or procedure-based?
A case-based funding model using Diagnosis Related Groups (DRGs) is being introduced. DRGs are a method of classifying patients into clinically meaningful and economically homogenous groups. This enables a transparent comparison of hospital costs, quality and efficiency.

Q.17  Is the DRG Case-based Model the best option for Ireland?
The international literature shows a strong convergence towards the implementation of DRG case-based hospital payment systems as they provide incentives for greater efficiency and more fairly and transparently allocate resources. The DRG case-based model is also consistent with the Government’s objective to move to an equitable single-tier system where every patient is insured and has their care financed on the same basis.

The Irish public hospital system is familiar with the DRG-case based model. The National Casemix Programme already makes adjustments to hospital budgets using this methodology.

Q.18  What services will be funded using the MFTP model?
Initially it is proposed that the MFTP model will fund Inpatient and Daycase activity. Comparable episodes of care that are provided on a sideroom or outpatient basis will also be incorporated as quickly as possible into the model, once coding and costing systems have been further enhanced to enable this.

Q.19  How will services outside of the scope of the MFTP model be funded?
Services such as Emergency Department, outreach services, teaching and research will not be funded under the MFTP model. While the scope of the services falling outside of the model will be kept continually under review, in the immediate term, such services will be funded separately and generally by means of a block grant allocation. Some services such as teaching and research will require new costing methodologies to be developed to ensure that these costs are funded on a fair and transparent basis.
Q.20 What about high cost cases? Will there be an outlier policy?
In any DRG case-based system it is likely that high cost cases will occur. To take account of this, an outlier policy will be developed based on average length of stay.

The payment system will also have to take account of high cost drugs and national specialties. Where the provision of national specialties is demonstrated by robust evidence to incur significant additional costs, a higher cost weight or top-up payment may be warranted. Supplementary funding for certain high cost drugs will also need to be considered, while taking account of existing initiatives such as health technology assessment and the work of the clinical programmes.

Q.21 What methodology will be used to set prices?
The technical process involved in setting prices based on average costs requires the development of relative cost weights. Simply put, a single national base price is determined for a DRG with a relative cost weight value of 1. DRG relative cost weights are calculated using the following process:

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\text{Relative Cost Weight} = \frac{\text{Average Costs of Cases within a DRG}}{\text{Average Treatment Costs of all Cases}}
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All prices can then be calculated automatically by reference to the relative cost weight of each DRG.

Q.22 What costs will be covered by the price?
The costs to be incorporated into the MFTP model when developing prices include pay costs, non-pay costs, costs of diagnostics and medical services etc., and the cost of the clinical indemnity scheme as it relates to public hospitals (albeit that a mechanism to incorporate this cost will need to be developed over time). Other costs that will be kept under review for inclusion in the model are bad debts, capital and superannuation.

Q.23 What Role will the National Information and Pricing Office have?
The new National Information and Pricing Office will be established as an independent agency and will have responsibility for managing the HIPE dataset and determining the national DRG price list. The production of a single national DRG price list differs from the current National Casemix Programme where prices are determined by reference to hospital categories i.e. teaching hospitals, non-teaching hospitals, paediatric hospitals and maternity hospitals.

The Pricing Office will be bound by legislation which sets out the policies and principles for calculating prices. The setting of prices will be informed by cost and activity data provided by hospitals. This ensures that there is a clear and transparent method for the setting of prices in the MFTP system. The Pricing Office will have a multi-stakeholder oversight which provides an opportunity for key stakeholders to input to the price setting procedure via a structured consultation process.

Q.24 What Role will the new Healthcare Commissioning Agency have?
The Healthcare Commissioning Agency will be the lead purchasing entity for the hospital system. It will be grown from within the HSE and will also incorporate the core purchasing functions of the National Treatment Purchase Fund. It will be responsible for purchasing hospital services via a robust performance contracting process whereby capped cost, volume and quality contracts will be negotiated with Hospital Groups. It will also have a strong performance management function to ensure that hospitals are meeting agreed performance targets, and it will also be responsible for the
payment of funding to hospitals on the basis of submitted claims, thereby requiring the agency to have a strong claims management function.