MONEY FOLLOWS THE PATIENT

POLICY PAPER ON HOSPITAL FINANCING

Thematic Analysis of Stakeholder Consultation Process

August, 2013

Executive Summary

Introduction

The Department of Health is currently overseeing the development of a new 'Money Follows the Patient' (MFTP) funding model for public hospitals. In recognition of the fact that successful implementation of MFTP will require the support and commitment of stakeholders, the Minister for Health, Dr James Reilly TD published the 'Money Follows the Patient Policy Paper on Hospital Financing' on 15 February, 2013 as a basis for consultation. The Policy Paper outlines draft proposals in relation to the introduction of an MFTP system in public hospitals. A total of 32 responses were received to the call for submissions on the Paper and a brief summary of the themes identified by stakeholders is set out below. A number of proposed changes to the Policy Paper are also identified. The findings of the consultation will now be used to inform the implementation planning process.

Establishing the Vision

Respondents were generally welcoming of the publication of the MFTP Policy Paper and the proposed move to a MFTP funding system. However, concerns were voiced regarding data protection issues and a perceived emphasis on cost saving rather than improved patient care. No objections were raised in relation to the stated objectives of MFTP.

Change to Text: Add clarification that all aspects of MFTP will be in line with data protection legislation.

Defining the Service

While some respondents agreed that an initial roll-out of MFTP in public hospitals is a logical starting point, others argued that it is crucial that money can follow patients out of hospitals to the most appropriate setting from the outset. It was suggested that, in the absence of MFTP in primary care at this point, a clear road-map of how MFTP will transpose to non-hospital settings should be developed.

There were differing views regarding the range of services to be covered by the MFTP system with respondents arguing for the inclusion or exclusion of various services. The key underlying point made was that there must be clarity in relation to how activity not covered by MFTP will be funded to ensure that there is no diminution of these services. No objections were raised to the proposed move away from the current hospital categorisation system. Respondents also supported the proposed move to ensure that services are defined by reference to the episode of care rather than the setting. They also concurred with the view that there is a need to clearly articulate the beginning and end points of treatment. It was recommended that references to Acute Surgical Assessment Units be added to the document as well as a minor textual amendment to further describe the role of the National Clinical Effectiveness Committee.

Although no alternatives to the HIPE system were specified by respondents, a number of concerns in relation to the system were raised. There were claims of weaknesses including: accuracy and data quality issues; shortages in trained HIPE coders; and variation among hospitals in relation to the level of development of clinical coding processes. Delays associated with coding of activity were also highlighted as a serious barrier to implementation of MFTP. A number of respondents agreed with the proposal that the DRG

grouper should be reviewed and on-going consultation in relation to the DRGs was also seen as being required. The move to base private patient charges on DRGs was also supported.

Respondents made a number of points in relation to the collection, access and availability of data. The need for the introduction of a system of unique patient identifiers and a single repository for all health data which can be accessed by appropriately authorised parties was highlighted. It was also stated that insurers will need access to additional data in order to assess claims. However, respondents also stressed the need for issues relating to confidentiality and the secondary use of data, to be addressed through the forthcoming health information legislation. One respondent was particularly concerned about the wider availability of data and stated that patients should be able to limit access to their record to those who are directly involved in their care.

Change to Text: Add reference to Acute Surgical Assessment Units where appropriate.
Change to Text: Add text to clarify that non-MFTP funded activity in hospitals will continue to be block funded.
Change in Text: Further describe the role of the National Clinical Effectiveness Committee.
Change to Text: Include reference to the importance of confidentiality, data security and integrity and the key role of the forthcoming health information legislation in this regard.
Change to Text: Include text to clarify that existing arrangements will apply to non-MFTP funded areas of the health service.

Designing the Price

Respondents emphasised the need for the methodology for calculating prices to appropriately reimburse hospitals for the cost of care provided. It was recommended that the price setting mechanisms be fully transparent and open to public scrutiny with appropriate stakeholder involvement.

Differing views were offered by respondents in relation to the use of best practice versus average prices. Some argued for the immediate introduction of best practice pricing while others acknowledged the difficulties in doing so and supported average pricing in the short-term. The view was expressed that both approaches greatly limit the scope for purchasers to use market forces to achieve better value for money, with “fee for service” and “packaged prices” identified as possible alternatives. No objections were raised to the use of indirect pricing through the use of relative weights.

The submissions included a number of arguments in relation to the various costs that are proposed for inclusion and exclusion in the overall calculation of cost. One respondent pointed to the need for the average cost to reflect the true costs of providing services in line with the approach of private hospitals. The difficulties associated with isolating certain costs, such as teaching, were highlighted and it was stated that any model for extracting such costs would have to be agreed with hospitals. A key point raised in relation to the excluded items was the need for clarity on how such costs will be funded in the future.

There was acceptance of the need for a robust outlier policy to include additional reimbursement, provided that the medical need for the extended stay is established and supported by documentation. A number of respondents argued that it would be unfair to penalise hospitals for delayed discharges when the delay is not due to the performance of the hospital in question. A system of "per diem" payments was suggested for such occurrences.

Change in Text: Clarify that hospitals will continue to be reimbursed for patients medically fit for discharge in the near term when delays in discharging are beyond their control. The payments will be in line with a protocol to be developed.

Governance Structures

Respondents were supportive of the proposed separation of pricing and purchasing functions and the requirement for legislation to underpin the new structures was stressed. It was suggested that further consideration be given to whether information should fall within the remit of the National Information and Pricing Office. It was suggested in one response that narrowing the remit would allow the Office to focus solely on pricing issues.

Several respondents warned of the need to ensure financial control and to avoid unnecessary increases in activity under the new funding system. A number of options for maintaining control were identified in the submissions. Respondents agreed with the need to have clearly set out capped costs and volumes. However, it was also suggested that the performance contracts need to take account of hospitals with high levels of emergency work which may drive demand beyond the level of activity allowed as well as a mechanism for funding such activity.

It was commented that the seven day turnaround target for submission of claims to the Healthcare Commissioning Agency would be very difficult to achieve and would only be possible following the introduction of sophisticated electronic claims management systems. Respondents noted that the reduction in the turnaround time will play an important part in minimising cash flow challenges. The absence of expertise in claims management, as envisaged in the Policy, was identified as a barrier to implementation and outsourcing was suggested as a possible solution. It was noted that the NTPF held some skill-sets in addition to those already outlined in the Policy Paper that would be of benefit to a roll-out of MFTP.

A number of respondents voiced concerns about the potential for the new funding model to have a negative impact on innovation. In line with the Policy Paper proposals, it was suggested that a process for discussion and agreement on innovation related costs be established in order to avoid any negative impact from the new funding model. It was recommended that the National Centre for Pharmacoeconomics be referenced in relation to the initiatives that must be taken into account when considering whether supplemental payments should be provided in respect of innovation.

Respondents agreed with the Policy Paper proposal that the funding system should be underpinned at the outset by quality guidelines together with effective regulation and quality monitoring mechanisms, including targets. However, some remained concerned about potential negative consequences for quality arising from MFTP. Respondents agreed that steps, such as a clear set of ground rules, will be required in order to address unintended consequences and perverse incentives. It was also stated that adequate governance and oversight will be required to ensure that the financial rewards and penalties proposed are fair, equitable and do not lead to distortions in how care is provided.

Change in Text: Incorporate text outlining the prospective ordering and claims administration skills held in the NTPF.
Change in Text: Include reference to the National Centre for Pharmacoeconomics in relation to the initiatives that must be taken into account when considering whether supplemental payments should be provided in respect of innovation.

Implementation

The Policy Paper recommendation on the timelines for the introduction of MFTP in shadow form in 2013, ahead of full phased implementation from January 2014, was one of the areas of greatest concern among respondents. The timetable was described by some respondents as "ambitious", "challenging" and even "unrealistic". The timing of the roll-out was seen as a particular difficulty because it represents another layer of change in the system which is already dealing with a massive programme of reform including the establishment of hospital groups. Respondents emphasised the need for a robust project planning process for implementation.

Hospital readiness for MFTP, particularly in the areas of staff resources and IT, was another area of concern highlighted in submissions. Several respondents noted that the hospitals will not be starting from the same position in terms of resources, systems and processes and that this will have to be addressed as part of the transition process for MFTP. It was proposed that a hospital level analysis of readiness be carried out in order to identify gaps and weaknesses in the various hospitals which need to be addressed. It was also suggested that consideration be given to a phased roll-out in accordance with the differing stages of organisation development.

Change in Text: Include reference to a hospital level analysis of ICT, processes and staff resources required for MFTP.

Next Steps and the Journey Ahead

The need for communication and consultation with stakeholders was frequently cited by almost all respondents in order to achieve buy-in. An effective communication plan and consultation process to engage all relevant stakeholders was recommended.

1. Introduction

Background and Purpose of Paper

The Department of Health is currently overseeing the development of a new 'Money Follows the Patient' (MFTP) funding model for public hospitals. This new model is being introduced in order to:

- ensure a fairer system of resource allocation where hospitals are paid for the quality of care they deliver;
- drive efficiency in the provision of high quality hospital services;
- increase transparency in the provision of hospital services; and
- ultimately, support the move to an equitable, single-tier universal health insurance system where every patient is insured and has their care financed on the same basis.

The proposals represent an important first step in the process to transform the healthcare funding system so that it is truly patient-centred, value focused and, therefore, supportive of wider health sector objectives. The Department recognises that successful implementation of MFTP will require the support and commitment of many people across the health service and that effective consultation with stakeholders is essential. For that reason, the Minister for Health, Dr James Reilly TD published the 'Money Follows the Patient Policy Paper on Hospital Financing' on 15 February as a basis for consultation. The Policy Paper outlines draft policy proposals on the introduction of a prospective case-based payments system which will replace the current block grant allocation mechanism for public hospitals.

The purpose of this thematic analysis paper is to outline the main points made by respondents as part of the consultation process and to identify any necessary changes to the text of the Policy Paper. The proposed changes are specified throughout this analysis paper. The analysis will also be used to inform the implementation plans for MFTP.

Objectives of the Consultation Process

The objectives of the consultation process were:

- To build awareness of the MFTP policy amongst key stakeholders;
- To get feedback from stakeholders on the policy so as to allow consideration of changes to the detail of the new funding model;
- To secure commitment to the policy aims; and
- To ensure that key consistent messages on MFTP are delivered.

Call for Submissions

A total of 96 key stakeholders were identified as part of a stakeholder analysis and each was invited by letter to take part in the consultation process. Interested parties were also invited to participate in the process via a call for submissions on the Department's website. The Policy Paper was available from the publications section of the Department's website (www.doh.ie) and respondents were asked to make their submission in writing.

The consultation period was initially set for a five-week period. However, this period was subsequently extended to nine weeks in order to give stakeholders every opportunity to participate. A small number of responses were received after the nine-week consultation period but were included in any event (all responses received up to 30 July, 2013 are included in this analysis). The Department intends to continue to consult with stakeholders on an on-going basis throughout the implementation process.

Responses Received

A total of 32 responses were received (this figure includes 3 submissions from one individual). Submissions were made by hospitals, sections of the HSE, health agencies, private health insurance companies, a regulator, health sector interest groups, colleges and universities, not-for-profit organisations and a service user. A full list of respondents is set out at Appendix 1. 26 responses were returned by email while 6 responded by post. Each submission was acknowledged by letter or email.

Analysis of Responses

While a questionnaire was not used, respondents were encouraged to use the chapter headings of the Policy Paper as a structure for their submission. Submissions were analysed using an iterative process whereby particular themes were identified and grouped. This process formed the basis for this report with the themes grouped to broadly follow the chapter structure of the Policy Paper (Establishing the Vision; Defining the Service; Designing the Price etc.). It should be noted that this report does not attempt to list every point made by every respondent but instead aims to identify the key themes, concerns and suggestions.

2. Establishing the Vision

Policy Context and Objectives

This chapter provides background in relation to the Governments commitments to far-reaching reform of the health service and MFTP. The main objectives of MFTP are outlined and can be summarised as fairness; efficiency; transparency and supporting the move to an equitable single-tier system.

Respondents were generally welcoming of the publication of the MFTP Policy Paper. The

current funding model, based on historic allocations, was deemed to be unsatisfactory and a change to a more progressive health financing system was seen as crucial to the health reform programme and as a key step towards the introduction of Universal Health Insurance.

There was widespread support for the proposed move to a MFTP funding system. MFTP systems were recognised as supporting efficiency and transparency in the funding of health services as well as encouraging hospitals to get a better understanding of their costs. The introduction of a funding model that more closely relates to the work done and allows money to effectively follow the patient was also seen as providing a greater level of flexibility to keep pace with the changing nature of the health service. However, there was strong opposition to the introduction of MFTP in one response with data protection concerns cited. Concerns were also voiced that the new funding model emphasises cost-saving rather than improved patient care.

No objections were raised by respondents to the objectives specified in the policy document and the confirmation that MFTP was not about reducing budgets was welcomed. However, it was suggested that the objectives could be broadened to include 'keeping people healthy' and 'patient-centredness' as well as an objective to actually reduce the cost base of health services.

Change to Text: Add clarification that all aspects of MFTP will be in line with data protection legislation.

3. Defining the Service

Chapter 3 of the Policy Paper examined the issue of services that will be funded under the MFTP and those that will not. The chapter begins by stating that MFTP will be limited to hospital services in the first instance. This was one of the most frequently cited causes of concern with respondents stating that confining the roll-out of MFTP to public hospitals represented a missed opportunity and a major weakness in the plan. While some suggested that an initial roll-out in public hospitals is a logical starting point, others argued that it is crucial that money follows patients to the most appropriate setting from the outset. One respondent went as far as to suggest that implementation should not be considered until it is possible to have MFTP across the entire health system.

Respondents identified a number of problems that would arise as a result of the limited initial roll-out. These examples included:

- causing a distortion in provider behaviour and further incentivising hospital care over

primary care;

- failing to support chronic disease management in the community;
- not supporting the movement of resources to other areas of the health service which may provide the most appropriate setting for care; and
- excluding private providers might be a missed opportunity to provide market tension in achieving medical quality and best value.

Linked to these concerns was the regularly cited point that MFTP must effectively drive integration. It was suggested that the new funding model should be developed in the context of an integrated model of care "all the way into the community". This would help to address the issue of hospital delayed discharges, whereby patients are medically fit, but still require some care that is not available in the community. However, it was recognised that MFTP is not the sole driver of integration and that there are a wide range of issues which would also need to be addressed if integrated care is to be delivered, including: the effective use of information and communications technology (ICT); the appropriate standardisation of care through the use of clinical guidelines; the effective management of resources (particularly in primary care) and the appropriate incentivising of care providers.

A number of areas were also suggested for further roll-out of MFTP in the future. These included: independent hospitals; not-for-profit service providers; chronic disease management; night nursing and end of life care in individuals' homes; health promotion; and prevention programmes.

It was suggested that in the absence of MFTP in primary care at this point, a clear road map of how MFTP will transpose to non-hospital settings should be developed.

Range of Services

The Policy Paper outlines proposals regarding the range of hospital services that will be funded under MFTP as well as those that will not. It is proposed that the MFTP model will initially fund inpatient and daycase activity and comparable outpatient episodes of care (eg. services which might be termed 'side-room' services in private hospitals) with other areas such as Emergency Department (ED), long-term care, outreach services, teaching and research costs, remaining outside MFTP. Respondents made a number of comments in this regard.

There were differing views in relation to the exclusion of ED activity from MFTP with some commenting that the approach was appropriate. However, others suggested that it should be

included and funded in line with activity. Another point made was that the availability of ED in a hospital influences the complexity of the patient group admitted as inpatients and may not be adequately catered for under the DRG system.

An issue was raised with the proposal to consider Medical Assessment Units (MAU) and Clinical Decision Units (CDU) collectively with inpatient and daycase services. It was pointed out that while MAU and CDU activity is currently coded as inpatient, most activity is emergency in nature. For this reason, it was suggested that it may be more appropriate to treat these like ED and exclude them from MFTP. It was also suggested that references to MAU/Acute Medical Assessment Unit/Acute Medical Unit/CDU throughout the document should also include Acute Surgical Assessment Unit (ASAU) as described in the Model of Care for Acute Surgery.

A number of respondents indicated that they agree with the exclusion of outpatient services at this point with some noting that further work would be required in these areas before inclusion in MFTP. However, it was suggested that some outpatient services for routine diagnostics should be included with the service offering. Concerns were voiced that the exclusion of outpatient services along with other services such as long term care and outreach services could lead to a diminution of these services. This is related to a further central point made by respondents that there needs to be complete clarity in relation to how non-MFTP services will be funded. This includes services provided by hospitals but not directly related to their patients such as laboratory tests. The point was also made that hospitals still need to undertake detailed costing work for services that do not fall within MFTP funding.

It was recommended that the approach taken needs to be consistent with minimum benefits regulations and should not increase the cost base of private health insurers by expanding the scope of services required to be covered. However, another respondent advocated an approach whereby all activity, including side-room procedures, should be coded, assigned a DRG code and billed under MFTP.

Change to Text: Add reference to Acute Surgical Assessment Units where appropriate.
Change to Text: Add text to clarify that non-MFTP funded activity in hospitals will continue to be block funded.

Range of Hospitals

The Policy Paper recommends that we move away from the current hospital categorisation

system. No objections were raised to this proposal with some respondents explicitly supporting to the move. However, one respondent added a note of caution and suggested that there is a need to better understand the implications of eliminating hospital categories and creating hospital groups in order to assess the financial impact and identify any potential unintended consequences.

Efficiency and Quality – Encouraging Care in the Right Setting

The Policy document emphasises the need to ensure that services are treated on a 'like with like' basis in order to avoid problems such as gaming and cost shifting, and in order to support the provision of care at the lowest level of complexity that is safe, timely and effective, including, ultimately, the provision of more care in the community.

Respondents supported the move to ensure that services are defined by reference to the episode of care rather than the setting. However, one respondent pointed to evidence from other jurisdictions which shows that setting national prices independently of the setting in which care is provided, can be a very challenging task. This was identified as being a particularly important issue because settings impact on what is covered by minimum benefit regulations and therefore by private health insurance companies. A minor textual amendment was suggested to further describe the role of the National Clinical Effectiveness Committee.

Change in Text: Further describe the role of the National Clinical Effectiveness Committee.

Classification System

The Policy Paper proposes that the HIPE system, currently used by hospitals, would be maintained as the standard classification and coding system upon which future universal prospective payment systems will be based.

There was recognition among respondents of the need for an efficient, timely, accurate, auditable coding and grouping solution and no alternatives to the HIPE system were specified. However, a number of concerns were voiced about the system with one respondent claiming that it was not "fit for purpose" and another stating that the introduction of MFTP brings a new focus on the need for a more robust patient information system. Examples of the concerns expressed included:

- Accuracy of coding is an issue;
- Certain activities and specialties cannot be easily coded;
- The IT system requires an overhaul;

- There is a need for more trained HIPE coders;
- There is anecdotal evidence that some services, such as preventative care, are provided but not coded;
- It is not clear that clinical coding processes/systems are developed enough in all hospitals to base a funding system on the data produced; and
- Data quality needs to improve and consultant input is required in agreeing DRG codes and improving case classifications.

Delays associated with coding of activity were also highlighted by a cross-section of respondents as a serious barrier to implementation of MFTP. The expansion of coding to new areas, such as outpatients, was seen as putting more pressure on already stretched coding resources.

A number of suggestions were made in relation to the future for the HIPE system:

- HIPE data should be the basis for coding of private as well as public patient activity in public hospitals;
- A standard coding system should be introduced across all hospitals but this will require significant change in the private hospitals;
- Clear and transparent information should be available as to how HIPE data is collected, measured and verified;
- Consultants should have an oversight role to ensure accuracy of coding; and
- While some areas will be outside of MFTP, they should still be coded in HIPE.

MFTP was also seen as offering an opportunity to protect and improve other areas such as the functionality of the National Cancer Registry, through a comprehensive approach to linking information technology development, real time data capture and audit.

Other Data Issues

Respondents made a number of points in relation to the collection, access and availability of data. Several respondents highlighted the need for the introduction of a system of unique patient identifiers and a single repository for all health data which can be accessed by appropriately authorised parties. It was suggested that the proposal to manage the HIPE dataset as part of the overall health dataset rather than as a stand-alone entity which, in their view, is significantly under-exploited at present, would help to widen the use of HIPE data.

It was recommended that the Pricing Office and the Healthcare Commissioning Agency (HCA) should be able to access all data they require to carry out their functions. It was noted that this may require legislative change. It was stated that insurers will need access to the data used to develop prices "at an early stage in order to model and understand the downstream effect on the private health insurance market". One respondent also pointed to the need for insurers to have access to more data in order to assess claims. This would include "complete details regarding all diagnoses and procedures associated with an admission and the relevant ICD-10 codes will be required in order to confirm that the claim is consistent with the DRG claimed and payment made".

However, not all respondents were comfortable with the wider availability of data. Serious data protection concerns were voiced by one respondent who stated that all patients should be able to limit access to their medical record to only those who are involved in their care. It was proposed that no other party should have access to patient files without informed consent. Another respondent said that issues relating to confidentiality and the secondary use of data will need to be addressed through the Health Information Bill.

Change to Text: Include reference to the importance of confidentiality, data security and integrity and the key role of the forthcoming health information legislation in this regard.

Grouping System

The MFTP Policy Paper proposes that the existing AR-DRG grouper should be the starting point for MFTP in Ireland, but that it should be reviewed so that services are defined without reference to the setting, to the greatest extent possible.

Respondents agreed that the DRG grouper system should be reviewed. It was suggested that work is required to refine the DRGs because some groupings do not accurately reflect the resources used. One respondent pointed out that the variety of costs associated with different procedures under one DRG causes some risks. For instance, if the pattern of treatment shifts from one year to the next (shift to a more straightforward procedure to take advantage of higher reward) this could be inflationary even within the same overall capacity. A number of stakeholders pointed to the need for on-going consultation in relation to DRGs with one stating that they support "on-going discussion, dialogue and evaluation of DRGs to reflect changes in technological and resource inputs". It was proposed that detailed and technical consultation take place with private hospitals so that common or linked DRG-based systems for both public and private hospitals can be introduced within a relatively short time-frame when it comes to implementing UHI. It was also suggested that that the review should result in the coding of all activity in side-rooms with DRGs and associated billing.

The move to base private patient charges on DRGs was also supported in order to have charges that more accurately reflect the cost of patient care.

Boundary Issues

The Policy Paper states that the episode of care under MFTP should begin at the point of admission and end when the patient is deemed medically fit for discharge. However, it recognises that boundary issues, such as that between acute care and step-down or long-term care, will require careful consideration.

Respondents concurred with the view that there is a need to clearly articulate the beginning and end points of treatment. However, it was commented that there remains a lack of clarity in relation to who will pay for treatment following discharge. It should be noted that there was considerable overlap in the views expressed in relation to boundary issues and the plans for an outlier policy. Further discussion of these issues can be found in the "Designing the Price" section below.

Change to Text: Include text to clarify that existing arrangements will apply to non-MFTP funded areas of the health service.

Mental Health

The MFTP Policy Paper recommends that while mental health care should not be initially included, the MFTP system should transition towards its inclusion. Respondents recognised that there are particular challenges associated with including mental health within the MFTP system. However, there was support from a number of respondents for the inclusion of mental health within MFTP at a later stage. This should follow consultation with stakeholders. It should be noted that an argument was also made that mental health should not be excluded at any point.

4. Designing the Price

This chapter considers the design principles which should underpin the determination of prices. It offers recommendations on the basis for setting price, the overarching methodology for calculating price, and the treatment of various costs when calculating price.

A number of respondents made comments relating to the need for prices to take into account the level of complexity at the patient level and to appropriately reimburse hospitals for the cost of the care provided. A respondent also suggested that the price must also reflect hospital costs incurred historically to provide a high level of service and be commensurate with the standard of accommodation provided.

It was recommended that the system to define pricing and activity levels should be fully transparent and open to public scrutiny. Stakeholder involvement in the establishment of prices was also seen as essential.

It was also mentioned that clarity is needed in relation to how private fees will be calculated in the future and that any regulatory change which causes a significant increase in prices could destabilise the private health insurance system.

Setting the Price – On What Basis?

This section of the Paper outlines the policy options for setting the price. It proposes that prices should initially be set by reference to average costs but with a view to implementing best practice prices on an incremental basis.

Differing views were offered by respondents in relation to the use of best practice versus average prices. Some responses recommended the use of best practice pricing from the outset. It was suggested that "the new system should examine and understand how the most efficiently priced, best practice DRG services are provided in order to educate and incentivise less efficient hospitals to improve". However, others acknowledged that it was not possible to roll-out such a system now given the difficulties and time required to achieve consensus on what constitutes best practice, but supported a move to best practice pricing in the longer term. There was support for the use of the median average because experience suggests that this approach drives efficiencies. It was also commented that insurers have a wealth of knowledge of best practice pricing from their experience with private hospitals and should be given the opportunity to contribute at an early stage.

Weaknesses which were identified in relation to average pricing include:

- The average price will not reflect the level of patient service currently provided and the higher cost base in hospitals that relate to the historic development of services which were required as a level 4 hospital.
- DRG reimbursement does not adequately reimburse the hospital for certain high cost service provision.
- It is not clear how average cost pricing can accommodate patients suffering from more than one illness which increases the complexity of care.

Setting Prices through Negotiation

It was commented that a system of fixing prices, either through average or best practice pricing, would greatly limit the scope for purchasers to use market forces to achieve better

value for money. Linked to this point was the support from a number of respondents for the adoption of a different approach to price setting whereby purchasers negotiate all-inclusive prices for care with individual providers. It was pointed out that such a procedure based pricing approach, also known as 'fee for service', is already in use in private hospitals in Ireland and working 'packaged price' lists for surgical elective treatments have been in place in public hospitals since 2011. However, it was highlighted that a key risk with a market-based approach is ensuring the delivery of quality medical care. Such quality issues could arise as a result of providers achieving lower prices by virtue of sub-standard practices or other changes that would potentially worsen outcomes for patients.

Calculating the Price – Overall Methodology

The Paper considers the merits of direct price setting through tariffs versus indirect price setting. Following consideration of the options it recommends introduction of an indirect price setting mechanism which uses relative weights. No objections to this approach were raised by respondents.

Treatment of Costs

This section of the Paper considers the elements of pay, non-pay and other costs, which are to be included in the calculation of the cost of care on which the price will be set. Respondents agreed that accurate cost data is essential and made a number of arguments in relation to the various inclusions and exclusions proposed. One respondent argued that the "overarching principle to be applied to costing should be to ensure that the appropriate medical care is undertaken in the appropriate setting, based on the consultant's determination of what is medically necessary". The need for transparency in the treatment of costs was also emphasised.

It was suggested by respondents that costs associated with the Clinical Indemnity Scheme be excluded from the DRG price in order to incentivise the management of such costs and that it should instead be funded separately by the Department of Health.

Concerns were voiced that any move to exclude teaching and research from the calculation of cost may lead to a reduction in funding for these areas or a shift in cost towards academic institutions. Either outcome was considered undesirable by respondents. Issues were also raised about the practicality of extracting these costs given the absence of a methodology to do so and the integrated nature of teaching, research and patient care. It was suggested that teaching services should not be viewed as one block with a respondent commenting that "there is undergraduate teaching which, arguably, should be separately funded. However, postgraduate teaching is a synergistic process with service in which considerable service input is provided by trainees who also receive education. As we move away from the apprenticeship model and shorter training, more resources will be required for education and teaching. However, they will continue to provide service input while receiving training through service which may be delivered less efficiently". It was commented that research

costs should be easier to strip out than teaching costs as they can be isolated from hospital operating costs. Any methodology for extracting these costs needs to be agreed with hospitals and, should either or both areas be excluded, there is a need for clarity on how they will be funded in the future.

The intention to reimburse unique costs separately and potentially use top up payments to compensate for different costs associated with structural differences was described as reasonable.

It was stated that pay costs must factor-in more than annual salary in order to be accurate and that DRG costs are usually constructed to exclude medical professional charges. It was recommended that consultant costs continue to be excluded in the calculation of private charges under the DRG system.

Respondents differed in their views regarding the proposal to exclude capital, depreciation, bad debts and superannuation from the calculation of costs under MFTP. One respondent offered the view that given the average cost must reflect the true cost of providing the services, all costs, including those listed above, must be included in line with private hospitals. It was also suggested that "the ability of the system to identify optimal cost-effective care and to compare the cost-effectiveness of care in different settings (primary vs secondary care) may be compromised by these exclusions, leading to inappropriate decisions". Another respondent stated that, while it is understandable to exclude the items at this stage, they will probably have to be included under UHI.

There was support from a number of parties for the exclusion of high cost drugs. However, the need for detailed operational policy/guidelines on the use of such drugs to control expenditure was highlighted.

Other comments related to the treatment of costs included:

- It is important that excluded areas are accurately costed and funded;
- Excluded items should be kept under review as we move to Trusts; and
- Consideration of additional payments needs to be taken into account where the location of hospitals is remote or disadvantaged or there is a requirement to ensure delivery of a particular type of service such as paediatrics.

Outlier Policy

The Policy Paper advocates an outlier policy based on average lengths of stay with additional payments explicitly linked to medical necessity and not inappropriate delays in leaving hospitals. It states that, ultimately, once a patient is deemed medically fit for discharge, no payment should apply for any further days spent in the hospital setting.

There was acceptance by a number of respondents of the need for a robust outlier policy to include additional reimbursement, provided that the medical necessity for the extended stay is established and supporting documentation is provided. However, it was recommended that the policy should be combined with an approach that allows for no reimbursement for a number of days when the average length of stay is exceeded. Such an approach is already in place in agreements between insurers and private hospitals. Another respondent recommended an outlier policy based on best practice lengths of stay. Concerns were voiced that the outlier policy could encourage hospitals to discharge patients earlier than is appropriate and that steps must be taken to ensure that the system does not incentivise such behaviour.

A number of responses argued that it would be unfair to penalise hospitals for delayed discharges when the delay is not due to the performance of the hospital in question. Such a situation could arise when a patient is medically fit for discharge but no step down bed or community service is available. Respondents highlighted the need for guidelines in relation to this issue so that there is clarity for both providers and purchasers. Hospitals suggested that they should be reimbursed for delayed discharges that are outside of their control and this should be factored into the outlier policy. This could come in the form of 'per diem' payments.

Change in Text: Clarify that hospitals will continue to be reimbursed for patients medically fit for discharge in the near term when delays in discharging are beyond their control. The payments will be in line with a protocol to be developed.

5. Governance Structures

Chapter 5 of the Policy Paper introduces proposals in relation to the governance structures and governance processes for MFTP. As a general comment, one respondent stated that while there is excellent detail on some of the governance structures, greater clarity in relation to the governance arrangements to apply in areas such as the defining of best practice, quality standards and the value of innovation would be welcome.

Interim Functions to be Delivered

This section outlines the functions to be delivered under MFTP relating to price-setting and

purchasing.

One respondent suggested changes to Table 4 in order to reflect additional skills that are already in existence within the system that would be of benefit under the new funding model. It was stated that agreeing price and volume contracts and claims management has been a key component of how the NTPF has operated in relation to working with both private and public hospitals. This includes: (a) prospective ordering for individual patients; (b) hospital pricing negotiation process/maintenance of hospital pricing agreements and contracts; (c) a national public hospital elective treatment price list; and (d) tracking, administration and payment of individual claims/patients.

Change in Text: Incorporate text outlining the prospective ordering and claims administration skills held in the NTPF.

Structures for Delivering Interim Functions

The Policy Paper recommends that the price-setting function should be independent of the purchasing function in order to ensure the integrity of the process and garner support and buy-in from the hospital system. It envisages that the price setting function would be absorbed into a National Information and Pricing Office (NIPO) with the purchasing function being built up from within the HSE. This single, national, interim purchaser will act on an administrative basis prior to the establishment of an independent statutory commissioner.

Respondents were supportive of the separation of pricing and purchasing functions. The need for clear governance structures, accountability and transparency was emphasised with an overarching governance structure to include representatives from hospitals and the commissioner of services recommended. The requirement for legislation to underpin the new structures was highlighted.

There was also support for the establishment of the NIPO. However, it was mentioned that further thought needs to be given to the inclusion of the information function in the NIPO. It was suggested that there are two distinct roles and "while information is required for pricing, pricing does not need nor should it be distracted by the full range of information required to support all aspects of the health system". It was also suggested that it may be more appropriate for HIQA to produce the Medical Data Dictionary than the NIPO. The Australian Medical Data Dictionary was identified as a useful starting point in this regard.

It was recommended that more clarity be brought as to how the HCA will operate, including

whether it will be a national or regionally based operation. It was also suggested that there should be only one interim purchaser and as such the NTPF should be brought into the new purchasing agency.

Overview of Governing Process

This section of the Paper outlines the closed loop governance process that will underpin the flows of funds under MFTP. It also focuses on the processes aimed at retaining strict cost control over the system which includes the agreement of capped cost, volume and quality contracts with each public hospital group.

Several respondents warned of the need to ensure financial control and to avoid unnecessary increases in activity under the new funding system. Supplier induced demand was identified as a serious threat to financial control with the experience of the private health insurance market in recent years cited as an example of how cost can rapidly escalate.

A purchase ordering system was recommended to further strengthen control over the volumes of patients treated and funded. This would involve orders being placed and then matched to funding, thereby decreasing risks. Such a system would also help the purchaser exercise a degree of control over the location of the medical treatment. Another initiative to increase control, recommended by a respondent, involves the linking of the booking/administration systems in hospitals with the HCA financial control system. This would help to flag when further admissions were likely to exceed budgets.

It was also recommended that consideration be given as to how costs will be controlled, particularly under a UHI system with multiple insurers and multiple hospital providers.

Agreeing Performance Contracts

The Policy Paper outlines how the HCA will purchase services through the agreement of capped cost and volume contracts with providers.

Respondents agreed with the need to have clearly set out capped costs and volumes. However, it was recommended that service targets be based on a realistic assessment of the likely number of patients as opposed to being rationed to fit budgets. Two hospitals pointed to the need for the performance contracts to take account of hospitals with high levels of emergency work which may drive demand beyond the level of activity allowed as well as a mechanism for funding such activity. Another hospital pointed to the practical issue of the lack of expertise in contract negotiation in the hospital system.

Submission and Approval of Claims and Management of the Payment Process

The Policy Paper stipulates that payment for agreed activity would be contingent on the submission of completed claims to the HCA. The submission and claims would be facilitated through a fully integrated and electronic process and hospitals would be encouraged to achieve a maximum of seven day turnaround time from date of discharge to date of claims submission. The Policy also states that in the initial phased implementation years, submission of claims might consist of directly transmitting HIPE data using the web portal.

Respondents pointed to the need for sophisticated electronic claims management systems in order to be able to support the proposed process, achieve the seven-day turnaround target and allow an efficient claims adjudication and auditing process. The ICT system will require integration between HIPE and financial systems as well as integration with the commissioning agency. However, it was pointed out that even with the ICT systems, the seven day turnaround time will represent a significant challenge for hospitals given that their current average is over ninety days. One solution suggested by a respondent was to allow electronic sign-off of claims in parallel to the submission of invoices to the commissioning agency. The absence of expertise in claims management, as envisaged in the Policy, was identified as a barrier to implementation and outsourcing was highlighted as a possible solution. A specified turn-around time for the HCA that matches the suggested time for hospitals was also seen as being required.

One respondent stated that there are likely to be significant data gaps when HIPE is used as a claims processing production system as proposed for the interim solution. Therefore, a data analysis exercise to ensure all the necessary data is captured to process the claim was seen as an essential pre-requisite.

Financial Reporting and Troubleshooting

This section of the Paper described how the HCA will make payments based on pre-agreed activity targets and prices and on receipt of submitted claims. There is a focus on how the HCA will project and monitor expenditure over the year and avoid cashflow problems at hospital level.

Respondents agreed with the need to clarify how the new funding model will affect cashflow management for hospitals, particularly during the transition phase, and make provision for this. They again pointed to the need for efficient electronic claiming and reimbursement processes to ensure that the lag time in the claims process is reduced so that cash flow challenges are minimised. The provision that long lengths of stay patients will only be reimbursed after discharge was seen as problematic from a cash-flow point of view. It was suggested that reimbursement based on “spells of care” could be an alternative. The time taken for post-operative medical care and completion of checks and balances before payment

is made was also highlighted as impacting on cash-flow. One respondent identified the management of a MFTP system within a "Voted" disbursement of funds as being a key challenge.

Innovation and Feedback Loop

The Policy Paper acknowledges the need for further detailed deliberation and consultation on issues relating to specific payment measures aimed at supporting innovation.

Respondents were concerned about the potential for the new funding model to have a negative impact on innovation. It was stated that "average price reimbursement may discourage hospitals from engaging in service developments as funding may not reflect increased costs incurred". In order to address this, one hospital suggested that a process for discussion and agreement on innovation related costs be established. It was also suggested that the work of the National Centre for Pharmacoeconomics be referenced in relation to the initiatives that must be taken into account when considering whether supplemental payments should be provided in respect of innovation.

Change in Text: Include reference to the National Centre for Pharmacoeconomics in relation to the initiatives that must be taken into account when considering whether supplemental payments should be provided in respect of innovation.

Quality and Regulatory Mechanisms

The Policy emphasises the need for strong regulatory mechanisms to support the delivery of quality services and combat the unintended consequences and perverse incentives that can be associated with DRG systems. It also outlines the regulatory measures which should play a critical role in supporting effective management and good governance of the system: integrated performance management systems; auditing; contracting process; and structured consultation and continuous updating of the system.

Respondents agreed with the idea that the funding system should be underpinned at the outset by quality guidelines with effective regulation and quality monitoring mechanisms including targets. However, some remained concerned about potential negative consequences for quality arising from MFTP. Evidence from other countries was cited regarding reductions in quality which resulted due to providers being overly focused on efforts to keep costs down and stay within the fixed prices. Concerns were voiced that the desire to reduce lengths of stay and treat more patients could shift the focus to finalising episodes of care quickly, without taking the time to adequately address chronic diseases. Another respondent warned of the need for robust clinical involvement and respect for the quality of patient care.

It was suggested that the quality targets should incorporate preventative services agreed under the HIQA National Standards for Safer Better Healthcare. However, it was emphasised that corporate targets should not be used as quality indicators. One respondent pointed to the significant international evidence which shows that a focus on quality is likely to promote greater efficiency and use of resources in addition to improving quality. The interface between MFTP and the clinical programmes was seen as providing opportunities to enhance quality and quality assurance.

Respondents agreed that steps, such as a clear set of ground rules, will be required in order to address unintended consequences and perverse incentives resulting from MFTP. Unintended consequences identified in responses included supplier induced demand and a move away from a focus on prevention or treatment in the community. One respondent stated that some perverse incentives could be addressed by ensuring that hospitals are not reimbursed for readmissions for the same condition within 30 days as well as hospital acquired infections. It was also stated that adequate governance and oversight will be required "to ensure certain financial rewards and penalties identified in the document are fair, equitable and do not lead to distortions in how care is provided".

6. Implementation

Chapter 6 of the Policy Paper identifies the building blocks required to translate the MFTP Policy into practice as well as mapping out the first steps in the journey and the implementation timetable.

Implementation Timetable

The Policy Paper recommends the introduction of MFTP in shadow form during 2013 ahead of full phased implementation from January 2014. This was one of the areas of greatest concern among respondents.

The proposed timelines were described by some respondents as "ambitious" and "challenging" given the massive change that it represented. However, other respondents identified the timetable as a major concern with some going so far as to regard them as "unrealistic" given the level of groundwork required. One response from a hospital suggested that the funding model should not be implemented until historic funding deficits in hospitals are addressed. It was also suggested that in order to meet the deadline of beginning implementation in 2014, shadow pricing would need to begin six months earlier.

Issues identified as being particularly problematic included dealing with coding deadlines and the absence of fully developed structures to measure quality. One respondent stated that the Policy should not be put into operation until there are strong, effective internal processes in

place. More detailed comments on resources and infrastructure issues are outlined below.

The timing of the roll-out was also seen as a difficulty because it represents another layer of change in the system which is already dealing with a massive programme of reform. One respondent said that there are significant risks associated with trying to roll out a new funding model while managing the transition to a new hospital group structure that comprises multiple sites. A clearer picture of the current and future landscape of how services will operate was described as being essential prior to introducing this policy. One hospital stated that the 2014 deadline was unrealistic for them and suggested a phased approach in accordance with the differing stages of organisation development.

A number of suggestions were also offered in relation to how the new model could be trialled:

- Use the eight cancer centre hospitals in Ireland to assess the state of readiness and to encourage at least two of the centres to begin a test basis process towards the end of this year. It would also be necessary to engage at the start with paediatric and maternity units to ensure that we achieve a full range of hospital services from the beginning.
- Trial the model in an area of complex chronic disease management prior to full roll-out.
- Extend the current successful orthopaedic project to a range of high cost procedures such as cardiology.

One respondent highlighted the need for the private health insurance market to be given sufficient time to develop and to negotiate the new reimbursement system with hospital groups.

Hospital Readiness

Hospital readiness for MFTP, particularly in the areas of staff resources and IT, was another area of great concern to respondents. Several respondents noted that the hospitals will not be starting from the same position in terms of resources, systems and processes and concerns were voiced that some hospitals would be left behind as a result. It was suggested that this will need to be managed with steps taken to address imbalances during the transition to MFTP.

It was suggested that the availability of appropriately skilled staff in the various agencies and hospitals is a critical success factor for MFTP. It was also noted that the hospitals will only

be able to compete on an equal basis if they are given the resources to do so. It was proposed that a first step to address this would be to undertake a hospital level analysis of the state of readiness to act as a gap analysis. It was predicted that such an exercise would disclose particular shortfalls in the areas of coding, general administration, finance (particularly patient level costing), negotiation and claims management. Training for all involved in the new system was also seen as crucial.

ICT infrastructure was another major hospital readiness concern and risk for respondents. Responses pointed to the need for major investment in systems capacity at the hospital and central level in order to address deficiencies and for MFTP to operate successfully. The requirement for integration of the various systems was also noted. It was recommended that the difficulties associated with the roll-out of such infrastructure should not be underestimated. Patient level costing systems were also highlighted as being of particular importance due to the crucial role they play in assisting hospitals to understand their costs.

It was pointed out that the hospital groups will also be differ considerably in terms of composition due to the different hospitals included in each. It was suggested that this may need to be reflected in the approach to reimbursement.

Respondents said that public hospitals and private hospitals will be starting from different positions, each with their own strengths and weaknesses, advantages and disadvantages. For instance, public hospitals have many of the key building blocks for MFTP that are not in place in private hospitals. However, private hospitals have experience of implementing and complying with the comprehensive payment ground rules that underpin the payment made to private hospitals in a way that public hospitals do not.

Change in Text: Include reference to a hospital level analysis of ICT, processes and staff resources required for MFTP.

Other Risks

Respondents also outlined additional risks that they associate with implementation of MFTP.

A number of respondents saw particular risks for smaller and rural hospitals from the MFTP system. One response said that "hospitals serving relatively remote areas with low population densities may not have sufficient volumes of activity to maintain revenue and thus may require a different funding model". It was also stated that a roll-out focused on the hub hospitals could create significant incentives to undertake activity in the hub at the expense of

other hospitals. Another respondent with similar concerns said that measures should be put in place to ensure that such hospitals are not placed at a disadvantage.

Significant potential risks for the private health insurance market during the transition phase, in particular between prices being set and becoming applicable to private patients were also noted in a submission.

Project Planning

Respondents made a number of suggestions in relation to planning for the implementation of MFTP. Several highlighted the need for a detailed project plan, highlighting realistic and achievable short and medium term goals, milestones and a critical path. Establishment of a project team to progress MFTP was recommended. Other planning related recommendations included (i) development of a detailed business case to support implementation showing itemised costs and benefits over a number of years; (ii) a Health Impact Assessment of the proposals; and (iii) a risk assessment.

7. Next Steps and the Journey Ahead

Consultation

The Policy Paper acknowledges the crucial role that communication and consultation will have in implementing MFTP.

The need for effective communication with stakeholders was frequently cited by almost all respondents in order to achieve buy-in. It was suggested that the communication plan should be aimed at all levels of health sector employees, primarily in the hospitals but also other affected areas of the service.

A clear message from many of the respondents was that consultation with stakeholders is essential. There was some criticism of the lack of engagement to date. It was recommended that all relevant stakeholders be included in a process during the planning, management and implementation phases of the system. Examples of stakeholder groups identified included: hospital management; clinical staff; administrators; patients; and private health insurers. Consultations should be broadened to include information sessions and workshops to engage the public and patient representatives in a meaningful way.

Future Evolution of Policy

This section of the Paper highlighted the need for further policy development aimed at developing a new integrated model of care which treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. The development of such policy was seen as crucial by several respondents who identified integration as

necessary to delivering better care.

Appendix 1 – List of Submissions Received

Organisation/Name
Age Action Ireland
Alzheimer Society of Ireland
Children's University Hospital, Temple Street
Galway and Roscommon Hospital Groups
Health Information and Quality Authority
Health Insurance Authority
HSE Information Executive Group
HSE Prevention of Chronic Disease Programme
HSE Tobacco Control Framework Implementation Group
IMPACT
Independent Hospitals Association of Ireland
Irish Cancer Society
Irish Heart Foundation
Irish Hospice Foundation
Irish Hospital Consultants Association
Irish Medical Organisation
Irish Nursing and Midwifery Organisation
Laya Healthcare
Mater Misericordiae University Hospital
Mid-Western Regional Hospitals Group
National Cancer Control Programme
National Cancer Registry
National Treatment Purchase Fund
Ms Norrie Neary (x3)
NUIG College of Medicine, Nursing & Health Sciences
Royal College of Physicians of Ireland
Royal College of Surgeons in Ireland
St. James's Hospital
St. Vincent's University Hospital
VHI Healthcare