Activity Based Funding (ABF) – Good in principle but harder in practice in the private sector

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Dr Brian Hanning
Medical Director
Australian Health Service Alliance (AHSA)

Australian Health Service Alliance

Introduction

- A robust Activity Based Funding (ABF) Model should:
  - Be driven by clinical considerations
  - Be based on an appropriate classification system e.g.
    - Acute care type - DRGs
    - Overnight rehabilitation - AN-SNAP
  - Relative Payments - based on up to date clinical costing studies
  - Changes in payment rates at boundary or step down points based on National LOS
  - Promote the balance between clinical care and financial efficiency
  - That is fair to funders and providers and that results in fairness to members/patients

- Increasing acceptance of these principles over the last twenty years
  - In both public and private sectors

The Public and Private Sectors Differ in Significant ways

AREA	PUBLIC	PRIVATE
Costing and LOS data by year	Readily available	Variable
Payment model and payment rates	Set by Jurisdictions	Negotiated between funder & provider

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Costing data

- **Private & Public**
  - both use relevant National Hospital Cost Data Collection (NHCDC) data

BUT

- **Private sector**
  - NHCDC participation is voluntary
  - Prostheses and doctor costs not relevant to private sector ABF models
  - Some years with no private sector NHCDC
  - Delay in NHCDC studies in newer DRG version availability
    - 5 year delay after both ARDRGv5 and ARDRGv6 introduction before results released

LOS Data

- Used in different ways in different models to set step down or boundary points

- **IHPA** uses national public sector data
- **Private sector** funders vary
  - **AHSA** uses national private sector data because
    - AHSA does not have large sample sizes in all important DRGs
    - Multistate groups increasingly common
    - All hospitals should have same step down points
  - Step down points based on statistical analysis of LOS by DRG
    - all private sector separations based on a record by record
    - Obtained through AIHW - de-identified by person, hospital and state
    - Permission from all jurisdictions needed to release data

Payment Model Parameters

- **Both Costing** and **LOS** data are essential:
  - To derive relative weights and step down points
  - Must be from same period
  - Comes currently from two different sources

- It can take some time to access data
  - AHSA first derived parameters for ARDRGv6x in early 2014
  - No earlier private sector NHCDC results released in any ARDRGv6 version
  - No private sector NHCDC based on ARDRGv7 has been released

Implementing ABF in the Private Sector

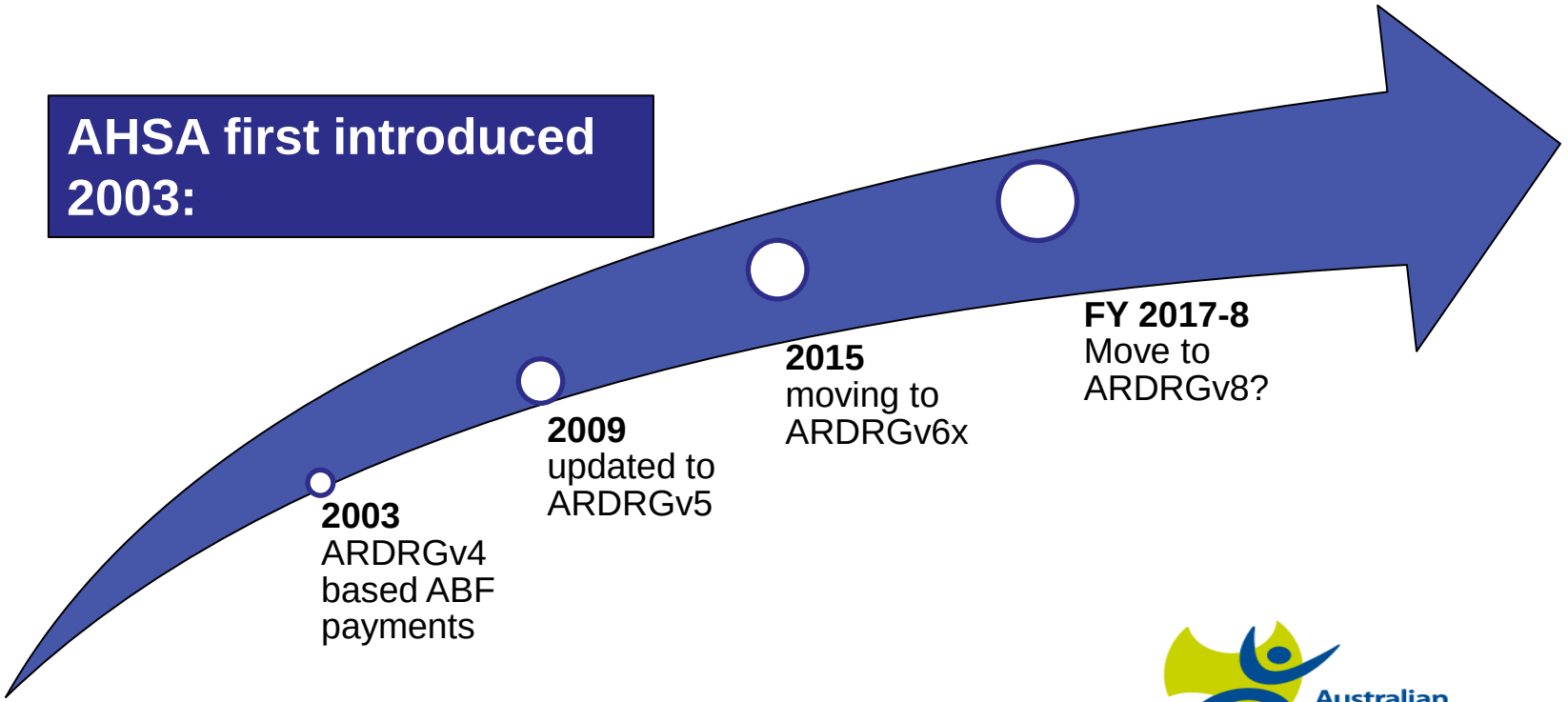
- A robust set of payment model parameters is necessary to introduce an ABF model into the private sector

AND

- Introduction must be by negotiated agreement
  - Different to the public sector

- Agreement to implement ABF is not always reached
  - Multiple attempts may be necessary

Updating ABF in the Private Sector



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Updating ABF in the Private Sector

- Approaches made to hospitals on ARDRGv4 to convert to ARDRGv5 about 2009. There was mixed success
- AHSA is now trying:
  - To move some hospitals from ARDRGv4 to ARDRGv6x
  - Other hospitals from ARDRGv5 to ARDRGv6x

- Change of ABF classification version must be by negotiation

Updating ABF in the Private Sector – Case Payments are a particular problem

AHSA

- Introduced accommodation case payments (ARDRGv4) in 2000
- As LOS fell in the early 2000s attempts were made to modify the case payment parameters
  - Hospitals did not want to reduce the basis payments e.g. if they were based on a 10 day average they wanted to them to stay based on 10 days even when LOS fell substantially
  - This is very different to the public sector where parameters are revised regularly
- Given this AHSA has stopped introducing case payments
- Other private sector funders have experienced similar problems

Some other differences between public and private sectors

- No private sector equivalent of NEP
  - Prices are negotiated on a contract by contract basis
- No private sector equivalent of annual output indexation used by IHPA
  - Increments negotiated on a contract by contract basis
  - Often in a multi year agreement
- Typically added payment in the private sector for private rooms
  - These are in addition to ABF payments

Suggested Future Actions

- Rigorous private sector NHCDC studies
  - Timely use of up to date DRG versions
  - Quicker access to results may increase participation in NHCDC

- Improved access to private sector deidentified LOS data by case –
  - Jurisdictions' permission to release can be slow
  - Could AIHW have delegated authority to release such data?

- Cessation of support for backward mapping into old DRG versions would help movement to new versions
  - Also would resolve increasing anomalies found as extent backward mapping grows

Conclusions

- ABF has much to offer the private sector
- Data necessary to construct robust ABF models is harder to access in the private sector
- Always be necessary in the private sector to negotiate:
  - Introduction of models
  - Updating of models

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- Any Questions?

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