ABF PRICING FRAMEWORK FOR THE 2022 PRICE LIST

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

CONTENTS

ABBREVIATIONS AND ACRONYMS

ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AR-DRGs	Australian Refined Diagnosis Related Groups (also referred to generally as DRGs)
COVID-19	Coronavirus disease 2019
ED	Emergency Department
HIPE	Hospital In-Patient Enquiry Scheme
HOP	HIPE Online Portal
HPO	Healthcare Pricing Office
HSE	Health Service Executive
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICS	Irish Coding Standards
IHPA	Independent Hospital Pricing Authority
NSP	National Service Plan
NTPF	National Treatment Purchase Fund
OPD	Outpatient Department
PLC	Patient-Level Costing
SLRON	Saint Luke's Oncology Radiation Network
SNOMED-CT	Systemised Nomenclature of Medicine for Clinical Terms

1. INTRODUCTION

This is the first Pricing Framework produced by the Healthcare Pricing Office (HPO). It describes the strategic approach to developing the Activity Based Funding (ABF) pricing model and Price List for 2022 and will be reviewed and published on an annual basis.

This year's Pricing Framework provides a starting point for broader regular stakeholder engagement in the pricing model. For the next annual cycle, the HPO will undertake a consultation process starting in 2023 to inform development of the Pricing Framework for ABF Price List 2024. This will enable stakeholders to provide input into the pricing model and future ABF policy directions. This consultation will be undertaken annually.

1.1 ACTIVITY BASED FUNDING IN IRELAND

ABF is an approach which sees providers funded in line with the activity that they undertake. Prices are set for the combination of diagnoses and procedures which occur in an episode (described as a DRG) based on the actual cost of providing services, taking into account patient complexity, and hospitals are funded based on how many patients they treat. The goal of ABF is to increase transparency in funding, to encourage efficiency, value for money and sustainability, and provide greater accountability for the way money is spent. It can also increase hospital autonomy to deliver care in the most appropriate, localised way, by separating out the roles of funder and healthcare provider, allowing service managers to allocate their budgets based on real levels of patient care and informing strategic decision-making.

The Government committed to the introduction of ABF in 2012. In 2014 the HPO was established within the Health Service Executive (HSE) to set the national DRG prices on which the ABF system is based and manage the Hospital In-Patient Enquiry (HIPE) system. Since then, it has worked with hospitals and Hospital Groups to support the implementation of ABF across the Irish hospital system, guided by ABF Programme Implementation Plans. In 2018 the Government committed to the ongoing implementation and expansion of ABF in the Sláintecare Implementation Strategy. The Sláintecare Implementation Strategy committed to expanding ABF to other parts of acute services, significantly increasing the ABF proportion of hospital budgets and examining the use of ABF for outpatient services.

The ABF Programme Implementation Plan 2021-23 sets out a series of actions for the Irish health system which will enable the ongoing implementation and expansion of ABF by embedding and further developing ABF; improving data and data collection; strengthening leadership, understanding of ABF and the supporting workforce; and working to support a broader policy context. This document should be read alongside the ABF Programme Implementation Plan.

1.2 PRICING FRAMEWORK

To date, the focus of ABF in Ireland has been on developing the skills, capacity and infrastructure within the HPO to build a robust pricing approach, and within the hospital system to collect comprehensive, high quality data to support pricing and ensure an understanding and utilisation of ABF. To support this, the HPO has published a number of documents on its website and has shared material with stakeholders which together explain how the price is developed. The Pricing Framework brings together this information in a structured way to provide an overview of the current pricing approach and areas of development for future years.

This Pricing Framework describes the current approach of the HPO in developing the ABF Price List for 2022. It sets out:

- The guidelines which the HPO intends to use to inform its pricing approach.
- The scope of ABF in Ireland and changes being considered.
- The classifications used to describe services and those new classifications being developed.
- The data collected by the HPO for the purposes of ABF and processes to improve data collection and quality.
- How the price is set.
- How the price works within a broader funding context.

- Existing and new policy work being undertaken by the HPO. om next year, through an annual consultation process the Pricing Framework will also give an opportunity for stakeholders across the healthcare system to provide input into the approach taken. This is detailed in the final chapter of this document.

1.3 ABF AND COVID-19

COVID--19 has had a significant impact on the healthcare system and has created major challenges for funding and accounting for new and unknown patterns of healthcare usage and costs . Whilst emergency measures in response to the pandemic have included temporary increases to block funding, ABF and its building blocks have proved essential in providing the information needed to monitor the impact and effects of the disease and make important decisions as to where resources should be deployed and will continue to be critical for health system insights and funding into the future.

Internationally, many public ABF healthcare systems opted to block fund health services for 2021, due to the drop in activity levels and increased expenditure caused by COVID-19. Despite the decision to block fund, these countries still proceeded with their annual ABF processes so that the impact of COVID-19 in terms of the impact on costs and activity could be fully understood. This is to ensure that the data underpinning the ABF process continues to be collected for the future return to normal ABF funding, and to ensure that the commitment to ABF is not undermined by this temporary setback.

In Ireland, while hospitals were funded on a block grant basis for 2021 and will continue to be in 2022 and 2023, ABF activities will continue as usual, including the ABF benchmarking exercise and the calculation of transition adjustments from this process. It is important that we continue to recognise and promote the ABF process as an important tool in monitoring and managing our healthcare system despite the requirement to tactically move to a block grant funding arrangement in response to the COVID-19 pandemic.

2. PRICING GUIDELINES

The mission of the ABF Programme, as stated in current and past ABF Programme Implementation Plans, is:

- To establish and facilitate an evidence-informed system of healthcare resourcing that drives transparency, equity and efficiency.
- To promote stakeholder cooperation and trust, healthy competition and the greater use of quality health data in the Irish health system.
- To improve the health status of service-users by, in time, combining accurate cost measurement systems with the systematic measurement of outcomes.
- To improve patient access to care together with the overall quality and safety of care they receive.

This Pricing Framework sets out a set of guidelines to inform the HPO's ABF pricing approach. It is intended that these guidelines are used to assess the appropriateness of the pricing policy, model and elements supporting them, and to assess the appropriateness of any proposed changes to it.

These guidelines use the Australian Independent Hospital Pricing Authority's (IHPA) ABF pricing guidelines as their basis, adapted to account for Irish health system policy approaches, including the Sláintecare Implementation Strategy, HSE Corporate Plan and the principles and objectives set out in the ABF Programme Implementation Plan 2021-23. The IHPA guidelines have been used as a starting point because of the similarity of approach between the two systems, noting that the HPO is modelled on IHPA, with Ireland adopting the Australian pricing model as a basis for its own, as well as the Australian acute classification system (AR-DRGs).

2.1 ABF PRICING GUIDELINES

Overarching guidelines

- **Timely – quality care:** Funding should support timely access to quality health services.
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across all publicly funded hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.
- **System responsibilities:** Funding design should recognise the complementary responsibilities of each structural level of the health system in funding health services.[1]

Process guidelines

- **Transparency:** All steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Stability:** The payment relativities for ABF should be consistent over time.
- **Evidence-based:** Funding should be based on best available information.

[1] Including but not limited to the DoH, HSE, HPO, Hospital Groups and hospitals.

System design guidelines

- **ABF pre-eminence:** ABF should be used for funding public hospital services wherever practicable.
- **Patient-based:** Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **Price consistency:** Pricing should facilitate timely transition to provision of patient care at the most appropriate, cost-effective service level.
- **Single unit of measure and price equivalence:** ABF pricing should support a flexible approach to provision and models of care across settings and service streams through a single unit of measure and relative weights.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **Promoting value:** Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.
- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.

These guidelines will be reviewed annually, and in future years will be consulted on as part of an annual public consultation on the Pricing Framework.

3. SCOPE OF SERVICES

ABF currently applies to admitted care services in Irish public hospitals.[2] This includes inpatient care (excluding long-term psychiatric and long-term geriatric care) and day cases.

Services provided in the hospital utilising staff and resources from community services are outside of the current scope of ABF, as are private hospitals. Private patients in public hospitals are considered in the same manner as public patients within the ABF process however, an income target is applicable to each hospital in respect of private activity which is netted from their gross budget allocation.

Hospital services out of scope of ABF are funded via block payments.

ABF is in operation at 43 hospitals across Ireland, which account for approximately 90 per cent of national acute hospital activity. Admitted care itself currently accounts for approximately 70 per cent of total acute expenditure on public hospitals.

Hospitals are classified by model, with Model 1 being the least complex community hospitals (operating outside of Hospital Groups) and Model 4 being the most complex, tertiary referral hospitals. All seventeen Model 3 and all nine Model 4 hospitals are funded using ABF, with ten of fifteen Model 2 hospitals currently in scope. Three of four maternity hospitals are in scope. Saint Luke's Oncology Radiation Network (SLRON) is currently out of scope of ABF.

3.1 EXPANDING THE SCOPE OF ABF

In line with the Pricing Guidelines in Chapter 2 and actions under the Sláintecare Implementation Strategy, ABF should be used for funding public hospital services wherever practicable.

Practical considerations include the availability of systems to provide the relevant patient-level activity and cost data required for ABF. In 2021, in line with Sláintecare action 7.1.1 to 'expand ABF for inpatient and day-cases to other acute hospitals', the HPO developed a policy paper outlining the thresholds and considerations for expanding ABF to other acute hospitals. This paper concluded that all acute hospitals should be funded through ABF. This led directly to the inclusion of an additional 5 hospitals in the 2021 ABF process. These were, St Josephs' Hospital, Raheny (included as part of Beaumont Hospital), University Maternity Hospital Limerick, Ennis General Hospital, Nenagh General Hospital and Monaghan Hospital.

Activity in outpatient (OPD) and emergency departments (ED) is not currently within the scope of ABF. The HPO is currently developing new classification systems for both settings. Once these are in place and patient-level data collection has commenced, a timeline for expanding the scope of services and funding activity in these settings using ABF will be developed. This work will also support delivery of action 7.1.3 under the Sláintecare Implementation Strategy, to 'examine the use of ABF for outpatient services'.

Finally, the HPO is giving consideration to how community services can be costed using an ABF approach, in line with action 7.1.4 under the Sláintecare Implementation Strategy. A scoping exercise will be carried in 2021 to determine the range of services to be considered as part of this work and a timetable for progressing this work will to be developed and detailed in a future Pricing Framework.

[2] These are HSE hospitals which are owned and funded by the HSE, and voluntary public hospitals, most of whose income comes from state funds. Voluntary public hospitals are sometimes owned by private bodies, for example, religious orders, or are incorporated by charter or statute and run by boards often appointed by the Minister for Health.

4. CLASSIFICATIONS USED TO DESCRIBE PUBLIC HOSPITAL SERVICES

Healthcare classification systems help to describe the activity that happens in hospitals or other healthcare settings consistently and accurately by providing a standardised language and structure for describing this activity. They typically capture diagnoses, symptoms, interventions, complexities and other characteristics of the patient or care provided.

Classification systems use these rules to translate information from the patient medical record into consistent language so that the results can be organised and measured for performance, management, funding and other purposes. Relevant information in the medical record may be drawn out from clinical information and input into a data collection system by specially trained clinical coders (such as is the case for admitted care), or input directly by clinical or other administrative staff in accordance with the data requirements for the classification system (as is envisaged for the outpatient care classification system under development).

This consistency means that activity and cost data across hospitals can be matched to produce an average cost, and in turn a price, for each episode or other class of care under ABF.

The HPO is responsible for managing the classification systems used for ABF, recognising that these will also have utility beyond hospital funding.

4.1 ADMITTED ACUTE CARE – INPATIENT AND DAY CASES

Admitted acute care, including both inpatient and day case activity, is classified using Diagnosis Related Groups (DRGs) and reported through the HIPE system. DRGs are a means of classifying patient hospital encounters into a manageable number of groups which can be used to describe the mix of cases or casemix of the activity being carried out by a hospital. DRGs are designed to group cases which are clinically similar, and which are expected to consume similar resources. DRGs and casemix systems are widely used internationally to manage and fund healthcare systems as well as for performance and quality monitoring.

Ireland uses the Australian version of the DRG system, the Australian Refined DRG system (AR-DRGs). The AR-DRG system is developed by IHPA and underpinned by the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), the Australian Classification of Health Interventions (ACHI) and the Australian Coding Standards (ACS). These are complemented by the Irish Coding Standards. The Irish Coding Standards are developed for use with the Australian Coding Standards and are revised regularly to reflect changing clinical practice and to ensure that the classification and its application are relevant to the Irish healthcare system.

For the funding years ABF2019 and ABF2020 (benchmarking years 2018 and 2019), the HPO classified admitted acute care using AR-DRG version 8.0. AR-DRG version 8.0 uses the Eighth edition of ICD-10-AM/ACHI/ACS for coding of activity.

On 1 January 2020, the Irish system moved to the Tenth edition of ICD-10-AM/ACHI/ACS. However, cases will continue to be grouped and reported using AR-DRG version 8.0 for ABF purposes until the end of 2022, at which point AR-DRG version 10.0 will be used exclusively. This lag between ICD-10-AM and AR-DRG version is necessary to allow for a continuous like-for-like comparison of ABF target activity level and actual ABF activity levels, and for sufficient data to be available in ICD-10-AM ACHI/ACS Tenth edition and AR-DRG version 10.0 to allow for the generation of robust costs and activity data using those classifications.

The AR-DRG system is regularly updated by IHPA (currently every two years). Each update is an evolution of the previous version, informed by clinical and statistical review and stakeholder feedback. AR-DRG version 10.0, developed by IHPA, has included a clinical review of the diagnoses that contribute to complexity scoring within the DRG complexity model, resulting in differentiation of caesarean section deliveries according to whether they are performed prior to the commencement of labour or following the commencement of labour and a review of new health technology.

The HPO meets with the Central Statistics Office and the Department of Health on a regular basis to monitor the development and implementation of ICD-11, which was released in 2022. The Central Statistics Office uses the World Health Organisation's ICD-10 for mortality coding. As the HPO requires an interventions classification and a complementary grouper (software which groups coded data into a classification version),

the move to ICD-11 is dependent on these being available. Intention to move to ICD-11 will be flagged in future versions of this document.

4.2 EMERGENCY CARE

Activity within EDs is currently block funded and there is not sufficiently consistent or appropriate activity data nationally to classify ED care for ABF at present.

Since 2016, the HPO has been working with the Emergency Medical Programme to determine an approach to classify ED activity as a building block for ABF. Following an international review of classification systems, it was agreed that Ireland will adopt the Australian Urgency Related Group system developed by IHPA. This system is being adopted on the basis that it is a relevant and mature model well-suited to Irish healthcare, noting in particular its utilisation of ICD-10-AM and the alignment of the system with the use of AR-DRGs for admitted acute care. The main variables required are episode end status, type of visit, triage field, diagnosis and sex.

Unlike acute care where patient records are coded and reported through HIPE by clinical coders, ED attendances are not currently coded. Given the vast number of ED attendances it is not feasible for clinical coders to extend coding to the ED, and therefore it is envisaged that ED clinicians will record patient diagnosis using a classification system that is suitable for the ED setting.

The first stage of a pilot project on diagnosis recording in an ED was carried out in Midland Regional Hospital, Tullamore using the Australian ED ICD-10-AM Principal Diagnosis Short List and this project confirmed the feasibility of clinicians assigning diagnosis codes in the Ed setting using existing systems. This project is being expanded in 2022 to generate coded ED data for up to 4 additional sites. In parallel, the HPO team will be assessing the costing and pricing dimensions of ABF in ED which together with the data will be used to create an initial ED ABF model.

In the long-term it is envisaged that the Acute Floor Information System and Dataset use SNOMED-CT as the coding system and mappings will be developed between SNOMED-CT and ICD-10-AM to provide coded ED presentations for ABF use. However, internationally this mapping is in its infancy and in Australia it is specific to local ED reference sets, and a similar local mapping is required in Ireland.

The HPO will consult in more detail on the implementation of the Urgency Related Groups system and long-term plans for the use of ABF in EDs in a future Pricing Framework Consultation Paper.

4.3 OUTPATIENT CARE

Activity within OPDs is currently block funded and there is not sufficiently consistent or appropriate activity data nationally to classify outpatient care for ABF at present.

Unlike inpatient care, and as with ED care, OPD records are not ‘coded’. Unlike EDs, OPDs do not currently have data collection systems which enable widespread electronic patient-level reporting, noting that there are approximately 3.3 million OPD attendances per year. This means that any classification system to be delivered in the present system needs to be based on service- rather than patient-based attributes. In the future, consideration may be given to a patient-based classification, but this first requires long-term investment to develop the data collection and coding capacity in OPDs.

To enable outpatient activity to be classified as a first step towards ABF, Ireland is reviewing the Australian Tier 2 Non-Admitted Care Services Classification to consider its suitability and how it could be adapted to develop the Irish Outpatient Classification System.

Tier 2 categorises a hospital’s non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service. The structure of the classification is first differentiated by the nature of the non-admitted service provided. The major categories are procedures, medical consultation services, diagnostic services and allied health and/or clinical nurse specialist intervention services. This structure reflects the Australian system and will need to be reviewed for the Irish context.

Tier 2 has been selected due to its service-based structure, as well as the attributes it shares with the acute DRG system. Tier 2, while clinic- rather than patient-based, aligns its main categories in a similar way to DRG Major Diagnostic Categories, distinguishing by the predominant specialisation of the clinic at the lower

level. In addition, it has the capacity to classify other non-admitted and emergency activity which takes place outside of the OPD.

The HPO has commenced work to map all outpatient clinics to Tier 2, make adaptations where required to reflect Irish practice, and examine data collection capabilities and data in outpatient services. In 2022, the HPO intends to develop an online clinic register as a central source of hospital outpatient clinics to enable these to be mapped to Outpatient Clinic Groups and pilot this mapping in a sample of hospitals.

The HPO will consult in more detail on the implementation of the new Irish Outpatient Classification System, potential data collection requirements and long-term plans for the use of ABF in outpatient care in a future Pricing Framework Consultation Paper.

5. DATA COLLECTION

5.1 ACTIVITY DATA

Hospitals submit clinical and administrative patient-level activity data to the HPO. This data is used to fulfil a number of functions in the HPO and HSE including management of the health service and monitoring of the system. The data is also used to set the price for public hospital services and to determine the volume of activity which is then funded.

Hospitals submit patient-level activity for inpatient and day case episodes to the HPO monthly via the HIPE system. Submissions are made one month in arrears and are finalised annually for reporting, pricing and funding purposes. Activity data must be submitted in line with HPO and DRG standards set out in Chapter 4.

The HIPE system does not currently collect activity data relating to EDs, OPDs, psychiatric units or long stay units. Developmental work for ED and OPD classification systems is underway and is detailed in Chapter 4. Future data collection plans for these streams will be included the upcoming ABF Data Plan described below.

All HIPE data returned to the HPO undergoes extensive data quality review both at hospital and HPO level before being finalised. These checks include data entry edits, review of coding versus coding standards, data integrity checks, peer review and on-site chart based audit. Data quality checks are augmented with provision of additional training when required. The HPO provides full education and supports to the clinical coders.

5.2 COST DATA

Hospitals also submit cost data to the HPO, which is used to set the price for public hospital services. Cost data must be submitted in line with the Irish Hospital Costing Standards 2020.

Two levels of cost data are used by the HPO: specialty cost data, which assigns costs down to the specialty based on usage and best allocation statistics; and patient-level costing (PLC) data, which assigns costs down to the patient level based on actual resource use. PLC data is essential for ABF to operate. Within the ABF price setting process, PLC data is used to set the cost relativities between DRGs, while specialty cost data is used to adjust and calibrate the initial relativities to the wider set of ABF hospitals.

Specialty costing covers all ABF hospitals and is submitted to the HPO annually by 31 May for the previous calendar year for acute, ED and OPD services. PLC is in place in 18 acute hospitals. Hospitals are currently at different points in processing cycles, with the HPO supporting hospitals in processing data from 2019 onwards.

The HPO has a detailed data quality review process for both speciality and PLC data with queries raised on submissions and required amendments made by hospitals before inclusion in the price-setting process. Costing audits are carried out in all hospitals over a two-year period.

To improve the accuracy of ABF pricing, the HPO is working with hospitals to improve the quality, quantity and timeliness for PLC data, including expansion to more hospitals from 2022.

5.3 DATA PLAN

There are challenges within the system in regard to the timely provision of activity and cost data. To improve communication and increase transparency, in 2022 the HPO published an ABF Data Plan for the first time. The Plan sets out a schedule for current and future ABF data collection requirements, including plans to collect activity data for ED and OPD services and expand the collection of PLC data. This will provide a more transparent way of setting out future data collection requirements for hospitals and provide a means for services to provide feedback and contribute to data development.

5.4 ACCESS TO DATA

Publicly available data

All information in the public domain is anonymised aggregate data. HIPE data are available in aggregate form in published reports, supported by the HIPE Statistics Reporter which allows users to analyse the diagnosis and procedures categories outlined in annual activity reports. In addition, members of the public,

including researchers may apply to the HPO to access anonymised and/or aggregate level activity and cost data.

Data available to participating hospitals

All hospitals returning data to HIPE have full access to their own data through the HIPE Online Portal (HOP) which is developed and maintained by the HPO. The HOP provides extensive reporting capabilities for hospitals to exploit the richness of HIPE data for service provision and management purposes. Access to HOP is strictly controlled and designated hospital staff can only access information on cases treated in their own hospital.

Hospitals which participate in the PLC programme have access to their own patient-level PLC data via the PLC Reporting Tool and have the ability to compare their aggregate level costs to those of their peers using the PLC Peer Review Tool. These tools allow designated hospital staff to comprehensively understand the costs of running their hospital at a very granular level and compare those costs with their peer hospitals.

All hospitals returning costing data to the HPO (either PLC or specialty costs) also have access to an internal website which gives them access to a variety of resources directly relevant to costing and ABF.

The HOP, PLC Reporting Tool and PLC Peer Review Tool are all developed and maintained by the HPO. Access to these systems is strictly controlled and adhere to the GDPR and HSE data protection policies to ensure that the rights of data subjects are protected.

5.5 DATA SECURITY

As the office responsible for the management of a number of national data collections, the HPO takes its data protection responsibilities very seriously. The HPO recognises that the information contained in these data collections requires that all appropriate measures are taken to ensure that this data is collected, stored and utilised in line with regulations and best practice guidelines in a secure and transparent manner.

In particular, the HPO adheres to the Data Protection Acts 1998 to 2018 and Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016, also known as the General Data Protection Regulation (GDPR). These acts and regulations set out the rights of individuals in relation to their personal data and the responsibilities for organisations that collect, store and process this data.

In addition to adhering to national and international law, the HSE has also developed national IT and data protection policies which apply to the HPO. These policies cover areas such as information security, access control, data encryption, password standards, data sharing, information classification and handling and data protection breach management. These policies have been put in place to help ensure that data is collected, stored and processed according to the appropriate legislation and best practice guidance.

6. SETTING THE PRICE

The HPO sets prices for each admitted episode of care (as classified by the DRG for acute care) based on the average cost of all hospitals with activity in that DRG, using HIPE activity data and PLC data. The goal of this is to increase transparency in funding, to encourage efficiency, value for money and sustainability, and provide greater accountability for the way money is spent. ABF has a number of safety mechanisms, both in price setting and in reporting to help ensure that the price is not one that compromises on patient care. From 2019, the Price List has been published on the HPO website.

The HPO is developing a document which describes the technical approach to the pricing model in detail. This will be published in 2023. The purpose of this chapter of the Pricing Framework is to explain the general approach to the model and set out any changes that will be applied this year, or that are being considered for future years.

6.1 PRICING MODEL

The key steps in developing the pricing model are described here. No changes are proposed this coming year to the methodologies in Stage A. Some changes are being considered for future years as part of the steps in Stage B, as detailed below.

Stage A: developing the cost model

1. **Set inlier boundaries:** The first step is to determine the 'inlier boundaries' for each DRG, which set a window for the typical length of stay for episodes in that DRG. Episodes which lie outside of these boundaries (that is, last longer or shorter) have an adjusted payment based on the length of stay ('per diem rates'), calibrated so that the payments do not result in over payment to a DRG and there is not an incentive to admit patients for longer or shorter than is clinically appropriate.

   The last three years' HIPE data is used to determine the inlier boundaries. Three years' data are taken to reduce year-to-year variability in the boundaries and increase stability in pricing.

2. **Cost outlier detection:** After determining the inlier boundaries, cost outliers are detected. This stage is carried out in three separate phases. Each phase is applied to the dataset excluding the records determined as outliners in the prior phase.

   a. Initially, values in the data with a total cost value of less than €20 are flagged for omission.

   b. Specified checks on individual 'cost bucket' values (used to describe the costs of a particular part of the system, for example, medical salaries, theatre costs, etc) are carried out to ensure that sensible costs have been allocated to the cases. For instance, in the Adjacent DRG F12 which relates to the implantation/replacement of a total pacemaker system, a minimum prosthetics/ implantable item cost of €1000 is expected.

   c. In the final phase, mean costs per DRG per hospital are compared, and those DRG-by-hospital combinations which have significantly different costs from their peers are flagged for omission.

3. **Derive initial cost estimates:** Next, initial cost estimates are derived using PLC data from the two latest available years from hospitals participating in PLC.

   This cost data is used in conjunction with the inlier boundaries to calculate average costs for inpatient inlier cases, day cases and per diem rates where applicable. The use of the most recent two years' data increases the stability in the prices while still remaining responsive to changes in clinical practice and improvements in costing methodologies.

4. **Calibrate activity and costs to a fixed point:** The initial cost estimates described above are derived from PLC data (for which there is a time lag) and returned from only a sample of the hospitals which are funded through ABF. To account for this, the initial costs are applied to the latest year's activity data and the total cost estimated is compared to the latest year's ABF cost data which is available from specialty costing returns from all ABF hospitals. The specialty costing returns allow for total hospital costs to be broken out into those in scope for ABF and which are to be funded on an ABF basis through the DRG, and those which are out of scope for ABF and which are to be funded on a block grant basis. Initial costs are then calibrated to take account of the different composition of the set of PLC hospitals compared to

the wider set of ABF hospitals, and to ensure that the estimated cost of ABF activity based on initial cost estimates equals the actual cost of the ABF activity based on specialty costing returns.

This step is referred to as 'fixed point calibration' because it is the latest point at which actual activity levels can be matched with actual costs. This fixed point is the current year -1.

Stage B: converting the cost model to a pricing model

5. **Calculate ABF pricing adjustments:** In order to account for systemic and legitimate variations in the cost of providing care and avoid incentivising poor quality care in more complex and costly settings, a number of ABF co-payments are applied through adjusting the DRG cost relativities and/or making cost adjustments at the hospital level.

   These co-payments are paid on top of the value of activity as determined by the ABF Price List, with the approach depending on whether the co-payment is patient-specific or institute-specific.

   Currently there are ABF adjustments for:

   - specialist paediatric hospitals (through cost adjustment)
   - agency staff premiums (through cost adjustment)
   - high-cost oncology drugs (through DRG relativity and cost adjustment).

   These are described in detail below.

6. **Calculate pricing incentives:** DRG prices are adjusted in order to incentivise particular clinical practices as part of the broader policy of increasing 'value-based care'. Currently, one pricing incentive is in place for AR-DRG H08B: *Laparoscopic Cholecystectomy, Minor Complexity* where the inpatient and day case prices are adjusted to incentivise treatment in a day case setting. The policy approach to this, and future consultation of additional pricing incentives, is discussed in detail in Chapter 9. The HPO will consult with stakeholders in the coming year with the aim of introducing additional pricing incentives to help further clinical objectives.

   It is at this point that ABF benchmarking is carried out. This compares each hospital's efficiency to its peers and determines the level of transition payment to be provided for the following year. Transition payments are described in detail in Chapter 7.

7. **Final adjustments:** Ultimately, the prices set for ABF purposes are dependent on the total acute hospital budget available and the level of activity expected in the coming year. Therefore, the final prices to be paid for activity in the funding year are calibrated so that the total expected value of ABF activity for the year equals the total available ABF budget.

   Typically, the activity levels are set at the expected level of service as outlined in the National Service Plan. The HPO continue work with HSE Acute Operations and HSE Strategy and Planning to refine the estimation methodology for expected levels of activity.

6.2 PRICING ADJUSTMENTS DETAILS

This section provides further detail on Step 5, above.

Specialist paediatric hospitals

The cost of treating patients in a specialist paediatric hospital tends to be higher than the cost of treating those same patients in a general hospital setting. To account for this, specialist paediatric hospitals are excluded when deriving initial DRG prices to ensure their costs do not artificially inflate general DRG prices, and adjustments are calculated to ensure that their costs are appropriately reimbursed through the pricing process.

The initial DRG prices are later applied to specialist paediatric hospitals' PLC data to calculate cost-to-value ratios for each DRG, which determine a DRG-level price adjustment for specialist paediatric hospitals. This is later provided as a total co-payment to hospitals. Two hospitals currently receive the specialist paediatric adjustment: Temple Street Children's University Hospital and Our Lady's Children's Hospital, Crumlin.

Agency staff premium

Some hospitals are more reliant on more expensive agency staff than others, notably in more remote areas. Whilst the funding system should not incentivise more costly staff, it should not prohibit recruitment where

other staffing options are limited due to geographical constraints. In order to account for this variation, a portion of the expenditure from all hospitals which use agency staff is ring-fenced and excluded from the DRG price-setting process. The amount of ring-fenced expenditure is equal to the premium paid for agency above that which would be paid for full-time staff.

High-cost oncology drugs

Use of high-cost drugs can distort the average DRG cost, resulting in payments for patients who received high-cost drugs attracting a DRG payment which is too low, and payments for patients who did not receive high-cost drugs attracting a payment which is too high. As only certain hospitals dispense these drugs this can lead to systemic over- or under-funding.

To account for this, the costs relating to high-cost oncology drugs are removed from the relevant DRGs and the amount is ring-fenced to be paid to the hospital as a co-payment. As this adjustment is applicable at the individual episode-level rather than at the institute-level, it results in a change to specific DRG prices as opposed to the 'whole system' adjustments resulting from the other price adjustments.

The above pricing adjustments are updated and reviewed on an annual basis to ensure that they adequately reflect and account for systemic and legitimate costs which may not be correctly funded through a DRG payment.

6.3 REVIEW OF PRICING ADJUSTMENTS

In previous years, a tertiary referral hospital pricing adjustment was also made to account for the fact that the cost per weighted unit (base cost) in tertiary referral hospitals is higher than in the other hospitals. Observing that this adjustment had been decreasing over recent years, in 2021 the HPO undertook further analysis on this and found that the introduction of AR-DRG version 8.0 in 2016 which better reflects the complexity of care provided in tertiary referral hospitals, together with the high-cost oncology drugs adjustment which is largely applicable to care in these same hospitals has negated the need for a separate tertiary referral hospital pricing adjustment. Therefore, this adjustment does not appear in the 2022 Pricing Model.

As part of its 2022 work programme, the HPO is examining the feasibility of introducing a co-payment for time spent in a Level 3 or 3S Intensive Care Unit. The aim of this potential co-payments is to unbundle the cost of ICU treatment from the DRG, so that the resulting DRG price reflects a more homogeneous underlying cost, and the additional cost associated with ICU can be targeted towards the appropriate patient cohorts. The HPO is working with the HSE Critical Care Programme and the National Office of Clinical Audit to better understand the costs associated with Intensive Care Units and a final report on that work including recommendations is expected to be published in Q4 2022.

In addition, as part of actions in the ABF Programme Implementation Plan 2021-2023 to reduce ABF transition payments (discussed in more detail in Chapter 7), the HPO will work with hospitals over 2022/2023 to identify any further legitimate structural costs not accounted for in the ABF system which are currently being covered by transition payments and/or unique issues submissions from hospitals. Where these exist, these should be accounted for in the ABF pricing system, which may require additional or amended pricing adjustments.

In 2022/2023, the HPO will consult with relevant parties on the results of this work and any potential adjustments and will outline the approach in a future Pricing Framework Consultation Paper.

7. FUNDING

Once the price is set, the HPO makes further adjustments which determine the ultimate amount of funding that a hospital receives. These are intended to take account of other funding sources and overall budgetary restrictions.

7.1 MANAGING FUNDING WHERE SOME HOSPITALS DO NOT BEAR FULL COSTS

Specialty and PLC processes seek to obtain the full cost for providing care within a particular DRG, even if that full cost is not borne entirely by the hospital, for example, IT and other shared services provided centrally by the HSE and not paid for by the hospital, and work carried out by a consultant who is paid by another hospital.

As approaches to this can vary by hospital, to ensure consistency across hospitals for pricing purposes the value of these services is subtracted from the ABF budget of hospitals who use external services. For example, a hospital with an initial ABF budget of €100m which receives central and/or external services to the value of €5m will actually receive €95m in ABF budget. There are no changes proposed to this approach in the coming year.

7.2 ACCOUNTING FOR OTHER FUNDING SOURCES

Apart from ABF, there are a number of other funding sources which are available to hospitals.

National Treatment Purchase Fund activity

Patients who have been on a waiting list for a certain period of time can be treated through the National Treatment Purchase Fund (NTPF). The HSE does not pay the hospital for such patients as the NTPF has already done so, and this activity is flagged and excluded from the ABF budget setting process.

The amount of activity taking place in public hospitals which is funded through the NTPF has been increasing in recent years and it appears likely that this trend will continue. Such activity is flagged on the national HIPE file as NTPF activity and is excluded from the ABF funding model so that it does not attract double funding (that is, from the NTPF and through the ABF model). To date, verification of the number of NTPF cases by hospital has been difficult as there is no direct link between the data held by the NTPF and HIPE data. To account for this ambiguity, NTPF activity and the corresponding costs are included in the annual benchmarking exercise which determines the level of ABF adjustment applicable to each hospital.

In 2022, the HPO will consult with the NTPF and other relevant stakeholders to investigate how to best account for NTPF activity in the ABF model in light of the above verification difficulties. The results of this investigation and any proposed change in approach will be outlined in a future Pricing Framework Consultation Paper.

Other sources

Hospitals can also receive income for one-off items such as winter planning and waiting list initiatives, but ultimately these types of funding will be matched by activity. There are also some smaller commissioners who will fund hospitals for specifics items of expenditure. These include the National Cancer Control Programme, the National Cancer Screening Programme and the Primary Care Reimbursement Scheme for some high-cost drugs. The expenditure on these items is included in the costs of treating patients and therefore in the DRG price, however appropriate deductions are applied to ABF budgets to avoid double payment. There are no changes proposed to this approach in the coming year.

7.3 PRIVATE PATIENTS IN PUBLIC HOSPITALS

Hospitals in Ireland are funded by a combination of exchequer funding and private patient income. From an ABF perspective, the total funding to a hospital is calculated based on all activity, both public and private.

Private patients in public hospitals are treated in the same manner as public patients within the ABF process, with the same price applying at the patient level. Private patients generate income for the hospital on a ‘per

diem' basis, but this is not subtracted against the DRG price at a patient level. Rather, the projected income for all private patients (the 'income budget') is deducted from the ABF and block funding totals to determine a net budget. There are no changes proposed to this approach in the coming year.

7.4 TRANSITION ADJUSTMENTS

To ensure financial stability for hospitals when ABF was introduced, temporary transition adjustments were put in place for hospitals operating above and below the national price. The 2015-17 ABF Programme Implementation Plan required that hospitals operating above the national price make plans to reduce their unit-costs and associated need for transition payments. At the same time the HPO would work with hospitals to identify any structural disadvantages (for example, operating in a remote location) which could result in legitimately higher operating costs which should be accounted for in the ABF system.

The transition adjustments sit alongside the ABF pricing system to either inflate or deflate payments to hospitals. Under the transition adjustment system, some hospitals' funding is increased because their expenditure is higher than ABF prices, with some funding decreased where ABF prices are above expenditure and providing funding at the ABF price level would represent a 'profit' for the hospital.

This approach is counter to the principle of ABF that efficiency in the system is rewarded. This was appropriate at the introduction of ABF in Ireland to allow the system to adjust to the new way of funding: to smooth the transition for hospitals, to allow time for improvements in activity and cost data reporting, and to enable the HPO and hospitals to better understand and account for legitimate variations in costs. However, over time these factors need to be addressed in the ABF system and under the Sláintecare Implementation Strategy the ABF proportion of hospital budgets is to be significantly increased by reducing transition payments.

In 2019, transition adjustments were 87.5 per cent of the difference between ABF expenditure and revenue. Due to the effects of Covid-19 in 2020, 2021 and 2022 hospital funding reverted to a block funding methodology and therefore no further changes to transitions could be made.

The ABF Programme Implementation Plan 2021-23 includes actions for the DoH, HSE, HPO and Hospital Groups to work together to review transition adjustments and develop a timetable for incremental reduction of transition adjustment, taking into account the impacts of COVID-19 on funding processes.; and for the HPO to work with hospitals to identify any legitimate structural costs not accounted for in the ABF system which are currently being covered by transition adjustments. Particular effort will also be made to identify and isolate COVID-19 related expenditure so that it can be appropriately handled and the principle of matching cost with activity can be maintained. Progress on these actions will be included in future Pricing Frameworks.

A roadmap document to outline the timetable for transition adjustment reductions will be published in 2023.

7.5 OUTSOURCING AND INSOURCING OF ACTIVITY

In response to increased waiting lists in recent years, the HSE has been allocated funding for the Access to Care Plan with the purpose of securing treatment for those patients on the waiting list who have been waiting the longest. Unlike treatments procured through the NTPF, the budget for this activity is held by the HSE. The treatment may take place in either a public or private setting similar to treatments procured through the NTPF

The HPO has taken steps to allow for the clear identification of this activity so that it can be matched with the funding source. These include:

- Addition of Access to Care flag to HIPE data specification
- Development of process to clearly identify and authorise waiting list patients for treatment
- Development of process to receive claims, including treatment information, from private hospitals

The clear identification of this activity will allow the HPO to treat, for ABF purposes, these cases in a manner consistent with the National Service Plan (NSP). The inclusion or exclusion of activity will be carried out in line with the ABF matching principle i.e. if activity is to be included in the model then the relevant costs will be included and similarly if activity is to be excluded then the relevant costs will be excluded from the model.

7.6 MANAGING ABF WITHIN THE FUNDING ENVELOPE

The introduction of ABF means that activity carried out in acute hospitals can be quantified in terms of cost and volume. However, this cost and volume analysis does not determine the actual level of funding which will be available for acute hospitals in any given year. Therefore, in reality the available funding envelope may not be sufficient to cover the full expected costs of the 'expected level of service'.

In order to work within the available funding envelope, prices and adjustments are first set based on actual costs, and then adjusted by a fixed factor based on the available funding envelope and the previous year's expenditure after all adjustments have been applied. This factor is also applied to block funding amounts.

This process is different to that of ABF in other countries where growth factors would typically be applied to reflect demographic impacts and health inflation. There are no changes proposed to this approach in the coming year.

7.7 BLOCK FUNDING

The term block funding refers to the practice of allocating funding to hospitals based on their budget for the previous year with some adjustments made for factors such as inflation, expected service levels, reconfiguration and available overall budget. Block funding of hospitals does not explicitly take the type and complexity of patients treated into account, it is unable to link funding with activity, and therefore does not support hospitals to stay within budget.

Block funding relates to the funding of activities that do not come within the scope of ABF. At present this includes OPD and ED care, as well as the many services that hospitals provide to GPs and the community, for example radiology and laboratory testing. Block funding also includes any expenditure on unique issues not appropriately reimbursed by the DRG payment or any co-payment.

One of the objectives of the ABF Programme Implementation Plan 2021-23 is to transition from existing block budgets to ABF allocations to improve transparency and accountability for funding. In 2019, 39 hospitals were funded by ABF for 70 per cent of their total funding.

The ABF Programme Implementation Plan includes a series of actions to transition from block budgets, including developing a framework to determine the thresholds for the application of ABF and expanding ABF to other acute hospitals; with these supported by other efforts including the long-term expansion of ABF to ED and OPD services. Future Pricing Frameworks will detail how these actions are being progressed and implications for hospitals and service streams.

7.8 COVID-19

The onset of the COVID-19 pandemic in 2020 has caused significant disruption in the global healthcare environment and this is reflected in the changes which have been implemented in the Irish healthcare system over the year. The major effects on the admitted care include:

- reduced numbers of patients attending acute hospitals for non-urgent care
- reduced capacity in acute hospitals to respect social distancing
- establishment of COVID and non-COVID pathways for emergency admissions
- significant reallocation of resources and re-designation/repurposing of hospital wards to meet COVID-specific demand
- creation of temporary large-scale step down for patients treated for COVID-19
- establishment of contracts with private healthcare providers to treat public patients and to provide COVID-19 surge capacity
- funding provision for a significant increase in the number of acute hospital beds across the system
- funding provision for additional personal protective equipment, additional equipment and cleaning required in a COVID-19 setting.

These changes in the acute healthcare environment have a profound effect on relationship between costs and activity that underlie ABF. In particular, the increased costs and reduced activity levels due to the COVID-19 response mean that the relationship between cost and activity in 2020 and 2021 have been significantly different from that in previous years.

In light of this, the decision was taken in Ireland and in other ABF systems internationally to temporarily revert to block funding of acute hospitals for 2021. In Ireland block funding will continue for 2022 and 2023. ABF activities have continued as usual, including the ABF benchmarking exercise and the calculation of transition adjustments from this process. It is important that we continue to recognise and promote the ABF process as an important tool in monitoring and managing our healthcare system despite the requirement to tactically move to a block grant funding arrangement in response to the COVID-19 pandemic.

8. STABILITY

The 'stability' Pricing Guideline in Chapter 2 states that "The payment relativities for ABF should be consistent over time".

In a relatively small country like Ireland and with ABF currently applying to a subset of hospitals, the system can be very sensitive to outliers and data quality issues, meaning that the performance of a single hospital can have a dramatic effect on the funding of other ABF hospitals. Therefore, the HPO currently uses a range of methods to seek to ensure stability in the ABF process.

8.1 IN ACTIVITY DATA COLLECTION AND VALIDATION

Regular coding audits and use of data quality tools help to identify, understand and/or correct unexpected coding variation. As coded clinical information forms the basis of the funding model, these methodologies allow the HPO to investigate whether distortions or unusual patterns in the model are due to changes in coding, and whether those changes are valid within the context of the coding standards and are likely to reflect the true complexity of cases in the hospital. In cases where it is deemed that the changes are not a true reflection of the underlying patient complexity or are due to non-compliance with coding standards, the HPO will make appropriate adjustments in the funding model to account for this. To date, two hospitals' casemix index (a measure of the complexity of a hospital's caseload) have been adjusted to account for large unexplained changes.

The HPO also funds uncoded activity at a reduced rate of 80 per cent based on a hospital's casemix index. This is a means of accounting for uncoded cases which provides a more complete picture of acute hospital activity whilst also incentivising the timely return of coded data.

8.2 IN THE COSTING PROCESS

Costing data is reconciled to Annual Financial Statements, to account for all expenditure. Costing returns are made according to accounting standards and are subject to detailed reviews, with year-on-year variances and hospital cost and activity profiles that are different to peer hospitals being identified and investigated. ABF hospitals are subject to an on-site review of their costing return every second year.

PLC data from the two latest available years from hospitals participating in PLC are used to calculate average costs which form the basis of the DRG prices. This ensures that common data is used in each iteration of the pricing model which increases stability whilst still remaining responsive to changes in clinical practice and improvements in costing methodologies.

PLC service weights are also smoothed with the prior weights (by taking an average of prior and current estimates) to reduce large fluctuations. No changes are proposed to this approach.

Hospitals are invited to make submissions on unique and high-cost items that have a material impact on their costs relative to peers. These submissions are analysed within the framework of overall hospital ABF performance and if granted do not form part of the price setting process.

8.3 IN THE PRICING PROCESS

As set out in Chapter 6, the HPO uses the last three years' HIPE data to determine the inlier boundaries for DRG prices. This reduces year-to-year variability in the boundaries and increases stability in pricing. Due to the relatively small number of hospitals returning PLC data and because returns are not compulsory, there can still be significant variation in the resulting estimates, therefore a smoothing (year-on-year averaging) step is also carried out so that the changes in resulting prices are minimised.

As discussed in Chapter 9, the HPO is also investigating how 'work in progress' cases (patients who have not been admitted and discharged in the same year) can best be accounted for in the pricing model. Funding these patients based solely on the year of discharge leads to a mismatch between the time period where costs are incurred and when funding is allocated, which results in distortions in the funding model.

8.4 IN DETERMINING OVERALL FUNDING

In order to fully understand the effects of changes made to the funding model, the HPO breaks down year-on-year changes in performance in terms of each contributing factor (expenditure, activity, coding, prices, DRG and coding versions, work in progress, service reconfiguration etc). This allows all stakeholders to clearly understand the drivers of change in any given year and provides hospitals with a basis from which to investigate and improve their ABF performance.

Finally, as discussed in Chapter 7, temporary transition adjustments have provided an interim measure to allow the hospital system to adjust to the introduction of ABF in Ireland. Concurrent with the phasing out of these adjustments as part of the ABF Programme Implementation Plan 2021-23, in 2022/2023 the HPO will work to identify and account for legitimate and unavoidable costs in the system with the aim of continuously improving the accuracy of the ABF model.

9. POLICY DEVELOPMENT

The goal of ABF is to increase transparency in funding, to encourage efficiency, value for money and sustainability, and provide greater accountability for the way money is spent, working as part of a range of policy approaches and levers to incentivise movement of care to the most appropriate locations, and support wider value- and population-based initiatives.

The HPO works with stakeholders across the healthcare system to deliver ABF, guided by the ABF Programme Implementation Plan and the Sláintecare Implementation Strategy. As part of this, the HPO has a responsibility for looking beyond current ABF practices to see how funding and the data that supports it can be used to better deliver on ABF's goals. This includes:

- Specific ABF projects such as the development of stronger and more real-time financial incentives for productivity to drive value, including (but not limited to) Best Practice Tariffs, in line with Sláintecare action 7.1.2.
- Support for broader initiatives across the health system, for example, supporting wider Sláintecare actions to move towards population-based funding and multi-annual budgeting.
- Monitoring international policy trends in value-based care.

These international trends include building safety and quality measures into ABF models, as has been seen in Australia with funding adjustments for hospital acquired complications and plans for adjustments for avoidable readmissions, and the use of Payment by Results cost data in England to develop Best Practice Tariffs. The HPO works with equivalent agencies internationally to share knowledge and information in developing value-based care funding models.

To date, the HPO has introduced two new pricing mechanisms designed to increase value in the system:

- **Best practice tariff for hip fracture care:** The HPO, National Office of Clinical Audit and the National Trauma and Orthopaedic Clinical Programme are collaborating on a trial Best Practice Tariff for hip fracture care, informed by ABF data. In 2018, 278 cases were funded using the Best Practice Tariff, indicating that care in each case met the Irish Hip Fracture Standards.

  This work will continue through 2022.

- **Laparoscopic cholecystectomy:** On 1 January 2018, an ABF pricing mechanism was introduced to incentivise the performance of laparoscopic cholecystectomy on a day-case basis, with many uncomplicated procedures performed as an inpatient procedure unnecessarily. Between 2017 and 2018, the number of hospitals meeting the 60 per cent day-case rate increased from 11 to 14, suggesting that pricing incentives can be used to influence behaviour.

  Success has been limited compared to the targets set for the hip fracture Best Practice Tariff. 21 hospitals met the 60 per cent day-case rate target in January 2018; however, this initial change was short lived and not maintained throughout the year, indicated that pricing signals should be combined with clinical leadership to be most effective. This represents an important trial in learning which factors are critical in implementing quality pricing measures.

  In 2022, the laparoscopic cholecystectomy pricing mechanism trial will be reviewed by the ABF Clinical Advisory Group, to determine how the findings of this work should best be utilised in the future.

In addition to these, in 2021 the HPO commenced work to consider potential approaches to linking patient quality and safety targets to funding. This will continue in 2022 to include consultation with relevant divisions within the HSE, as well as international partners including IHPA in Australia, to examine the feasible of adjusting funding on the basis of hospital acquired complications and avoidable readmissions. The HPO will consult on this work as part of a future Pricing Framework.

9.1 'WORK IN PROGRESS' EPISODES

The HIPE system, and by extension the ABF model, is based on patient discharges, that is, patient records do not appear on HIPE until the patient has been discharged and similarly only discharged patients are included in the total activity for ABF purposes.

The effect of this is that when a hospital has a particularly long stay patient spanning more than one year, the hospital receives no ABF value for that case until the year of discharge. This means that the value of the hospital's activity is overstated in the year of discharge and understated in each of the prior years. Previous analysis by the HPO has indicated that there is a high degree of year-on-year variation in this 'work in progress', which results in distortions in the ABF model.

In 2022, the HPO will investigate the use of downloads of work in progress patients (admitted patients who have not yet been discharged) to better reflect the activity carried out in the hospital in a given year. The HPO will consult with relevant parties on the results of this work and will outline the conclusions and any proposed change in approach in a future Pricing Framework Consultation Paper.

10. CONSULTATION AND REVIEW

This is the first time that the HPO has published a Pricing Framework for the ABF Price List.

10.1 PROCESS FOR THIS YEAR

The HPO is issuing this document, the 'Pricing Framework for the ABF Price List 2022' concurrent with the ABF Price List 2022 to assist stakeholders in understanding the price setting process. The HPO will support stakeholders in this, including through education events such as the ABF Conference. The HPO will also accept submissions during July and August 2022 for consideration in the price setting process for 2023 with the caveat that it may not be possible to address all submissions given this later submission window.

10.2 PROCESS IN FUTURE YEARS

In future years, the HPO will undertake a formal public consultation process to inform development of an annual Pricing Framework, based on the following timetable:

- **April: The HPO will release the 'Pricing Framework Consultation Paper for the ABF Price List'.** This relates to the ABF Price for the *following year*. For example, in April 2023 the consultation paper will be released for the ABF Price List 2024. It will:
    - outline the issues that the HPO intends to consider in developing the next and future prices and provide stakeholders with an opportunity to provide comment on these
    - provide an opportunity for stakeholders to raise other issues that they would like the HPO to consider in development of the Price List.
- **April-May: Public submission window.**
- **June-December: The HPO will review submissions and consult with stakeholders as required.** This may include clarification on submissions, further analysis etc. As part of this process the HPO will determine which issues:
    - will be considered in the upcoming Price List
    - will be included in the work plan for consideration as part of future Price Lists
    - are outside of the scope of the Pricing Framework but will be considered as part of the HPO's broader remit, or
    - are outside of the HPO's remit.
- **Q1: The HPO will release both the 'Pricing Framework for the ABF Price List' and the 'ABF Price List'.** For example, in Q1 2023 the 'Pricing Framework for the ABF Price List 2023' and the 'ABF Price List 2023' will both be released. The Pricing Framework will set out the pricing approach for the year, as reflected in the Price List. It will summarise the issues raised by stakeholders as part of the earlier consultation and the HPO's responses to those issues.

This more extended process will commence in April 2023 to inform the ABF Price List 2024.

The Consultation Paper, Pricing Framework and Price List will all be released on the HPO's website, with stakeholders advised via email. Stakeholders can sign up for email alerts via the HPO website.