

National Reforms – Activity Based Funding HDSS Forum - June 2011

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Development

ABF Overview

- Evolving national reforms
- What it actually means
- Key deliverables/timeframes
- Progress and Next Steps

Reform Evolution: ABF commitments

2008 (NPA)

- COAG agreed to establish national classifications for activity based funding.
- Stage over a number of years, recognising DRG's were well developed, other areas less so.
- Development of a funding model (subject to COAG agreement) to begin in 2014-15.

2010 (NHHN)

- COAG agreed to accelerate the introduction of ABF, from 2012:
 - Admitted acute patient on ABF basis using DRG's.
 - ED, subacute and outpatient services on an ABF basis using activity 'proxies'.
- State and Commonwealth payments to LHNs via a state-based payment authority.
 - Small rural and teaching, training & research will continue to be block funded.

2011 (NHR)

- Heads of Agreement – National Health Reform: timelines for introduction same as NHHN. ABF payments from state accounts within a national funding pool to health services.

National Health Reforms

National Health Reform

- i) 2008 NPA – “National ABF System”
- ii) 2010 COAG – “Dominant Funder”
- iii) 2011 COAG – “Transparency, Transparency and Transparency”

But one common theme – National ABF, National Efficient Price, based on nationally consistent costing, classification and counting.

National Reform

Clear Changes from NHHN

- No GST dedication.
- Commonwealth no longer majority funder.
- National Funding Body (with 8 separate State accounts).

Unclear Changes from NHHN

- Funds direct to health services.
- How block funds will be determined.
- Relationship between National Efficient Price and price paid to health services.

Heads of Agreement - NHR

Main Points

- From 2014-15 Commonwealth will contribute 45% towards efficient growth (growth in service volume at the efficient price).
- From 2016-17 this increases to 50%.
- This will deliver a minimum of \$16.4 billion by 2020.
- Overtime, this means the Commonwealth share of funding could increase.

Independent Hospital Pricing Authority (IHPA)

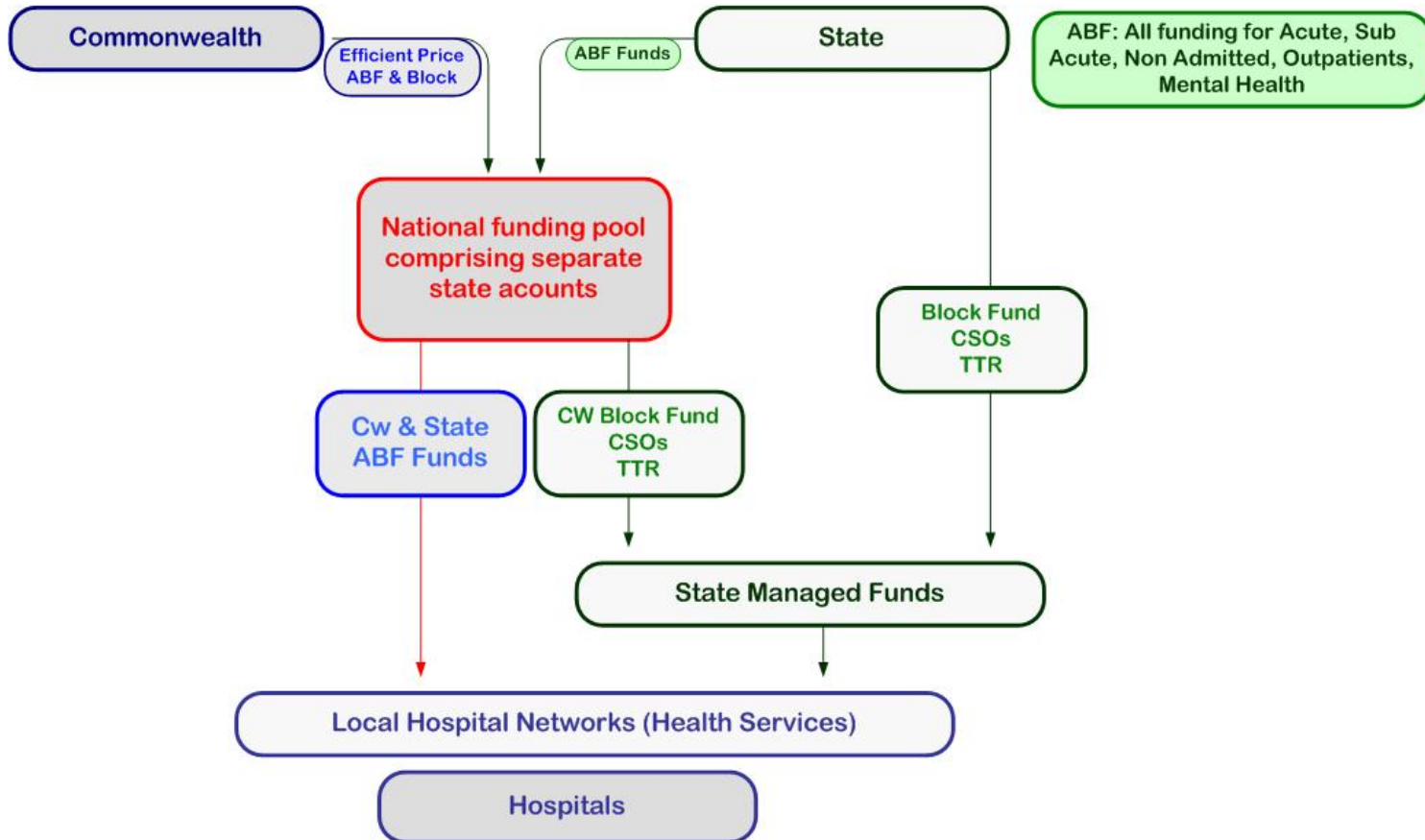
- States are responsible for management of the public hospital system.

BUT...

- IHPA will determine the national efficient price (from 2012-13) for ABF services.
- IHPA will determine the funding model for block funding of non-ABF services:
 - (eg: Small Rural Health Services, teaching, training and research)
- Maintain, update and determine the national ABF classification and costing models.
- The IHPA will develop advice on the process of transition to the national efficient price.

Funding Flow

Payment Flows



2011 National Health Reform Agreement

- Current developments:
 - Health Reform Implementation Group (HRIG) established.
 - HRIG ABF Sub Group: to provide national ABF development advice to HRIG.
 - Workplans being developed to meet timelines.
 - Commonwealth realising the scope of work to be done.

National Reform – Key Deliverables & Timelines

Now What?

ABF funding for acute admitted patients from 1 July 2012.

- ICD-10-AM 7th Edition and AR-DRG V6.0.
- National Costing Standards to be implemented.
- Boundary issues unlikely to be resolved (e.g. chemo, renal) – strive for price equivalence.

There will be proxy classification systems from 1 July 2012 for:

- ED: Urgency Related Groups (URGs).
- Sub-acute: AN-SNAP for admitted sub-acute.
- Non Admitted: NHCDC Tier 2.
- Mental Health: combination of DRGs, URGs, Tier 2 and AN-SNAP.

National Reform – Emergency Departments

Background

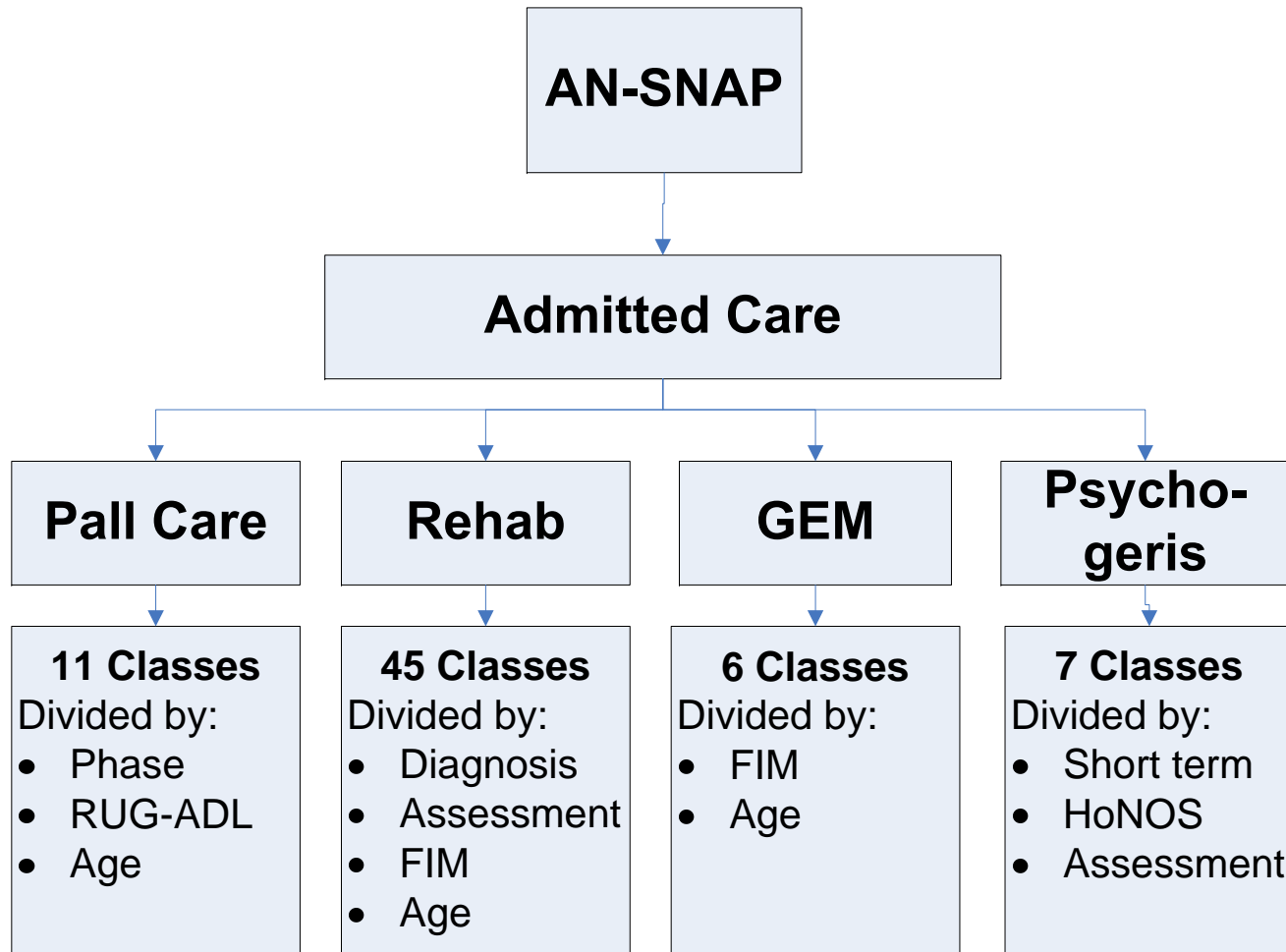
- In Victoria, ED are currently funded as follows:
 - Non Admitted Patients: Non Admitted Emergency Services Grant (NAESG).
 - Admitted: WIES payments.
- HRIG approved Urgency Related Groups (URGs) as the national proxy classification system.
 - Groups disposition, triage and diagnosis into 73 classifications.
- All jurisdictions agree that the original URG groupings are not suitable as a proxy classification system.
 - Developmental work using Victorian data underway.

National Reforms – Sub acute

Background

- Victoria currently funds Sub acute via:
 - CRAFT: for most admitted rehab
 - Other admitted by weighted per-diem
 - SACS: block funds for non admitted sub acute
- HRIG approved AN-SNAP as the national proxy classification system.
- AN-SNAP covers sub acute admitted activity for: palliative care, rehabilitation, GEM, maintenance and psycho-geriatrics.
- CRAFT is limited to admitted rehab patients only (approx 70% of all admitted rehab).
- AN-SNAP for non admitted is unproven and largely untried.

AN-SNAP : Admitted care



AN-SNAP vs. CRAFT

AN-SNAP

6 related to stroke

Differentiated by

FIM motor score

FIM cognitive score

Age

- Mot 63-91, Cog 20-35
- Mot 63-91, Cog 5-19
- Mot 47-62, Cog 16-35
- Mot 47-62, Cog 5-15
- Mot 14-46, Age ≥ 75
- Mot 14-46, Age ≤ 74

CRAFT

13 classes

2 relate to stroke

Split on Barthel Score

- Low Barthel ≤ 59
- High Barthel ≥ 60

National Reforms – Non Admitted

Background

- National Reforms group outpatients, subacute and mental health under Non Admitted
- Victoria currently funds Outpatients (OP) via VACS:
 - Mix of ABF and block funding approaches.
 - VACS comprises 35 medical/surgical and 12 allied health categories
 - Majority of VACS funded hospitals are peer group A&B with some C's. However Community Services Obligations (small rural's) out of scope.
- HRIG approved “NHCDC Tier2” clinic categories as the national proxy classification system:
 - Tier2 comprises 81 categories including 16 distinct allied health allocations.

National Reforms – Non Admitted

Next Steps

- Issues:
 - Tier2 has limitations due to poor category differentiation, overlap and ambiguity.
 - VACS or Tier1 could be implemented without additional data collection changes but requires rework to develop national cost benchmarks.
- Further work will be undertaken to a more robust OP classification system but will not change the current VACS model, however:
 - There is scope to expand the VACS funding model to a number of non-VACS funded hospitals.
 - There is opportunity to roll up a number of specified grants allocated to VACS funded hospitals.

National Reforms – Non Admitted

SAC and Mental Health

- Issues:
 - Tier 2 requires substantial modification in order to accommodate SAC and Mental Health – is also likely to need a setting of care dimension as well.
 - Hopeful that we can access the rich MH data sets already in existence.

Full activity counts (VACS, MBS and others) will be critical (and large challenge) in the non admitted area.

National Reforms – Mental Health

Background

- Victoria currently funds Mental Health (MH) via:
 - The basis of available bed-days for inpatient services, input funding for acute admissions plus copayments and block grants for non admitted
- DRGs provide the basis for patient classification but there are specific concerns about lack of capability of integrating the complexities of MH funding.
- HRIG endorsed a combination of modified DRGs, URGs, AN-SNAP and Tier2 as the proxy national classification system:
 - Clear understanding that the proposed proxy systems will not be appropriate in the medium or long term and alternative systems will be undertaken.

National Reforms – Mental Health

Next Steps

- Extensive work is required across boundary issues and definitions to assist in the development of an appropriate classification system.
- Victoria is establishing an internal working group to oversee the work related to ABF for MH:
 - Scope advantages, risks, practicality, cost and likely acceptance of introducing an alternative admitted classification system.
 - Identify feasible candidate classification systems for non-admitted activity.
 - Understand data element gaps and compliance with required elements for ABF proxy classification systems.
 - Coordinate work defining non-admitted boundaries for services included in ABF funding mechanisms.

National Reforms – Non ABF

Background

2008 NPA:

- Community Service Obligations (CSO) were to have developed a common costing approach (not adequately funded by ABF) by 1 July 2011.
- Teaching, Training and Research (TTR) was originally part of the ABF approach for non clinical hospital services and required to establish a common funding approach by 1 July 2011.

2010 NHHN:

- Both CSO and TTR were to be block funded against COAG agreed funding models.
- Commonwealth contribution was 60%.

2011 NHR:

- Both CSO and TTR will continue to be block funded – but subject to efficient growth funding within block funds.
- No clear understanding yet how the Commonwealth will determine this.

National Reform – Non ABF

Progress and Next Steps

- CSO's: (Small Rural Health Services in Victoria)
 - Capacity survey work carried to inform upon CSO service provisions and identify how services and programs are counted and allocated to cost centres.
 - Further work is required to document existing funding approaches and advance future model development for possible national uptake.
 - Revise CCOA and costing governance to re-invigorate allocation processes and understanding.
- TTR:
 - Development and methodology work carried out to determine appropriate block fund to be paid by Commonwealth to all States and Territories.
 - Victoria to engage health services upon agreement to ensure compliance with data requirements and allocation methods to meet Commonwealth standards.

Non-Admitted Patient Minimum Data Set Project

- Project update
 - 26 health services in scope for the collection
 - Project plans required by the project team in order to release funding
 - 20 health services have supplied project plans
 - 11 health services have been allocated \$2.5m in implementation funding
 - 9 health services will receive implementation funding in June subject to further information being made available
 - Continued engagement with the 6 outstanding health services
- The reference groups established for the project have been extremely valuable in helping the project team understand the challenges faced by health services
- Various implementation documentation has been developed by the project team to assist health service project teams
 - » Implementation framework – May 2011
 - » Implementation guide – June 2011

Non-Admitted Patient Minimum Data Set Project

- Project risks
 - Health services ability to coordinate the various aspects of the VINAH data collection
 - **Data collection** – the ability to collect the required data from 1 July 2011
 - **Data migration** – Entering the required data to adhere to the VINAH data model
 - **Data transmission** – Getting the data from the health service to the DH. Two possibilities:
 - » Traditional data extraction
 - » Direct data acquisition
 - Software vendor engagement (incl. HealthSMART) to meet the deadlines required by the project
 - Interpretation of DH policies e.g. (HealthSMART participation policy)

Funding Model Development

Yet to commence in earnest

Realisation that this is critical

Will need to be similar to WIES for inpatients:

Multiple weights

Inlier policy

Payments for ICU etc

Copayments

Specified Grants

No discussion yet on other workstreams

DH goal will be nil disruption to Health Service budgets in
Year 1

Timelines are tough

- the health reform timeline is very tough!

Very keen to support health services and costing staff

We intend to keep in touch regularly

But don't hesitate to get in touch if you need to

National Health Reform - Implementing Activity Based
Funding for Australia's Public Hospitals

3-7 October 2011

Radisson Resort, Gold Coast

Monday – Pre-conference workshops:

Introduction to costing – Day 1

Opening for seminar or workshop on topic to be decided

Tuesday – Pre-conference workshops:

Introduction to costing – Day 2

One day - Advanced Costing Workshop

One day - Casemix Statistics

Half day - Beginners guide to casemix

QUESTIONS?