



Casemix Costing in Ireland

- Uses beyond ABF

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Healthcare Pricing Office

The Healthcare Pricing Office (HPO) is part of the Health Service Executive Finance and Procurement Division and plays a central role in providing leadership for and management of activity based funding (ABF).

Formed in 2014, it merged the HIPE Unit from the ERSI with the Casemix Unit from the HSE (Previously Dept. of Health).



*HSE Website



Dual Costing Processes

1. Specialty Costing

- 44 hospitals
- Allocate financial costs/service use to clinical specialty
- Fixed Excel – 3 Files – HPO designed and managed
- Finance focused exercise
- Used by HPO
 - Block/ABF split for benchmarking
 - Full set of costs for price setting
- High Level (Specialty)
- Underpinned by Standards, Manuals, Training, Audits
- Effectively the National Cost Collection

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Dual Costing Processes

2. Patient Level Costing

- 20 hospitals (not every year)
- Allocate financial costs/service use to patient
- PPM2 – Power Health Solutions
- Used by HPO
 - To set relativities between DRGs (weights)
- Huge potential to properly benchmark costs across sites but not used for this currently
- HPO manage Standards, Training, Detailed reviews,

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Dual Costing Processes – Reasons

- Historical
- Resources
- Lack of Classifications, OPD, ED, Sub Acute
- Externs/Intercompany
- Enterprise Structures – Medical Pay
- Immature Data Landscape – Data Strategy, Shared Care Record, EHR



Costing Processes – Dual Process Issues

- Overhead Allocations
- Differences between Inpatient and Daycase cost pools
- Coverage for Pricing
- Resources



Current Scope of ABF

Activity based funding

Block funding

Acute admitted care

All other activity

Daycase

Inpatient

Outpatients

Emergency department

Other



Components of ABF

Costs

HIPE

Adjustments

ABF Adj

SPECIALTY COSTS

DRG VALUE

OTHER ITEMS

RESULT

Collected from 44 Acute Hospitals

DRG Value based on PLC Weights

Agency, Oncology Co Payment

Cost-Value

Audit/Other Adjustments

Positive or Negative

Splits Full Hospital Cost in ABF/Block

Uncoded Penalty (60%)

Transition Adjustment Applied

Model Type



Using Costs for Other Purpose

- National Service Planning – Marginal Costs and Fully Inclusive Costs of Patient Types
- Budget V Actual - Explaining the Gap
- Productivity and Savings
- Inform a standard Enterprise Structure in National Financial Management System
- Encourage use and embedding of ABF – increasingly being linked to productivity
- Surgical Hubs – potential to be fully ABF funded



Using Costs for Other Purpose – Marginal Cost

- Used 44 Consolidated Specialty Costing Files
- Re-engineered to determine patient type cost at GL line item
- Identified with costs were marginal – clinical non pay and pay



Modelling - Basic

Enter the Number of Cases to be Modelled @ 2025 Estimated Cost	1.00	1.00	1.00	1.00	
	IN PATIENT SPECIALTIES	DAY CASE SPECIALTIES	OUTPATIENT CLINICS	ED & MIU	Marginal
Discharges/Cases (Number Entered in Row 1)	1	1	1	1	
Cost Per Modelled Number Of Discharges	2023	2023	2023	2023	Total
Total Cost per Discharge					
Marginal Pay by Discharge					
Other Pay per Discharge					
Total Pay per Discharge					
Marginal Clinical Non Pay Cost Per Discharge					
Non Clinical Non Pay by Discharge					
Total Non Pay per Discharge					
					-
Pay/Clinical NP/Non Clinical NP % Split	2023	2023	2023	2023	
Pay %					
Clinical Non Pay %					
Non Clinical Non Pay %					



Using Costs for Other Purpose

- **Results**
- Analysing trends in cost per case.
- New Development funding requests were benchmarked against marginal cost results
- Enhanced the traditional block grant method of budgeting
- Gives a focus to costing
- Not perfect but only place where these costs are gathered
- Shed a light on how a national patient level cost collection would hold valuable information that could support not just ABF and price setting but financial planning and analysis.
- It also allowed for focus to be placed on the inherent productivity in a reducing cost per case during a time of price increases and inflationary pressures.



Conclusions

- **Discussion/Conclusions**
- How can we reframe the conversion from budget versus actual in traditional finance to what patient care costs.