NSW GOVERNMENT | Health

H16/79312

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Dear James

Thank you for the opportunity to comment on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18*. NSW is generally supportive of the approach taken by IHPA. A detailed NSW Health response is enclosed, and key aspects of the NSW submission are highlighted as follows:

- NSW considers the review of the Intensive Care Unit Adjustment as a priority area and raises for IHPA's consideration comments on the current approach to the determination of this adjustment.
- NSW is supportive of IHPA's intention to introduce a bundled price for maternity care but has reservations about the proposal and requests that IHPA consider undertaking further work to clarify the scope of bundled services.
- NSW supports elements of Options 1 and 3 proposed for the pricing and funding of safety and quality of Hospital Acquired Complications, however NSW has serious reservations about Option 2.
- NSW proposes an alternative option of including a safety and quality adjustor in the NWAU calculation to determine the pricing and funding for public hospital services.

In support of the National Health Reform Agreement's principle of transparency, I endorse the publication of NSW Health's submission on IHPA's website. If you would like to discuss NSW Health's position, please contact Ms Jacqueline Ball, Executive Director, Government Relations on 9391 9469.

Yours sincerely

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31/10/16

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IHPA Consultation Paper
Pricing Framework for
Australian Public Hospital Services 2017-18

NSW HEALTH SUBMISSION

This submission provides comments on the Consultation Paper prepared by the Independent Hospital Pricing Authority (IHPA) regarding the Pricing Framework for Australian Public Hospital Services 2017-18.

Chapter 4 Classifications Used by IHPA to Describe Public Hospital Services

4.4 Australian National Subacute and Non-Acute Patient Classification

Consultation Question:

1. What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient Classification?

NSW notes that IHPA is undertaking further consideration regarding whether there is sufficient data to price subacute paediatric services using the classification from 1 July 2017. NSW commenced reporting paediatric SNAP activity against the AN-SNAP V4 paediatric classes in 2016/17. NSW recommends continuing the care type per diems until NEP19 when costed paediatric activity is collected through the National Hospital Cost Data Collection. As an intermediate step, NSW suggests IHPA considers developing preliminary weights for the classes.

In relation to cognitive impairment, consultation across the NSW Local Health Districts has indicated that the Standardised Mini-Mental State Examination data item may no longer be an appropriate assessment tool for degree of cognitive impairment. Issues such as:

- patients who present frequently can remember the previous answers; and
- limited effectiveness for non-English speaking patients or patients with impaired verbal communication.

NSW supports developing Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5 and recommends that IHPA includes investigating new and emerging models of subacute care, such as palliative care in the home, in the AN-SNAP work program.

NSW recommends that IHPA take into consideration safety and quality issues in Version 5 of AN-SNAP with the view that there is an opportunity to incorporate aspects of safety and quality, including better recognising Hospital Acquired Complications.

Recommendations of additional areas for IHPA to consider in V5 of AN-SNAP:

- Continue to use care type per diems to price subacute paediatric services.
- Investigate new and emerging models of subacute care in the AN-SNAP work program, such as palliative care in the home.
- Consider safety and quality issues in AN-SNAP Version 5.

4.7 Teaching, Training and Research

NSW provides the following comments for consideration by IHPA in relation to Teaching, Training and Research (TTR).

NSW acknowledges that the outcome of the TTR costing study is a reasonable starting point for the development of a classification for teaching and training only (excluding research capability as results were insufficient for use in classification development).

It will be important for classification development to acknowledge and where possible compensate for data limitations highlighted in the Costing Study Report. Data limitations include concerns around the exclusion of embedded teaching and training, accounting for 80 per cent of total costs, and about the small data set sample sizes of midwifery and dentistry trainees, which would benefit from more robust collection and analysis.

Clinical advice from NSW's key clinical networks indicates that further work is required to increase the clarity in staff categories and the application of weighted workforce costs, particularly in midwifery and dental. Further clarity in the classification categories would help to smooth significant data volatility and improve the likelihood of clinical consensus on applying weighted workforce costs.

NSW supports IHPA undertaking further developmental work on a teaching and training classification and will continue to participate in the development of this classification through pilot studies across the state and membership on key working groups. When available, further information regarding the proposed research development plan would be appreciated.

Recommendations in relation to Teaching, Training and Research Classification:

- Undertake further development work on a teaching and training classification.
- Consider data limitations in capturing embedded TTR.

4.8 Australian Mental Health Care Classification (AMHCC)

NSW provides the following comments for consideration by IHPA in relation to the AMHCC.

NSW would encourage IHPA to consider and test the relativities within this classification and recommends that IHPA ensures that there is sufficient data to test these relativities between settings. For example, there is concern that the weighting threshold in the acute phase of care in the community setting is higher (20) than in the admitted setting (14). This appears to provide a disincentive to managing acutely unwell consumers in the community. NSW also queries whether the AMHCC takes into consideration specialist mental health services providing long term care.

Recommendations in relation to the Australian Mental Health Care Classification:

- Consider and test the relativities of AMHCC.
- Propose a staged approach to implementation of the AHMCC taking into account that some standalone psychiatric facilities are currently block funded.

Chapter 6 The National Efficient Price for Activity Based Funded Public Hospital Services

6.1 Technical Improvements

Consultation Question:

2. Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2017-18?

Pricing non-admitted services

NSW notes that IHPA is considering whether the NHCDC is sufficiently mature to determine non-admitted price weights in NEP17. NSW supports the use of the NHCDC to price non-admitted services.

Pricing mental health services

NSW, as system managers, continues to invest significant resources to prepare for the introduction of the AMHCC. NSW was a lead contributor to the development of the classification, participating in both the pilot and costing study. Based on these experiences, it is our considered view that there is significant risk in pricing admitted mental health services in 2017-18 due to the large number of episodes that would result in unknown end-classes. Until such further development and testing for pricing of the NEP for mental health services, NSW supports IHPA's timeframes for implementing the AMHCC to price mental health services in NEP20.

To assist Local Health Districts prepare for the implementation of this classification, NSW recommends that IHPA investigates using care type as a proxy measure until sufficient data is available to support the full implementation of phase of care variables in the NEP.NSW requests that IHPA clarify the intention to price any branch of mental health using the AMHCC to enable jurisdictions prepare for this new classification. NSW reiterates its position to delay the pricing of mental health services using the AMHCC until systems and processes are updated and a level of assurance about the quality of data is provided, and further recommends IHPA implement a staged approach of this classification.

Recommendations on technical improvements to the pricing model:

- Support the use of the National Hospital Cost Data Collection for the pricing of non-admitted services instead of the costing study.
- Defer implementing AMHCC for pricing mental health services in NEP20.
- Consider using the proxy of care type to determine a shadow price until the time that the AMHCC is implemented for pricing.

6.2 Adjustments to the National Efficient Price

NSW provides the following comments for consideration by IHPA in relation to adjustments to the NEP.

Patient Remoteness Area Adjustment

NSW broadly supports IHPA's approach for NEP17 to better recognise patient transfer costs related to treating high cost outliers in the national pricing model. NSW suggests that further work is required to ensure any revised pricing approach best reflects where costs are incurred. Specifically, the costs for inter-hospital transfers are incurred by the sending hospital (often rural) whilst the benefit of the Remoteness Adjustment is currently accrued by the receiving hospital (often metropolitan). Furthermore, NSW notes that transport costs are unavoidable cost drivers for rural areas, affecting in particular a group of adversely impacted small NSW rural hospitals that are priced using ABF since IHPA's change to the small volume block funding threshold in NEP15.

NSW recommends that IHPA works with jurisdictions to undertake further analysis prior to proceeding with the proposed amendment to the Remoteness Adjustment.

Intensive Care Unit Adjustment

NSW considers that reviewing the Intensive Care Unit (ICU) Adjustment is a priority area for NEP17. Continued use of mechanical ventilation hours to determine an ICU's eligibility for the ICU Adjustment was noted in 2013 as a clinically confounding measure that does not promote patient outcomes nor best practice models of care.

ICU models of care increasingly use non-invasive intervention methods, and extend the ICU's traditional reach into acute care wards. This outreach approach is not supported by the current ICU threshold requirements. NSW requests that IHPA undertake a further review of the ICU pricing methodology and strongly recommends that to maintain stability in sites that are on the fringe of ICU eligibility, IHPA should adopt the tolerance of one standard deviation from the current threshold.

In line with IHPA's pricing guidelines to foster clinical innovation, NSW recommends that IHPA consider using patient based factors, such as clinical measures, to determine the ICU Adjustment. This could include the testing of the appropriateness of using APACHE scores as well as the inclusion of non-invasive mechanical ventilation. NSW also recommends that IHPA further investigates alternative data sources to test new approaches to the ICU Adjustment, such as registries data, in developing NEP17.

NSW requests IHPA evaluates the following patient-based factors as the basis for further adjustments to the pricing model for NEP17:

- *Obesity/Bariatric adjustment* - NSW Emergency Department (ED) clinicians consider this patient characteristic to be a significant cost driver for EDs.
- *Culturally and Linguistically Diverse (CALD) patients* — propose that the ABF Data Set Specification is amended to include the introduction of an 'interpreter services flag' to assist in identifying and costing CALD patients.

Recommendations to adjust the National Efficient Price:

- Undertake further analysis prior to proceeding with the proposed amendment to the Patient Remoteness Area Adjustment.
- Adopt a tolerance of one standard deviation from the current threshold to ensure stability in sites on the fringe of ICU eligibility.
- Consider using patient-based factors to determine an ICU adjustment.
- Investigate alternative data sources to test new approaches to the ICU Adjustment, such as registries data
- Evaluate new patient-based factors as the basis for further adjustments for NEP17.

6.3 Stability of the National Pricing Model

Consultation Questions:

3. Should IHPA further restrict year-on-year changes in weights?
4. What are the priority areas for IHPA to consider when evaluating adjustments to NEP17?
5. What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

IHPA needs to balance the need to maintain the stability of the national pricing model with the ability to provide accurate and relevant data to clinicians to identify clinical variation. The States as system managers have the ability to mitigate some of the volatility due to sudden changes in price weight provided that these changes are the results of a more accurate reflection of the cost of providing care, reflecting new and emerging models of care and establishing a transparent environment to foster clinical engagement. NSW recommends that IHPA invests in data quality initiatives to strengthen the quality of the cost data and works in collaboration with the jurisdictions to develop a data quality framework.

Recommendation relating to stability of the National Pricing Model:

- Invest in data quality initiatives to strengthen the quality of the cost data and works in collaboration with the jurisdictions to develop a data quality framework.

Chapter 7 Setting the National Efficient Price for Private Patients in Public Hospitals

Consultation Question:

6. Should IHPA phase out the private patient correction factor in 2018-19 if feasible to do so?

NSW does not support the phasing out of the private patient correction factor in 2018-19 as the costing standards are inadequate. NSW recommends IHPA undertake consultation with system managers as originally planned in 2015-16 prior to the implementation of AHPCS Version 4. NSW recommends that AHPCS Version 4 needs to be successfully implemented in the NHCDC prior to phasing out the private patient correction factor.

Recommendation relating to the private patient correction factor:

- Maintain the private patient correction factor until AHPCS Version 4 is successfully implemented in the NHCDC.

Chapter 9 Bundled Pricing for Maternity Care

Consultation Questions:

7. Do you support IHPA's intention to introduce a bundled price for maternity care in future years?
8. What stages of maternity care and patient groups should be included in the bundled price?
9. Should IHPA include postnatal care provided to the newborn in the bundled price?
10. What other issues should IHPA consider in developing the bundled price?

NSW is supportive of IHPA's intention to introduce a bundled price for maternity care in NEP18, if feasible and aligned with evidence-based models of care. NSW will continue to support IHPA through representation on the Bundled Pricing Advisory Group.

Bundled pricing is aligned with IHPA's pricing guideline of efficiency particularly improving the value of public investment in hospital care because it represents a step towards factoring in allocative efficiency in addition to technical efficiency, and moving from purchasing at an average price to purchasing for value.

Initial data analysis conducted by NSW suggests that the conceptual framework for bundling pricing for maternity care services is potentially sound, but requires further analysis as concerns remain in respect to the timeframe for implementation and the potential impact on the Data Set Specifications/Data Request Specifications, as well as the ability of the Administrator of the National Health Funding Pool to implement such changes.

NSW has a number of reservations about the proposal for a bundled price for maternity care and seeks consideration and clarification on the following issues:

Maternity care across multiple sites

Bundled pricing models will need to take into consideration the potential for a patient to be serviced by both ABF and Block funded hospitals. In regional areas where services are networked to maximise both effective and efficient delivery of services, patients who move between Block and ABF funded services for a single 'patient journey' is a confounding factor to working within an ABF model. For example, one of our clinical networks has an ABF funded Base Hospital, with sub-acute and palliative care services for the region predominantly provided out of a Block funded hospital that also provide regional non-admitted services under a Block funded model.

Consideration should be given to situations where the patient delivers baby at a metropolitan centre and returns to a rural region for follow-up care. Data linkage across Local Health Districts and settings remains a challenge.

Scope

IHPA states that some patients are unsuitable for the bundled price due to service utilisation or clinically warranted reasons; NSW seeks further clarification for the conditions that will determine if a patient is in or out of scope for the bundled price.

NSW seeks clarity on the pricing rules regarding when a patient is initially treated in a public hospital setting within the bundle, then moves to a public/private shared care arrangement, or if the reverse situation occurs. Similarly, NSW seeks clarity on how a patient would be treated when they commence on a bundled price pathway, but changes in their condition mean bundled pricing is no longer applicable.

NSW seeks clarity on how a maternity bundled price would account for qualified and unqualified babies if postnatal care to the newborn is included, especially if there are any changes over time in the mix of qualified to unqualified infants.

Patient casemix complexity, complication and comorbidities, and demographics including Aboriginality need to be considered when establishing patient complexity specifically for antenatal and post-natal care provided by Child & Family Services and Maternity Services.

If post-natal care is included, IHPA needs to give consideration to the differing models of post-natal care delivery and the evidence based outcomes of these models.

Other issues to consider

NSW seeks clarification on how the bundled price will treat patients whose treatment covers more than one financial year, and the relationships with the functions of the Administrator of the National Health Funding Pool.

NSW seeks clarification on how the bundled price will be applied to patients who receive cross border treatment.

NSW notes that tracking the activity and data requirements for this funding model will be a challenge and potentially administratively heavy.

Recommendations to consider in regards to bundled pricing of maternity care:

- Support a bundled approach across the patient journey continuum of maternity care, including pre and post natal.
- Exclude from the bundle those patient journeys not fully undertaken in the public system.
- Clarify the scope of bundled services.
- Undertake further analysis of the data, such as high complexity care, cross border/LHD or financial years and in particular an exploration of the cost drivers such as primipara versus multipara.

Chapter 10 Setting the National Efficient Cost

While no consultation questions have been raised in this section, NSW includes the following comments for consideration.

Teaching Training and Research

NSW is continuing to improve the cost allocation to better reflect Local Health District costs incurred to provide TTR in preparation for the introduction of a TTR classification. NSW recommends IHPA continue its work towards developing a national classification.

Non-admitted mental health services

NSW is continuing to use an interim state based Non-Admitted Mental Health classification in 2016-17.

Chapter 11 Pricing and Funding For Safety and Quality

11.4 Overview of Scope and Approaches to Pricing and Funding

Consultation Question:
11. Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?

NSW welcomes the Heads of Agreement commitment by First Ministers in April 2016 to improve safety and quality in public hospital services and patient health outcomes. NSW supports the development and implementation of evidence-based pricing and funding reforms that meet the stated reform objectives in the Ministerial Direction of sending a price signal to the health system of the need to reduce instances of poor quality patient care, while supporting improvements in data quality and information available to support clinicians' practice.

Pricing and funding adjustments that incentivise improved patient health outcomes and decrease potentially avoidable demand for public hospital services can only be effective if they are based on up-to-date, high quality data that is acceptable to clinicians. This is an essential requirement for introducing new pricing and funding models. More importantly pricing and funding models must be part of a broader set of changes to improve safety and quality in public hospital services, including patient safety initiatives and local clinical engagement and co-design.

In recent years, NSW Health has introduced an incremental, collaborative and evidence-based approach to improving safety and quality in public hospital services, using both purchasing and performance levers. NSW has gradually introduced purchasing adjustors as incentives and disincentives to provide quality, appropriate and effective care as part of its purchasing strategy. Service Agreements between the Ministry of Health and Local Health Districts and Health Networks contain performance measures relating to safety and quality, unplanned readmissions, unplanned re-presentations and potentially preventable hospitalisations. NSW Health continues to use the Hospital Acquired Complications list to

inform the evolution of adjustors included in the purchasing model and performance measures included in Service Agreements.

A major focus to support funding adjustments in NSW has been on improving data collection and analytic capabilities, such as developing the NSW Activity Based Management Portal to improve data quality and provide clinicians with access to data to inform decision making. Links between datasets in different parts of the public hospital system (e.g. safety and quality information linked to service access and patient flow data and mental health data) have also been established to improve understanding of a patient's experience across public hospital services.

Our experience tells us that a model that incentivises better performance and provides the information and tools that are actionable by individual clinicians will work best.

Recommendations in relation to scope and approaches to pricing and funding:

- Consider ways to support data collection and analytic capabilities to drive data quality improvements.
- Consider pricing and funding models that incentivise improved performance and provide accessible tools and information for clinicians to action change.

11.4.4 Risk Adjustment

Consultation Question:

12. What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?

Age and complexity or co-morbidities are the most important factors to consider in risk adjustment for hospital acquired complications. This could potentially be accommodated by using an episode clinical complexity score. Hospital peer group and geographic location are also important.

Adjusting for risk will be essential, especially in the introduction phase of such a critical development. NSW supports risk adjustment that is meaningful and clinically relevant to support the introduction of safety and quality pricing or funding. Jurisdictions will need to focus efforts on improving data quality to ensure accurate and robust data is available for risk adjustment purposes.

Risk adjustment is also important to give clinicians confidence that their performance is comparable and considered in a relative way.

Recommendations in relation to risk adjustment:

- Consider age and complexity or co-morbidities as risk adjustment factors for HACs.
- Improve data quality to support risk adjustment.

11.4.5 Criteria for Assessing Pricing and Funding Options

Consultation Question:

13. Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing for safety and quality? Are there other criteria that should be considered?

NSW is generally supportive of IHPA's assessment criteria to evaluate the different approaches, subject to the following points. Two additional criteria are suggested as essential to evaluating a preferred approach – actionable by clinicians and value-based care.

NSW recognises that IHPA has determined criteria most relevant to assessing options in terms of the national funding model. However, a broader set of criteria must be used by decision makers on preferred approaches for shadowing and implementation given that pricing and funding approaches will impact and be impacted by other initiatives to improve safety and quality. A number of additional considerations are outlined in the Ministerial Direction to IHPA and remain relevant to options assessment.

Assessment criteria	NSW position
Preventability	NSW agrees that pricing and funding approaches must be based on good evidence of the preventability of a hospital acquired complication or event including taking into account its relative preventability. Further work is needed to define the process for determining preventability. The Australian Commission on Safety and Quality in Health Care's work to assess acceptable preventability rates in relation to individual items on the Hospital Acquired Complications list should be considered as part of developing and implementing pricing and funding approaches.
Equitable risk adjustment	NSW agrees that equitable risk adjustment must be considered in developing pricing and funding approaches, particularly taking into account age and complexity. NSW accepts that the current National Weighted Activity Unit (NWAU) calculation adjusts for cost in relation to indigeneity and geographic location, and that this is in some cases a proxy for complexity. The DRG system is another proxy for risk adjustment given its different casemix ratings.
Proportionality	NSW agrees that pricing/funding adjustments to public hospital services should be commensurate with the additional costs incurred as a result of diminished safety and quality.
Transparency	NSW supports the design of simple and transparent pricing and funding approaches to safety and quality to encourage action at all relevant levels of the health system.
Ease of implementation	NSW agrees that implementation of pricing and funding approaches that achieve the reform intent should be as straightforward as possible, and should not result in undue administrative burden on any part of the system.
Actionable by clinicians	Consistent with the Ministerial Direction, NSW considers that each of the options must be assessed to determine whether adjustments relate to conditions or complications on which clinicians are reasonably able to take action to reduce their incidence or impact.

Assessment criteria	NSW position
Value-based care	NSW considers that each of the options must be assessed as to whether it drives better value care, in terms of improved clinical outcomes, resource use, and patient experience. This is also consistent with the Ministerial Direction that requires options be developed that add to the evidence base for strategies to address safety and quality and their impact on patient outcomes.

Recommendations in relation to criteria for assessing pricing and funding options:

- Recognise that a comprehensive set of criteria is relevant to assess options for introducing pricing and funding for safety and quality.
- Add two assessment criteria: 'actionable by clinicians' and 'value-based care'.

11.5 Sentinel Events

Consultation Questions:

14. Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?
15. Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?

Sentinel events have serious consequences for patients. NSW supports the considered implementation of evidence-based policies that reduce the likelihood of sentinel events occurring.

An important aspect of introducing a funding adjustment will be the ability to identify sentinel events in collected data. As IHPA notes, there is currently no reporting of sentinel events in the Admitted Patient Care NMDS. These are reported separately through the Incident Information Management System (IIMS) dataset in NSW. IHPA has therefore proposed a workaround whereby jurisdictions self-report sentinel events by applying a flag to any episode including a sentinel event.

NSW notes that requiring jurisdictions to add a sentinel event flag will have resource implications, and jurisdictions will need to work through implementation challenges to ensure that clinicians can accurately identify and code sentinel events. NSW is already working to implement a new version of IIMS to improve the timeliness of data submissions.

It is noted that attaching the sentinel event flag to the Admitted Patient record would require an intermediate step to link the records as the data is captured by separate systems. NSW expects that this linking step would likely be required by every jurisdiction and a policy will be required on how to treat records that cannot be probabilistically linked.

NSW recommends development of agreed definitions and data collection methodology for sentinel events to ensure consistency across jurisdictions.

NSW notes that the ACSQHC is currently reviewing the national sentinel events list and that a report is due to be submitted to COAG Health Council in mid-2017.

NSW agrees with IHPA that the option of removing episodes with sentinel events from the calculation of the NEP would not achieve the reform intent or be targeted or transparent. It is noted that this approach would result in a negligible reduction in the NEP across all public hospital services.

Recommendations in relation to sentinel events:

- Develop an appropriate, nationally consistent policy for treating records captured in separate systems that cannot be probabilistically linked.
- Develop agreed definitions and data collection methodology for sentinel events, in partnership with appropriate national health agencies and ministerial councils.

Consultation Questions:

16. Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?

NSW agrees with IHPA's assessment of this option against the criteria, while reiterating the resource implications and potential for inconsistency of the proposed flag to self-report sentinel events to IHPA.

11.6 Hospital Acquired Complications

NSW acknowledges IHPA's efforts in developing pricing and funding options for national discussion. NSW supports elements of Options 1, recognises the value of a mix of positive and negative incentives in Option 3, but has serious concerns about Option 2 and elements of Option 3. The rationale for these views is set out below.

NSW proposes an alternative option of including a safety and quality adjustor in the NWAU calculation.

Consistent with the Ministerial Direction, any agreed pricing or funding models should be preceded by a shadow year. This shadow period will need to determine, based on evidence, which model and potentially which individual HACs should move from shadowing to implementation.

Before implementing any pricing/funding model, data quality improvement must be prioritised. Unless actions are taken to improve data quality, adjustments to pricing or funding will be met with resistance by clinicians and are unlikely to achieve the desired effect of improving patient health outcomes. The shadow year will be important to improve and embed better data practices.

Option 1: Remove the HAC so that it does not contribute to DRG assignment

Consultation Questions:

17. What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC?
18. Do you agree with IHPA's assessment of this option [1]?

The key advantage of Option 1 is that the adjustment is made at the episode level, establishing a clear linkage with the service provided to the patient by a clinician.

The main disadvantage of Option 1 (and other options) is that the funding adjustment is made retrospectively. Retrospective adjustment will make it extremely challenging to communicate to clinicians that they receive less funding on account of actions they took two years ago, which they may have taken steps to resolve since then.

Further, Option 1 is not risk adjusted. Recognition of the fact that procedures performed in hospitals carry varying levels of risk will be critical to reforms being meaningful to and accepted by clinicians. For example, among the top 20 NSW facilities with the highest HAC rates, half are Principal Referral hospitals that often perform the most complex procedures. Option 1 would penalise clinicians performing complex and potentially lifesaving procedures, such as a heart transplant, that carry a higher risk of complication than non-comparable procedures with a lower risk profile. IHPA will need to consider carefully the rates of preventability for each HAC and recognise that there may be unavoidable costs.

NSW notes IHPA's analysis shows that, for around 85 per cent of episodes with a HAC, the Commonwealth contributes, on average, significantly less towards these episodes than States and Territories.

It is also noted that Option 1 would only address 15 per cent of episodes with a HAC, sending a relatively weak signal to the health system.

Assessment criteria	NSW position on Option 1
Preventability	Disagree with IHPA that this measure appropriately accounts for relative preventability as it is not risk adjusted and only targets a small number of episodes.
Equitable risk adjustment	Disagree with IHPA's rationale that risk adjustment is not appropriate because the adjustment would apply to only a minority of episodes. Age and complexity are key factors that affect the likelihood of a HAC occurring and the higher risks can and should be reflected in any pricing or funding model.
Proportionality	Agree with IHPA that this approach does not apply reductions in Commonwealth funding in a way that effectively targets episodes with a HAC. Further, the reduction in funding is not commensurate to the preventability of the HAC.
Transparency	Disagree – presents a difficulty in ascertaining the degree that DRG complexity has increased due solely to the HAC. The real cost of the HAC could be masked if the HAC is not accurately identified in the DRG. In addition, this option's feature of regrouping episodes is not currently possible at the hospital level, requiring the introduction of additional steps by system managers. This is likely to adversely impact the perceived transparency of the model.

Assessment criteria	NSW position on Option 1
Ease of implementation	Agree with IHPA that this option would be easy to implement relative to Options 2 and 3. However, IHPA also needs to consider the challenges with respect to developments of the AR-DRG v9.0 and what is being proposed as a process for alternative DRG assignment for the purpose of funding. The integrity of the classification needs to be maintained where assignment is driven by patient clinical attributes, in order to achieve clinical coherence (noting the broader use of the DRG classification by health system managers, health funds, researchers, epidemiologists, health economists and statisticians).
Actionable by clinicians	Episode level adjustment establishes a clear linkage between the HAC and the service provided to the patient by a clinician. However, the retrospective adjustment and the required regrouping will make it extremely challenging to communicate to clinicians that they receive less funding on account of actions they took two years ago, which they may have taken steps to resolve since then.
Value-based care	This option provides a disincentive for poor quality care, with no incentives for improvement to drive change in a positive way. In addition, this option targets only a subset of HAC episodes – the limited coverage could be perceived as reducing the ability to transition to a value-based care model that focuses on improving patient outcomes, experience, and better use of resources.

NSW notes that IHPA considered an option whereby all episodes with a HAC would be removed from the cost and activity data prior to calculating the NEP, and agrees with IHPA that this would be a blunt approach that would not achieve the targeted reform required.

Recommendations in relation to Option 1:

- Include risk adjustment for age and complexity.

Option 2: Funding adjustments made on the basis of differences in HAC rates across hospitals

Consultation Question:

19. What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?
20. Do you agree with IHPA's assessment of this option [2]?
21. What are the advantages and disadvantages of the approaches to risk adjustment?

NSW has serious reservations about Option 2 for the following key reasons:

- Applying funding adjustments at the hospital level is too far removed for clinicians to be able to see the linkage with their actions

- No matter the rate of improvement, the lowest-ranked quartile of hospitals will always be penalised even if they have improved performance significantly
- As for Options 1 and 3, the funding adjustment would be made retrospectively based on old data, effectively penalising clinicians for actions taken two years ago, which may now have been improved on and resolved.

Option 2 will not drive the change intended by Ministers and First Ministers to improve patient outcomes.

Assessment criteria	NSW position on Option 2
Preventability	Disagree with IHPA – does not account for varying preventability rates of HACs.
Equitable risk adjustment	Disagree – risk adjustment at the hospital level rather than the episode level will not achieve equitability for episodes with HACs.
Proportionality	Disagree – LHDs and clinicians may make significant improvements in quality of care yet still receive adjusted funding because there will always be a 'lowest quartile'. In particular, this would have an unfair financial impact on a hospital at the margins of the proposed quartiles.
Transparency	Disagree – a hospital level adjustment will generalise accountability for episodes with a HAC, rather than using the available architecture of the ABF model to be specific and targeted about the change required.
Ease of implementation	Disagree – this option relies on IHPA processing and reporting results, which might not be timely, leaving system managers to implement successful mitigation strategies. By that time, the data would become too old to be actionable.
Actionable by clinicians	As for Options 1 and 3, a retrospective adjustment will make it extremely challenging to have meaningful conversations with clinicians, as the adjustment would be based on old data.
Value-based care	This option provides a disincentive for poor quality care but no incentives for improvement to drive change in a positive way.

Recommendations in relation to Option 2:

- Nil – other options will better achieve the reform intent.

Option 3: A quality-adjusted NEP with funding incentives for hospitals with the lowest HAC rates

Consultation Question:

22. What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties?
23. Do you agree with IHPA's assessment of this option [3]?

NSW recognises that Option 3 provides for positive adjustments to incentivise delivery of better value care by clinicians, which could be used to invest in further improvements and strategies for safe, quality care. However, NSW has serious reservations about Option 3 because:

- As for Option 2, it relies on a hospital level adjustment, which is too far removed for clinicians to be able to see the linkage with their actions
- As for Options 1 and 2, funding adjustments would be made retrospectively based on old data, effectively penalising clinicians for actions taken two years ago, which may now have been improved on and resolved.

Assessment criteria	NSW position on Option 3
Preventability	Disagree with IHPA – does not account for varying preventability rates of HACs.
Equitable risk adjustment	Disagree – risk adjustment at the hospital level rather than the episode level will not achieve equitability for episodes with HACs.
Proportionality	Fairer than Option 2 but still does not apply reductions or adjustments in a targeted way because adjustments are not made at the episode level.
Transparency	Disagree – LHDs and clinicians would struggle to see the linkage between funding adjustments and patient care.
Ease of implementation	Disagree – more difficult than Option 2, requiring governance arrangements regarding funding adjustments.
Actionable by clinicians	Withdrawing funds from hospitals that perform relatively less well in safety and quality might have the perverse effect of creating a reluctant environment to report HACs and sentinel events, and could result in facilities becoming reluctant to treat high risk complex patients. As for Options 1 and 2, a retrospective adjustment will make it extremely challenging to have meaningful conversations with clinicians, as the adjustment would be based on old data.
Value-based care	Provides an incentive for improving the quality of care, but not at an episode level.

Recommendations in relation to Option 3:

- Nil – other options will better achieve the reform intent.

Consultation Question:

24. Are there any other pricing or funding options that IHPA should consider in relation to HACs?

Alternative proposal: Safety and Quality NWAU adjustment

NSW recommends that IHPA consider an alternative option that addresses concerns with other proposed options, by refining the national funding model to include a Safety and

Quality NWAU adjustment as part of setting the NWAU formula to apply to the National Efficient Price annually. Adjustments to the NWAU are currently made for other factors, such as paediatrics, indigeneity, and geographic location.

Under this option, IHPA would calibrate the adjustment factor for each DRG using the known cost difference between HAC episodes and non-HAC episodes. IHPA would then reduce the NWAU for episodes with one or more HAC within a particular DRG, and correspondingly increase the NWAU weights for episodes without a HAC within the same DRG.

Importantly, refining the national funding model in this way would send a dual signal of reducing funding for poor quality care (episodes with a HAC) at the same time as increasing funding for good quality care (episodes without a HAC) – all within the current ABF model. Off-setting reductions with positive adjustments that can be used to invest in strategies to further improve safety and quality is essential to sending the right signal at the health system level that can actually improve patient health outcomes and achieve the reform intent of First Ministers and Health Ministers.

IHPA needs to balance the risks associated with introducing significant penalties to HAC episodes with the ability of hospitals and system managers to absorb and implement the change. Too swift a change without appropriate resources and support for clinicians and LHDs risks them not being able to deliver improved patient and system outcomes, and potentially even reduces their ability to deliver care or activity.

NSW suggests that the introduction of an incentive would create the right signal to support the changes required to make significant improvements in safety and quality in the short term. These short-term gains will also realise further efficiencies, potentially contributing to lowering the NEP and freeing up additional capacity to treat more patients.

The key advantages of this option over Options 1-3 are:

- Prospective adjustment because it is done as part of setting the NWAU formula
- Risk adjusted because it relies on the DRG complexity rates, and is amenable to further risk adjustment for age and complexity
- Positive, value-based signal to the system because it includes incentives for high quality care as well as disincentives for poor quality care.

Assessment criteria	NSW position on Alternative Proposal
Preventability	**Targeted:** Can incorporate evidence on preventability rates for HACs as it becomes available from work underway by the ACSQHC.
Equitable risk adjustment	**Risk adjusted***:* Incorporates risk adjustments as it is DRG-based, which serves as a proxy for casemix complexity, particularly given that AR-DRG version 8.0 includes new measures for capturing patient complexity. Further risk adjustment for age and complexity could be built into this proposal.
Proportionality	**Targeted:** Effectively targets all episodes with a HAC.
Transparency	**Episode not hospital level adjustment:** Pricing and funding adjustments are made at the episode level, where changes will be most transparent to clinicians

Assessment criteria	NSW position on Alternative Proposal
Ease of implementation	**Refines rather than creates an additional funding model:** A Safety and Quality adjustment is a natural evolution of the current approach to setting and funding based on a National Efficient Price, and applies to all HACs rather than the minority identified for adjustment in Option 1. This sends an important signal across the system. **Flexible**: Allows for flexibility in changes in the applicable discounts on a yearly basis, as this option will form part of the regular update of the National Funding Model. This option can also inform further refinements in the DRG classification system, and respond quickly to casemix changes.
Actionable by clinicians	**Prospective not retrospective***:* Prospective adjustment aligns with national and jurisdictional approaches to funding and purchasing, requiring hospitals to make plans to improve safety and quality prospectively as there is a clear signal in the NWAU values. Prospective approach also addresses issue of out-of-date data forming the basis of funding adjustments, and can respond quickly to casemix changes. **Meaningful to and actionable by clinicians**: A by-product of the transparent Safety and Quality adjustor will be provision to clinicians of meaningful information for benchmarking performance to reduce unwarranted clinical variation, while vesting clinicians with control over changing patient outcomes with measureable incentives. The incentive built in this proposal would ensure that resources are allocated to be invested in appropriate clinical programs to ensure improvements can be achieved.
Value-based care	**Positive, value-based signal to the system:** Clinicians (and by extension the facilities they operate in) who are good at reducing HACs are not penalised, and are incentivised to more routinely deliver safer and higher quality care (non-HAC) episodes of care by the redistribution of funding within the national funding model. **Articulation with outcomes-based management**: This option positions IHPA and jurisdictions well to begin investigation of appropriate outcomes measures that could support future developments in improving safety and quality and patient outcomes.

Jurisdictions would receive the same level of Commonwealth funding for the base, and have discretion to adjust jurisdictional funding through local purchasing models. The Commonwealth 6.5% growth funding cap and State and Territory budgetary constraints will limit the volume of activity delivered.

Additional rules could be applied to this model to ensure that some DRGs are not unfairly affected by this policy. For example, the DRG adjustments could be capped as per IHPA's stability policy (ie 20% maximum). Alternatively, a four year reduction plan could be considered in capping the discounts (ie if the cost variance between a HAC and non-HAC is 40%, the discount and reinvestment would be capped at 10% for four years). This will ensure that clinical improvement programs would have time to be implemented. Consideration could also be given to applying the adjustor only once an unacceptable rate

has been reached, tying in with the work underway by the ACSQHC to develop preventability rates for each HAC. This will be important to support innovation in complex areas and not deter clinicians from innovation.

NSW recognises that further investigation of this approach is required and is happy to work with IHPA and partners to develop it. NSW considers that it could be developed in time for a shadow Safety and Quality adjustor to be in place in 2017-18, and, pending evaluation, adjustments to NWAU price weights applied from 2018-19.

Recommendations in relation to NSW alternative proposal:

- Consider the development of an NWAU adjustment for safety and quality.

11.6.8 Responding to Condition Onset Flag Data Quality Issues

Consultation Question:

25. How should IHPA treat hospitals with poor quality Condition Onset Flag (COF) reporting?

NSW acknowledges the importance of COF reporting and has made significant improvements in recent years.

NSW suggests that with time and the expected data quality improvements, IHPA consider treating all records with a missing COF (i.e. COF 9) as if a HAC was presented (i.e. COF 1). The number of records with missing COFs is a very small, and progress to improve coding is underway (e.g. in NSW COF 9s represent less than 0.2% of the data now that remedial actions have recently been taken).

Regular reporting and benchmarking of COF reporting quality at facility level could drive higher and better quality reporting and monitor implementation to avoid gaming (which is less likely as the AR-DRG classification system continues to be refined). Clear guidance in the Australian Coding Guidelines on how to define a COF in respect of HACs will also be important to improve clinical coding.

Recommendations in relation to condition onset flag data quality issues:

- Consider an incremental move to treating all records with a missing COF as if a HAC was present.

11.7 Avoidable Hospital Readmissions

Consultation Questions:

26. What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?
27. Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes?

NSW notes that the Ministerial Direction to IHPA specifies the intention of jurisdictions to focus only:

- on avoidable hospital readmissions within 5 days of discharge, and
- on those readmissions arising from complications of the management of the original condition that was the reason for the patient's original hospital stay (i.e. the original episode contained a HAC).

NSW acknowledges IHPA's analysis that shows limiting the scope of policy reform to these criteria will have a low impact on national funding ($2.3M, 289 episodes).

NSW recommends the current definitional work being undertaken by the AIHW to report on the National Health Agreement (NHA) Progress Indicator 23 be leveraged to agree an appropriate definition for avoidable hospital readmissions. This work is being undertaken under the auspice of AHMAC (through the National Health Information and Performance Principal Committee and the National Health Information Standards and Statistics Committee).

A key issue that still needs to be addressed as part of this definitional work is the identification of clinically-relevant readmission intervals for select principal diagnoses in scope of the indicator, rather than the currently specified 28-day period used for all principal diagnoses and surgery types. These intervals as currently drafted vary from 7 days to 60 days, depending on the diagnosis code and the surgery type.

NSW supports a limited focus on 5 day readmissions at this stage as per the Ministerial Direction. There must be better integration with the primary health sector, Primary Health Networks, other Commonwealth funded services, and public hospitals, before robust consideration of the readmission risk on account of hospital actions can be delineated and an appropriate threshold determined.

The 2016–17 funding proposal to AHMAC outlines the following tasks for the AIHW:

- To coordinate agreement on the 'unit of care' that is to be the basis for reporting unplanned readmissions—that is, is it just the acute care separation during which surgery was performed, or the whole of hospital stay in cases where the surgical separation is followed by a change of care type and/or hospital transfer.
- To organise expert clinical advice for further review of the ICD-10-AM principal diagnosis codes to be used for identifying unplanned readmissions (in particular, following hysterectomy, prostatectomy and cataract surgery).
- To evaluate the potential for applying risk adjustment to the readmissions data, with the aim of accounting for factors beyond a hospital's control such as patient age and comorbidities.
- In consultation with the National Health Information and Performance Principal Committee (NHIPPC), to establish mechanisms to use data linkage to capture readmissions between public sector and private sector hospitals and between hospitals in different States and Territories.
- To finalise an indicator for unplanned readmissions following hospitalisation for acute myocardial infarction, based on the NHA PI-23A draft specification that the AIHW distributed to NHISSC members in August 2014.

NSW suggests that this scope of work be reviewed against the Heads of Agreement commitment by First Ministers and adjustments be made as appropriate to ensure the work underway can inform future funding and pricing adjustments in a nationally consistent way. It will also be important to align with work being progressed on coordinated care reform and greater integration between hospital and community services, given that avoidable hospital readmissions can result from underperformance in primary care.

Recommendations in relation to avoidable hospital readmissions:

- Leverage current definitional work being undertaken by AIHW to identify clinically-relevant readmission intervals for select diagnoses in the scope of the indicator.
- Review the scope of work being undertaken by AIHW against the Heads of Agreement commitment by First Ministers and make appropriate adjustments.

Consultation Questions:

28. Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?

NSW considers that national agreement on an appropriate definition for avoidable hospital readmissions is the first necessary step. Only then can a pricing or funding mechanism that applies to avoidable hospital readmissions within the same LHD (rather than the same hospital) and its effects be robustly considered, such as which hospital would be penalised.

Consistent with previous points, any adjustment should be at the episode level.

Recommendations in relation to avoidable hospital readmissions:

- Nil – before consideration of pricing and funding approaches for avoidable hospital readmissions and adjustments should apply within the same LHN, work with the Australian Commission on Safety and Quality in Health Care and other relevant partners is required to determine a nationally consistent definition.

Consultation Questions:

29. When should a pricing and funding approach for avoidable readmissions be implemented?

Further work must be undertaken with stakeholders to agree a nationally consistent definition and a way to identify avoidable hospital readmissions in datasets before timeframes for implementation can be determined.

A pricing or funding approach for avoidable hospital readmissions will also depend on progress in introducing a pricing or funding model for hospital acquired complications, since a policy in respect of avoidable hospital readmissions are to be seen as a subset of those readmissions with a HAC.

Recommendations in relation to avoidable hospital readmissions:

- In partnership with the Australian Commission on Safety and Quality in Health Care and other relevant parties, agree on an appropriate definition for avoidable readmissions and a way to identify avoidable hospital readmissions in datasets.

11.8 Implementing a Pricing and Funding Approach

Consultation Questions:

30. What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?

As IHPA notes, the success of safety and quality initiatives is dependent on national, state and local levels of the health system working together. A coordinated approach must be robustly designed, carefully tested and implemented, and appropriately evaluated to ensure it is achieving the desired objectives. Incremental implementation and gradual adjustment is likely to allow the system more time to adapt and reap the benefits of sustainable change.

The approaches must be clinically meaningful and within the control of clinicians in order to actually change behaviour. Approaches must be prospective and not interfere with clinical innovation, particularly given that some adverse events may be the results of new drugs or specific treatments.

The approaches must be achievable, noting that not all HACs can be completely prevented. There should be opportunities created to share experiences and lessons learned across jurisdictions.

NSW considers the assessment criteria, with NSW suggested amendments, represent a useful suite of considerations for implementation of approaches. It will be important to continually monitor data to prevent gaming and to ensure that the risks of the agreed model are not too great for systems and hospitals to adapt to.

NSW recommends excluding mental health services from consideration of pricing or funding approaches for safety and quality at this stage due to the transition to a pricing model based on the Australian Mental Health Care Classification, which NSW considers should be delayed until NEP20.

Recommendations in relation to implementation of a pricing and funding approach:

- Consider the NSW suggested amendments to the assessment criteria to enable a robust assessment of possible pricing and funding models.
- Exclude mental health services from consideration of pricing or funding approaches for safety and quality until the Australian Mental Health Care Classification is implemented in NEP20.

Consultation Questions:

31. Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?

NSW strongly supports that IHPA back-cast the impact of introducing any agreed new measures.

Back-casting will be essential to be able to compare year-on-year NWAU values and accurately account for the introduction of a significant change. Back-casting will also ensure that any incentive built into the model will not have an impact on the overall baseline funding from the Commonwealth, creating the best environment to set up a truly value-based platform to build the future funding model for public hospital services in Australia.

Back-casting will also be critical as jurisdictions will need to ensure the system is safe and operating in the first instance. The financial impact for jurisdictions would be significantly greater if no back-casting were applied, and could expose systems and hospitals to unnecessary and unwarranted financial risks that may eventuate in deteriorations in safety and quality, which is the opposite of the policy intention agreed by the parties.

Back-casting new measures for safety and quality aligns with IHPA's back-casting policy, which states that for calculating the actual growth in Commonwealth funding, the Administrator should apply the current year price weights to the previous year's activity data, to ensure that methodological changes in the national pricing model are accounted for.

Recommendations in relation to implementation of a pricing and funding approach:

- Back-cast the impact of introducing any new measures for safety and quality.