Australian Health Service Alliance

5th July 2018

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

Dear James

Re: IHPA Pricing Framework for Australian Public Hospital Services 2019-20

Thank you for the opportunity to comment on the 2018/2019 IHPA work program. As you are aware, there are areas which have either a direct impact or a flow on effect to the private sector.

Below are AHSA's responses to those questions relevant to the private sector.

Australian Refined Diagnosis Related Groups classification

1. ***How could 'Australian Coding Standard 0002 Additional Diagnoses' be amended to better clarify what is deemed a significant condition for code assignment?***

   Some general principles which should be included for consideration are:
   - Statements that this standard should be universally applied, regardless of:
     - Sector (public or private)
     - DRG version
     - Jurisdiction
     - Hospital type (ie hospital or same day facility)
   - The version of the DRG that the episode is funded should not drive coding practice or coder behaviour
     - prudent when working across older and multiple DRG versions in the private sector
     - the need to code some complications are legitimate in SOME circumstances but not routinely, for example
       - enema vs Coloxyl for constipation, the latter being insignificant
   - The standard should wherever possible be tight enough to remove perverse incentives for over-coding
   - ACS 0002 should always be intended to be aligned with the spirit and intent of the Code of Ethics
   - The need for clear documentation remains paramount
   - The culture of coding transient abnormal findings which are not treated (such as electrolyte balance) needs to be phased out.

   Further more detailed comments have been sent to the ICD Technical Group via our PHA representative.

Head Office 979 Burke Road, Camberwell VIC 3124 Phone 03 9813 4088 Fax 03 9813 4099
Australian Health Service Alliance Ltd. ABN 75 062 860 584 www.ahsa.com.au

2. ***Do you support the proposed timeframe to phase out support for AR-DRG classification versions prior to AR-DRG Version 6.X from 1 July 2019?***

No.

AHSA supports the cessation of AR-DRGv4 from 1/7/2019, and the cessation of AR-DRGv5 from 1/7/2021. These older DRG versions are locked into contracts between hospitals and insurers, and as such, lead time of 3 years notice is required. This has occurred for v4, but not for v5.

3. ***Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?***

It could be argued that the alternate biennial cycle be to update for only new/deleted ICD codes or to fix any bugs, rather than changes in the DRG classification itself; i.e. incremental versions.

AHSA suggests there be a rigorous process to assess whether a complete classification review is warranted biennially, rather than routine updates for changes' sake. It would certainly facilitate the private sector in catching up.

Developing AN-SNAP Version 5

4. ***What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?***

We are seeing more complex cases treated in the private sector. We are also seeing a push to classify impairments to multi trauma (impairment code) where patients were multi trauma during their acute phase, but not having rehabilitation to meet the multi trauma definitions.

AHSA suggests that this could be due to the lack of ability to classify complications and co-morbidities (either at commencement or arising during the acute phase) in the AN-SNAPv4 classification. This has also been reported in the public sector. However, it may also be due to the change in purpose of Function Impairment code from purely clinical, to financial and clinical.

Some of the challenge arises due to patients leaving the acute stage and commencing rehabilitation with these comorbidities or co-existing injuries in place, this at times causing some overlapping of the boundaries between care type changes between acute and rehabilitation. This is more likely to occur when the acute care occurs in a public facility, and rehab occurs in a private facility.

Given this, AHSA would like to see:

- Consideration of comorbid and complicating conditions in the rehab setting to be built into the classification
- Greater clarity around the allocation of AROC Impairment Codes which should have greater involvement/co-ordination from IHPA now that they are linked to funding by:
    - Greater transparency around the process for updating and maintaining classification standards to accompany the allocation of Functional Impairment Codes.
    - Impairment codes being treated as equivalent (in concept) to ICD-10-AM and its relationship to AR-DRG grouping. There needs to be clear standards as to the classification of impairment codes that underpin AN-SNAP grouping which ultimately drives funding, and this needs to be maintained by IHPA in order to maintain a degree of independence.

The development of a more usable classification for same day rehab would be beneficial across sectors.

Access to public hospital data

5. ***Should access to the public hospital data held by IHPA be widened? If so, who should have access?***

   As a general principle data should be freely available for analysis by any interested party with a bona fide interest in health service research. The default position should be that data is will be made available unless there is a specific reason not to do so. In saying this it is reasonable that IHPA charges a fee for provision of such data to cover its costs in the extraction.

6. ***What analysis using public hospital data should IHPA publish, if any?***

   It would be appropriate for IHPA to publish in more detail the results of its analysis on a wide range of issues and the examples given re quality (HACs, avoidable readmission) are examples of this. Care is needed to ensure there is no duplication of work that may be undertaken by other bodies such as AIHW and the Safety and Quality in Health commission. Ideally this work would be the first steps towards benchmarking all Australian hospitals irrespective of sector over a wide range of quality and efficiency parameters in the interests of transparency

Adjustments to be evaluated for NEP19

7. ***Do you support price harmonisation for the potentially similar same-day services which are discussed above?***

   This is sensible and could provide a catalyst for a similar process in the private sector.

Approach to measurement of avoidable hospital readmissions

8. ***Do you agree with the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Hospital Network (either to the same hospital or to another hospital within the same Local Hospital Network)?***

   This is an issue that can be generalised to the private sector. It does not seem appropriate that a hospital which accepts a readmission be financially disadvantaged because of issues related to another hospital which is financially part of a different body for funding purposes.

Should you have any queries regarding this matter, please do not hesitate to contact either Dr Brian Hanning brian@ahsa.com.au or myself nicolle@ahsa.com.au.

Yours sincerely

Nicolle Predl
Senior Health Information Manager