DEPARTMENT OF
HEALTH

Northern Territory submission

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20

IHPA position / Consultation question	NT response
Classifications	
Australian Refined Diagnosis Related Groups (AR-DRG)	
IHPA will continue to use AR-DRG Version 9 to price admitted acute patient services for NEP19 underpinned by ICD-10-AM/ACHI Eleventh Edition.	NT advises that there is potential for a significant change in coding practice with the implementation of the Eleventh Edition of ICD-10-AM/ACHI, particularly around the proposed change in classification guidelines for Diabetes Mellitus (diabetes) and the update to coding rules for wound management. NT recommends that the IHPA undertake an impact assessment to identify the potential change to reported activity prior to implementing a change to the codes that underpin the classification. The changes to coding practice outlined below create changes to 'casemix', which may potentially impact pricing and funding. These impacts should be understood prior to implementation of the Eleventh Edition of ICD-10-AM/ACHI to mitigate any unintended consequences. ***Diabetes:*** While NT recognises that the change in classification guideline will ensure patients with diabetes will now be assigned a more appropriate Diagnosis Complexity Level (DCL) and bring diabetes in line with other chronic conditions, the subsequent change in coding practice is likely to present growth above benchmark levels. This change should be determined prospectively for transparency and stability of the Australian health system. ***Wound Management*** NT notes that there will be an update to the coding rules relating to excisional debridement where any type of debridement performed on the ward by an Allied Health Professional will have an Allied Health code (not the debridement procedure). NT advises that there is potential for inappropriate DCL assignment, given that excisional debridement impacts AR-DRG assignment, which will consequently effect identified growth. **Example** Prior to the coding rule update (June 2018), NT coders were coding excisional debridement performed on the ward by podiatrists, wound management specialists or junior surgical staff. Following the update, excisional debridement will not be coded when performed by a Podiatrist and may be assigned a lower complexity DRG for an episode where the same procedure performed by wound management specialists or junior surgical staff may be assigned a higher complexity DRG.

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How could 'Australian Coding Standard 0002 Additional Diagnoses' be amended to better clarify what is deemed a significant condition for code assignment?	NT recommends that the Australian Coding Standard (ACS) 0002 Additional Diagnoses be revised to clarify circumstances where pathology ordered for specific conditions in an admitted episode qualifies for code assignment. Currently ACS 0002 states *"…where findings or conditions [on the results] are incidental to the episode of care and are only flagged for follow-up or referral post discharge they do not qualify for code assignment under ACS 0002 Additional diagnoses"*. This is ambiguous with regards to pathology ordered for specific conditions that are flagged for follow-up or referral post discharge. **Example** A doctor orders Iron Studies during two day admitted episode of care for an Asthmatic patient. There is no documentation which indicates why the studies were ordered, however results show the patient's iron levels are low and on the discharge summary it is noted this is to be followed up with the patients General Practitioner (GP). This condition may be coded inconsistently under the current ACS 0002 as some coders may determine that it qualifies for code assignment as the pathology was for a specific condition, however others may determine that it does not qualify for code assignment as there was no treatment instigated during the inpatient episode as it was followed up with the GP.
Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?	NT does not support a rigid biennial AR-DRG development cycle and recommends that IHPA consider changing from a *development cycle* to a *review cycle* where a materiality and impact assessment is undertaken regularly to determine whether a new version is necessary rather than determining a new version is necessary based primarily on timing. This would create a more agile environment for development which is better able to balance the clinical relevance of the classification with the potential for unintended consequences. A regular materiality assessment would ensure that suggestions for refinement are appropriately reviewed. There may be occasions where change may not be required for more than two years or circumstances which require a delay to development to allow system modification and staff training (such as the introduction of a new ICD classification (ICD-11)).
Data collection	
Access to public hospital data	
Should access to the public hospital data held by IHPA be widened? If so, who should have access?	NT agrees that greater publication of analysis using IHPA data would assist in the development and evaluation of health policy and programs, however, NT recognises that data access has been restricted to protect patient privacy, in accordance with legislative requirements. NT supports broadening access to the National Benchmarking Portal, provided that IHPA assures that patient privacy is protected by: • obtaining legal advice to ensure compliance with all state and territory laws; • implementing rigorous safeguards (as agreed by all jurisdictions) that ensures data is used appropriately; and • consulting with the human research ethics committees across all jurisdictions to ensure that access would not be over and beyond the data that should be ethically released (such as adhering to 'small' number rules).
What analysis using public hospital data should IHPA publish, if any?	NT notes that IHPA is considering publishing research beyond what IHPA has previously published. NT supports further publication of public hospital data analysis, subject to appropriate de-identification to protect patient privacy. NT encourages IHPA to work closely with the Australian Institute of Health and Welfare to leverage off their existing successful processes which identify key areas to analyse and engage with States and Territories in developing and consulting on their reports.

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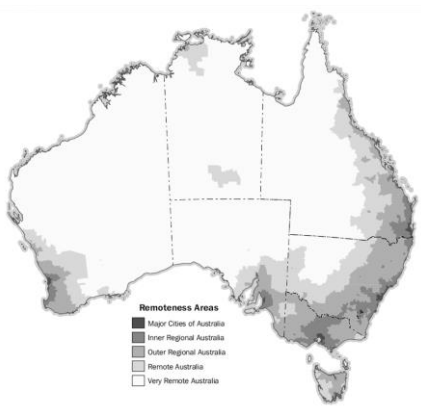
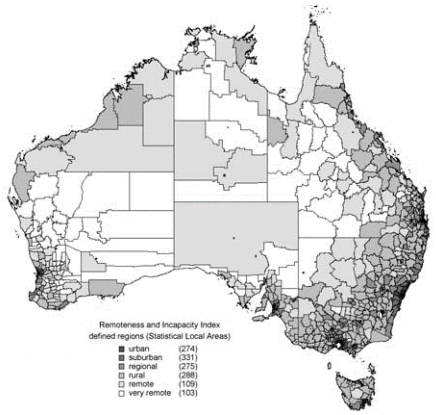
National Efficient Price	
Technical improvements	
IHPA will use available cost data to price emergency department services using the Australian Emergency Care Classification (AECC) for either NEP19 or NEP20.	NT does not support pricing emergency department services using the AECC for NEP19 as it introduces a significant change to an ABF classification system, the impact of which has yet to be understood. NT will not support pricing using AECC until the effect of this significant change is appropriately considered through an impact assessment. NT recommends that the IHPA shadow price emergency department services using the AECC and available cost data to determine the funding impact prior implementation. This will mitigate the risk of unintended consequences as it allows jurisdictions to implement any system improvements and allow appropriate transitional arrangements to be determined (if required). NT also recommends that the IHPA determine the funding impact of the introduction of the proposed additional data items, at which point, an informed decision can be made regarding whether the items are necessary. If the additional data items present a material funding impact, pricing using the AECC should not proceed until reliable data is available.
IHPA will only price or shadow price mental health services using the Australian Mental Health Care Classification (AMHCC) for NEP19 if the 2016-17 cost data is robust enough to support it.	NT does not support pricing mental health services using the AMHCC for NEP19. NT is a small jurisdiction and requires additional time to implement major changes to classifications to be able to capture the data and as such NT was not in a position to provide 2016-17 cost data. NT advises that any price based on 2016-17 cost data would not appropriately represent the nation, as it would be based on data that excludes NT due to our unavoidable inability to implement changes as quickly as metropolitan areas. This would potentially disadvantage the NT population which consist primarily of those living in remote areas and/or Indigenous Australians. NT recommends that the IHPA shadow price mental health services using the AMHCC and available cost data to determine the funding impact prior implementation, similar to the recommendation related to the AECC above.
What are the advantages and disadvantages of changing the geographical classification system used by IHPA?	NT notes that IHPA intends to review the NT's alternative approach for determining patient and hospital remoteness ahead of developing NEP19 and NEC19. NT recommended this approach as it uses a population density measure. The proposed remoteness classification increases the granularity of what the current classification considers 'very remote' as illustrated below, which more appropriately relates the measure of remoteness and the associated service delivery and accessibility requirements. **Current remoteness areas** / **Proposed remoteness areas**  

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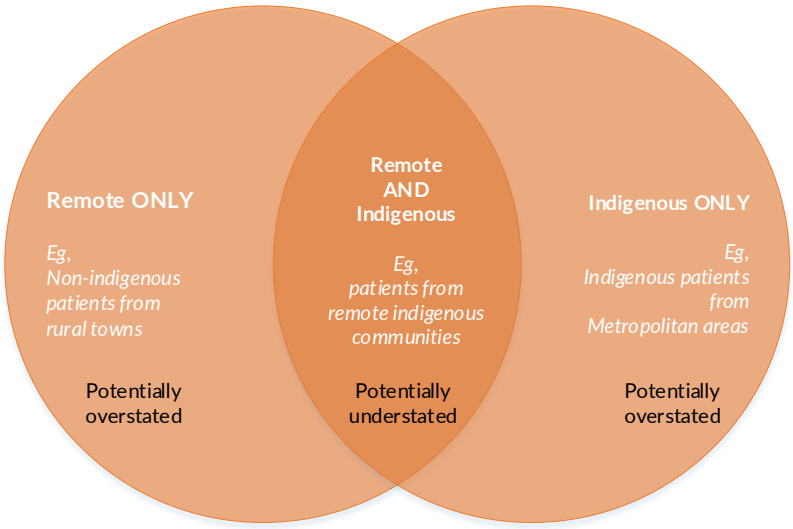
What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?	**Extending adjustments to sub-acute and non-admitted care** NT recommends that IHPA prioritise the application of adjustments to sub-acute and non-admitted patients as these care types generally treat complex comorbid patients. The absence of adjustments across care types disadvantages these hospitals as the legitimate and unavoidable costs are unrecognised. **Evaluating adjustments for patients from remote indigenous communities** NT recommends that IHPA consider the appropriateness of adjustments where a patient lives in a remote indigenous community. This may be done by examining whether the current additive adjustment is sufficient to reflect the specific health needs of patients from remote indigenous communities. NT requests that IHPA review whether remote and indigenous adjustments currently reflect the legitimate and unavoidable costs associated with the three different patient cohorts shown below. 
Shadow implementation periods	
When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model?	NT notes that IHPA intends to shadow price major changes to the ABF classification system, but not all changes such as new AR-DRG classification versions. NT recommends that IHPA apply a shadow implementation period to all changes to the ABF classification systems and National Pricing Model, unless otherwise agreed by States and Territories, where criteria is developed to provide the parameters around when it is appropriate to consider **not** applying a shadow implementation period.
Costing private patients in public hospitals	
Do you support the proposal to phase out the private patient correction factor for NEP20?	NT notes that IHPA proposes to phase out the private patient correction factor for the 2017-18 costing year and NEP 20. NT supports the proposal to phase out the private patient correction factor, subject to implementation of a shadow period. NT recommends that IHPA undertake an impact assessment to determine whether the application of the Australian Hospital Patient Costing Standards Version 4 adequately addresses the issue relating to missing private patient costs. Additionally, this change should be back-cast to understand effect of removing the private patient correction factor to 2017-18.

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National Efficient Cost	
IHPA introduced 'low volume' thresholds in 2015-16 to determine whether a public hospital is eligible to receive block funding. IHPA will retain this approach for NEC19	NT recommends that the low volume threshold only apply to activity without indigenous and remoteness adjustments. This is in line with the application of the HAC penalty approach which recognises that these relate to cost variations that cannot be avoided. NT requests that Tennant Creek Hospital is block funded, based on the low volume threshold, where activity is calculated as per the recommendation above. Tennant Creek Hospital is Australia's smallest ABF hospital and there is an absence of economies of scale that mean its services are not financially viable under ABF. This is evident where hospitals in other remote areas servicing similar sized populations are block funded, which are comparable with the calculation of activity without indigenous and remoteness adjustments.
Public hospital services are eligible for block funding where they are not able to meet the technical requirements for applying ABF.	NT recommends that emergency medical Inter hospital transfers (IHT) are block funded for remote hospitals, as the isolation of remote hospitals creates variability in the service provision which cannot be consistently classified and counted. Emergency medical IHTs from remote hospitals are therefore unable to meet the technical requirements for applying ABF. NT is heavily reliant on interstate IHTs given the relatively small size of its hospitals with no alternative other than referral and transfer to specialty facilities in southern parts of Australia. Therefore IHTs are an essential service which facilitate equitable access to high quality health care for those living in regional and remote areas. These services have a significantly high cost due to the isolation of NT hospitals and the inability to apply ABF means that NT is significantly underfunded for these services. **Example** A 15-year-old indigenous patient with lymphoma and non-acute leukaemia required an emergency medical interstate IHT as specialist clinical care for this type of aggressive paediatric cancer is not available at the Royal Darwin Hospital. The cost incurred for the emergency medical interstate IHT was over $130,000. Given that emergency medical interstate IHT is not a block funded service, the hospital was only eligible to receive activity based funding of approximately $6,500 for providing this patient access to the required health care. In 2016-17, the NT's Top End Health Service (TEHS) provided IHT services for 602 patients, incurring an associated IHT cost of $10.7 million. These costs have had to be absorbed by the hospital thereby disadvantaging its patients as the national ABF system does not currently appropriately reimburse these services. The block funding of this service should be implemented in 2018-19 to ensure remote hospitals and their patients are not disadvantaged.

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Pricing and funding for safety and quality	
Avoidable readmissions	
Should measurement be based on readmissions occurring within the same hospital and financial year?	NT supports models for avoidable hospital readmissions being based on readmissions to the same hospital. NT supports the proposal to limit the measurement of readmissions to those occurring within the same financial year.
Do you agree with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions?	NT agrees with the proposal not to include pricing options for avoidable hospital readmissions. NT recommends that funding approaches for safety and quality introduce incentives to improve care rather than solely through penalty. Funding incentives are required to facilitate systematic improvement in safety and quality particularly for small and isolated hospitals, as they already operate with limited resources.
What are the advantages and disadvantages of each option?	NT advises that the proposed options do not adequately address the heavy reliance of hospitals on the primary care system to avoid readmissions. Any risk adjustment should consider the degree that the hospital is responsible for the readmission, particularly where patients are referred to post discharge services in community settings. This should be considered to ensure any funding model drives accountability and improvement to provision of care.
Do you agree with IHPA's implementation pathway?	NT supports IHPA's proposal to shadow fund all three potential funding options and NT recommends also shadow funding an option which introduces incentives. NT recommends a 24 month shadow period, which will provide the opportunity to understand drivers for avoidable readmissions through review of available reports and readmissions data, while mitigating the risk of unintended consequences. NT also supports an incremental approach to introducing funding adjustments for avoidable hospital readmissions. NT recommends that activity data (particularly regarding readmissions) be made available quarterly in line with quarterly submissions. This will allow regular review and benchmarking, which will likely enhance data quality.
Evaluation of safety and quality in healthcare	
What questions regarding the safety and quality funding reforms should be included in the Evaluation Framework?	The NT recommends that the Evaluation Framework focus on determining whether the national funding penalty is the driver for any identified change in HACs, which may be assessed by: • Determining whether changes are due to changes in clinical practice or coding practice. • Reviewing the variation in jurisdictional implementation of safety and quality measures. • Reviewing actions undertaken by related national bodies to assist implementation of the safety and quality funding reforms.