July, 2018

SA Health

Response to Independent Hospital Pricing Authority Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20

Department for Health and Wellbeing

Introduction

South Australia appreciates the opportunity to be able to comment on the Independent Hospital Pricing Authority (IHPA) *Pricing Framework for Australian Public Hospital Services 2019-20*, through the public consultation paper. On behalf of our jurisdiction, SA Health offered the relevant stakeholders an opportunity to make their own comment on the content of the consultation paper, and responses to the consultation questions are summarised in this submission.

While not a consultation question, SA Health would like to refer to the Pricing Guidelines in Box 1 (page 6). One of the guidelines states *Administrative ease: Funding arrangements should not unduly increase the administrative burden on hospitals and system managers*. SA supports the refinements to the classifications and the funding model, however we question if the IHPA has considered the resource requirements for the changes that are expected relative to benefit. Refinements need to take into account the full range of data and reporting burden and amount of change required of data providers at any one time. It is important that the IHPA accepts advice from the AHMAC Health Services Principle Committee (or their nominated delegate sub-committees) on feedback provided by jurisdictions on the proposed changes.

What changes, if any, should be made to the criteria and interpretive guidelines in the *Annual Review of the General List of In-Scope Public Hospital Services* policy? (pg 8)

South Australia has no issues with the criteria and interpretive guidelines of the General List, but emphasises that it should come under regular review to maintain the high standard of current services and support the implementation of new services. This being said, South Australia supports consistency of services across jurisdictions, in order to achieve fairness.

How could 'Australian Coding Standard 0002 *Additional Diagnoses'* be amended to better clarify what is deemed a significant condition for code assignment? (pg 12)

From consultation with the coding workforce, South Australia recommends ACS 002 Additional Diagnosis should include more detail and give examples to demonstrate what does and what does not meet the requirements of:

- Commencement, alteration or adjustment of therapeutic treatment, and
- Diagnostic procedures, and
- Increased clinical care and/or monitoring.

Conditions should be considered significant if they are ongoing, continue to cause concern, are outside of the normal course of recovery, delay discharge or requires further investigation, clinical consultation or treatment. Documentation of clinician assessment with a resulting treatment plan or change to treatment plan, diagnostic test ordered or therapeutic intervention prescribed would satisfy the criteria for coding. For example a CT scan ordered to investigate ongoing/severe headache, laxatives administered for ongoing constipation, increased medication dosage or change to medication for a documented condition would meet criteria for coding.

Conditions should not be considered significant if they are transient, brief, not investigated further or resolve after short-term treatment. Documentation of general nursing staff giving non-prescription medications or advice on how to manage a condition should not be considered significant. For example administration of Panadol for headache, application of heat pack for lumbar pain, patient advised to drink more to avoid hypotension would not meet the requirements for coding.

Administration of ongoing regular medication for a pre-existing condition would not be significant. A pre-existing condition would only be significant if a change or exacerbation occurred which necessitated a change to the treatment plan or alteration of medication. For example increased dosage of diuretics to treat exacerbation of congestive cardiac failure would meet coding criteria, but administration of the regular dose of antihypertensive medication for hypertension would not. If regular medication for a pre-existing condition is withheld due to another condition that does not qualify the pre-existing condition for coding.

Diagnostic procedures that are routine in nature are not indications of clinical significance unless they are specifically ordered to establish a diagnosis, monitor a significant condition within the inpatient episode or to add specificity to a diagnosis.

Increased clinical care should be considered an indication of a significant condition when it goes beyond the routine care plan or is outside of the standard treatment protocol. General nursing care such as medication administration, checking vital signs, recording fluid balance, pressure area prevention etc. is not considered significant when routine in nature. Conditions that require assessment or consultation with a clinician which result in a documented change of treatment plan, management or ongoing monitoring would meet criteria for coding. Care over and above routine care in postoperative or preoperative period would qualify as significant. For example four hourly observations increased to hourly, intravenous antiemetic administered for ongoing post-operative nausea following clinician consultation would meet criteria for coding.

It is also important for the IHPA to keep in mind that diagnosis codes are used for more than funding purposes, and amendments to standards and codes may have further implications.

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? (pg 12)

South Australia has no issues with the proposed timeframe to phase out support for previous AR-DRG versions prior to AR-DRG v6.X. The Department of Health and Wellbeing only holds the latest AR-DRG version and the previous two versions.

Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle? (pg 12)

South Australia understands the reasoning behind the current biennial cycle, as it has the ability to achieve greater contemporaneity. The current cycle means that there is either an ICD change or an AR-DRG change each year, this can have an impact on the stability of the data used to derive the price weights and fund activity. While SA believes that changes should be considered based on beneficial value rather than a time based cycle, as a start, a three year cycle should be strongly considered. This would enable a year of "stability" (Yr 3) in between the rotating ICD (Yr 1) and AR-DRG (Yr 2) changes but also provide jurisdictions breathing room between implementations.

What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification? (pg 13)

As noted in the Pricing Framework, South Australia suggests that there needs to be more time to allow quality capture and completeness of existing subacute and non-acute data to be able to fully assess any opportunities for improvement.

4.6 Teaching, training and research (pg 16)

Although there is no question related to this section, SA would like to reiterate comments that have been made previously about this data collection and classification in terms of value. SA has accepted that the teaching and training classification will start to be used on the data submitted by jurisdictions, however caution must still be exercised on the data submitted by jurisdictions until the robustness of the data has been verified given the lack of systems in place (in SA at least) to currently support this detailed output. At present, improvements in costing for SA are focused on refining palliative care and mental health phases and introducing posthumous organ procurement. These changes have already been flagged and are being incorporated into our workplan but due to resource impacts, teaching and training effort is being more finely balanced.

With regards to research activity, SA does not support the collection of the data, let alone classification and costing given the size of this funding pool relative to the other categories as the cost benefit has not been proven. There will be a greater benefit focussing on the data collection changes that will be required for emergency care and non-admitted service events rather than an area with a small funding pool.

Should access to the public hospital data held by IHPA be widened? If so, who should have access?
What analysis using public hospital data should IHPA publish, if any? (pg 21)

We believe that public access to hospital data should not be widened in an unrestricted manner and the approval system should remain. Whilst SA is keen to support rich data assets being utilised to their full potential, SA would be very concerned should data that has not been quality assured (ie not a National Minimum Dataset) be made available broadly, particularly where there is no opportunity to understand whether any findings are real or artefactual. Further, presentation of findings without appropriate contextual information can lead to false findings and interpretation. Jurisdictional input is valuable for all data users

as it provides additional quality checks and validations as well as insights into local context and any observed anomalies.

As for additional analysis published by the IHPA it should be considered in tandem with what is provided by the Australian Institute of Health and Welfare.

What are the advantages and disadvantages of changing the geographical classification system used by IHPA? (pg 24)

South Australia is not opposed to reviewing the geographical classification system. In saying this, before a new geographical classification is implemented, it must be critically analysed to determine its accuracy, improvement and relevance, and question whether the administrative burden, and education, which accompanies a change in classification is justified.

What areas of the National Pricing Model should be considered as a priority in undertaking the fundamental review?
Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2019-20? (pg 24)

The activity reconciliation processes (of the Administrator of the National Health Funding Pool) of the past couple of years have shown the importance of stability on data collection, pricing and funding. In any review or technical improvement the stability of the model must be maintained wherever possible. It is acknowledged that this is already being considered with the delayed implementation of the new mental health classification until the data has reached a certain level of robustness.

Another area that could be improved is the work around the indexation rate. At present the indexation rate is derived by the IHPA each year as part of the National Efficient Price (NEP) process. The difference between the cost escalation seen at a local level and the published indexation rate should in the first instance be reviewed to determine if a methodology change is required. It would also be appreciated if an explanation that could be easily understood by those not intimately involved in Activity Based Funding be provided to assist with local education.

Do you support price harmonisation for the potentially similar same-day services?
What other services, which can be provided in different settings of care, could benefit from price harmonisation? (pg 26)

South Australia is of the opinion that price harmonisation should be a point of focused improvement, especially given the different admission policies jurisdictions have in place. For example, there should be minimal difference, if any at all, between admitted and non-admitted hospital based renal dialysis price weights. There are legitimate reasons for some patients to be a sameday admission rather than a non-admitted service event and a review of the patient's comorbidities may provide a way to differentiate between "regular" services and those that require admission. In lieu of a national admission policy, growth funding incentives should not exist to change models of care through a lack of harmonisation.

SA supports dialysis, chemotherapy and scopes being reviewed as part of this work. Further to this any admitted activity where there are strong links between the admitted sameday and non-admitted service events should also be considered. For example, sameday rehabilitation and non-admitted multi-disciplinary rehabilitation, other areas would need to be easily identifiable in the admitted and non-admitted classifications. This may be an issue with Tier 2 classification and would need to be postponed until the new non-admitted classification is developed.

When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model? (pg 27)

The shadow funding criteria listed are reasonable to SA however the important issue that requires agreement is that when shadow funding is not implemented, there is an understanding that no retrospective adjustments are to be applied in the assessment of activity growth funding. If this important principle cannot be agreed, then all new implementations will need to be shadow funded to avoid the issues of the past couple of years.

Do you support the proposal to phase out the private patient correction factor for NEP20? (pg 29)

In order to phase out the private patient correction factor, the costing for private patients would have to be assured as accurate, and although sites have had time to prepare for reporting changes, we do not believe the costing for private patients will have the desired accuracy. If private patient costing can be proven accurate through evidence then we will support the phasing out of the private patient correction factor, but until that point in time, it should remain.

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)?
Do you prefer an alternative scope for measuring avoidable hospital readmissions and, if so, how would this be measured?
What evidence or other factors have informed your views? (pg 46)

To maintain the ability to manage the system appropriately there is an argument for readmissions to be identified at the sites level. However, this may not be feasible initially and a broader approach would need to be considered. SA is supportive of a broader methodology providing it is robust and drives practice change in the right direction. There would need to be analysis on the impact on the size, service provision and colocation of private hospitals within LHNs to see if this methodology would achieve the desired results.

What are the advantages and disadvantages of use of the Medicare PIN and/or the Individual Healthcare Identifier (IHI) for the purposes of pricing and funding of hospital readmissions?
What strategies can be used to overcome existing disadvantages for each of these approaches? (pg 47)

Data custodians and analysts understand the importance of having a linking identifier that enables care pathways to be measured instead of the standard unit of activity. Using a Medicare PIN or IHI would enable possible readmissions to

be accurately traced back to the index episode. To this end the implementation is supported by SA, however there are issues that need to be considered before it can be used for pricing/funding. The first is all jurisdictions need to be collecting and submitting this information with the same rates of coverage. This may be delayed due to infrastructure and data governance requirements of jurisdictions, therefore jurisdictions need to be provided adequate time to collect and supply such variable. Unless there are additional resources provided to assist jurisdictions' roll-out of the IHIs, sufficient lead in time is required before being relied upon.

The second is the ability of jurisdictions to be able to replicate what the IHPA implements. There are no issues with the IHPA undertaking analysis using, for example Medicare PINs, but unless all jurisdictions have access to this they cannot be used to implement a readmission policy. To manage this issue, jurisdictions would need to ensure that legislation enables the use of the data for the reasons listed. Resolving any issues nationally would ensure that all have equal access to the required data.

Do you support the proposal to limit the measurement of readmissions to those occurring within the same financial year? (pg 47)

Initially there would need to be a time limit on the data due to activity and funding reconciliation currently being undertaken on a financial year basis. If the purpose is to improve quality of care and therefore reduce cost of the health system this will be achieved through the impact of within financial year readmissions. Practice improvement for the readmissions that have a 90 day threshold will need to be monitored to ensure positive change is occurring.

There would need to be a tight methodology as to how this might be expanded in future years as it would need to be replicable by all jurisdictions. As there is potential for cross-border activity to occur, the timing of this would need to be agreed upon as well.

Do you agree with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions? (pg 47)

South Australia agrees that funding approaches are the preferred methodology for avoidable readmissions as they can more accurately target the issue and reduce the impact on other episodes.

What patient-specific factors should be examined in a risk-adjustment approach to avoidable hospital readmissions? (pg 51)

South Australia agrees that avoidable readmissions needs to be risk adjusted for individuals who are more likely to be readmitted than others, and the current HAC risk adjustment model is a good starting point. While the avoidable readmissions data will provide valuable insight in effective care, we must be sure not to unfairly penalise sites because patients who have been separated, have not accepted responsibility for their own care, for example; refusing to take antibiotics on discharge aimed at avoiding an infection, thus potentially leading to an infection. As research has suggested, patients who experience a HAC during their episode of care are not likely to be readmitted to hospital due to avoidable circumstances,

but consideration should be given to risk adjust patients who experience a HAC, as to not penalise the site/LHN twice.

What are the advantages and disadvantages of Option 1?
Do you agree with IHPA's assessment of this option? (pg 52)
What are the advantages and disadvantages of Option 2?
Do you agree with IHPA's assessment of this option? (pg 53)
What are the advantages and disadvantages of Option 3?
How should the threshold be set for 'acceptable' rates of avoidable hospital readmissions? How should the funding adjustments be determined for 'excess' rates of avoidable hospital readmissions?
Do you agree with IHPA's assessment of this option? (pg 54)

At the moment there is limited analysis on the three options presented for South Australia to make a definitive decision on which option is preferable. The aim of these funding adjustments is to drive change that leads to better outcomes for patients therefore more detail on how each option would do that would be beneficial. Option 1 is easy to implement when it comes to an adjustment as there is no funding for the readmission, but this could mean more work behind the scenes when it comes to assigning the impact if the activity occurs across sites/LHNs. Option 2 is reasonable as the premise is that the patient should not have been discharged in the first place, again from a model perspective this would be reasonable, especially if jurisdictions submit bundled data. The issue is how the combination of two sets of episodic coding will be handled. With a shortage of clinical coders there would need to be care exercised that this approach did not increase the complexity of their workload, and if the codes were bundled by IHPA then how will they be sequenced? This option also requires more work behind the scene to assign the impact.

The third option is a reasonable place to start where hospitals are encouraged to reduce their avoidable readmissions rate rather than focussing on individual episodes initially. One methodology put forward was the highest 10% of sites/LHNs are adjusted but this methodology implies that there must be an adjustment applied regardless of the actual result for that top 10 percent. The methodology that all sites/LHNs must be under a certain rate (ie 2.5%) to not incur a penalty is preferable. Peer adjustment of the rate should be considered as more complex sites/LHNs may see different readmission rates due to the complexity of their patients.

Until the data is available and jurisdictions can understand all implications (ie how identification of episodes will occur) and appropriate linking of cross site/LHN episodes are available these options are theoretical.

Should benchmarks for avoidable hospital readmissions be measured and calculated at the level of individual hospitals or at the level of Local Hospital Networks? (pg 54)

Safety and Quality experts should be consulted as to how the avoidable readmissions should be calculated so that it drives improvement. Grouping at the LHN level is a broad first step but as mentioned previously there is a requirement to understand the potential implications of the size and casemix of LHNs before a final decision is made.

Do you agree with IHPA's implementation pathway?
For what period of time should the three proposed funding options be shadowed?
Do you support an incremental approach to introducing funding adjustments for avoidable hospital readmissions based on one or two clinical conditions from the list of conditions considered to be avoidable hospital readmissions?
What other options do you recommend for the implementation of a funding model for avoidable readmissions? (pg 55)

South Australia reserves judgement on the implementation of how avoidable readmissions should be adjusted until there is more robust data available for jurisdictions to interrogate. The application of an adjustment is reliant on a suitable linking key being available for all jurisdictions to use. Determining an implementation plan with so many unknown variables makes it difficult for jurisdictions to understand what the implications will be, not just on funding but also on data collection systems. No definitive date has been provided for this implementation therefore there is time to properly analysis the funding options before deciding how to implement the recommended one.

What questions regarding the safety and quality funding reforms should be included in the Evaluation Framework? (pg 56)

South Australia is comfortable with the broad framework proposed by the IHPA and will work with them to refine aspects as required going forward.