Attachment 1.

Responses to the Consultation Questions - IHPA Consultation Paper on the Pricing Framework for Public Hospital Services 2019-20

Section 3: Scope of public hospital services

Section 3.2.1 Policy review of the General List of In-Scope Public Hospital Services

Consultation question

- 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?

Tasmania does not believe there needs to be any changes to the criteria and interpretive guidelines for the General List of In-Scope Public Hospital Services.

Section 4: Classifications used by IHPA to describe public hospital services

Section 4.2.3 AR-DRG development cycle

Consultation questions

- How could 'Australian Coding Standard 0002 *Additional Diagnoses'* be amended to better clarify what is deemed a significant condition for code assignment?
- 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?
- Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?

The Australian Coding Standard 0002 Additional Diagnoses requires clarification of what is required to assign as a significant condition code. The guidelines need to:

- Provide instruction to Coders to reasonably use as much information as is needed and available to accurately represent events of admission i.e. can use all areas within the patient record (including prior correspondence /discharge summaries and correspondence after episode that explains the circumstances of the episode but not any subsequent information or updated diagnoses)
- Provide instruction to generally code conditions listed in 'issues' lists without requiring explicit clinician detail as to how it meets ACS-0002
- Seek clarification from specialist colleges as to how patients with certain conditions would always require extra care or in given common circumstances (certain combinations of chronic disorders) and have a 'College driven push that these be documented' whenever a patient is admitted with

them – e.g. current gross under-documentation of morbid obesity in situations when it would have impacted on care of patient during admission. The ACS-0002 improvement is then to code what the Clinician writes rather than the Coder to decide if relevant.

Tasmania is concerned that the review of ACS-0002 will severely diminish capture of chronic conditions that are material to the care of the patient during the episode and instead limit that focus to conditions that are specifically treated in the episode.

Issues that the changes to ACS-0002 are attempting to address should better be managed in the AR-DRG grouper logic and that there should be a process where the statistical aspects of the DCL severity loadings can be combined with a clinical review process to improve the alignment of complexity loadings between the statistical and clinical perspectives. For example, the impact of constipation can be severe, but that severity depends to some extent on the associated conditions. Associated with Subarachnoid or Cardiac surgery, constipation is a more significant issue that perhaps in orthopaedic cases. Clinical review of the impact of constipation would be able to provide guidance to the behaviour of the grouper. To introduce both the ACS-0002 proposed changes and the alterations to grouper severity at the same time will result in confusion and introduce a detrimental impact on data time series.

The current level of support provided to older versions of AR-DRG does not support the requirement to update and as such, Tasmania supports the phasing out of Australian Refined Diagnosis Related Groups classification system versions prior to AR-DRG V6.X from 1 July 2019.

A balance is required between updating the AR DRG and ICD 10 AM/ACHI classifications in respective to changes to clinical practice and terminology and the stability of the classifications for health services. Resent issues with the changes between versions 6.x, 7.0 and 8.0 would indicate that the current biennial cycle may be too often and not proved enough time for the classification system and costing cycles to align. The cycle should be extended to six years with minor updates to the classification systems and ICD-10-AM editions, at the very least the version change cycle should be extended from the current biennial to minimum of four years. There is no requirement to modify the current biennial development cycle of the ICD-10-AM classification system.

Tasmanian would recommend that when changes like the recent updates to AR-DRG are undertaken that NWAU calculation for both Versions (similar to what took place under the NHCDC process when cost weights were released in both versions of the AR-DRG) are released with only one version used for National Health Reform Agreement Growth calculations and funding.

Section 4.3.1 Developing AN-SNAP Version 5

Consultation question

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

Tasmania supports the development of Version 5 of the Australian National Subacute and Non-Acute Patient (AN-SNAP v5.0) classification system. However, Tasmanian has concerns regarding the increasing data burden on smaller states and territories particularly in low volume care types.

Tasmania has concerns regarding the overlap between the care types of Psychogeriatric and Mental Health care which at times can be clinically similar and the only differentiation being clinical speciality looking after the patient.

Section 5: Data Collection

Section 5.3.2 Broadening access to data

Consultation questions

- 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?

Tasmania supports the current scope of data provision and current approval process and at this time does not support expanding the access (and in particular access to the Data Portal).

Tasmanian supports that analysis of public hospital data is proved by the Australian Institute of Health & Welfare (AIHW). The Independent Hospital Pricing Authority (IHPA) primary function is to calculate and deliver an annual National Efficient Price (NEP). The NEP is a major determinant of the level of Australian Government funding for public hospital services and provides a price signal or benchmark for the efficient cost of providing public hospital services. Analysis should be conducted by the AIHW in partnership with states and territories and not by IHPA.

Section 6: Setting the National Efficient Price for activity based funded public hospitals

Section 6.1.4 Fundamental review of the National Pricing Model

Consultation questions

- What are the advantages and disadvantages of changing the geographical classification system used by IHPA?
- 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?

Tasmania has reviewed the "2008 research paper" on rethinking remoteness written by research fellows at the Charles Darwin University and proposed to IHPA by the NT Government. Tasmania is concerned that the premise embedded in the proposed methodology, that population dispersion causes variation in unit hospital costs, is not as compelling as the premise embedded in the Australian Bureau of Statistics remoteness area classification, which is based on population size, proximity to alternate population centres, variation in hospital size and role delineation which directly impacts unit costs.

Section 6.2.2 Adjustments to be evaluated for NEP19

Consultation questions

- What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?
- What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.
- Do you support price harmonisation for the potentially similar same-day services which are discussed above?
- What other services, which can be provided in different settings of care, could benefit from price harmonisation?

In Tasmania, the public sector is the only provider of a range of highly specialised services including: regional critical care and emergency department care, neo-natal intensive care, neurosurgery and burns. The sustainability of these services is challenging in a small population where there are no economies of scale.

As highlighted in previous submissions the cost of providing health services in Tasmania is affected primarily by three factors which generally have compounding effects in their interaction:

- Small scale due to small population
- The most decentralised population pattern in the nation (with Hobart being the only capital city with below 50 per cent of a state or territory population), and
- Regionality, in terms of both intrastate characteristics (as indicated by the decentralised population spread) and interstate characteristics, due to its small population size and isolation from the mainland.

Tasmanian does not believe the current adjustment in the NWAU and NEP ABF model adequately describes the increase cost where the public sector is the only provider of clinical services or the cost pressures created by the community expectations for service, which is one of the initial objectives of the National Health Reform Agreement (NHRA).

Tasmania supports IHPA undertaking further work to investigate the application of a paediatric adjustment, to be applied to the acute admitted event for patients outside of Specialised Children's Hospitals.

Tasmania believes that the ICU component should be reviewed, as a priority, and particularly for invasive ventilated patients, to develop a weighting if an invasive ventilated patient is managed in a regional centre critical care unit. The current exclusion of ICU units below 4,000 hours of ICU care, of which at least 20 per cent involves mechanical ventilation, effectively reduces the Commonwealth contribution in regional centres. The costs involved in ventilating a patient are the same irrespective of location. A critical care unit is more resource-intensive than a general ward area. At the moment this is not recognised in the national ABF model.

Patient travel can accumulate a significant portion of jurisdictional cost which the current model doesn't recognise. It is important to better understand cost component of healthcare, the developing a separate NHCDC cost bucket would enable the IHPA to develop a pricing framework that recognises the variation in this area, therefore improving equitable pricing for patients.

Tasmania also would support the expansion of the dialysis adjustment to all admitted patients, not just acute - for example: rehabilitation and palliative care. The additional costs of providing dialysis care to care types, other than acute, are currently averaged in the classification.

Tasmania also would support a review of the impact of obesity (such as: obese class 2 or 3 i.e. BMI > 35) on the cost of care. There are additional costs for these patients such as the need for reinforced / different wheelchairs, beds, theatre etc. as well as increased costs associated with the complexity of treating patients where 'normal' treatment guidelines are inappropriate or insufficient.

The inclusion in the model of these adjustments would assist Tasmania in sustaining the provision of highly specialised services in the public sector.

The National ABF model needs to ensure that the funding model is neutral to treatment setting, Tasmania supports the price harmonisation of same day renal dialysis, chemotherapy and sleep disorders this is particularly important as many public hospitals shift previously admitted hospital based procedures to the ambulatory setting. Tasmania supports IHPA undertaking investigating price harmonisation of angioplasty and angiography procedures.

Tasmanian recommend that IHPA standardise NWAU adjustments between settings of care (admitted or non-admitted) and NWAU where the service is the same, such as gastrointestinal endoscopes, renal dialysis and chemotherapy etc, is provided in both settings.

Section 6.3 Shadow implementation periods

Consultation question

- When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model?

Tasmania supports IHPA, in consultation with the states and territories, developing a policy framework regarding the requirement to implement a shadow period for ABF classification systems and the National Pricing Model when there are significate structural changes to any of the ABF stream classification systems as took place in the recent development of version 7.0 and version 8.0 of the AR-DRG or new classification systems have been developed for any of the ABF streams as will take place with the implementation of the new Australian Mental Health Care Classification (AMHCC) and Australian Emergency Care Classification (AECC) .

Tasmania believes for structural changes to classification systems, the shadow period should be two annual data submission cycles and two NHCDC costing cycles, and for implementation of completely new classification systems the shadow period should be longer than three annual data submission cycles and two NHCDC costing cycles. For Structural Changes to the model like the avoidable hospital readmissions the shadow period should be 3 annual data submission cycles and two NHCDC costing cycles .

Section 7: Setting the National Efficient Price for private patients in public hospitals

Section 7.2.1 Phasing out the private patient correction factor

Consultation question

- Do you support the proposal to phase out the private patient correction factor for NEP20?

Tasmania still believes there are distortions of medical salaries across the product streams because of private patient reimbursement arrangements - and as such, does not support the phasing out the private patient correction factor for NEP20.

Section 8: Treatment of other Commonwealth programs

No consultation questions

Section 9: Setting the National Efficient Cost

Section 9.1.1 Consideration of alternative NEC methodologies

Consultation questions

- What other models might IHPA consider in determining funding for small rural and remote hospitals?
- What cost drivers should IHPA investigate for rural and remote hospitals for potential inclusion as adjustments in the NEC?

Tasmanian supports the current revenue of National Efficient Cost (NEC) model by the IHPA Small Rural Hospitals Working Group (SRHWG). Tasmania has no alternative NEC methodologies.

Section 10: Innovative funding models

Section 10.3 International funding models

Consultation questions

- What countries have healthcare purchasing systems which can offer value in the Australian context and should be considered as part of the global horizon scan?

Tasmania supports the review of International healthcare purchasing systems by IHPA. Tasmania has no recommended models from other countries to propose but has some concerns regarding the compatibility of criteria between the Australian and International systems particularly around the

Australian same day admitted activity in predominately overnight DRGs and the impact on the readmission criteria within the International funding model.

Section 11: Pricing and funding for safety and quality

Section 11.4.4 Approach to measurement of avoidable hospital readmissions

Consultation questions

- 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?

Tasmanian has concerns with the proposal that pricing and funding models for avoidable hospital readmissions be based on readmissions within the same Local Hospital Network. All readmissions to any hospital should be counted and attributed to the source (index admission) hospital.

As demonstrated on page 46 of IHPA's consultation paper, using an LHN approach instead of an 'any hospital' approach will exclude about 15% of readmissions. That is, IHPA's proposal is that 15% of readmissions not be subject to pricing or funding penalties. However, these 15% of readmissions are not randomly distributed, in particular, they will be practically absent in jurisdictions with a single LHN. In effect, IHPA's proposal will discriminate between jurisdictions based on the size of the jurisdiction, the proximity of hospitals to each other and the choices made on the scope of LHNs – none of which should be directly related to the pricing or funding signal for readmissions.

Tasmania disagrees with IHPA's proposition that the introduction of pricing or funding incentives that require adjustments between different LHNs or states would be complex and reduce transparency. It would be simple and transparent for payments to continue to be made for all episodes as is the case now, but then during the reconciliation process adjustments (deductions) are made to the source (index admission) hospital's funding. Under this approach the signal would appear as a discrete penalty. This approach would also overcome the problem with measurement across financial years, as the penalty can be applied for the readmissions occurring in the financial year, regardless of when the index admission occurred.

Consultation questions

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

Tasmania does not maintain information on Individual Healthcare Identifiers in either the patient information system or health information data warehouses. Tasmanian has a long term solution, but this does not overcome the identified problems in the short or medium term.

Consultation question

- Do you support the proposal to limit the measurement of readmissions to those occurring within the same financial year?

Tasmanian recommends that identification of readmissions should not be limited to the same financial year. Limiting readmissions to those occurring in the same year as the index admission would be likely to fall randomly across hospitals, LHNs and states.

Section 11.4.5 Pricing and funding approaches for avoidable hospital readmissions

Consultation question

- Do you agree with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions?

Tasmanian cautiously supports the proposal to include funding options, but not pricing options, for avoidable hospital readmissions.

Consultation question

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

Tasmania supports IHPA using a similar approach to development the risk-adjustment model as was used to develop the risk adjustment model for hospital acquired complications. Tasmania will work with IHPA and the Australian Commission on Safety and Quality in Health Care (ACSQHC) to critique the risk adjustment model.

Section 11.4.6 Analysis of funding options for avoidable hospital readmissions

Consultation questions

- What are the advantages and disadvantages of Option 1?
- Do you agree with IHPA's assessment of this option?

As identified by IHPA, the complexity in this option is that the financial penalty needs to fall on the hospital responsible for the index admission, which may be different from the hospital providing care for the readmission episode.

Tasmania is concerned that Option 1 may result in a disincentive being created to discharge patients and encourage longer admission in order to avoid a potential readmission and penalty thus placing stress on the public system.

Consultation questions

- What are the advantages and disadvantages of Option 2?
- Do you agree with IHPA's assessment of this option?

Tasmania supports IHPA proving analysis on the risk-adjustment model and the impact of option 2 on the system and will work with IHPA and ACSQHC to provide analysis of the outcomes and robustness of the model.

Consultation questions

- What are the advantages and disadvantages of Option 3?
- Should benchmarks for avoidable hospital readmissions be measured and calculated at the level of individual hospitals or at the level of Local Hospital Networks?
- 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?

Tasmania supports IHPA proving information on the risk-adjustment model and the impact of option 3 on the system within the state and will work with IHPA and ACSQHC to provide analysis of the outcomes created under this model.

Implementation of the avoidable hospital readmissions methodology will need to ensure that funding doesn't discriminates between states/territories based on the number of LHNs (or size of the jurisdiction). The methodology would need to recognise the internal structures within the state, for example, if review at the LHN level, Victoria has the potential to be penalised for only 85% of their re-admissions, whilst Tasmania is penalised for 99% of its readmissions - just simply based on the fact that Tasmania only has one LHN.

Section 11.4.7 Implementation pathway for funding adjustments for avoidable hospital readmissions

Consultation questions

- 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?

Tasmania cautiously supports the implementation pathway however is concerned that the estimated 24 month period starting 1 July 2019 fails to provide enough time for these reforms to be understood at the Jurisdictional, hospital and clinician level.

Section 11.5 Evaluation of safety and quality in health care

Consultation question

- What questions regarding the safety and quality funding reforms should be included in the Evaluation Framework?

Tasmania supports IHPA establishing a baseline prior to the implementation of the national health reforms however, without further information and an understanding of the avoidable hospital readmissions adjustment methodologies, is unable to comment at this stage.