Consultation paper on the pricing framework for Australian public hospital services 2019-20

Victorian Department of Health and Human Services response

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VICTORIA State Government | Health and Human Services

Contents

1. Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20* and support continual improvements to this Framework. The Pricing Framework 2019-20 forms part of the Independent Hospital Pricing Authority's annual process for establishing a national activity based system for the pricing of public hospital services in Australia, in support of the efficiency and transparency goals of the National Health Reform Agreement.

The *Pricing Framework 2019-20* is an opportunity to further refine and improve the pricing models introduced in 2012-13 and revised in subsequent years. Victoria is generally supportive of the direction of the national pricing framework development, however, Victoria continues to reiterate a number of concerns related to the need to further mature aspects of the national pricing model.

Victoria recognises the Independent Hospital Pricing Authority is continuing to progress work to incorporate safety and quality into the pricing and funding of public hospital services in order to improve health outcomes, avoid unnecessary or unsafe care and decrease avoidable demand for public hospitals.

Victoria recommends that the Independent Hospital Pricing Authority continue to work with states and territories to address the challenges associated with consistent capture of quality and cost information, and to minimise the risk of unintended consequences. As the introduction of this model constitutes a significant change, Victoria anticipates that the Independent Hospital Pricing Authority will act in accordance with the National Health Reform Agreement, specifically the back-casting and transitional provisions outlined at Clause A40.

2. Pricing guidelines

The Pricing Framework includes important pricing guidelines that direct how the Independent Hospital Pricing Authority should undertake its work. In assessing how the Independent Hospital Pricing Authority has implemented Activity Based Funding to date, there should be greater regard for applying these guidelines in a more consistent, balanced and comprehensive manner.

Victoria supports the Independent Hospital Pricing Authority's view that the Pricing Guidelines are working well and therefore no changes are proposed for the Pricing Framework 2019-20.

3. Scope of public hospital services

3.2.1 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?

Victoria supports a review of the General List decision criteria and application process. Victoria would support changes to allow more flexibility in the criteria in order to encourage innovative clinical and funding models. This will support the provision of more integrated and patient-centred care, which over time will likely reduce acute hospital activity.

The current approach dis-incentivises the development of innovative funding models for service delivery. As an example, section 2c point 5 of Version 4.2 of the document *Annual Review of the General List of In-Scope Public Hospital Services* states that in assessing an application for inclusion the Independent Hospital Pricing Authority will "determine whether the service is operational at the time of the application". While to some extent this provision is understandable, Victoria is concerned that if applied in a blanket fashion it can act as a further barrier to the development of innovative services. The practical impact of a delay until a new service is operational and has data available is that it will not be recognised for a Commonwealth funding contribution for between one and two years after commencement, requiring it to be funded solely by states and territories.

Victoria encourages the Independent Hospital Pricing Authority to consider the following when examining innovative funding models:

- Is this model a pilot that, with a time limited funding modification, has the potential to develop into a valuable new model of care?
- Is the model likely to improve the health, or better manage the symptoms of, persons with physical or mental health conditions?
- Will the model add to the total costs of care over and above the value achieved by the model?
- Is the model scalable and translatable across jurisdictions?

Victoria would support changes to the criteria and interpretive guidelines that encourage the development of innovative funding models.

4. Classifications used by IHPA to describe public hospital services

4.2.3 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?

Victoria introduced an addition to the Australian Coding Standard 0002 on 1 July 2017 in recognition that Victorian clinical coders needed further direction in determining clinical significance for the purposes of reporting to the national morbidity data collection. This addition further defines the three criteria in Australian Coding Standard 0002 to determine if a condition is significant in terms of treatment required, investigations needed and resources used in an episode of care. Victoria has submitted its work in this area to the Australian Consortium for Classification Development to inform the development of the national standard and Victoria is pleased with the progress to date and supports the revision to this standard. It should be noted, however, that whilst the aim of this revision is to ensure consistent, reliable and complete coded data so it can used with confidence for many purposes, standards can only be applied consistently when other factors such as improvements to clinical documentation and ethical documentation queries are also considered.

Victoria supports the proposed time-frame to phase out support for AR-DRG classification versions prior to Version 6.X from 1 July 2019. Victorian public hospitals transition to the latest available version of the AR-DRG classification by default. The question of transition timeframes is best directed to the private hospital sector which operate against fixed-term funding contract arrangements.

Victoria supports the current biennial AR-DRG development cycle. However, more recent cost and activity data should be used in the development of new versions than is currently used. Moreover, the Independent Hospital Pricing Authority should consider extending the DRG development cycle on a case-by-case basis to ensure inclusion of cost data that becomes available during the development cycle, in particular when it can inform significant DRG classification issues (e.g. AR-DRG v10 should be informed by 2016-17 cost data, which may mean extending the development period by 3 to 6 months to ensure inclusion of this cost data).

4.3.1 Consultation question

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

Victoria supports the Independent Hospital Pricing Authority's endeavours to improve AN-SNAP. Victoria believes that the Independent Hospital Pricing Authority should continue to work through the Subacute Care Working Group and existing committee structure to consider improvements to AN-SNAP. From Victoria's perspective, the priority should be to explore improvements to the GEM part of the

classification. Victoria provides significant GEM services and considers there is significant opportunity for improvement of the current classification.

4.5 Emergency care classification

The proposal to move to a diagnosis-based emergency care classification will require all hospitals to report patient level data, including diagnosis. Ten of Victoria's local health services which report aggregate data will not be able to do this within current reporting systems. Victoria suggests the Independent Hospital Pricing Authority has regard to the impact on these health services, and ensures flexibility in reporting to accommodate the capacity of smaller agencies to provide data. Victoria suggests the Independent Hospital Pricing Authority has regard to Clauses B86(e) and B86(f) of the National Health Reform Agreement when finalising their data requirements.

5. Data collection

5.1.1 Phasing out aggregate non-admitted data reporting

Victoria is progressively improving the local non-admitted patient level reporting systems in line with the Independent Hospital Pricing Authority's three year data plan that phases out the Non-Admitted Patient Care Aggregate National Minimum Data Set from 2019-20. However, Victoria continues to highlight the risk that not all health services will be able to do this by 2019-20. Victoria suggests the Independent Hospital Pricing Authority has regard to the impact on these health services, and ensures flexibility in reporting to accommodate the capacity of smaller agencies to provide data. While Victoria supports the transition towards patient level reporting, the Independent Hospital Pricing Authority will need to implement a methodology to ensure that from 2019-20 the non-admitted funding model and the calculation of efficient growth in activity adequately accounts for the changed reporting requirement.

5.1.2 Individual Healthcare Identifier

Victoria supports the inclusion of the Individual Healthcare Identifier in the national data sets, but notes there are implementation risks due to the lead time and costs associated with this initiative.

5.3.2 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?

In principle, Victoria believes that the Australian public has a right to access activity level data for the national public hospital network to improve transparency and accountability; subject to appropriate safeguards to ensure the confidentiality and commercial sensitivity of individual providers. However, the decision to release data lies with the originating state or territory, not with the Independent Hospital Pricing Authority, as per Clause B100 of the National Health Reform Agreement.

Furthermore, the national benchmarking portal is not a complete dataset to the extent that not all hospitals report cost data. Victoria has previously raised concerns with the Independent Hospital Pricing Authority regarding the reconciliation of the data presented in the national benchmark portal with data

submissions. The consultation paper states that rigorous safeguards would be required to ensure the data is appropriately managed and that data is only used for research purposes. However, it is unclear if access was widened how the Independent Hospital Pricing Authority would assess:

- Whether access to the data will continue to be fit for purpose;
- Whether the data will continue to be of suitable quality for use;
- Whether the data will continue to be suitable for release.

Therefore, at this stage, it is Victoria's position that any requests for the Independent Hospital Pricing Authority to broaden access to the portal beyond its current users for research purposes should continue to be agreed by jurisdictions on a case-by-case basis. Victoria supports the existing process for research requests for public hospital data as set out in the Independent Hospital Pricing Authority's Information Release policy Version 4.1, May 2018.

Victoria does not support the Independent Hospital Pricing Authority producing ad-hoc analysis using public hospital data, as this is outside the scope of their direct responsibilities. The provision of data to the wider public will greatly improve the breadth and depth of analysis more than what could be conducted by a single institution. Furthermore, Victoria notes that conducting analysis and producing reports on health-related information is the function of the Australian Institute of Health and Welfare, not of the Independent Hospital Pricing Authority. We see a role for the Independent Hospital Pricing Authority to manage and direct the national conversation in the research space and act as a conduit for this research to improve international comparability and transparency to assess the ongoing efficacy of the Australian public hospital funding model, and note opportunities for improvement.

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

6.1.2 Pricing of mental health care

The consultation paper states that Independent Hospital Pricing Authority will only price or shadow price mental health services using the Australian Mental Health Care Classification (AMHCC) for NEP 19 if the 2016-17 cost data is robust enough to support it. While Victoria supports work to further develop the AMHCC, we believe that the Independent Hospital Pricing Authority should consider in advance the criteria it will use to determine whether the data is robust enough to support pricing.

Victoria also believes that pricing should only be on a shadow basis in the first instance. Victoria strongly recommends shadowing is implemented for a full 24 months, and then that data is used to inform the decision in the future (rather than having a decision in 24 months, which would mean only ~12 months of data is considered).

Victoria recommends that the Independent Hospital Pricing Authority considers the following questions before introducing a shadow price using the AMHCC for NEP 19.

1. Is the available data using AMHCC representative of the clear majority of states and territories and the national mental health population;
2. Does the available data provide a reasonable sample size across all the AMHCC classes for which pricing is being considered; and
3. Is the available data of reasonable quality?

If the answer to any of these questions is no, Victoria recommends that shadowing pricing for NEP19 be deferred.

6.1.4 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?

Victoria supports the Independent Hospital Pricing Authority's intention to review alternative remoteness classifications. However, Victoria advocates that any resulting change to the Patient Remoteness Adjustment should be supported by evidence-based analysis and evaluated against the materiality, stability, added complexity and alignment with pricing guidelines associated with any changes. It is also unclear who would be responsible for determining, calculating, and maintaining the newly proposed 'Remoteness and Incapacity Index'; jurisdictions themselves, the Independent Hospital Pricing Authority or the Australian Bureau of Statistics?

Victoria suggests the Independent Hospital Pricing Authority should review, as a priority, its back-casting policy used for calculating the Commonwealth's growth funding contributions to make transparent and accountable the extent to which the Independent Hospital Pricing Authority are prepared to retrospectively change their published methodology for calculating NWAU growth beyond that which has been agreed to by jurisdictions.

Additionally, the Independent Hospital Pricing Authority need to assess and manage the impact that the introduction of the new Episode Clinical Complexity Model under AR-DRG v8.0 will have on successive versions of the NWAU admitted acute cost model. In the first instance, the Independent Hospital Pricing Authority will need to assess the impact that coding volatility captured in the 2016-17 cost data will have on the NWAU19 admitted acute cost model. For example, the coding profile captured in the NWAU19 admitted acute pricing model (i.e. 2016-17 cost data) should be the same or similar to the coding profile captured in the activity to be funded (i.e. 2019-20 activity data). Any misalignment in coding profiles may result in significant misalignment (volatility) in funding and an increase in financial risk that jurisdictions will need to manage.

6.2.2 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?

The Independent Hospital Pricing Authority should investigate replacing the current NWAU adjustment for Intensive Care Unit (ICU) (based on ICU hours) with an adjustment based on a combination of invasive mechanical ventilation hours and non-invasive ventilation hours that are delivered in an ICU. This approach would more closely align the national funding model with national pricing guidelines such

as fairness, greater alignment of funding with cost, and minimisation of undesirable consequences. It would also align the national funding with more contemporary service delivery models within ICUs (i.e. ventilation practices).

Victoria supports price harmonisation for similar same-day services, subject to appropriate consultation with Clinical Advisory Committees and thorough assessment of cost compatibility. Price harmonisation should be applied across same-day chemotherapy services in order to support the significant changes that have occurred in recent times in the administration of chemotherapy agents; i.e. growth in oral and subcutaneous forms of chemotherapy (outpatient basis) and the introduction of immunotherapies which require more frequent intravenous administration over longer periods spanning up to several years.

6.3 Consultation question

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

Victoria agrees that not all changes to the National Pricing Model should necessitate shadowing. Victoria suggests the Independent Hospital Pricing Authority consider the implementation of a shadow period in instances where;

- Changes represent intended permanent changes where there is insufficient data to provide robust analyses. For example, New Tier 2 Non-Admitted Services classes, as the change to the NEP model is intended to be permanent and there is no precedent/historical data to facilitate effective analyses prior to implementation. It is presumed that a change of this nature is sufficiently novel that existing data cannot be used to model the impact, and the permanency of the change necessitates a benchmark period to ensure health services can account for the ongoing funding impact prior to implementation.
- Changes are profound and potentially materially significant. For example, the implementation of AR-DRG version 8.0 would have benefited from a one year shadow implementation period. Furthermore, the upcoming implementation of the ICD-11-AM classification of diseases will need a shadow implementation period of at least one or two years (as occurred in Victoria during the introduction of the ICD-10-AM classification of diseases).
- Changes require amendments to data specifications, collections or reporting systems.

Furthermore, shadowing periods should ensure that at least one complete year of data is available for consideration and analysis before pricing goes live. In some cases two years complete data should be available.

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

7.2.1 Consultation question

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

Victoria supports in principle the phasing out the private patient correction factor for future NEPs. However, Victoria does not consider this feasible for NEP20. There is still inconsistency with the application of the rule and therefore if the private patient correction factor was phased out from NEP20 there would need to be an assurance that the application of the Australian Hospital Patient Costing Standards rule is consistently applied.

From a costing perspective, Victoria generally agrees with the business rule relating to the treatment of medical expenses for private practice arrangements. However, the application of the rule still needs to be further developed. Victoria has always maintained that in order for this business rule to be applied adequately and consistently across the nation further discussion and development should occur due to the technical application being more complex than the rule maintains.

8. Treatment of other Commonwealth programs

Victoria is supportive of no changes to the treatment of other Commonwealth programs for NEP19.

9. Setting the National Efficient Cost

9.1.1 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?

Victoria understands that there may be circumstances where the transfer of a service from an ABF hospital to a block funded hospital may result in a decrease in NWAU at the ABF hospital but no corresponding movement in NEC grouping for the receiving block funded hospital. This could result in a decrease in Commonwealth funding to a state in a situation where activity across the two hospitals involved has not reduced.

Victoria supports further investigation by the Independent Hospital Pricing Authority into this and detailed discussion between jurisdictions to ensure there is a clear understanding of the issues, the frequency with which this occurs, and the best options to try to address this.

However, it is important to note that while the NEC currently provides a mechanism to equitably distribute the Commonwealth share of funding, most (if not all) states and territories use local approaches to determine the budgets of health services. In Victoria, the existing NEC model is not a barrier to adjusting funding to a small rural health service where additional service capacity is warranted. Victoria notes that the extent to which the current NEC model is a barrier to development of new service capacity across the country has not been quantified.

In Victoria, there is a significant level of activity and NWAU movement from year to year at many smaller health services and hospitals covered via the NEC. The activity movements are down as well as up. This

contrasts to the situation at the overwhelming majority of larger ABF funded services in Victoria where overall NWAU increases from year to year.

If an alternative NEC model is intended to be a potential model for funding individual services, the consideration of alternatives to the current model needs to be aware that a new NEC model with a component linked to activity can move down as well as up. Careful consideration of this is recommended in assessing possible alterative options. Any change in the model will need to ensure that agencies are not significantly impacted. There are concerns that the proposed model may not align with the Pricing Guidelines; in particular those relating to Transparency, Administrative Ease and Stability.

10. Innovative funding models

10.3 Consultation question

- 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?

Victoria supports the Independent Hospital Pricing Authority in considering models of value based care and reviewing international health funding systems and initiatives. However, it is important that the Independent Hospital Pricing Authority also considers research and evidence of funding and purchasing policy that may result in adverse or negligible outcomes, along with those only those with positive outcomes.

11. Pricing and funding for safety and quality

11.4.4 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?

Victoria is currently completing work that could inform the decision of whether to base readmissions within the same Local Hospital Network. The Victorian Agency for Health Information is investigating a similar question in the context of 30 day mortality measures and the attribution of the 'death event' to the appropriate hospital. The investigation is ongoing, however, preliminary consultations with state peers suggests that the scope should be expanded to readmissions outside the original Local Hospital Network.

Victoria notes that deliberations are still ongoing and this does not constitute a final decision from our jurisdiction. The outcome of the investigation is expected in the coming months, and will inform a more comprehensive answer from Victoria.

11.4.4 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?

Victoria supports the use of a robust and consistent approach to link patients. The advantages of linking patients will flow not only to safety and quality reforms but will also positively impact bundled pricing, the evaluation of innovative models of care and innovative funding models, as well as supporting research initiatives. However, Victoria questions how patients that do not have a personal identifier will be treated in the model.

11.4.4 Consultation question

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

Victoria agrees that the improvements to the funding model by measuring readmissions across financial years are likely to be marginal compared to the offset in transparency and ease of implementation by measuring readmissions within financial year. In the national context, the impact on measurement error of avoidable readmissions could average out. If jurisdictions consider that there is an acceptable margin of error, then Victoria agrees the gains do not justify the additional burden.

Retrospective adjustments do not meet the National Health Reform Agreement objectives of funding stability. While Victoria recognises the practical limitations of adjusting funding based on the readmissions data, it is possible that a separate funding stream could be set aside on which retrospective adjustments could apply.

11.4.5 Consultation question

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

Victoria agrees with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions. However, Victoria notes that there is limited evidence supporting the use of financial penalties alone to drive improvements in unplanned readmission rates.

Any reduction in unplanned readmissions will likely be the result of multiple programs of work rather than just financial levers. In 2018-19, Safer Care Victoria will be engaged in projects looking at unplanned readmissions following tonsillectomy and unplanned readmissions following hip replacement. Victoria will watch with interest as the model is further developed by the Independent Hospital Pricing Authority.

11.4.5 Consultation question

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

Evidence from within Victoria and overseas indicates that a wide range of factors at the health system level, together with individual patient/family/carer circumstances (e.g. willingness and capacity to follow medication instruction or carer stress), and social determinants of health (e.g. isolation, homelessness, housing factors), are key factors in each individual patient readmission. It is important to note the limitations with the current data may result in an inability to measure key patient-specific risk factors. This is likely to limit risk adjustment and highlights the importance of a staged implementation approach, piloted and incrementally introduced over a number of years, to minimise the likelihood of unintended consequences.

Understanding the role and prevalence of these key factors is a prerequisite for determining whether a re-admission is preventable – and by whom. This information is also necessary to determine whether the readmission is "due to complications from the management of the original condition" and arising from clinical factors within the control of the hospital.

11.4.7 Consultation questions

- 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?

It is important that the data/shadowing is implemented for the full 24 months suggested, and then that data is used to inform the decision in the future (rather than having a decision in 24 months, which would mean only ~12 months of data is considered).

To ensure that the linking algorithms are robust and consistent, and that there is a low risk of false positives, recognition needs to be given to the time taken and costs involved in improving the underlying data. For instance, the outcomes of a shadow readmissions funding model could be published quarterly in year 1 and 2, and those outcomes could be used by jurisdictions in years 3 and 4 to strengthen and test underlying data systems, to enable readiness for live funding options from year 4 to 5 onwards.

In the longer term, health services and clinicians will be able to respond to avoidable readmissions better by being able to access the readmissions outcomes on a near-to-live basis.

Victoria supports an incremental approach to introducing funding adjustments for avoidable hospital readmissions based on one or two clinical conditions.