ATTACHMENT

WESTERN AUSTRALIA SUBMISSION TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2019-20

1. Introduction

Western Australian (WA) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the Consultation Paper for the *Pricing Framework for Australian Public Hospital Services 2019-20.*

2. Pricing Guidelines

WA is generally supportive of the Pricing Guidelines outlined in the Consultation Paper and notes that no changes have been proposed for the *Pricing Framework 2019-20.*

3. Scope of 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?

WA acknowledges the recent improvements to Appendix B of the policy.

The application of the criteria and interpretive guidelines for inclusion should be consistently applied across services. WA Health also recommends the level by which a service meets or does not meet the guidelines be defined better.

WA, along with several other jurisdictions, advocated that community Child and Adolescent Mental Health Services (CAMHS) met the criteria for inclusion under the General List. However this was deemed otherwise by IHPA.

It would appear that the application of the criteria and interpretive guidelines is subjective in that some services have been included, whereas community CAMHS has not despite both meeting the criteria and guidelines.

It is noted that IHPA is leading a project to review the criteria for community CAMHS.

4. Classifications used by IHPA to describe Public Hospital Services

WA supports the ongoing classification refinement and development for activity based funding purposes and will continue to participate in this work through its representation on the IHPA working groups and advisory committees. The IHPA should ensure that jurisdictions are provided with adequate time to implement any new classifications before introducing pricing based on that new or revised classification.

Australian-Refined Diagnosis Related Groups (AR-DRG)

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

WA, in principle, supports the proposed changes to ACS 002 for the Australian Coding Standards Eleventh edition.

WA notes that the proposed changes to ACS 002 articulated to Coding Area Managers is the alignment of the standard to Victoria's current practice. If this proposal is to progress, increased clinical care and monitoring criteria would be removed. Additionally, the new criteria would require the condition to be clinically significant, which requires clear guidelines to be established with specific rules and decision pathways. Thereby, proposed changes would significantly impact on current coding practices and Diagnosis Related Groups (DRGs).

WA will provide further comments during the feedback on the revised standards.

Consultation Question – 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?

Yes, in principle, noting that the timing of such changes should be cognisant of the pending implementation of ICD-11.

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

Yes.

Australian National Subacute and Non-Acute Patient (AN-SNAP)

Consultation Question – What areas should be considered in developing Version 5 of the AN-SNAP classification?

WA recommends that IHPA investigate weighting FIM scores rather than using raw Mini Mental State Exam (MMSE) scores for GEM. The cost drivers for GEM are frailty and cognition, and the outcome measures are FIM and MMSE. FIM measures frailty and impairment adequately however the MMSE does not measure improvement in performance well. As such, selective weighting of FIM scores may be a more appropriate measure than raw MMSE scores.

Tier 2 Non-Admitted Patient Services

WA supports the IHPA work plan to develop the new Australian Non-Admitted Care Classification.

Emergency Care

WA supports the use of the Emergency Department Principal Diagnosis Short List in line with the implementation of the Australian Emergency Care Classification (AECC).

WA supports the use of shadow funding for a period of at least one year, when implementing the AECC.

Teaching, Training and Research

WA acknowledges that IHPA will continue to block fund teaching, training and research activity in NEC19 and until suitable classifications are adequately tested for pricing and funding purposes.

WA notes that the reporting of activity and cost data for teaching and training remains a significant hurdle. In particular, health services have indicated that identifying direct and indirect costs is problematic and will take time before services are able to provide quality data in line with the Australian Hospital Patient Costing Standards Version 4.0.

Australian Mental Health Care

WA supports the refinements to the Australian Mental Health Care Classification through the Phase of Care Clinical Refinement Project.

5. Data Collection

Consultation Question – Should access to the public hospital data held by IHPA be widened? If so, who should have access?

WA supports widening access to public hospital data held by IHPA. Access could be expanded to various stakeholders including but not limited to the health sector, private sector and education institutions; on the proviso that appropriate governance and approval processes are established. A key risk however, will be how this data will be interpreted and used. As such, the governance and approval processes to providing access should canvas these considerations.

WA notes that increased access to public hospital data may encourage the following:

- public hospitals will benefit from wider disclosure of research IHPA undertakes in support of funding adjustments to the national model,
- openness in public administration leads to good governance,
- greater public scrutiny will serve to better inform the public of the difficulties and costs of delivering public services in rural and remote locations.

Consultation Question – What analysis using public hospital data should IHPA publish, if any?

WA supports exploratory activity or cost data analysis to support the integrity of the model, investigate potential areas for improvement, and to inform future model refinement. IHPA could also undertake activity analysis to provide comparisons on service delivery characteristics across jurisdictions. For example, stakeholders have expressed interest in national data disaggregated by care type, setting and age group. Topics could be suggested to IHPA via the IHPA Advisory Committees or through the Pricing Framework consultation process.

As raised in IHPA's Technical Advisory Committee, WA supports further analysis of specific issues as part of the annual NHCDC Cost Report. An example of this could be further consideration of overhead components and allocation across jurisdictions.

General Comments

Regarding phasing out aggregate reporting of non-admitted data, WA notes concern that a complete transition to patient-level reporting for all non-admitted services by 1 July 2019 is most likely unachievable.

Whilst the transition to patient level reporting is a work in progress in WA, significant local effort will be required to transition all services to patient-level reporting, noting WA currently has nine feeder systems in use for recording non-admitted data. Additionally, WA also contracts to several non-government organisations (NGOs) that provide outreach hospital avoidance and community-based non-admitted services. These NGOs currently submit aggregate data.

6. Setting the National Efficient Price for Activity Based Funded Public Hospital Services

As noted in previous years' Pricing Framework submissions, WA is strongly opposed to any change in the calculation of the NEP that has the potential to reduce the Commonwealth contribution to jurisdictions under ABF going forward. Furthermore, WA does not support a move away from the current process of setting a NEP based on the weighted mean cost of admitted services. This is particularly an important issue as it would result in more funding being subject to funding guarantee considerations.

Technical improvements

Consultation Question – What are the advantages of changing the geographical classification system used by IHPA?

WA appreciates IHPA's efforts to improve the loadings for regional and remote services under the current model. WA recognises there are still improvements that can be undertaken to better account for the additional costs borne by these services, and welcomes IHPA's intention to study different alternatives to current arrangements and model loadings. For example, the current model lacks sufficient specificity when attempting to articulate remoteness. WA notes that in the current model, hospitals in the same category may demonstrate varying degrees of remoteness or geographical distance (i.e. some less remote and other substantially more remote), which may dampen the true cost impost of the more remote hospitals.

Consultation Question – What areas of the National Pricing Model should be considered as a priority in undertaking the fundamental review?

As per comment above to better understand variations in remoteness of services for both NEP and NEC funded hospitals. Further, WA recommends IHPA consider economies of scale and scope effects on the model.

Consultation Question – Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2019-20?

WA recommends that IHPA further investigate private patient adjustments and child and adolescent mental health services to better understand the impact and variance of these patient cohorts on the model.

WA notes that IHPA is currently undertaking a Fundamental review of the National Pricing Model and will provide further comments on technical improvements to the model based on the outcomes of this review.

Adjustments to the National Efficient Price (NEP)

Consultation Question – What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?

WA considers recent adjustments to facility location costs for admitted acute episodes as a welcome recognition of a significant cost impost. WA notes that subacute and outpatient services delivered in regional and remote facilities are similarly subject to additional cost pressures. WA recommends IHPA consider extension of this adjustment to subacute and outpatient service delivery, as this would provide better consistency in the model across settings and equitable compensation for the costs of this service delivery.

Consultation Question – What patient-based factors would provide the basis for these other adjustments? Please provide supporting evidence, where available.

Further to the above, WA recommends that IHPA consider the impact of the following on episode costs:

- homelessness, recognising the quality of data to identify this cohort of patients maybe poor
- patients with a mental health condition receiving treatment where the care type is not mental health
- the presence of drugs (such as methamphetamine)
- regarding child and adolescent mental health services, the inclusion of parents/guardians or other services increases costs required to provide these services.

Consultation Question – Do you support price harmonisation for the potentially similar same-day services which are discussed above?

WA supports price harmonisation in principle, but recognises the possibility that when harmonising services, there may be financial incentives to drive care into less acute settings which in some cases may be contrary to quality clinical practice. WA therefore recommends that any proposed price harmonisation is reviewed on a case by case basis through IHPA's Advisory Committees.

WA will require further consideration of the examples noted in this section, i.e. non-admitted and admitted same-day chemotherapy services, renal dialysis and sleep disorders, prior to providing feedback. WA notes that the reporting of related encounters for a chemotherapy episode needs further consideration, specifically where initial or follow up visits are not recorded in the patient administration systems as this may be presenting an inaccurate representation of episode costs.

Consultation Question – What other services, which can be provided in different settings of care, could benefit from price harmonisation?

Gastrointestinal scopes, transfusions and infusions are suggested candidates for initial review.

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

WA generally supports IHPA's proposal for shadow funding implementation periods. WA recommends that the implementation of new classification systems (excluding version updates unless this may result in uncertain outcomes) should always be shadow funded, even where there is robust existing data, unless otherwise agreed to by jurisdictions. An example of this would be the new Australian Emergency Care Classification system.

7. Setting the National Efficient Price for Private Patients in Public Hospitals

Consultation Question – Do you support the proposal to phase out the private patient correction factor for NEP20?

WA does not support the proposal to phase out the private patient correction factor in NEP20.

WA supports the current process of IHPA estimating and adding back additional costs incurred by private patients that are not currently included in NHCDC submissions by the States, as well as the continued adjustment to the price weights to recognise this external funding source.

Given the current significant jurisdictional differences in private patient percentages in public hospitals, without appropriate adjustments to the price weights it would further compromise the capacity: (1) to have a single national efficient price and (2) to provide an equitable funding distribution or make assertions around the relative efficiency of one hospital compared to another.

If the private patient adjustment is inadequate, jurisdictions with higher private patient utilisation will be advantaged.

8. Treatment of other Commonwealth Programs

WA acknowledges that IHPA is not proposing any changes to the treatment of Commonwealth funded programs for NEP19.

9. Setting the National Efficient Cost

Consultation Question – What other models might IHPA consider in determining funding for small rural and remote hospitals?

WA supports the proposal to consider alternate models for determining funding for small rural and remote hospitals. WA notes these proposals are currently being evaluated through the Small Rural Hospitals Working Group and will continue to provide input through this group and other IHPA Advisory Committees.

Consultation Question – What cost drivers should IHPA investigate for rural and remote hospitals for potential inclusion as adjustments in the NEC?

WA has previously provided a submission through the Legitimate and Unavoidable Cost Variations Framework in support of changes to the National ABF model to recognise the cost disadvantage faced by hospitals in remote and very remote locations. WA supports the continued recognition of these issues in assessing the fairness of the current and future NEC models in funding small rural hospitals effectively.

10. Innovative funding models

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?

WA supports the investigation of bundled pricing models. WA recommends IHPA consider both qualitative and quantitative aspects when evaluating such models to ensure consideration is given to both: what is deemed as best practice, and what is demonstrated by the available data.

11. Pricing and Funding for Safety and Quality

Avoidable hospital readmissions

Consultation Question - Do you agree with the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Health Network (either to the same hospital or to another hospital within the same LHN)?

WA supports IHPA's proposal that funding adjustments are intended to target the initial treating hospital in which the index admission occurred.

A proposed model could be that a proportion of the costs of the return episode are deducted on the basis of risk adjusted likelihood of re-admission of the individual patient on the basis of the principal diagnosis/DRG being considered at the initial hospital separation. Another model worthy of consideration is a modest financial penalty applied at a facility level for hospitals that exceed the risk adjusted national mean rate of re-admissions (provided that this mean rate is condition specific).

Alternatively there is potential that a positive funding incentive could be applied at a facility level for top performing services with the lowest avoidable re-admission rates for specified conditions. Percentage reductions in accordance with weighted complexity scores would be necessary in any model to counteract effects on re-admission rates of chronic disease and complex co-morbidities

WA generally supports the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same LHN. However, WA notes that there may be a degree of inequity in applying this approach due to the differences in the number and geographical boundaries of LHNs across the country.

For example, due to geographical constraints and service availability it is more likely that a patient readmitting within a remote/regional context in WA would be returning to a facility within the same LHN, when compared with the same patient in the metropolitan context. Equally, it would be reasonable to assume that a patient in WA would be more likely to be readmitted to the same LHN, given there are only five in the state when compared with for example a patient in Victoria where there are over 80 LHNs for a significantly smaller geographical area. This consideration extends to remote/regional patients who are initially treated by a metropolitan hospital and represent to a remote/regional hospital in a different LHN.

Consultation Questions - Do you prefer an alternative scope for measuring avoidable hospital readmissions and, if so, how would this be measured?

Nil comment.

What evidence or other factors have informed your views?

WA notes that the following challenges exist when trying to analyse this issue for internal management reporting.

- Readmission data within the same LHN may not adequately reflect the readmissions that occur across local hospital networks due to proximity of WA country areas to metropolitan health sites and tertiary services available only at metropolitan health sites.

- Timely acknowledgement and review of readmissions that have occurred across WA country regions (and sites) has previously been constrained by access to patient information and communication between health services.

Use of Medicare PIN

Consultation Question – 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?

WA supports the use of a patient identifier noting this will enable:

- more effective comparisons to be made with health services within and across jurisdictions;
- better modelling of national long-term health trends and outcomes; and
- more transparent means of tracking individual patients and models of care.

Noting the legislative constraints on the secondary use of identifiers, WA's preference is for the use of the Individual Healthcare Identifier (IHI) over the Medicare PIN. Neither identifier is completely reliable. The IHI will provide a more unique match (as a patient may have more than one Medicare number), however may not be applicable for patients from overseas.

It has also been noted that the integration of the IHI across care settings may not be as straightforward. Further, WA has requested through IHPA's Advisory Committees that IHPA provide jurisdictions with further information on the governance processes with providing third parties data incorporating the IHI. WA has commenced processes to access and integrate this item into routine data collection and reporting processes.

Consultation Question – What strategies can be used to overcome existing disadvantages for each of these approaches?

Nil comment

Readmissions within or across financial years

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

WA supports in principle the proposal to limit the measurement of readmissions within the same financial year, as WA has previously advocated strongly against retrospective adjustments across financial years.

However, WA recommends that IHPA monitor readmissions that occur across financial years and analysis on these be provided back to jurisdictions through IHPA's Advisory Committees. This will enable jurisdictions to better understand the impact of these cases on the funding model.

Funding and pricing approaches

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

WA agrees with this approach consistent with Sentinel Event and Hospital Acquired Complication (HAC) arrangements.

Risk-adjustment factors

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

WA supports the proposal to base initial modelling of a risk-adjustment approach on the variables considered for HACs. WA notes the derivation of an appropriate risk-adjustment approach will be critical given the potential for contention in what may or may not be an avoidable admission.

WA stakeholders noted concern regarding the readmission intervals for "cardiac complications" deemed avoidable, and thereby potential funding penalties associated. Clinicians voiced concerns over the methodology behind readmission intervals. For example, how atrial tachycardia is ascertained as 14 days, as well as, clarity on inclusion of atrial arrhythmias under the 'cardiac complications,' which are known to recur after treatment, and the development of arrhythmia is generally not avoidable.

Additionally, within General Surgery the decision to re-admit at times is not clinical. For example: it may be possible for a patient to be discharged home to a supportive family, however this may not be possible due to family circumstances.

Funding options

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

Option 1 provides the simplest funding approach that focusses heavily on index admission accountability. However, this would need to ensure that the model is properly risk adjusted and the classification of avoidable readmissions is just given the severe funding penalty.

WA agrees with IHPA's initial assessment of this option.

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

Option 2 may allow for better comparison with patients where readmission does not occur by creating a more comprehensive view of the index and readmission as one episode. This may be advantageous when setting benchmarks and thresholds.

WA agrees with IHPA's initial assessment of this option.

Consultation Question – What are the advantages and disadvantages of Option 3? Do you agree with IHPA's assessment of this option?

WA notes that Option 3 is most closely aligned with the requirements specified in the previous Heads of Agreement and the Ministerial Direction to develop an approach that adjusts funding to hospitals that exceed a predetermined avoidable readmission rate.

WA believes thresholds for 'acceptable' rates of avoidable hospital readmissions should be set with reference to best practice, and not defaulting to historical performance.

WA supports the consideration of a more graduated approach including combined partial funding penalties with lower benchmarks.

WA agrees with IHPA's initial assessment of this option.

Consultation Question – Should benchmarks for avoidable hospital readmissions be measured and calculated at the level of individual hospitals or at the level of LHN?

Comparison by hospital or LHN allows for specific thresholds to be developed and adjusted by geographic and patient factors. This may address some of the WA concerns raised above. Assuming a suitable framework is put in place for patient related risk adjustments, WA would anticipate benchmarks set at the level of LHN would be more appropriate than at an individual hospital level.

WA recommends IHPA consult further with jurisdictions to understand what benchmarks are currently used by health services, as this may provide an indicative base for further hospital or LHN modelling.

Consultation Question – 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?

WA recognises the need to maintain transparency across jurisdictions, of which thresholds set at a national level and risk adjusted would be the most appropriate.

Implementation pathway for funding adjustments

Consultation Question – Do you agree with IHPA's implementation pathway?

Yes, WA supports the proposal for shadow funding the implementation of avoidable readmissions; consistent with the advice provided in previous sections regarding the use of shadow funding for adjustments to the model.

WA looks forward to reviewing further modelling on the three proposed funding options, noting that a 'simple' approach is preferred i.e. to not overcomplicate the model if the benefit is not justified.

Consultation Question – For what period of time should the three proposed funding options be shadowed?

WA recommends a minimum period of two years to allow for jurisdictional modelling of the proposed funding options.

Consultation Question – 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 avoidable hospital readmissions?

WA believes that the experiences from the introduction of HAC funding approaches should guide how the avoidable readmissions adjustment is adopted. WA recognises IHPA's reasoning for an incremental approach, however advocates for a continuation of an all at once approach to avoid successive disruption to management processes that rely on year on year comparisons. An effective shadow funding period should negate the need to incrementally introduce funding adjustments for avoidable readmissions.

Consultation Question – What other options do you recommend for the implementation of a funding model for avoidable readmissions?

Nil comment

Evaluation of safety and quality in health care

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

WA supports the development of an evaluation framework and appreciates that this is being developed in consultation with jurisdictions and the Commission.

WA recommends that the questions for this evaluation should cover both:

- Quantitative measures to assess how reforms have contributed to improvements in patient outcomes (e.g. reductions in HACs, avoidable readmissions and sentinel events).
- Qualitative measures e.g. health service/clinician assessment of the extent to which the focus on avoidable patient harm within the pricing framework has led to service/clinical practice improvements and clinician engagement in these activities.

WA notes the draft Evaluation Framework and evaluation questions presented to the Jurisdictional Advisory Committee in May 2018. Other potential questions for consideration include:

- Is data transparency reflected throughout the system? That is, can the benchmarking/comparisons be applied in a consistent manner across all jurisdictions?
- Are current data collection systems able to accommodate changes required for new data reporting and funding approaches? If not, what is the sufficient time for implementation?
- Are systems and structures in place to support the implementation of the proposed reforms?

- What are the mechanisms for data validation used by health services or LHNs? For example, having a state "unplanned" readmission indicator which clinicians review cases has identified a number of data validity issues with readmissions.
- What are the considerations or mechanisms required to avoid perverse incentives? For example, not treating high risk patients to reduce risk of financial penalties.
- Does the desired clinical action improve patient outcomes?
- Are there valid reliable and practical measures of the desired clinical behaviour?
- Have barriers and enablers to improving clinical behaviour been assessed?
- Will financial penalties work better than other interventions to change behaviour?
- How much should be paid, to whom, and for how long? Will this be adjusted over time?
- How will the financial penalties be delivered?
- Have other factors that measure the quality of care from a patient's perspective been considered? For example, the Your Experience of Service (YES) questionnaire.

WA supports the consideration of outcomes such as length of stay and cost reduction as a result of the reform. WA notes the importance of establishing clear baselines and validating causal relationships when validating the impact of the reforms.