July, 2019

SA Health

Response to Independent Hospital Pricing Authority Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21

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 2020-21*, through the public consultation paper. On behalf of our jurisdiction, the Department of Health and Wellbeing (DHW) offered the relevant stakeholders within SA Health 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.

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

South Australia supports the Pricing Guidelines and still views them as relevant in providing guidance for future developments. In saying this, SA Health stresses the relevance of the Pricing Guideline '*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 encourage the IHPA to consider the resource requirements for the changes in terms of the cost-benefit. There needs to be account of the 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, especially when significant concerns are raised by a number of members.

Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support value in hospital and health services?

The new guideline which aims to promote innovation in models of care in the development of funding systems is supported by South Australia. With this in mind, a stable funding environment will be a key component for the delivery of quality and efficient care, allowing departments to build on a steady and established framework where supporting patient outcomes is the first priority.

What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?

In the past AR-DRG and ICD-10-AM classifications were developed independently, so in the interest of stability in the funding model it is crucial that they now evolve in a cohesive manner now that they both sit under IHPA. In the past, there has been a reactive response occurring between the ICD and DRG

classifications. A forward thinking, unified approach would provide more stability for the admitted activity data.

There is a very real question as to whether there is a need to move to DRG Version 11, rather make only those changes that are necessary and update the edition (ie DRG Version 10.1) to provide some stability in the system. The decision to move to a new version will have more clarity once the change requests and new ICD codes are evaluated, but South Australia would not object to only an edition change if that is the most appropriate outcome.

Changes sought in the ICD codes are:

- Clinicians are concerned about the resources required to deal with social issues and functional decline. The predominant focus of some admitted episodes is addressing the patient's social issues or circumstances and not necessarily centred on an actual physical complaint. Currently there is no provision in the classification to capture this as most Z codes are unacceptable diagnoses and do not have a DCL value. Example scenarios supplied by health care services include cases involving child protection, paediatric eating disorders, discharge delayed by homelessness etc.
- Recognition that there is inadequate provision in ICD-10-AM to accurately reflect care provided to infants aged over 28 days who are admitted concurrently with their mother whilst she receives treatment (most commonly for mental health disorders) and are themselves receiving treatment. The options available for the classification of conditions such as failure to thrive, excessive crying, feeding problems, behavioural disorders etc. in infants are deficient.

Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

Timely responses to coding queries and public submissions are an important factor in promoting consistent code assignment nationally, this has been an issue historically. Queries and submissions are also valuable indicators of what areas of the classification are deficient and require review. Jurisdictions need to be confident in receiving timely feedback, which is currently deficient.

In addition to regular MBS and WHO updates, routine review of all Australian Coding Standards should be part of every development cycle to ensure currency and consistency.

Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?

The support for implementation of AECC v1.0 from 1 July 2020 is dependent on the ability of SA to analyse and model changes under the new classification to determine the scope of variation to activity and funding. While we believe our infrastructure is of a sufficient quality to accurately price Emergency data using Version 1.0, we need to understand the potential changes to pricing and funding that may occur with the implementation of this classification. In saying this, South Australian LHNs are continually working toward improving the collection of their ED data, with a focus on upgrading current IT systems and improved mapping of codes. Through consultation with LHNs, a limitation in the ability to collect three diagnosis codes has been identified. Hospital sites are aware of this and are working to improve their system's capacity and increase their clinician's education to be able to collect three appropriate diagnosis codes.

Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

South Australia has invested time and resources into improving the collection of mental health data and the associated costing. However, at this stage South Australia does not support the implementation of AMHCC Version 1.0 from 1 July 2020. The costing data that is to be used for NEP20 is the 2017-18 NHCDC data which analysis has already shown to not have the level of consistency jurisdictions require in implementation of a new classification. SA Health does support the start of shadow funding and reporting on mental health data in the new classification to prepare stakeholders for its eventual implementation.

Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

Since Activity Based Funding has been used nationally for a number of years there is a question about the cost pressures that smaller jurisdictions may face given the pricing is driven by the larger states.

South Australia is requesting that IHPA undertake a review of classes where there is a significant cost differential between jurisdictions consistently in certain cost buckets. A specific example is the outpatient classification for the genetics class (20.08), the pathology costs range from under $5 in NSW and Queensland to over $900 in Tasmania and South Australia. It is a legitimate question to ask if all jurisdictions are including the same costs, in the same way, as our clinicians

are questioning the differences to which we may have limited answers other than it is driven by high volume states whose costs are different to SA.

Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

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, and be kept under review for change annually.

Do you support IHPA making the National Benchmarking Portal (NBP) publicly available, with appropriate safeguards in place to protect patient privacy?

SA supports access to hospital data being widened in an unrestricted manner through the NBP mirroring the DHW commitment to increased transparency and rich data assets being utilised to their full potential. It is critical however that good governance and process surrounds the data. This is an important caveat, it is also important that any presentation of findings is provided with appropriate contextual information to minimise false interpretation. Jurisdictional input will be valuable for all data users and provide additional quality checks and validations as well as insights into local context and any observed anomalies.

In all instances where the data provided by Hospitals and Local Health Networks is utilised for reasons outside of their intended use, it is important that said sites and LHNs are consulted in regard to the extracurricular use of their data, thus; sites and LHNs need to be considered through the provision of data.

What are the estimated costs of collecting the Individual Healthcare Identifier (IHI) in your state or territory?

Digital Health SA, through the NHDISC in November 2018, provided a figure, to which IHPA had access to, for South Australia to implement the IHI throughout our systems. This figure is expected to grow once hidden costs such as administration and increased security are realised.

Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?

South Australia is supportive of the implementation of the IHI, as we believe it will add great value to our provision of care, but the cost of its adoption will rest heavily on the DHW and vendors who will need to do the bulk of the implementation. It is for this reason that we believe Departments need to be supported through the implementation of the IHI with financial support and guidance to ensure the IHI is implemented effectively. With the incentive payment system, being attached to the patient episode, the financial support will flow straight to the Hospitals and LHNs, bypassing the Department who will be doing the bulk of the implementation work. A mechanism that allocates payment to where the cost is incurred will be required to ensure the payment was distributed where needed.

Hospitals and Local Health Networks will also need some financial support and guidance through the implementation of the IHI due to the increase in information collected, and the administration and system improvements that are required to implement the system effectively.

What initiatives are currently underway to collect PROMs and how are they being collated?

Throughout the state, a body of work is being developed in respect to rehabilitation and through the national pilot project through the Australian Orthopaedic Association National Joint Registry. The development of the collection of PROMs will have an increased focus in 2019-20.

Should a national PROMs collection be considered as part of national data sets?

A national approach to PROMs would be welcomed as a tool which could be used to improve the provision of patient care through its feedback mechanism. They also need to be considered in a broader context for other uses such as Clinical Quality Registries. The subjective nature of the patient's experience may mean the measurement can be skewed due to the individual's expectation of care being unrealistic, where the care they desire may not be deemed as 'high value'; which we strive for.

Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20?

South Australia supports the shadow pricing of the 'fixed plus variable' model as it is aligned with our current Grant Funded Unit model.

Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

South Australia support investigating Value Based Funding or Capitation models in order to develop the most appropriate models of care for an Australian context which would deliver positive patient outcomes. It was also noted that there is a need for more robust pricing and funding for community delivered services, however, it is hoped that these will be one of the outcomes of the new outpatient classification system that is being developed.

IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

South Australia supports the investigation of bundled payments for services that are deemed to effectively have a standardised model of care across the country. The limiting factor to any implementation of bundled payments is the ability to track patients across the system as required. This was seen when the bundling of maternity services was considered, without a patient identifier that can track patients across care settings and sites (ie IHI) it would be difficult to implement this type of payment.

Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

In the last two years SA Health has worked closely with the LHNs in identifying the drivers/contributing factors for Hospital Acquired Complication. This has resulted in a number of the LHNs seeing a steady decline in HACs over a number of years both due to improved quality of documentation and care pathways. 30% of HAC funding was withheld from LHNs in 2018-19 to establish a Quality Improvement Pool – this was focused on improving quality and safety of care. SA Health plans to increase this to 50% in 2019-20. Further evaluation is required, as SA Health has taken the quality approach as the driver rather than the funding, albeit LHNs do pay attention to the funding implication. Benchmarking has primarily been through SA Chapter Health Roundtable and HAC KPI Reports. It may be still too early to fully evaluate this approach nationally, however over several years the value should become evident (or otherwise)

What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

For a hospital avoidance system that addresses the question of potentially avoidable readmissions to be completely fair and reasonable, all patient

characteristics need to be assessed and taken into consideration when developing hospital avoidance software. This means the IHI will hold significant importance in the comparability of patient characteristics and outcomes and also the comparability of hospital performance.

South Australia would prefer if all logic was able to be provided in SQL as this is a globally used language and will enable us to embed the software within our own systems and processes.

If you require any further information on SA Health's responses to the Pricing Framework Consultation 2020-21 please contact Ms Krystyna Parrott, Senior Manager, Funding Models on (08) 8226 7263.