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Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLNGHURST NSW 1300

Dear Mr Downie

Subject: Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21

Thank you for the invitation, as part of the public consultation process, for Tasmania to provide comment on the Independent Hospital Pricing Authority's '*Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21'.*

Please find attached the submission from the Tasmanian Department of Health.

Thank you for the opportunity to comment.

Yours sincerely

Ross J Smith
Deputy Secretary, Planning Purchasing and Performance

July 2019

Attachment 1. Tasmanian DoH Submission

Attachment 1.

Responses to the Consultation Questions - IHPA Consultation Paper on the Pricing Framework for Public Hospital Services 2020-21

Section 2: The Pricing Guidelines

Consultation questions:

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

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

While not a consultation question, the Tasmanian Department of Health (DoH) would like to refer to the Pricing Guidelines in figure 1 (page 6). One of the guidelines states 'Administrative ease: Funding arrangements should not unduly increase the administrative burden on hospitals and system managers'. Tasmania supports the refinements to the classifications and the funding model, however questions the resource requirements for the changes and expected relative benefit. Refinements need to take into account the full range of data and reporting burden and amount of change required of data providers at any one time.

Tasmania has no issues with the criteria and interpretive guidelines of the General List. Tasmania supports IHPA's role in pricing Australian public hospital services and the inclusion of new System Design Guidelines.

Section 4: Classifications used to describe and price public hospital services

The Tasmanian DoH supports:

- IHPA phasing out older versions of the Australian Refined Diagnosis Related Groups (AR-DRGs).
- Development of the Australian Non-Admitted Care Classification system.
- Continued block funding of home ventilation services.
- IHPA plans to shadow price medical-led MDCCs where the patient is not present.

Tasmania notes that the reporting of activity and cost data for teacher training remains a significant hurdle. In particular, it has been identified that the collection of the required data elements is problematic and will take time before data is able to be provided as required under the Australian Teaching and Training Classification (ATTC) National classification and Australian Hospital Patient Costing Standards.

The Tasmanian DoH would support the splitting of the Home Ventilation clinic into differing levels of intensity for 2020-21 as was proposed for 2018-19 under Version 6.0 of the Tier 2 classification system.

Section 4.2 Admitted acute care

Consultation questions:

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

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

The Tasmanian DoH will work through the ICD-10-AM Technical Group (ITG) and the DRG Technical Group (DTG) to inform the development and refinements of the acute care, ICD-10-AM and ACHI and AR-DRG classification systems.

Section 4.5 Emergency care

Consultation question:

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

Tasmanian support HPA's commitment to the AECC Version 1.0. Tasmania supports a shadowed pricing model during 2020-21 to assist in reducing any adverse outcomes. Having the pricing model shadowed during 2020-21 will assist in analysing the impact of the new classification system and increase stability during the initial year.

Section 4.7 Mental Health care

Consultation question:

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

Tasmania has concerns with the increased data burden on hospital staff and lack of clarify around phase of care and possible continued instability in data linking. Tasmania is supportive of funding being available to the ABF Hospitals either by AMHCC or the acute pricing model where AMHCC data element are available. Tasmania supports the continued block funding arrangements for stand-alone and residential mental health care facilities.

Section 5: Setting the National Efficient Price for activity based funded public hospitals

Section 5.2 Adjustments to the National Efficient Price

Consultation question:

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

Tasmania DoH 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. This approach would more closely align the national funding model with national pricing guidelines such as fairness, greater alignment of funding with costs, and minimisation of undesirable consequences.

While there may be issues with the ability to identify patients within the data sets, Tasmania recommends IHPA consider the impact of the following on the episode costs:

- Patients (including Admitted child and adolescent mental health service) with a mental health condition receiving care where the admitted care type is not mental health.
- Homelessness Patients
- National Disability Insurance Scheme (NDIS) eligible Patients

Section 5.4.2 Phasing out the private patient correction factor

Consultation question:

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

The Tasmanian DoH 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 NEP21.

Section 6: Data collection

The Tasmanian DoH supports the phasing out aggregate non-admitted data reporting.

Section 6.3 Access to public hospital data

Consultation question:

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

The Tasmanian DoH supports the current scope of data provision and current approval process and at this time does not support expanding access to the National Benchmarking Portal.

Section 6.4 Unique patient identifier

Consultation questions:

What are the estimated costs of collecting the IHI in your state or territory?

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

The Tasmanian DoH supports the use of the Individual Healthcare Identifier (IHI) as the most robust collection. However, noting that the ability to comply with reporting this data element is problematic and not feasible for Tasmania at this time, because of the significant investment in IT required.

The Tasmanian DoH cannot provide an estimated of costs for collecting the IHI.

Section 6.5 Patient reported outcome measures

Consultation questions:

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

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

The Tasmanian Department of Health does not currently centrally coordinate any information on PROMS. The Tasmanian Health Service (THS) however, is currently collecting and regularly reporting PROMs through the clinical networks of renal, pain, stoke, orthopaedic and cardiac. Questionnaires are completed by patients and entered into the clinical networks data repositories and reported back to clinicians as part of the clinical service improvement process.

The Tasmanian DoH supports the consideration of PROMS as part of National Best Endeavors Data Set however, because of resource requirements Tasmania request that any collection mechanism seeks to the data burden of the requirement to provided data from multiple programs were variables overlap

Section 7: Treatment of other commonwealth programs

Tasmania supports the current adjustments for funding received from Commonwealth programs such as:

- Blood products (through the National Blood Agreement)
- Commonwealth pharmaceutical programs including:
    - Highly Specialised Drugs (Section 100 funding)
    - Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding), and
    - Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme Access Program.

Tasmania would support increased reconciliation between the agreed commonwealth program amounts and the Commonwealth program amounts identified in the cost studies.

Section 8: Setting the National Efficient Cost

Section 8.2 Consideration of alternative NEC methodologies

Consultation question:

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

Tasmania is supportive of a "fixed plus variable" model to determine the National Efficient Cost model for small rural and remote hospitals.

Section 9: Alternate funding models

Section 9.2.3 Bundled payments

Consultation questions:

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

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

Tasmania wishes to provide the following commentary.

- Any pricing model development needs to ensure that any models of care developed are flexible enough to ensure that local clinical capabilities are respected and that any capitation of funding is not just seen as an initiative that reduces commonwealth funding to the states and territories.
- Any developed models of care may require an integrated funding arrangement with the primary health care sector.

Tasmania supports the investigation of bundled pricing models. The Tasmanian DOH support further investigation of bundled pricing models in of the following areas:

- Chronic obstructive pulmonary disease (COPD)
- Cardiovascular diseases:

    - Implantable cardiac devices, pacemakers,
    - Percutaneous coronary intervention,
    - Coronary artery bypass graft (CABG), and
    - Acute myocardial infarction (AMI)
- Musculoskeletal conditions, low back pain
- Vision disorders, Cataracts

Section 10: Pricing and funding for safety and quality

Section 10.3.1 Approach to funding of HACs

Consultation question:

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

The Tasmanian Health Service and DoH has undertaken several different approaches to improve the reporting of hospital-acquired complications these are:

- Reviewing the clinical coding process to ensure the condition onset flag was correctly applied,
- Refining reports to enable THS clinical staff, access to data on HAC's, and
- Having the Australian Commission on safety and Quality in Health Care provide a presentation to the THS on using the data to improve care.

Section 10.4.3 Commercial readmissions software

Tasmania is comfortable with the framework proposed by the IHPA, of a 24-month shadow period for funding options to assist in reducing avoidable hospital readmissions on 1 July 2019 and the development of three proposed funding options. However, has concerns as to the suitability of linking data set without the use of the Individual Healthcare Identifier (IHI) especially in an environment where the internal structures within the state and LNH have the potential to effect the identification of readmissions.

Consultation question:

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

Tasmania is comfortable with the framework for readmissions proposed the Australian Commission on Safety and Quality in Health Care (ACSQHC).