Consultation paper on the pricing framework for Australian public hospital services 2020-21

Victorian Department of Health and Human Services response

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VICTORIA State Government | Health and Human Services

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1. Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21* (the framework) and is supportive of the continual improvements to the framework. The framework forms part of the IHPA'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 framework 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 and has used its response to provide input into how to further mature aspects of the national pricing model.

Victoria recognises the importance of the addendum to the National Health Reform Agreement and the IHPA's progress on work to incorporate safety and quality into the pricing and funding of public hospital services. This will be an important feature of the future National Health Reform Agreement from 2020 onwards and will lead to improved health outcomes, avoidance of unnecessary or unsafe care and a decrease in avoidable demand for public hospitals services.

2. Pricing Guidelines

The Pricing Guidelines direct how the IHPA should undertake its work and Victoria encourages the IHPA to continue applying them in a consistent, balanced and comprehensive manner.

Victoria supports the IHPA's view that the Pricing Guidelines are working well and supports the proposal not to change the Pricing Guidelines 2020-21.

3. Scope of Public Hospital Services

The General List of In-Scope Public Hospital Services (the General List) is published each year by the IHPA as part of the National Efficient Price (NEP) determination. In addition, the IHPA maintains a General List of In-Scope Public Hospital Services Eligibility Policy (the General List policy) that defines public hospital services eligible for Commonwealth funding.

Victoria supported the IHPA's comprehensive review of the General List policy in late 2018 and welcomes the ongoing opportunity to participate in the consultation on the annual review of the General List.

4. Classifications used to describe and price public hospital services

4.2 Consultation question

- 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?

Consideration for development of AR-DRG V11.0

1. **Retention of AR-DRG v7.0 for comparative purposes -** Victoria considers it worthwhile to keep AR-DRG v7.0 as a comparative reference for measuring episode clinical complexity, at least until AR-DRG v 11.0 has been implemented for funding for at least one financial year (i.e. AR-DRG v11.0 will be used to fund 2022-23). Phasing out versions prior to v 7.0 is acceptable.

   Victoria is concerned about the suitability of AR-DRG v 11.0 as it will be the first DRG version that will include 2016-17 cost data in the determination of the Episode Clinical Complexity Model (ECCM). Notably, 2016-17 is the first year of activity that was funded under the new Episode Clinical Complexity Model that was first introduced under AR-DRG v8.0.

   Keeping AR-DRG v7.0 as a benchmark will allow comparison of the new AR-DRG v 11.0 with the last of the old method of measuring clinical complexity (i.e. AR-DRG v7.0). This is especially significant for private hospitals which are mostly still using DRG versions prior to V8.0.

2. **Patient gender and diagnosis codes** – Victoria encourages a review of patient gender coding as a patient's gender identity may conflict with the gender assigned by administrative staff in reporting systems. This can lead to classification grouping conflicts and error outcomes. Victoria will continue to work with the IHPA to address these issues.

3. **Review of recently deleted AR-DRG classifications** – Victoria encourages the IHPA to review the decision to delete AR-DRG classifications relating to A11 - *Insertion of Implantable Spinal Infusion Devices* and A12 - *Insertion of Neurostimulator Devices* from AR-DRG V9.0. Victoria continues to receive correspondence from the clinical sector expressing concern over the impact of the changes in the national classification of funding for these procedures.

Considerations for development of Twelfth Edition

1. **Chronic conditions codes –** Victoria encourages continuation of temporary supplementary codes (stemming from developments in earlier editions), because there is growing dependence on the information they provide.

2. **ACS 0002 Additional diagnoses –** Victoria encourages the IHPA to undertake a post implementation impact assessment of the assignment of additional diagnoses codes as it considers the consistent interpretation of the standard across jurisdictions will not be known until it is implemented.

3. **Multiple condition coding –** Victoria encourages further clarification on this issue as it considers this a fundamental coding convention. Confusion can arise when two codes are assigned to classify a clinical statement or whether one code should be assigned when a clinical statement contains two conditions not fully described by following an Index pathway.

4. **Mental health coding –** Victoria notes that there is a growing need to capture social determinants of mental health and more broadly across other types of care in an admitted episode of care that do not

always meet criteria for coding. Current coding standards instruct clinical coders to assign a code for a condition if it is 'relevant to the current episode of care' but which is difficult to apply consistently.

Considerations for the review of the ICD-10-AM/ACHI/ACS development process

1. **Commencement of cycle and work plan priority** – Victoria encourages the IHPA to consider commencing its work plan earlier in the cycle to reduce pressure on jurisdictions to produce papers for review, to allow adequate time to consider issues and provide advice and enable a longer preparation period for implementation by jurisdictions.
2. **Publication of national advice** – Victoria encourages the IHPA to consider that all queries submitted for national advice should be published and that the IHPA consider developing guidelines outlining under what circumstances national advice will not be published.
3. **Education process** – Victoria encourages the IHPA to consider the re-introduction of either face to face education or a 'train the trainer' model when changes are expected to have a big impact on coding practice.

4.5.1 Consultation question

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

Victoria does not support pricing using the AECC from 1 July 2020.

The main impediment is that Victorian budget outlays are informed by the National Efficient Price. Changes to the national funding model in 2020-21 would create significant budget uncertainty on the 2020-21 Victorian budget.

Other impediments to pricing are that, at the time of preparation of this response, IHPA are yet to publish the AECC grouper which is needed to inform a discussion around changes to the national model. Victoria is likely to support pricing using the AECC when changes are consulted on through the relevant national committees. This consultation should show NWAU flows between jurisdiction and hospitals, grouped by URG and AECC so that the changes and financial impacts can be better understood.

The AECC is so fundamentally different to the URG classification that IHPA should proceed cautiously in light of the potential for unintended funding consequences. Victoria supports working towards shadow pricing from 2021 with a view to pricing from 2022. This timeframe will allow Victoria, as the system manager, to adjust budget to ensure the sustainability of the health system.

4.7.2 Consultation question

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

Victoria believes that there are significant barriers to pricing mental health services using the AMHCC from 1 July 2020 and feel that pricing within this timeframe risks significant errors in the pricing data. Victoria's concerns include:

- poor inter-rater reliability reported in 2017 by the IHPA with three of the five Phase of Care phases having significant implications for the quality and consistency of the data collected with a significant risk that pricing will be incorrect
- major gaps currently exist in cost and activity data that is needed to inform a truly national approach to pricing. To date, only Queensland has been able to provide cost and activity data at phase level for community mental health.
- limitations in current data quality and comparability that would potentially inform pricing using the AMHCC.

Victoria further emphasises its concerns about the proposed changes and notes it would not be reasonable to modify collections until after a new inter-rater reliability study has occurred.

In Victoria's response to the 2018-19 IHPA Consultation Paper, Victoria said that pricing using the AMHCC and phase of care should only be considered after a reasonable and representative quantity of both activity and cost data based on phase of care is available. The data should:

- come from a majority of the most populous jurisdictions
- be representative of all parts of the classification that are under consideration for pricing.

Once these conditions are met, a significant period of shadow funding will be essential.

Currently, Victoria is not confident about the quality and consistency of the way the data is feeding into the development of the AMHCC and is not supportive of pricing or shadow pricing via the AMHCC from 1 July 2020.

Victoria recommends the IHPA should;

- foster better understanding of the underlying cost and activity data that underpins the AMHCC
- establish a forum to give jurisdictions the opportunity to jointly identify options to improve the quality and comparability of the data
- to reach a resolution about the approach and efficacy of the phase of care collection.

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

Victoria will consider the issues stemming from the First Principles Independent Review of The National Pricing Model by the IHPA once the review is finalised.

6. Data Collection

6.4 Consultation question

- 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?

Victoria supports in principle the scope of the Individual Healthcare Identifier across both inpatient and outpatient settings – to support the My Health Record System - as well as provide Victoria with linked data benefits.

Victoria is continuing to determine the cost of collecting an IHI and notes that there would likely be cost impacts on health services as a result of implementation changes by their software vendors. To mitigate impacts of delivery of core public health services, Victoria considers that the introduction of an incentive or contributory payment may facilitate health service implementation.

7. Treatment of other Commonwealth programs

Victoria supports the decision by the IHPA to propose no changes to the treatment of other Commonwealth programs for 2020-21.

8. Setting the National Efficient Cost

8.2 Consultation question

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

Victoria does not object to the shadowing of the fixed plus variable model for NEC20.

Victoria has previously stated the existing NEC model is not used to set the budgets for Victorian health services and therefore the perceived limitations identified in the existing NEC model have limited impact in Victoria.

There are some concerns about the impact of the fixed plus variable model, therefore Victoria recommends the model is shadowed for at least one year from NEC 20. Issues arising during the shadowing period should be evaluated and discussed before a final decision is taken from NEC21.

9. Alternate funding models

9 Consultation question

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

Victoria is currently looking to expand and align the HealthLinks program (a capitation funding model) with the activity based classification system. Key considerations include shifting to a bundled funding arrangement which reflects service use across different care settings a well as identifying distinct patient clusters to ensure optimal resource allocation.

From Victoria's experience with HealthLinks, it notes that key factors that need to be considered in adopting new models of care include;

- managing and sharing financial risk
- ensuring a skilled and flexible workforce
- designing programs that have broad applicability to health services with different configurations
- managing expectations in terms of changing behaviours of patients and service providers
- the need to ensure a timely approach and adequate support from the IHPA.

Victoria also considers that there are opportunities to support growth in value based services. If evidence supports delivery of targeted ABF services using value based funding, this may be a pragmatic way to incrementally develop new funding models and reporting requirements.

10. Pricing and funding for safety and quality

10.3.1 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?

Victoria is currently shadowing the impact of the national HAC adjustment on the local funding model and has not yet passed on a funding discount to health services. In terms of changing clinician behaviour, Victoria partners directly with clinicians on a range of data-driven activities designed to improve patient outcomes, particularly through Clinical Network initiatives. For example, substantial work involving the development of improvement goals is currently underway on perineal tears and delirium.

Victoria continues to assess the impacts of HAC and sentinel event reporting across the health system and the implications on both clinicians and patient outcomes.

10.4.3 Consultation question

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

Victoria is supportive of software that should be able to provide actionable reports for clinicians and should make the rationale for any variables used for risk adjustment clear to clinicians.

The capacity to provide access to the software, and reports showing a statewide overview, to jurisdictional improvement agencies such as Safer Care Victoria will also be key to improving rates of potentially avoidable readmissions.

Work is currently underway in Victoria looking at definitions of potentially avoidable hospital readmissions and is highlighting areas that need further clinical input.