Questions	Page number
What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?	9

Introduction of Tele Health has been very beneficial to both the health service and patients. It provides flexibility for patients with remote, mobility issues, full time workers, immunocompromised etc particularly where a face to face interaction is not imperative (e.g. I've attended the Gene Clinic remotely and no physical review is required). It also provides benefits to the Health Service to address some of the space issues – no needs for a clinic or waiting room space.

Targets should be set outside of a COVID environment. It is difficult to predict what impact COVID has without knowing the scope / size of the outbreak / wave. Where an outbreak occurs, activity should be able to be moved from one target group to another. E.g. ED activity may decrease but inpatient or specialist clinic activity may increase.

Elective Surgery - The Cat 2 & 3 elective surgery cancellations due to COVID mean that less elective surgery activity will be reported for 2020/21. We will need to see how these cancellations/postponements are managed for the rest of the year to understand what the activity looks like.

Emergency Department – Fewer ED presentations due to COVID restrictions. Also the 'stigma' of presenting to hospital during COVID times could be a possible factor.

Acute Inpatients – Fewer separations due to less elective surgery and ED presentations. This would also impact on the overall WIES result.

Subacute Inpatients – Elective surgery cancellations would result in less patients transferring over for subacute care/rehab.

How will these changes affect the costs of these services in the short and long term?	9

Consideration should be given to alternative service delivery models and greater acceptance of this even if the proposal doesn't fit within the current service delivery model. E.g. Pacemaker Car Park clinic is an example of Austin adapting to the challenges of keeping vulnerable patients safe during COVID but still maintaining care. Funding models should provide greater flexibility to operate outside the 'scope of normal'.

What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?	9

Funding models/pricing is based on costed data three years prior, so when it comes time to calculate pricing for activity three years post-covid, some considerations need to be made not only for the impact covid had directly on activity that year, but also what concessions, or innovations have arisen post-covid. For example, will the increase in telehealth usage become a commonly adopted practice post-covid? What areas will have less activity?

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?	11
Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?	11
What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?	18

Clear explanation of all new and/or revised coding standards. Including examples of how to code different scenarios. Have a variety of scenarios, not just one simple scenario.

How should AR-DRG education be delivered and what should it include?	18

Videos explaining all major changes, work books with questions and answers, webinars to attend after workbooks completed which include Q&A section at end, or ability to submit questions which are then answered in webinar or provide direction on what is discussed in webinar. Include all major changes to

Questions	Page number
standards etc.	
What improvements to the content and format of the electronic code lists could be made to enhance their utility?	18
Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions? Yes, most staff are working remotely in some form so electronic copies would be preferable, easier to share, find information, copy and paste information to send to team etc.	18
Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely? Allow time before move to ICD 11. IHPA to communicate findings, then ask for further suggestions	19
Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?	20
How would activity that falls under these proposed new classes previously have been classified? Current Tier 2 codes: 10.4 - Pain Management Interventions 20.3 - Pain Management 40.06 - Pain Management – Occupational Therapy 40.09 - Pain Management – Physical Therapy 40.39 - Chronic Pain Management (Neurology) 40.29 - Exercise Physiology Consultation (Psychology) 40.60 - Exercise Training (Pulmonary Rehab)	20
What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0? There has been little to no impact on emergency data since IHPA commenced with using the AECC Version 1.0.	20
Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21? Data required for the AECC Version 1.0 was already being captured as standard data items through VEMD so there are no barriers to implementing pricing as this information is already being captured in the system.	20
How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing? At present Phase of Care is not collected in Victoria, more bedding down and education will be provided to get this measure more integrated into the standard suite of outcome measures which are generated for patients. Very clear definitions for costing in the area of Community Mental Health needs to be documented to ensure that all services cost in the same way for example, the costs associated with Mental Health Tribunal, which are only just now starting to evolve. Changes will be required to be implemented in Victoria to the CMI (Client Management Interface) to enable collection of Phase of Care. As this is currently not being collected by Victorian Services and the current focus of care is being mapped to phase of care. This is not a direct map as Phase of Care and Focus of Care have a different number of categories. Until Victoria is reporting Phase of Care in the same way that other states are it	21

Questions	Page number
would be difficult to compare categories of patients.	
Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?	21
Very clear definitions for costing in the area of Admitted Mental Health needs to documented to ensure that all services cost in the same way for example, the costs associated with Mental Health Tribunal, which are only just now starting to evolve as well as costs associated with ECT Therapy. There appears to be no category within AMHCC in the admitted setting for different settings of care, for example there are aged, child/adolescent and adult are groups, but the settings of care will be quite different. Acute Adult Mental Health may have the physical set up of high dependency units, which would have costs associated with them which would be different to those admissions into a child and family based mental health inpatient unit.	
Do you support the adjustment IHPA has proposed for NEP21?	24
What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?	24
Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?	25
Agree that price harmonization is needed for dialysis. Only concern with Chemo is where a patient has additional co-morbid conditions treated during the day chemo appointment. E.g. anaemia. With price harmonization would we still be coding these episodes? If not, are we going to capture the entire clinical picture of these patients. Likely to be a minor impact but worth considering for data comparison reasons.	
Are there other clinical areas where introducing price harmonisation should be considered?	25
Not aware of any	
Is there any objection to IHPA phasing out the private patient correction factor for NEP21?	26
Are there refinements to the 'fixed-plus-variable' model that IHPA should consider?	33
While fixed + variable model for NEP is a good formula, the impact of reduced activity due to COVID spanning two financial years should be considered in the fixed and variable model for a period of time. The variable component of NEP will decrease due to decreasing activity in intra- and post-COVID lockdown. That would mean larger tertiary hospitals would be struggling to pay off contribution margins (Contribution Margin = Price – Variable Cost). The NEP represents 94 percent variable and 6 percent fixed as per NEP20 (4998 / 5320). The remote adjustment of 39.1% does not apply to metropolitan tertiary hospitals like Austin Health in Victoria. Austin fixed remains at 20% to pay for management and overheads. A hgiher fixed rate could pay for capacity and availability in larger tertiary hospitals like Austin Health. For example, liver transplants would represent a good example for capacity and availability fixed costs. In summary, the fixed capacity and availability elements should be added to the NEP.	
What comments do stakeholders have regarding the innovative funding models being considered by IHPA?	38
What happens if a Health Service doesn't provide all components of the bundled service? E.g. They'll do the hip replacement but have no Rehab beds? Does the Health Service develop a contract arrangement with a specified provider or can a patient elect where they'd like to be treated at? (e.g. location close to home). How are bed blockages managed if services are at different Health Services? What happens if a HAC occurs in the Rehab facility and the patient is readmitted to the original service? Where is the financial disincentive applied?	
What innovative funding models are states and territories intending to trial through bilateral agreements under	38

Questions	Page number
the Addendum?	
Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?	38
What other strategic areas should IHPA consider in developing a framework for future funding models?	38
Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models? Patient consent, reliability of information collected. E.g. are patients expected to be aware / provide their IHI? We can currently submit data without a medicare card, what happens if a patient presents without knowing their IHI? Are patients only eligible for bundled services if they provide their IHI? (e.g. knee replacement and then Rehab).	38
Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level? Preference would be option 3, where the actual rate of re-admissions needs to be lower than the expected rate, however this would be difficult to monitor due to the expected rate incorporating national data that isn't accessible to Victorian health services. This preference for option 3, as mentioned in the document, is the preferred choice for the majority health services consulted.	47
Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?	47
What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions? Option 1, which is being proposed, would be the easiest to monitor, however readmissions to another hospital would be difficult to monitor or manage. It needs to be clear on how to identify re-admissons (ie, who is using linked data?), and there needs to be specifications on what kind of deduction is to be applied to the index episode. It is unclear how this would work from the documentation.	47