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

Our ref H20/106222

Dear Mr Downie

Thank you for the opportunity to comment on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22*. A detailed NSW Health response is enclosed.

Representatives from NSW Ministry of Health are willing to meet with IHPA to discuss in detail the submission to the Consultation Paper, including the impacts of COVID-19.

If you have any questions, please contact Ms Jacqueline Connelly, A/Executive Director, Government Relations on 9391 9541 or at Jacqueline.Connelly@health.nsw.gov.au.

Yours sincerely

Dr Nigel Lyons
Deputy Secretary, Health System Strategy and Planning
13 October 2020

Encl.

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IHPA Consultation Paper
Pricing Framework for
Australian Public Hospital Services 2021-22

NSW Health Submission

This submission provides comment on the Consultation Paper prepared by the Independent Hospital Pricing Authority (IHPA) regarding the Pricing Framework for Australian Public Hospital Services 2021-22.

2 Addendum to the National Health Reform Agreement 2020–2025

2.1 Working with Australian governments, AHMAC and the CHC

The Addendum to the National Health Reform Agreement 2020–2025 (the Addendum) has introduced new arrangements to strengthen consultation and transparency of how IHPA discharges its functions.

In particular, IHPA is required to involve jurisdictions in consultation on decisions and must consult with the COAG Health Council (CHC) on changes that materially impact the application of the national funding model, in addition to existing consultation processes (Clause B10).

NSW notes IHPA intends to implement its updated consultation approach by December 2020 and welcomes the opportunity to participate in further consultation through the Technical and Jurisdictional Advisory Committees to inform the development and detail of this policy. NSW notes the changes to COAG governance arrangements resulting from recommendations in the Conran Review are expected to be considered by National Cabinet in October and these will impact the final consultation arrangements. Embedding the key principles of transparency and improved jurisdictional engagement will be critical.

Recommendations:

- IHPA should consult with the CHC on the following proposed changes (outlined in this Consultation Paper) given they will materially impact the application of the national funding model:
    - Business rules addressing significance of changes, process and consultation around retrospective adjustments.
    - Pricing emergency using Australian Emergency Care Classification Version 1 after only one year of shadow pricing.
    - Pricing acute mental health using Australian Mental Health Care Classification Version 1 after only one year of shadow pricing.
    - Adjustments to private patient pricing and funding, noting variation in approach to the draft impact report.
    - Funding methodology to support the trialling of Innovative Models of Care.
- IHPA should provide a draft statement of impact for consideration to its Technical Advisory Committee and Jurisdictional Advisory Committee, prior to formalising with the CHC.
- IHPA should provide relevant analysis requested within this submission to jurisdictions before releasing draft or final advice on the matter.

2.2 Shadow pricing periods

The Addendum also introduced requirements for:

- IHPA to shadow price classification changes for two years or a period agreed with the Commonwealth and a majority of States (Clause A42).
- National Bodies to develop business rules in consultation with jurisdictions addressing significance of changes, process and consultation around retrospective adjustments where appropriate (Clause A42b).

NSW supports a two-year shadow period noting that changes to classifications and costing methodologies are lengthy and resource intensive.

NSW notes IHPA has yet to update its policy approach to address the shadow pricing and transitional arrangements. NSW expects IHPA to obtain agreement from the Commonwealth and a majority of States to reduce a shadow period to less than two years, and that IHPA will not shorten a shadow period unless formal agreement is reached. IHPA must also make transparent the impact analyses resulting from the shadow pricing periods along with any plans to manage unintended consequences.

NSW welcomes the opportunity to be consulted on the development of business rules addressing significance of changes, process and consultation around retrospective adjustments, and IHPA's new policy to address the shadow pricing and transitional arrangements.

Recommendations:

- IHPA's policy to address the new shadow pricing requirements in the Addendum should reflect the requirement for the Commonwealth and a majority of states to formally agree to shorten a shadow period to less than two years.
- IHPA to provide transparent impact analyses resulting from the shadow pricing periods along with any plans to manage unintended consequences.
- IHPA to consult with jurisdictions to inform development of business rules and their new policy for shadow and transitional arrangements.

2.3 New high cost, highly specialised therapies

NSW notes that identification of a funding process for the high cost, highly specialised therapy, adult diffuse large B-cell lymphoma (DLBL), has taken a significant amount of time and funding has not commenced nine months after the Ministerial announcement in January 2020.

NSW reiterates the importance of agility and responsiveness in the approach to funding new high cost, highly specialised therapies. NSW does not believe changes within the *Impact of New Health Technology Framework* will meet this need for agility. Classification changes for ease of identification of the patient cohort also need to be addressed. NSW welcomes IHPA's involvement in the Working Group convened by NSW to progress the implementation of the governance arrangements for these processes.

As these therapies are exempt from the pricing cap for two years under the Addendum, NSW believes the services/patients should also be excluded from other pricing adjustors such as hospital acquired complications (HAC) and avoidable readmission.

Recommendations:

- IHPA to ensure the approach for funding new high cost, highly specialised therapies under the Addendum is agile and responsive.

2.4 Other issues arising from the Addendum

NSW note that since signing the Addendum, the Council of Australian Governments (COAG) has been disbanded and the existing CHC and Australian Health Ministers' Advisory Council (AHMAC) governance structures are undergoing review. The COVID-19 response has also constrained jurisdictions capacity to engage with issues and changes brought about by the Addendum. Whilst NSW remains supportive of the commitments in the Addendum, we acknowledge there may be a need for flexibility in timeframes to ensure IHPA is able to deliver high quality products which are adequately informed by jurisdictions. Any decisions on priorities should be made in partnership with the Commonwealth and States, involving Health Ministers.

3 Impact of COVID-19

3.1 Implications of COVID-19 on the pricing of public hospital services

Consultation Question:
Question 1: What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?

The impacts of COVID-19 on activity, cost and models of care in the short term and those that will extend into the longer term are extraordinary. It is expected that for NSW, activity levels will be lower in 2019-20 and costs will be significantly higher, along with increased patient complexity. These impacts will extend into the 2020-21 data and possibly beyond.

The increased utilisation of personal protective equipment (PPE) and other risk reduction strategies in the delivery of care, will change the nature of “business as usual” into the future. This needs to be considered in the overall pricing and funding approach.

COVID-19 saw an initial spike in non-admitted patient activity delivered via telehealth in NSW, however recent months have seen a reduction from this spike, but remain above pre-COVID levels, including for mental health. NSW Health recorded an increased uptake of virtual meetings by 641 per cent and peer-to-peer calls by 1,060 per cent between February and April 2020, compared to the same period last year. NSW recognises the key role virtual care will play in ongoing models of care and is developing a statewide strategy and has established a new multi-agency business unit called the Virtual Care Accelerator, in partnership with the Agency for Clinical Innovation (ACI) and other key stakeholders such as Local Health Districts (LHDs), Specialty Health Networks, the Ministry of Health, the Clinical Excellence Commission (CEC), HealthShare NSW and other pillars.

In NSW the immediate impacts are evident in the admitted data by a significant drop in activity between March and June 2020. The decrease in activity was due to several factors including the cancellation of elective surgery, reduced emergency department presentations and a reduction in activity typically presenting during autumn and winter such as influenza, bronchiolitis and gastroenteritis. The number of deaths recorded has decreased. Other than for elective surgery, admitted activity has not yet returned to the normal levels expected.

Despite the overall decrease in admitted activity, there were large increases in other often complex activity that will incur high cost that need to be considered. A large increase in adolescent mental health has been observed particularly in eating disorders and behaviour conditions requiring specialling. The costs of specialling are considerable. There has also been an observed increase in drug and alcohol intoxication and withdrawal (mental health DRGs). LHDs report a higher complexity of patients attending including those with frailty and social isolation related conditions and comorbidities. Hospital in the Home (HITH) activity increased particularly in LHDs that treated COVID 19 positive cases in the HITH setting.

The health effects of COVID-19 are not yet fully understood and it cannot currently be determined what the impact on health services will be in terms of the longer-term impacts of COVID-19 on patients. Clinicians consultation indicated that long term cardiac and respiratory issues will occur. Patients with chronic conditions such as those described are frequently best managed through integrated care models components of which are often out of scope of ABF. Volume of Triage 1 emergency department presentations are at the same level as this period last year despite the overall decrease in emergency department presentations to date. Returning travellers to Australia are reportedly being treated with more complex conditions.

There has been an increase in multidisciplinary case conferencing.

An impact to activity that occurred across all settings was reported in rural LHDs where clinicians were unable to treat patients due to factors including isolation/quarantine and border closures.

The largest impact in terms of models of care continues to be virtual care. Virtual care has allowed health services to treat patients while contending with the barriers of social distancing and isolation, being unable to travel and clinicians themselves needing to social distance. The increase in telehealth in the non-admitted setting has been significant and activity levels remain high. It has been widely reported that telehealth will remain in health services and will be encouraged to continue as a dominant non-admitted model of care.

A new normal is being realised and was a key factor in the suspension of the National Non-Admitted Costing Study as it was widely recognised that models of care will change.

Additional changes in models of care identified as due to COVID-19 include:

- Cross border services
- Aerosol treatments requiring additional resources particularly in ear, nose and throat (ENT) and dental
- Increase in negative pressure rooms
- Increase in patient ICU acuity changed between 1st and 2nd wave. The model of care changed – 1st wave patients were ventilated and 2nd wave non-invasive ventilation.
- Increase in Hospital in the Home (HITH) services

Consultation Question:
Question 2: How will these changes affect the costs of these services in the short and long term?

The short-term costs to many services have increased substantially and will potentially increase service costs in the long term. The cost of COVID-19 was consistently reported by all LHDs as being significant in the short term and that will have impacts into the future. Costs are related to the models of care, staffing and equipment. These include:

<u>Models of care</u>

- Increase in specialling – there has been an increase in the specialling of patients particularly adolescents. Specialling considerably increases costs as the patient/clinician ratio is one to one.
- Increase time in theatre due to cleaning and PPE preparation
- Red and green zones that have been established to prevent the potential spread of COVID-19.
- Isolation of patients – requires more staffing. Isolation for COVID positive and negative (tests pending) patients. Early analysis indicates that isolation is a cost driver
- Staffing numbers – maintain capacity and un-utilisation
- Aerosol generating procedures required modified practices
- Social distancing required changes in patient locations – infrastructure issues.

- ED concierge – set up costs including wi-fi
- Hand washing, hand sanitizer resources
- Costs of preparedness – ventilators and capacity building "in case scenario" that continues at the time of reporting
- Training of clinicians – upskilling in areas such as intubation, PPE

Equipment

- PPE costs include the actual supplies, as well as training costs for the putting on and taking off of equipment and buddying system (observation by another staff member)
- Fit testers (masks). The costs of marks and the fitting with a mask.
- RQ app systems are being installed across many districts for COVID tracking
- COVID screening e.g. NBMLHD additional 66 extra FTE required for screening services
- Telehealth infrastructure costs, capital costs.
- Testing at borders – tests needed to return to Broken Hill hospital to be analysed instead of being analysed 15 minutes across the border.
- Negative pressure rooms – high cost of maintenance
- COVID testing clinics continue despite very low activity

Staffing

- COVID testers FTEs (temperature checks), COVID marshals ensuring visiting restrictions were adhered to and ensure no gatherings of more than 2 people across hospital campuses
- Increased use of agency staff due to high numbers of sick leave (awaiting COVID results), backfill for staff unable to get to work due to border closures or in isolation
- Increased use of agency staff – FTE indirect costs
- COVID testing clinics – fully staffed
- Leave allowances – massive increase in annual leave accrual
- Increase in overtime
- One District reported an additional $25 million of COVID expense in July 2020
- Tiger teams – mobile infection control teams employed to ensure hygiene practices were adhered to
- Increase in workers compensation claims
- Nursing staff rotating through the ICU and ED required upskilling
- Increase in administrative staff to help with COVID screening and setting up telehealth services
- Cost of trainers – clinical and PPE
- FIFO models of care in rural areas were severely impacted due to border closures and resulted in an increase in clinician overtime for local clinicians and additional cost impact as clinicians contracted for FIFO model were on payroll.

Consultation Question:
Question 3: What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

IHPA must consider the degree to which current costing standards can accommodate the changes to service delivery as a result of COVID-19, and therefore whether cost data sets will be fit for purpose for pricing in upcoming years. Applying the 2019-20 costing to a 2021-22 NEP or NEC may not be appropriate as the new normal may be more in line with the first 9 months, the last 3 months or a combination of both. Each of these time frames could be applied differently to different clinical services depending on the change to the service due to COVID-19.

The change to the telehealth model of care and virtual care has been significant in NSW and allowed patients to continue to be treated during times of physical distancing. However, there are many factors identified that require consideration such as patient complexity and patient safety. LHDs across NSW reported that telehealth will continue, and expand and, that the community response has been positive.

In the context of value based care, it should be noted that LHDs are reporting the continuation of the risk management, "just in case" scenario that will see equipment costs, staffing costs and other costs remain high into the future in the event of a COVID-19 outbreak.

IHPA will also need to consider how these increased costs will be factored into the 'new normal' as it is anticipated that some changes will not be time limited. The need for ongoing changes to practice, such as increased PPE use have resulted in increased base costs which will need to be factored into the national pricing model.

Recommendations:

- NSW recommends a significant piece of work be undertaken to fully assess the activity and financial impacts of COVID-19. NSW has already completed some analysis and extend an offer to work with IHPA to continue this work.

4 The Pricing Guidelines

Consultation Question:
Question 4: Are the Pricing Guidelines still relevant in providing evidence on IHPA's role in pricing Australian public hospital services?

NSW acknowledges the importance of the Pricing Guidelines in providing a consistent approach to IHPA's operations, and note the changes proposed to reflect the new Addendum. NSW encourages further updates to the System Design Guidelines in light of the changes introduced by the Addendum.

NSW requests the **Fostering clinical innovation** guideline is updated in response to the Addendum (Clause A101) to support the trialling of innovative models of care, while ensuring evidence requirements do not inhibit timeliness of care.

NSW requests the **ABF pre-eminence** guideline is updated to reflect the requirement of the Addendum for ABF to be not only practical, but also appropriate (Clause A3).

NSW recommends the **Patient-based** guideline is updated to reflect that adjustments will be made on patient-related characteristics where practicable *and appropriate*.

IHPA has previously considered the Patient-based guideline to be an inhibitor in proposing approaches that are not patient-based. For example, a hospital-based approach to implement an avoidable hospital readmission adjustment. Clinicians advised that that a hospital-based approach was preferred as it focussed on improving hospital systems, which would appropriately address safety and quality.

In line with the **Administrative ease** guideline, NSW suggests IHPA should consider a consolidated approach to classification that does not separate activity into streams which require separate and complex data collection processes. For example, consider including sub-acute data collection within the inpatient/acute data collection using ICD to capture clinical scores. This would reduce burden on clinicians and the system for data collection.

Recommendations:

- Consider revising the **Fostering clinical innovation** guideline to "Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes and do not penalise those undertaking trials of innovative care pathways."
- Consider revising the **ABF pre-eminence** guideline to "ABF should be used for funding public hospital services wherever practicable and appropriate."
- Consider revising the **Patient-based** guideline to "Adjustments to the standard price should be based on patient-related rather than provider-related characteristics, as far as is practicable and appropriate."

Consultation Question:

Question 5: Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

NSW has concerns with the following terms introduced in IHPA's **Public-private** neutrality guideline and proposed alternative wording below.

"ensure" implies that the national price must be adjusted for any and all variations. Adjustments to account for variations in the State funding contribution would undermine the State's role as system manager. NSW request IHPA use the term enable so as not to undermine the system manager role.

"funding neutrality" introduces a new term. NSW requests IHPA use the term "financial neutrality" in line with the Addendum (Clause A13).

"service provider" introduces ambiguity as it may be interpreted as an individual doctor, hospital or local health district. NSW consider it the State's role as system manager and as a party to the Addendum to ensure financial neutrality and that IHPA's pricing should enable States to do this.

NSW is also concerned the proposed wording focuses on reducing payment and does not recognise cost variation, which could result in underfunding of some services.

Recommendations:

- Consider instead revising the **Public-private neutrality** guideline to "ABF pricing should enable Commonwealth and State funding models to be financially neutral with respect to all patients, regardless of whether patients elect to be private or public."

5 Scope of Public Hospital Services

NSW reiterates feedback from previous submissions that the General List criteria for in-scope services should be refined to align with IHPA's pricing guideline, that *pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care*.

Innovative and alternate funding solutions require the list of in-scope services to change as services and models of care advanced to include integrated care, hospital avoidance and expanded forms of service delivery. Funding solutions also need to support different mechanisms of service delivery, such as commissioning through the private or non-government sector.

Limitations with the current General List criteria inhibits such services from being in-scope. NSW recommend IHPA recommence work to refine the General List criteria and welcomes the opportunity

to collaborate with IHPA on this. NSW also acknowledges the work IHPA is undertaking to enable funding of innovative models of care and has provided further comment on this in Section 11.

Recommendations:

- IHPA include a review of the General List eligibility criteria as it develops an innovative models of care funding methodology.

6 Classifications Used to Describe and Price Public Hospital Services

6.1 Admitted acute care

NSW strongly supports the concept of placeholder Australian Classification of Health Interventions (ACHI) procedure codes for new technology as it will ensure that the classification keeps pace with the technology and activity is captured with minimal impact to the structure of data collections.

Review of admitted acute care classification systems

No comments.

Extending the current development cycle

NSW supports a three-year cycle development cycle. This will relieve some of the burden in implementation costs and provide more time for classification development.

NSW notes an error in Table 1 New acute care classification. The two-year cycle date for AR-DRG Version 12.0 should commence in 2024.

Embedding principles to focus the development approach

No comments.

Streamlining clinical and technical input into the classifications

NSW supports IHPA's decision to redevelop the Australian Classification Exchange (ACE) portal to align with the principles outlined in Figure 2 of the Consultation Paper. This will provide robust evidence for change requests before a submission is accepted and facilitate a more transparent process for all stakeholders by dynamically displaying the stage and outcome of a submission.

Enhancing education material and other support for implementation

Consultation Question:
Question 6: What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?

NSW supports IHPA's comprehensive online education for new editions to ensure quality, standardised education that reaches the entire workforce.

Online education materials should include comprehensive analysis of any updates between versions.

Examples used should be clear, comprehensive and involve real data scenarios. Where possible, scenarios should be interactive with examples of medical record documentation for users to practically apply their knowledge.

NSW acknowledges the limitations in terms of standardisation and audience for face to face training. Stakeholders are supportive of interactive webinars as an alternative option, with the opportunity for participants to ask questions in real time then watch again as needed.

Feedback received from LHDs indicates more information on changing in weightings and the drivers of those changes would be welcomed. A tool to see how ECCS works (at DRG level) and the DCL values for each diagnosis code would further assist understanding.

Recommendations:

- 'One page' flyers to outline details and impacts should be developed, either at a whole of system level or individual chapter level.
- Online education should include comprehensive, real data scenarios.
- Plain English delivery via webinar or in video format.

Consultation Question:

Question 7: How should AR-DRG education be delivered and what should it include?

NSW suggests interactive online, video and written material detailing changes between versions. This includes new classes, splits and mapping changes and be inclusive of a broad range of patient scenarios to show the application of the changes and their effects on classification and funding. This would provide a greater chance of meeting user's needs.

Education materials should address:

- What the AR-DRG classification system is; its link to coding (ICD10AM codes, DCLs); steps to group (edit checks, MDC & Pre MDC processing; AR-DRG grouping; complexity splitting and ECCS to AR-DRG)
- DRG weights and calculation of NWAU dollar values
- Information about adjustors – what constitutes an adjustment and how adjustors are applied
- Importance of high quality Admitted Patient (AP) data and quality data from a registration perspective and its impact on ABF funding
- The Coder's role in AR-DRG assignment and what they should review to ensure they have contributed to appropriate AR-DRG allocation.

For clinical staff and business managers who need to understand their casemix and performance reports, NSW recommend short videos targeted to each Major Diagnostic Category to engage with clinical specialities.

Recommendations:

- Interactive online, video and written material detailing changes between versions.
- Combination of short, 5-minute, specialty orientated videos and longer videos for those who need significantly more detail.

Consultation Question:

Question 8: What improvements to the content and format of the electronic code lists could be made to enhance their utility?

The electronic code lists could be improved by ensuring they are readily and easily accessible, and in multiple formats such as txt and Excel. It would also be beneficial to have a complete listing including blocks, descriptions, addenda etc., rather than having separate listings for each.

Furthermore, the search functionality for electronic code lists must be efficient, facilitate fast navigation, and return the most appropriate response. The content needs to be detailed enough to enable a comprehensive and accurate search function.

Drop down boxes for the electronic code lists which are colour coded in neutral colours would also enhance their utility. Other improvements could be explored including MBS mapping/reference for finance teams and eMR Linkage of ANDRG electronic lists for ease of training and reference for clinicians.

Consultation Question:
Question 9: Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

NSW appreciates that digitalisation is an integral part of current business models and that significant resources are required to publish hard copies of the manuals.

Hard copies are frequently used for quick reference in times of information technology downtime and serve as an easier navigation tool for accurate extraction of information.

The requirement for multiple licenses for electronic copies is also a significant cost burden, especially in areas which only use the reference occasionally. NSW also recommend that the software for electronic versions is enhanced to enable notations.

NSW therefore do not support replacement of hard copy AR-DRG Definitions Manual and ICD-10-AM/ARCHI/ACS.

Recommendations:

- NSW does not support replacing hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions.

Phasing out support for older AR-DRG versions

No comments.

Release of ICD-11

Consultation Question:
Question 10: 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?

The formation of the codes used within ICD-11 are significantly different to ICD-10 and will require significant lead in time for Hospital IT systems to be updated. This will result in a significant cost burden for Local Health Districts and Networks. In addition to infrastructure impacts, there will also be workforce impacts noting the need to adequately train and educate for the new system.

IHPA should ensure that it does not duplicate any work undertaken by the Australian Institute of Health and Welfare (AIHW) as it investigates the feasibility for implementation of ICD-11.

Recommendations:

- NSW suggests IHPA should develop a study for some sites to undergo testing using ICD-11 with real examples, then assess the changes and impact.

Phasing out support for older AR-DRG versions

No comments.

6.2 Subacute and non-acute care

NSW recommends that classification development for sub-acute include the integration of the current subacute classification and ICD classification. IHPA should consider the inclusion of subacute clinical scores (FIM, RUG-ADL) into the classification to enable transition from two data collection systems (currently disparate systems in NSW) into a single data collection process. This would align with the principle of administrative ease and reduce the burden of data collection on the system.

NSW notes that the current classification development process is hindering the progression of the above recommendation.

Recommendations:

- Classification for subacute should include the integration of the current subacute and ICD classifications, with the inclusion of subacute clinical scores to enable a single data collection process.

Developing AN-SNAP Version 5.0

NSW welcomes the opportunity to view and input into the proposed changes to subacute and non-acute patient reporting via AN-SNAP v5.0.

6.3 Non-admitted care

Tier 2 Non-Admitted Services Classification

Consultation Question:

Question 11: 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?

NSW supports the inclusion of 40.65 Exercise Physiology.

NSW recommends the inclusion of usual provider: Exercise Physiologist (EP). An exclusive provider, EP, for Tier 2 40.65 EP is consistent with Tier 2 40.09 Physiotherapy clinic, usual provider, physiotherapist. An EP usual provider for Tier 2 40.65 would also reflect the reasoning for why the National Exercise Physiology Advisory Group Network have advocated and recommended such an exclusive clinic be established to “identify the important therapeutic services provided by this professional group”. This is supported by the NSW Exercise Physiology Advisory Network.

NSW supports the inclusion of 40.64 Pain Management.

Recommendations:

- NSW supports the inclusion of 40.65 Exercise Physiology and 40.64 Pain Management.

Consultation Question:

Question 12: How would activity that falls under these proposed new classes previously have been classified?

40.64 Pain Management

This service is also delivered by hospitals where the care is Allied Health/Nursing Pain Management lead. Current activity falls under Tier 2 20.03- Pain Management.

40.65 Exercise Physiology

From 2017-18 to 2019-20, exercise physiology is recognised by the provider type across 51 Tier 2 Clinics. NSW evidence suggests that a large proportion of activity falls under cardiac rehabilitation and hospital avoidance programs rather than physiotherapy. Several allied health services have their own establishment type by provider type (e.g. physiotherapy, occupational therapy, dietetics), therefore, NSW supports an establishment type for exercise physiology.

Australian Non-Admitted Care Classification

No comments.

6.4 Emergency care

Consultation Question:
Question 13: What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?

NSW advises that the current COVID-19 pandemic has created difficulty in determining the impact of shadow pricing using Australian Emergency Care Classification (AECC) Version 1.0 on emergency department data. Priorities and resources have moved away from the shadow implementation of new classifications. Therefore, the activities expected to be undertaken in preparation for the full pricing using AECC Version 1.0 have been delayed.

The COVID-19 pandemic resulted in the following changes to data:

- Recording of COVID-19 screening undertaken within the emergency department.
- Reduction of other emergency department activity across the system.

NSW considers the shadow implementation period crucial to be able to manage these adverse disruptions and unintended consequences. NSW undertakes various activities, which include, but are not limited to the following:

- Provide Districts and Networks opportunities to review and evaluate their data in the new classification to understand management and funding impacts;
- Develop an education campaign prior to full implementation and pricing, appropriate to meet the needs of various stakeholders, including clinicians, clerical staff and managers; and
- Review and update IT systems to ensure readiness and capability to incorporate additional diagnosis at all sites, including testing of tools to ensure data is processed as expected.

NSW note that IHPA intends to price emergency department activities using the new AECC Version 1.0 to price emergency department i.e. a shadow pricing period of one year. Such a proposal is inconsistent with the requirements under the Addendum to shadow price for two years or a period agreed by the Commonwealth and a majority of states (Clause A42).

NSW does not support this reduction to the shadow pricing period. Disruption to the shadow pricing period has meant that states have not been provided adequate lead time to assess the impact on funding, implement system changes and provide education.

Recommendations:

- NSW does not support pricing using the AECC Version 1.0 for NEP21.
- IHPA should use transitional arrangements, including shadow pricing, for a period of two years or a period agreed with the Commonwealth and a majority of States as stipulated by the Addendum (Clause A42).
- IHPA should provide a Statement of Impact to jurisdictions (Clause B38).

Consultation Question:
Question 14: Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

NSW recommends IHPA expand the AECC to facilitate telehealth in emergency departments. In NSW, emergency departments are increasingly under pressure to reduce their activity. As an emergency department avoidance strategy, there is an increased amount of emergency department telehealth (videoconference) provided to the community. For example, within the emergency department, calls are made to assess and diagnose patients from residential aged care facilities to avoid an admission or provide some other resolution. Telehealth is a model of care that has significantly increased due to COVID-19 and is being utilised increasingly in the hospital setting.

NSW has previously advised IHPA through IHPA's Technical Advisory Committee of issues identified with the AECC grouper and the mapping of SNOMED to the ICD shortlist. Mapping issues have been identified with 'did not wait' and 'left at own risk' which are mapping to the same AECC class which NSW does not believe is appropriate.

Recommendations:

- IHPA should expend the AECC to facilitate telehealth in emergency departments.
- IHPA should continue to monitor and investigate issues with the AECC grouper and mapping of SNOMED to the ICD shortlist.

6.5 Mental health care

NSW is participating in the IHPA Mental Health Phase of Care refinement project and will continue to work with IHPA on the development of Australian Mental Health Care Classification (AMHCC).

NSW has been approached by the Mothers and Babies Unit to discuss the merging of the mother and baby episode as it is believed this removes transparency around the resource needs of both the mother and the baby and puts them at a funding disadvantage. NSW support IHPAs review into the costs of this Unit.

Consultation Question:
Question 15: How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

NSW recommends that IHPA invest further work in understanding the complexity of service provision in mental health, including long term non admitted care and care across settings and facilities. IHPA should consider whether the proposed classification is suitable across jurisdictions if models of care and data collection systems are so disparate. This includes different community care integration models involving use of NGOs for contracted Mental Health care.

The AMHCC data collection focuses on long term case managed patients. Current mismatch in AMHCC and the service event data collections appear to mostly be in short term patients with less interaction. These patients are often interacted in less typical settings such as telephone help lines, police stations or in the community. The AMHCC data collection is affected by increases in these shorter, sharper interactions, where patients are often evaluated and referred to other services. Enhancing the collection to more easily collect and differentiate information on this patient cohort (not just assessment only) would improve the development of pricing and reporting for AMHCC.

NSW is also concerned that the AHMCC is reliant on patient scores and diagnoses and does not consider other factors which impact cost or funding requirements of community consumers. For

example, home visits are paid at the same rate as a telephone consultation. NSW notes the importance of considering all cost drivers to ensure the model does not support cheaper forms of care which may not be in the patient's best interest.

NSW questions the validity of shadow pricing of community AMHCC if the episodes have a high proportion of records with a single phase of care; high level of ungroupable phases and the data demonstrating a requirement for a different funding model for each phase type.

Recommendations:

- IHPA to consider whether the proposed classification is suitable across jurisdictions.
- Classifications should incorporate long term rehabilitation for addiction medicine managed via mental health services.

Consultation Question:

Question 16: Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

NSW notes that IHPA intends to use AMHCC Version 1.0 to price admitted mental health care for NEP21 and shorten the shadow implementation period to only one year. NSW does not agree with reducing the shadow pricing period for the AMHCC Version 1.0 given the disruption to the shadow pricing period caused by COVID-19. This is in line with comments made with respect the pricing AECC Version 1.0 in response to Question 14, due to unforeseen circumstances jurisdictions have not been provided adequate lead time to assess the impact on funding, implement system changes and provide education.

NSW remains concerned about the high volume of records with a single phase, non-assigned class or open phases of care across full financial years. NSW questions whether this is a local data quality issue or that the phases are not appropriate such that clinicians are unable to adequately identify.

Recommendations:

- NSW does not support pricing using the AHMCC Version 1.0 for NEP21, in line with the recommendations made for Question 14 relating to pricing AECC Version 1.0.

6.6 Teaching and training

No comments.

7 Setting the National Efficient Price for Activity Based Funded Public Hospitals

7.1 Technical improvements

No comments.

7.2 Adjustments to the National Efficient Price

Consultation Question:

Question 17: Do you support the adjustment IHPA has proposed for NEP21?

NSW notes that regional facilities are most likely to incur costs associated with ensuring access to services; transport costs and higher technology costs for delivery of appropriate care are inevitable.

NSW is supportive of assessing the need for an adjustment for patient transport in rural areas, including medical transfers and other inter-service transports in rural areas.

NSW recommends that IHPA extend their analysis to ensure rural patients have equity of access to care when this care provided from a metropolitan hospital to a rural one, virtually. This includes considering adjustments for telehealth/virtual care support across hospital networks from metropolitan to rural hospitals such as the telestroke and ICU collaborations that are being implemented in NSW. The current funding model does not provide security or appropriate Commonwealth funding to the larger centres who are providing the care to the rural or semi-rural areas.

Recommendations:

- IHPA extend their analysis to ensure rural patients have equity of access to care even when this care is provided virtually from a metropolitan hospital.

Consultation Question:

Question 18: What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

NSW seeks a balance regarding adjustors and is generally supportive that the funding model does not increase in its complexity, especially if this is to provide an adjuster to just one cohort. For example, a jurisdiction who has cost outliers. Materiality would need to be significant to allow adjustors to be implemented in this type of scenario.

NSW recommends IHPA undertake analysis of the cost of privately referred non inpatients (PRNIP) and if found to be higher than the MBS payment consider a flat rate for NAP activity with a discounted NWAU for PRNIP. Whilst PRNIP are currently considered out of scope for ABF, it is unclear whether the public non admitted work is subsidising the PRNIP work. The principle would adhere to that of private inpatients.

NSW would value the opportunity to work with IHPA on costing of special care nurseries, interpreter costs, consultation liaison across all streams, and regional retrievals. This may not lead to an adjuster as such but an improvement in the costing and funding approach.

Recommendations:

- IHPA undertake analysis of the cost of privately referred non inpatients (PRNIP) and if found to be higher than the MBS payment then consider a flat rate for NAP activity with a discounted NWAU for PRNIP.
- IHPA to work with NSW on costing other areas which may lead to an adjuster or improvement in the costing and funding approach.

7.3 Harmonising price weights across care settings

Consultation Question:
Question 19: Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?

NSW supports harmonisation of price weights across care settings. The harmonised weights must reflect an accurate price to ensure there is an incentive to move to non-admitted chemotherapy and haemodialysis.

NSW notes that there are clinical obstacles to achieve harmonisation as the cost drivers can be vastly different in the admitted chemotherapy or haemodialysis admission. Reasons include the insertion of a fistula for dialysis or central line device for chemotherapy.

In addition, some chemotherapy patients, may have experienced prior chemotherapy drug reactions or effects in the outpatient setting and will require booked admissions for future treatments. Within the admission the patient may require diagnostics for example global pain, chest pain, and hypertension secondary to chemotherapy. Investigative diagnostics include pathology- blood troponin levels, chest x-ray or CT scans depending on the severity of the problem or concern by the medical officer to investigate the medical complication. Some patients may also require an overnight observation.

Recommendations:

- IHPA should consult more broadly with clinical specialists to understand the times when a non-admitted service event is inadequate for appropriate care.

Consultation Question:
Question 20: Are there other clinical areas where introducing price harmonisation should be considered?

No comments.

7.4 Setting the National Efficient Price for private patients in public hospitals

NSW suggest the following changes to Figure 3 on page 25 of the Consultation Paper:

- Add a line joining the Private Health Insurers and LHN boxes to reflect the accommodation payments that are made to the hospitals;
- Clarify the line from the Clinicians to the LHN box to indicate facility fees are passed through and only a percentage of the Medical Benefits Schedule (MBS) is received by clinicians; and
- Acknowledge that the clinicians in the box are only staff specialists and not Visiting Medial Officers (VMO)s.

Private patients and the new Addendum

NSW will continue to work with IHPA through the Technical Advisory Committee and Jurisdictional Advisory Committee on the methodology for pricing private patients in public hospitals under the Addendum.

Costing private patients in public hospitals and the private patient correction factor

Consultation Question:
Question 21: Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

NSW note that IHPA intends to establish an additional data collection to ensure all hospital revenues are captured to enable its work pricing private patients in public hospitals. NSW does not agree with phasing out the private patient correction factor given IHPA does not consider the current data adequate to address related funding mechanisms.

NSW is seeking clarification from IHPA regarding the scope of the proposed additional data collection to ensure all hospital revenues were captured, specifically the use of the term "all". IHPA suggests that jurisdictions be required to submit the Hospital Casemix Protocol (HCP) data however, even if agreed, these two requirements will not be implemented in time to phase out the private patient correction factor for NEP21. The Public Health Expenditure (PHE) already details for each hospital the revenue received.

NSW notes that consistency and standardisation of arrangements has yet to be achieved. For example, there remain significant differences in the allocation of costs to private patients for diagnostics. NSW request that IHPA undertake a state by state assessment to acknowledge the differences in arrangements in place as evidence to support feasibility.

NSW is working towards implementing best endeavours for the 2019-20 NHCDC submission. However, compliance with Business Rule 1.1A Medical expenses for public and private patients is subject to the availability of data held in restricted fund assets.

Recommendations:

- NSW does not support phasing out the private patient correction factor for NEP21.

7.5 A pricing approach for hospital and academic-led clinical trials

No comments.

8 Data Collection

8.1 Overview

NSW note IHPA intends to make the National Benchmarking Portal (NBP) public in 2021. NSW does not support the NBP becoming publicly available. NSW reiterates the following concerns previously raised:

- Comparability issues across states and jurisdictions: There are known comparability issues that need to be resolved. For example, the treatment of business unit services will have a significant impact on the ability of the users to compare across states for cost buckets (such as pathology).
- Patient privacy measures have not been specified: Protection of patient data is vital. NSW request IHPA detail the specific safeguards and parameters it will use to protect patient or provider privacy. Making the NBP publicly available may constitute a "disclosure" of potentially identifiable patient information. NSW suggests IHPA consult with a privacy expert familiar with privacy legislation across all jurisdictions. Potential for misinterpretation: The data also requires a level of understanding that is unique to health and complex in nature. The tool requires a high level of technical skill and it would be easy for the filters to be

incorrectly applied and the data misrepresented. Public access to the NBP with HAC data without an understanding of complexity, rules and classification systems creates a high risk of misunderstanding and misuse. IHPA would need to provide training to the public on how to understand (including variations and limitations), use and interpret the data.

- Potential for commercial misuse: There is a risk of commercial misuse if the data are broadened.

Recommendations:

- NSW does not support IHPA making the NBP public in 2021.

8.2 Phasing out aggregate non-admitted data reporting

NSW provides a high percentage of data at patient level when it is available, but NSW does not support completely phasing out aggregate non-admitted data reporting, given that patient level collections are not possible where there are privacy considerations, for example, vulnerable services such as violence and abuse. Patient level data may improve data reliability but should not compromise patient safety and privacy. NSW has remained consistent in this position across all fora.

Recommendations:

- NSW does not support phasing out aggregate non-admitted data for 2021-22.

9 Treatment of other Commonwealth programs

9.1 Overview

No comments.

10 Setting the National Efficient Cost

10.1 Overview

No comments.

10.2 The ‘fixed-plus-variable’ model

Consultation Question:
Question 22: Are there refinements to the ‘fixed-plus-variable’ model that IHPA should consider?

No comments.

11 Alternate Funding Models

11.1 Overview

NSW strongly supports considered work to develop alternate funding and payment mechanisms that enable a system-wide shift to outcomes that matter to patients rather than a focus on performance and cost savings. There remain opportunities to focus funding reform on patient outcomes across the

whole pathway of care rather than discreet episodes of care. This would involve a funding model which enables increased collaboration across care settings.

NSW notes that funding reform in itself does not result in value, however it is a key enabler of a value based healthcare system. Funding reform can provide the flexibility needed to plan, fund and deliver new models of care that achieve the outcomes that matter to patients and improve the sustainability of the health system, and equally can present a barrier when flexibility is absent. Funding reform should ensure appropriate incentives are in place for providers to coordinate and deliver the interventions that have the best outcomes for patients in the most efficient and effective way. Initiatives are likely to fail if conceived narrowly as a way to achieve immediate short-term cost-savings.

NSW welcomes opportunities beyond the Pricing Framework Consultation Paper to be consulted and provide advice on the development of IHPA's work in this space.

11.2 Requirements under the Addendum

NSW notes that, under the Addendum clause A101, IHPA has been tasked with supporting jurisdictions to trial innovative models of care by:

- developing a funding methodology that does not penalise States undertaking trials
- providing advice to jurisdictions on the application of this methodology
- providing advice to Health Ministers on proposals to translate an innovative funding model to the national funding model.

The development of this funding methodology is a critical enabler of the long term system wide health reforms that the Commonwealth and States have committed to under the Addendum (Schedule C); in particular, the *Paying for value and outcomes*, the *Joint planning and funding at a local level*, and the *Prevention and wellbeing* reforms.

11.3 Innovative funding models being explored by IHPA

NSW notes that innovative models of care, particularly those that target system pressures such as chronic conditions, need to enable integration with primary care services to be truly effective. This requires opportunities for shared and sustainable investment across health sectors and funding sources, such as NHRA funding and MBS funding.

IHPA's approach and initial findings

Consultation Question:
Question 23: What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

NSW notes the approach taken to date by IHPA to explore funding models that support innovative models of care and welcomes the further progression of this work.

Incremental steps will be required to increase flexibility before fully fledged reforms are implementable. Given this, approaches that can incorporate principles of value based healthcare within the current ABF system are a good stepping stone in the transition from pure fee for service towards value.

The bundled and capitated models proposed by IHPA are well explored in international and national literature and have the potential to better align financial incentives with behaviours that improve outcomes for patients. However, adopting innovative funding models based on international evidence needs to carefully consider the differences and complexities of the Australian context, which may limit their success. For example, bundled models may not be appropriate for smaller ABF hospitals and

LHDs due to geography and/or limited human resourcing. The Global Horizon Scan referenced by IHPA was primarily based on the United States of America context and funding models, which includes many for profit insurers and vertically integrated healthcare organisations where value based payment mechanisms are more easily applied.

NSW notes that, to date, Australian trials and innovation have been led by States in the most part. It is essential that IHPA closely consult with States on lessons and applicability to the Australia context in order to develop the funding methodology and framework referred to in 11.4.

The ability to cost the patient across streams should be considered, along with factors such as a combination of public, private and primary care services. Financial sustainability for all partners in the bundling must be considered, and public services must be able to be sustainably funded if they share care with providers outside the scope of ABF.

NSW has provided IHPA with a Framework document for developing a new non-admitted classification and believe innovative models could come from the use of a Major Health Issue concept as discussed within the NSW Framework document. In light of the formal suspension of the Australian Non-admitted Care Classification Costing Study, elements of the framework could be incorporated into funding models for innovative models of care.

NSW also notes that no single value based funding model is appropriate for all situations or all patient groups. The challenge will be to marry these models to the right situation or patient group and to link them together into a comprehensive value based measurement and payment system. In recognition of this challenge NSW has four key initiatives in its approach to value based healthcare; addressing the health needs of a range of cohorts; the most recent of which is a trial of a collaborative commissioning approach to test the feasibility of partnering with primary care and other partners to deliver innovative models in a way that is financially sustainable for all partners.

The implementation of innovative funding models is hindered by the requirement for the activity to be classified. Services that can be costed, reported and evidenced with patient outcomes should be considered. This may be due to a lack of ICD/ACHI/DRG codes. The placeholder code concept for ACHI codes could be further expanded to cover diagnosis and class codes in new models of care.

As value based healthcare is focused on outcomes, any shifts towards innovative funding models will need to consider what measures to include to determine whether outcomes have been improved. It is important to collect data items on patient outcomes, health system outcomes as well as on the quality of care delivered to ensure patients who may be eligible under the proposed innovative funding models have optimal outcomes as they would under the ABF funding model. This should include measuring the experience of receiving and the experience of providing care. Patient Reported Measures (PRMs) are a good step in this direction.

Success in this shift is dependent on several factors noted below in the response to Question 27, which should be considered when trialling initiatives to ensure sustainability and scalability.

Recommendations:

- Incorporate principles of value based healthcare within the current ABF system as a stepping stone in the transition from pure fee for service towards value.
- IHPA closely consult with States on lessons from Australian trials, innovation and application to the Australia context to develop the funding methodology and framework.
- Review NSW Framework document for developing a new non-admitted classification model in the context of innovative models of care.
- Further expand the placeholder code concept for ACHI codes to cover diagnosis and class codes in new models of care.
- Consider measures to include in a funding methodology to determine whether outcomes have been improved, including PRMs.

Consultation Question:
Question 24: What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?

NSW notes that decisions on which innovative models of care to trial through a bilateral agreement, as allowed under the Addendum Schedules A and C, is dependent on the development of the funding methodology being developed by IHPA.

NSW is currently delivering a number of programs that support more coordinated care and improve patient outcomes under the Value Based Care banner that would be appropriate for alternate funding models. This includes NSW's:

- Leading Better Value Care initiatives
- Integrated Care initiatives
- Commissioning for Value initiatives
- Collaborative Commissioning initiatives

Other NSW models of care that may be appropriate for alternate funding models include:

- A virtual care hospital (rpaVirtual) established by the Royal Prince Alfred Hospital in Sydney, which is a new model of care that combines the LHD's provision of care in the community with the latest digital healthcare strategies. The model provides a greater scale of care on a non-admitted basis and has the potential to cut the number of unnecessary Emergency Department presentations, reduce hospitalisations or a patient's length of stay in hospital, and empower patients, especially those with chronic illness, to lead a better quality of life.
- A model of care that allows Mental Health patients who have lived within the hospital setting for a year or more to move back into assisted living within the community, and who would require an intense level of ongoing clinical and peer support care.

NSW would need to understand the methodology proposed by IHPA under the Addendum before deciding on models to trial through a bilateral.

Consultation Question:
Question 25: Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?

While NSW is supportive of alternate funding approaches to support innovative models of care, it is essential that this does not overly complicate an already complicated funding model or damage the integrity of the ABF model.

Clause A100 of The Addendum states that 'The outcomes of any trials of an innovative model of care would be provided to IHPA and the CHC'. It is NSW's interpretation that the jurisdictions would bring innovative models of care to IHPA for review under the new funding methodology as opposed to IHPA imposing innovative funding methodologies that may not be suited to delivery of care within each jurisdiction.

Often innovative models of care do not sit in one care setting only. IHPA must take this into consideration when developing its methodology. For example, LHD workers may be based in the community working closely with primary care in a hospital avoidance program. Funding may need to flow to both primary care and LHD providers.

NSW also notes that IHPA should consider the development of models to adequately fund innovative models of care that cross the ABF/Block hospital divide. Technology enables remote monitoring of patients in small hospitals allowing them to remain at home or, in their local health service. However,

the funding does not consider the cost of the services delivered from the Hub hospitals in a way that is recognisable to clinicians or that is fair if outside of the same LHD.

Much international evidence suggests that focusing on a disease group is not the best way to deliver innovation and tackle system fragmentation. There are limitations with selecting patient cohorts for innovative funding models based on Adjacent Diagnoses Related Groups (ADRGs). This may limit the patient cohort to specific speciality groups or by discreet interventions which do not consider the full pathway of care (such as chronic conditions that extend for a number of years), which is where the greatest opportunities for improving outcomes and value are.

Value based healthcare considers the full care pathway ranging from primary care, in-patient services and outpatient/specialty care systems. Therefore, it would be more appropriate to select patient cohorts by defined patient characteristics associated with care pathways which can then be linked to specific outcomes. Examples of this may include maternity care, non-urgent emergency department presentations (triage category 4 and 5), cancer patients, and joint replacement.

NSW recommends there would be greater alignment with trialled funding methodologies when selecting cohorts based on a defined pathway of care rather than a DRG.

It would also be useful for NSW to have further information on the ADRGs that IHPA selected to review applicability of innovated funding models.

As noted in response to Question 23, the unique Australian context must also be considered. For example, smaller ABF facilities may be disadvantaged due to low NWAU and raw numbers in some ADRGs.

Recommendations:

- Consider innovative models of care in multiple care settings, across ABF/block, and the integration with primary care.
- Select patient cohorts by defined patient characteristics associated with care pathways which can then be linked to specific outcomes.

11.4 Development of a framework for future funding models

NSW notes that the Addendum requires IHPA to seek Health Ministers' (COAG Health Council) approval by April 2021 of a funding model that supports jurisdictions to trial innovative models of care. It is essential that this framework is fit-for-purpose and effectively supports jurisdictions to trial innovative models of care, including by ensuring that the methodology is appropriate to the Australian context and is sufficiently flexible to meet the needs of each jurisdiction and the full range of innovative models of care that would benefit from alternate funding approaches. This includes considering funding models outside of bundling and capitation. In line with requirements under the Addendum for IHPA to strengthen the involvement of jurisdictions in consultation, NSW recommends that IHPA consult early and often with jurisdictions to develop the framework in partnership, including to set the scope of the framework. A Steering Committee with cross-sectional representation is likely to be an effective complement to existing Jurisdictional Advisory Committee and Technical Advisory Committee processes.

Consultation Question:

Question 26: What other strategic areas should IHPA consider in developing a framework for future funding models?

NSW's interpretation of Clause A101 is that IHPA would develop a funding methodology that is significantly broad as to be able to assess all innovative models against an appropriate criterion.

NSW also notes it is essential that the framework consider the four essentials of value based care (quadruple aim) and requires trials to articulate how these will be supported (i.e. the health outcomes that matter to patients, the experience of receiving care, the experience of providing care, and the effectiveness and efficiency of care).

The framework should be developed in a way that acknowledges it can take time to demonstrate efficiency and value, in line with the intent under the Addendum that the new methodology does not penalise jurisdictions undertaking a trial.

The role of new technologies in implementing innovative models should also be considered, including the application of virtual care delivery, including what is considered a 'Service Event'.

Recommendations:

- IHPA to consult early and often with jurisdictions to develop the framework in partnership, including to set the scope of the framework.
- Establish a Steering Committee with cross-sectional representation to complement IHPA's existing Advisory Committees.

11.5 Individual Healthcare Identifier

While in principle NSW supports the ability to reflect a complete patient journey, NSW does not support the collection of the Individual Healthcare Identifier (IHI) at this stage. Ethics approval would be needed to allow NSW to release this data to IHPA, once we get to an acceptable level of patients with valid IHI numbers.

NSW has raised concerns and explained barriers in previous submissions; these remain unchanged.

Consultation Question:
Question 27: Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

NSW notes there are several critical success factors required to support and successfully trial innovate funding models, including:

- Value based funding models must be underpinned by systematic measurement of outcomes through clinical data and patient-reported data (such as PRMs).
- Sharing, linking and access to data from across health care settings is imperative to monitor and evaluate cost, effectiveness and value. Interconnected IT is also essential.
- Sophisticated approaches to risk adjustment and improved governance and accountability across care settings and funders are required.
- Innovative funding models require safeguards in place for 'cherry picking' low acuity patients. This has been identified as a risk in both bundled and capitated payment models.
- Patient attribution is also a critical component of value based funding models. Through patient attribution, patients are assigned to a provider who is responsible for the care delivered to that patient. When considering alternative funding models across a pathway of care a robust attribution methodology is critical for accountability and to mitigate risk.

12 Pricing and Funding for Safety and Quality

12.1 Overview

No comments.

12.2 Sentinel events

No comments.

12.3 Hospital acquired complications

NSW support IHPA's adoption of HAC V3.0 for adjustment calculations.

12.4 Avoidable hospital readmissions

NSW recognise that measurement and review of potentially avoidable hospital readmissions by relevant clinical teams is a potentially important additional avenue for enhancing high quality, safe care.

Funding options

Consultation Question:
Question 28: Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

NSW supports the implementation of funding option three and does not support option one, consistent with advice from the Clinical Advisory Committee.

Changes to care bundles that effect reduced readmissions require clinician engagement at a local (hospital) level. It is imperative that data is available to clinicians at the local level in a contemporaneous timeframe. This would suggest that the initial application of any funding option should be at a hospital level and clearly visible to clinicians.

Jurisdictions will be unable to monitor the Unavoidable Readmission rate as IHPA is using a linkage key that is unavailable to jurisdictions. Therefore, it is unable to send a pricing signal to clinicians if the reports will be at least 4 months post the end of the period where the avoidable readmission occurred.

NSW proposes that IHPA review the work being undertaken in NSW on Risk of Hospitalisation. This is an algorithm that presents a meaningful prediction of a patient's unplanned hospitalisation in the next 12 months. This project has greater than 40 risk factors that are analysed to determine the hospitalisation index. A key finding of this work is that socioeconomic status is a predicter of rehospitalisation, notably this risk factor is not incorporated into the IHPA Avoidable Readmission model. This model also allows for progression of disease which the IHPA model does not in some readmission conditions such as cardiac complications and renal failure.

Recommendations:

- NSW does not support funding option one at a jurisdiction scope level.
- Application of a funding option should be at a hospital level, clearly visible to clinicians.
- IHPA review the work being undertaken in NSW on Risk of Hospitalisation.

Scope options

See response to Question 28.

Approach to risk adjustment

Consultation Question:
Question 29: Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

NSW notes that the best performing model will still identify within the risk model a disproportionate number of false positives. NSW considers a robust risk adjustment model to be a crucial element of any funding adjustment as it ensures that it does not unfairly impact anyone, or group of providers as a result of characteristics beyond their control.

Current risk adjusters need to be expanded and their application more clearly defined. There is ample data to show that the presence of diabetes and/or many malignant conditions increases the risk for most HACs. It is likely that the risk profile for readmissions are similarly affected. For funding adjustors to be reasonably applied risk profiles need to be transparent and visible to clinicians who care for these patients.

NSW requests IHPA provide stakeholders an assessment of risks associated with implementing a funding adjustment with a risk adjustment model that may not be adequately robust. NSW notes the following risks:

- The risk adjustment model may inaccurately assign risk due to identifying disproportionate numbers of false positives, which may unfairly impact some providers.
- The funding model could be ineffective in decreasing avoidable hospital demand if jurisdictions are unable to replicate results.
- The risk adjustment model may not be robust enough for readmissions given the small sample sizes.

NSW note that stakeholders called for separate risk adjustment models to be developed for each funding option.

Recommendations:

- IHPA provide stakeholders an assessment of risks associated with implementing a funding adjustment with a risk adjustment model that may not be adequately robust.

Individual Healthcare Identifier

No comments.

Readmissions across financial years

No comments.

Implementation of the readmissions funding adjustment

No comments.

Commercial readmissions software

No comments.

Consultation Question:
Question 30: What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

The fundamental effectors of improvement are clinicians at the patient care level. The risks, risk adjustors and the funding adjustments must be transparent and easily available for all clinicians to monitor as close as possible to real time if improvement is to be expected.

NSW notes that a major impact of this piece of work is a change to the NHRA growth funding entitlement. The funding model could be ineffective in decreasing avoidable hospital demand if jurisdictions are unable to replicate results.

NSW questions the appropriateness of an adjuster that is applied across different LHDs where near hospital has any knowledge of how well the other is coding or documenting related variables, for example mode of separation. Mode of separation has not been included as a required variable in the shadowing period as IHPA excluding transfers in and out of hospital at the final stages of the two-year shadow period.

NSW seeks clarity as to whether the adjuster will have a disproportionate impact on rural hospitals.

Recommendations:

- Risks, risk adjustors and the funding adjustments must be transparent and available for clinicians to monitor in real time.