Attachment 1.

Responses to the Consultation Questions - IHPA Consultation Paper on the Pricing Framework for Public Hospital Services 2021-22

Section 3: Impact of COVID-19

Consultation questions:

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

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

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

The peak period of COVID-19 response activities occurred in Tasmania between March 2020 and June 2020. As a result of those responses, there was noticeable change in hospital activity levels when compared to the previous months of 2019-20 and the March 2019 to June 2019 period.

The reduced activity can primarily be attributed to both national and state measures put in place to respond to COVID-19, including:

the national suspension of elective surgery (except Category 1 and urgent Category 2 patients) between 25 March 2020 and 26 April 2020;

- the closure of the North West Regional Hospital (NWRH) in April 2020;
- the Mersey Community Hospital Reset Plan;
- fewer accidents and injuries due to the impacts of community lockdowns; and
- social distancing initiatives which have impacted on the number of patients able to be seen.

As part of its response, Tasmania has seen a greater acceptance of alternative models of care, including:

- non-admitted Telehealth service provision, which has presented issues with current IT infrastructure and business processes;
- non-admitted home-based services, coordinating care directly from local GPs, which has bypassed the need to present to emergency departments, and
- admitted Hospital-in-the-Home services as clinicians develop models of care that avoid stays on hospital campuses.

Tasmania is still developing an understanding of the long-term impacts of COVID-19 on the clinical service profile of 'business as usual'. Currently, Tasmania only produces an 'annual' cost study, and has therefore been unable to provide a monthly or quarterly allocation of activity to costs across the COVID-19 period, making it difficult at his stage to estimate the impact of any cost variation outside of normal operations and processes within the 2019-20 data set. Tasmania has concerns that 'business as usual' costs in 2019-20 and 2020-21 will have increased. For example, in 2019-20 and 2020-21 staff from outside the State have been required to quarantine for two weeks, emergency services have required to be put on bypass by ambulance services, and greater surveillance of the infection control risks to patients has led to disruption in non-emergency treatment.

Tasmania will have a better understanding of the long-term impacts of the changes in service provision when the 2020-21 cost study is produced.

Section 4: The Pricing Guidelines

Consultation questions:

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

Tasmania is generally supportive of the annual Pricing Guidelines to enable consultation, and as a tool to provide consistency in IHPA's approach to policy decisions and Pricing. However, Tasmania notes that in some circumstances, Activity Based Funding (ABF) can be restrictive of efforts to implement 'clinical innovation' as classification changes and pricing determinations can lag several years behind innovations.

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

Tasmania generally agrees that the change in wording reflects the intention of the Addendum. However, Tasmania is concerned the underpin NWAU price weights do not actually describe the projected cost of treating private patients.

In Hospitals where third-party providers are contracted to provide Medical Practitioner, Imaging and Pathology services, the hospital does not always see the costs. In Tasmania, contract third-party providers often directly claimed Medical, Imaging and Pathology service costs directly from the private health insurer and billing does not get processed through the hospital.

Section 6: Classifications used to describe and price public hospital services

Tasmania is concerned that, while the four principles that guide the classification development cycle assist in creating a robust classification system, due to the lack of a nationally consistent admission policy framework, local admission policy arrangements reduce the ability to compare same-day ambulatory services between jurisdictions.

Within the Tier 2 classification system, greater segregation or subcategories within the current end-classes (particularly in the procedural classes) may increase the ability to harmonise service overlaps across admitted/non-admitted settings. Without this change, the ability to harmonise those services are limited.

Tasmania is also concerned about the impact of changes to the Australian Coding Standards (ACS) that remove the ability to record conditions that are monitored and not actively managed. Tasmania believes monitored conditions can have an impact on the care of other conditions within the episode.

Tasmania recommends that IHPA consider the capture of chronic conditions, patient social and functional determinants, and behavioural issues in ICD-10-AM/ACHI/ACS.

Section 6.1 Admitted acute care

Consultation questions:

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

Tasmanian is supportive of online education for ICD10 AM/ACHI/ACS however it still believes that face-to-face and local education sessions are important. Tasmania will work with IHPA though the ICD Technical Group (ITG), and other IHPA processes, as online education products are developed.

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

Tasmania is supportive of online education for DRG's however it still believes that face-to-face and local DRG education sessions are important. Tasmania is supportive of the move by IHPA to increase DRG education, as currently the majority of training can be vendor software based.

Tasmania will work though the DRG Technical Group (DTG), and other IHPA processes as online education products are developed.

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

Tasmania will work with IHPA as the electronic products are developed, to ensure that they are flexible enough to provide support to the local environment.

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

Tasmania is supportive of moving the AR-DRGs Definitions Manual and ICD 10-AM/ACHI/ACS to electronic platforms and requests that both desktop and mobile applications be developed to support the coding and clinical workforce.

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?

Tasmania will work though the ITG and other IHPA processes, to assess the impact of ICD-11 on the Tasmanian health system.

Section 6.3 Non-Admitted care

Consultation questions:

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?

Tasmania is supportive of the change to include the new end-classes and requests IHPA to investigate whether there is a need to establish a clinical procedure clinic to identify the insertion or replacement of cardiac pacemakers and Ophthalmology procedures (Intravitreal injection).

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

In Tasmania, Exercise Physiology is relatively new in the clinical care pathway for Tasmanians and, where it is provided, it is reported under Physiotherapy. It is important to note that it is a very low volume number within the 2020-21 non admitted fiscal year data set.

Section 6.4 Emergency Care

Consultation questions:

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

Tasmania is still using the Urgency Related Group (URG) classification to analyse and fund emergency departments during 2020-21 and did not shadow price or fund emergency departments using the AECC classification system or weights for 2019-20.

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

Tasmania does not envisage any impediments to pricing the AECC Version 1.0, as the underpinning data elements are the same as the current URG classification system and the National Minimum Data Set requirements. Tasmania believes the AECC provides better specificity within certain disease groups than the URG system.

Section 6.5 Mental Health Care

Consultation questions:

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

Tasmania, supports the concept of pricing with AHMCC, however suggests the classification is not yet robust enough for use in the community. Tasmania believes that pricing using AMHCC within the community mental health setting is premature at this point and does not consider shadow pricing relevant.

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

Tasmania is concerned that pricing using AMHCC is premature in Tasmania at this point and does not consider the application of AMHCC in mental health mature enough to migrate from the shadow environment at this stage.

Section 7: Setting the national efficient price for activity based funded public hospitals

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

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

Tasmania supports an additional adjustment for NEP21.Tasmania believes that the Critical Care component costs should be reviewed, as a priority, and particularly for invasive ventilated patients, to develop a weighting if an invasive ventilated patient is managed in a regional Critical Care Unit. The current exclusion of ICU units below 4,000 hours of ICU care, of which at least 20 per cent involves mechanical ventilation, effectively reduces the Commonwealth contribution in regional centres. The costs involved in mechanical ventilation of a patient are the same irrespective of location. A critical care unit is more resource-intensive than a general ward area and, at the moment, this is not recognised in the national ABF model.

Section 7.2 Adjustments to the national efficient price

Consultation questions:

Do you support the adjustment IHPA has proposed for NEP21?

Tasmania is supportive of IHPA assessing an adjustment for patient transport in rural areas. Tasmania is unable provide linked patient level data elements at this stage.

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

Tasmania is supportive of IHPA assessing an adjustment for mechanical ventilated patients outside of the IHPA approved Critical Care Units.

Section 7.3 Harmonising price weights across care settings

Consultation questions:

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

Tasmania is generally supportive of the proposed harmonisation, however, it is concerned that important clinical information will be lost, as the current outpatient collection and reporting systems do not contain diagnosis and comorbidity information which underpins the DRG classification system.

Tasmania is concerned that amalgamating non-admitted and admitted settings will create pricing compression and would recommend further investigation of the pricing of non-admitted dialysis and chemotherapy. Tasmania believes that the pricing of non-admitted chemotherapy may not be as robust as the admitted procedures, as often the data elements in the non-admitted setting are not as rigorous and complete as the admitted setting.

Harmonisation - Dialysis:

Tasmanian recommends that IHPA revise the Tier 2 clinic *10.10 Renal dialysis – hospital delivered* into two end- classes: Renal dialysis – hospital delivered Peritoneal dialysis; and Renal dialysis - Hospital delivered - Haemodialysis.

Tasmania would recommend that, at implementation of harmonisation for dialysis, the two new clinics price at be set to the admitted dialysis service price for haemodialysis (L61Z) and peritoneal dialysis (L68Z).

Harmonisation - Chemotherapy

As with dialysis, Tasmania has its concerns that the pricing of non-admitted chemotherapy may not be as rigorous and complete as the admitted Chemotherapy setting. Tasmania would suggest there is significant enough cost difference between the various methods of delivery to warrant greater segregation within the current end classes of 10.11 Chemotherapy treatment.

Tasmania would recommend in the interim (until the new non-admitted Classification system) that IHPA revise the Tier 2 clinic *10.11 Chemotherapy treatment* into two clinical ones for what has traditionally been identified in the MBS as Type C and another for what is traditionally been identified in the MBS as Type B.

Tasmania would recommend that the pricing harmonisation be set for the new Chemotherapy clinics at the:

- current non-admitted setting (current MBS Type C equivalent), and
- current admitted setting (current MBS Type B equivalent).

This change would create an environment where flexibility of setting is encouraged.

Are there other clinical areas where introducing price harmonisation should be considered?

Tasmania has not identified any additional areas where harmonisation should be considered at this stage.

Section 7.4 Setting the national efficient price for private patients in public hospitals

Consultation question:

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

Tasmania strongly recommends IHPA does not remove the private patient correction factor adjustment. Tasmania notes that there remain significant differences in the allocation of costs to private patients. Tasmania 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 and expenditure information not often held by the departmental clinical costing unit or public hospital clinical costing unit.

Section 10: Setting the National Efficient Cost

Section10.2 The 'fixed-plus-variable' model

Consultation question:

Are there refinements to the 'fixed-plus- variable' model that IHPA should consider?

Tasmania is generally supportive of the 'fixed-plus-variable' model, however is cautious in regards to any changes until the impact of changes created by COVID-19, on the Tasmanian district hospitals, is fully understood especially as 2019-20 was the first year of implementation and this has been affected by the public hospitals response to COVID-19.

Section 11: Alternate funding models

Section11.5 Individual Healthcare Identifier

Consultation questions:

What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

Tasmania supports IHPA exploring alternative funding models that support Value, Outcomes and Long-Term Reform. Tasmania notes the need for IHPA, when developing new funding models, to consider:

- The strength and alignment of primary care and secondary care
- Timely and adequate support from IHPA
- The availability of data linkages between primary care, secondary care and hospital-based care
- Managing and sharing financial risk between all parties
- Ensuring a skilled and flexible workforce is available
- Ensuring any designed programs are appropriate and relevant to health services with different configurations, demographics and sizes
- Expectations in terms of managing changing behaviours of patients and service providers, and
- Recognising Information and Communication Technologies (ICT) limitations within the States and Territories.

Tasmania believes a bundled payment model needs to be careful and clear about what level the activity gets bundled at. Tasmania believes that local clinical and administrative governance is important in the designing of the bundled clinical product streams.

Tasmania believes that any capitation-based funding formula will need to incorporate risk/gain-share and

additional financial incentives for delivering improved patient and clinical outcomes. Any capitated health care model will require addition adjustments to reduce inequalities among those populations that are known to have the worst health status.

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

Tasmania is currently working on several alternative programmes and these are not expected to be in a position to be considered for 2020-21.

These include Hospital-in-the-Home, non-admitted outreach and in-reach programmes.

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

Tasmania believe that there may not be enough flexibility within the current classification systems to adequately describe the care provided to patients with multiple complex conditions, for example acute patients requiring complex medical care and mental health care simultaneously.

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

While Tasmania understands the complications imposed on the public hospital system when claims are made against the Medical Benefits Schedule under the Health Care Act and National Health Reforms Agreement, Tasmania would like IHPA to investigate a pricing model framework that enabled the Public hospital service that provides outreach and in reach services such as:

- Hospital-in-the-Home and non-admitted outreach programs to residential aged care facilities, and
- In-reach programmes that provide integration of public hospital medical specialists to support the management of patients with complex medical healthcare needs in their local communities.

Tasmania recommends IHPA consider developing classification system and funding models that identify and respect the cost impact of the burden of disease and chronic illness on the public hospital system across admitted and non-admitted settings.

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

Tasmania supports the use of the IHI, however notes Tasmania's ability to comply with reporting this data element is problematic and not feasible for Tasmania at this time, because of the significant investment in IT required.

The ability to address fragmentation within the system, across multiple facilities, (because of the configurations of health services. with different demographics and sizes), needs to be understood in the development of any innovative funding models

Section 12: Pricing and funding for safety and quality

Section 12.4 Avoidable hospital readmissions

Consultation questions:

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

Tasmania is generally supportive of funding option one, however, has concerns that:

- without the IHI health service with greater fragmentation of services and systems in some Jurisdictions. Jurisdiction without state-wide integrated PAS will not have the index intervention or the subsequent readmitted event identified, and
- without a nationally consistent admission policy framework, local admission policy arrangements may reduce the ability to identify same-day ambulatory (non-admitted) index or readmitted events.

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

Tasmania will work with JAC and TAC, however it has concerns the current refinement of ACS 0002 may limit the inclusion of ICD codes that impact on care of other conditions but are not seen as active management and could be considered risk factors.

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

IHPA needs to recognise ICT limitations within the States and Territories, and that any tool developed by 3M will need to be able to interphase with multiple patient information systems and data warehouses.