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Appendix A: Consultation questions

Questions	Page number
What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?	6
Are there any recommendations for how IHPA should account for COVID-19 in the coming years?	6
Do you support the proposal to establish standard development cycles for all classification systems? Yes, this should fall in line with the current 3 year admitted acute care development cycle. Christina Belevski, Coding Manager	13
Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?	13
Do you have any feedback on what measures should be standard as part of the review and development of an updated version of an established classification?	13
Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22? The AN SNAP version 4 doesn't apply well to state-wide specialist services. We would strongly advocate for a review and a change of the application of this categorisation to these groups. Current state is that there are other compensation mechanisms applied e.g. supplementary grants that recognise that state-wide services manage a different group of patients to other hospitals even though they are coded the same under the ANSANP category. There is also a program identifier applied at a state level to identify that these patients are different. Debbie Munro, Divisional Director – Continuing Care	15
How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?	16
Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?	17
What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model? While the adjustment of 8 to 30% based on 'rurality' (distance) is reasonable, we feel that the 'waiting time' [to transport] and other qualitative independent variables are not taken into account. For example, the latest Austin Health patient transport pricing has a significant waiting time component. IHPA may be using a 'linear regression' methodology to calculate this adjustment where the 'fixed' cost nature of the waiting time and the sustainability of 'clinical safety' at regional and rural health services (2-hour away from Metro) may not be properly captured in the formula.	20

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We mean ‘clinical safety’ in this context as a patient safety measure to transport ‘out’ to teaching hospitals by having ambulance in-house or nearby and to employ specialists in-house. Both measures have high fixed costs. Moreover, the linear regression usually uses ‘continuous’ variable like kilometres, which fails to reflect the qualitative nature of the real rural business as mentioned above. Conclusion is that the patient transport adjustment formula might ignore many other significant variables. Ronald Ma, Clinical Costing Analyst & Don Rixon, Service Manager	
What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment? Austin Health meets the specified ICU eligibility criteria.	20
What factors should IHPA consider in reviewing the Indigenous adjustment?	20
What evidence is there to support increased costs for genetic services or socioeconomic status?	20
What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22? Austin Health supports the introduction of an AR-DRG for endovascular clot retrieval. However, this is not proposed to occur until the introduction of AR-DRG Version 11.0 in 2024. Until this AR-DRG is introduced, there should be consideration for an additional adjustment for patients who have this procedure performed given the high costs associated with this procedure. This was a previously recognised Victorian specific DRG given the complexity involved in treating these patients. Kate Hunt, Manager – Corporate Reporting	20
Are there other clinical areas where introducing price harmonisation should be considered?	20
What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns? Not applicable to Austin Health	21
Are there any objections to IHPA phasing out the private patient correction factor for NEP22?	22
What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?	28
What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?	33
What innovative models of care or services are states and territories intending to trial for NEP22?	33
What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms? Need to acknowledge that Austin’s treats a number of high-risk patients many of whom have significant co-morbid illnesses that may have complications during and following that lead to more frequent hospitalisations, e.g., Spinal Patients Mary O’Reilly Medical Director, Quality & Patient Safety | Deputy CMO Sarah Daffey Associate Director Patient Safety	36

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What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations? While funding penalties are additional incentive for improved quality of care, they can also be problematic. For example, patients with high of falls risk who are admitted from Residential Aged Care facilities with associated delirium will likely have increased likelihood of Hospital Acquired Complications and increased length of stay despite maximal strategies being implemented. Mary O'Reilly Medical Director, Quality & Patient Safety | Deputy CMO Sarah Daffey Associate Director Patient Safety	37
What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations? In evaluating the merit of different pricing and funding approaches in reducing avoidable and preventable hospitalisations Health Services need to acknowledge the increasing complexity of high-risk patient cohorts. At the Austin this includes but is not limited to: Elderly from home Elderly from RACS Transplantation services Liver and Kidney Specialist Spinal Services Complex Care needs e.g. Brain disorders Home Ventilator Dependent patients Palliative Care Penalties should be graded related to complications not only avoidable and preventable hospitalisations. Mary O'Reilly Medical Director, Quality & Patient Safety | Deputy CMO Sarah Daffey Associate Director Patient Safety	37