IHPA Consultation Paper
Pricing Framework for
Australian Public Hospital Services 2022-23

NSW Health Submission

1 Introduction

1.1 IHPA's role under the Addendum

Noted.

1.2 Impact of COVID-19

See Section 2.

1.3 Changes arising from the federal budget

NSW notes the changes announced in the federal budget. Consultation with jurisdictions is needed on any potential changes to the structure and resourcing of IHPA and the impact or interplay this change may have on IHPA's existing hospital pricing responsibilities.

2 Impact of COVID-19

NSW notes the response to COVID-19 has changed the delivery of health care and will significantly impact the national pricing model for years to come. These changes need to be carefully considered and impacts assessed to ensure the operation of the national pricing model remains responsive and effective. This includes consideration of the interplay with the National Partnership on COVID-19 Response (NPCR) and the National Health Reform Agreement (NRHA).

Whilst IHPA price Hospital in the Home (HITH) and Telehealth non-admitted services, the casemix of patients using these services is likely to have changed as a result of COVID-19, with additional technological items now becoming mainstream such as wearables for observations. Further work is needed to clearly define the use of telehealth items and to understand the impact of providing virtual care on the workforce. Virtual modes of delivery will take time to embed and realise efficiencies.

Recommendations:

IHPA should work with jurisdictions to:

- Assess different patterns of COVID-19 and non-COVID-19 activity across jurisdictions, noting:
  - unutilised capacity across jurisdictions
  - timing of costing COVID-19 impacted periods by jurisdictions
  - different treatment of cost structures across jurisdictions, i.e. NSW removed the State Public Health component from NHCDC costs and put them under NPCR
- Develop a framework or principles to manage the impact of COVID-19 for current and future years:
  - engage with the Administrator to understand NPCR costs relevant to the impacts of NRHA costs
  - consider an in-year adjustment to NEP21 due to impact of COVID-19 on NEP21

2.1 Impact of COVID-19 on NEP22

Consultation Question:

Question 1: 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?

NSW recommends that IHPA review the cost structure of the last three months (April to June 2020) compared to that of the full 12 months. NSW considers that analysing quarters within the dataset will identify significant variations impacted by reduced activity and inflated costs when calculating the NEP and associated NWAU22 price weights. IHPA need to consider each jurisdiction individually to reflect the patterns of COVID-19 activity across States and Territories. In NSW, the major COVID-19 impact to date was the period April to June 2020.

The 3 month period at the end of 2019/20 will not necessarily be a representative period for the impact of COVID-19 in the subsequent 2 years, as the COVID-19 pandemic is still present and ongoing. Patterns of activity at the start of the pandemic when work was undertaken to mitigate any overwhelming of the health system (with some non-essential services delayed with others going to telehealth) is very different to the current situation. This can be seen in some LHDs/SHNs where the casemix with a reduction in respiratory Diagnosis Related Group (DRG) activity and increase in mental health activity. Activity levels have increased in some cases to pre-COVID-19 levels, with a return to more face-to-face care.

Throughout the pandemic there has been a large increase in the cost of PPE, security, patient screening and procedures for patient movements etc., some of which has persisted. Fixed salary costs were largely unchanged which made the reduced activity look much more costly in 2019/20 and some of 2020/21. Ideally the COVID-19 testing and vaccinations should in NEP22 be included with an appropriate price weight.

NSW further recommends that the COVID-19 analysis is used to determine whether a specific pandemic period back casting multiplier is required separately from the normal back casting multipliers. The COVID-19 impact period cost data may also be used to calculate a pandemic adjustment amount per jurisdiction and stream in the event of similar impacts on hospital activity in NEP22 and the previous NEP21. The adjustment could be applied to a jurisdiction's NWAU results at the time of reconciliation to account for periods of inflated costs or deflated activity when there is a clearly defined pandemic period of time.

NSW suggests IHPA consider data trimming based on July 2019 to March 2020 actual data as the change in casemix and complexity during the COVID-19 period may result in over or under trimming in particular activity areas, for example medical and obstetrics. Pre-COVID-19 period data may also be used to determine length of stay bounds and per diem price weights to ensure normal volumes and casemix are represented in the sample for the calculations.

NSW has undertaken a comprehensive analysis of the impact of COVID-19 on hospital casemix across all streams. A summary of the findings can be made available to IHPA.

NSW held a workshop with LHD/SHN Directors of Operations to discuss the impact of COVID-19 in September 2020. Key findings from this workshop were included in the NSW 2021-22 Pricing Framework Consultation response.

Recommendations:

- Analysis to understand the change in volume and casemix by stream.
- Separate analysis for ABF and block funded facilities, noting the percentage of in-scope costs for block funded facilities may be impacted by NPCR payments.

- Within the acute stream:
    - Analysis of Major Diagnostic Category level in the first instance to identify any changes in casemix, and then if required by DRG
    - Episodes undertaken in a private hospital under contract with the public sector may need to be removed from any bucket analysis, most of these costs will be in the goods and services line item
    - The average cost of episodes in the COVID-19 period compared with the average cost of episodes in the pre-COVID-19 period will provide some indication of the cost of capacity created for the anticipated COVID-19 related activity
- Within ED, analysis should include mode of arrival and mode of separation. NSW noted a significant decrease in 'Did Not Wait' activity during the COVID-19 period.
- Within mental health, analysis should include changes in length of stay in the COVID-19 period as opposed to the pre-COVID-19 period. NSW noted a slight increase in length of stay, perhaps as the demand on beds was not as great during the COVID-19 period, and a couple of the high volume DRGs have very narrow inlier day ranges.
- Review additional long-term training needs related to COVID-19 treatment or staff and patient safety and whether they are considered embedded Teaching, Training and Research (TTR) or TTR.

2.2 Impact of COVID-19 on future determinations

Consultation Question:
Question 2: Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

To account for COVID-19 in coming years, IHPA must ensure that the costing standards and costing data can identify COVID-19 related costs specifically and accommodate temporary or permanent changes to service delivery. These results could then be used to identify if a COVID-19 ABF and block adjustment is required.

There is a very real potential that Australia could be dealing with COVID-19 for many years to come. IHPA may need to accept this as the new normal and recognise the step-up in the cost structure, whilst maintaining the ability to identify the COVID-19 costs separately as needed.

NSW welcomes the opportunity to participate in workshops that IHPA has scheduled in 2021 to discuss the COVID-19 pandemic impacts to cost and service delivery.

3 The Pricing Guidelines

In line with the **Administrative ease** guideline, NSW requests IHPA adopt advice from jurisdictions in relation to the cost and benefit of all and any changes to data collection and submission. Sending a pricing signal is not a strong enough purpose to introduce significant changes.

With regards to the **Minimising undesirable and inadvertent consequences** guideline, NSW notes risk management is required to ensure funding proposals do not have a negative impact on patients.

4 Scope of Public Hospital Services

4.1 General List of In-Scope Public Hospital Services

NSW supports further revisions to the General List criteria to support innovation and better align with IHPA's pricing guideline, that *pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care*.

Detailed comments on options for trials of innovative models of care are provided at Section 10.

5 Classifications Used to Describe and Price Public Hospital Services

5.1 Standard development cycles for all classifications

Consultation Question:
Question 3: Do you support the proposal to establish standard development cycles for all classification systems?

NSW supports the proposal to establish standard development cycles, provided there is flexibility to make urgent updates or respond to changes during the cycle (as required).

Consultation Question:
Question 4: Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?

NSW supports a three-year development cycle. Less than two years would be difficult to manage for training/updates to staff and may challenge the robustness and stability of the ICD-10-AM classification. A cycle four years or more may not be responsive enough to changes in the health care environment.

Consultation Question:
Question 5: 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?

NSW supports the standard measures proposed and add that they must include broad specialist consultation relevant to the data set under review, including clinicians and classification experts. Any 'rules' associated with the classification should be reviewed as well. Review and feedback on classifications from clinicians is important to ensure they accurately reflect in a clinical care setting to support greater utilisation of classification data by clinical staff.

The measures should also require a minimum of the latest three-year dataset available to IHPA to be analysed to support any changes.

To maintain flexibility and responsiveness, IHPA should also consider the relevance of new technology and models of care across streams. An example of this is if there is a new Australian Classification of Health Interventions (ACHI) code for an admitted procedure, or a new Tier 2 class is created to capture activity occurring in procedure rooms in the non-admitted patient setting.

NSW recommends a measure should also be introduced to determine if a larger scale redesign of the classification is needed. The classifications should also be tested to ensure that they remain clinically relevant, incorporating current concepts, language and models of care.

5.2 Admitted acute care

Enhancing education materials for admitted acute care classification systems

Availability of comprehensive education & training materials is critical – it will ensure standardised approach to content and delivery of education including the interpretation and application of ACS.

Phasing out support for older AR-DRG versions

NSW notes the phasing out older AR-DRG versions is a regular practice, however suggests a minimum of two prior versions should always be supported. This would ensure continuity for research and minimises the added financial burden of change on small private operators.

Release of ICD-11

NSW notes that ICD-11 is not an upgrade as such, but a major change to the classification compared to the previous version. Given the issues and significant changes associated with ICD-11, NSW requires a more definitive timeframe and documented implementation plan for its introduction. A significant lead time for implementation into relevant IT systems is required. The cost of undertaking this change will be considerable.

5.3 Subacute and non-acute care

AN-SNAP Version 5.0

Consultation Question:
Question 6: Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?

NSW notes the Addendum to the National Health Reform Agreement 2020-25 (the Addendum) Clause A42 requires IHPA to shadow price classification changes for two years or a period agreed with the Commonwealth and a majority of States to ensure robust data collection and reporting to accurately model the financial and counting impact of changes on the National Funding Model.

AN-SNAP v5 is significantly different to the previous version and therefore should be shadow priced for a two-year period under the Addendum. This is particularly important as NSW notes clinician concern with the implementation of the Frailty Related Index of Comorbidities (FRIC) where it does not support clinical practice, has not been validated in the Australian context, does not address the under 75 years of age cohort, has diagnosis exclusion codes and is applied retrospectively. NSW notes that frailty is not isolated to the over 65 years cohort and it is important to acknowledge and accommodate for frailty in the younger cohorts as well. This may require further investigation and analysis by IHPA.

NSW notes the proposal to implement the FRIC is potentially temporary while the Rockwood Scale data is collected and analysed. Should the Rockwood Scale be implemented, detailed consultation is required with clinicians and subject matter experts with additional consideration for the use of the Frail Scale and/or the Clinical Frail Scale.

NSW is concerned IHPA are introducing a new classification version which, prior to implementation, is already considering a replacement frailty score. In the same manner as the Australian Mental Health Care Classification (AMHCC) change to phase, NSW is concerned that this will undermine its own

classifications. This adversely impacts clinical confidence in using the classification, and by extension, any funding model based upon it. These issues could be addressed in the shadow pricing period.

NSW is unlikely to be able to implement AN-SNAP v5 should IHPA proceed to pricing in July 2022.

Recommendations:

- Shadow price AN-SNAP v5 for NEP22 in line with Addendum Clause A42 and to allow time to address clinician concerns and other issues prior to pricing.

5.4 Emergency care

Noted. IHPA should better capture shifts in provision of care, particularly the increased use of virtual care in Emergency Departments.

5.5 Non-admitted care

A new non-admitted care classification

NSW has implemented a number of initiatives delivering care to selected patient cohorts in the non-admitted setting which were traditionally delivered in the admitted setting. Reflecting non-admitted costs more accurately is important to enable assessment of the impact of these – in terms of both efficiency and resource allocation.

For example, asynchronous communication 'store and forward' is not appropriately costed activity. This activity should be reportable as a service event particularly in relation to care delivered by specialist teams as part of ongoing care to spoke services e.g. burns / high-risk foot services (and others). Images are captured and sent for review and management advice to a specialist team, the specialist team reviews (generally not same day unless emergency), management advice is provided and sent back to the clinician (patient end), and the clinician provides treatment for patient (generally not same day). The specialist team monitor and review ongoing care for the patient, but the patient is not present, so the care is costed at lower rate.

Consultation Question:

Question 7: How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?

NSW recommends that IHPA undertake the intended review of the 2019-20 cost and activity data before the initiation of a new non-admitted care costing study. Given the significant changes in models of care that occurred in the non-admitted setting during the COVID-19 pandemic, IHPA must understand what are the material cost drivers that impact price weights going forward. This needs to be considered before the recommencement of the study.

NSW also recommends that IHPA determine a minimum national scope of clinics to ensure enough information is collected to develop a new classification. This would include new services, or changes to existing services, as the original scope of clinics will require review.

The COVID-19 pandemic has shown that far more detailed non-admitted patient clinical care can be provided outside of a hospital bed. The new technologies that allow for this should be incorporated into the costing study. A focus of attention should be the clinics that were significantly disrupted and required new models of care. Models of inpatient care that were quickly moved to outpatient care and evaluations of this care for better clinical outcomes and sustainability should be sought. Examples of shifts away from inpatient care can be seen in Royal Prince Alfred Hospital (rpaVirtual) where a

hospital quarantine facility was set up almost overnight based on patients remaining away from the hospital but receiving hospital like care.

NSW recommends that IHPA maintain an ongoing Non-Admitted Care Working Group (NACAWG) agenda item to continuously review the feasibility of recommencing the study. This will provide jurisdictions with enough time to consider re-entry into the costing study. IHPA need to consider various options of recommencing the study such as individual jurisdictions commencing, revised scope and volume based on statistical requirements, tranche approach and revised methodology for actual data collection to make data collection and assistance from IHPA or FMTs more manageable. IHPA needs to consider funding observers for data collection as the workload of clinicians is deemed greater now than pre-COVID-19.

NSW recommends that IHPA provides training, support and development opportunities to personnel involved in the costing study.

Recommendations:

- Determine a minimum national scope of clinics to ensure enough information is collected to develop a new classification.
- Maintain an ongoing Non-Admitted Care Working Group (NACAWG) agenda item to review the feasibility of recommencing the study.

5.6 Mental health care

Mental health phase of care

The intended refinement of the phases within AMHCC validates reasons to defer pricing of AMHCC until IHPA implements changes which may improve data integrity and clinical application or acknowledge the timing of an AMHCC v2 within which these changes should take place. The continuing long-term refinement of AMHCC has impacted clinician confidence in AMHCC.

Consultation Question:

Question 8: Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?

Admitted mental health care

NSW looks forward to reviewing IHPA's analysis of the admitted AMHCC shadow period and the updated Impact Assessment prior to the implementation of pricing for the admitted AMHCC. Whilst NSW believes the move of block funded mental health hospitals to ABF is premature and should be deferred, NSW looks forward to working with IHPA to consider the appropriate progression of mental health block funded standalone hospitals once admitted AMHCC pricing has been in place and the impact analysed. See further commentary at Q17.

NSW notes that admitted data has shown improvement and with further work over the next 12 months, improvements will continue to occur. However, NSW recommends IHPA consider mental health intensive care units in the pricing of admitted mental health. The existing pricing does not consider recognition of the resources required in managing mental health intensive care patients.

NSW also recommends that IHPA considers the recognition of same-day or short stay episodes of less than three days, as these encounters are problematic in terms of collecting outcome measures, which often map to an unknown phase of HoNOS. In NSW in 2020-21, 22 per cent of admitted episodes were unknown phases. Of the 22 per cent, 61 per cent of unknown phases had a length of stay of three days or less. This validates the need for IHPA to introduce a short stay and same day

AMHCC class. Electroconvulsive Therapy (ECT) is an example of same day procedural activity. Whilst there are AR-DRGs for same day ECT, there is no consideration within the AMHCC. In addition to this, it is not feasible to conduct a HoNOS for every occasion of an ECT session.

NSW notes Mental Health Legal Status is only recognised as a variable AMHCC split for the acute phase of care between the ages 18-64. However, significant numbers of clients have an involuntary status and greater resource intensity across other phases of care and the age spectrum. NSW suggests the Mental Health Legal Status is extended across all age groups and phases of care.

Community mental health care

NSW does not support the pricing of non-admitted mental health care for NEP22 and notes there has only been one year of shadowing pricing for community mental health care to date, i.e. NEP21. A second year of shadow pricing is required given the incomplete and developmental nature of national data and the current impact of COIVD-19 which has reduced our ability to undertake this work. A second year of shadow pricing is also supported by Clause A42 of the Addendum.

NSW also notes that the current shadow price weights for non-admitted mental health includes the calculation of a phase length to determine NWAU. This concept is particularly confusing in the non-admitted setting and is unlikely to be an accurate reflection of cost, as it bears no resemblance to the number of actual times the patient has been in direct contact with clinicians for care/services.

There are a number of community mental health services which cannot be made to fit the proposed model as they are delivered to de-identified clients, triage only and/or are secondary support services. It is recommended that consideration is given to maintaining block funding for these services until the model evolves. At this stage, it is not known whether the proposed monthly case payment for community mental health services will cover the cost of providing treatment.

The proposed AMHCC model does not make provision for clients on Community Treatment Orders (CTOs) who tend to be more resource intensive due to supervisory nature of their care and extensive reporting requirements to Tribunals. NSW suggests IHPA considers including community Mental Health Legal Status in the model with an additional weighting or split on end classes to renumerate services for the additional costs of managing these complex clients in an ambulatory setting.

Recommendations:

- Provide jurisdictions with an impact assessment for the proposal to price admitted mental health using AMHCC v1 for NEP22 and shadow price community mental health for NEP22.

5.7 Teaching and training

Noted. Teaching and training should be reviewed to ensure that it reflects contemporary practice.

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

6.1 National pricing model

Noted.

6.2 Adjustments to the national efficient price

Consultation Question:

Question 9: What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?

NSW has non-government organisation contracts with the Royal Flying Doctor Service and taxi services that are problematic in costing in NSW and relate mainly to non-ABF facilities which are not currently reported though the NHCDC.

NSW notes the costs associated with patient transport are based on the charge provided by services. This may not truly reflect the cost of each individual service that has been provided as it is based on the charging model. NSW is continually looking for ways to improve costing. This is reflected in projects such as the NSW Ambulance Costing Project, which may improve the allocation of costs to individual services.

Consultation Question:

Question 10: What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment?

NSW would like to work with IHPA to undertake a review of funding requirements for intensive care. This review should include broadening mechanical ventilated hours as a proxy of eligibility to include non-invasive ventilation (NIV), inotropic support and continuous renal replacement therapy (CRRT) and a review of the resources needed by ICU to manage patients external to ICU. NSW ICU clinicians have expressed interest in being involved in a collaborative review of the ICU funding model.

IHPA should review the ICU adjustor to consider inclusion of High Dependency within a combined ICU. Patients in these beds experience an increase in cost compared to a general ward due to increased staffing levels (usually 2 patients to 1 nurse) which is not always appropriately adjusted for.

IHPA should also consider reviewing the bundling of ICU hours in neonatal care. SHNs have reported a large cost variance in neonatal episodes with long ICU length of stay vs the bundled NWAU. Similar patients may end up in 2 different DRGs with significantly different NWAU based on allocation to a neonatal DRG or a non-neonatal DRG.

Consultation Question:

Question 11: What factors should IHPA consider in reviewing the Indigenous adjustment?

Safety and quality adjustments should only be applied to the base weight and not to the final weight, as incentive for the Indigenous adjustment is removed whilst the need for it remains until we have closed the gap on health care in Australia. An analysis of Indigenous activity in ED should be undertaken, particularly in the areas of ‘Did Not Wait’ to determine if an incentive could be implemented to reduce ‘Did Not Wait’ levels.

Consultation Question:

Question 12: What evidence is there to support increased costs for genetic services or socioeconomic status?

Genetic services

Genetic services are costly for the following reasons:

1. **The use of expensive highly specialised pathology:** due to its associated genetic/genomic tests, which are expensive ranging from a few hundred to a few thousand dollars per tests, most of which are not publicly funded;
2. **Time resource requirement:** due to complexities surrounding a genetic consultation which takes on average 1 hour per patient;
3. **Intensive human resource requirement:** often a clinical geneticist (specialist doctor) needs a genetic counsellor (allied health) support in the same clinic setting due to the significant psychosocial issues that are often present in these families by the time they get to be seen at a genetics service towards the end of their diagnostic journey.

The traditional funding model for genetic services is non-sustainable in the long-term, and an alternative funding model needs to be critically considered.

NSW is aware that genetics activity counting is understated and there is significant variation across involved sites in the ability to count all clinicians and service events for this service. A particular issue is the costing of genetic testing when undertaken externally to the host LHD. NSW have begun a process of improvement in this area and supports the need to review the costing for genetics services. It is essential costings evolve in response to the rapid changes in the clinical application of genomics and emerging models of care for genomics.

Genetic developments and discoveries and associated testing and therapies are having a significant impact on costs of services in both admitted and non-admitted categories, in addition to laboratory costs. The causation of conditions that can now be connected to genetic conditions and treatment options is increasing at a rapid rate. With intergenerational risk factors and disease linkages genetic testing will continue to grow. Additionally, embedding genetic services within specialties as seen in adult cancer genetics, will become the norm as linkages between genetics and diseases become more common. This will impact the costs of episodes of care.

Socioeconomic status

NSW acknowledges that socioeconomic status impacts the cost of care for individual patients however a valid measure is not currently available. The best approximations, based on area of residence, are not patient centric and only suitable for population level funding adjustments. Adjustments to pricing based on socioeconomic status may therefore prove difficult.

Consultation Question:
Question 13: What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?

Nil comment.

6.3 Harmonising price weights across care settings

Consultation Question:
Question 14: Are there other clinical areas where introducing price harmonisation should be considered?

NSW supports harmonisation of price weights across care settings in principle. The harmonised weights must be based on robust clinical consultation, particularly to identify and assess any potential unintended consequences of price harmonisation. The harmonised price weights must accurately reflect cost variations for patients at higher risk of comorbidities.

Other areas for consideration, subject to further clinical and jurisdictional consultation, could include:

- Surgical specialties where there is activity variously recorded as admitted and non-admitted are recommended for further review/consideration e.g. cataract extraction
- Same day gastroenterology patients i.e. scopes

Recommendations:

- IHPA complete Haemodialysis and Chemotherapy price harmonisation before introducing other clinical areas.

6.4 Unqualified newborns

Consultation Question:

Question 15: What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns?

NSW clinicians support that all newborns, both qualified and unqualified are recorded as admitted inpatients with a separate but linked record to the maternal record, to promote best practice and value based clinical outcomes for both mother and baby.

NSW supports IHPA investigating this further and suggests reviewing the following:

1. Develop clearer definitions for unqualified babies as there remains confusion regarding the requirements and conflicting business needs for recording the baby record in hospital systems.
2. Develop a costing standard to ensure all costs are based on similar reasoning so a differential can be made for different clinical care provided to mother and baby.
3. Significant appropriate clinical consultation should be undertaken to fully understand clinical and administrative issues associated with any changes to qualified status, such as the impact on private health insurance payments and the impact on operational and administrative burden.

Detailed feedback from NSW clinicians include the following:

- Perinatal clinicians are concerned that unqualified newborns are considered an absorbed cost and are funded within the maternal DRG. To qualify a newborn creates unjustified routine separation of mothers from their babies, stifles innovation of models of care, does not identify the incidence of clinical issues requiring care and does not support breast feeding. In addition, it does not acknowledge the increasing number of babies requiring assistance from maternal complications and illness and does not support the documentation and coding of the same.
- Many problems of the newborn can be managed without separating the mother and baby that supports best practice. The maternal or newborn length of stay can be longer than the other. Time limited problems usually relate to the transition from the in-utero environment and include hypothermia, maternal indisposition post LSCS, cardio-resp monitoring for TTN, hypoglycaemia, narcotic intoxication, antibiotic administration, hyperbilirubinaemia, NG/OG feeding (late preterm and SGA babies), mild hypoxic ischaemic encephalopathy and psycho-social assessment and support. Other conditions that can be cared for at the bedside include neonatal abstinence syndrome, clef palate, assessment and management of genetic conditions (e.g. Trisomy 21) and limb deformity.

The ‘qualification’ definition for newborns may need to be modified based on the presence of problems/conditions that require care or interventions that are distinct from the care of the mother. In NSW some years ago, the newborn was always a separate patient in their own right and costed as such, however, clear costing rules must be developed to guide which costs should be allocated to the mother (e.g. lactation) and which to the baby (e.g. pathology). The costing process would re-align the

value of care received by mothers/babies. The current methodology does not align with practice, where babies are kept with the mother as much as possible and receive care at the bedside.

NSW welcomes the opportunity for further consultation on this.

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

NSW remains committed to the principle of private patient neutrality, as outlined in the Addendum Clause A13. However, at this time, NSW does not support the methodology IHPA has developed to implement this. This has been raised in previous advice and also directly with the Commonwealth. Further consultation is needed between IHPA, the Administrator and jurisdictions to fully assess the impact of this change. Furthermore, the current model is biased towards the Commonwealth as it only recognises an adjustment where jurisdictions owe the Commonwealth but does not recognise any adjustment from the Commonwealth to jurisdictions.

Phasing out the private patient correction factor

Consultation Question:
Question 16: Are there any objections to IHPA phasing out the private patient correction factor for NEP22?

NSW supports the concept of phasing out the private patient correction factor, however, it will be problematic to meet this change in the costing standards for NEP22. NSW is not compliant with Business Rule 1.1A Medical expenses for public and private patients in R24.

There have been several studies undertaken to determine a methodology for identifying the true cost of medical treatment to both public, compensable and private patients. These have been limited by:

- Unpacking the Rights of Private Practice (ROPP) arrangements and associated revenue
- Determining if all the revenue is in lieu of expenditure, for example, a clinician that has a high proportion of private patients compared to another clinician and whether all revenue should be considered in reducing the costs to NSW Health
- Revenue associated with ROPP arrangement can be used to purchase other goods and services and non-medical salary expenditure
- Understanding facility fee expenditure by LHD/SHN, which are generally used to purchase other goods and services and non-medical salary expenditure related to private patients
- Access to trust fund information including legality and/or ethics
- The rates of contracted clinicians in NSW, for example, Visiting Medical Officers (VMOs) which NSW Health does reimburse for treating private patients
- Understanding VMOs licence to occupy fee for treating privately referred non-inpatient activity
- In 2019-20 staff specialists may have moved level due to drop in private patients due to COVID-19

Costs of salaried junior medical staff and VMOs are included into both public and private patients. Private pathology, imaging and patients privately purchased pharmaceuticals and prosthetics may not be included in the costs of private patients. NSW is unsure if this is included in the correction factor.

NSW oppose phasing out the private patient factor in NEP22 due to:

- Lack of understanding of the current factor and therefore its impact
- The inability of NSW to meet business rule 1.1A
- If other jurisdictions are also unable to meet business rule 1.1A, phasing out the factor would unfairly bias establishments/ jurisdictions with low rates of private patients

Recommendations:

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

7 Data Collection

7.1 Overview

National Benchmarking Portal

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

- 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.
- 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:

- A risk assessment is undertaken to assess the impact of making the National Benchmarking Portal publicly accessible. Unintended consequences impacting all stakeholders should also be assessed, including the additional administrative burden on jurisdictions.

8 Treatment of other Commonwealth programs

8.1 Overview

Noted.

9 Setting the National Efficient Cost

9.1 Overview

Noted.

9.2 The 'fixed-plus-variable' model

Standalone hospitals providing specialist mental health services

Consultation Question:
Question 17: What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?

Considerable analysis and discussion is required to understand the impact of transitioning block funded stand-alone hospitals that provide specialist mental health services to ABF. Based on AMHCC, this is particularly the case for forensic hospitals.

NSW notes that AMHCC price weights would need to be recalculated with the activity and costs of standalone psychiatric facilities included in the baseline. An impact assessment, including impact on the acute stream will need to be re-evaluated prior to transitioning these services back into scope for ABF.

There are risks for funding continuity in transitioning these hospitals to ABF using a new classification where phase of care is still being refined. These hospitals don't have the mix of services that enable facilities to balance the risk and are reliant on the effective performance of just one classification. There should be extensive testing and shadowing to compare ABF allocation with actual costs. Without the range of services being delivered as other ABF hospitals the infrastructure costs of these types of facilities may be so different that the same NWAU value is not applicable even within the same class as mental health cases in a general hospital.

NSW also notes added complexity in transitioning stand-alone psychiatric facilities to ABF due to long stay patients who may be inpatients for many years and low/unpredictable number of annual separations. These specialist facilities would not attract funding under ABF until a patient is discharged.

The ABF model would need to consider these issues to prevent significant cashflow issues within standalone public hospitals and ensure these facilities can remain viable to provide services to the community.

9.3 New high cost, highly specialised therapies

Noted.

10 Future funding models

10.1 Overview

The Addendum intends to facilitate exploration and trial of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes (A96) and support jurisdictions to trial innovative models of care (A97-A101). The development of a funding methodology by IHPA (as per A101.a) 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*.

10.2 Investigation of alternate funding models

NSW notes IHPA's investigation of alternate funding models to date has focused on how existing activity could be treated differently through bundled payments or capitation payments but does not consider options for funding innovative models of care which currently sit outside acute ABF/block.

This does not fully address the intention to fund and encourage new models of care. There is a need and an opportunity to explore other flexible funding options, for example ABF contingent on outcomes (e.g. pay for performance), or innovative ways of delivering care to multiple cohorts (e.g. virtual care).

See response to Q18 for further comments on this.

10.3 Next steps for alternate funding models

NSW supports flexibility for states and territories to nominate their own models of care or services for consideration under the innovative funding model clauses of the Addendum, rather than specific models of care or services determined by IHPA. This will provide flexibility NSW Health to identify the scope of innovative funding trials that are most appropriate for our health system. States and territories can agree with the Commonwealth to trial innovative models of care, and the model should support a broad range of approaches and approaches to bearing of risk to support the long term reforms committed to by all jurisdictions under the NHRA Addendum.

Consultation Question:
Question 18: What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?

The Innovative Models of Care clauses in Schedule A of the Addendum, including the funding methodology being developed by IHPA, are key enablers for implementing the long-term system wide health reforms in the Addendum. While trialling bundled and capitated models are a good first step, there must be more flexibility to enable States to trial novel ideas.

For example in Clause C21c, parties to the Addendum agreed the reform plan for *Paying for Value and Outcomes* could include developing and progressing trials of funding and payment reforms at a program level (bundled payments, refinements to ABF, capitation models and outcomes-based payments, among others) and at a system level (blended funding models and pooling of payment streams across programs and providers).

Without broadening the scope of the methodology, the financial risk of trialling innovative models of care will continue to be borne by states and territories, significantly limiting states and territories' ability to implement the long-term reforms. There needs to be clear recognition that there is the option to incorporate other funding models into IHPA's methodology in future in an agile and responsive way.

Some other considerations IHPA should have in investigating innovative models of care and exploring trials of new and innovative funding approaches include:

- The ability for clinicians to coordinate and deliver interventions that achieve the outcomes that matter to patients across all care settings
- The need for mutual commitment and accountability for achieving outcomes across hospital, primary and community settings
- The ability to integrate funding for Innovative Models of Care under the Addendum with other streams of funding which contribute to delivering the model of care, in a way that does not penalise or disincentivise the State(s) undertaking trials
- Sophisticated approaches to risk adjustment and improved governance and accountability across care settings e.g. when considering alternate funding models across a pathway of care a robust attribution methodology is critical for accountability and risk mitigation
- Evaluation of trials should measure the impact on experience of providing and receiving care in addition to patient outcomes and efficiency
- Appropriateness of funding approaches for virtual care (such as Telehealth, Remote Monitoring etc.) which have increased during the COVID-19 pandemic

Recommendations:

- IHPA closely consult with states, territories and the Commonwealth, for example through the NHRA Reform Implementation Group (RIG), to further develop and broaden the proposed methodology and ensure alignment with ongoing work to implement the long-term reforms.

Consultation Question:

Question 19: What innovative models of care or services are states and territories intending to trial for NEP22?

NSW notes that under Clause A97 of the Addendum, trials of Innovative Models of Care need to be agreed between the Commonwealth and a State(s) through a bilateral agreement in accordance with Schedule C. As noted above, IHPA's funding methodology is a key enabler of these trials.

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 and NSW may seek to trial under Clause A97. This includes NSW's:

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

11 Pricing and Funding for Safety and Quality

11.1 Overview

Noted.

11.2 Sentinel events

Noted.

11.3 Hospital acquired complications

Noted.

11.4 Avoidable hospital readmissions

NSW notes IHPA has developed a risk adjustment model with the intention of it applying a funding adjustment to readmissions that have occurred within the same jurisdiction.

NSW do not believe that linking readmissions outside of the index hospital creates the appropriate quality signal to clinicians, as they have no visibility outside of their own hospital largely and would not be aware that the readmission even occurred.

Given clinician engagement is the single most important factor in delivering reforms to safety and quality of care, NSW reiterates previous feedback that changes to care bundles that enable reduced readmissions require clinician engagement at a local (hospital) level. For effective engagement, clinicians require data at the local level in a contemporaneous timeframe. Initial application of any funding option should be at a hospital level and clearly visible to clinicians.

The relationship between the predisposing events at the index admission to potentially avoidable readmission is not well established. Much of the evidence around potentially avoidable readmissions is around care in the community after the index admission. Currently, clinical teams have less control/influence over these deliverables. Regardless of this, the caring teams for the index case will be held accountable for factors they cannot control. There is a risk that this will disengage clinicians from the process and potentially from improvement work in general.

NSW further notes the avoidable hospital readmission definition has not been endorsed by Health Chief Executives.

Recommendations:

- IHPA reassess the scope of this adjustment to readmissions that have occurred within the same hospital, to consider clinical responsibility of patient care.

11.5 Evaluation of safety and quality reforms

Consultation Question:
Question 20: What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms?

NSW notes the responsibilities of IHPA to work with parties to develop an evaluation framework and evaluate safety and quality reforms under Clauses A172 and A174 of the Addendum.

IHPA should ensure evaluation measures are:

- Clearly defined and articulated prior to implementation
- Directly related to the intended purpose of the programs being developed
- Developed in conjunction with programs using an evidence-based approach
- Developed in consultation with service providers to ensure fitness for purpose
- Transparent and be able to be replicated at jurisdiction and LHD level
- Prioritise on patient outcomes and experiences
- Meaningful and actionable by clinicians

NSW agrees with the comments in the Consultation Paper that any evaluation framework will require extensive consultation with the Australian Commission on Safety and Quality in Health Care (the Commission), jurisdictions and other national bodies. In addition to the IHPA Jurisdictional Advisory Committee (JAC) and the Commission's Interjurisdictional Committee (IJC), NSW suggest IHPA engage with jurisdictions through the RIG on this work to ensure strategic alignment with other Addendum commitment and reform activities.

11.6 Avoidable and preventable hospitalisations

Consultation Question:

Question 21: What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?

NSW notes IHPA, the Commission and the Administrator have been tasked with providing advice to Health Ministers on options for the further development of safety and quality-related reforms, including examining ways that avoidable and preventable hospitalisations can be reduced through changes to the Addendum (Clause A173).

NSW recognises this is an important piece of work, which will require significant consultation with a broad range of stakeholders, over a longer timeframe, to explore viable options for future approaches. In addition to existing advisory committees, NSW recommends IHPA considers standing up a time limited Safety and Quality Working Group to consider this program of work.

To date, jurisdictions have had limited opportunity to input on the scope, direction and outputs of the National Bodies' work under A173 to develop safety and quality reform options, including ways to reduce potentially avoidable and potentially preventable hospitalisations. This work must provide opportunities to improve safety and quality, beyond changes to pricing and funding. Some initial feedback from NSW is included below.

NSW suggest rewording avoidable and preventable hospitalisations to 'potentially avoidable' and 'potentially preventable' hospitalisations, respectively. Further details of an evidence-based approach of the impacts the changes in pricing will have on reducing potentially avoidable and potentially preventable hospitalisations. Without clinical review of all individual cases, potentially avoidable and potentially preventable hospitalisations are generic terms and attribution of the reason for the admission needs to be clinically verified. Further evidence is also needed of the defective care at the index admission that results in the potentially preventable hospitalisation.

Models where care is shared or delivered across settings and enabled by technology are crucial in reducing avoidable and preventable hospitalisations. For example, aged care rapid assessment teams providing services into residential aged care facilities (RACF); partnership models between primary care providers, RACF and emergency departments; and mental health virtual emergency care models (including those linking first responders to emergency triage). Technology is used to support virtual assessment, triage and management and enable early escalation if required. Better data collection and funding incentives for these types of models would provide opportunities to further scale and understand current activity nationally.

NSW recommends IHPA explore how funding models could support innovative models of care such as those where hospitals and LHDs/SHNs work with Primary Health Networks and private GPs to enable the improvement of managing patients post hospitalisation, community care and access to services.

In the Consultation Paper, IHPA notes a potential approach for reducing preventable hospitalisations for chronic conditions is through identifying at risk chronic condition groups and developing a capitation style funding approach. It is important that safeguards are put in place against 'cherry-picking' low acuity patients.

Recommendations:

- Safety and quality reform options developed by IHPA, the Administrator and Commission, as required under Clause A173 in the Addendum, are not limited to funding adjustments and enable broad and meaningful improvements to safety and quality.
- IHPA establish a time limited Safety and Quality Working Group to facilitate consultation, particularly for reforms targeting potentially preventable hospitalisations.

- IHPA, the Administrator and Commission engage with jurisdictions e.g. through the NHRA RIG to align safety and quality reforms with broader Addendum commitments and reforms.

Consultation Question:

Question 22: What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?

The impact on patient care and patient outcomes and experiences is essential when evaluating the merit of different pricing and funding approaches for safety and quality, along with financial results. To date there has been no evidence demonstrating improvements in the safety and quality of care or improvements in patient health outcomes through addition of sentinel event or HAC funding approaches.

NSW recommends that measures need to be able to be reproduced by hospitals and implemented prospectively. Currently avoidable readmissions are not able to be determined at the time a patient presents to hospital, which does not enable forward care planning to prevent future readmissions. Jurisdictional (including clinician) feedback should be carefully considered by IHPA in the assessment of evaluating the merit of pricing and funding approaches for reducing potentially avoidable and potentially preventable hospitalisations.

NSW also suggests IHPA reviews the Admission policy for certain patient cohorts nationally prior to evaluating potentially avoidable and potentially preventable hospitalisations as admission criteria can alter between jurisdictions, hospitals and even between doctors within a hospital which can create variation in the analysis.

As flagged in Q21, further consultation is needed on potentially avoidable and potentially preventable hospitalisations.

Recommendations:

- Assessment criteria should consider the impact on patient care and patient outcomes and experiences, as well as financial results.
- Measures should be meaningful to and actionable by clinicians.