Ms Joanne Fitzgerald
Acting Chief Executive Officer
Independent Hospital Pricing Authority
Email: submissions.ihpa@ihpa.gov.au

Our ref H22/47259

Dear Ms Fitzgerald

Thank you for the opportunity to comment on the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24* (the Consultation Paper).

Key issues raised in the NSW submission relate to the methodology adopted by IHPA to account for the impact of COVID-19 on NEP23, and the need to adequately reflect increasing costs, wage growth and inflation in the national pricing model despite the three-year lag in cost data.

The Consultation Paper is silent on IHPA's commitment to review NEP22 assumptions, which was noted in IHPA's letter Health Ministers and the published NEP22 Determination. NSW requests clarity on how and when IHPA, in consultation with jurisdictions, will review the NEP22 assumptions. If this is not done within year, NSW seeks to clarify whether IHPA will undertake this as a retrospective exercise.

NSW also raises concern over IHPA's proposal to price the new Australian Mental Health Care Classification (AMHCC) v1.0 classification for community mental health activity for NEP23. NSW strongly encourages IHPA to shadow price community mental health for an additional year due to the change in pricing model and the need to undertake analysis comparing the two models using recent data.

A detailed response from NSW Health is enclosed.

For more information, please contact Ms Jacqueline Worsley, Executive Director, Government Relations Branch, NSW Ministry of Health, at jacqui.worsley@health.nsw.gov.au or on 9391 9469.

Yours sincerely

Dr Nigel Lyons
Deputy Secretary, Health System Strategy and Planning
20 July 2022

Encl.

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Independent Hospital Pricing Authority (IHPA)

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24

NSW Health Response

NSW Health's responses below are made with reference to the relevant sections of IHPA's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24* (Consultation Paper).

1. Introduction

1.2 Impact of COVID-19

Ongoing cost and activity volatility makes it challenging to address the impact of COVID-19 in a historical based national funding model, which relies on long term trends and stability. The impact of COVID-19 will vary in 2019-20, to 2020-21 and again in 2021-22 due to the changing face of COVID-19 and its variants. Therefore, the national funding model must be flexible enough to cater for this significant change year on year.

As previously raised in feedback on the 2022-23 Determinations and in advisory committee meetings, NSW believes IHPA's normalisation methodology needs to be balanced with both activity and cost normalisation. In particular, the calculation in respect of escalation of variable cost normalisation.

As the NEP22 is based on only the Acute stream, the cost increase in other streams during 2019-20 due to COVID-19 has not resulted in equivalent change in price weights. This is significant as in NSW for example, the largest cost increase in 2019-20 occurred in the ED and non-admitted streams.

In addition, the Australian Government has not identified funding for the National Partnership on COVID-19 Response (NPCR) past 31 December 2022. When the NPCR ceases, expenditure will need to be reviewed and transferred from NPCR funding to NHRA funding to ensure the NEP is reflective of the operating environment.

1.3 Pricing aged care services

NSW notes the expansion of IHPA's functions to include aged care pricing from 1 July 2023 is subject to amendment of Commonwealth legislation. If legislation is passed, IHPA must expand their workforce and resources to incorporate their new functions. This must not jeopardise the work plan for existing hospital pricing functions, which has already been deferred due to COVID-19. NSW considers current refinement of newly developed classifications and subsequent pricing remains a priority.

NSW notes this Consultation Paper only applies to developing the NEP and NEC Determinations for Australian public hospital services in 2023-24, and that a separate pricing framework for pricing Australian residential aged care services will be developed and released later in 2022.

2. Impact of COVID-19

2.1 Accounting for the impact of COVID-19 on NEP22

The Consultation Paper states that cost data analysis indicated hospital expenditure remained relatively stable throughout the COVID-19 impacted period despite the significant reduction in activity in 2019-20. This should not be a surprise for two reasons.

First, a significant portion of hospital costs are fixed and cannot be adjusted, at least in a short-term period of a couple of months.

Second, the lower activity level was deliberately engineered to create additional bed capacity for the expected influx of COVID-19 cases. Providing capacity for care requires resources and therefore expense.

IHPA committed to review NEP22 assumptions in its letter to Health Ministers and the published NEP22 Determination (Section 3.3).

Recommendations:

- IHPA clarify how and when IHPA will review NEP22 and its assumptions. If it is not done within year, will IHPA undertake it as a retrospective exercise?

2.2 Plan to assess COVID-19 impacts on NEP23

NSW supports and requests visibility of all analysis undertaken on the impact of COVID-19 in 2020-21 and 2021-22 to provide an informed decision on price setting for 2023-24. While some of the COVID-19 impacts will carry over, there will also be new impacts that must be considered for NEP23.

Different strains of COVID-19 resulted in different clinical scenarios affecting activity and cost in NSW. Clinical models that emerged during the pandemic and have continued, and grown, include for example a move from inpatient rehabilitation to rehabilitation in the home (RITH) and the significant increase in virtual care.

Consultation Question:

Question 1: Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

The NSW State Budget 2022-23 introduced a number of measures which had a significant impact on workforce costs. Of significance is the workforce resilience program, COVID-19 bonuses, and clinical workforce incentives. Also, the impact of Commonwealth digital security legislation on hospital emergency departments (EDs) needs to be taken into account.

Many of these increases are permanent and NSW recommends IHPA adjust the normal NEP determination model to incorporate these additional costs using published service agreements and budget as opposed to waiting until the costing cycle catches up. A NSW adjustment may be needed to reflect this so that the collective averaging does not dilute the Commonwealth share of these changes, nor allow the model to put unnecessary pressure on other states who have not had these increases.

Changes to cost structure

The new cost structure indicates that a number of the costs related to responding to COVID-19 are now incorporated into the cost of providing all hospital services. For example, increased PPE, infection control measures, supply chain changes.

Advice from Districts and Networks regarding changes as a result of COVID-19 with an impact on cost for consideration in the development of the NEP22 and NEC22 include:

- Moving to 7-day response capability for COVID-19 and other diseases
- PHU support for outbreaks in sensitive settings
- Outbreak logistics
- Additional staffing costs to fill shifts and positions (such as use of locums + agency staff)

Casemix considerations

IHPA should also examine changes in casemix that have occurred as a result of COVID-19.

There is an increase in medical episodes of care with an increased length of stay (LOS). These episodes typically have a low NWAU, in comparison with surgical episodes, however these NWAU values will increase as the cost data flows through in following years.

It must also be noted that NWAU20 was developed prior to the advent of COVID-19. Further analysis must be undertaken to ascertain if the NWAU20 values require any adjustment or loading, particularly for COVID-19 episodes. This is important given the emergency use codes do not impact DRG assignment. The increased use of Hospital in the Home (HITH) for COVID-19 patients during 2021-22 also suggests analysis of this cohort may be required. In essence, NSW believes that an analysis is needed to establish new price weights to incorporate COVID-19 costs. IHPA currently believe activity has not changed but are using pre-COVID-19 price weights that bear no relation to COVID-19 clinical care to make that assumption.

Analysis of outsourced elective surgery should be undertaken to determine the impact of premium charges for this activity. Further, the impact of deferred care is still unfolding and as information becomes available, where required it should be incorporated in NEP23.

Other considerations

Finally, given the volatility of hospital activity as a result of COVID-19 over the last three years, the development of NEP23 should incorporate an undertaking for a mid-year review as has been provided for NEP22. The impact of COVID-19 varied between States in 2020-21 and care must be taken in assessing a national impact.

Recommendations:

- IHPA adjust the normal NEP determination model to incorporate additional costs using published service agreements and budgets as opposed to waiting until the costing cycle catches up.
- IHPA examine changes in casemix that have occurred as a result of COVID-19, including increased length of stay, adjustments or loadings for COVID-19 episodes, the impact of HiTH and virtual care, and the impact of deferred care and outsourced elective surgery.
- In recognition of significant volatility and the impact of assumptions on the model, IHPA should undertake a mid-year review for NEP23.

3. The Pricing Guidelines

NSW recommends the System Design Guidelines should be broadened to overtly cover the use of ABF to promote a sustainable primary health care model. NSW recommends IHPA undertake further jurisdictional consultation on this suggestion – under the "Fostering clinical innovation" and "Promoting value" guidelines – with the aim of improving integration across health funding models. The number of people with complex health and social needs at risk of unplanned hospitalisation is significant. Providing adequately funded services to deliver primary care, community care and non-admitted patient services is paramount to keeping people well in the community.

4. Scope of public hospital services

4.1 General List of In-Scope Public Hospital Services

In recognition of the nature and speed of innovation and service delivery in the health system, IHPA should remove the restriction of annual submissions to the General List. This will bring it into line with the proposed New Health Technology Policy submission process of assessing submissions on an ongoing basis. If this is not feasible, then a quarterly submission should be introduced.

Recommendations:

- IHPA to remove the restriction on annual submissions to the General List, to ensure the process is more agile and responsive to changes in models of care and service delivery.

5. Classifications used to describe and price public hospital services

5.1 Admitted acute care

5.1.1 AR-DRG Version 11.0

Consultation Question:

Question 2: Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?

NSW supports the use of AR-DRG V11.0 as the acute admitted classification for pricing NEP23.

NSW recommends IHPA review the impact of the 28-day age split within the intensive care related DRGs. This split appears to be artificially increasing or reducing price weights dramatically depending on the age of the patient at admission. The difference of one day can be hundreds of thousands of dollars difference in funding.

Involuntary Drug and Alcohol Treatment Program (IDAT)

NSW recommends greater differentiation and segregation between AR-DRG end classes of involuntary and voluntary consumers within MDC20 Alcohol/drug use and alcohol/drug induced organic mental disorders.

IDAT is a specialised service with the Drug and Alcohol service. While IDAT is a small proportion of the total workload of some Drug and Alcohol services, it is more resource intensive and has a distinct clinical profile. Within MDC20 there are three (3) distinct, differentiated, clinical profiles:

- Consumers treated in dedicated Drug and Alcohol units
    - IDAT / Involuntary
    - Voluntary consumers
- Consumers treated in general acute medical wards.

Consumers treated in general acute medical wards have no interaction with the Drug and Alcohol service and typically have significantly shorter lengths of stay when compared to consumers (voluntary and involuntary) treated in a dedicated Drug and Alcohol unit.

Typically, IDAT / involuntary consumer admissions have a length of stay of one to three months in duration. in comparison to the average of seven days e.g., alcohol dependence requiring withdrawal management. In addition, IDAT consumers generally have more relapses and associated readmissions and have multiple associated complications and co-morbidities requiring treatment along with their addiction withdrawal.

5.1.2. ICD-10-AM/ACHI/ACS Twelfth Edition

NSW supports using ICD-10-AM 12th Ed as the acute admitted classification for pricing NEP23.

5.1.3. ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0

NSW supports the commencement of development for ICD-10-AM 13th Ed and AR-DRG V12.0 in 2022.

5.1.4. Release of ICD-11

Consultation Question:
Question 3: Do you support IHPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation? Please provide suggestions for any specific 'readiness' projects you would like to see progressed.

NSW supports the preparation to transition to ICD-11-AM via a readiness project and a gap analysis.

NSW seeks further information from IHPA as to whether other identified pieces of work that have been delayed will continue to go ahead despite a refocus of resources, for example price harmonisation and a review of the ICU funding model.

A decision regarding adoption of ICD-11 and a date for implementation needs to be communicated as early as possible to enable preparation for this change (both for the health sector and software providers).

Other suggestions for readiness projects include:

- Robust site testing of ICD-11 to assess impacts and inform training and education required to implement
- Workforce projects to address a potential shortfall in coding workforce to transition to ICD-11
- System enhancements to capture the new classification variables and format of character codes
- Assessment of DRG grouping and funding impact

5.2 Subacute and non-acute care

5.2.1. AN-SNAP Version 5.0

Consultation Question:

Question 4: Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?

The Consultation Paper outlines IHPA's proposal to price admitted subacute and non-acute services using AN-SNAP Version 5.0 for NEP23, following one year of shadow pricing. NSW notes the Addendum to the National Health Reform Agreement 2020-25 (the Addendum) Clause A42 allows a two-year shadow pricing period, or a period agreed with the Commonwealth and a majority of States, when developing new ABF classifications or costing methodologies.

NSW seeks to review analysis of the costing impact of AN-SNAP v5.0 during the shadow period of 2022-23.

NSW also requests IHPA release an impact statement for pricing AN-SNAP v5.0.

There is not widespread clinical support for use of the FRIC, as some clinicians do not consider the FRIC clinically meaningful being a retrospective application and not assisting with prospective patient management.

NSW supports the mandatory inclusion of the Rockwood CFS and the WeeFIM™ in the NBEDS for 2023-24.

Recommendations:

NSW does not support pricing admitted subacute and non-acute services using AN-SNAP v5.0 for NEP23 at this time. Recommendations:

- IHPA to provide analysis of the costing impact of AN-SNAP v5.0 during the shadow pricing period to date.
- IHPA to provide the Statement of Impact for pricing AN-SNAP v5.0.
- Mandatory inclusion of the Rockwood CFS and the WeeFIM™ in the NBEDS for 2023-24.

5.3 Emergency care

NSW considers IHPA should review the mappings between SNOMED CT and ICD10AM codes (the ICD10AM maps to AECC) which NSW has raised during the IHPA Emergency Care Advisory Working Group (ECAWG) meetings and subsequently provided details of in 2020 and 2022. IHPA advised at the time (2020) that the mappings would be assessed post the stabilisation period. NSW is keen to work with IHPA to address the mapping issues provided to IHPA as most of NSW utilises SNOMED CT codes for diagnosis.

NSW supports in principle the collection of new variables such as investigations and telehealth, provided that IHPA makes transparent all analyses undertaken to support the refinement.

The advice to commence collection of the procedure codes needs to be provided to the ECAWG for jurisdictional engagement with adequate lead time as they are not currently routinely captured and would require significant investment in system change and change time.

5.4 Non-admitted care

5.4.1. Tier 2 Non-Admitted Services Classification

Recommendations:

- IHPA to ensure that the cost drivers of virtual care are adequately reflected in the Tier 2 classification and price weights.
- IHPA to clarify how Long COVID-19 activity will be reflected in the Tier 2 clinics.

5.4.2. A new non-admitted care classification

Development of a new, more clinically relevant non admitted care classification is strongly supported and recommended as a priority. NSW also supports recommencement of the non-admitted costing study, and welcomes the opportunity for further consultation to ensure a lower impact on clinical service delivery – including the proposal to leverage non-admitted service activity data from jurisdictional eMR systems.

Recommended areas of potential improvement in the current classification, or for future classification development raised by Districts include:

- Home visits, they are a known increased expense compared to a hospital appointment, due to staff travel time and with high-risk patients the need to have an additional clinician present. This area will continue to grow in the coming years.
- A new, separate Tier 2 class for supervised administration of Opioid Agonist Treatment to minimise the disproportionate impacts of the high-volume activity on the NAP price weights. The addition of a new code will provide a readjustment opportunity for the 40.30 and 20.52 codes, informed by existing health service data. A more granular classification will improve the costing data across all AOD NAP activity and enable a better reflection of Price Weights in accordance with the activity being delivered.
- There are a number of low volume services that are within *20.52 Addiction Medicine / 40.30 Alcohol and Other Drugs* that are not appropriately reflected by the NAP Tier 2 ABF model. These services include, and are not limited to, Substance Use in Pregnancy and Parenting Service (SUPPS), Assertive Community Management (ACM and Magistrates Early Referral into Treatment (MERIT). SUPPS and ACM in particular are low volume, intensive services that expend significant resources servicing either a single or low volume number of consumers. The workload of the MERIT programs are driven by the court referral process and is further impeded by court attendance each week. The resourcing in terms of duration is not accommodated within the current NWAU for these services.

Recommendations:

- IHPA provide clear timeframes for progressing the non admitted costing study so that jurisdictions are able to prepare for it.

5.5 Mental health care

5.5.1. Mental Health Phase of Care

NSW acknowledges the transition of the Assessment Only phase to a data item. NSW support the development of a nationally consistent suite of educational resources for clinicians to support application of phases of care.

5.5.2. Admitted mental health care

NSW has concerns that the selection of HoNOS is restricted to the age of a patient. NSW has raised this concern with IHPA and note that the Australian Mental Health Care Classification (AMHCC) data specifications allow clinicians to choose which HoNOS they consider appropriate, however the AMHCC grouper will group the episode to an unknown HoNOS if the HoNOS doesn't align with the patient's age. NSW has undertaken analysis to validate this issue and findings show that the issue is systemic and relative to all Districts across NSW. NSW requests that IHPA make adjustments to the AMHCC grouper to address this issue which will have negative funding impacts for mental health activity. NSW is happy to share the analysis undertaken.

NSW strongly recommends IHPA to consider an AMHCC admitted class for Electroconvulsive Therapy (ECT) noting the difference in cost drivers for this activity. ECT is a procedure that is performed either as a same day procedure or as part of an ongoing inpatient admission under the Mental Health Act. There are AR-DRGs for same day ECT but no equivalent class within the AMHCC if this conducted on a same day basis. The completion of a Mental Health Phase of Care and HoNOS is not clinically meaningful for each ECT session. The current AMHCC model and NWAUs does not recognise the resource intensity (e.g. theatres and anaesthetics), associated with the procedure.

NSW recommends that IHPA consider AMHCC legal status is extended to all age groups in the admitted setting. Consumers with persistent mental health disorders, who would be associated with the Intensive Extended Mental Health Phase of Care requiring intensive interventions over an extended period, are additional likely to be detained

under order of the Mental Health Review Tribunal, hence require additional supervision and resources. These consumers may not be differentiated with the Mental Health Phase of Care and Outcome Measures.

Clinicians have also identified issues with the implementation of AMHCC in that services, especially Alcohol and Other Drug, that fall outside of the Mental Health arena have all experienced a drop in LOS boundaries and weights.

Recommendations:

- IHPA make adjustments to the AMHCC grouper to address concerns that the selection of HoNOS is restricted to the age of a patient.
- IHPA introduce an AMHCC admitted class for ECT.
- IHPA extend AMHCC legal status to all age groups in the admitted setting.

5.5.3. Community mental health care

In the Consultation Paper, IHPA states, "In NEP22, a new pricing model structure was introduced based on the number of service contacts with a MHPOC" (p.18). NSW considers this is a fundamental change in the community AMHCC model, requiring the shadow time frame to restart from 1 July 2022.

NSW understands that analysis comparing the two models was undertaken by Taylor Fry however, we believe that this analysis was done in 2020 and only based on Queensland data. Given that there is significantly more community mental health data available now, we recommend that this analysis is re-done to accurately compare the two models before progressing to pricing.

Also supporting a shadow period reset, is the fact that the 2019-20 NHCDC submission included community mental health care phase data from only three jurisdictions – NSW, Victoria and Queensland. NSW suggests the cost data from additional jurisdictions is required to ensure confidence in the community AMHCC price weights.

Recommendations:

- IHPA restart the shadow pricing period for AMHCC v1.0 for community mental health care from 1 July 2022 due to the change in pricing model for NEP22 and the need to undertake comparative analysis of the two models.

Consultation Question:

Question 5: Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

NSW does not support the pricing of community mental health for NEP23 for the following reasons:

- The change in the pricing model for NEP22 from NEP21 and the need to undertake comparative analysis of the two models. NSW understands analysis was undertaken in 2020. This should be re-done now that there is significantly more community mental health data available, to accurately compare the two models.
- The immature data collection for community mental health which is compromised by the high numbers of 'unknown' end classes which cloud the true costs of treatment.
- Clinicians in NSW have raised concerns over the higher costs of unknown phases.
- In the August 2021 TAC paper, the data tables provide a comparison between national activity and cost profile and the unknown phase in Ambulatory/Community MH. Between 2018-19 and 2019-20 there was an increase from 259,320 unknown phases to 303,991 unknown phases. The deterioration in the data quality emphasises the need to extend shadow pricing for community AMHCC, whilst the issues are investigated by IHPA and the jurisdictions. This deterioration requires education resources to assist in improving the data quality. IHPA is still to produce such a package.
- Recognition by IHPA that community mental health data collection has been more problematic than the admitted data collection, in particular:

- The Impact of COVID-19 has slowed any improvements to mental health data collections at the source level due to significant disruption to the mental health workforce and the health workforce in general.
- NSW would like to see improved synergies with the AMHCC data collection against IHPA Technical Specifications and the rules under the National Outcomes Collection (NOCC) protocol. This would ensure jurisdictions are collecting data in a uniform manner that would assist improved data integrity. This age related HONOS grouping will only be further emphasised in the Ambulatory setting due to the increase in volumes of activity, unless IHPA rectifies this issue.
- The need for further education as acknowledged by IHPA during the phase of care refinement projects. At this time the educational resources in development via IHPA will not be available until the latter part of 2022. This reduces the time for clinicians to utilise these educational resources that aim to improve consistency and application of the AMHCC, prior to pricing 1 July 2023.
- Significant education and change management has taken place in NSW to prepare Districts and Networks for the transition to AMHCC admitted pricing for NEP22. This has been despite the delay in educational resources being made available by IHPA. As the focus has been on admitted AMHCC, a new focus on Ambulatory AMHCC will be required for Districts and Networks to be adequately educated and prepared.

Other barriers and additional considerations raised by Districts and Networks include:

- Mental health legal status – a number of consumers seen within the ambulatory / community setting are on "Community Treatment Orders" and / or are involuntary. These consumers require additional resources to manage that is not accounted for within the proposed ambulatory model.
- Secondary Services – there are a number of secondary services such as exercise physiology that are used as therapeutic intervention to offset the side effects of medication. These ancillary support services provide proven support to the health and wellbeing of the consumer but may not be recognised as an additional cost of providing care under the proposed model. There may be a disincentive to provide proven secondary support services or trial new ones. In addition, a number of ambulatory mental health services, such as, Pathways to Community Living (PCLI), Peer Support, Family and Carer Programs, and Housing and Accommodation Support Initiative (HASI) provide support services to other mental health services and may not directly complete an HoNOS assessment, or Mental Health Phase of Care, hence would fall outside of the proposed AMHCC funding model.
- Services with De-identified Clients - The current block funding model has enabled mental health services to innovate and develop services to meet emergent needs. The proposed AMHCC model does not fit many of the services which include de-identified client profile such as: Consultation / Liaison Services, Telephone Assistance Lines, Towards Zero Suicide, Police Ambulance, and Early Clinical Response (PACER), Getting on Track On Time (GoT It), Vulnerable Persons & Homelessness Services. Support is provided to populations where the service is unable to collect sufficient information to register the client and/or complete Health of Nations Outcome Score (HoNOS), as they are triage services (for example, the Telephone Assistance Line). Some services include a focus on providing education / health promotion activities. As these services are triage, or mental health promotion services they would not necessarily complete an age appropriate HoNOS assessment and/or a Mental Health Phase of Care for individual consumers. Consequently, the only valid Mental Health Phase of Care would be 'Assessment Only' as a number of services will have difficulty in collecting data for funding purposes.

Recommendations:

NSW does not support the pricing of community mental health for NEP23 due to the change in pricing model from NEP21 to NEP22, immature data collection and high volume of 'unknown' end classes which cloud true costs, and in recognition of problematic data collection during the shadow period.

Recommendations:

- Restart the shadow pricing period for AMHCC v1.0 for community mental health care from 1 July 2022 and undertake analysis comparing the two models before progressing to pricing.
- Legal status is recognised in the community setting for all age groups under the AMHCC.

5.6 Teaching and training

NSW supports the continued use of block funding for teaching, training and research (TTR) under NEC23, however NSW requests IHPA provide a timeline on the move to pricing given that TT data has been collected since 2014-15 (NBEDS) and the TT classification in place since 2018-19.

NSW requests clarification from IHPA on the 'research' NBEDS and whether this data is mandatory or optional for 2023-24.

NSW requests clarity on the nature of the work to be undertaken with stakeholders to improve data quality.

6. Setting the national efficient price

6.1 National pricing model

NSW seeks clarity on the statement and meaning of "IHPA will also investigate the criteria for assessing specialist paediatric hospitals" (p.20).

6.2 Adjustments to the national efficient price

NSW does not consider all the assumptions underpinning the adjustments for NEP22 appropriate or reflective of the cost of providing services for 2022-23. NSW requests an independent review be conducted of the models and calculations adopted by IHPA in determining price weights and the NEP22. As noted in Sections above, NSW is keen to understand the review process IHPA will adopt of the assumptions used in NEP22, as foreshadowed by IHPA in the NEP22 Determination and accompanying correspondence to Health Ministers.

NSW is also concerned adjustments to the NEP will not be sufficient to manage the increases published in the NSW Budget for 2022-23. The level of increased workforce which is designed to support the current workforce and includes incentive bonuses to retain staff is not designed to bring additional NWAU activity. The pandemic has highlighted flaws in the historical pricing methodology. NSW encourages IHPA to review the methodology and consider other sources of proof as to the cost model for the forthcoming year.

NSW supports IHPA's intention to investigate the adjustments outlined in Section 6.2 of the Consultation Paper. COVID-19 can no longer be a reason to not continue business as usual.

Recommendations:

- An independent review of the models and calculations to determine price weights and NEP22.
- Clarification of the review process IHPA will adopt to assess assumptions used in NEP22.
- IHPA consider other sources of proof as to the cost model for the forthcoming year to mitigate the risks of data lag, such as published service agreements and budget.

Consultation Question:

Question 6: Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?

NSW recommends an adjustment to the NEP for mental health intensive care units (MHICU). NSW has six referral MHICUs across the state and would like IHPA to recognise the additional costs associated in treating these patients. NSW is willing to work with IHPA on data analysis to better understand the activity and costs for mental health ICUs.

NSW requests that IHPA review the cohort of patients who are retained in the acute care classification for MDC 20 Alcohol and Other Drug (AoD) and continue that analysis with a review of the drug and alcohol clinics in the Tier 2 classification.

NSW has recently opened mental health parent baby units and recommend IHPA acknowledge the additional costs in treating these patients. NSW would like to understand how IHPA has priced/classified similar services in other jurisdictions and recommends national data collection and costing guidelines for this activity. The NHCDC submission will need to be updated to easily identify these patients.

NSW recommend IHPA undertake an analysis to ascertain if an adjuster is needed for facilities and Districts without Adolescent Mental Health Beds. The facilities have of necessity and with increasing frequency admitted adolescents under the age of 18 years to adult mental health units, and consequently incur significantly higher nursing and other labour costs to provide a secure environment. The cost of treating an adolescent in an adult unit is higher than the cost of treating an adolescent in an adolescent mental health unit.

Recommendations:

NSW supports the prioritisation of the following investigations to inform the development of NEP23:

- Review the specified ICU eligibility criteria and adjustment.
- Review an adjustment for MHICUs.
- Review an adjustment for patient transport in rural areas.
- Investigate the need for a genetic services adjustment.
- Review the Indigenous status adjustment.
- Investigate the need for a socioeconomic status adjustment.

Consultation Question:

Question 7: What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

As mentioned above, NSW has had significant 2022-23 budget increases that were announced after NEP22 was published and that therefore require an adjustment for NSW for NEP22 and NEP23. These are outlined in the NSW published Service Agreements and NSW LHD/LHNs published Budgets and include:

- Workforce costs. Of significance is the workforce resilience program, COVID-19 bonuses, and clinical workforce incentives.
- Additionally, the impact of Commonwealth digital security legislation on hospital EDs needs to also be considered.

The recent Fair Work Commission decision regarding a 5.2 per cent increase in the minimum wage is also anticipated to contribute to ongoing wage rise pressures.

Furthermore, CPI/escalation is higher than what IHPA estimated for 2022-23 and requires adjustment in the NEP22 and NEP23 model.

IHPA should also consider undertaking analysis of the impact of the Strategic Agreements between the Commonwealth and Generic and Biosimilar Medicines Association (GBMA) and Medicine Australia on pharmaceutical costs in public hospitals.

6.3 Harmonising price weights across care settings

NSW supports price harmonisation across care settings as it aligns with the NSW strategic direction to avoid hospital admissions where possible. NSW recommends IHPA consider the impacts of COVID-19 while undertaking analysis and include clinical consultation for services considered for harmonisation.

6.4 Unqualified newborns

NSW strongly supports IHPA's consideration of unqualified newborns in the development of NEP23 following concerns raised by clinicians on this issue. NSW recommends robust data analysis (that takes into account COVID-19 impacts) to assess and further investigate pricing unqualified newborns. NSW requests broad specialist consultation.

NSW acknowledges legislative changes are considered out of scope, however, this should not preclude a new pricing arrangement for unqualified newborns.

NSW advised IHPA that there is strong clinician engagement and willingness to participate in this piece of work.

6.5 Setting the national efficient price for private patients in public hospitals

6.5.1. Phasing out the private patient correction factor

NSW does not support phasing out the private patient correction factor for NEP23. NSW is working towards compliance with Australian Hospital Patient Costing Standards Business Rules Version 4.1 "1.1A_2 1.1A Medical expenses for private and public patients."

6.6 Organ donation, retrieval and transplantation

NSW looks forward to the release of the National Strategy for Organ Donation, Retrieval and Transplantation for consultation in 2022. NSW notes that national minimum dataset requirements to accurately reflect the journey of patients who become donors once Brain or Circulatory death still needs to be undertaken and that this work needs to be progressed prior to any costing study, refinement of classification or pricing model development to ensure the required activity information is available.

NSW suggests IHPA undertake as a high priority the larger non-admitted patient (NAP) costing study and classification development over any ODRT study, noting that pre and post transplantation services care could be incorporated in the larger NAP costing study. This will ensure that all the clinical work undertaken by these teams is adequately understood and allocated costs, as opposed to a portion of their clinical load which may risk an over or under cost allocation.

In the interim, the NHCDC Advisory Committee should document the current organ donor, retrieval and transplant costing process in each jurisdiction. This information can then be used to inform refinement of the AHPCS which will in turn facilitate a costing study when the posthumous organ procurement national best endeavours data set (POP NBEDS) is implemented.

Consultation Question:
Question 8: Which initiatives to refine the national pricing model should IHPA prioritise investigating?

In addition to the adjustments noted under Section 6.2 and Question 6, NSW recommends prioritising the following and requests inclusion in IHPA's work plan:

- Review the assumptions made in developing NEP22 to determine if an in-year review is needed. Review the cost normalisation impact in more detail.
- Refine the approach for private patient neutrality
- With jurisdictions, determine the feasibility of methodology changes for unqualified newborns
- Clinical consultation to investigate opportunities for price harmonisation across settings, with consideration of the impacts of COVID-19 in undertaking analysis.

Consultation Question:
Question 9: What additional data sources are available to support refinement of the national pricing model in relation to adjustments, price harmonisation, unqualified newborns, private patients or organ donation?

As mentioned above, in addition to the National Hospital Cost Data Collection (NHCDC), that IHPA should consider other supporting documentation such as State budgets and LHN Service Agreements. This would also align with IHPA's Pricing Guidelines of transparency and evidence based.

7. Setting the national efficient cost

7.2 The 'fixed-plus-variable' model

Consultation Question:

Question 10: What cost pressures for regional or remote hospitals should be considered in the development of NEC23?

NSW recommends IHPA consider the following cost pressures for rural or remote hospitals:

- Recruitment and retention costs and incentive payments
- Locum medical practitioners
- Accommodation for staff particularly locums
- Fly-in fly-out arrangements
- Rural specific award conditions
- Patient transport
- Fixed contract costs (e.g., imaging provider).

7.2.1. Standalone hospitals providing specialist mental health services

Consultation Question:

Question 12: What should IHPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?

NSW has three stand-alone specialised mental health services that are currently block funded. The activity in these facilities is a mixture of acute and non-acute, with long lengths of stay. NSW recommends IHPA defer its decision to transition these facilities to ABF until a reasonable assessment can be made under the new AMHCC and endorsed by jurisdictions.

This includes consideration of:

- Ageing infrastructure –increased maintenance costs for core services and infrastructure due to diverse campus footprints and typically ageing infrastructure.
- Mental health legal status – a higher proportion of consumers are involuntary, i.e., admitted for specialised mental health care under various legislation and/or are forensic consumers.
- Unit type – units and age groups located within standalone facilities vary, i.e., rehabilitation, extended care.
- Wellbeing and rehabilitation programs – consumers in standalone facilities tend to have significantly longer lengths of stay. Associated with the extended lengths of stay is numerous Wellbeing and Rehabilitation programs that are provided to facilitate recovery and the transition into the community. These types of services are not typically provided in acute settings, particularly for the duration necessary in standalone hospitals providing specialist mental health services.
- Staffing requirements – standalone facilities are unable to leverage the economies of scale utilised by their co-located counterparts, with minimum staff operating levels always required.

Recommendations:

- NSW recommends that IHPA defer its decision until a reasonable assessment can be made under the new AMHCC and endorsed by jurisdictions.

7.3 Quality assurance of public health expenditure data

Consultation Question:
Question 11: What specific areas of the Local Hospital Networks and Public Hospital Establishments National Minimum Data Set would you recommend IHPA focus on when developing its independent quality assurance process?

NSW considers it inappropriate for jurisdictions to submit data quality assurance reports to IHPA for data submitted to other agencies and for different requirements. NSW encourages IHPA to work closely with the Australian Institute of Health and Welfare (AIHW) to resolve data definition variations and data specification requirements. Once this has been completed, AIHW can update its requirements for jurisdiction submissions

7.4 New high cost, highly specialised therapies

NSW acknowledges the timeframes for reconciliation in the Addendum. However, NSW disagrees with the requirement to provide a NHCDC study for high cost, highly specialised therapies (HST) patients months ahead of the overall NHCDC and at the same time as the quarter 4 activity. This will result in standard costing from previous periods allocated to the patient, will not enable appropriate payment of actual patients in that time period and will not account for the outlier patients specifically. Furthermore, the requirement to essentially collect the HST costs twice is inconsistent with the Addendum principle of collecting data once (B67d).

8. Future funding models

8.2 Investigation of alternate funding models

NSW notes that IHPA will continue to work with stakeholders and jurisdictions to investigate options for further developing and implementing alternate funding models.

NSW has provided feedback to IHPA on the draft funding methodology in 2021 and reiterates the position that states and territories should be able to trial other innovative models which may not fit these parameters. There needs to be more flexibility for novel ideas that states and territories can trial, or clear recognition that there is the option to incorporate these into the methodology in future in an agile and responsive way.

Exploration of additional funding models beyond bundled and capitation payments is needed to give providers flexibility to determine the care intervention and care setting to meet the outcomes that matter most to patients. Funding models need to consider the options for collaboration with other parts of the health system, including primary care.

NSW supports the investigation of different payment models that support paying for value and patient outcomes and strongly recommends IHPA work closely with jurisdictions on this investigation.

8.3 Trialling innovative models of care

In the Consultation Paper, IHPA notes the preference 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. NSW supports this, noting the Addendum allows states and territories to trial these innovative models of care under a bilateral agreement with the Commonwealth.

The Consultation Paper also states IHPA is investigating innovative models of care and services related to virtual care, with an initial focus on telehealth video consultations delivered by EDs. The inclusion of telehealth video consultations delivered by EDs on the General List for 2022-23 is supported, and NSW recommends IHPA review the use of virtual care in all settings. NSW supports and welcomes further consultation on this work.

The Consultation Paper refers to the example of telehealth consultation by emergency departments to support urgent care centres. With three Urgent Care Centres in NSW currently (that are part of NSW Local Health Districts, not Primary Care) and the potential for more, NSW is very interested in this work.

Telehealth models also exist for ED to specialty and admitted patient to specialty. For example, ED physicians in rural hospitals consult a designated neurology service to provide appropriate and timely clinical interventions for

stroke patients, monitors over bassinets in Broken Hill Hospital enable specialist clinicians in Sydney Children's Hospital Network to review babies and transfer patients where clinically indicated.

NSW acknowledges IHPA's intention to consult and engage with jurisdictions on this through the Reform Implementation Group, and we note the importance of ensuring the work of IHPA is aligned with the reform priorities of jurisdictions in this space.

Consultation Question:
Question 13: How is virtual care delivery captured in information systems and data collections?

Currently NSW captures audio and audio-visual modalities for non-admitted patient services within the non-admitted data collection. It is anticipated that NSW Health will have the capability to measure admitted and ED virtual activity in future. Consideration needs to be given to the minimise any potential burden of data collection across and within settings (non-admitted, admitted and ED) in line with the pricing guideline of administrative ease, as well as any limitations across systems and locations.

Consultation Question:
Question 14: IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?

NSW is supportive of the introduction of ED telehealth video consultations (TVC). The growth of TVC has been substantial during COVID-19 and has proven beneficial and cost effective for both clinicians and patients.

Across NSW there are a number of emergency services that utilise virtual care for:

- Video consultations to emergency department (ED) patients
- Medical management of acute inpatients
- Virtual ward rounds for inpatients
- Clinical support for residential aged care (RAC) residents in rural MPSs where the local general practitioner (GP) is not available
- Specialist Emergency Physician (FACEM) management provided to emergency care centres

Telephone and video consultations are already widely used across many settings in NSW. Reducing patient presentations and management of care at home or in the community, hospital in the home and remote monitoring are areas of focus. Further comment is provided under Question 15.

Consultation Question:
Question 15: What changes, if any, to the national pricing model should IHPA consider to account for innovative models of care and services related to virtual care?

As technology evolves, it will enable care to occur asynchronously (not in real time) for example a clinician may review a picture of a patient's wound well after it has been sent by the patient and provide management advice. IHPA need to consider how to keep the funding model evolving as fast as the technology to support virtual care evolving and being adopted.

Remote patient monitoring is also rapidly becoming a feature of care delivered in NSW Health services. NSW is developing a statewide approach for remote monitoring. This will mean services across NSW Health will be using remote patient management for a wide range of disease cohort such as diabetics with cardiovascular conditions. IHPA should consult with jurisdictions, via the NHCDC Advisory Committee, to expand the Australian costing standards to incorporate consistent advice on remote monitoring costing.

Remote monitoring activity is not accurately identified, costed at the patient level, and priced to include the digital costs of service delivery. As the patient is generally not present, under current counting methodologies these activities do not generate NWAU. However, staff are spending considerable time reviewing patient results and interpreting these in the medical record. Remote monitoring improves patients care through more frequent monitoring and detection of issues earlier in patients, particularly with chronic diseases. The number of remote monitoring consults can range from one to four consults, can be resource intensive and may happen on the same day, depending on patient needs.

An important consideration is to define time or episode boundaries for remote monitoring, such as episode start and end date. Therefore, the entire episode could be costed and priced determined for an agreed amount of time.

NSW recommends the investigation of enrolled patients on remote monitoring models of care to be monthly care bundled. This means remote monitoring activity is bundled and counted as one non-admitted patient service event per patient per calendar month regardless of the number of occasions of service delivered, known as temporal care bundling. A period of shadow pricing is necessary before the care is price determined.

Service delivery for virtual care hospitals also needs consideration.

Further information on these services can be provided to IHPA.

9. Pring and funding for safety and quality

9.3 Hospital acquired complications

Districts and Networks have raised concern with using condition onset flag (COF) to determine HACs. ICD-10 codes were not intended to be used for HAC identification and it seems that the ACS and HAC classification often mismatch. This leads to frustration of staff who are monitoring and reviewing to improve quality of care and coded data quality. NSW recommends more clarification or explanation to ensure that the COF captures “true” HACs.

9.4 Avoidable hospital readmissions

Noted.

9.5 Evaluation of safety and quality reforms

Noted.

9.6 Avoidable and preventable hospitalisations

Noted.