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Ms Joanne Fitzgerald
Acting Chief Executive Officer
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Dear Ms Fitzgerald

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

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

In order to provide representative feedback on the Framework, the Department of Health Tasmania has consulted broadly with all areas of the department and the Tasmanian Health Service.

Tasmania's feedback is provided in Attachment A

Should you require any further information, please contact Mr Laurie Kinne, Manager – Funding and Pricing, Strategic Purchasing and Funding, on 6166 1088 or by email at laurie.kinne@health.tas.gov.au

Yours sincerely

Dr Sonj Hall
Deputy Secretary
Policy, Purchasing, Performance & Reform

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Appendix A: Consultation questions

Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts?

Tasmania is unsure that our system is "back" to normal or what the new normal is with the constant distortions created to the system by:

- high levels of staffing absences.
- surveillance screening pre-emergency attendance, outpatients, theatre and its effect on staff movement and patient flow within the system and system costs.
- issues with recruitment as protocols for overseas medical practitioners have affected the filling of positions.
- suppression of private patient revenue from privately referred non-inpatients, and its effect on gross expenditure.
- unknown demand but substantial costs of deferred care.
- cost associated with National Partnership on Covid-19 response, Public Health Payments which include PPE, infection control, and cleaning which are currently excluded from the costings.

It would seem appropriate for analysis of the 2021-22 activity and National Hospital Cost Data Collection (NHCDC) data by the Independent Hospital Pricing Authority (IHPA), to develop and understand at a jurisdictional level:

- changes in service provision, profiles, and product end classes.
- jurisdictional initiatives to offset the impacts of Covid-19 in elective surgery or planned procedures such as. gastroscopes or endoscopes. For example, prioritising higher urgency categories, different purchasing behaviours from the private sector or scheduling of elective surgery at night or after-hours to shorten waiting times and reduce overcrowding of daytime.

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

Tasmania supports the introduction of AR-DRG Version 11.0 for NEP23 without a 2-year shadowing funding period.

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.

The change from ICD-10 to ICD-11 is significant, and Tasmania does not believe there has been enough preparation for its implementation. As such Tasmania does not support the introduction of ICD-11 in NEP23. Tasmania has concerns and would need assurances that:

- patient administration and management systems and other management software products would be able to accommodate the changes.
- coding and analytical workforces' education training requirements would not be burdensome and expensive for smaller jurisdictions such as Tasmania.

- the implementation of ICD-11 would not create a reduction in productivity of the already strained coding workforce.

Tasmania will work though the IHPA International Classification of Diseases (ICD) Technical Group (ITG) and other committees to increase Tasmania's preparedness and understanding of the operational requirements for implementation.

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

Tasmania supports the changes to the classification system with:

- the introduction of the Frailty Related Index of Comorbidities into Geriatric Evaluation and Management and Maintenance episodes of care.
- the inclusion of the new impairment group for Joint replacement in the rehabilitation branch. and
- some existing variables in the classification have been reordered or expanded, including the use of the Health of the Nation Outcome Scales 65+. In relation to the introduction of the Frailty scale, Tasmania is currently not collecting the item and work needs to be progressed to assess the ability to do so within the current ICT infrastructure capability.

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

Tasmania does not support the pricing of non-admitted mental health care for NEP23.

The costing of mental health services outside of the admitted patient component is still relatively immature and although all jurisdictions, submitted mental health care activity data for the community setting, Tasmania remains uncertain of the robust nature of the AMHCC pricing model and would request that the shadow pricing model continue for 2023-24.

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

1. Tasmania is supportive of IHPA reviewing the eligibility criteria for Intensive Care Units (ICU), as the current threshold means that smaller health services which currently deliver ICU services are not recognised and may not be adequately funded to cover the associated higher costs than the average system wide AR-DRG classifications.

   The inherent pricing signal in the National ABF is that smaller health services which provide ICU capacity should not be separately recognised, although there is a clear clinical and population needs-based rationale for doing so.

   Tasmania believes service capability and requirements are ever more important factors for consideration for ICU loading eligibility. Smaller hospitals incur significant costs to deliver ICU capability when delivering services below the thresholds currently outlined in IHPA's criteria.

Tasmania recommends IHPA review whether the existing funding model adjustments should be updated to a two-tier ICU adjustment to reflect contemporary clinical practices and models of care, that require smaller hospitals to provide ICU services.

2. Tasmania is strongly supportive of IHPA reviewing the development of a weighting for hospitals that provide state-wide Specialist Services.
3. The COVID-19 pandemic has caused a shift in the service delivery model. As such, Tasmania supports IHPA in considering adjustments for telehealth and other expanding and emerging technologies.

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?

The Superannuation Guarantee is set to rise to 11% on 1 July 2023 for the 2023–24 financial year. The NHCDC and Public hospital establishment superannuation data needs to be indexed to account for this increase.

Which initiatives to refine the national pricing model should IHPA prioritise?

Tasmania is generally supportive of the direction of the national pricing framework development and has used its response to provide input into how to further mature aspects of the national pricing model.

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?

1. Tasmania is generally supportive of the proposed harmonisation, as the cost of care and resources for the same product / administration route are the same across admitted and non-admitted settings.

   Tasmania strongly supports the continued review of haemodialysis and chemotherapy, where activity can be provided in both outpatient and inpatient service settings. However, outside of these areas, due to the current differences in practices across states and territories, Tasmania has concerns of unintended consequences if changes are introduced without detailed consultation and planning across system planners and health services. Any introduction should also consider the impacts it may have on the development of future models of care.

2. Tasmania would like to see changes that allow IHPA to price newborn care where clinical care is provided on postnatal wards with their mothers rather than within the Special Care nursery. The funding model should not discourage the mother and baby dyad remaining together where possible. Tasmania does not believe the current methodology, where the cost of care is allocated to the mothers' AR-DRG adequately funds the care within our public hospital maternity centres when clinical care is provided on postnatal wards with their mothers rather than in a nursery.
3. Tasmania remains committed to the principle of private patient neutrality, as outlined in the Addendum Clause A13. Tasmania is concerned that the current methodology, with the used of Hospital Casemix Protocol (HCP) changes information, fails to recognise that expenses for private patients are subject to the availability of expenditure data not often held by the clinical costing units and, as a result, the units are unable to identify actual

expenditure or payments made for private patients in hospital billing systems - especially for directly contracted services or medical practitioners that are exercising their right of private practice and do not bill through hospital systems. Tasmania supports the continued use of the private patient correction factor for NEP23.

4. Tasmania is generally supportive of a refinement of the national pricing model to include a pricing mechanism for organ donation, retrieval, and transplantation. Tasmania currently does not perform organ transplantation services but requests that IHPA develop a separate pricing mechanism for this service. Because of the fixed nature of the Tasmanian organ donation and retrieval service, Tasmania would also recommend the development of the Fixed a variable funding model for organ donation and retrieval.

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

1. The Superannuation Guarantee increases to 11% on 1 July 2023 for the 2023–24 financial year.
2. The impact on activity and cost pressures introduced by continued:
    a. high levels of staffing absences.
    b. issues with recruitment, as protocols for oversees medical practitioners impacted on the filling of positions.
3. The costs of PPE, cleaning and security, claimed through the public health component of the NPA, that may be held centrally and have not been captured in the NHCDC and Local Hospital Networks/Public hospital establishments National Minimum data Sets, will need to be identified and included at the rural facility.

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?

Tasmania has no feedback at this stage.

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

Tasmania does not support transitioning standalone hospitals providing specialist mental health services to AMHCC Version 1.0 for 2023.

Tasmania believes there are significant issues regarding stand-alone, block funded facilities versus acute facilities, with vastly different patient profiles and length of stay, not accounted for in the classification. Tasmania is concerned that these facilities in particular, the nature of the patient-care, length of stay, and treatment type is highly specialised, resource intensive care, including high security for those patients subject to Forensic Orders. Accordingly, these services would not be suitable for setting an average efficient price based on other mental health services, and therefore do not lend themselves to an ABF environment.

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?

The Tasmanian COVID@homeplus service assesses, monitors, and supports eligible people to safely recover from illness such as COVID-19 or other respiratory illnesses such as Influenza (flu) or flu-like illness, at home.

Patients are provided a Kit which enables the virtual monitoring of oxygen levels, heart rate and temperature. Data is collected and submitted daily using smartphones and, where anomalies are detected, the COVID@homeplus clinic team will contact the patient and update the care plan as required.

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?

Tasmania recommends that IHPA reviews pricing for virtual care (including evolving models of care such as email, telephone and video modalities) to ensure it reflects the resources required to effectively deliver care in this form.

IHPA should review whether it is appropriate to maintain provider centric pricing for recipient-end telehealth or move to specialty specific pricing for all telehealth services.

Analysis also needs to be conducted to review the patient service event—service delivery mode services, to understand any variation in delivery cost. For example, under the National model, telephone consultations are considered equivalent to face to face consultations, however, telephone consultations have the potential for lower non-labour costs than face to face consultations and therefore increasing use of this delivery mode may dilute the price of face to face consultations.