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Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25

Dear Professor Pervan

Thank you for the opportunity to comment on the Independent Health and Aged Care Pricing Authority's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25* (the Consultation Paper). NSW appreciates the significant work that goes into the consultation paper and framework and welcomes the opportunity to engage collaboratively with the agency in these important matters.

Key commentary raised in the NSW submission relates to the review of the national efficient price (NEP) and national efficient cost (NEC) indexation methodologies and phasing out of the private patient correction factor.

Concerns are further raised over the Pricing Authority's proposal to price community mental health activity with the Australian Mental Health Classification Version 1.0 and subacute and non-acute care with the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 for the NEP 2024–25 (NEP24).

NSW does not support pricing of ambulatory mental health for 2024–25 and does not support phasing out the private patient correction factor for NEP24.

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

Deb Willcox AM
Deputy Secretary, Health System Strategy and Patient Experience
13 July 2023

Encl. NSW Health submission to the IHACPA *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25*

Independent Health and Aged Care Pricing Authority

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25

NSW Health Response

NSW Health's responses below are made with reference to the relevant sections of the Independent Health and Pricing Authority's (the IHACPA's) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 20254–25* (Consultation Paper).

1. Introduction

NSW notes previous consultation papers on the Pricing Framework for Australian Public Hospital Services included a chapter on 'Scope of public hospital services'. Consultation with all states and territories is essential should there be any change to the definition of in-scope public hospital services.

Recommendations:

- NSW requests clarification on the rationale for removal of the section 'Scope of public hospital services'.

2. Pricing Guidelines

2.1 The Pricing Guidelines

Process Guidelines:

Regarding the 'Evidence-based' Process Guideline: NSW is concerned "nationally applicable and consistently reported" may limit or inhibit the implementation of innovative approaches in the future.

Recommendations:

- NSW recommends the 'Evidence-based' Process Guideline be reworded to 'Funding should be based on the best available information, that as a general principle is both nationally applicable and consistently reported.' This amendment would allow for exceptions for inclusion of innovative trials and General List services.

3. Classifications used to describe and price public hospital services

3.1 Admitted acute care

NSW acknowledges the proposed work program for the Thirteenth Edition of the International Statistical Classification of Diseases and Related Health Problems (ICD), Tenth Revision, Australian Modification Classification (ICD-10-AM), the Australian Classification of Health Interventions and the Australian Coding Standards, the Australian Refined Diagnosis Related Group (AR-DRG) Version 12.0 and ICD-11. NSW will continue to monitor, review, and respond as required.

Recommendations:

- NSW would welcome review by the IHACPA of care types, including virtual care, primary care embedded models and technology assisted care.
- NSW recommends the ICD-10-AM Thirteenth Edition include a code for vaping. There are an increasing number of presentations related to the harmful use of vaping. Currently the Emergency Care Principal Diagnosis Short List (EPD Short List), which is based off ICD-10-AM, does not include a code that allows for easy and retrievable data to capture this activity.
- NSW recommends the admitted acute care classifications incorporate consultation liaison for all clinical specialties. This inclusion will enable a more accurate capture of activity, cost and price. For example,

supportive and palliative care clinicians provide consultation liaison for a range of acute admitted patients admitted under other specialties such as oncology, renal, respiratory, cardiology and neurology.

3.2 Subacute and non-acute care

3.2.1. AN-SNAP Version 5.0

NSW supports the inclusion of frailty as a cost driver and marks progress towards recognising factors that contribute to patient-level variability in cost of care.

Recommendations:

To assist with the implementation of AN-SNAP Version 5.0, NSW recommends

- The IHACPA circulate further information on how frailty would be measured and recorded, to assist with activity reporting.
- The IHACPA consider aligning AROC Paediatric impairment codes with Synaptix impairment codes to streamline rehab data collection. The alignment would establish a unified set of impairment codes for comprehensive use and simplify the data collection process, promoting consistency in capturing impairment information. Additionally, enhancements should be made to data collections and reporting for In-Reach rehab services to effectively inform and track rehab key inputs utilized in the treatment.

Consultation Question:

Question 1: Are there any significant barriers to pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for NEP24?

NSW notes a justification for pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for the National Efficient Price Determination (NEP) 2024–25 (NEP24) has not been presented to jurisdictions to enable the identification of issues or barriers. NSW recommends the results of the IHACPA's analysis is circulated and discussed with jurisdictions prior to the decision to implement AN-SNAP Version 5.0 is finalised.

3.3 Emergency care

NSW supports the refinement of the Australian Emergency Care Classification (AECC) and the EPD Short List.

NSW advises the AECC has been incorporated for emergency services.

Recommendations:

- NSW requests the IHACPA share analysis undertaken to refine the AECC and provides adequate lead time for jurisdictions to respond and implement changes.

Consultation Question:

Question 2: Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?

The AECC could be improved by inclusion of codes for pain management:

- E5010 *Pain syndrome* category includes only one ICD-10-AM code, R52.9 *Pain, not referable to a site*.
- The IHACPA should consider including additional ICD-10-AM codes for pain management, such as G58.9 which includes *Chronic Regional Pain Syndrome* and *Mononeuropathy*.

- NSW is happy to work with the IHACPA on this, and suggests there would be benefit in a discussion with Prof. Paul Wrigley, Pain Management Consultant, Royal North Shore Hospital, to better identify a chronic pain cohort applicable for new ICD-10-AM pain management codes.

NSW also recommends the IHACPA undertake a review of clinical information and assignment of AECC diagnoses to identify conditions that are being seen in emergency departments but not adequately captured within the current classification list. Further, emergency departments treat a significant number of homeless and vulnerable patients. These patients are more likely to represent and require additional services, and may have comorbidities that require treatment for both their mental and physical well-being.

Consultation Question:
Question 3: What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition?

Undertaking COVID-19 precautionary measures has introduced longer consultation timeframes when processing emergency department presentations due to risk mitigation strategies. NSW queries if the additional time during these consultations are accounted for in current AECC end classes.

3.4 Non-admitted care

NSW supports the new classes introduced in the Tier 2 Non-Admitted Services Classification (Tier 2) Version 8.0.

NSW queries how Tier 2 accurately accounts and captures for multi-disciplinary case conferencing.

Consultation Question:
Question 4: Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25?

NSW supports the refinement of the Tier 2 classification and the development of new Tier 2 classes related to opioid service delivery and home-based infusion therapies related to subcutaneous immunoglobulin.

Alcohol and other drugs

NSW provides the highest number of public Alcohol and Other Drugs (AOD) services in Australia. Of around 1,300 publicly funded agencies providing services for clients seeking AOD treatment in Australia, 475 are in NSW. Accordingly, the NSW Health Centre for Alcohol and Other Drugs (CAOD) is well placed to comment on the predicted and realised consequences of classifications and price weights on activity base funding (ABF) funding within the AOD sector. CAOD notes that the introduction of electronic clinical information systems in community health and outpatient services in NSW from 2015 to 2017 significantly improved the volume and quality of patient level non-admitted patient activity data. The corresponding sharp increase in reported AOD activity due to increased reporting capability from 2018 onwards has led to a downward unit price adjustment by the IHACPA based on an assumption of improved efficiency, and downstream service consequences. As a result of the drop in price weights, AOD non-admitted patient activity targets have been reduced across NSW.

NSW welcomes the proposed refinements for Tier 2 for 2024–25, to capture activity for supervised administration of opioid agonist treatment to minimise the disproportionate impact on the price weights for the existing Tier 2 classes 20.52 *Addiction medicine* and 40.30 *Alcohol and other drugs*. NSW would be happy to work with IHACPA to examine the feasibility of developing a proof of concept and leveraging non-admitted service activity data from eMR systems.

NSW further supports the addition of a new code to provide a readjustment opportunity for 20.52 *Addiction medicine*, informed by existing health service data, and a more granular classification to both improve costing data across all AOD non-admitted patient activity and enable a better reflection of price weights in accordance with the activity being delivered.

The CAOD recommends work is recommenced on a national costing study to further progress revision of, and/or the development of a new non-admitted care classification(s). In addition to looking at accurate capture of costs of low

volume, resource intensive services such as addiction medicine and alcohol and drug use intensive services, the scope should include high volume low intensity activity (as described above).

Remote patient monitoring

Remote patient monitoring (RPM) is a service contact mode used to digitally monitor biometric information to symptom manage chronic care clients. Biometric information monitoring through RPM ensures chronic disease management intervention is timely to avoid the exacerbation of disease symptoms, presentation to the emergency department, or ensure post-acute care management is appropriately delivered for when a client transitions safely into the community. NSW have implemented remote patient monitoring services to prevent acute hospital admissions.

To count remote patient monitoring, NSW recommends the IHACPA investigate and develop a mechanism to improve the counting, reporting and pricing of RPM. This is inclusive of investigating the option of temporal bundling to encompass RPM where the attributes of the service are low level interactions with clinicians alongside a periodic chronic disease management plan. This work should be added to the workplan of NACAWG.

Virtual care

NSW will continue to work with the IHACPA on appropriate approaches for virtual care. NSW reiterates the importance of accurately capturing the costs of virtual care activity by clearly outlining the counting, classification and pricing rules associated with this activity.

Additional considerations

Recommended areas of potential improvement for consideration in Tier 2 raised by Districts include:

- Additional clinics to provide a delineation in the AOD services provided to improve the differentiation related to the complexity of clients seen.
- Capture patient complexity within Tier 2.
- Consideration of the impact of social vulnerabilities.
- Inclusion of additional factors such as accommodation status, for instance no fixed address / homeless; and indigenous status to incorporate the complexity of case managing these clients.
- Integration of services and consideration of the cost to provide in-reach from community services to inpatient facilities where there is no incentive to do so as the facility generating the NWAU is not the facility providing the in-reach.
- increasing the need for multi-agency case management in community settings where case conferencing takes additional time, planning, and coordination to deal with complex social situations and vulnerabilities and requires multi agency partnerships in order to keep patients safe at home.
- Violence and neglect Tier 2 clinics are at a granular level to identify sexual assault services, child protection and domestic violence responses.
- The addition of a '20' clinic added for forensic examinations and medical wellbeing examinations to reflect the time and cost required for this service.
- Consideration of appropriate funding mechanisms for Primary Health Clinics of 40.08 and 40.11, as they do not fit into current NWAU funding.

Recommendations:

- Work is recommenced on a national costing study.
- The IHACPA investigate and develop a mechanism to improve the counting, reporting and pricing of RPM

3.5 Mental health care

3.5.1. Admitted mental health care

NSW is concerned the delayed implementation of Australia Mental Health Care Classification (AMHCC) Version 1.1 will frustrate clinicians and further lose momentum with the engagement of clinicians with this classification.

NSW welcomes the proposal to allow phases with up to two missing Health of the Nation Outcome Scales (HoNOS) item scores to attract a valid complexity score and a high or moderate HoNOS complexity grouping.

The addition of a same day mental health class will allow a split for same day electroconvulsive therapy (ECT) from other same day models of care due to different cost drivers.

Recommendations:

- The IHACPA prioritise the missing HoNOS items and removal of the age-related grouping to align with the National Outcomes and Casemix Collection protocol for AMHCC Version 1.1.
- The IHACPA remove the requirement for HoNOS for any same day activity to reduce the administrative burden.
- The IHACPA implement a same day mental health class.
- The IHACPA implement a same day ECT AMHCC class.

5.5.2. Community mental health care

Consultation Question:

Question 5: Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?

NSW has undertaken a considerable effort to improve the quality of data prior to transition to ABF, however considers the national data on which it will be based on to be significantly immature.

Considerations for ambulatory mental health that indicate the data are not yet fit for purpose for pricing for 2024–25 include:

- Data linkage is problematic. The IHACPA has acknowledged the need to include additional linking fields and NSW has requested these through the Mental Health Working Group. Additional fields as agreed by the IHACPA in Technical Advisory Committee papers will improve data linkage, data quality and grouping. Reconciliation of the AMHCC data will be difficult until this work is undertaken.
- Recent IHACPA requests to complete a 'workbook' to assess the composition of ambulatory mental health activity and funding have proved to be problematic, with both definition and data quality issues.
- The appropriateness of using the general ABF criteria for establishments that have only one stream, for instance specialist mental health services, generally mostly only the ambulatory component of that stream.

Until clarity around counting can be established (see recommendations), NSW does not support pricing of ambulatory mental health for 2024–25.

Recommendations:

- The IHACPA clarify work in progress and phases that extend across financial years.
- The IHACPA clarify how activity is linked to phases where a patient is seen by multiple teams at the same time.
- The admitted AMHCC must be refined to ensure it is fit for purpose before transitioning ambulatory mental health to ABF. Urgent refinement to the AMHCC is required, such as recognition of a same day class with

or without ECT and the IHACPA's proposal to allow up to two missing HoNOS scores and remove the age-related grouping.

- The IHACPA provide advice on how secondary services will transition to AMHCC. These secondary support services provide therapeutic interventions that impact the health and wellbeing of the consumers, for example Towards Zero suicide and mental health hotline services. These services either do not have the ability to record patient level data or, complete outcome assessments that will group activity to unknown phase/ unknown end classes.
- The IHACPA clarify transition arrangements when current analysis shows some jurisdictions and/or Districts would be significantly underfunded if non-admitted mental block funding were moved to Ambulatory AMHCC funding.

Consultation Question:

Question 6: Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

NSW recommends the IHACPA develop more detailed guidelines and business rules within the *Activity based funding: Mental health care national best endeavours data set – Technical Specifications* to include common examples and scenarios for ambulatory AMHCC. The current guidelines and technical specifications do not reflect the complexity of ambulatory mental health and the myriad of support teams that are involved in patient care. As a result, there is inconsistency and confusion across the state in the way activity is captured.

To ensure the IHACPA has sufficient details on the issues and develop practical examples, NSW also recommends the IHACPA hold a workshop in 2023 with jurisdictions.

Other measures raised by District and Networks include:

- Ensuring a price weight remains assigned to unknown end classes.
- Consideration of including additional factors such as accommodation status, for instance no fixed address / homeless; and indigenous status, co-morbidities to incorporate the complexity of case managing consumers.

3.6 Teaching and training

NSW supports the continued use of block funding for teaching, training and research (TTR) under NEC24, however NSW requests the IHACPA provide clarification on the move to pricing given that TTR data has been collected since 2014–15 (NBEDS) and the TTR classification in place since 2018–19.

4. Setting the national efficient price

4.1 Impact of COVID-19

4.1.1 Impact of COVID-19 on NEP23

NSW notes the increased costs arising from the COVID-19 response associated with infection control and supply chain changes are now incorporated as business as usual in the cost of providing all hospital services.

4.1.4 Review of the COVID-19 Response — Costing and Pricing Guidelines

NSW notes the *COVID-19 Response - Costing and Pricing Guidelines* were published in 2020, however recommends the IHACPA update the guidelines to remove any inaccuracies.

Consultation Question:

Question 7: How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?

Models of care that emerged and/or expanded during the COVID-19 pandemic include, for instance, virtual care, rehabilitation in the home, hospital in the home and hospital avoidance services. Therefore, NSW recommends the IHACPA ensure the funding model is agile and flexible to appropriately classify and fund new models of care including hospital avoidance services where these services are now undertaken by clinical, non-clinical and peer workers. This combination of care significantly reduces the amount of hospitalisation and emergency department attendances. If non-clinical and peer workers are excluded from the funding model, NSW advises a significant increase in hospital presentations would likely occur.

Other impacts raised by District and Networks include:

- Additional loading to non-admitted patient services for pre-appointment screening of clients and visitors, risk assessments prior to in-person contacts, which may include the input and expertise of Infection Control Clinicians.
- Bed blocks during lockdowns due to infection prevention and control precautions involving a vulnerable population requiring isolation.
- Deep clean processes and isolation of units for up to seven days for close contacts following identification of positive COVID-19 cases.
- Extend the COVID-19 treatment adjustment beyond the acute admitted funding stream.

Consultation Question:

Question 8: For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis, including patients in an ICU, to support retention of the:

- COVID-19 treatment adjustment
- temporary ICU measure for COVID-19 patients
- temporary HAC and AHR measures for COVID-19 patients?

NSW notes activity data provided to the IHACPA contain an identification flag for COVID-19 positive patients to enable the analysis of cost differentials.

If the COVID-19 treatment adjustment is retained, NSW requests the inclusion of E62 *Infections and Inflammations* in the COVID-19 treatment adjustment review process, where volumes for COVID-19 positive episodes are the second and fourth highest in volume from July – December 2022–23, third and fourth highest in volume for 2021–22 and fifth and seventh highest in volume in 2020–21. NSW notes E62A had the highest reported total cost in the 6-month 2022–23 and the full year 2021–22 and, was the second highest total cost in 2020–21.

4.2 Adjustments to the national efficient price

Consultation Question:

Question 9: To inform the review of the ICU adjustment:

- what available evidence demonstrates the underlying drivers of cost variation for complex ICUs?
- what additional or alternative measures, other than mechanical ventilation hours, should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?

NSW supports the IHACPA's decision to review the intensive care unit (ICU) adjustment and notes recent feedback was provided to help inform the review.

Available evidence demonstrating underlying cost driver variation

The current ICU adjustment in the NEP includes a criteria to meet the ICU facility eligibility list within each Australian jurisdiction. NSW notes a clinical shift from mechanical ventilations to non-invasive ventilations (NIV) (including BIPAP, high-flow oxygen therapy) in most Australian ICUs based on current ANZICS data[1].

Additional or alternative measures for inclusion

- NIV, continuous renal replacement therapy (CCRT), vasopressor support and haemodynamic monitoring have become intrinsic to intensive care models of care and should therefore be considered (+/- other variables) to inform new criteria for funding ICUs. NSW's recent consultation has also identified other areas for funding consideration such as tertiary versus regional ICUs, networked ICUs, and that based on clinical criteria set by the College of Intensive Care Medicine (CICM)[2].
- Neonates are more expensive to care for and have potential for increased associated costs.
- Include additional ICU data or measures from ICU databases to assist in determining complexity other than mechanical ventilation hours. For example, increasing use of extracorporeal membrane oxygenation (ECMO) for severe respiratory illness where two to one nursing ratios are required.

NSW has conducted a literature review that demonstrates variance among funding models. While models built on the level of organ support plus or minus per diem-based ICU support payments are common, which may include the level of support within a single organ system or the number of organ systems requiring support overall, other models internationally include tele- and virtual ICU and a bundled versus unbundled approach. Several countries incorporate additional DRGs for the intensive care component of a patient stay instead of a per diem payment.

Recommendations:

- The IHACPA undertake a review of all levels of ICU and rather than limited to 'complex' ICUs.

Consultation Question:

Question 10: To inform the review of the paediatric adjustment:

- what available evidence demonstrates the underlying drivers of cost variation between specialised and non-specialised children's hospitals?
- what additional or alternative measures should IHACPA consider for inclusion in the eligibility criteria for a specialised children's hospital?

NSW supports the current process for identifying specialist paediatric hospitals. However, as above, NSW recommends a review of the mechanical ventilation hours requirement for designation as a specialist paediatric hospital.

NSW also recommends the inclusion of paediatric subacute and non-acute rehabilitation episodes to the qualification list for the paediatric adjustment.

Additional or alternative measures for inclusion in the eligibility criteria

- The use of innovative technologies/techniques during care.
- Specialist hospitals providing advice and care to patients and their families in other hospitals via phone and telehealth, require consultation and review from staff in a specialist paediatric facility.

[1] ANZICS – Australia and New Zealand Intensive Care Society https://www.anzics.com.au/
[2] CICM – College of Intensive Care Medicine of Australia and New Zealand https://www.cicm.org.au/Home

4.3 NEP indexation methodology

Consultation Question:
Question 11: To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

NSW notes in the IHACPA Board Chair's correspondence to the NSW Minister for Health that the IHACPA has acknowledged limitations of using historical data to inform a forward-looking pricing model. NSW supports the IHACPA in reviewing the NEP indexation methodology.

NSW has committed to a four per cent salary and wages increase, in addition to other workforce initiatives, at the same time as consumer price index on goods and services is running at approximately seven to eight per cent. The indexation should factor in known forward impacts as they have done with superannuation adjustments in recent NEPs and as per the Residential Aged Care Pricing Advice for 2023-24.

NSW seeks clarity on the applicability of shadow pricing to indexation and how this would operate.

4.4 Harmonising price weights across care settings

Consultation Question:
Question 12: What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?

NSW recommends the IHACPA ensure that for the different modalities of care, adjustments are fair and equitable and reflective of the type of care provided.

Consultation Question:
Question 13: Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

Nil response.

4.5 Unqualified newborns

NSW supports a review of the pricing methodology for qualified/unqualified newborns to ensure increased transparency and accuracy of individual (stand-alone) newborn and maternal episodes. An example of a model of care that may benefit from a revised approach is the Mothers and Babies Mental Health Unit. There is strong clinician engagement and willingness to collaborate in this piece of work.

NSW acknowledges challenges with legislation, which may require review, however notes this should not preclude a new pricing arrangement for unqualified newborns.

Recommendations:

- The IHACPA undertake broad specialist consultation when reviewing the pricing methodology for qualified/unqualified newborns.
- The IHACPA's National Hospital Cost Data Collection (NHCDC) Advisory Committee consider and solve costing challenges with interrogating the combined mothers and unqualified baby's cost.

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

4.6.1 Phasing out the private patient correction factor

NSW notes the IHACPA will continue to consult with jurisdictions on phasing out the private patient correction factor. NSW does not support phasing out the private patient correction factor for NEP24.

NSW notes the private patient funding neutrality adjustment formula does not appear to achieve its stated aims. NSW reiterates the Administrator of the National Health Funding Pool (the Administrator) applied constraints in their application of the formula as shown below.

"The adjustment is subject to two constraints:

1. *The adjustment is to be less than or equal to zero, that is the adjustment can only be zero or negative and act as a discount against ABF*
2. *There is a floor to the magnitude of the adjustment when private patient GWAU growth is negative such that the adjustment is set at zero.*

This floor constraint avoids scenarios where there is a reduction in activity and / or revenue for public and private patients, and if the private patient reduction is not the same as for public patients there is still a PPN funding adjustment. It was deemed that these scenarios did not align with the policy intent".

- Extract from Calculation of Commonwealth National Health Reform Funding 2020-2025

NSW is concerned that the proposed implementation by the IHACPA will only apply as a penalty due to constraint (1) above. The Administrator's application does not align with the IHACPA's definition of financial neutrality and payment parity as it ignores instances where all revenue received by a local hospital network (LHN) for public patients is greater than all payments made for a LHN service for private patients. The IHACPA's decision to apply only a penalty may encourage differentiation between public and private patients. NSW notes that had the formula worked as intended, the additional constraint (2) above would not be necessary.5.

5. Setting the national efficient cost

5.1 Overview

5.2 The 'fixed-plus-variable' model

5.3 Standalone hospitals providing specialist mental health services

NSW notes a robust analysis is required prior to transitioning standalone psychiatric hospitals from block funding to ABF. The robust analysis will ensure the AMHCC is fit for purpose for the unique characteristics of admitted patients in these standalone hospitals.

Recommendations:

- The IHACPA allow sufficient time for robust analysis to be completed prior to transitioning standalone psychiatric hospitals from block funding to ABF.

5.4 NEC indexation methodology

Consultation Question:

Question 14: To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?

NSW strongly supports the IHACPA's committing to review the indexation methodology for NEP24 and that the agency considers expanding its indexation methodology beyond reliance on historic data to ensure it appropriately accounts for the effect of inflation.

NSW recommends the IHACPA incorporate additional costs not reflected in the data by using information available in published District/LHN service agreements and budgets (as opposed to waiting until the costing cycle concludes). This recommendation aligns with the pricing guideline around being evidence-based as it ensures funding is based on best available information. NSW notes the IHACPA states that it "accounts for...the effect of inflation through the indexation methodology." NSW also notes that Ernst and Young's Fundamental Review of the National Efficient Price stated "the current approach to calculating the indexation rate projects forward the change in cost per NWAU over time, leveraging historic data as the basis. The current approach presents challenges as prior years may not be reflective of future years' experience, which can lead to under-or overestimation of the rate of indexation."

NSW notes cost drivers unique to rural hospitals for consideration include:

- additional difficulty in getting and retraining doctors,
- the increasing cost of locums and nurses,
- the shortage and cost of rural accommodation,
- incentives in place for attracting staff to move to rural locations.

5.5 Quality assurance of public health expenditure data

NSW considers that the Australian Institute of Health and Welfare (AIHW) is better placed to review the data. However, NSW notes the IHACPA has implemented a series of internal data validation checks to ensure high quality input data for cost modelling for the National Efficient Cost Determination (NEC) is maintained. NSW seeks transparency of these checks as it will assist NSW in the initial AIHW submission due to a heightened awareness of potential issues.

Recommendations:

- The IHACPA is transparent when undertaking additional internal data validation and quality checks of the public health expenditure data.

6. Data collection

6.1 Assurance of cost data

Consultation Question:

Question 15: What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

NSW notes that for the Round 27 NHCDC, Self Assessment, is not required. NSW notes the Self Assessment has been a primary tool for jurisdictions to indicate adherence to the individual Australian Hospital Patient Costing Standards (AHPCS) and document reasons for variation from the AHPCS. However, Section 3 of the Data Quality Statement includes confirmation around adherence to the AHPCS. There are questions that jurisdictions should consider to note when responding, however these are not listed as mandatory and do not necessarily allow an individual assessment of compliance to each standard. NSW recommends specific mandatory questions around the AHPCS to ensure jurisdictions cover all compliance confirmations and allow effective comparison between jurisdictions.

NSW also recommends the introduction of a more robust structure around quality assurance in general, with additional quality checks and tests to be applied to the NHCDC data on submission. This extended quality assurance structure could also include some tests that consider compliance to the AHPCS.

6.2 Virtual models of care

Consultation Question:

Question 16: Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?

NSW recommends the IHACPA first define the overall strategy for counting and classifying virtual care. This will then establish additional standards in the AHPCS for this care which will reinforce funding models to ensure this new and emerging care is appropriately and accurately funded.

Areas the IHACPA should prioritise for further investigation:

- Non-Admitted Care RPM: to count RPM, NSW recommends temporal care and price bundling.
- Hospital in the home.
- Emergency department diversion services.
- Early supported discharge.
- Multidisciplinary team care.

Care streams the IHACPA should prioritise for further investigation:

- Hospital avoidance.
- Hospital substruction.
- Health Coaching and Wellness.
- Ongoing community care.

Consultation Question:

Question 17: Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?

NSW recommends the IHACPA review the pilot emergency virtual care consultation collection. NSW does not have the capacity to support the pilot emergency department collection and notes it is an administrative burden for clinicians and jurisdictions. NSW has previously recommended the Non-admitted patient emergency department care national minimum data (NAPEDC NMDS) set be amended to implement visit type videoconference, and has provided clinical examples and advice on what data items to amend related to the NAPECD NMDS.

NSW is undertaking significant work to develop a process for costing wearable devices costing the virtualKIDS Urgent Care Service.

6.3 Organ donation, retrieval and transplantation

NSW supports the costing study and classification review.

Recommendations:

- The IHACPA review all post-organ transplantation care as there are indications that patients requiring any post-transplant care have higher costs within the same class compared to patients who have not received a transplant

7. Treatment of other Commonwealth Programs

7.1 Overview

NSW is not a party to the Pharmaceutical Benefits Scheme, hence adjustments are required to ensure discounts are not applied to NSW.

8. Future funding models

8.1 Overview

NSW supports the investigation of different payment models that pay for value and patient outcomes, and welcomes the opportunity to collaborate with the IHACPA on this work.

NSW notes funding models need to consider collaboration with other parts of the health system, including primary care.

8.2 Trialling of innovative models of care

NSW welcomes the inclusion of the four Innovative models of care as part of the NEC Supplemental Determination 2022–23.

Recommendations:
• The IHACPA review the submission process for trialling innovative models of care to reduce the time needed to finalise submissions.

9. Pring and funding for safety and quality

9.1 Overview

NSW would welcome the inclusion of incentives for high quality, safe and effective care delivery, rather than funding penalties.

Appendix A: Consultation questions

Consultation Question:
Question 18: Do you have any further comments to inform the development of the NEP and NEC Determinations for 2024–25?

Nil response.