Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

ADD/17/16383

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie James

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 2018-19.

Victoria supports the proposal by the Independent Hospital Pricing Authority to implement payment reforms that support the improvement of safety and quality in healthcare. Victoria understands the role funding and pricing play in supporting the delivery of better care as well as avoiding unnecessary costs.

If you have any queries about Victoria's response, please contact Mr Richard Bolitho, Acting Assistant Director - Service and Funding Projects on 9096 7616 or via email Richard.bolitho@dhhs.vic.gov.au.

Yours sincerely

Terry Symonds
Deputy Secretary
Health and Wellbeing Division

15/8/2017

VICTORIA State Government

Consultation paper on the pricing framework for Australian public hospital services 2018-19

Victorian Department of Health and Human Services response

August 2017

VICTORIA State Government | Health and Human Services

Contents

1. Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19*. The Pricing Framework 2018-19 forms part of the Independent Hospital Pricing Authority's seventh annual process for establishing a national activity based system for the pricing of public hospital services in Australia, in support of the efficiency and transparency goals of the National Health Reform Agreement.

The *Pricing Framework 2018-19* is an opportunity to further refine and improve the pricing models introduced in 2012-13 and revised in subsequent years. Victoria is generally supportive of the direction of the national pricing framework development however Victoria continues to reiterate a number of concerns related to the need to further mature aspects of the national pricing model.

Victoria supports the Independent Hospital Pricing Authority's proposal not to introduce bundled pricing for maternity care in 2018-19, recognising that further development of a bundled pricing model for maternity care must adequately acknowledge the variation in care provided and be based on accurate data.

Victoria recognises the Independent Hospital Pricing Authority is continuing to progress work to incorporate safety and quality into the pricing and funding of public hospital services in order to improve health outcomes, avoid unnecessary or unsafe care and decrease avoidable demand for public hospitals.

Concurrent with the introduction of the safety and quality funding reforms, Victoria recommends that the Independent Hospital Pricing Authority work with states and territories to address the challenges associated with consistent capture of quality and cost information, and to minimise the risk of unintended consequences.

As the introduction of this model constitutes a significant change, Victoria anticipates that the Independent Hospital Pricing Authority will act in accordance with the National Health Reform Agreement, specifically Clause A40.

Victoria recognises the Consultation Paper on the Pricing Framework is continuing towards improving the national Pricing Framework.

2. Pricing guidelines

The Pricing Framework includes important pricing guidelines that direct how the Independent Hospital Pricing Authority should undertake its work. In assessing how the Independent Hospital Pricing Authority has implemented Activity Based Funding to date, there should be greater regard for applying these guidelines in a more consistent, balanced and comprehensive manner.

Victoria supports the Independent Hospital Pricing Authority's view that the Pricing Guidelines are working well and therefore no changes are proposed for the Pricing Framework 2018-19.

3. Scope of public hospital services

Victoria would encourage the Independent Hospital Pricing Authority to exercise flexibility when determining whether a service is ruled in-scope as a public hospital service, and therefore eligible for Commonwealth funding under the National Health Reform Agreement. Challenges faced by states and territories by the Independent Hospital Pricing Authority making determinations can include limiting opportunities for implementing new/innovative clinical and funding models, whereby the Independent Hospital Pricing Authority requires services to be operational before considering these to be in-scope.

4. Classifications used by IHPA to describe public hospital services

Consultation question

- What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?

The Independent Hospital Pricing Authority should review the Episode Clinical Complexity Model to determine a strategic approach to dealing with the increased reporting of secondary diagnosis codes that are currently statistically significant in terms of moving cases to higher-complexity AR-DRGs (i.e. have a non-zero Diagnosis Complexity Level (DCL) value) but that represent minor clinical conditions that have little to no influence on patient complexity during the episode of care and that mask those occasions when these conditions do actually represent a significant issue. In particular, for the codes that represent minor conditions, the Independent Hospital Pricing Authority should consider whether these codes should be added to the unconditional exclusion list for AR-DRG V10 or whether the statistical significance of these codes and their effect on DRG outcome be allowed to find their equilibrium (e.g. dilute their statistical significance through greater reporting or overuse).

Consultation question

- Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?
- What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

Victoria supports the phasing out of older versions of the AR-DRG classification but recommends that at least one AR-DRG classification based on the older episode-complexity methodology (e.g. AR-DRG V7.0) be maintained as a baseline status-quo option for measuring episode clinical complexity until the current episode complexity model has established equilibrium within the classification.

Victorian public hospitals transition to the latest available version of the AR-DRG classification by default. The question of transition timeframes is best directed to the private hospital sector which operate against fixed-term funding contract arrangements.

Consultation question

- Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18?

Victoria does not support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18 using the current Tier 2 Classification.

As previously raised with Independent Hospital Pricing Authority, Victoria's primary concern is that focus should be on providing an integrated & coordinated approach to patient care in specialist clinics - especially for chronically ill older patients. The current classification does not promote linked up non-admitted-multidisciplinary-case-conferences approach where joint care and treatment goals are discussed. Victoria is supportive of a separate classification of non-admitted-multidisciplinary-case-conferences but with a preference for non-admitted-multidisciplinary-case-conferences to be incorporated into the Australian non-admitted care classification rather than the existing Tier 2 classification.

The cost/benefit of counting this activity remains of concern. The proposal will increase the data burden placed on clinicians. It will not increase overall funding, it will though reduce the cost weights of Tier 2 classes where this activity is currently costed. The proposal also sets a precedent for counting indirect activity.

This will require significant changes to jurisdictional and health services data collection systems, which will again require changes when a new classification system is implemented for non-admitted services.

Consultation question

- Do you support investigation of the creation of multiple classes in the classification for home ventilation?

Consistent with comments in responses to formal consultation processes in previous years, Victoria supports work to consider changes to the home ventilation class. Victoria believes that this work needs to be based on clinical relevance and robust evidence.

Consequently Victoria believes that for 2018-19 it would be prudent for the Independent Hospital Pricing Authority to limit creating multiple classes for home ventilation to only account for the cost variation between patients requiring overnight and continuous ventilation. This would involve waiting until after 2018-19 to consider whether the evidence supports a further split between adult and paediatric patients.

Victoria has previously raised concerns about the range of costs covered by the existing ventilation Tier 2 class 10.19. Victoria thinks that as part of the investigation of the ventilation class, the Independent Hospital Pricing Authority should also consider the range of costs that are covered.

Consultation question

- What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

Victoria welcomes the Independent Hospital Pricing Authority's decision not to price mental health services via a proxy for phase of care.

Victoria believes that pricing based on phase of care should only be considered after a reasonable and representative quantity of both activity and cost data based on phase of care is available. For the quantity of data to be considered reasonable and representative, at a minimum data should be available from a clear majority of states and territories. The data should also come from states and territories that account for the clear majority of the Australian population. It should also contain data with a good spread across all parts of the classification that are under consideration for pricing (e.g. Older Persons, Child & Adolescent, Adult). Victoria also believes that a significant period of shadow funding will be essential.

Apart from the work to address the issues with Phase of Care, at this stage Victoria has no new issues that it wishes to put forward for consideration in the development of version 2 of the Australian Mental Health Care Classification.

5. Data collection

Victoria supports the ongoing development of the National Hospital Data Collection as a key dataset used to analyse costs. Victoria welcomes the expected release of Version 4 of the Standards in 2018 for future rounds of the National Hospital Cost Data Collection and will continue to work with the Independent Hospital Pricing Authority to develop these standards going forward.

6. The National Efficient Price for activity based funded public hospital services

Consultation question

- Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?
- What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?
- What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

Victoria requests that the Independent Hospital Pricing Authority consider phasing out the hospital-based specialist paediatric adjustment to align with its pricing guidelines of using patient-based pricing adjustments rather than hospital-based pricing adjustments, particularly given that the new Episode Clinical Complexity Model under AR-DRG V8.0 (and V9.0) better captures and measures the clinical complexity of paediatric patients.

Victoria requests that the Independent Hospital Pricing Authority investigate replacing the current Intensive Care Unit (ICU) allocation metric (time in ICU, ICU hours) which is a broad, non-specific proxy measure of patient complexity with an alternative, more-specific proxy measure of patient complexity such as mechanical ventilation hours (invasive and non-invasive) received in ICU.

Victoria is supportive of the Independent Hospital Pricing Authority conducting further analyses to quantify patient-centered cost differences that arise for patients treated in very remote hospitals, including more sensitive differentiation of a patient's remoteness in larger states compared to other smaller states.

Victoria is also supportive of Independent Hospital Pricing Authority's periodic investigation of annual variations in the prices of high volume or high-cost services as documented under its recently updated National Pricing Model Stability Policy.

7. Setting the National Efficient Price for private patients in public hospitals

Victoria supports that Independent Hospital Pricing Authority's work with states and territories to better identify the treatment of private patient costs in the 2015-16 National Hospital Cost Data Collection (Round 20).

The Australian Hospital Patient Costing Standards will need to be clear and concise in the approach to be taken to fully comply to cost private patients in public hospitals. This guidance is not due to be published until 2018. Given the complexity surrounding this treatment, there will need to be sufficient time to implement the guidance at a hospital level. The retention of the correction factor will need to be beyond NEP20.

Victoria also supports the further investigation of the adjustments made for private patients.

8. Treatment of other Commonwealth programs

Victoria continues to support the Independent Hospital Pricing Authority's work with other jurisdictions to investigate how blood costs can be more accurately captured in the National Hospital Cost Data Collection in future years.

9. Setting the National Efficient Cost

Consultation questions

- Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?
- If so, how should this be carried out?

Victoria understands that there may be circumstances where the transfer of a service from an Activity Based Funding hospital to a block funded hospital may result in a decrease in National Weighted Activity Unit at the Activity Based Funding hospital but no corresponding movement in National Efficient Cost grouping for the receiving block funded hospital. This could result in a decrease in Commonwealth funding to a state in a situation where activity across the two hospitals involved has not reduced.

Victoria supports further investigation by the Independent Hospital Pricing Authority into this and detailed discussion between jurisdictions to ensure there is a clear understanding of the issues, the frequency with which this occurs, and the best options to try to address this.

Victoria's initial view is that the best approach is to ensure that in these circumstances a state is not disadvantaged by a reduction in Commonwealth funding contribution as a result of the movement in activity between health services. Our understanding is that most (if not all) states do not use the National Efficient Cost model as the basis for funding smaller health services. Our understanding is that states use local funding models to ensure that the small hospital is appropriately funded for delivery of the new service.

Consultation question

- Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

Victoria questions whether an Activity Based Funding model, which provides a price signal to support throughput, is the most appropriate funding model for residential mental health service where patients are cared for in a more residential/home like environment and can be expected to have a long and in many cases ongoing length of stay.

Victoria therefore supports the Independent Hospital Pricing Authority's proposal that these services remain block funded for the immediate future.

In addition to this, Victoria believes that it is important that Independent Hospital Pricing Authority undertakes to understand the differing approaches to reporting across states and territories. An

inconsistent approach across states and territories about whether people receiving a similar service with similar costs are reported differently and activity for some states is therefore allocated to the "admitted setting" arm of the classification and in other states it is allocated to the "community setting" arm (or block funded residential) could create a risk of distortions to pricing and/ or unintended consequences.

10. Bundled pricing for maternity care

Consultation questions

- Do you support the proposed bundled pricing model for maternity care?
- Do you agree with IHPA's assessment of the preconditions to bundled pricing?
- Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

Victoria supports the Independent Hospital Pricing Authority's proposal not to introduce bundled pricing for maternity care in 2018-19. As noted in the second consultation question further work to explore the development of a bundled pricing model for maternity care must adequately manage the variation in care provided and be based on accurate data.

The proposed preconditions appropriately summarise the key components for the possible further development and testing of a bundled pricing approach. In particular the information provided notes that:

- Bundling is not feasible until service delivery to patients can be accurately identified.
- Bundling must demonstrate clear benefits to patients and the health system.
- Strong clinical and stakeholder support as key to the successful introduction of bundled pricing.

The pricing model needs to be clinically relevant and support the delivery of the most appropriate care in the right setting. Development of a pricing or funding model should not create perverse incentives or cause unintended consequences especially in relation to the patient's choice to elect a mix of public and private services. The model should also provide fair payment for partial episodes that include out-of-hospital care. Further, the model needs to be flexible to recognise the variation in delivery of services within jurisdictions and across Australia, for both complicated and non-complicated births.

Victoria is currently continuing to work on the statewide maternity plan, however, in developing a bundled price, it will be challenging early on to set the right funding level, given that a significant proportion of women who give birth in a public hospital will access antenatal care from a general practitioner or other community-based provider. Given that Commonwealth and state funding is involved, the Independent Hospital Pricing Authority need to consider how the practical application of this model will work, especially in determining how community-based providers will be "reimbursed" from a hospital's bundle payment.

Investigation regarding the establishment of an Individual Healthcare Identifier is a matter that the Independent Hospital Pricing Authority should raise with jurisdictions through existing mechanisms rather than through a consultation process.

11. Innovative funding models

Consultation questions

- What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?
- Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

Victoria understands that new models of care require changes to structures, processes, relationships and in many cases, provider culture. These changes take time and investment. In many cases new models of care fail to provide value, either in improvements to patient outcomes or as restraint of costs. Innovation rarely happens as planned and failure is an expected outcome. With each failure the likelihood of success increases (e.g. HealthLinks Chronic Care has benefited from the Victorian Co-ordinated Care Trials and many similar trials in other jurisdictions).

While there are many strengths to single episode constrained activity based funding it encourages organisations to treat presenting patient symptoms and conditions without incentive to prevent recurrence or exacerbation.

Victoria encourages the Independent Hospital Pricing Authority to consider the following when examining innovative funding models:

- Is this model a pilot that, with a time limited funding modification, has the potential to develop into a valuable new model of care?
- Is the model likely to improve the health, or better manage the symptoms of, persons with physical or mental health conditions?
- Will the model add to the total costs of care over and above the value achieved by the model?
- Is the model scalable and translatable across jurisdictions?

Victoria fully supports the Independent Hospital Pricing Authority in considering models of value based care. An environment where funding is not a barrier to innovation is a minimum requirement.

12. Pricing and funding for safety and quality

Consultation question

- Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?
- Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

The proposed risk adjustment model for Hospital Acquired Conditions is a well-designed statistical model maximising the use of existing activity and cost information. Ideally the final model must be clinically relevant and able to be easily implemented and understood by the health sector.

The pricing signals proposed under the risk adjusted model for hospital acquired conditions must provide the right incentives to the sector to achieve the desired reform objectives rather than develop a model

that may result in unintended consequences, such as under-reporting of hospital acquired conditions or adversely affecting service delivery.

The pricing approach to hospital acquired complications must support government initiatives of the Australian Commission on Safety and Quality in Health Care and hospitals to better measure and improve the safety and quality of patient care.

Further development and consideration of unintended consequences is warranted before the model should be integrated into hospital pricing and funding. The design of a risk adjusted model must balance the casemix of the hospitals (specifically those that take on more high-risk patients) with the patients requiring high quality care. In particular, the pricing and funding model should also take into consideration of four key criteria detailed in the addendum to the National Health Reform Agreement being: Preventability; Impact; Feasibility; and Equity and how the Independent Hospital Pricing Authority model will meet these criteria. Preventability is a key selection characteristic for hospital acquired conditions and the success of this funding reform hinges on the ability of hospitals to prevent hospital acquired complications. Victoria encourages the Independent Hospital Pricing Authority to continue to work with the Australian Commission on Safety and Quality in Health Care to further develop and communicate evidence of preventability as a companion to the Hospital Acquired Conditions funding policy.

The Independent Hospital Pricing Authority's Hospital Acquired Conditions model provides different incentives to report different hospital acquired condition codes. For example, the Independent Hospital Pricing Authority's model double penalises the reporting of hospital acquired condition codes that do not change DRG outcomes (i.e. coding that does not impact on AR-DRG complexity assignment) i.e:

- Penalty in the base weight due to cases with a hospital acquired condition attracting costs in excess of the average DRG cost.
- Penalty through the HAC discount rate.

By contrast, the Independent Hospital Pricing Authority's Hospital Acquired Condition model rewards the reporting of hospital acquired condition codes that change DRG outcomes (i.e. coding that promotes cases up the AR-DRG complexity hierarchy); i.e. changing DRG outcome will offset any penalty imposed by the Hospital Acquired Conditions model.

Victoria recommends that the Independent Hospital Pricing Authority include third and fourth degree perineal lacerations during delivery and neonatal birth trauma into its Hospital Acquired Conditions model. Inclusion of this Hospital Acquired Conditions model is more about creating opportunities to drive genuine systems improvements and less about sample sizes and statistical significance.

Consultation question

- What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

The consultation paper references the work that is still in progress through the Australian Commission on Safety and Quality in Health Care to develop an approach to defining a list of avoidable hospital readmissions.

Ideally, this work should consider a range of additional issues, including:

- Factors within and outside a hospital's control that may result in an unplanned readmission.
- The appropriate time period post hospital discharge that should be considered.

- Whether those time periods should vary by condition.
- Whether there is a small higher priority sub-set of conditions that should be reviewed.

Evidence from within Victoria and overseas indicates that a wide range of factors at the total health system level, together with individual patient/family/carer circumstances (e.g. willingness and capacity to follow medication instruction or carer stress), and social determinants of health (e.g. housing factors), are key factors in each individual patient readmission.

This means it is only by understanding the causes of each single patient re-admission that it is possible to be sure whether a re-admission was preventable – and by whom. An understanding of the evidence and circumstances for each patient readmission is also necessary to determine whether the readmission is "due to complications from the management of the original condition" and whether it is primarily due to factors within the control of the hospital. An approach which relies solely on existing data sources and statistical modelling is unlikely to be able to provide this level of understanding.

Victoria therefore stresses the need for patience and care in determining both the definitions and the most appropriate pricing/funding approach (including whether an approach based on pricing/funding is the best approach). Victoria believes that there is a significant risk of unintended consequences – including perverse incentives that act contrary to the shared intent of improving quality care and patient outcomes, if the pricing and funding model is developed without any consideration of these matters.

Victoria's preference is that the development of the model provides sufficient time for consideration of all these issues.

Consultation question

- Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?

Victoria is generally supportive of the Independent Hospital Pricing Authority's assessment criteria to evaluate the different approaches to pricing and funding adjustments for avoidable hospital readmissions.

Victoria acknowledges that the Independent Hospital Pricing Authority has determined criteria most relevant to assessing options in terms of the national funding model. However, it is recommended that a broader set of criteria must be used by decision makers on preferred approaches given that pricing and funding approaches will be impacted by other initiatives to improve safety and quality.

Victoria recommends that the following criteria are also considered:

- The risk of unintended consequences.
- Does the approach incentivise under reporting or adversely affect service delivery.