Health
Department for
Health and Wellbeing

A2354535

Office of the Chief Executive
Citi Centre Building
11 Hindmarsh Square
Adelaide SA 5000

PO Box 287, Rundle Mall
Adelaide SA 5000
DX 243
Tel 08 8226 6541
Fax 08 8226 6111
ABN 97 643 356 590
www.health.sa.gov.au

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 2010

Dear Mr Downie

RE: IHPA CONSULTATION PAPER PRICING FRAMEWORK 2021-22

Thank you for your letter of 9 September 2020 about the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22* and for the opportunity to participate in the consultation process.

Please find attached the SA Health response to IHPA Consultation Paper Pricing Framework 2021-22.

I also comment specifically on *Section 8 Data Collection, 8.2 Phasing out of aggregate non-admitted data:*

The Department is supportive of the move to report and fund non-admitted patient level activity and currently has significant projects underway to achieve this. Activity Based Funded hospitals will be ready for patient level reporting in 2021-22, however, there is still work to be undertaken on block funded hospitals and community activity where data collection methods differ from the larger ABF sites. SA will keep IHPA informed of our progress in this project throughout the next year.

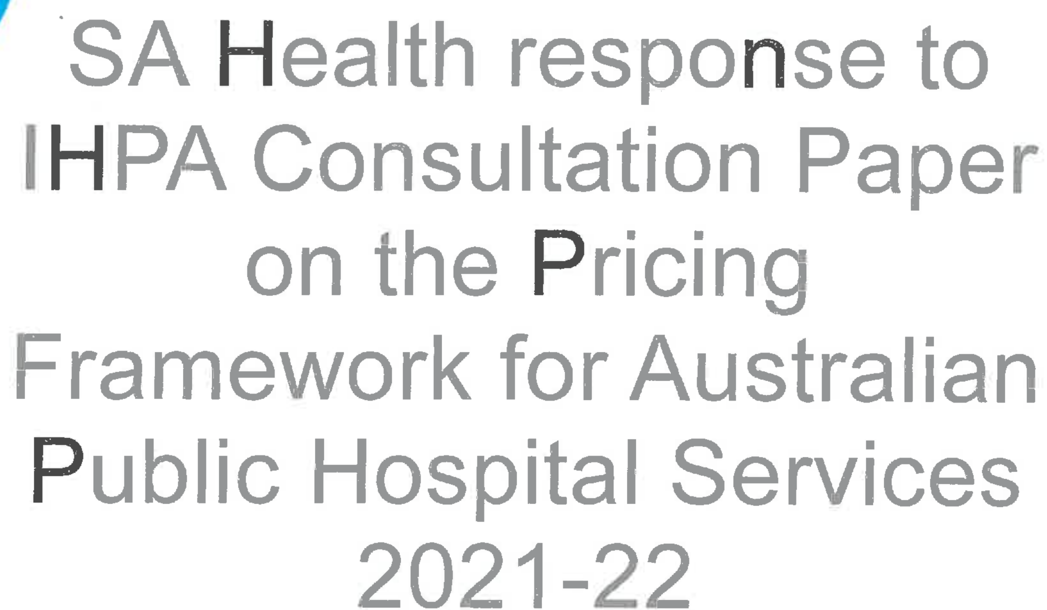
Should you require further information, please contact Krystyna Parrott, Acting Assistant Director, Funding and Costing on 08 8226 7263.

Yours sincerely

DR CHRISTOPHER MCGOWAN
Chief Executive

21/10/2020

Att: SA Health response to IHPA Consultation Paper Pricing Framework 2021-22



SA Health response to IHPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22

6 October 2020

Health Services Programs & Funding

SA Health

Government of South Australia

SA Health

Response Overview

On 9 September 2020 the Independent Hospital Pricing Authority (IHPA) released its *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22* for public comment. SA Health has developed the following response through consultation with stakeholders in the Department for Health and Wellbeing (DHW) and the Local Health Networks (LHNs).

Please contact Krystyna Parrott, Acting Assistant Director Funding & Costing, with any questions.

Section 3 - Impacts of COVID

What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?

How will these changes affect the costs of these services in the short and long term?

Recent overseas experience has demonstrated that an uncontrolled pandemic can have significant impacts on the capacity of a health system. In an effort to ensure all patients continued to receive safe, timely care during the peak of the COVID-19 pandemic within the State, SA hospitals changed their way of working.

The intent of the majority of changes made across the system were designed to protect patients and staff from transmission of the disease and to effectively treat those who were COVID positive or suspected COVID positive (SCOVID). The major changes in health service delivery included:

- Increased utilisation of videoconferencing and teleconferencing.
- Expansion of Hospital in the Home (HITH) services, both capacity and the scope of treatment provided, and services out of hospital.
- Development of a Statewide Intensive Care Unit Model of Care for COVID-19.
- Development of an Integrated Inpatient Strategy (utilising public and private hospital providers), also known as a decant strategy.
- Strengthening of primary health care in-reach (clinical pathways).
- Strengthening utilisation of electronic health records (e-Health).
- Improvement of supply chain availability and timeliness for consumables including Personal Protective Equipment (PPE) and Pharmaceuticals.

In relation to activity levels, SA's experience did not differ materially from the national COVID-19 experience in terms of a considerable decrease in hospital activity from mid-March 2020. However, success in flattening the curve meant that SA did not sustain the level of restrictions seen in other States and as a result, was one of the first jurisdictions to see an increase in public hospital activity from May 2020. Since then, the demand on hospital services has continued to grow. As of October 2020, demand reflects the levels experienced at the same time last year.

As the State's recovery continues, it has been identified that a number of initiatives implemented in response to the pandemic have been successful in improving the management of hospital capacity and influencing Length of Stay (LOS). The main contributors to these improvements were:

- The expansion of service program diversity and capacity; and
- Increased utilisation of technology.
- Changed utilisation of PPE, and different PPE.

As a result, SA's public hospitals are seeking to implement these initiatives into business as usual activity.

These initiatives will lead to an increase in hospital operating costs in particular costs for PPE, pharmaceuticals and hospital services.

The increased usage of PPE is one aspect of COVID that will continue after the pandemic is declared over. This change will need to be accounted for in the National Efficient Price (NEP) in future years.

COVID has seen an impact on the availability and cost of some pharmaceuticals. How this impact plays out in the NEP in future years remains to be seen.

Finally, the measures implemented to manage COVID have had an impact on hospital services and how other infrastructure is used. The data indicates that COVID has had a material impact on hospital throughput and patient flow. Current activity indicates that in SA the average ICU length of stay for COVID patients was 20 days and, should COVID become an issue in SA again will impact our capacity to treat other patients requiring ICU.

What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

IHPA needs to consider when and how activity and costing data impacted by the response to COVID is included in the national pricing model. The activity and cost data will have an impact on clinical complexity measures and, therefore, DRG allocation and price weights. While some of the changes may be of a more temporary nature (i.e. additional COVID clinics) there are others that will be ongoing, notably the increased use of PPE for treating all patients.

Section 4 - The Pricing Guidelines

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

The pricing guidelines are still relevant and reflect the environment in which Activity Based Funding (ABF) is implemented. However, there are principles that could be improved on with particular focus on administrative ease and fairness. For example, when reviewing the data for price harmonisation of chemotherapy services it was noticeable that SA's costs were comparable to those States that are admitting patients e.g. Victoria. In SA, this activity is delivered in an outpatient setting. Where instances like this are identified and are occurring on a regular basis IHPA should examine and explain the cost differences between states as it would assist in explaining the discrepancies to our clinicians.

Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

Yes, the guideline reflects the intent of the Clauses in the Addendum to the National Health Reform Agreement.

Section 6 - Classifications Used to Describe and Price Public Hospital Services

What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?

The online education for ICD-10 requires more complex and real life case note examples. This would enable coders to test their understanding of the changes to the new edition. Sample documentation is also required and, wherever possible, should include explanations of changes, including the decision logic or reason behind the changes as well as forward and backward mapping for changes.

In relation to ongoing education, the timeliness of the responses to Coding Queries needs to be improved. The delay in responding to some queries can have a negative impact on the coding timeliness.

How should AR-DRG education be delivered and what should it include?

There is a need for AR-DRG education and ideally it should be aligned to the ICD-10 education. While worked examples are not necessary, information pertaining to the reasons for the change would be beneficial. These examples should not just be designed for technical staff but also understandable by other staff who are part of decision making processes. As with ICD-10, education should include a documented explanation of changes including the decision logic or reason behind changes.

What improvements to the content and format of the electronic code lists could be made to enhance their utility?

With each update of the ICD-10 edition jurisdictions are provided with a list of all applicable code changes. An improvement would be the supply of a complete list of valid ICD-10-AM codes. This would enable a proper cross-referencing of the codes being used.

Another improvement would be the availability of a DRG complexity calculator for transparency on calculation and jurisdictions can test their own systems are functioning correctly.

Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

There is still a need for hard copies of the Definition Manuals and they cannot be fully replaced by an online version. The hard copy is still required for disaster recovery purposes and to archive for future reference. This does not mean that the format of the books cannot be modified. For example, the AR-DRG hard copies are used when discussing the grouper logic as the flow diagrams enable the user to walk others through the decision tree. Another example is the Medicare Benefits Schedule, which used to be provided in hard copy and is now predominantly provided online. The online version is sufficient for looking up codes however the descriptions that explained the rules and logic are not as easy to use online. Potentially, the AR-DRG books could be broken into components online however at this stage they are still required in hard copy.

Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely?

In assessing the readiness for ICD-11 it is considered that a jurisdictional review of ICT capability and the costs associated with the change to new version would be beneficial for all, especially with regard to understand the cost and impact of the change. A national plan addressing education, trial implementations and IT resources would be a significant benefit for all jurisdictions.

In terms of additional engagement, given the wide-ranging impact of the change, it is suggested that IHPA engage with the medical specialty colleges to be involved in the process and to provide feedback on the impact of the changes on clinical staff.

Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?

How would activity that **falls under** these proposed new classes **previously** have been classified?

SA has worked with IHPA in the development of the two new Tier 2 classes and are satisfied with the proposed definitions. In the development of price weights for these clinics in 2021-22 SA will provide as much detail as possible of the current clinics that would map to these new clinics.

What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?

SA's aim for 2020-21 was to provide the AECC classes in tandem with the URG classes with the submitted data to enable LHNs to undertake a review of their emergency care data. Due to COVID the implementation of this release has been delayed but the plan is still the provide LHNs with their data for comparative purposes this financial year. In anticipation of the commencement of AECC the Department is working with LHNs to improve the diagnosis code allocation that will see more alignment to the ICD Shortlist.

The impending commencement of the AECC for funding emergency care has seen a change in focus Due to COVID the implementation of AECC in SA has been delayed and the impact is still being assessed by SA Health. It is expected to occur during the course of the current financial year.

How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

IHPA could support development of pricing for community Mental Health (MH) services by facilitating the development of costing rules such as allocation statistics appropriate to community based MH services, where cost structures are significantly different from admitted patient services.

It should also establish a national project over an appropriate time period to focus on the capture of known missing data elements from community collections.

Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

The major impediment to pricing for admitted MH relates to the potential lack of engagement from clinicians on recording Phase of Care activity. At this stage another year shadow funding is considered appropriate.

Section 7 - Setting of the National Efficient Price for Activity Based Funded Public Hospitals

Do you support the adjustment IHPA has proposed for NEP21?

SA supports the proposal.

What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

SA is not requesting consideration for any additional adjustments, however the evidence for any future adjustments should be informed by the existing costing data.

Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?

SA is supportive of the proposed price harmonisation for chemotherapy given the setting the care is provided in is generally more policy driven rather than service led. If harmonisation is not undertaken in
2021-22, as indicated in the last Technical Advisory Committee, then SA requests a review of the costing data used to create the price weights for this activity to provide a better understanding of the price weight differences between the settings.

Are there other clinical areas where introducing price harmonisation should be considered?

SA believes there may be additional clinical areas that would benefit from a review where activity is provided in both outpatient and inpatient service categories. However, this should wait until the new non-admitted classification is implemented as there will be greater granularity of the activity occurring in the outpatients setting to enable better comparisons.

Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

SA can partially comply with the costing standards related to the private patient correction factor. It should be noted that:

- Rights of Private Practice earnings are included in doctor's earnings and that these are either brought into the costing ledger directly from the General Ledger or through Third Party expense adjustments from ROPP Trust Accounts. Consistent with the Australian Hospital Patient Costing Standards, all patients are costed in the same manner using the doctor's total income and this occurs regardless of the patient's election status.
- Private pathology income is not able to be determined as it is unfeasible to trace pathology performed based on a doctor's referral back to public hospital doctors as distinct from tests ordered for patients seen in the community. Private patient pathology is therefore excluded from patient costing systems.
- In addition, SA has a number of smaller hospitals where Third Party radiology contracts prevent the gathering of data to support the allocation of all private medical costs back to individual patients.

Essentially SA has no objection to the phasing out of the correction factor however SA needs to be able to allow for adjustments to the costs for SA Pathology.

Section 10 - Setting the National Efficient Cost

Are there refinements to the 'fixed-plus-variable' model that IHPA should consider?

At this stage SA considers it important that IHPA maintain stability with the current model to determine how the fixed plus variable model works before any further refinements.

Section 11 - Alternate Funding Models

What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

The previous attempt to introduce bundled pricing to the NEP was supported by SA but there are learnings from that process that need to be addressed for it to be considered again. Aside from the need for a unique identifier the first step should be a strong consensus with clinicians on the model of care that will be bundled. Uncomplicated maternity care sounded reasonable, however there was a significant amount of time in the meetings spent debating the definition to be used. SA recommends that any further attempts to introduce bundled pricing should first see jurisdictional (and private) clinicians agreeing on a definition that will then be used for pricing.

Our view on capitation is it needs to be closely aligned with outcome assessments and have clear KPIs. Both models need strong costing data to support them.

And again, critically, a unique identifier is essential for this to succeed.

What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?

At this stage SA has no trials planned.

Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?

SA suggests that the first engagement should be with clinically representative groups for their insight and feedback. Any changes that could occur will be accepted more readily if the clinical care providers are consulted for their opinions and advice.

What other strategic areas should IHPA consider in developing a framework for future funding models?

SA notes that work is continuing in relation to funding for Nationally Funded Centres and although this work is entering its final stages it is important that access to health care technology (including where below the current national threshold) is fair and equitable across the system.

Apart from the Individual Healthcare Identifier (IHI), what other critical success factors are required to support the implementation of innovative funding models?

Apart from the above mentioned clinical involvement there needs to be early consideration of the business rules and definitions around the activity being considered for innovative funding models.

Section 12 - Pricing and Funding for Safety and Quality

Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

SA accepts that as part of the 2020-2025 Addendum was the implementation of adjustments for avoidable readmissions. Of the options put forward by IHPA Option 1 and Option 3 are the two that

we would consider for implementation. It is SA's view that there are benefits with both, Option 3 is designed to work better to incentivise hospitals whereas Option 1 is better aligned with the Hospital Acquired Complication (HAC) model being used and would be easier to implement. The LHNs have indicated a preference for Option 3 which is designed to incentivise behaviour rather than being punitive.

We are comfortable with the current risk adjustment model that has been put forward but recognise that once LHNs are able to review the data on a timelier manner there will be enhancements that will be put forward for consideration. One area where further investigation is planned is the number of readmissions that return to hospital after being in care of other organisations, for example disability and aged care.

The main concern in SA regarding the implementation of avoidable readmissions 1 July 2021 is the lack of transparency that is available for LHNs. We acknowledge that without the IHI being submitted there is a gap in the ability to link episodes but these limitations mean SA could not implement the reporting required to internally monitor and analyse data during the shadow period. This means the State must need to rely on IHPA for access to information which is a time lag of months before SA is able to review the impact of issues associated with avoidable hospital admissions. For this implementation to be supported jurisdictions would need to be provided with the capability to monitor the readmissions in real time, or as close to as possible.

For more information

Funding Models SA Health
Health Services Programs and Funding
L6 Citi Centre, Hindmarsh Square
Email: Health.ABF@sa.gov.au
www.sahealth.sa.gov.au

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