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Joanne Fitzgerald
Acting Chief Executive Officer
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Dear Ms Fitzgerald

Thank you for your letter dated 11 April 2022 addressed to the Secretary, Professor Euan M Wallace AM regarding the Data quality statement for the Round 25 National Hospital Cost Data Collection. As the matter you raise falls within the responsibilities of Commissioning and System Improvement Division, Funding Policy, Accountability and Data Insights Branch your letter has been referred to me for my consideration and response.

Victoria's submission to the 2020-21 Round 25 National Hospital Cost Data Collection (NHCDC) has been finalized in accordance with your Three-year data plan and the Data Quality Statement (DQS) has been prepared in accordance with your template, signed and attached.

Consistent with advice provided in prior years, there are several key factors regarding Round 25 NHCDC, and activity data linked to the cost data. Victoria has been committed to improving the costed results in accordance with the Australian Hospital Patient Costing Standards (AHPCS) where possible.

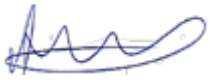
Victoria recognises the opportunities to work collaboratively with IHPA to improve the quality of the cost data and identify areas requiring development. Victoria is pleased to participate in the Independent Financial Review (IFR) and nominate Joanne Siviloglou, Manager Modelling and Costing policy as our representative.

Joanne will work with IHPA and KPMG to select three sites to participate in the IFR that meet the criteria based on the volume of patient activity, casemix complexity, and remoteness, as well as ensure representation of focus areas.

VICTORIA State Government

If you have queries regarding this advice, please contact Joanne Siviloglou on (03) 9668 7377 or email Joanne.Siviloglou@health.vic.gov.au.

Yours sincerely



Andrew Haywood
Executive Director, Funding Policy, Accountability and Data Insights
Commissioning and System Improvement Division

18 / 05 / 2022

VICTORIAN DATA QUALITY STATEMENT

ROUND 25 (2020-21) NATIONAL HOSPITAL COST DATA COLLECTION

OFFICIAL

All data provided by Victoria to Round 25 (2020-21) of the National Hospital Cost Data Collection (NHCDC) submitted to the Independent Hospital Pricing Authority has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 4.1 as described in Section 3 of this statement.

Data provided to this submission has been reviewed for adherence to the AHPCS Version 4.1 and is complete and free of known material errors.

Section 3 provides details of any qualifications to our adherence to the AHPCS Version 4.1.

1 Overview of costing environment

The individual public health services undertake patient costing and subsequently submit to the Victorian Department of Health (the department) via the Victorian Cost Data Collection (VCDC).

Victorian public hospitals are required to report costs for all activity, regardless of funding source, and are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Generally costing is undertaken once a year however some (few) health services do cost either quarterly or six monthly. The submission to the department is yearly.

1.1 Which costing systems are in use?

In Victoria there are three different costing vendors used – PowerHealth Solutions (16 sites), Syris Consulting (20 sites) and cbs – Business Intelligence Specialist (2 sites).

1.2 Training/support provided for costing practitioners

There is no official jurisdiction-wide training conducted for costing practitioners by the department. However, the department offers a variety of support such as:

- Monthly VCDC Technical Working Group meetings
- Funding and Costing Forums
- On-site assistance by the VCDC team where required
- Access to the VCDC Team as needed
- Provision of state-wide underlying costed data to assist health services undertake further business intelligence analysis.

1.3 Changes/ improvements in costing process and methodology

- The VCDC is reviewed yearly to ensure that the data submitted meets the local and national requirements. Health services costing practitioners also undertake reviews, in conjunction with relevant stakeholders, of their allocation methodologies, underlying data used in the costing process, general ledger reported expenses and linking/matching rules. Enhancements to feeder extracts have been

undertaken, specifically for non-admitted services, overhead allocations, mental health services and various other specific services identified by health services that can provide more granular detail to improve the allocation of costs.

- Victoria has submitted 2020-21 community mental health cost data at phase and episode level for 12 of the 17 Local Health Services (LHN) that deliver community mental health services. This is an increase from the 9 LHN included in the 2019-20 submission for community mental health. Further stipulations to this submission can be found in section 4.3.
- For some health services, their Clinical Management Information (CMI) system for non-admitted contact data was affected because of industrial action by the workforce which started in November 2020 and is ongoing (2/3 of the financial year, or 8 months). Work bans can be imposed which reduce data entry for CMI without affecting patient care. It has been estimated that 25% of contacts might be missing for a health service during this period. The extent of this impact cannot be determined as contact data entry varies between sub-centres. Therefore, costing teams adopted a methodology to ensure consistency in costing across these periods and ensure that the costing of patient contacts in periods unaffected by work bans is high quality. The preferred option is to create aggregate episodes with appropriate volumes for the missing contacts and use them to allocate costs. This was done in line with planned activity patterns and consultation with the mental health services.

2 Governance and use of cost data

2.1 How is patient level cost data used?

2.1.1 Hospital/district or network

Some health services use the data for:

- Funding analysis:
- Clinical and other research:
- Supporting evidence for business cases and decision making:
- Nationally Funded Centre works:
- Inform price setting for international patients:
- Reviews of contract arrangements:
- Inform planning of clinical services:
- Inform resource utilisation and effect clinical practice improvement:
- Supporting decisions on some inpatient clinical proposed changes to practice.

2.1.2 Jurisdiction

The department's use of the cost data includes, but not limited to:

- Assist in the implementation of a National Funding approach:
- Assist in the development of future funding models:
- Enable analysis of cost data across health services:
- Inform development of budget proposals:
- Analyse the cost of health care:
- Perform comparative benchmarking:
- Inform best practice quality improvement initiatives:
- Inform future initiatives:
- Provide costed results for consultations, research, and other studies:
- Enable Health Data Integrity reviews and audits: and

- Meet the cost data requirements of the National Health Reform Agreement (NHRA), via the National Hospital Cost Data Collection (NHCDC).

2.2 Patient cost data submitted to other collections

Some health services may submit patient level cost data to Health Roundtable, Women's Healthcare Australasia (WHA), Children's Healthcare Australia (CHA) and PowerHealth solutions for inclusion into their benchmark tool.

2.3 Consistency and standardisation of costing practices

Victorian public health services costing practices are consistent in their methodologies. Our health services follow guidance provided by the department which takes into consideration feedback after consultation with relevant stakeholders and costing practitioners.

2.3.1 Guidelines

To ensure there is consistent, reliable, and quality costed data, health services are to adhere to VCDC documentation, and any other documentation or guidance provided by the department as well as comply with the national Australian Hospital Patient Costing Standards (AHPCS) Version 4.0 or the most recent version available.

The VCDC documentation assists health services in the reporting and costing of patient level cost data providing details in relation to:

- Data Request Specifications – details of the requirements of the files to be submitted including the structure, values, and validation rules.
- Business Rules – guidance of specific criteria and conditions of the reporting and costing requirements to the Victorian Cost Data Collection.
- Specific Costing Guidance – guidance on specific conditions of areas for the reporting and costing requirements to Victorian Cost Data Collection.
- Review and Reconcile – details of the data quality assurance checks and reconciliation reporting requirements
- Communication – notifications at each stage of the submission process.

2.3.2 Forums

The department also conducts yearly Funding and Costing Forums. The forum is designed to assist in understanding service trends, explore variation in average costs, share information about costing practices, models of care and consider opportunities for improvements. It also enables valuable communication between health services and broaden knowledge about the quality and use of cost data.

These forums have led to improvements in the quality of cost and activity data reported leading to more, consistent, reliable, and higher quality comparable data as well as informing the continual development of Victorian patient level cost standards.

Due to the COVID-19 pandemic impacting 2020 and 2021 the full forum was not conducted, however specific settings were analysed, reviewed, and presented via on-line mediums.

2.4 Process for review and approval before submission to NHCDC

The VCDC submission involves a five-phase process to ensure the data submitted meets the reporting requirements and adherence to any guidance provided. The five phases include:

Phase 1 - receipt of submission. Acknowledgment of receipt of files and a summary report of the details submitted for verification.

Phase 2 – file validations. The submissions must follow the Data Request Specifications and where validations of each field have identified critical errors, these must be rectified by the health service and resubmit.

Phase 3 - linking/matching VCDC to activity. The VCDC follows a single submission multiple use format where the collections include a few fields that will enable the cost data to be linked and matched to activity records already submitted. Reports on the level of linking/matching are provided to health services for confirmation.

Phase 4 - data quality assurance checks. A suite of reports is provided to health services where records have been flagged as not meeting the criteria. The checks provide a level of understanding of the usefulness of the patient level data for development of funding models and interpretation for analysis and reporting. They compare the data submitted for the current year to prior years and to a state average where specified. It takes into consideration the total costs as well as specific cost bucket costs.

Phase 5 - reconciliation report and Data Quality Statement (DQS).

Once the final VCDC has been consolidated, the submission to the NHCDC is developed by the department ensuring that the reporting requirements are met in terms of the final cost centres, line items and activity reported. The NHCDC submission is reconciled to the VCDC and a brief prepared for sign off by the Secretary.

The NHCDC submission through the portal is also reconciled and any file validations are rectified. The quality assurance reports are reviewed and checked for inconsistencies not already known.

3 Compliance to standards

The Victorian submission to the Round 25 (2020-21) National Hospital Cost Data Collection (NHCDC) is based on the 2020-21 VCDC submissions.

The business rules for the VCDC collection are published annually by the department and provides guidance to health services in the costing and reporting of patient level cost data to the VCDC.

Victorian health services are required to adhere, where possible, to the Australian Hospital Patient Costing Standards (AHPCS) – version 4.1 (or the most recent version in the instance that a successor becomes available), the VCDC business rules and specifications and any other guidance provided by the department in the submission year. All expenses related to the treatment of patients have been allocated in accordance with the AHPCS v4.1.

3.1 Exceptions

3.1.1 Exceptions to the AHPCS standards include the following:

Capital and Depreciation - Victoria does not include non-cash expenditures such as depreciation as it does not impact upon operational costs and comparisons should not be driven by an asset’s estimated life.

Teaching and Training costs - where the sole purpose of the activity is teaching, and training Victoria includes these costs as an overhead. Where teaching and training cannot be separated from routine work undertaken, it has been included as a salary and wages expense.

Research costs - these activities and costs are excluded from Victoria’s submission pending further developments in the Activity Based Funding work stream.

Posthumous organ donation – the application of this standard is being considered within the Victorian cost group however extensive updates to the development of the specific guidance in V4.1 of the AHPCS is required to ensure full costing of Posthumous organ donations.

3.1.2 Transitioning to AHPCS standards for:

Allocation of Medical costs for private and public patients - Victorian health services will allocate medical expenses only relating to private patients where these can be distinguished between medical expenses relating to public. Otherwise, all medical expenses are allocated to patients regardless of funding source.

- The department is currently working with health services to determine their capability to comply with this standard as outlined in V4.1. However, Victoria will be reliant on further development of the V4 to the AHPCS to provide clarification and specific guidance on this standards application.

3.1.3 Specific areas

All prior year costs relating to patients discharged within the submission year but admitted in prior years have been included and no escalation of costs have been applied.

Blood product costs have been included as a line item in the submission as has the separation of PBS and NPBS drugs.

Medical costs associated with private patients have been included in the submission however Eastern Health is the only health service to exclude private patient medical costs for their non-admitted services only.

3.1.4 Ancillary costs for private patients

Most of the Victorian Health Services include ancillary costs for private patients in their NHCDC submission except for:

- Northern Health (Private patient pathology and radiology costs are excluded from the VCDC)
- Barwon Health (Private patient pathology costs are excluded from the VCDC)
- Ballarat Health (Private patient pathology and radiology costs are excluded from the VCDC)
- Peninsula Health (Private patient pathology costs are excluded from the VCDC)
- Western Health (Private patient pathology costs are excluded from the VCDC)
- Alfred Health Caulfield Campus (Private patient radiology costs are excluded from the VCDC)

4 Submitted cost data

4.1 Reporting hospitals

The number of health services submitting to the NHCDC can vary from year to year due to the timing of the submission date required by the IHPA. In 2020-21 38 health services incorporating 81 campuses providing costed data to the Victorian Cost Data Collection has been submitted to the NHCDC.

4.2 Costed activities

All costs in Victoria's NHCDC submission have accompanying activity that is recognised. Specific areas to note are outlined below.

4.2.1 Costed results and significant movements

4.2.1.1 Impact of COVID-19

Victoria began preparing for the impact of the COVID-19 pandemic from early March 2020 following the first case reported in late January 2020. The department developed specific Data capture guidelines for COVID-19, Principles for data capture of COVID-19 impacts and guidelines for COVID-19 cost centres, Finance, and patient level costing principles. These guidelines are to:

a. support the provision of estimates to the Commonwealth in relation to Hospital Services Payments and State Public Health Payments under the National Partnership on COVID-19 Response Agreement.

b. give visibility of the full range of impacts of COVID-19 which may or may not be covered by the NPCRA as recorded by health services in their General Ledgers in accordance with these guidelines.

c. enable clinical costing systems to reasonably allocate captured COVID-19 expenses to patients and report costing details nationally as required by the NPCRA and NHRA via the Victorian Cost Data Collection.

These guidelines identified activities related to COVID which were isolated into specific cost centres identified for those that are used in the treatment of patients and those that are considered as state public health.

Accompanying the guidelines, a cost allocation template was used to capture all activities related to the COVID-19 impact. The purpose is to provide guidance on the completion of the financial impact and the recording of data within health services' general ledgers and patient activities for COVID-19 to ensure data is captured consistently across health services.

The activities captured in the template may not have been fully translated into the general ledger which is used in the patient level costing process. Costing practitioners have endeavoured to replicate the template within the costing system GL and endeavoured to adhere to the guidance considering the overall impact to health services resource availability.

The pandemic had a significant impact on all patient services, workforce, patient volumes and data capture. The unprecedented impact of COVID-19 on the delivery of health care continued to be felt throughout the 2020-21 year with residential aged care COVID-19 outbreak continuing into FY20/21.There were 3 state mandated lockdowns, the first began early in the financial year. Many measures and changes in models of care were introduced and adapted to meet rapidly changing patient and bed demand, and support Commonwealth and the Department pandemic orders and public health recommendations. The costing process and structure were revised and updated to reflect and align with all these measures.

The national COVID-19 response – costing and pricing guidelines published in August 2020 was not updated to provide guidance on costing COVID-19 activities for 2020-21. Given that, Victorian health services were advised to continue to adhere to the Data capture guidelines which were updated as changes occurred.

The Data capture guidelines anticipated that isolating the expenses in distinct cost centres and the transfer of expenses related to the impact of COVID-19, will ensure expenditure throughout the financial year are aligned to the resources consumed during the treatment of all patients.

From March 2020 patients with confirmed or suspected of contracting COVID-19 were isolated into specific cost centres identifying expenses related to the treatment of patients and using the ICD codes related to COVID to allocate these expenses. Other specific cost centres were established to capture expenses relating to incremental costs attributable to resources/services related to factors associated with the outbreak of COVID-19 and not associated with NHRA in-scope health service activity.

Due to the complexities in providing the care and constantly be responsive and reactive to the patient care and bed demand from the COVID19 pandemic, a variety of ward locations were used to treat COVID-19

patients throughout the 2020-21 year. Due to this, the ICD10 codes were used to identify Covid impacted patients, who received a share of the costs reported in centralised and/or site-specific COVID cost centres.

Some health services also established Covid-19 Positive Pathway teams, COVID testing facilities and vaccination clinics for staff and the community where the activities were difficult to identify and therefore cost. This was also evident for the data capture of screening clinics. For the first half of the 2020-21 year, these were reported through our emergency dataset, where these were easily identified and costed. However, the latter half of the year saw a change in reporting requirements by the department where this activity was counted aggregately through a DH web portal and costed as such. That activity has not been reported to the NHCDC.

Like the previous year, the requirement to meet the State of Victoria's health network supply needs during the COVID-19 pandemic, arrangements are still in place with Health Purchasing Victoria (HPV) and Monash Health (the Arrangement). Victoria has negotiated with the Commonwealth to be able to claim expenditure relating to the consumables and equipment for COVID-19 purchased through the Arrangement on a cash basis. To avoid the Commonwealth paying for these items twice through the National Partnership Agreement and future versions of the National Efficient Price, it is important that as these items are consumed by individual hospitals, they can be separately identified and excluded from the normal costing exercise for 2020-21 or future years.

4.2.1.2 Non-admitted services

Victoria allocates a cost to all non-admitted activity whether at a patient level or aggregate level. We have submitted all cost records that have been able to link to a non-admitted activity record as well as provided cost records for those not linkable to activities due to under reporting and aggregate activities where they have not met our quality assurance checks for excluded records.

The records submitted to the VCDC at a patient level (or contact) may have been aggregated to a service event for submission to the NHCDC. Our reconciliations will be at a patient level.

Our health services review allocations and methodologies yearly to ensure that the resources are costed reasonably and accurately as possible. These reviews will vary results from year to year indicating improvement in the costed data.

4.3 Challenges with costing of specific products in Round 25

4.3.1 Phase of care

For the 2020-21 NHCDC collection, Victoria has submitted phase of care cost data for Palliative Care records and for Admitted Mental Health as well as some Mental Health community records.

4.3.1.1 Mental Health community

This community mental health cost data is submitted on a best-endeavours basis and in the spirit of trying to assist the IHPA with further development of the Australian Mental Health Classification (AMHCC) and the shadow pricing process. The Department of Health (DH) has conducted a high-level review of this data for these AMHS and it is considered reasonably complete in terms of coverage and inclusion of underlying data at contact level.

We stress that the quality and coverage of Victorian community mental health data submitted for 2020-21 can be expected to continue to improve over time. If the IHPA uses the 2020-21 community cost data for shadow pricing, the department emphasises that it needs to be treated with caution as it is still subject to review and potential revision. In particular, the data for Melbourne Health and Barwon Health needs to treated with

greater caution as the department has identified parts of the underlying data at these two health services that require further discussion/clarification with health services as part of our local quality review process.

Victoria is transitioning to report the cost data at a phase of care for Mental Health at both a bed based and community level for all health services who have a mental health service.

Health services access to the underlying data used to inform the resource allocation of expenses has been varied. This will impact on the consistency of allocation of costs. The department has developed guidance in relation to costing mental health however further enhancements to the guidelines are underway to ensure all aspects of patients and source data used in costing are addressed and adhered to.

4.3.1.2 Impact of COVID-19

The impact of COVID-19 since 2020 has provided some challenges with data collection, accounting for expenses and costing. To the best of our knowledge, our health service has adhered to the guidance and advice provided by the department and the Commonwealth in respect to the treatment of activities and costs related to the impact of COVID-19.

4.4 Quality assurance tests undertaken on the patient cost data

The VCDC submission involves a five-phase process to ensure the data submitted meets the requirements specified in Victoria's documentation. The five phases include:

Phase 1 - receipt of submission

Phase 2 - summary of submission and file validations – summary of details in submissions and validate the files upon submission for file format, structure, and value ranges

Phase 3 - linking/matching VCDC to activity dataset

Phase 4 - data quality assurance checks

Phase 5 - receipt of reconciliation report and Data Quality Statement (DQS)

4.4.1 Data quality assurance checks

Victoria ensures the cost data is relevant, reliable, and fit for purpose based on a set of validations and quality assurance checks performed. These enhance communication with health services by gaining knowledge of the reasons for some of the quality and completeness inconsistencies of the cost data across all service streams.

The continuous use of the quality assurance checks has led to improvements in the cost data. This in turn has increased the use of the cost data within health services by assisting in their decision making and understanding the implications that changes in practices/procedures/policies have on the resource consumptions of patients and/or services.

4.4.2 Reconciliation

Victoria's reconciliation report is designed to assist the department to understand the completeness of a health service's final submission including the source data by which the VCDC is created and its reconciliation. The data entered represents the data used for the final VCDC and NHCDC submissions for FY2020-21.

In accordance with local and national financial reviews it is recommended that a director's attestation will need to be signed when submitting the reconciliation report. This will acknowledge the validity and completeness of the data to be submitted and used through the local and national cost collections.

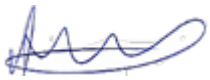
4.4.3 Data quality statement

For users to understand the quality of health services costed data, there is a requirement that health services complete a Data Quality Statement (DQS) which is a signed declaration confirming adherence to the national and local requirements including the standards and acknowledging the validity and completeness of the data submitted. As well as outlining any details impacting health services VCDC submission.

5 Assurance

Assurance is given that to the best of my knowledge the data provided are suitable to be used for the primary purpose of the National Hospital Cost Data Collection, which includes development of the National Efficient Price and National Efficient Cost.

Signed:



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