SA HEALTH RESPONSE TO THE INDEPENDENT HOSPITAL PRICING AUTHORITY *CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2017-18*

What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification? (pg 12)

SA Health is supportive of the review of AN-SNAP and in particular GEM classifications. Feedback from geriatricians has been that the FIM Cognitive score does not differentiate sufficiently between clients and their needs, therefore their preference was to use the SMMSE as the tool. SA agrees with the ultimate use of a combination of FIM Motor and SMMSE. However, in the interim, continued use of FIM is acceptable. Clinicians are collecting FIM and SMMSE but the funding system uses FIM and the ICD-10 code for dementia/ delirium (NEP is presently limited to a FIM score paired to 'with dementia' or 'without dementia'). We believe that this may (if not resolved quickly) lead to a problem with collecting SMMSE insofar as if it's not actually being used then how is it tested for accuracy etc. At the same time we are concerned that the use of ICD-10 codes could be inaccurate, or at the minimum, a very blunt way to measure. Hence, delays in the use of SMMSE as a differentiator for funding may become more problematic.

Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2017-18? (pg17)

SA supports the decision to start using the National Hospital Cost Data Collection (NHCDC) data to price non-admitted services for NEP17. SA also supports not introducing pricing for multidisciplinary case conferences where the patient is not present. Aside from the administrative burden this would place on outpatient departments, there is a chance that this could result in double counting of additional non-admitted activity. Such case conferences are probably better linked back as a service to a non-admitted service event where a patient was consulted/ treated. For patient costing, SA currently does this where possible, for example Allied Health preparation and follow-ups that occur on different days to the consult.

SA does not support the use of a proxy for mental health phase of care in the price determination. This is due to its potential inaccuracy and the message sent to clinicians that the collection of the mental health phase of care is not needed. However, SA does support the proxy work on mental health phase of care to be used in analysing the impact of implementing the new mental health classification system.

Should IHPA further restrict year-on-year changes in price weights? (pg 18)

SA believes there needs to be a balance between stability in the model and allowing the costs to speak for themselves. A cap of 20 percent allows for the majority of the DRGs to move in line with cost changes while restricting outliers to a maximum change. In supporting the cap of 20 percent being the current cap, SA would support no change for NEP17.

What are the priority areas for IHPA to consider when evaluating adjustments to NEP17? What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available. (pg 18)

It is South Australia's position that if the derivation of the NEP result strengthens the principles of the model, then the change should be seriously considered. For example, there should be consideration to have patient remoteness determined using

SA2s before postcodes, which SA supports and has previously provided data to IHPA. This would see remoteness allocated based on where a patient lives rather than how Australia Post delivers mail now that SA2 are in existence and allows the model to better account for remoteness (as an established feature).

Should IHPA phase out the private patient correction factor in 2018-19 if it feasible to do so? (pg 20)

SA does not support the removal of the private patient correction factor. The proposal to phase out the private patient correction factor is based on the assumption that the Costing Standard 3A.002 Allocation of Medical Costs for Private and Public Patients has or is being implemented. The effect of implementation of this standard across jurisdictions has not been formally assessed, although it is our understanding that no Jurisdiction has implemented it. At the April 2016 NHCDC Advisory Committee, the option of including this standard in the Round 19 Independent Financial Review or to otherwise have a workshop, was discussed and neither has occurred. The current work on Costing Standards Version 4 has to date not clarified the implementation of this standard and given that Version 4 is to be published in June 2017, it would impact the 2017-18 costing (at best) which would be used for NEP20.

This raises the general issue on how private patients are costed which needs to be better appreciated and accepted based on the review of actual outcomes / impacts before considering the cessation of the private patient correction factor.

Do you support IHPA's intention to introduce a bundled price for maternity care in future years? What stages of maternity care and patient groups should be included in the bundled price? Should IHPA include postnatal care provided to the newborn in the bundled price? What other issues should IHPA consider in developing the bundled price? (pg 24)

Bundled pricing for uncomplicated maternity care is supported by SA in principle. The definition of uncomplicated care must be acceptable to clinicians and have clear administrative guidelines to enable ease of implementation. If implementation is to go ahead, SA Health's preference would be for all stages of maternity care to be included or it defeats the purpose of the bundle. The bundle should only be applicable to uncomplicated births. As an initial position only those births that are classified to the AR-DRG O60C (Vaginal Delivery, Minor Complexity) should be included noting that any complex antenatal care should render the birth ineligible for bundled funding. Tertiary hospitals by their nature provide care to the most complicated antenatal patients. A bundled pricing approach must ensure that tertiary hospitals are not financially disadvantaged by achieving an uncomplicated birth after providing care for a complicated antenatal woman. It is SA Health's view that this type of patient (complex antenatal) should be excluded from a bundled pricing model.

The question of whether a newborn should be incorporated into the bundle is valid, however it is our belief that the mother and newborn should be funded separately. Uncomplicated births could result in a newborn that requires significant care and vice versa, linking the funding of the mother and newborn to the birth is not appropriate. Incorporating payment for the newborn into the bundle has the potential to disadvantage tertiary referral hospitals that will see more complex newborns, and hence higher cost, than other sites.

There are two key issues around the implementation of bundled pricing that must be addressed, the clinical implications and the administrative implications. Based on feedback received both from the Bundled Pricing Advisory Group and from our own clinicians there is interest in this pathway. This must however be weighed up against the administrative burden that such a model will place on sites and jurisdictions in capturing the necessary data.

One of the Pricing Guidelines (pg 7) states that funding arrangements should not unduly increase the administrative burden on hospital and system managers. Without a clear indication of how IHPA plans for the bundling of maternity care to be implemented it is hard to provide comment on whether this is practically possible. For example patient level non-admitted data is not collected by all site/jurisdictions and this is seen to be a key requirement in making the bundling of services viable.

Another consideration is that not all jurisdictions have a statewide patient identifier. Without this ID it will be very difficult to track patients across LHNs or the state. Part of South Australia's maternity model of care is that patients receive their ante and post-natal care at hospitals closer to home, while the birth occurs in more centralised locations. Care can also include a combination of public and private funded care, ie GPs provide antenatal care and the woman births in a public hospital. These difficulties are further compounded by the reality that antenatal, intrapartum and postpartum care will be provided across financial years in approximately 70% of pregnancies, thus making payment more difficult without a patient identifier

SA does not rule out the inclusion of bundled pricing in future NEP models but before agreement would like to understand how IHPA believes this will be technically implemented. Also how IHPA plans to deal with the fact that a good proportion of the bundles will span financial years which could have an implication on the costing of these services.

Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings? (pg 28)

South Australia (SA) is supportive of efforts to improve the safety and quality of healthcare through reducing the incidence of all avoidable complications. Regardless of care settings or hospital location, the safety and quality of patients should be monitored at all levels. While the ultimate aim is to ensure safe and quality care is provided, there is a need to operationalise any changes in a way that is practical to implement and monitor. It is also noted that pricing as a signal to change behaviour is one of a range of measures that should be implemented concurrently to improve the quality of healthcare.

The implementation of pricing and funding for safety and quality is arguably simpler in Activity Based Funded hospitals where the implications of each proposed option in an Activity Based Funding (ABF) environment can be modelled and understood.

Although SA supports the application of pricing for safety and quality in all hospitals, further consideration should be given to the methodology used to account for differences in how the National Efficient Cost (NEC) in block funded hospitals is applied compared to the National Efficient Price (NEP) in ABF hospitals. That is, block funded hospitals are paid an average cost based on size, complexity and remoteness not on individual episode NWAUs as is the case in ABF hospitals.

SA considers all care types to be in scope for safety and quality pricing and funding adjustments but the implementation should be staged to ensure each care type collects the requisite data. At present SA can see no data limitations in respect of admitted activity, in particular in relation to sentinel and some form of hospital acquired complications (HACs). Non-admitted activity (emergency and outpatient) is more difficult given the limited data collection of diagnosis and procedure codes. In addition, not all sites are currently submitting patient level data which would make identification and monitoring difficult. In light of changes to emergency and outpatient classifications in progress, it may be prudent to align any execution of safety and quality adjustments to the implementation timeframes of these new classifications.

What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care? (pg 30)

The Australia Commission in Safety and Quality in Health Care (ACSQHC) is currently undertaking further work on risk adjustments to the HAC list for use in a pricing and funding model. Should this work be completed prior to the proposed shadowing year, additional risk adjustment by IHPA may not be necessary. Until this time, the most appropriate methodology would be one that would be supported by clinicians. This would require some form of peer grouping of hospitals along with risk adjustment for relevant patient characteristics.

Based on presented analysis at the 29 September Technical Advisory Committee meeting, age seems to be a reasonably valid factor to recognise as a risk adjustment along with hospital peer groupings. It is also noted that a comorbidity measure (Charlson Index) which is used by ACSQHC in regard to Mortality Indicators could be incorporated into the model. SA would also recommend that palliative care type patients be excluded.

Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality? Are there other criteria that should be considered? (pg 31)

It is noted that in discussions at the DSOM Safety and Quality Sub-group, the following should be considered as potential assessment criteria for inclusion in a pricing and/ or funding model

- Preventability – Clinical evidence is available to demonstrate that the Hospital Acquired Condition (HAC) can be prevented with 'best clinical practice'
- Impact – The introduction of the financial adjustments related to specific hospital-acquired conditions will result in a significant enough change to funding at the hospital level to drive the intended clinical practice outcome, impact appropriately on patients and improve patient outcomes.
- Feasibility – Reporting mechanisms are sufficiently robust to ensure that any benefit obtained through under reporting is minimised.
- Equity – The application of pricing and funding adjustment does not unfairly impact any one, or group, of providers as a result of characteristics beyond their control (e.g. size, location and type of hospital)

In terms of preventability, it is also noted that clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of a complication occurring. Ultimately, these uninvited outcomes are a function of the given circumstances, some of which are beyond the direct control of the hospital. The recognition of an adjustment in the Pricing Framework (and Commonwealth funding) should not immediately support a legal claim for hospital based negligence should this occur.

Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently? (pg 33)

SA's position to date has been to support that no funding would be paid in respect of sentinel events. Given this represents a model change, consistent with other model changes, on first implementation, there would need to be a baseline established such that growth calculations performed by the Administrator are accurately calculated from a funding perspective.

For block funded hospitals, it is important to understand how this would work with the premise of the NEC model of funding (ie hospitals are paid an average cost based on size, complexity and remoteness not on individual episode NWAUs).

It is noted that there is currently a process underway through the Australian Health Ministers Advisory Council (AHMAC) for the ACSQHC to update the sentinel event list to make it more contemporary. Thought must be given to the process by which an updated sentinel event list will become incorporated into a pricing model. SA would favour a two-step process whereby a revised sentinel events list is first considered from clinical perspective (through ACSQHC), then separate consideration is given to the appropriateness of the revised list for pricing and funding. This second step should be incorporated into future IHPA Pricing Framework consultation processes and approved by Health Ministers through the COAG Health Council.

Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes? (pg 34)

The number of sentinel events IHPA has identified through the use of ICD-10-AM codes is substantially higher than the number of events being flagged in the Productivity Commission Report on Government Services data and internally reported. SA therefore supports methods that improve the accurate identification of these events and patient level flagging is considered a suitable option with sufficient lead time for system modifications.

Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)? (pg 35)

We note that IHPA has flagged that some work would need to be undertaken to create and administrate the use of a sentinel event flag.

What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC? (pg 44) What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates? (pg 46) What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties? (pg 47)

South Australia reserves its position on the options presented by IHPA noting that further detail on the operation of these options will be scoped. South Australia has a preference, however, for those options that are administratively simple, provide a clear signal to clinicians and where a risk adjustment can be appropriately applied. South Australia's assessment of each option is detailed below.

Option	Advantages	Disadvantages
1. Remove the HAC so that it does not contribute to DRG assignment	• Simple to administer and understand/explain. • States can monitor and report internally on the incidence of HACs and likely associated costs at the episodic level.	• Does not peer group hospitals. May inadvertently penalise hospitals that have a higher propensity to treat patients more likely to develop HACs. Further analysis on any potential bias across age groups or peer grouped hospitals is required. • May not send the appropriate price signal given the low proportion of episodes that actually change DRG complexity, as a result this option may not be adequately adjusting for risk. • To assist jurisdictions in monitoring the impact of this option it would be preferable for the AR-DRG grouper to be adjusted at a national level to account for this change then provided to jurisdictions.
2. Funding adjustments made on the basis of differences in HAC rates across hospitals	• Peer grouping of hospitals is a preferred safety and quality measure as it enables clinicians to benchmark their performance against their direct peers. • The ability to risk adjust the HACs to account for higher prevalence among certain groupings.	• States will be unable to effectively monitor the impacts outside of national reporting periods (currently 6 monthly). • An increase in the frequency of national reporting may be required. We note that other jurisdictions have previously expressed concern about increasing national reporting frequencies. • Risk that hospitals that fall just outside the top quartile to have no funding impact (and the reverse also applies). Consideration should be given to a scaled approach to reducing funding. • It is unclear under this option how differences in individual HAC rates across peer grouped hospitals would be assessed.
3. A quality-adjusted NEP with funding incentives for hospitals with the lowest HAC rates	• An option which combines funding incentives and penalties is likely to be viewed favourably by State Treasuries. • The Heads of Agreement (10.b) says: *Any downward adjustment to an individual state would not be deducted from the available pool of funding under the overall cap of 6.5 per cent*.	• As per above, monitoring of impacts is problematic. • SA would not necessarily receive back the funding lost as a result of a HAC. • Safety and Quality have previously expressed concern about funding options that distinguishes “good quality” care from “poor quality” care. • Introduces significant additional complexity to the funding model. • There is a risk that this could unfairly penalise hospitals that are improving the incidence of HACs. • The Commonwealth has previously indicated that it does not support the redistribution of funding in block grants.

Do you agree with IHPA's assessment of this option? (pg 44, 46 and 47)

IHPA has assessed each of the options as being transparent and easy to implement. We note, however, that the ability for jurisdictions to adequately monitor the incidence and funding impact of the HACs is significantly hampered under options 2 and 3. Both Option 2 and 3 would require additional information on how jurisdictions can monitor sites internally as there will be a need to monitor progress and quantify the potential impacts.

We also note that Option 1 may not meet the equity test in that the impact of this is likely to be felt more by hospitals that treat more patients with a higher propensity to have HACs. Further analysis (or risk adjustment) on any potential bias across age groups or peer grouped hospitals should be undertaken and provided to jurisdictions.

What are the advantages and disadvantages of the approaches to risk adjustment? (pg 46)

SA would prefer an approach which stratifies hospitals within peer groups. It is also indicated that an age adjustment should be investigated if this option is selected.

Are there any other pricing or funding options that IHPA should consider in relation to HACs? (pg 47)

SA is not proposing any additional pricing or funding options. IHPA may be in a position to provide additional advice in relation to the disadvantages noted in relation to each of the proposed options above.

South Australia notes that a further option has been presented by NSW that may have merit for further consideration. We note that this options aligns with SA's preferences for an adjustment that is administratively simple and provides a clear signal to clinicians. .

How should IHPA treat hospitals with poor quality COF reporting? (pg 48)

A hospital shouldn't escape adjustments on the basis of poor quality reporting, if confirmed to be the case. There should be some attribution to account for data gaps and promote improved reporting. This could include that the hospital in question automatically placed at the bottom of the hospital rankings or include a statewide average (minus hospitals that represent themselves as outliers) being applied to the recognised sites with poor reporting.

What approach is supported for setting timeframes within which avoidable hospital readmissions are measured? (pg 51)

There has been limited discussion about any of these options at Deputy Senior Officials level. However, it seems sensible that appropriate re-admission timeframes vary according to clinical condition.

Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes? (pg 51)

ACSQHC will be working with clinical panels to explore clinically meaningful readmission timeframes and is likely to recommend that these must be at the individual HAC level.

Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN? (pg 51)

SA notes that in an ideal sense, once a definition of avoidable readmissions is settled, all avoidable readmissions should in theory be treated similarly in the pricing model, but understands there are practical limitations to this.

It is also noted that the use of a Medicare PIN by IHPA to link readmissions to the same LHN will not readily enable States to match these records and independently vet data on readmissions as States do not currently have access to the Medicare PIN information. If this approach is to be used, additional access to information would be required. The methodology used by IHPA in identifying readmissions should be reproducible by the jurisdictions.

In SA's case, it should be noted that there will be many patients from rural/country areas that have had significant medical treatment (eg surgery) in metropolitan Adelaide LHNs. As a result, any potential avoidable readmissions to the Country SA LHN will not be caught in a definition of readmissions to the same LHN.

It is also important to note that it will not necessarily be the hospital which is responsible for re-admissions once the patient has left hospital. Post discharge, over time an increasing component care will be provided in the primary care sector (including general practitioners and community specialists). Therefore to create a financial penalty aimed purely at the hospital for a lack of community based care may not be appropriate and some sort of shared responsibility model could be considered.

When should a pricing and funding approach for avoidable readmissions be implemented? (pg 53)

It is considered that the work around avoidable readmissions as is in its infancy compared to the HACs and sentinel events and that significant further developmental work will be required (potentially in conjunction with ACSQHC) before this can be incorporated into the pricing model. It is noted that at a recent DSOM, a view was expressed that that any measure around this should not be implemented before 2019. SA is supportive of delayed implementation of this part of the pricing model.

It will be important that the methodology use to determine readmissions can be replicated by the jurisdictions. A phased approach to implementation could be taken whereby existing monitoring in respect of unplanned readmissions for selected surgical procedures is considered in the first instance.

What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality? (pg 54)

As noted in the IHPA paper, pricing and funding models for safety and quality should be considered as one element of a comprehensive solution to improving the quality of healthcare. It is noted that a significant concurrent work is being undertaken by the ACSQHC and within States and Territories. The IHPA paper also notes:

> *IHPA will also include information on safety and quality measures in the National Benchmarking Portal to allow clinicians, hospital managers and jurisdictions to compare data across hospitals to allow for meaningful comparisons to be made of the different rates of incidence in comparable hospitals*

Any pricing and funding models should seek to minimise perverse incentives that may lead to under reporting the incidence of adverse events of any kind.

Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models? (pg 54)
SA is of the opinion that incorporating pricing for safety and quality is a significant enough change to the current pricing model to require back casting.

ADDITIONAL COMMENTS

Shadowing: the implementation of shadowing from 1 July 2017 needs to allow jurisdictions to monitor how the HAC Option would be applied and what the implications would be. The aim would be that come 1 July 2018, sites are already familiar with the changes that are occurring. SA would want to understand the potential financial implications from implementing the model, but this information does not have to be publically released.

Timeframes for NEP/NEC Publications: While SA is keen to understand how pricing and funding for safety and quality will be implemented, it is also important that modelling for 2017/18 commences at the earliest possible instance. To this end SA would prefer the Final NEP and Final NEC to be released as soon as possible, with a further addendum once the safety and quality component is finalised if necessary.