Attachment 1: Tasmania's submission to IHACPA

Question	
1	What, if any, barriers are there to pricing emergency department services using the Australian Emergency Care Classification Version 1.1 without a shadow pricing period for NEP25? Tasmania agrees to the implementation of AECC V1.1 without a shadow pricing period and asks that IHACPA undertakes the usual analysis to safeguard jurisdictions from any adverse impacts that may arise from the implementation of the new version.
2	Are there any other proposed refinement areas to be considered in the development of an updated version of the Australian Emergency Care Classification? Mental health presentations in emergency care settings pose unique challenges and often require specialised assessment and management. Reviewing the classification system to ensure it captures the complexity of mental health presentations and interventions could improve care delivery and resource allocation for this patient cohort. These patients often present with acute issues which are reflected in the primary diagnosis and AECC end class however these issues are often the result of an acute mental episode.
3	Are there any barriers or known issues associated with reporting patient level data, specifically in relation to reporting principal diagnosis and patient's age in emergency services? Tasmania has experienced some issues relating to the recording of diagnosis, these were largely system related and are currently being worked through.
4	Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification for NEP25? Tasmania note the potential issue regarding diagnostics and the funding allocations to hospitals where care is provided by multiple hospitals virtually. This can result in funding for diagnostics being allocated to the wrong hospital due to diagnostic events being bundled in the costing process to the consultation rather than the patient location. There is no code that Allied Health Advanced Practice clinics can be accurately allocated to. As a result, in practice clinics are assigned inconsistent Tier 2 codes and may not attract funding in line with the cost to provide the service. Allied Health advanced practice clinics provide evidence-based care and treatment pathways, but funding is a barrier to establishing services. Nurse Practitioners are recognised within the Tier 2 services definition as providing services that a medical practitioner also provides (20.55 and 20.56), but appropriately credentialled autonomous Allied Health practitioners are not. Tasmania suggest that IHACPA investigate accurately defining and pricing advanced practice allied health clinics to support innovative evidence-based outcome driven models of care.

5	What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification Version 1.1 for NEP25? Tasmania has a concern that the end classes within the community setting of the AMHCC do not reflect resource homogeneous groups. Tasmania believe that patients classified within given end classes receive differing care and that the current price weights are an average of the variation in care provided. For example multidisciplinary case conferences, individual and group sessions are often provided to patients who would be grouped to a single end class in the AECC. Tasmania also note that for some of its remote mobile mental health services, for safety reasons, multiple clinicians may be involved in single patient contact. Tasmania is exploring these issues and will provide information it has to IHAPCA via the Mental Health Working Group.
6	Are there any persisting barriers to collecting activity data following the COVID-19 pandemic response? If so, what potential strategies could IHACPA use to support states and territories overcoming these barriers? Tasmania has no comment at this time.
7	What data-driven processes can be used to determine the efficient cost of teaching and training services to improve the transparency of block-funded amounts provided for these services, ahead of a potential longer-term transition to ABF? Tasmania has no comment at this time.
8	What evidence can stakeholders provide that demonstrates the costs and changes to models of care associated with the COVID-19 pandemic response have persisted into 2022–23, or changed over time? Tasmania has no comment at this time.
9	What principles and processes could guide an appropriate pricing response to significant disruptions to the health system, including natural disasters and epidemics? As noted by Tasmania in previous submissions regarding normalization of activity, defining what constitutes a "significant disruption" is key, there should be no ambiguity regarding when a policy should apply.
10	Should the ICU adjustment be restricted to a list of eligible hospitals? If so, what factors should be considered in determining the level of ICU complexity, required to be eligible to receive the ICU adjustment, noting that individual units cannot be identified in the current national data collections? Tasmania note that the cost of lower-level ICU care may already be included within specific end classes. Tasmania has not examined if the price weights adequately adjust for this. Tasmania notes the current review into ICU and recommend that the above issue be considered as part of this process.
11	Are there any barriers to a tiered adjustment that would allow for different ICU adjustment prices to apply, based on the characteristics of eligible hospitals or episodes of care within those hospitals? As per the response above
12	Are there any barriers to including a fixed national weighted activity unit adjustment for eligible hospitals, regardless of activity levels? As per the response above.
13	To support IHACPA's investigation, what factors may help explain the reduction in the Indigenous adjustment, observed in recent years? Additionally, what factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public hospital services for Aboriginal and Torres Strait Islander peoples across Australia? Tasmania has no comment at this time.

14	How should IHACPA account for the changes in data reporting when developing a costed dataset? Quality cost data should be emphasized over quantity. Having large volumes of data does not necessarily mean it is of a usable standard. It is important to ensure that data is representative of the given end classes.
15	How can IHACPA ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity? Ensuring adequate timelines for provision of clinical costing data by jurisdictions will allow that the best data is made available for pricing.
16	What quality assurance approaches are being implemented at the hospital or state and territory level that should be considered by IHACPA to apply to national data collections? The ability of small jurisdictions to dedicate resources to quality assurance processes is limited.
17	What changes would enhance the user experience and functionality of the National Benchmarking Portal to inform improvements in public hospitals, and policy making? Length of stay data is often needed for analysis and benchmarking purposes, there is currently no length of stay information available on the public National Benchmarking Portal. Further, jurisdictions should be given access to the more detailed National Benchmarking Portal that was previously available prior to the public launch. This included considerable more detail than the public portal.
18	What impact has the introduction of the pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions had on public hospital service delivery? Safety and quality data is used clinically by the Tasmanian Health Service to improve patient care, the impact of pricing adjustments has been minimal in comparison to the improvements made based on the clinical data.
19	To inform the further development of safety and quality measures, are there other pricing-related approaches that could be used to reward high quality care? How can IHACPA identify such care in national data collections? Incentive approaches to high and low value care provide lower risks than disincentive models. Tasmania has a concern that disincentive approaches to low value care must be very specifically defined to ensure that health systems are not unduly penalized. It is also important to note that there is not always a corresponding high value care to offset low value care.