Mater Misericordiae Limited (Mater Brisbane) – Feedback to IHPA on the "Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19"

AR-DRG classification

Question:

- Do you support the phasing out of older versions of AR-DRGs?
- What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

Mater Brisbane supports the phasing out of older versions of ARDRGs however the timing needs to be such that private providers and health funds have sufficient forward notice to ensure contracts are not reliant on unsupported DRG versions. As some health fund contracts cover a 3 year period, all versions of DRGs must be supported for at least 5 years to allow providers and health funds time to update funding models and contracts. There is significant systems, modelling, contract management and negotiation implications to major changes to contracts (such as DRG version changes) so the cost of these changes needs to be balanced against the potential benefit of more contemporary DRG versions.

Non-Admitted Services classification

Question:

- Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP 18?

Mater Brisbane supports data collection and analysis of this activity for the purposes of shadow pricing**.**

Stability of the National Pricing Model

Question:

- What are the priority areas for IHPA to consider when evaluating adjustemnts to NEP 18?
- What patient-based factors would provide the basis for these or other adjustments?

Mater Brisbane would support review of homelessness as a new adjustment for NEP18. Patient address information such as "no fixed address" would flag this patient cohort.

Bundled pricing for maternity care

Question:

- Do you support the proposed bundled pricing model for maternity care?

- Do you agree with IHPAs 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 IHPAs national data sets?

Mater Brisbane does not support the intention to introduce a bundled price for maternity care. We see the anticipated complexity of administering a bundled price for only a select group of patients to be an unnecessary impediment upon the delivery of healthcare. For health services (such as Mater) providing care to complex women every year, we see that only a small proportion of women would meet the criteria of being low risk. A more liberal use of bundled pricing could disadvantage services providing care to large numbers of complex patients.

Further explanation of the benefit the bundled price is to the patients/users of the healthcare system would be useful.

As acknowledged in the consultation paper, there are significant administrative and patient data impediments to current development of this model. Mater Brisbane will be interested in commenting further once these impediments have been addressed.

Risk adjustment model

Question:

- Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?

Yes, in general.

- Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

Yes, these (indicators) need to be looked at in the context of trends in other indicators

Policy context of pricing and funding models to reduce avoidable hospital readmissions

Question:

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

Preventability for more commonly occurring readmissions is a scale (of probability) as opposed to a statement of fact. There are few readmissions that can be determined through administratively derived intelligence that can be absolutely described as ‘preventable’. The date range where selected readmission has its highest correlation with health care organisation preventability lives somewhere from 7 days and fewer. As a result, it would be valuable to see the cut off range of readmission to be set at 7 days and using a scale of probability derived from studies and the application of a funding adjustment that models the identified probability (p = adjustment) of the avoidable readmission.

Criteria for assessing pricing and funding options

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?

Yes, assessment criteria appears adequate.