16 October 2020
Independent Hospital Pricing Authority

RESPONSE TO CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2021-2022

Thank you for the opportunity to contribute to the consultation on the pricing framework for Australian public hospital services 2021-2022. Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 15% of healthcare in Australia. Our members also provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly.

The following comments relate to the Consultation paper on the pricing framework released by IHPA and our responses to the consultation questions listed in the document.

Chapter 3:

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

- There have been many changes to hospital services as a result of COVID-19, particularly for screening, PPE usage, additional cleaning, and models of care.
    - Considerable costs have been incurred as a result of additional screening measures including additional staff to monitor entrances, policing visiting, and making on spot infection determinations. Hospitals testing patients receive pre-surgical COVID testing, requiring administrative follow which has also slowed down admission processes.
    - The additional management of theatre processes requires additional time between cases for cleaning and preparation time for staff due to increased PPE requirements including a PPE observer to ensure the appropriate preparation of each staff member.
    - There is considerable increase in the costs associated with PPE use including the additional time between patient encounters and providing care. These leads to increases in costs per case.
    - Processes for discharge have changed as some patients express the desire to be discharged home as soon as clinically stable to seek care in the home as an alternative to in hospital. This process for addressing needs may not be well developed in all cases and pressure upon the nursing staff numbers has complicated this care process. Many nurses have chosen to reduce hours, work in areas that

carry less risk or have been reduced in numbers due to COVID contact. While some moderate gains in length of stay may be evident for some procedures, the controls on Category 1 surgeries negate any hospital efficiency while not always being the most efficient solution for staffing.

- Activity levels have also been impacted. Surgical efficiencies have been lost through the inability to arrange 'common' procedure theatre lists and the method for surgical theatre time shifting to 'urgent' rather than speciality driven. Noticeable decreases in ED presentations, consultant appointments, and GP attendance indicate that there will be latent conditions not adequately addressed which implies late presentation being a feature of care needs. Patients with higher acuity needs when presenting will impact upon resource consumption for future services.
- Telehealth has led to a significant change in the hospital model of care. Antenatal, rehabilitation, and mental education and group therapy has successfully transitioned to video telehealth platforms with investment in rapid scale up by hospitals. There has also been greater use in telehealth by consultants and pre-admission for initial screening. Patients have expressed greater satisfaction with telehealth including the ease of communication and accessibility of care.

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

- It has been demonstrated that with the resumption of elective surgeries, the public system requires additional support from the private system in order to remediate waiting lists and manage the back-log of surgeries that were on hold during the quarantine restrictions, particularly for category 2 and 3 procedures. When utilising private hospitals, this will likely come at a higher cost per episode. Similarly, any use of overtime to extend services will increase the cost per case. These increases are likely to vary across states and territories dependent upon the level of restrictions that were implemented over time.
- CHA hospitals have seen reductions in ED presentations, consultant appointments, and GP attendances. Further studies in Australia have yielded similar results. Reductions in preventative screening and clinical presentations indicate many patients may delay seeking medical interventions. This will lead to potentially higher costs associated with delayed screening and higher acuity of needs of patients who present late to health providers.

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

- CHA recommends a video telehealth pricing model for group engagement as part of IHPAs considerations.
- The impact of 'COVID preparation time' will need to be captured in the clinical continuum

Chapter 4

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

- CHA agrees in principle with the revised wording for the IHPA pricing guide for public-private neutrality guidelines as it reflects the addendum intent. However, this funding neutrality is specific to the service provider and does not reflect the impact to the patients, e.g., previously waived OOPs for patients. Further analysis would need to be conducted on the impact this will have on patient choice and preference to reflect the principles guiding transparency.

Chapter 6

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

- CHA recommends that education releases should include a summary of changes at a high level, including number of code changes, rule changes, and shift in DRG impact. There should also include a summary of the rationale for these changes.
- There should also be an explanation of ACSs with a comparative table of edition changes that apply to previous editions, i.e., v8.0, 9, 10 etc. This is of particular importance to the private sector who work across multiple versions.
- An accompanying format that includes case examples for some of the more complex changes would assist in providing appropriate guidance for interpreting various scenarios as they arise from the changes.
- Analysis of the impact at the DRG level that includes a table of changes that may be seen as a result of ECCL value changes.
- Following the development of these changes, CHA recommends a post-implementation process for contact that allows hospitals to raise case concerns and an opportunity to seek guidance on the impact of resulting changes in a timely manner.

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

- CHA cautions against full replacement of the hard copy books and consideration for allowing both versions to be made available as required. CHA recommends retaining clinical coding hard copy books to provide a resource when system issues arise or disaster recovery is required to allow the continuation of workflows. Some coders and smaller rural hospitals still rely upon hard copy as a retained practice.

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

- CHA cautiously supports the new phase out periods for older AR-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. The proposed timing would take into consideration any required IT system changes, modelling and validations to avoid the possibility of any catastrophic unintended consequences, particularly for small hospitals with narrow casemix. Across the private sector, there are still come contracts that align to older DRG versions. CHA cautions that any changes to funding models will have an impact on the private sector and current contractual arrangements. The new proposed phase out period of 1 July 2022 for versions 5.0, 5.1, 5.2, 6.0, 6.0x, and 7.0 is achievable providing private sector availability of contemporary costing studies are produced with a 65%+ hospital participation rate. It is important to have greater commitment by the private sector to participate in the private NHCDC data collection.
- The impact of ICD-11 should also be tested in the private sector prior to implementation with modelling assessed between versions to ensure it is not implemented until all parties understand the relevant impacts to revenue.
- CHA also recommends the consideration of transfers in rural health. This would recognize the costs associated with accessing services in regional rural and remote areas and is necessary for rural hospitals. These services have limited capability in more acute areas of

care that should not be financially penalised in recognising the need for transfer at the earliest opportunity for patient safety and for not duplicating services where expert staff is not available.

- As a general principle, it would be beneficial to have consistency across the sector (state, federal, and private) on what is classified as admitted and non-admitted care. There is considerable variation across states and with respect to the private sector that is not well defined. The current HCP and PHDB data collections do not fully capture this information. Further datasets would need to define the overarching intent of the classifications to bring consistency in counting activity, similar to Victoria's Not Automatically Qualified for Admission (NAQAL) and Automatically Admitted Procedure List (APPL). CHA is supportive of the proposal to establish a national minimum dataset for non-admitted patient level data from 2021-22 and recommend this work continue with the view to consider private activity including the work completed in Victoria, the Victorian Integrated Non-Admitted Health (VINAH) dataset.

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?

- In reviewing the two refinements for nurse-led pain management and exercise physiology, IHPA should consider how variations in the model and mode for services impact delivery of care. There is currently wide variation across the sector that will need to be accounted for in future classifications.

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

- CHA supports IHPAs approach to carry out further testing in proposed MHPoC definitions. Currently, there is wide variation in the programs and therapies for similar diagnostic groups between services. Evidence based programs need to be the basis to determine a threshold for pricing.

Chapter 7

- Price Harmonisation: While the notion of seamless care provision that in hospital or out of hospital care depending on patients need is an efficient concept for hospitals, it should not be assumed that this choice is an either/or proposition. For example, many hospitals deliver complex chemotherapy regimens that are not considered cost efficient to be delivered in non-admitted settings. Comprehensive cancer services wrap-around patients that ensure the focus is upon holistic care and not purely drug delivery, including breast cancer nurses, psychological services, reconditioning strategy management, and management of side effects. Clinic or in-home service pricing addresses whether there is sufficient volume to accurately 'harmonise' pricing between service providers. For example, stand-alone clinics have a different investment in clinical governance processes and generally do not manage patients on complex clinical trials. Not all chemotherapy is the same. In the private sector, hospitals are required to track patient's outcomes in the non-admitted setting. However, small clinic environments do not have the same transparency in data reporting to State and Commonwealth authorities as there are no requirements to capture this data. Considering these variations in models and data requirements, CHA cautions whether non-admitted care can be captured to produce a harmonised price model.

- CHA suggest in Figure 3, the funding flows to LHN's should also reflect the funding received from private health insurers and the MBS directly.

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

- CHA requests clarification on whether there is evidence that the Costing Standards v4.0 have accurately addressed the collection of this data to measure the variance. In considering the equalisation of pricing for private patients treated in public hospitals, a vast majority of public hospitals 'waive' associated patients PHI policy excesses (out-of-pocket costs to consumers) which is entitled to be collected when private health insurance is elected. The private patient adjustment does not recognise the 'write off' of this revenue in addressing neutral pricing objectives. Public hospital compliance with HCP data submission to PHIs to cross validate costings should be mandatory to ensure this recognition is achieved.

Chapter 11

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

- Proposed outcome based funding models for bundling and capitation are predicated upon an integrated health care system (primary, secondary, and tertiary healthcare networks being seamless) and all reporting data via a single identifier in common databases. CHA is not confident that Australia has such a system that would support a true capitation model. While outcome based care is an important and appropriate objective, systems to assess and collect data across disparate providers and networks are problematic. The movements of patients between public and private sectors is more commonplace, especially in key specialities such as obstetrics (e.g., antenatal care provided by a GP or public hospital with patient electing a 'known gap' private delivery in a private hospital or vice versa). If the intention is to trial by April 2022, such alternative 'innovative' funding models should also be considered as to their impact across other sectors. In the private sector, any structural changes in funding will lead to health funds attempting to replicate the architecture of any such model. Private hospital involvement should be sought at the earliest opportunity as it is evident that public pricing methodologies are implemented in the private sector. This recognizes that public and private hospital care and funding models are no longer mutually exclusive. CHA advises IHPA should be aware of the downstream impacts earlier in the conception of changes and involve the broader sector in consultation.

Chapter 12

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

- CHA supports this approach as the most appropriate methodology, however the rule needs to include a provision that if the readmission episode costs more than the index episode, then the index episode cannot be reduced by more than $0. Alternatively, CHA considers whether there is a need to set a base price for the index episode.

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

- CHA notes that IHPA is seeking to remodel HAC readjustments to align with the approach adopted for the avoidable readmissions list. Private sector adoption of the ACSQHC list of

HACs are already in place and therefore any substantive change to adjustments needs to involve consultation with private hospital providers. It is also noted that the introduction of the 'avoidable readmission' financial adjustment penalty has a two year amnesty for shadow reporting. IHPA should make it evident that any adopting of a new model that applies financial adjustments needs to be also validated in the private sector and clearly explained that it remains unvalidated and not fit for purpose in the private sector until this work is also undertaken. For example, IHPA's modelling suggests a 0.15% to 0.63% impact to funding based upon the deduction of the readmission episode from the index episode. This adjustment factor outcome could have a profound impact on upon private hospital financial performance if the outcome modelled at a similar level. The work that IHPA does is not solely considered in isolation as a public sector impact.

- IHPA's work with 3M in co-developing software to accurately track readmissions is welcomes and noted for completion by the end of 2021. The provision of this software would provide for national benchmarking by peer grouped hospitals and would be a valuable benefit by utilising a single software provider for the purposes of reporting. It may provide a unique opportunity to have both public and private hospitals quality data measured in the same way and provide accuracy as a comparative outcome measure – patient outcome being the central premise in seeking private hospital participation. CHA wishes for clarification on whether IHPA is considering making this software freely available to all hospitals, public and private.