Healthscope submission:

Consultation Paper on Bundling Arrangements for General Use Items on the Prostheses List

14 October 2022
(extension granted)

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Executive summary

Healthscope thanks the Independent Hospital and Aged Care Pricing Authority for the opportunity to provide comments on the consultation paper on bundling arrangements for general use items on the Prostheses List.

Healthscope is not against the removal of General Use items from the Prostheses List, as long as an industry-endorsed funding mechanism is in place so private hospitals continue to be paid for their ongoing use and cost. We are, however, concerned any proposed 'bundled' payment methodology may inappropriately shift risk to private hospitals. We therefore need to reiterate that, should this occur, Healthscope will be unable to absorb further costs and will have no option but to pass these costs onto patients.

In our view, a bundled payment methodology has two core requirements to be successful:

- There needs to be clear and consistent consumption data against the diagnostic classification chosen for the bundle, and
- The classification must be sufficiently granular and homogeneous to minimise variability in item consumption within the classification.

As of today, Healthscope does not believe there is a credible, quality, Australian healthcare classification available supporting the allocation of General Use items for the purposes of bundling that does not result in the unreasonable risk transfer to private hospitals.

This is because the classification of General Use bundles by Australian Refined Diagnosis Related Group (AR-DRG) is not sufficiently homogeneous in clinical practice and resource use, which would therefore transfer procedural outlier risk to private hospitals.

Private health insurers are capitalised and regulated to manage outlier risk, not private hospitals.

While bundling General Use items to the level of AR-DRG and Principal Procedure based on the Australian Classification of Health Interventions (ACHI) would improve homogeneity, this would require development of an adjusted AR-DRG classification to ensure accuracy and consistency across the private health industry.

Under this approach, private hospitals would still need outlier protection as exists for other clinical services.

As such, Healthscope proposes the following solutions to issues with bundling:

1) An adjusted AR-DRG classification would need to be developed at AR-DRG and ACHI level to define General Use bundles to improve homogeneity and reduce risk to private hospitals.
2) The bundles must be made mandatory and cannot be subject to private health insurer 'approvals', documentation, or *ex gratia* payments.
3) The bundles should be priced at a premium per AR-DRG and ACHI to account for the increased and enduring risk transferred from private health insurers to private hospitals.
4) An outlier add-on price should be developed per AR-DRG and ACHI to ensure private hospitals are not unfairly penalised for undertaking complex work.

Healthscope has below provided general comments as well as our responses to the consultation questions contained in the paper.

Healthscope

Healthscope is Australia's only national private hospital operator, with 39 hospitals across all states and territories. We employ more than 19,000 people and partner with more than 17,500 accredited medical practitioners.

We provide the following submission in good faith, and to the best of our ability, however, should future consultations provide further detail, we reserve the right to provide more nuanced commentary at that stage.

Context for this submission

Healthscope acknowledges recent reforms and the current work streams into regulation reform in the private sector, including

- Private health insurance reforms (waves 1 and 2)
- Prostheses List reforms
- the EY consultation on default benefit arrangements
- the actuarial studies of Lifetime Health Cover and risk equalisation
- the actuarial studies of the Medicare Levy Surcharge and the private health insurance rebate.

Healthscope is concerned this many work streams of reform, consultations and stakeholder engagement processes, risks seeing a siloed approach to sector reform, overlooking key interdependencies between policy initiatives, and delivering fragmented advice to Government. Stakeholders also risk missing essential reform proposals or, worse, in preparing responses miss the bigger picture. Healthscope believes adopting a holistic, system-wide approach is essential to achieving sustainable private health sector reform.

In providing input into these various reform processes, Healthscope has sought to be as consistent as possible in our approach. We note we make our submissions with a number of overarching principles to reform, to enable this consistency across submissions where possible. These principles are:

Reform principles

1. Any health reform should be **patient-centric**, and should only be made to improve patient outcomes.
2. The **primacy of clinical independence must be a central tenet** for any health reform.
3. The **critical role of the private hospital sector in the Australian health ecosystem** should be recognised. This role is significant and necessary for the effective functioning of the Australian health system overall.
4. Any private health reform needs to improve **the sustainability of the health sector as a whole**. Reform which simply transfers cost or risk between players in the sector is not addressing its long-term viability or its relationship to the cost of public health provision.

We posit these principles remain, and make our submission within that context.

Current environment

It is impossible for us to provide this submission without acknowledging the current tumultuous operating environment for the private hospital sector. We are experiencing a once-in-a-century pandemic, with the operational and financial impacts that entails. We felt the impact of elective surgery stoppages acutely, and continue to be financially impacted by the pandemic, through staff and doctor furloughing and burnout (our people's sick leave was twice as high as usual this winter), higher cleaning and personal protective equipment costs, and fewer than expected patients accessing care.

Concurrently, the private hospital sector is facing a large number of Government reviews and reforms, including the Private Health Insurance reforms listed above, the Medicare Benefits Schedule (MBS) review implementation and Prostheses List reform. All of these reviews and reforms carry a large amount of uncertainty for the sector and sometimes-significant risk of revenue loss as experienced with the outcomes of the Medicare Benefits Schedule review and the first stage of Prostheses List review. These impacts are exacerbated by the costs of new government regulation (state and federal), rising inflation and workforce shortages.

Healthscope consultation response

General comments

Healthscope believes safeguards need to be put in place to ensure private hospitals and patients are not adversely impacted by the proposed bundling of General Use items.

Remuneration of General Use items

Healthscope is not against the removal of General Use items from the Prostheses List, however, we reiterate the items coming off the list remain clinically necessary (as acknowledged both by EY in their options paper for the General Miscellaneous Category in 2021 and the Department of Health and Aged Care on multiple occasions). As such, there needs to be a payment mechanism in place for the items coming off the Prostheses List.

However, Healthscope is pessimistic private health insurers will continue to fund these items when they are no longer compelled to do so. If the Department does not make the bundles mandatory, private hospitals will be left to foot the bill of the General Use items, which is not a cost we will be able to absorb. If private health insurers do not compensate or adequately compensate private hospitals for the cost of these bundles, we will have no choice but to pass on these costs to patients.

Transfer of risk

Healthscope is concerned bundled payments will inappropriately shift risk to hospitals. In analysing the available data on prostheses utilisation, it has been shown there is significant variation in prostheses cost between procedures as well as between hospitals and doctors. The nature of bundling will mean an average payment will be devised for items taken off the Prostheses List, decreasing the risk of variation for private health insurers (who are structured to manage outlier risk) and transferring this risk to private hospitals (who are not).

These changes will result in the transfer of risk for both the price and utilisation of General Use items from private health insurers to private hospitals. Private health insurers may not adequately reflect the transfer in cost and risk to private hospitals that will result from removing items from the Prostheses List. Therefore, private health insurers should be required to ensure price adjustments to their funding mechanisms for hospital services not only ensures continued funding of General Use items, but that they include a price premium and outlier arrangements to reflect the increased and enduring risk transferred to private hospitals as a result of these changes.

Outlier risk

Current DRG-based funding mechanisms are meant as risk sharing arrangements between payers (private health insurers) and healthcare providers (private hospitals). Therefore, while there is an average payment per DRG, there are also outlier arrangements in place. If a patient episode was more simple than expected (based on bed days), the payment is reduced. If the episode was more complex (again on bed days), there is an add-on payment. However, payers and healthcare providers will only accept a DRG funding model if they agree both (a) the DRG appropriately defines each case, on average; and (b) the outlier arrangements appropriately acknowledge and share risk. A risk sharing agreement would need private health insurer, private hospital and clinician endorsement.

Lack of robust data

The IHACPA's bundling methodology (yet to be developed) will need two core elements to be successful:

- Clear and consistent consumption data on cost and utilisation
- Sufficiently granular and homogeneous classification to minimise variability in item consumption.

As of today, Healthscope does not believe there is a credible, quality, Australian healthcare classification available supporting the allocation of General Use items for the purposes of bundling that does not result in the unreasonable transfer of risk to private hospitals.

This is because the classification of General Use bundles by AR-DRG is not sufficiently homogeneous in clinical practice and resource use, which would therefore transfer procedural outlier risk to private hospitals. Private health insurers, not private hospitals, are capitalised and regulated to manage outlier risk.

While bundling General Use items to the level of AR-DRG and Principal Procedure based on ACHI would improve homogeneity, this would require development of an adjusted AR-DRG classification to ensure accuracy and consistency across the private health industry.

However, there is only standardised, complete cost data available for public hospitals – not private hospitals – in Australia to support AR-DRG development, which would complicate the ability of IHACPA to undertake this work.

Under this approach, private hospitals would still need outlier protection as exists for other clinical services.

What is the solution?

Noting the above limitations in the available data, Healthscope notes there are some threshold issues to resolve for if bundling of items is to be successful.

1) An adjusted AR-DRG classification would need to be developed at AR-DRG and ACHI level to define General Use bundles to improve homogeneity and reduce risks to private hospitals.
2) The bundles must be made mandatory and cannot be subject to private health insurer 'approvals', documentation, or *ex gratia* payments.
3) The bundles should be priced at a premium to account for the added and enduring risk transferred from private health insurers to private hospitals.
4) An outlier add-on price should be developed per DRG to ensure private hospitals are not unfairly penalised for complex work.

Healthscope would also encourage Government to monitor how the implementation of bundling is affecting admissions to public hospitals and whether significant shifts in casemix in private will become evident as a result of these changes.

Implementation implications

Noting the above issues with the development of the bundles, there are also a number of implementation issues Healthscope wishes to flag.

If private health insurers do not compensate or adequately compensate private hospitals for the cost of the bundles, private hospitals will have no choice but to pass on these costs to patients. Healthscope therefore strongly urges the Australian Government to ensure the bundle prices, once developed, are made mandatory, and not left up to negotiations and/or private health insurer 'goodwill' to reimburse private hospitals.

Broken down into stakeholder groups, Healthscope believes the implications of un-funded bundles will be as follows:

Implications for patients

- As private health insurers might no longer fund the actual costs of unexpectedly complex procedures, and hospitals cannot themselves manage or absorb this risk, hospitals will need to pass these costs on to patients. As such, out of pocket costs will increase.
- Uncertainty will increase, as hospitals will be unable to advise patient in advance how much the out of pocket cost may be.
- Private patients in private risk having their clinical care and choices compromised.

Implications for clinicians

- Clinical decision making risks being inappropriately influenced by financial considerations based on what funders will pay for or not. The decision algorithm a surgeon uses during one single procedure is a complex interplay of many factors all of which must centre on the best patient outcome and not economics.

Implications for the Australian health system

- The above point on impact on clinical choice will ultimately further erode the value proposition for maintaining private health insurance, including if hospitals and funds go out of contract more frequently based on disputes about appropriate cost recovery.
- Where prostheses cost is clear and easily derived prior to surgery, an 'average unit price' may provide perverse incentives for surgeons (and hospitals) to cherry pick or encourage procedures at the lower end of the cost spectrum and direct more expensive prostheses cost cases to the public sector. Should this start occurring, it will have a significant financial impact on public hospitals and on their surgery waiting times, and is not beneficial to patients or their clinical outcomes.

- The private hospital sector does two-thirds (66%) of all elective surgery in Australia. Both the nature and range of devices and the proportion in which they are used is different to the public sector, and the complexities of funding for private hospitals has not been adequately contemplated in the proposed reforms, with concerning consequences for long-term sustainability if cost and risk transfer occurs from funders to hospitals.

Timeframes

Finally, the timeframes for implementation of bundling will be important. Pricing in private hospital and private health insurer contracts are fixed over longer timeframes, such as a two to three-year term. Any pricing changes can generally only be negotiated after this period ends and a new contract needs to be negotiated. It is therefore essential the Department ensures new funding mechanisms are established in contractual arrangements between private health insurers and private hospitals *before* items are removed from the Prostheses List.

Healthscope notes the current timelines are that information on the bundles will be made available in April 2023, only allowing three months for administrative and system changes to be implemented. Should the Department not mandate both the approach and the defined amount for General Use bundles, these would require renegotiations with private health insurers that would be impractical to undertake before the current proposed implementation on 1 July 2023.

We therefore reiterate the announcements around the bundling of items are not delayed lest the implementation deadline of 1 July 2023 will arrive before the sector has worked through the necessary changes.

Consultation questions

1. **Are you aware of any issues with the HCP data collection that may impact on the way it captures utilisation of General Use Items for private patient services? Please provide detailed examples that illustrate these issues where possible.**

Hospital Casemix Protocol (HCP) data is a dataset of private hospital episodes funded by private health insurance. This data is provided from private hospitals to the private health insurer who pays for the episode, who adds financial information to the episodic data and then forwards it on to the Department to be included in the dataset.

HCP only includes activity paid for by private health insurers. While most (80%) of private hospital activity is funded by private health insurance, the HCP data does not capture any information on patients funded through other means, including those who are self-funded.

By contrast, the Prostheses List is used more broadly, also by other funders in health, such as the Department of Veteran Affairs, the Australian Defence Force, WorkSafe Victoria, the Transport Accident Commission, and others. In other words, one in five episodes occurring in private hospitals is not captured in the HCP dataset.

As HCP data are not a complete snapshot of private hospital activity, they will need to be cross-referenced and supplemented as suggested by the consultation paper.

2. **Do you have any comments on the quality and utility of the proposed data sources for the development of advice on bundling arrangements for General Use Items? Please provide details.**

IHACPA has covered the main quality issues of the proposed data sets in paper, however, Healthscope is also engaging with your team through the Working Group, and will provide our detailed input through those processes.

Furthermore, as stated above, we do not believe there is sufficiently robust data available to support allocation of General Use items to any form of classification system in use in private hospitals in Australia:

- Classification at an AR-DRG level is not sufficiently granular and homogeneous on clinical practice and resource use, which would transfer procedural outlier risk to private hospitals.
- Bundling to AR-DRG and ACHI would improve homogeneity but would require the development of an adjusted AR-DRG classification for application across the private health sector.
- There is only standard, complete cost data available for public hospitals – not private hospitals – in Australia to support AR-DRG development, which would complicate the ability of IHACPA to undertake this work.

3. **Are there any other sources of data or empirical information that may be useful in defining alternative bundling arrangements for General Use Items? If so, please identify the specific information and describe the way in which the information could be utilised.**

Yes, the bundling of General Use items should be considered in the context of the overall funding that private hospitals receive under various funding models used by payers, including private health insurers.

While IHACPA has developed a single funding model to support activity based funding (ABF) for the majority of public hospitals, Healthscope is subject to a large number of funding models across our 39 private hospitals with private health insurers as well as other funders. Inconsistent and complex funding models result in Healthscope needing to cross-subsidise across our 39 hospitals and various types of services in order to provide hospital care to patients on a profitable basis.

The funding models used by private health insurers and other funders vary across the following components:

- **Healthcare classification** – IHACPA uses AR-DRG version 10.0 to define acute hospital episodes for public hospital funding but there is no requirement on funders to use a standard classification to fund private hospitals.
- **Pricing** – IHACPA has developed a national efficient price (NEP) that applies to the funding of most public hospital care but funders use inconsistent pricing across private hospitals.
- **Outlier arrangements** – IHACPA uses a standardised methodology (L3H3) to define typical and outlier episodes of care as well as outlier payments (short-stay, long-stay), however, funders use custom, *ad hoc* arrangements with private hospitals.
- **Add-on payments** – IHACPA has a standard methodology to define and fund intensive care (ICU) treatment but funders have a range of custom definitions and payment mechanisms for these and other services in private hospitals.
- **Terms and conditions** – IHACPA has designed, tested and implemented funding adjustments for safety and quality (e.g. hospital acquired complications) in the public sector but funders apply a range of custom, ad hoc definitions and funding adjustments to private hospitals.
- **Indexation** – IHACPA has developed a cost inflation mechanism to apply to the NEP, but private health insurers and other funders are under no obligation to cover inflation costs of private hospitals in their funding models (and mostly don't).

Therefore, Healthscope recommends IHACPA seek access to the individual funding models used by private health insurers and other funders for funding private hospitals in order to assess:

a. Firstly, the underlying risk private hospitals are paid fairly and adequately under existing funding models with private health insurers and other funders.
b. Secondly, the capacity of private hospitals to absorb more risk of being paid fairly and adequately following the bundling of General Use items.
c. Thirdly, should the bundling of General Use items be implemented, the mechanisms required to mitigate the risks of private hospitals being paid fairly and adequately.

Healthscope would be willing to provide the details of funding models used across our 39 private hospitals with funders to IHACPA for these purposes on a commercial-in-confidence basis. However, it should be noted other private hospitals may not use the same funding models as Healthscope and therefore sourcing these details directly from private health insurers and other funders may provide a more comprehensive picture of the scope of different funding arrangements.

4. **Do you support or oppose the use of the PL product classification within the design of General Use Item bundles? Please provide details in terms of the specific features of the PL classification.**

The Prostheses List product classification is relevant for the management and utilisation of the Prostheses List in the current setting where private hospitals seek reimbursement from payers for the use of Prostheses List items on an itemised, pass-through basis.

However, for bundled arrangements, it is the mix, cost and variability of Prostheses List items to be bundled for specifically defined procedures and/or episodes of patient care that is of interest – not their current or previous Prostheses List product classification.

The items to be bundled are used in a broad range of procedures and their use will significantly vary depending on:

- The type of procedure
- The nature and complexity of the case
- The individual doctor (VMO) using the product.

Healthscope maintains serious concerns the bundles will not adequately protect private hospitals when performing complex procedures and 'outlier' work. It is essential the final bundles compensate private hospitals adequately for the items utilised in any given case. Failure to do so is likely to result in patient out of pockets and, in some cases, some procedures becoming unviable in private hospital settings, putting further strain on public hospitals.

5. **Do you support or oppose the use of the ICD-10-AM/ACHI/ACS classifications within the design of General Use Item bundles? Please provide details of any perceived issues or benefits regarding the use of these classifications.**

In our previous submissions to the Prostheses List reform processes, Healthscope noted:

> "Australian Classification of Healthcare Interventions (ACHI) procedure data are more influential factors driving device use."

We would therefore support the use of these classifications in combination with AR-DRG to ensure greater granularity and homogeneity in order to develop the necessary understanding of cost and utilisation of General Use items.

6. **Do you support or oppose the use of hospital characteristics within the design of General Use Item bundles? Please provide details of any perceived issues or benefits regarding the use of hospital characteristics.**

Healthscope acknowledges that potential healthcare classifications used to assess options for the bundling arrangements of General Use items, such as AR-DRG and ACHI, may not adequately differentiate the complexity – and therefore cost – of patient care in different types of hospitals.

Therefore, Healthscope supports the consideration of the impact of hospital characteristics on General Use bundling arrangements and presentation of these to the sector in public consultations for feedback.

However, Healthscope considers overall risk transfer and outlier arrangements that would result from the bundling of General Use items as more material items for IHACPA to consider.

7. **Are there any other classification systems that IHACPA should incorporate in the design of General Use Item bundles? If so, please provide details of these classifications and a rationale for their use.**

No.

8. **Are you aware of any short-term changes, brought on by the impact of COVID-19, to the utilisation of General Use Items among episodes in which these items are used? If so, please provide details that enable the changes to be examined using the 2020–21 HCP data collection.**

No. Healthscope recommends IHACPA uses the most current data available for the purposes of their analysis and recommends to reflect contemporary clinical practice and resource use.

IHACPA should consider, in this context, how bundling arrangements for General Use items are maintained and updated so they continue to reflect contemporary clinical practice and resource use by private hospitals.

9. **Are you aware of any existing contracting arrangements between hospitals and insurers that might be considered relevant in the formulation of advice on alternative bundling arrangements? If so, please provide details of the arrangements, noting that IHACPA will ensure confidentiality of this information wherever necessary.**

Please refer to our response under Question 3 above.

We also wish to reiterate that funding arrangements in the private healthcare sector are complex. Private health insurers have each developed their own funding mechanisms that the Grattan Institute labelled 'idiosyncratic'. The lack of standardisation of funding models means every funder has their own; which is unwieldy for private hospitals.

In contractual arrangements with private health insurers, we not only have different funding mechanisms for hospital services with each health insurer, but different funding mechanisms within a single health insurer across Healthscope hospitals. Any changes to the Prostheses List will need to appreciate and contemplate these complexities.

10. **Are you aware of any instances where a General Use Item charge is raised against an individual episode but where the item is used across multiple episodes, such as might occur for multi-pack or multi-use type items? If so, please provide details.**

Yes, there are a number of devices, especially drug delivery devices, where the item charge would be raised against the initial episode, but the item is continuously in use over a number of episodes.

However, it is worth noting here that even where this happens, it may not happen every time the item is used, and it would be entirely dependent on the individual patient's circumstances.

11. **Are there any other issues of relevance to the formulation of advice on alternative bundling arrangements? If so, please provide details on these issues and their materiality with regard to the formulation of advice.**

As mentioned in our general comments, Healthscope is pessimistic private health insurers will continue to fund these items. If the Department does not make the bundles, once developed, mandatory in some way, private hospitals will be left to foot the bill of the General Use items, which is not a cost we will be able to absorb, and we will need to pass on these costs to patients.