Australian Health Service Alliance

21st August 2017

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483, Darlinghurst NSW 1300

Dear James

Re: Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19

Thank you for the opportunity to comment on the recent consultation paper.

AHSA has made comments only on those topics where we have points to raise, and these are in appendix 1.

Should you wish to discuss any aspects of this response, please contact Dr Brian Hanning brian@ahsa.com.au or Nicolle Predl nicolle@ahsa.com.au.

Yours sincerely

B. W. J. Hanning

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Appendix 1 – Consultation Questions

Australian Refined Diagnosis Related Group classification

1) ***What additional areas should IHPA consider in developing Version 10 of the Australian - Refined Diagnosis Related Groups classification system?***

IHPA should ensure that the classification is fit for purpose for the whole of the Australian health system, not just the public sector. Care should be given to analyse utilization change of particular interventions or technologies that may occur more in the private sector. Whilst AHSA understands that cost data may not be available, the episode data is readily available. There was precedent for this in the AR-DRGv5 formulation.

A good example of this is the growth in neurostimulator devices which were removed from the last classification due to a reduction of cases in the public sector, despite a demonstrated significant growth in the private sector.

AHSA believes that AR-DRGs should be developed based on the experience of all hospitals – both public and private. LOS parameters are readily available for both sectors but as noted cost parameters are different particularly in relation to the treatment of doctor charges and the prices charged for prostheses. AHSA believes it would be possible to analyse a total hospital dataset based on relative costs with exclusion of costs not common to both sectors. This should be used for AR-DRG construction only and should be distinguished from the use of such information for funding

It will be helpful when we can differentiate those procedures done using a Da Vinci robot versus those which are not, as this will facilitate rigorously analysing the effect on readmissions, cost variation, LOS variation and patient outcomes.

Care needs to be taken with the new prolonged ventilation AR-DRGv9s – the A13 (over 336 hours where tracheostomy to facilitate prolonged ventilation is virtually certain) and A14 stems (between 96 hours and 336 hours where tracheostomy to facilitate ventilation will be uncommon). This point is made based on our internal AR-DRG model where high level ICU is paid on the basis of MV. This has raised issues of the precise definition of ventilation particularly in the context of weaning from MV and the role of non-invasive ventilation (NIV). This issue will become important for all funders under AR-DRGv9 as the count of ventilation hours will affect whether a case maps into an A13 or A14 stem. It is anticipated that A13 AR-DRGs will be more highly paid than A14 AR-DRGs. As part of development of AR-DRGv10 the effect of the changes made in this area in the development of AR-DRGv9 should be reviewed to ensure no unintended consequences have arisen

NIV as currently defined covers a wide range of conditions from the simple to the very complex where it may be in effect a substitute for MV. Consideration should to be given to defining subgroups of NIV so any subgroup equivalent to MV can be rigorously defined.

An area which is growing but where data is poor relates to the use of repetitive Transcranial Magnetic Stimulation (r-TMS). While this issue has been raised under AR-DRGs it also has implications for outpatient classification and the AMHCC .This modality is used in the context of resistant depression and has a body of evidence supporting its use in this context although there is a range of opinion among psychiatrists about its usefulness. It has also been used in other area where the evidence is much less persuasive. Highly specific codes should be introduced r-TMS for both the inpatient and outpatient settings. This will enable a much fuller understanding how often and in what context it is used, and facilitate understanding trends in its use. There is evidence that there are now thousands of instances of r-TMS administration in the private sector annually and it is also being used in the public sector in a number of jurisdictions.

2) ***Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?***

Yes, but in a wider context that needs careful consideration and consultation. Currently, the most current version of AR-DRGs available to the private sector for use in payment models is 6x, as this is the most current version with cost weights available to develop AR-DRG based payment models (see highlight in table below)

ICD Version	Native DRG version	Year of release	Grouper		Costing Study Released
			Start Date	End Date	
1002	4.2	2000	1/07/1998	30/06/2002	Round 13 most current
1004	5.1	2004	1/07/2004	30/06/2006	Round 13 most current
1007	6.x	2010	1/07/2010	30/06/2013	Round 16 most current
1008	7.0	2013	1/07/2013	30/06/2015	No costing study released
1009	8.0	2015	1/07/2015	30/06/2017	No costing study released
1010	9.0	2017	1/07/2015	30/06/2019	No costing study released
1011	10	2019	1/07/2019	30/06/2021	No costing study released

It is impractical to think that the private sector be mandated to move to AR-DRG versions that have no private sector costing studies. Furthermore, for those funds and hospitals that are still remaining on 4.2 and 5.1, there is little incentive to move to the "current" AR-DRG version (6x) when it in itself is becoming out of date. Given the resources required for hospitals and funds to move to a new version, it would be more attractive for hospitals to move to say AR-DRGv8 to have some longevity of their contracts, than move to 6x which could be phased out more quickly.

As the Private Healthcare Australia (PHA) representative on the AR-DRG Technical Group (DTG), AHSA has initiated discussion and consultation with industry regarding this topic This included a survey of the entire private health insurance sector to seek their views on the plausibility of ceasing support for version 4.2. AHSA has reported the findings back to the DTG and actively engaged with IHPA regarding this topic. To date, no meetings have been initiated by IHPA despite our best endeavours to set this up.

In relation to specific consultation questions asked:

- AHSA believes that a phase out of 4.2 by the end of June 2019 is workable.
- A phase out of version 5 would require significant consultation with the private sector, both private hospitals and insurers. Furthermore, any time period for cessation should be considered in context of the fact that some health insurers have long term agreements (>2 years) locked in under AR-DRGv5. There also needs to be more current private sector costing studies.
- AHSA does not support the phase-out of all AR-DRG versions prior to AR-DRGv7, due to the challenges in the private sector which are outlined below that do not exist in the public sector.

We reiterate the following barriers which exist for the private sector:

- Private sector costing studies currently do not exist beyond AR-DRGv6x
- Each insurer has their own agreements with each hospital or group
- They all have different contract periods, and some go for a term of up to 3 years
- Each hospital/fund needs to remodel any change to an AR-DRG version in terms of the impact to both parties
- Each hospital/fund then needs to agree to move to the new version.

3) ***What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?***

This question is answered with consideration to all points raised in question 2. Given the workload and financial impact (to both parties) surrounding conversions, hospitals and

insurers need stability in contracts within each AR-DRG version for several years, rather than a need to change on a regular basis.

As a guide, the private sector needs up to five years after the release of a generally endorsed costing study in a given AR-DRG version before the prior version is phased out. This statement is only achievable if current costing studies are regularly available in the private sector in current AR-DRG versions. It is also to be considered in context of the commercial arrangements that exist where any change in version requires mutual agreement by both parties.

It the context of the private sector this means that it would be five years after the release of a robust successor to the AR-DRGv6x study before support for 6x could be considered for phase out.

The private sector is currently at almost a standstill; why would hospitals currently consider moving off 5.1, when 6x is the only alternative, and the life span is proposed to be phased out soon, as per your consultation paper? AHSA cannot stress enough that the importance of current costing studies, so that hospitals in this situation could move to a recent AR-DRG version (such as 8 or 9) to ensure stability of that contract for several years.

It is simply unworkable for hospitals and insurers in the private sector to negotiate frequent payment model changes for each individual hospital or groups to accommodate new AR-DRG versions.

Australian Mental Health Care Classification

4) What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

While it is not contemplated that the AHMCC will be used in the private sector in the reasonably near future, AHSA is of the view that given the desirable trend of increasing benchmarking between sectors, it is highly likely that this will happen eventually. In addition, there is a need in the private sector for a robust classification system that facilitates cost based payment models, and well based private hospital benchmarking.

While clinician training may improve the inter-rater reliability, a necessary precondition to the wider adoption of the classification, some of the terms used concerning phases are confusing are consideration should be given to renaming them to reflect more closely the care being given e.g. the suggestion the phase "consolidating gain" be renamed "maintenance' seems sensible.

We are also uncertain whether five phases are needed e.g. should assessment should be regarded as an integral part of each definitive phase not a phase on its own, are three phases needed to describe care other than acute or would two serve e.g. the boundaries between some parts of "intensive extended" and "consolidating gain or maintenance" as defined is not intuitively obvious nor are the boundaries between some parts of "functional gain" and "intensive extended". a classification that contains such uncertainty as evidenced by the inter-rater reliability study may well need to be somewhat simplified to be able to be used as a sound basis for funding. It cannot be assumed that enhanced clinician training will suffice

Hospital acquired complications

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

The basis of the adjustment of payment for cases where HACs occur based on the independent analysis is reasonable. It captures the cost effect of the change irrespective of the nature of the DRG. The basis of risk adjustment of the reduction seems to be complex. While it is accepted that more than age needs to be adjusted for the current suggested

process seems very complex. In particular the Charlson score seems to have limited impact and it is unclear if its omission would greatly affect the risk adjustment outcome

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

6) ***What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?***

Provision to adjust payment when avoidable readmissions occur already exists in numerous private sector funder hospital contracts. While there is some commercial sensitivity in sharing this information, AHSA would be open to discussing in confidence the generic principles used in this area, including definitions of avoidable readmissions, payment effect and general administrative issues with IHPA

Criteria for assessing pricing and funding options

7) ***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?***

AHSA broadly agrees with the principles stated but there is likely to be a wide range of views expressed about their implementation in practice. AHSA would be agreeable to discussing these issues as part of general discussions on readmissions.