CATHOLIC HEALTH
Australia

21 August 2017

Independent Hospital Pricing Authority
PO Box 483
Darlinghurst NSW 1300

RE: Pricing Framework for Australian Public Hospital Services 2018-19

Dear Independent Hospital Pricing Authority,

Thank you for the opportunity to contribute to the Pricing Framework for Australia Public Hospital Services 2018-19. As the largest grouping of not-for-profit hospitals and aged care services in Australia, we hope our feedback will provide valuable insight for IHPA in the development of a pricing framework.

Please see our submission regarding comments and recommendations outlined in the consultation paper.

If you require any further information, please contact the Catholic Health Australia Office as we welcome the opportunity to give additional evidence to assist the agency in its work.

Sincerely,

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CATHOLIC HEALTH AUSTRALIA'S RESPONSE TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2018-2019

Thank you for the opportunity to contribute to the consultation on the pricing framework for Australian public hospital services 2018-2019. Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10% of hospital based 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.

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

- CHA recognizes there is a significant time lag between the inclusion of procedure codes for new technologies and in particular, this lag period can be as long as a decade in relation to identifying robotically assisted surgical cases. Greater agility in implementing a pathway for identifying new technologies could allow for a more timely allocation of procedure codes and DRG classification that increases specificity and improve differentiation between standard and new approaches to care. The current system requires providers to manually collect the data, proving administratively cumbersome and disincentivising investment in new technology.
- In July 2015, 'Codes for Special Purposes' - 'U' codes were introduced to identify co-morbid conditions present but not treated – supplementary codes for chronic conditions. While at present supplementary codes for chronic conditions is a small subset, consideration should be given to expansion and consequential use in determining patient complexity. Expansion and use may in turn help inform "11.3 – Promoting integration of services for chronic disease management –p.33", risk rating and greater clarity in service planning.

Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system? What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

- CHA members propose a sunset clause (recommended 5 years), of phasing out older versions to ensure there is sufficient planning opportunities to safeguard revenue neutrality and movements between versions for all parties. 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 (version 4.2). CHA cautions that any changes to funding models will have an impact on the private sector and current contractual arrangements.

Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18?

- CHA supports the shadow price to non-admitted multidisciplinary case conferences where the patient is not present.

- In 4.6.2 *ICD-10-AM / SNOMED interoperability tool*, IHPA acknowledged the complexities around the emergency department classification systems. In the current development of a mapping tool and review of allocations and weightings of triage consultations, CHA extends their expertise in any consultation for mapping that IHPA develops as well as ABF funding allocation for teaching, training and research.

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

- Traditional names and diagnoses of mental health conditions are rapidly changing and will need to be regularly reviewed. As the presence of a mental health condition does not indicate whether this diagnosis is a precursor or cause of another medical condition, CHA recommends the ability to apply a dual diagnosis to patients.
- In *5.2 Benchmarking*, hospital providers in NSW and WA commented that their state jurisdictions will not grant access to providers on PPP's. These providers have noted this creates barriers to benchmarking their public hospital performance in the state portal. Providers across state jurisdictions have inquired whether this benchmarking portal has been completed, and if so, whether all states will be allowing access to the portal by public providers.

Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?

- In section 6.2.2 *Patient Remoteness*, IHPA claims it is investigating whether the remote are and Indigenous adjustments are accounting for the costs of delivering hospital services to regional and rural areas. CHA recommends that IHPA review the population change and spread to better allocate what is defined as a "regional and remote area" as well as changes to Indigenous demographics
- If reviewing potential improvements to the pricing model, CHA recommends additional loading for homelessness (please see detailed response in next question).

What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

- Homeless patients who present at hospitals often have more complex with underlying chronic/severe conditions that require intensive time and treatment particularly in an Emergency Department setting. This places additional financial strain upon Catholic not-for-profit hospitals that have traditionally operated in resource poor areas to administer healthcare to the poor and disadvantaged. Evidence from a small sample size suggests homeless patients incur a greater length of stay and cost to treat. We would propose a prospective costing study be undertaken across selected hospitals to quantify the additional cost impact and qualitative impacts of treating homeless patients that warrant an appropriate loading.
- 7.2 *Costing private patients in public hospitals*: As both public and private hospital providers, CHA members have expressed concern over the disproportionate admission of private patients in public hospitals where private facilities exist, as an additional source of revenue for public hospitals. There is a growing body of evidence to suggest that the growth of private patient admissions in public hospitals is displacing public patients on waiting lists. As a consequence, private hospitals, are experiencing relatively flat growth in patient activity in all states and, in some states/localities, a corresponding increase in public patient activity.

This pattern is distorting the health system, and undermining the policy intent of private health insurance, which is to encourage patients to use private hospitals in order to relieve pressure on public hospitals. CHA recommends the inclusion of provisions in public hospital funding agreements between the Commonwealth and states to ensure neutrality of funding for public and private patients and to address the current funding incentives for public hospitals to maximise private patient activity, such as own source revenue targets. Funding mechanisms also need to incentivise prevention and deter avoidable hospital admissions. IHPA should maintain the private patient service adjustment for private patients in public hospitals and continue investigating whether these adjustments are fully capturing all of the costs. CHA recently published a report "*Upsetting the Balance: How the Growth of Private Patients in Public Hospitals is Impacting Australia's Health System*" and have contributed to the ongoing Senate Inquiry on *Value and affordability of private health insurance and out-of-pocket medical costs* to further detail our position in this complex issue.

Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

- CHA members support IHPA's proposal to continue to block fund residential mental health care in light of the available information.

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

- CHA cautions that there is the potential for a bundled funding model to act as a disincentive to the provision of optimal care given the range and nature of antenatal complications and their complexity – particularly where a hospital is located in an area with higher rates of social complexity, chronic disease, obesity, and primary languages other than English, which all incur cost. High-end obstetrics can be very costly and complicated, which has the potential to disadvantage hospitals that service disadvantaged populations if a flat weight is applied. A more liberal use of bundled pricing could disadvantage services providing care to large numbers of complex patients.
- It should also be noted that antenatal, in-hospital care and post-natal care may be delivered by different service providers and therefore consideration needs to be given to how payment will occur between providers and which parties incur the additional administrative costs.
- As acknowledged in the consultation paper, there are significant administrative and patient data impediments to current development of this model. CHA members will be interested in commenting further once these impediments have been addressed by the advisory council in their final report recommendations.

What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?

- There are several issues that IHPA should review for innovative funding models on the basis that future funding models should keep up with the pace and changes in technology for hospital and healthcare provision. There is a significant timing lag in capturing costs in studies; particularly pertaining to new technologies which may take many years to 'filer' through. This delay serves to stifle innovation. For example, any hospital who provides electrophysiology studies (EPS) are disadvantaged by the fact that this procedure falls into the same DRG as your standard coronary angiogram. Hospitals that conduct many EPS are grossly underfunded while hospitals that do not are receiving greater benefit. Equally, this

example applies to robotic assisted surgeries. A better system of classification for these items is needed to ensure adequate remuneration that incentivizes the utilization of innovative technologies.

Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

- CHA agrees that one of the large challenges to implementing a value based health system is the ability to acquire information technology platforms that allow providers to track patient care. The ability to acquire and implement the right technology to capture, record, collect, and report patient conditions has become a major barrier to developing value-based models in Australia's health system. Electronic medical record (EMR) systems are shown to improve healthcare delivery and outcomes of patients through enhancing communication of multidisciplinary services as well as reducing medical errors and encouraging better monitoring and reporting. Proposing government support for assisting hospitals in implementing EMR systems will incentivize providers to update their EMR systems for a more streamlined approach to patient care. Consideration of the large capital costs should be given to publicly contracted hospitals who do not have access to the same funding as state owned and operated facilities.
- Great caution needs to be taken in considering the private sector in any development of value based care models as these are often adopted by the health funds in contracting arrangements with private hospitals. Currently, private hospitals do not receive any additional funding support for the technology that is required to deliver EMR records in a value-based model, particularly where medical outcomes are coupled with patient experience and patient reported outcomes.
- CHA acknowledges there are some overseas jurisdictions that are implementing new models for value-based healthcare- with variable results. The introduction of new funding models into Australia's public hospitals needs to be evidence-based to avoid unintended adverse consequences. A recent report from the Commonwealth Fund found Australia's health system ranked second out of eleven industrialized countries based on seventy-two indicators across the spectrum of the health system. While CHA members recognize there have been successful value-based models enacted in other jurisdictions, we would like to caution government agencies about implementing multiple system changes too rapidly. The current changes to safety and quality will impact funding and service delivery across the health sector. Implementing too many changes in a small window of time will make it difficult to know where the gains and distortions are directed, and where there are gains, how those can best be invested in the system. Any future models will require robust evidence of better outcomes. If there is not sufficient time to evaluate current changes, it will be difficult to identify the areas of need to advocate for reform. CHA recommends a focus on the current investments in safety and quality to collect more robust data that will be beneficial in the development of any future value-based models.

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

- CHA supports the proposed risk adjustment model with additional comments:
    - Where there is a condition that is considered a risk adjusted HAC that the hospital strongly believes was unpreventable, there needs to be a mechanism for appeal. Where this HAC model is finally implemented, there will need to be a data validation exercise between the state authority and the Commonwealth to ensure they are

counting and collecting this information in the same way so any contestable cases are discussed and determined at the time of that allocation.
    - With the considerable $280m savings this new model is projected to generate, members agree that this savings be put towards EMR implementation or strategies for providers to track performance in a timely way to make necessary changes, particularly those who are in the greatest need of more investment and improvements.
    - Consideration could be given to the use of a maximum diagnosis risk score in the equation to support risk adjustments that are significant for a patient on admission that are not picked up elsewhere.
- Currently one of the failings of Medibank's Hospital Acquired Complication model is that it does not utilise any risk adjustment; however it does provide a mechanism for a case-by-case review process. Any equivalent process would be administratively burdensome and impractical in the public sector (and private sector). A proposed risk-adjusted model should be reviewed after 12 months and reassessed to ensure it remains a valid model, especially in light of an increasing ageing population.

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

- CHA agrees that the HAC third and fourth degree perineal laceration during delivery and neonatal birth trauma can be excluded from the funding adjustment.

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

- CHA acknowledges the current efforts by the Commission to develop clinical definitions for avoidable hospitals readmissions and timeframes for identified conditions and that these parameters must be determined before a model can be finalised.
- CHA has strong concerns about establishing a 28 day hospital readmission window as a measure of hospital quality and safety. CHA points to a US study that was recently published to examine readmission levels for elderly patients for three common conditions. This study determined after day 7 post-discharge, hospital readmissions were a result of community and household-level factors rather than hospital services and quality of treatment. CHA would propose that the future pricing framework not exceed the current recommended 7 days as readmissions after this date will not be reflective of hospital quality and safety and risk penalising hospitals for influences beyond their control.
- Preventability for more commonly occurring readmissions is a scale (of probability) as opposed to a statement of fact. There are few readmissions determined through administratively derived intelligence that can be absolutely described as 'preventable'. The date range where selected readmission have their highest correlation with health care organisation preventability, lives somewhere from 7 days or lower. As a result, it would be valuable to see the cut off range of readmission to be set at a maximum of 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.

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?

- CHA members agree that this assessment criteria appears adequate.