CATHOLIC HEALTH AUSTRALIA'S RESPONSE TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2019-2020

Thank you for the opportunity to contribute to the consultation on the pricing framework for Australian public hospital services 2019-2020. 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 changes, if any, should be made to the criteria and interpretive guidelines in the Annual Review of the General List of In-Scope Public Hospital Services policy?

- The General List funds in-scope public hospital services including admitted programs that are offered on an outreach basis. CHA notes there are a range of community housing and support services that have a direct health benefit to patients but services are not being delivered on site. These substitutional locations for care that are outside hospital facilities still impact hospital admission or readmission but have not yet been brought into scope. Many Catholic hospitals have social outreach health delivery programs to assist the community receive services outside of the hospital facility. These arrangements are currently excluded from the criteria for eligible Commonwealth funding.

How could 'Australian Coding Standard 0002 Additional Diagnoses' be amended to better clarify what is deemed a significant condition for code assignment?

- CHA notes there is a high degree of ambiguity in what constitutes a "significant" condition for coding assignment and is note easily measureable. The uncertainty in defining this "significant" condition leads to misinterpretations in how to assign codes. Changes to treatment, either new or existing, should be the driver for what correlates to additional diagnoses. With ongoing consultation and training with the sector, clinical coders may achieve better clarity on the coding assignment.

Do you support the proposed timeframe to phase out support for AR-DRG classification versions prior to AR-DRG Version 6.X from 1 July 2019?

- CHA welcomes IHPA's approach to undertake targeted consultations with the private sector to ensure that changes to funding models will have not have a deleterious impact on the private sector and current contractual arrangements. CHA members are supportive of the intention to phase out Version 4.2 from 1 July 2019. Later versions, including Version 5.1, will require additional lead-time to ensure there is sufficient planning opportunities to safeguard revenue neutrality and movements between versions for all parties. Version 5.1 is still regularly utilised in the private sector. 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.

Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?

- CHA supports the biennial AR-DRG development cycle and cautions against any shorter timeframe than two years. The speed at which these changes are introduced along with the nuances of different versions make it difficult to embed these changes before the next round of changes will be introduced. Any reduction in the two year timeframe could result in inadequate implementation of new versions.
- 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.

What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?

- In looking at areas for improvement of AN-SNAP Version 5, the Subacute Care Working Group should give consideration to the need for better classification of non-admitted admissions, particularly in the area of rehabilitation. At the moment there is no benchmarking standard and health services measure these classifications differently. As more services become offered in the home, CHA members wish for clarification in how IHPA intends to standardize these categories for ambulatory non-admitted patients following Version 4.
- The traditional structure of delivering non-admitted palliative care is out-dated in responding to changes in symptom treatment that were first developed when palliative care was aggregated with end-of-life care. This does not correlate with the contemporary nature of palliative care as it is offered today and it is not relatable to the integrated care model.

Should access to the public hospital data held by IHPA be widened? If so, who should have access?

- *5.3.1 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 and is a concern, particularly where benchmarking data may be used for funding purposes. This issue was identified in our previous submission and IHPA responded with feedback that our concerns would need to be provided to state and territory health departments. To date, state and territory health department are continuing to refuse access to CHA hospital providers on the basis that they are considered private hospitals, including those that are contracted to deliver public services. CHA supports IHPA's consideration to allow public access to the National Benchmarking Portal and produce benchmarking reports transparently for the public system, particularly around HAC's and avoidable hospital readmissions. This will assist hospitals improve their capabilities to address safety and quality issues.

What analysis using public hospital data should IHPA publish, if any?

- CHA recommends publishing data for patient homelessness using 'Z' codes to analyse where there might be areas for potential improvement in the pricing model to service this cohort of patients. Please see our response to "*patient based factors for adjustment*" consultation questions for further information.
- The Department of Health has engaged IHPA to conduct further analysis of prostheses pricing and other variable cost exercises across states and services. CHA recognizes the

importance of these reports to the committees and stakeholders that have been consulted and offers a request for IHPA to publish these reports in support of transparency in government sponsored approaches to funding health services.

What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

- CHA supports IHPA's review of adjusting for patient remoteness as distance is a major cost driver for delivering public services. In the consultation report, IHPA states they will consider the Northern Territory model based on population density and spatial distance between individuals. CHA requests more information on how IHPA intends to apply this statistical approach broadly and how often this model will be reviewed to account for changes in population density and the transient nature of many indigenous communities.

Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2019-20?

- CHA recommends further refinement of HAC benchmarking. Hospitals would like to be able to report on patient level data but the current system is not designed to capture this subset of information. This is why the Commission is currently unable to report on certain measures, e.g., unplanned ICU admissions, because it is not identified in coding practices.

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

- In CHA's previous 2017 submission, we made a recommendation to explore an adjustment for homeless patients. 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. IHPA reported in their feedback that they did not believe their evidence was sufficient to warrant an adjustment to the NEP, but further conversations between hospital providers and IHPA indicated that the volume of patients captured in ICD-10-AM data for homelessness (coded using 'Z' codes) may not always be adequately captured in the hospital setting. CHA members are currently doing further analysis of IHPA's data as well as internal hospital data to determine:
    - Whether 'Z' codes are being underreported at a national level;
    - Whether servicing this client group costs more;
    - What additional data is available to highlight the extra costs involved in servicing homeless patients.

  In accordance with legislation protecting patient privacy, IHPA will continue their analysis to review the following:
    - Whether there is a significant number of mental health patients where the admitting and discharging addresses are different;
    - Whether IHPA's previous studies identified and homeless patient issues.

  CHA members will continue their analysis of this issue and hold discussions with IHPA around the qualitative impacts of treating homeless patients.

Do you support price harmonisation for the potentially similar same-day services which are discussed above?

- CHA supports IHPA's approach to harmonising price weights across the admitted acute and non-admitted settings to avoid perverse incentives to admit patients.
- CHA notes there are still discrepancies in delivering some services, in particular chemotherapy, where the real cost of delivering chemotherapy drugs is much higher for admitted patients than non-admitted, but there is no difference in the price due to multiple payment structures for how drugs are allocated under Section 100. New models of care that deliver chemotherapy in the home will create another layer of complexity in reported data and payment systems.

What other services, which can be provided in different settings of care, could benefit from price harmonisation?

- There is not consistency in the data required as patients move into an outpatient system because hospitals lose a great deal of data that is not reported. As new models of care extend hospitals services to care delivered in the home, there will need to be robust data sets that are comparable, costable, and meaningful for care that is provided outside of a hospital facility. Harmonising will not be possible without adequate data which we are not able to currently captured in the non-admitted outpatient setting.

Do you support the proposal to phase out the private patient correction factor for NEP20?

- 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. While this appears to be the intent of the private patient correction factor, the business rules make this costing process unclear.
- Business rule 1.1A.3.4 stipulates*:*
  At a patient level, where a patient consumes medical resources, a cost is associated with this consumption and these costs should be allocated to the patient irrespective of funding source.
  This wording appears to counter the intent of the private patient correction factor that includes a downward adjustment on patients who use their private health insurance in the public hospital.
- 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.

What other models might IHPA consider in determining funding for small rural and remote hospitals?

- CHA is supportive of funding models that give special consideration to the remote and regional level hospitals that do not have equivalent economies of scale that exist in more urban environments. CHA suggests a funding model that links age related adjustments to include an age weighting as the rural communities that these hospitals serve tend to have older cohorts of residents that require additional resources.

What cost drivers should IHPA investigate for rural and remote hospitals for potential inclusion as adjustments in the NEC?

- IHPA should conduct further reviews in how to address the high costs of delivering supplies to these locations as this is a major issue for hospitals.

Pricing and funding for safety and quality

Do you prefer an alternative scope for measuring avoidable hospital readmissions and, if so, how would this be measured? What evidence or other factors have informed your views?

- Since the implementation of changes to the pricing for safety and quality, IHPA has trialled a model for avoidable readmissions that requires a level of reported readmissions within a designated range. Those hospitals that fall below this range must produce evidence that these are true results in order to avoid a penalty. The current criteria established by the Commission relies in clinical conditions that are related, avoidable, and measurable. CHA cautions that hospitals cannot accurately measure related and avoidable within our current data sets. Within the private hospital sector, some health funds have used this approach to debate funding disbursements for avoidable readmission, requiring hospitals to justify relatable and avoidable on a case-by-case basis. Current coding practices do not indicate what us actually relatable, avoidable, and measureable.
- The establishment of a readmission list that applies to varying day lengths is going to be administratively difficult to manage. To apply this model in the public system will be administratively burdensome.
- The Commissions model for avoidable hospital readmissions has not yet undergone any robust testing that would be beneficial to understand the how differences in hospital administration and performance are impacted across various settings.

What are the advantages and disadvantages of use of the Medicare PIN and/or the Individual Healthcare Identifier for the purposes of pricing and funding of hospital readmissions? What strategies can be used to overcome existing disadvantages for each of these approaches?

- CHA supports the use of a Medicare PIN to assist in measuring avoidable hospital readmissions.
- CHA also highlights with IHPA that building systems around HAC and avoidable readmission lists only increases the complexity and therefore the cost of delivering services. CHA cautions that government agencies must balance the intent of these changes in minimizing preventable issues to ensure they are not in fact driving costs.

Do you support the proposal to limit the measurement of readmissions to those occurring within the same financial year?

- In IHPA's proposed approach, readmissions would be calculated over an annual period and completing the adjustments the following year. CHA cautions that hospitals are currently undergoing improvement projects that make recommendations to clinicians to change the way in which they document clinical presentations to improve coding processes. This model

may penalize hospitals for improving documentation to support accurate representation of the patient's journey in a coding setting.

For what period of time should the three proposed funding options be shadowed?

- CHA supports a shadow period of 24 months to allow sufficient time for hospitals to adjust to these changes.