Australian Health Service Alliance

15th July 2019

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

Dear James

Re: IHPA Pricing Framework for Australian Public Hospital Services 2020-21 – Consultation

Thank you for the opportunity to comment on the 2020/2021 Pricing Framework. As you are aware, there are areas which have either a direct impact or an indirect flow-on effect to the private sector, for both health insurers and hospital providers.

Below I have taken the opportunity to respond to your invitation on behalf of the Australian Health Service Alliance (AHSA), which represents 28 health insurers nationally. Please note that our responses relate only to matters relevant to the private sector.

Phasing out support for older AR-DRG classification versions

I note that the consultation for the pricing framework did not specifically call for feedback on the matter of phasing out older AR-DRG versions, however, I wish to advise that that the proposed schedule poses significant challenges to the private sector.

I ask that IPHA considers a revised timeline for ceasing support for older AR-DRG versions to the timeline stated in the consultation communication on the flowing basis:

- private sector contracts, inclusive of payment mechanisms, are on a commercial basis and AHSA relies on 'agreement between respective parties' in order to effect a change in AR-DRG version. Both parties would generally agree that versions need to be updated over time, however, this can be challenging when historical payment structures are perceived of greater operational or fiscal benefit to hospitals in the setting of planned casemix change and/or growth;
- private sector payment mechanisms for newer AR-DRG versions need to be built, within the resources available, to replace older versions; and
- private sector contracts often are for periods of up to 3-years and negotiated as such, making the opportunities for AR-DRG version change less frequent than is the case in the public sector

FYI and specifically in terms of each specific AR-DRG version proposed to be ceased in June 2021, on behalf of AHSA, I can advise the following:

- **AR-DRGv5** – at this time AHSA has 30 hospitals under contract in this version, and the majority are multi-year agreements;
- **AR-DRGv6x** – at this time AHSA has 60 hospitals under contract in this version, and our priority will be to get hospitals of AR-DRGv5 in the first instance; and
- **AR-DRGv7** – at this time AHSA does not use this version for contracting and we believe that this is similarly the case for the broader private sector, and therefore is happy to support the phase out of AR-DRGv7 as proposed by IPHA

AHSA certainly has plans to migrate hospitals from AR-DRG v5.1 & v6x over coming years as part of a broader strategic purchasing methodology and payment mechanism.

Our experience over recent years with migrating hospitals off AR-DRG v4.2 (a long-standing platform for private sector contract payment mechanisms) has confirmed the requirement for additional time for contractual juncture and agreement.

It is considered too soon to undertake a thorough review of the process of cessation from AR-DRG v4.2. This was raised at the DRG Technical Group meeting (26th September 2018), and supported by the Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA) and is noted in the minutes, page 5.

Given the aforementioned volume of hospital contracts, the proposed IPHA schedule of the removal of support for AR-DRG v5.1 & v6x presents significant challenges for AHSA and I believe the private sector generally.

We would welcome greater consultation with the private sector on AR-DRG version timelines to develop a practically workable schedule for phasing out older versions, whilst also sharing the lessons learned from the phase out of AR-DRGv4.

If we may, AHSA would like to propose an alternate timeline that would met AHSA and I believe private sector timeline requirements:

- AR-DRG v5.1 – 1st July 2025
- AR-DRG 6x – 1st July 2025

What should IHPA prioritise when developing AR-DRG version 11 and ICD-10-AM/ACHI/ACS Twelfth edition?

<u>ICD-10-AM v11 & v12 - Repetitive transcranial magnetic stimulation (r-TMS)</u>

As the original author of a submission to ACCD for a code for repetitive transcranial magnetic stimulation (r-TMS), AHSA welcomes the newly introduced r-TMS codes in ICD-10-AM (11th edition). These new codes listed below have been placed in block [1908] 'Other therapeutic interventions:

96252-00	Repetitive transcranial magnetic stimulation, 1 treatment
	Repetitive transcranial magnetic stimulation NOS
96253-00	Repetitive transcranial magnetic stimulation, 2 – 20 treatments
96254-00	Repetitive transcranial magnetic stimulation, ≥ 21 treatments

Block [1908] is listed in ACS 0534 Specific Interventions Related to Mental Health Care Services.

This standard states that *"For admitted episodes of care it is not mandatory to assign code(s) for mental health care interventions with the exception of electroconvulsive therapy. However their use is encouraged in specialist mental health care facilities and units to better represent care provided to these patients. It should also be noted that these interventions are not exclusive to mental health and may be assigned outside of this context."*

The above standard negates the requirement to code this intervention, which is not only a growth area but a focus area for mental health in the private sector.

It is our hope that it may be an oversight that this ACS was not updated to correspond with the introduction of the new r-TMS codes, and that the appropriate r-TMS code must be assigned when performed.

Given the volume and complexity of documentation with new codes and related standards, it is our strong preference that this be addressed as an errata for 11th edition, rather than wait until 12th edition.

AR-DRGv11 and Beyond - Implantable Pain Therapy Devices (Neurostimulators)

AHSA, through the DRG Technical Group (DTG), opposed the removal of the neurostimulator DRGs from AR-DRGv9 onwards during the development phase. At the time, only public sector activity was used to justify removing these DRGs, so consideration was not given to the private sector growth.

Public and private sector data frorA12Z using NHCDC (from Round 20 2015/16 FY to Round 21 2016/17 FY) has shown a growth of approximately 18% in the public sector (382 to 453 cases) and approximately 20% (3166 to 3829 cases) in the private sector. Beyond this time period, we are unable to determine the growth in national datasets such as AIHW, NHCDC and PHDB unless the data is grouped in AR-DRGv8. The reason is that beyond this version, the implantation of these expensive devices is now grouping to DRGs that are spread over multiple MDCs. AHSA request that this decision be reconsidered in the development of new AR-DRG versions.

Given that there are no further updates to ICD-10 by the World Health Organisation, AHSA suggests that IHPA consider holding the classifications fairly constant until a decision is made regarding any future move to ICD-11. Of course updates and maintenance will be required, but a cost-benefit analysis of doing so is encouraged.

Pricing for Safety and Quality

Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behavior and providing opportunities for effective benchmarking?

AHSA is not in a position to report on changing clinician behavior. However we are very interested to receive annual benchmarks (public, private and national) regarding HAC rates and percentage NWAU reduction, in a similar form to the AROC benchmark data. This data should be publicly available as it does not identify hospitals, but simply provides a national benchmark to compare our activity.

Should you have any queries regarding this matter, please do not hesitate to contact me on 03 9805 0025 or email nicolle@ahsa.com.au.

Yours sincerely

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