CATHOLIC HEALTH
Australia

26 July 2019

Independent Hospital Pricing Authority
PO Box 483
Darlinghurst NSW 1300

Dear Independent Hospital Pricing Authority,

RE: Pricing Framework for Australian Public Hospital Services 2020-21

Thank you for the opportunity to contribute to the Pricing Framework for Australia Public Hospital Services 2020-21. 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 the refining the proposed pricing framework.

Please see our submission ***attached*** 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,

Suzanne Greenwood EMBA LLM LLB FAIM MAICD
Chief Executive Officer
secretariat@cha.org.au

CATHOLIC HEALTH AUSTRALIA'S RESPONSE TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2020-2021

Thank you for the opportunity to contribute to the consultation on the pricing framework for Australian public hospital services 2020-21. Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10% of public and private not-for-profit 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.

Consultation Questions

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

CHA members have recognized the significant body of work IHPA has undertaken in guiding activity based funding and are supportive of the existing guidelines. We draw attention to the system design guidelines outlined to minimise undesirable and inadvertent consequences whereby any changes to the pricing framework for public hospitals will also impact the delivery of services in the private sector. Our providers caution that any changes should be taken with careful consideration for impacts to the broader health sector and will continue to engage with IHPA on consultations and committees.

Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support value in hospital and health services?

CHA is supportive of including value in pricing models and support IHPA's current review of the national pricing model.

What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?

CHA welcomes IHPA's approach to conduct targeted consultations with the private sector to ensure changes to funding models do not have negative unintended consequences to the private sector and current contractual arrangements.

Private hospital administrators have advised that the timeframes suggested in *Figure 3: Timeline for phasing out AR-DRG versions* is insufficient. The complexity and mapping and developing these pricing frameworks, including the movement between DRGs and implications of newer versions, means that many health funds currently utilize older versions for private hospital pricing. The proposed timeline for phasing out AR_DRG versions 5.0-7.0 by 1 July 2021 is insufficient to allow a transition to newer versions of the classification system. Across the private sector, there are still some contracts that align to older DRG versions (including version 5.0). Implementing newer versions will require a large body of work across the private sector, including the integration into software systems, modelling and validation, and implementation following existing contractual arrangements that typically operate on three-year cycles.

In previous submissions, CHA have proposed a sunset clause (recommended for five years) to phase out older versions to ensure sufficient planning opportunities are in place that safeguard revenue neutrality and movements between versions for all parties. The current timeline proposed in this consultation paper for phasing out older versions is insufficient to ensure that the private sector has the necessary systems and safeguards in place to prevent adverse consequences to the delivery of services in the private hospitals and the wider implications to the health sector that could result.

Is there any objection to IHPA phasing out the private patient correction factor for NEP20?
CHA encourages IHPA to maintain the private patient service adjustment for private patients in public hospitals and continue investigating through the Fundamental Review whether these adjustments are fully capturing all of the costs.

What are the estimated costs of collecting the IHI in your state or territory?
We support the concept of an 'incentive' payment for states and territories with a patient episode that has a valid individual healthcare identifier is reasonable, however public services across states are at varying stages of evolution with electronic medical records (eMRs).

The public release of the data is complicated as IHPA currently collect HDC data from approximately 60% of private hospitals. With the recent funding round that includes incentive payments for private hospitals to report this data to IHPA, this will continue to increase participation across the sector. CHA members strongly recommend IHPA's regular engagement with the private sector to determine how this data might be used in future reporting, including appropriate safeguards for patients and hospital operators.

Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?
CHA would support a temporary incentive payment.

Should a national PROMs collection be considered as part of national data sets?
CHA is supportive of the inclusion of PROMs as a routine measurement once a standardized approach has been accepted, but notes a technical issue of collecting PROMs in the private sector due to the different approach to patient admission and reporting. For surgical patients in private hospitals, the surgeon manages the patient so the private hospital does not gain access to the patient until shortly before, often only a couple of days, before admission. This makes it challenging for private hospitals to coordinate the collection of pre-admission status of the patient to baseline PROMS.

Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?
The proposed options for alternative funding modes appear to be reasonable.

IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

CHA is supportive of the proposed investigation of bundled payments for stroke and joint pain through continued consultation with the sector. Some other disciplines where CHA have identified the need for further review of bundled payments include:

- Chemotherapy
- Radiotherapy
- Palliative Care (proposed 6 month episodic payment for the management of palliative care patients)

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

Some private hospital operators are currently in the early stages of conducting benchmarking. IHPA has completed a significant body of work in refining HACs and their adjustment is much fairer than other existing models. CHA members encourage IHPA to consider their role as a default benchmarking agency across public and private sectors. Currently, multiple agencies are responsible for developing benchmark reports that are often at variance with each other. IHPA is in a stronger position to provide the most comprehensive assessment as they have access to national data that none of the state agencies do with a wide range of participants involved in providing data.

What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

Option 3 involves benchmarking at the level of the LHN and would not be applicable in a private hospital setting.

There is support for IHPA developing a commercial readmissions software that would have defined rules that providers would know beforehand if the diagnosis given is an avoidable readmission. Having an independent determination would be more effective at identifying this status rather than the current arbitrary interpretation across various health funds that results in a reduction in claims paid and burdensome appeals process.