Comments on Independent Hospital Pricing Authority (IHPA) Consultation Paper on the Pricing Network for Australian Public Hospital Services 2017-18 – September 2016

1. Introduction:

The Australian Health Service Alliance (AHSA) is a company owned by twenty-five small and medium sized health funds and provides services to these funds on an outsourcing basis. These services include negotiating contracts, payment models, benchmarking of both efficiency and quality; and providing IT services particularly in relation to data.

There are numerous aspects of IHPA's work which have already impacted on the private sector. Some examples include classification systems and their underlying IT requirements, definitions of what are inpatients, their subgroups, and costing studies. AHSA also anticipates that there will be increasing attention to quality in payment models as is raised in the September 2016 consultation paper.

There is a legitimate public interest in the performance of private hospitals given they receive significant public monies, both directly and indirectly. Private and Public Hospitals share many overlapping interests including physicians and surgeons. Additionally they compete for funding sometimes directly or indirectly and Governments require both to perform at their optimum for funding and quality outcomes. Ultimately each sector could learn from the other.

Given this, it is appropriate that significant benchmarking of the two sectors occur to measure their relative efficiency and quality. For such benchmarking to occur there needs to be the ability to appropriately compare the two sectors. Among the pre-requisites for this are common classification systems, data definitions, criteria for admission and tools for benchmarking quality and efficiency.

AHSA is grateful to IHPA and other industry bodies for involving the private sector in their deliberations. AHSA believes that breadth and depth of such discussion has been improved by private sector representation and looks forward to this continuing and expanding.

For the above reasons, AHSA takes particular interest in the annual consultation paper on the pricing framework for public hospitals. For this reason AHSA will comment on a number of aspects in areas where we feel this is likely to be of interest and assistance to IHPA. The comments which follow reflect the order in which topics are canvassed in the discussion paper.

2. Classifications Used by IHPA to describe public hospital Services (page 11)

AHSA is grateful that IHPA has ensured private sector representation in in relation to the development and refinement of all relevant classifications; AR-DRG, ICD, AN-SNAP and AHMCC.
ARDRG refinement and development is important to the private sector given that it is the basis of reporting to the Commonwealth Department of Health as well as the basis of meaningful benchmarking between the sectors. Having private sector representatives involved in DRG development has been a positive step for a number of reasons including

but not limited to the need to consider data reporting issues and how private sector workload can inform DRG construction.

AN-SNAP is starting to be used as the basis of payment for overnight rehabilitation cases in the private sector as well as being used as the basis of benchmarking private rehabilitation hospitals. It is anticipated that the use of AN-SNAP will increase in the private sector.

One issue that AHSA would like to raise in relation to AN-SNAP is whether frequent revisions of this classification are needed, and whether a cost-benefit study on change frequency should be considered. Unlike acute care type where there can be significant technological and clinical change in a relatively short period as well as relative cost; the care given and cost relativities under AN-SNAP is relatively similar over a longer period of years. Given this, would it be more appropriate to revise this classification every four or so years, once the major changes foreshadowed under AN-SNAPv5 are implemented? AHSA anticipates DRG revisions in alternate years will continue for the foreseeable future.

It is noted that work is proceeding on the Australian Mental Health Care Classification (AMHCC). While it is understood that any decision to require the private sector to provide data in the AHMCC format lies with the Department of Health (DH) not IHPA, there is a need for such a classification to facilitate benchmarking between the public and private sectors.

3. National Hospital Cost Data Collection (NHCDC) (page 15)

AHSA appreciates that the NHCDC private sector is currently a voluntary collection, and that IHPA are taking steps to improve the participation of private hospitals to ensure a robust study can be undertaken. AHSA is also grateful that IHPA has facilitated private sector funder representation on the NHCDC advisory committee. In saying this, it is noted that continuation of this collection is essential if cost based payment models under a robust classification system are to continue in the private sector in current DRG versions; a pre-requisite to continuing efficiency within the private sector.

It is also suggested that where at all possible the most up to date available DRG version be used – it is less than optimal that the most up to date NHCDC available in the private sector is based on ARDRGv6x when work to finalise ARDRGv9 is nearing completion.

4. The NEP for ABF Public Hospital Services: - Stability National Pricing Model P18

AHSA's experience in regard to changing weight versions in its own DRG based payment model may be of interest. In the private sector, changes to DRG versions used as the basis of weights, and changes to weights under the same DRG version; have to be negotiated into contracts – they cannot be imposed. For this reason AHSA does not change weights within the same DRG version unless a significant movement in relative weights occurs between NHCDC versions under the same DRG version.

The measure we use of stability is that the correlation between the relative weights for acute DRGs is over 85% between NHCDC studies based on the same DRG version. This has generally proven to be the case over the last fifteen years. It may be that this would be a helpful principle for IHPA to consider as it may result in weights changing only when DRG versions change – currently alternate years in the public sector.

Having said this it is noted the NHCDC should be conducted annually – there is no other way of determining whether significant change has occurred. An annual study is also

necessary for the regression analysis of cost change underpinning indexation of the NEP in the public sector. In addition when private sector studies were not conducted for a given year, the quality of the next study was impaired due to loss of corporate knowledge.

5. Pricing and Funding for Safety and Quality (p 26):

AHSA is particularly interested in this section given it already has had significant experience with a number of the issues canvassed.

AHSA is of the view that similar measures based on a broad health consensus involving both the public and private sector has merits in terms of establishing the appropriateness of the measures introduced and benchmarking quality and safety on a comparable basis both within and between the two sectors.

This approach also minimizes the risk of a plethora of sub-optimal measures being proposed by individual funders which puts at risk the likelihood of any consistent and empirically supported measures being adopted.

In this context AHSA notes there are a number of organizations that manage hospitals in both the public and private sectors and this further enhances the likelihood such health wide measures would be implemented in the private sector.

AHSA has for some years been seeking a robust method by which costs associated with Hospital Acquired Complications (HACs) are not paid by funders. The approach of IHPA and the Australian Safety and Quality Commission is certainly of interest.

AHSA believes there is merit in a list of HACs agreed through broad industry consensus across all health sectors. This has numerous advantages.

- It is noted that the ability to appropriately reduce payment for HACs in the acute setting requires a payment model based on robust classification and underlying cost – in practice DRGs under pinned by the NHCDC.
- AHSA would suggest that HACs not be removed from costing studies with the derivation of DRG relative weights, be these related to the public or private sector, being more appropriate. This would distort costing studies. It is preferable that the cost of the HACs be removed from payments at the case level where appropriate
- AHSA notes that this approach requires two sets of DRGs to be derived for each case – the base DRGs (no removal of the effect of HACs) and the HAC modified DRG. We see this as necessary to fully understand the effect of this proposal and track the effects and changes over time. AHSA is of the view that this process would be simplified if the ability to derive both categories of DRGs was built into the standard DRG groupers used in Australia.

6. Avoidable Hospital Readmissions: (page 48):

AHSA welcomes any criteria pertaining to avoidable hospital admissions that could be considered in the private sector in future for the purposes of consistency.

As per the Private Health Insurance (Benefit Requirement) rules, the duration for a readmission in the private sector is 7 days rather than 5 (refer also to PH Circular 198). Given this, AHSA would appreciate that consideration be given use of 7 days for consistency.

7. Conclusion:

AHSA would welcome the opportunity to discuss the matters raised further with IHPA. The appropriate AHSA contact in the first instance is AHSA's Medical Director, Dr Brian Hanning. His email is brian@ahsa.com.au