IHACPA Consultation Paper response re: bundling arrangements for General Use Items on the Prostheses List

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Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services, accounting for about 15 per cent of hospital-based healthcare in Australia. Our members operate hospitals in each Australian state and in the Australian Capital Territory, where they provide around 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care services. CHA not-for-profit providers are also a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

CHA supports careful and considered evidence-based review and reform of the way prostheses are funded and utilised in Australia, and we remain committed to working with the Commonwealth Government and other stakeholders in this regard. An effective funding model for prostheses is critical to being able to provide high quality patient care, as it ensures that patients are fully covered for the medical products they need, thereby securing patient and doctor choice and underpinning the value proposition of the private health sector.

The primary driver of any reform to the private health sector must be to increase value to patients. Value in this context should consider, in equal weighting, the scope and depth of consumers' access to private health services, the contribution of this care to health outcomes and experience, and its financial cost. A patient-centred, principles-based approach to reform should, accordingly, consider the following:

- Reform must support patient choice and access to healthcare
- Reform must minimise patient out-of-pocket costs
- Reform must minimise complexity for patients, funders and providers
- Reform must improve transparency
- Reform must improve responsiveness to change
- Reform must optimise value for all stakeholders
- Reform must advance the sustainability of the private health sector.

Considering reforms through this lens, it is clear that transitional arrangements are required to ensure any prostheses reforms deliver net value to patients without unforeseen, unintended consequences.

CHA notes that the Independent Health and Aged Care Pricing Authority (IHACPA) considers the scope of its work to be limited to the development of General Use (GU) prostheses bundles by 12 April 2023. However, it is impossible for CHA to provide feedback exclusively within the blinkered remit of the Consultation Paper as the inextricably intertwined questions of how the GU bundles will be funded and how the GU bundles' modelling compares to actual experience, remains unanswered.

It is reasonable for IHACPA to consider its work in the context of the overarching reforms in which this work takes place. This is important to ensure the GU bundles delivered are fit for purpose, are based on data of sufficient quality and breadth, are able to be implemented by hospitals and health insurers at a technical level, and are achievable in the timeline suggested.

For the GU bundles to succeed, IHACPA will need to support the sector in implementation over a reasonable timeframe. This support should include building trust with all stakeholders that the bundles have been compiled in a manner which is fair and reasonable based on accurate data, and are up to the high standard IHACPA routinely delivers for the public hospital system. To achieve these outcomes it is appropriate and

necessary to re-calibrate IHACPA's approach to GU bundle development to more closely align to the approach taken when a change is made to the national funding model for public hospitals.

CHA considers it essential that, as with other changes to pricing models advanced by IHACPA across the health sector, GU bundles be shadow priced for a period of two years from 1 July 2023. This will allow time for robust data collection, reporting, and modelling of the changes to ensure the reforms have the desired positive impact on patients that the Department of Health and Aged Care (DHA) intends, with no unintended consequences.

Moving to GU bundles that are separate from the Prostheses List (PL) is a significant structural change to how inputs to private patient hospital care are funded. Such a change should not be implemented without considered understanding of its impacts. For public hospitals, state and territory governments viewed the benefits of shadow pricing so strongly as to include a mandated period for shadow pricing in the National Health Reform Agreement (NHRA). Given this significant precedent for shadow pricing, it is important that shadow pricing be applied to analyse the expected vs actual outcomes that follow the shift in the way critical GU items are funded. This would necessitate GU items remaining on the PL during the shadow pricing period.

As development of GU bundles is foundational work, a meticulous and conservative process is essential. There are too many unknowns to risk a drop-dead implementation date of 1 July 2023 when, as proposed, IHACPA-developed bundles would launch regardless of whether a funding mechanism is in place and without due care being taken to avoid negative and unintended outcomes. CHA's key feedback on the Consultation Paper is that the quantum of these unknowns, and the significance to patients if modelling is inaccurate, necessitates the need for the standard protections offered by a shadow pricing period.

Shadow pricing period proposal

Recommendation: GU item bundles should be shadow priced for a period of two years from 1 July 2023 to ensure robust data collection, reporting, and modelling of the financial and other impacts of changes. During this period, the existing funding mechanism, that is GU items listed on the Prostheses List (PL), should remain in place.

IHACPA is responsible for implementing new care classifications that are used to classify and ultimately price admitted and non-admitted hospital care in the public hospital system. This pricing then determines the degree of Commonwealth funding hospital services attract under the NHRA. Given their implications for care classification and funding, IHACPA ordinarily uses a 'shadow pricing' period prior to implementing a new classification (or a new iteration of an existing classification). This shadow pricing period is intended to ensure robust data collection and reporting, to accurately model the financial and counting impacts of changes.

Shadow pricing involves continuing to price and fund services using the existing system while concurrently pricing the same services using the new classification system. These two prices are then compared to understand the impact of moving to the new system.

When IHACPA makes a pricing methodological change, it is common practice for the shadow pricing approach to be adopted prior to the change being implemented. This ensures the delivery of benefits and the avoidance of any unintended consequences. Under the NHRA's current iteration (the Addendum, 2020-

2025), IHACPA is required to conduct a shadow pricing period of a minimum of two years unless the Commonwealth and the majority of states/territories agree to a shorter period.

Examples of recent shadow pricing periods applied to new classifications include:

- The Australian National Subacute and Non-Acute Patient Classification Version 5.0 (1 year shadow period, second year TBC) – notably, this shadow period is being applied even though a classification is only being updated;
- The Australian Mental Health Care Classification (2 year shadow period); and
- Australian Emergency Care Classification (1 year shadow period, with agreement from all parties). In this instance there is an additional stabilisation period also included with active support being provided to states and territories.

CHA has serious concerns, which have been raised with stakeholders in the private health sector, that elements of the planned GU item PL reforms will result in detrimental impacts to consumers. These include:

- Increased out of pocket costs to patients;
- The limiting of access to care due to service closure/scaling back; and
- The outsized impact on female patients and patients in rural and regional areas.

It is essential that a shadow pricing transition process be implemented to mitigate these, and other, adverse outcomes.

CHA contends that there is no justification for premature implementation of a new system of funding for GU items prior to having appropriate controls in place to ensure that detrimental impacts to patients are identified and minimised. As such, a standard two-year shadow pricing period is appropriate.

This is consistent with DHA's own advice, which calls for processes under any new funding mechanism to be "developed and tested so that there are no short-term adverse impacts on clinical outcomes and the cost of services". Further, DHA's advice notes that:

> *In particular, hospitals and clinicians will need to properly develop, test and implement procurement and usage monitoring processes and, given the clinical importance and volume of usage of these items, appropriate transition time should be allowed for this.*[1]

It is not possible for hospitals and clinicians to digest, let alone test and implement, such a fundamental change in the funding mechanism for these critical surgical items without a shadow pricing period, as is best practice in the public hospital system.

Timeline for implementation of shadow pricing

Figure 1 shows CHA's proposed timeline for shadow pricing bundles of GU items, based on IHACPA's own shadow pricing guidelines and announced timelines for bundle development and policy reform from IHACPA and the Department of Health and Aged Care. This timeline includes headline dates for the progress of shadow pricing and the eventual implementation of bundles as a mandatory alternative funding mechanism

1. https://www.health.gov.au/sites/default/files/documents/2020/12/review-of-the-general-miscellaneous-category-of-the-prostheses-list-report_0.pdf

for GU items. CHA is willing to work with IHACPA and other stakeholders to understand and adapt this timeline to any technical or logistical challenges IHACPA and others may face in delivering on this work.

Working Group

In addition to the dates in Figure 1, CHA proposes IHACPA implement a quarterly technical working group of key stakeholders to share information on:

- How hospitals, insurers, and medical device manufacturers are proceeding with implementing shadow pricing. This may include:
    - Modelling of the financial impact of the proposed changes
    - Identifying any procedures/services at risk of closure based on the initially proposed bundles
    - Identifying whether closure of services or increased out of pockets are likely to excessively impact specific demographic groups (for example female or rural residents)
- IHACPA's observations of Hospital Casemix Protocol (HCP) 1 and Private Hospital Data Bureau data collection quality and any gaps
- How IHACPA can support hospitals (particularly smaller entities) with implementing bundled pricing in their surgical environments
- Workshopping challenges raised by clinicians, as well as the clinical implications of potential incentives and dis-incentives for use of GU items as a consequence of adopting the bundle approach
- Does the data appropriately account for risk and legitimate and unavoidable cost variations, with particular consideration given to clinical significance

CHA suggests this working group could include representatives from organisations such as:

- Australian Medical Association
- Australian Orthopaedic Association
- Australian Private Hospitals Association
- Catholic Health Australia
- Consumers Health Forum
- Department of Health and Aged Care
- General Surgeons Australia
- Medical Technology Association of Australia
- Private Healthcare Australia
- Royal Australasian College of Surgeons

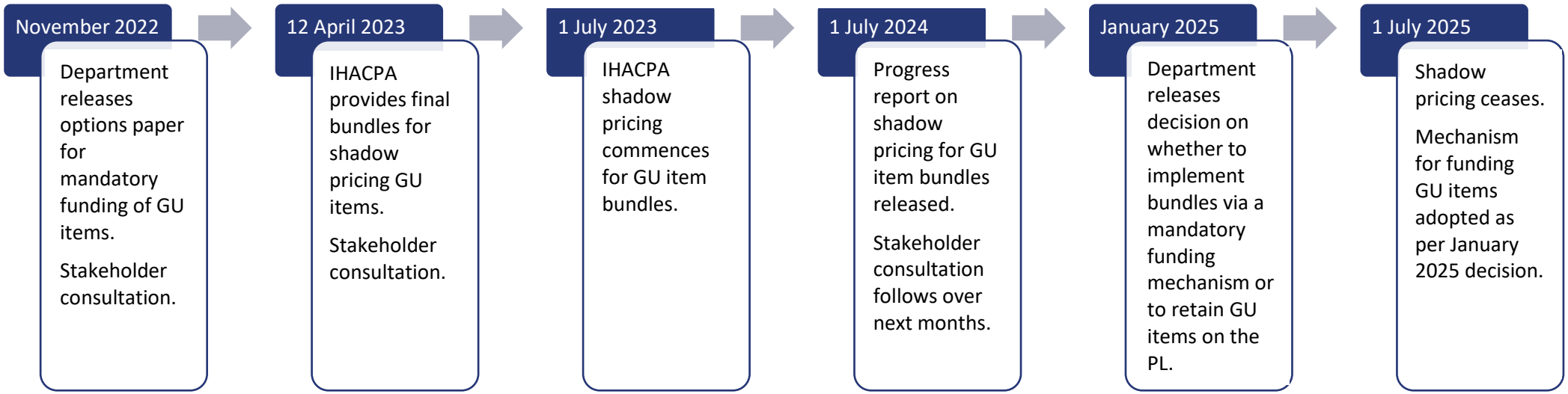
Supporting the private hospital sector to implement change

When implementing changes to the National Pricing Model IHACPA provides support to public hospitals to understand the changes being made and to identify and resolve rollout challenges. Similar support to private health stakeholders during the shadow pricing period will be instrumental in ensuring the success of the IHACPA bundles. This includes practical considerations such as:

- Providing advice that can be easily and simply operationalised. This includes reproduceable advice so that hospitals can understand the impact of the bundles on their individual operations.
- Tools such as a standardised calculator and methodology for hospitals to check their data, as IHACPA does in support of public hospitals. A method of easily understanding how any potential adjustments or alternative bundles might be applied to a hospital's circumstances is also important.

Figure 1.

Proposed shadow pricing timeline



Other issues

Given the complexities involved in moving to bundled GU items, it is understandable there are still many issues and questions to answer. The shadow pricing period offers the opportunity to methodically consider these across the sector. Some of these include:

- Consideration of a service weighting to account for future inflation in transporting GU items to hospitals, particularly rural and regional hospitals
- AR-DRG version control – Different DRG versions are in use across the sector, requiring consideration as to how bundles will be mapped across the versions in use
- The need for an ongoing methodology that continually updates the data underpinning the bundles' creation to ensure they are and remain fit for purpose. For example:
    - What is IHACPA's approach to clinically necessary volume growth?
    - Will the bundles be assessed year on year after the shadow period?
    - How will novel GU medical devices be integrated into the new system?
    - Without pushing an additional administrative burden onto hospitals, how will individual GU items used be captured and logged in a future where these items are bundled?
    - Ensuring outliers are captured and accounted for.

Consultation questions

1 & 9. Are you aware of any issues with the HCP data collection that may impact on the way it captures utilisation of General Use Items for private patient services? Are you aware of any existing contracting arrangements between hospitals and insurers that might be considered relevant in the formulation of advice on alternative bundling arrangements?

Some private health insurers bundle prostheses into contractual arrangements under a case payment model. In instances such as this, HCP data may not capture the full extent of prostheses (GU or otherwise) used in each bundled episode. In these instances, HCP1 data should include billing codes for each of the prostheses used. As IHACPA is aware, hospitals submit HCP data to health insurers who then add additional fields before making their HCP1 submission to DHA. It is important then that in its analysis IHACPA is able to compare hospital data on prostheses use to HCP1 data provided to DHA to ensure these items have been correctly captured in their entirety. CHA member hospitals are available to talk further and confidentially with IHACPA on this issue, including to make hospital data available for validation purposes. At Appendix A CHA includes a commercial-in-confidence analysis, not to be published or otherwise used or referenced publicly, for the purpose of initial assistance in this regard.

At a macro level, the integrity of the HCP dataset should be validated by comparing FY2021-22 data from hospitals with FY2021-22 HCP1 data from health insurers. As data is routinely updated, these two datasets should be taken on the same day to ensure as close a match as possible at the time of analysis. It will take time to reconcile these issues, and the two year shadow pricing period CHA has proposed is the appropriate process to achieve this.

6. Do you support or oppose the use of hospital characteristics within the design of General Use Item bundles?

CHA notes at the outset that hospital characteristics do influence casemix and therefore use of GU items, importantly though, operationalising this during the implementation of the GU bundles would be difficult. An overarching principle of the GU bundle reform must be that simplicity is paramount. That being said, without access to industry level data it is difficult to give definitive feedback on the simplest option that is also fair and reasonable. CHA is expecting IHACPA to analyse the variables across the sector and propose the bundling methodology that best meets the simple, fair and reasonable benchmarks. CHA and other sector stakeholders can then work constructively to understand the methodology used and the impact on patients before the bundles are finalised. The shadow pricing period then allows real-time analysis of impacts to ensure modelling across the sector was correct, and the bundles are behaving as expected.

In terms of which characteristics to consider in the analysis, CHA encourages IHACPA to stratify data by the common hospital considerations of AIHW peer groupings and by state and territory, and by the patient characteristic of age. This will create a foundation for the necessary analysis. CHA is not in a position to comment on whether these characteristics will or will not make a material difference to the development of bundles at an industry level, but when examining IHACPA's analysis, want to be sure that these key determinants have been considered.

4 & 5. Do you support or oppose the use of the PL product classification and ICD-10-AM/ACHI/ACS within the design of General Use Item bundles?

At a high level, a DRG-level bundle model could be sensitive to acuity in a way an MBS model could not.

As above though, CHA notes it is difficult to give conclusive opinions on preferred GU bundle methodology with the subset of data we currently have available. CHA has been working with our members and DHA to compile a dataset that reflects episodes and GU item usage across CHA member hospitals. As we pore over this data in the coming weeks we would welcome the opportunity to talk further with IHACPA on these issues.

10. Are you aware of any instances where a General Use Item charge is raised against an individual episode but where the item is used across multiple episodes, such as might occur for multi-pack or multi-use type items?

Anecdotally, CHA is aware that this occurs but input from device manufacturers would be particularly valuable here.