Australian
Private Hospitals
Association

Second Tier Arrangements

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Australian Private Hospitals Association ABN 82 008 623 809

Contents

Introduction

The purpose of this submission is to provide comment on:

1. The draft guidelines for administration of second-tier default benefits eligibility;
2. The draft application form for second-tier default benefits eligibility; and
3. The draft grouping of declared private hospitals by second-tier hospital category for calculation and payment of second-tier default benefits.

Private Health Insurance Second-tier Default Benefits Guidelines

1.1 Page 5-6 – Submit HCP data with claims for second-tier default benefits

"The department may also take into consideration:

- *whether the department has received HCP data from insurers for the hospital for any part of the previous 12 months that the hospital was treating patients;*
- *any unresolved complaints the department has received about the hospital not providing HCP data with claims for second-tier default benefits; and*
- *any steps the hospital has taken to ensure that HCP data will be provided to insurers with every future claim for second-tier default benefits"*

It is not clear how the Department will take these factors into consideration and whether there will be a process in place to allow the hospital to respond to any concerns that may arise from the Department considering these issues. There needs to be more transparency and objectivity around this part of the process.

More clarity is required on the Private Health Insurer's responsibility to provide individual hospital HCP data in a timely manner.

1.2 Page 6 – Application fee

"*Upon receiving an application the department will issue an invoice for the application fee, usually within three business days."*

"*The application fee must be paid within seven days."*

"The department may not commence any part of application assessment until the application fee has been paid in full. Hospitals should keep this in mind when deciding when to apply to renew eligibility."

From these statements it appears, although it is not specifically stated, that the 60-day period for assessment and notification will not commence until payment is received. If this

is the case it needs to be specifically stated. Therefore – please see comment under item 1.3 - Timeframes immediately below.

1.3 Page 7 – Timeframes

a) *"Hospitals will be notified of the outcomes of applications within 60 calendar days of the department receiving a valid application."*

Firstly, under current arrangements, the STAC completes all assessments within 45 days. This period includes 14 days for hospitals to provide additional information where requested. Given that the assessment task will be reduced under the new arrangements (e.g. no simplified billing requirements, IFC assessed during accreditation) it is unclear why the period for assessment has been increased. The period for assessment should be no longer than currently applies (45 days).

Secondly, the commentary relating to the application fee implies (but does not specifically state) that an application will only be considered "valid" once payment has been received. If this is the intention, it needs to be specifically stated.

b) *"Therefore, to ensure second-tier default benefits eligibility does not lapse during assessment, applications should be submitted at least 60 calendar days prior to expiry of a hospital's second-tier default benefits eligibility."*

In light of the fact that the 60-day period will only commence once payment is received, it would be necessary to allow an additional 10 days (3 days for issue of invoice and 7 days for payment) to the timeframe to ensure that the hospital second-tier eligibility does not lapse during the application and assessment process.

c) *"If the department requests additional information from an applicant, the requested information should be provided within five business days. If the requested information is not provided within the specified timeframe, and the department's 60 calendar day assessment timeframe expires, the department may assess the application as unsuccessful."*

Firstly, there is no explanation of the circumstances where the Department might request additional information (for example, is it to clarify information provided in an application or where an application may be incomplete?)

Secondly, presumably the Department will make a request for additional information before they have reached day 55 of the assessment process (noting comments above about the length of the process). There should be a statement to the effect that "where the Department requests additional information, it will do so no later than 50 days from the

commencement of the assessment process (noting that this needs to be better defined, as per above comments).

Finally, there needs to be a clarification about what happens where the department, for whatever reason, is unable to assess an application within the 60-day period which results in a hospitals' second tier eligibility lapsing. In such a case, there should be an automatic extension of eligibility until the assessment is complete and there should be a specific statement to this effect.

1.4 Page 8 – Changes in circumstances

> *"Second-tier default benefits eligibility may be revoked if at any time the hospital ceases to satisfy the assessment criteria in rule 7C of the Private Health Insurance (Health Insurance Business) Rules 2018. In such circumstances, the department may revoke the hospital's second-tier default benefits eligibility immediately."*

There needs to be clarification regarding what changes in circumstances are being referred to. It is assumed that this would relate to accreditation status, if this is the case this needs to be stated. If there are other changes that the Department requires notification of, these need to be outlined and the hospital provided with a reasonable timeframe (5 to 10 working days) to respond and demonstrate compliance with second-tier default requirements.

1.5 Page 9 – Comparable hospitals

a) *"A hospital may lodge a written request for an internal review of its categorisation within 28 calendar days from the day of notification by the department of the categorisation determination. The department will either confirm the categorisation or re-categorise the hospital within 28 days of receiving the request. In reviewing a determination, the department may also take into consideration evidence provided by other entities indicating that a hospital belongs in a particular second-tier hospital category*."

It is not clear what will constitute "evidence from other entities" and how this will be assessed against information provided by the hospital itself which includes a licence. There should be clear guidelines around what standards of evidence are required.

In addition, an "internal review process" by definition lacks transparency. What appeal rights and mechanisms arise if a hospital disagrees with the outcome of the Department's "internal review"?

Furthermore, if a hospital is successful in having its category changed following internal review, it should be entitled to be paid the difference in benefits that apply for the period between when the original categories were notified and the date its category is revised. There should be a specific statement requiring health insurers to pay any difference.

b) *"The department will request a copy of a hospital's licence as part of both the declaration process and the second-tier default benefits eligibility application process to inform categorisation of hospitals."*

If the Department already has a copy of the licence as part of the declaration process why does it also need it for 2nd tier purposes, this smacks of unnecessary bureaucracy. The Department should be able to access the licence it already has on file so a licence for 2nd tier purposes should only be required if the licence details have changed from the one provided for declaration purposes

1.6 Page 9 – Calculating second-tier benefits

"Insurers must calculate second-tier default benefits in accordance with Schedule 5 of the Private Health Insurance (Benefit Requirements) Rules 2011."

See comments below under Item 2.1(a) Application Form about the need to amend these rules to reflect the recommendation of the Contracting and Default Benefits Working Group.

1.7 Page 9 – Audit of second-tier rates

*"Each health insurer **is asked** to provide to the department a list of its second-tier default benefit rates by 31 August of each year. The list **should include** the second- tier default benefits payable by the insurer to each second-tier hospital category in each state between 1 September of that year and 31 August of the next year."*

Rather than be on the basis of a request, this should be a requirement for health funds with specified inclusions. If there is no current mechanism to require an audit of 2nd tier rates the rules must be amended to incorporate such a requirement.

Currently, insurers are asked to supply audited second-tier rates, however there is no transparency around these rates and it should be specified in the Rules for independent audited second-tier rates to be administered by the Department. This should involve the selection of one independent auditor to audit all private health insurance funds regarding the calculation of second-tier rates, this would ensure a fair and transparent process as recommended by members of the Contracting & Default Benefits Working Group of PHMAC.

1.8 Page 10 – Transitional requirements

"A hospital that is eligible for second-tier default benefits immediately prior to 1 January 2019 will continue to be eligible under the new second-tier arrangements. If that hospital's accreditation expires within 12 months

following its pre-existing second-tier default benefits eligibility expiry date, the second-tier expiry date will be extended to align with the accreditation expiry date. Otherwise, the second-tier expiry date will be as per pre-existing arrangements."

There is no clarification for hospitals who may not be re-accredited until 2020 or 2021. As the criteria for second-tier default benefits have been simplified and aligned to the accreditation cycle and where the hospital already has second-tier status, then the second-tier eligibility surely should be tied to the hospital's accreditation cycle whenever that may occur within the agreed 3-year period.

The inclusion of some examples here may be useful in clarifying these arrangements.

1.9 Page 10 - *Hospital category review*

Refer to our previous comments outlined above in Item 1.5 - Comparable hospitals.

In addition, where the Department confirms the categorisation following a requested review, it should be required to provide reasons why the request was rejected, as is proposed when it assesses a hospital as not having met the 2nd tier assessment criteria.

1.10 Page 11 – Revocation of second-tier default benefits eligibility

See previous comments under Item 1.4 - Changes in circumstances. As previously stated the hospital needs to be provided with reasonable explanations and a timeframe to demonstrate compliance with second-tier default benefits prior to revocation.

1.11 Page 11 – Changes in circumstances affecting eligibility

"Where an entity other than a specific second-tier eligible hospital has reason to believe that the hospital no longer meets the assessment criteria for second-tier default benefits eligibility, the entity may advise the department by emailing PHI@health.gov.au. Any claim should be accompanied by evidence in support of the claim."

See previous comments above under Item 1.5 - Comparable hospitals.

Definition of what is being referred to as an "entity", other than the second-tier eligible hospital should be clearly outlined.

See previous comments about the standard of evidence required to support such a claim. There is no mention of the process that will apply once such a claim is received by the Department. This process must be specified and at the very least the "evidence" provided should be presented to the hospital in question which must be given an opportunity to reply.

The hospital that is the subject of this claim should retain second-tier eligibility until the claim and the hospital's response have been fully and formally assessed and a determination made.

1.12 Page 12 – Appendix A: Application process Flowchart

The flowchart appears misleading as the first step indicates "apply at least 60 days before second-tier expiry date", whereas the 60-day period does not commence until payment has been received. However, as indicated above the current STAC process takes 45 days and if this suggestion is to be implemented hospitals would need to apply 55 days prior to expiry, or if the 60-day period outlined in this document then application would need to be at least 70 days prior.

See previous comments in Item 1.3 - Timeframe which should be incorporated in the flowchart, including a clear marker of where the 60 day (which should be changed to 45 day) assessment period commences.

Application to Become a Second-Tier Eligible Hospital

2.1 Page 1 – cover page

> *"Before completing this form, hospitals should seek independent advice about the value of being eligible for second-tier default benefits and the hospital's ability to meet the assessment criteria."*

What is the purpose of this statement? Why should hospitals seek independent advice and who is it suggested they seek it from?

Page 1, paragraph 3

> *"Schedule 5 of Private Health Insurance (Benefit Requirements) Rules 2011*
>
> *……second-tier default benefits are calculated as not less than 85 per cent of the average charge for the equivalent episode of hospital treatment under the insurers negotiated arrangements with comparable private hospitals in the State in which the second-tier eligible hospital is located."*

Significant changes to second-tier calculations were discussed and recommended by the Contracting & Default Benefits Working Group of PHMAC, in particular the need to revise the second-tier calculation so that contracted benefits, where no service or limited volume was provided over the past 12 months should be removed from the calculation process.

After reviewing both the Application and Guideline documents with respect to calculation of second-tier, it would appear that this significant recommendation has been ignored. This appears to be the only recommendation that has not been implemented and there has been no explanation offered for why this is so. Without this requirement there is potential for insurers to continue past practice of including in contractual agreements with private hospitals, services either provided in very low volume or not provided at all.

APHA is strongly of the view that this recommendation of the Contracting & Default Benefits Working Group of PHMAC must be implemented to ensure a transparent calculation process.

2.2 Page 1 – Application Fee

> *"An application to become a second-tier eligible hospital is not valid until an application fee has been paid in respect of the application."*

Please see our comments above on the Guidelines under Item 1.2– Application fee. If this marks the beginning of the assessment timeframe it should be specifically mentioned both here and in the guidelines (and the flowchart).

2.3 Page 3 – (d) make provision for informed financial consent

> *"If the hospital is **not** accredited against the **second edition** of the National Safety and Quality Health Service Standards, describe the procedures the hospital has in place to provide informed financial consent to patients or nominees."*

Hospitals not accredited under NSQHSS second edition should provide information outlining the informed financial consent process used at the hospital. This statement should also mention the requirement to attach a de-identified copy of the informed financial consent form.

2.4 Page 4 – (e) submit Hospital Casemix Protocol Data to health insurers electronically with every claim for second-tier default benefits

> *"If the hospital has not provided HCP data with any claims for second-tier default benefits in the past 12 months, please outline the reason".*

This statement does not apply to new second-tier applications (who by definition have not made any claims for Second Tier Benefits) and is only relevant for those hospitals re-applying for second-tier default eligibility, thus this should be clearly outlined in the above statement.

2.5 Page 5 – Attachments

Please refer to our above comments under Item 1.5 - Comparable hospitals regarding hospital jurisdictional licence.

Provision of the state licence should only be required if it differs to the one already provided for the purposes of declaration.

2.6 Page 5 – Signatory

> *"The signatory must be someone with legal authority to act on behalf of the hospital. An electronic signature is acceptable, **if the application form is emailed to the department** by the signatory."*

The purpose of this statement is unclear as the only method of lodgement is by email. Does it mean a different form of signature is required if it is emailed by somebody other than the

signatory? If so, what form of signature? There does not appear to be a space for a signature (electronic or otherwise) in this section of the form.

This is an unrealistic expectation with respect to the emailing of the form by the designated signatory as this will often be a member of senior management who is likely to have their assistant submit this on their behalf.

Draft grouping of declared private hospitals by second-tier hospital category for calculation and payment of second-tier default benefits.

APHA is aware of several instances where member hospitals have advised us that they do not agree with the draft categorisation that has been applied to their facility. We have urged them to contact the Department of Health as a matter of urgency so that the final categorisation can be determined prior to 1 January 2019.

It is essential that the Government implement a clear and transparent appeals process so that any concerns raised by hospitals can be resolved without detriment to the hospital concerned. If these appeals cannot be resolved prior to 1 January 2019, the difference in second-tier benefits between the original category and the corrected category should be payable and backdated to 1 January 2019.

There are also a number of implications that arise from the draft grouping that will need to be resolved.

3.1 Second Tier Benefits for services that are not routinely provided in a hospitals category.

There are some hospitals that have services mixes that are not typical of their assigned category. For example, they may have been assigned to Category B – Rehabilitation but also provide services in mental health. One consequence is that the second tier schedules calculated for Category B may not include rates for mental health services.

One solution for this anomaly would be to require the use of rates from the next most applicable category, for example Category A – Mental Health.

3.2 Categories where there are less than 5 facilities in a jurisdiction

It is also notable that the draft grouping of declared private hospitals by second-tier category shows that some hospitals are in categories for which there are less than 5 facilities in that jurisdiction. Consequently, it is impossible for any insurer to have 5 negotiated agreements with facilities in this category.

For avoidance of doubt it would be useful for the Department to specifically indicate on the Second Tier hospital list such cases where Schedule 5 - clause 3.8 is applicable.

Private Hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

The private hospital sector treats:

- 4.43 million hospitalisations a year.

In 2016–17 it delivered:

- 60% of all surgery
- 73% of eye procedures
- Almost half of all heart procedures
- 73% of procedures on the brain, spine and nerves.

Australian private hospitals by the numbers:

- Almost half (49%) of all Australian hospitals are private
- 657 private hospitals made up of:
    - 300 overnight hospitals
    - 357 day hospitals
- That amounts to: 34,339 beds and chairs (31,029 in overnight hospitals and 3,310 in free-standing day surgeries)
- Employs more than 69,000 full-time equivalent staff.

The Australian Private Hospitals Association

The Australian Private Hospitals Association (APHA) is the peak industry body representing the private hospital and day surgery sector. About 70% of overnight hospitals and half of all day surgeries in Australia are APHA members.