HealthCare Providers
New Zealand

HealthCare Providers NZ
2007/8 ARCC Annual Contract Review
Statement of Funding Claims and Contract Alterations

Introduction

1. This document sets out HealthCare Provider's NZ (HCPNZ) funding claims and contract alterations under clause A21 of the Aged Residential Care Contract.

Funding Claims

Capital Charge Update

2. TLA prices were built around capital charges and services costs. These costs were modelled in 1999 and established in the Price Water House Coopers (PWC) report in 2000.

3. The capital charge part of the TLA price was set by looking at:
    - Working capital required for a facility;
    - Capital cost of facilities, including fit out, chattels, equipment;
    - Expected economic life of assets;
    - Expected residual value of assets (if any);
    - Tax depreciation rates;
    - Required rate of return;
    - Expected rate of inflation; and
    - Company tax rate.

4. Over the last six years each of these elements has undergone changes, such as the land and building prices, which make up the capital cost part of the capital charge.

5. Providers believe the capital charge component of the TLA prices needs to be updated through a joint review within the next year.

6. As before, this review needs to be a joint exercise between funder and provider.

7. If DHBNZ do not wish to agree to participate in this review, or they agree and delay participating in the review, providers will be forced to proceed on their own.

    Claim One:
    That DHBNZ agree to update the capital charge component of prices through a joint review with providers.

Dementia TLA Rates

8. It has become apparent the average acuity of dementia patients has been steadily rising to the point where the current dementia rate does not reflect the costs of providing care.

9. This average increase in acuity has been driven by having a larger number of severe dementia clients, who require more interventions to guarantee their safety, other resident's safety and staff safety.

10. To address the issue there needs to be an increase in the dementia rate. To set the higher dementia rate, levels of need have to be measured and a threshold established. An accepted measure of need can be based on HONOS Scales which are already in place for the Ministry of Health statistics.

11. Providers wish to work with DHBNZ on this exercise and have it completed within six months.

Claim Two:
DHBNZ agree to work with providers to establish a higher dementia rate by September 2007.

Inflationary adjustment in line with FFT

12. Each year providers are faced with inflationary pressures just as DHB's are faced with inflationary pressures. It is essential that providers receive an inflation adjustment calculated on the same lines as DHB's, as service levels cannot be maintained in a situation where costs increase but income remains fixed.

13. We note that DHBs are compensated for inflation through the Future Funding Track (FFT) mechanism. This calculation is based on a formula that employs both the CPI and LPI indexes, i.e., (35% of CPI) + (65% of LPI) = % inflation adjustment.

14. The FFT percentage is then applied to the funding DHBs receive from the MOH, of which over $700 million is for aged residential care.

15. The FFT funding increase must be passed on to providers.

16. In the past, DHB's claim that a 1% increase in the TLA rates cost DHBs more than 1%. To date no supporting information has been presented to substantiate this claim.

17. We also note that when a resident's Superannuation increases, DHB's proportionately reduce their part of the Contract Price for Residential Care. Therefore any argument that DHBs proportionality pay more of the TLA price when it increases for inflation, cannot be sustained as this is returned following the superannuation increases.

Claim Three:
An inflation adjustment to TLA rates.

Acuity Measurement Exercise

18. Over the last ten years there has been a noticeable increase in the acuity of residents in all levels of aged residential care. It is in both parties' interests to measure acuity levels and establish an average acuity level per service.

19. As such we would like a bilateral commitment to establishing a measurement of present acuity levels in order to support the present dependency based funding model.

Claim Four:
Establish a process to measure present and future acuity levels in all levels of aged residential care.

Contract Alterations

Two Yearly Reviews

20. Currently under clause A21 reviews must be held annually:

A21.1 Each year there will be a single national review of all agreements between DHBs and providers for the provision of Age Related Residential Care Services.

21. Providers believe it is appropriate to have an annual review, but understand the large amount of resources each party has to devote to these reviews.

22. Therefore, Provider Representatives would like to propose that the annual review be changed to a two yearly review, with an automatic FFT inflation adjustment in the non-review year.

Amendment One

A21.1 Each second year there will be a single national review of all agreements between DHBs and providers for the provision of Age Related Residential Care Services. The review will be carried out on behalf of all DHBs by us, or by one or more DHBs that may include us. In the non review year prices will be adjusted for inflation by applying the Future Funding Track percentage to the TLA rates.

Costs of non-subsidized high cost medications

23. For the last two years providers asked DHBs to take into account the cost implications of medicines being prescribed which are not on the Pharmac free-list.

24. This was not addressed in the 2005/6 review, being delayed by agreement to the 2006/7 review. Last year, DHBs again agreed this issue needed to be addressed and proposed a joint working group between DHBs/MOH and providers.

25. Over the course of the last year DHBs did not established the work group, nor gave any indication of when they might do so.

26. Providers cannot wait further for this issue to be addressed. Therefore, providers will be meeting their medicine obligations, as originally intended when the ARRC contract was first negotiated, i.e., they will provide medicines as prescribed by a GP if they are on the Pharmac free list.

27. To clarify this situation we believe it is appropriate to insert a new clause D14.1(H).

Amendment Two

D14. EXCLUSIONS FROM SERVICE

D14.1 The Services do not include:
(H): Pharmaceuticals not on the Pharmac free list."

Incorporating Respite Care / Carer Support Contracts into the ARRC contract.

28. Providers believe that Respite Care/ Day Care and Carer Relief Care Contracts are better negotiated at a national level and should become schedules to the main ARC contract.

Amendment Three

A21.1 Each second year there will be a single national review of all agreements between DHBs and providers **<u>(including all contracts which cover short term care such as Respite Care contracts)</u>*****for the provision of Age Related Residential Care Services. The review will be carried out on behalf of all DHBs by us, or by one or more DHBs that may include us. In the non review year prices will be adjusted for inflation by applying the Future Funding Track percentage to the TLA rates.***
[As well as the consequential amendments to C1 and C2\

Evaluation for the current Transport policy.

29. When the ARRC contract and TLA prices were first established ambulance transfers were covered or subsidised by the DHB or the ambulance service.

30. For the last two years providers have asked DHBs to take into account the implications of the increasing transport costs associated with transferring residents to and from residential care facilities by ambulance.

31. In 2005/6 DHBs agreed to review the Ministry's Transport and Accommodation policy. This has not taken place and last year, DHBs again agreed this issue needed to be addressed and proposed a joint working group between DHBs/MOH and providers.

32. However, over the course of the last year DHBs have not established the work group, or given any indication of when they might do so.

33. Therefore, until DHBs meet their obligations as agreed in the previous two reviews, providers will be adhering to the terms of clause D20.2, which states:

    D20.2 You must meet the costs of transport, including specialised transport required for clinical reasons, to the services in clause D20.1(a) to (h), but are not required to meet the cost of transport to the services listed in clause D20.1(i) to (n).

34. In order to clarify the contract we propose the clause be amended the clause with a new clause D20.2.1. We accept that this clause is not strictly necessary as the contract clearly states providers have an obligation to transport residents to and not from the services listed on clause D20.1

    Amendment Four

    D20.2.1 You are not required to meet the costs of transport, including specialised transport required for clinical reasons, <u>from</u> the services in clause D20.1(a) to (h), and are not required to meet the cost of transport <u>from</u> the services listed in clause D20.1(i) to (n).

Rural Cost Issues

35. Many rural providers due to their location have higher costs associated with attracting qualified staff, transportation and even food. DHB have an obligation to ensure that their rural populations have the same access to health care services as the metropolitan populations.

36. To meet this obligation, DHBs need to ensure the price paid for residential care services in rural areas allows providers to provide the same quality care as in metropolitan areas. Last year, DHBs agreed this issue needed to be addressed and proposed a joint working group between DHBs/MOH and providers to look at the issue in detail. However, over the course of the last year DHBs have not established the work group, nor given any indication of when they might do so.

37. We note that DHBs recognise the increased costs for rural providers in their contracts with PHO's (see PHO contract version 17 Schedule F5 Rural Primary Health Care Premium).

38. One example where costs are clearly higher is for transfers to DHB hospitals. While rural providers wait for DHBs to establish the work groups these costs can be addressed.

39. Therefore, an amendment to the contract needs to be made, ensuing rural providers pay no more than their metropolitan counterparts in relations to transports costs to hospitals.

Amendment Five

D20.2.2 Providers in rural areas must meet the costs of travel in line with D20.2 up to but not exceeding the maximum cost incurred by any non rural providers in their DHB area.

Licence To Occupy and Subsidised Residents

40. In the 2005/6 review DHBs claimed, based on legal advice, that it was necessary to amend clause A14.1 following the implementation of the Social Security (Long Term residential Care) Amendment Act 2004. The amended clause is:

No Other Benefit For Services

A14.1 To avoid doubt you must not be party to any other arrangement (for example, a licence-to-occupy or similar arrangement) that results in you effectively receiving payment, benefit, or value whether from us or any other Person, for the supply of the Services, or any component of them, to a Subsidised Resident, whether or not the arrangement was entered into before you commenced receiving payment under this Agreement in respect of that Subsidised Resident.

41. At the time provider representatives contested this change, as legal advice confirmed the legislation did not make this change necessary. However, DHBs forced this change on providers by withholding a funding increase until agreement was reached.

42. Following an OIA to a DHB, we were sent an email between Jon Shapleski and DHBNZ's lawyer, Alastair Hercus of Buddle Finlay (dated Otober 4 2005) which noted, "it is not strictly necessary to make the changes". This email confirms the change to A14 did not need to be made.

43. Furthermore, since this change was made DHBs have stopped elderly residents (who have been needs assessed as requiring long term care and means assessed as entitled to a subsidy) from receiving that subsidy if they bought an LTO unit within a residential care facility.

44. This issue was raised during the course of the Social Security (Long Term residential Care) Amendment Act 2006, and resulted in the Minister publicly stating that this situation needed to be addressed in this years A21 annual review.

45. In light of the government's direction to DHBs, and the confirmation by DHBNZ's lawyer that the change to A14 was not necessary we believe the original A14 clause should be reinstated as well as inserting a new clause stating that residents eligible for a subsidy can receive that subsidy in an LTO unit.

Amendment Six

A14. COST SHIFTING

A14.1 You must not knowingly be party to any arrangement that results in you effectively receiving separate payments, whether from us or any other Person, for the supply of the same Services, or any component of them.

A14.2 You are able to enter by agreement into licence-to-occupy or similar arrangements with Subsidised residents.

Dual Auditing

46. The problem of dual auditing has been recognised and accepted by the Minister, Ministry and many DHBs. Minister Dyson gave public assurance at the Residential Care conference of 2004 that the Ministry did not intend to 'duplicate the audit process, and that that audits should be combined with the Certification Audit Process.' Recently, the issue has been taken up by Minister Dalziel as part of the government's review on unnecessary red tape and regulations.

47. Despite this many DHBs still refuse to adopt the 'clip on' audit tool. Therefore, we propose that clauses A15, A16 and A17 and all their respective sub clauses be deleted and replaced with the following amendment.

Amendment Seven

A15 "We agree our Contract Compliance audit shall be conducted at the same time, in a single process, as the HealthCert Audit, , whether undertaken by a Designated Audit Agency or otherwise"

Assignment and Transfer

48. The Assignment and Transfer clauses contained in A30 need to be more specific as many providers report that sales have been put in jeopardy due to lack of responses from DHB's and HealthPac.

49. To address this there needs to be a contractually established timeframe with regard to DHB's acknowledgement of receipt of notification, DHB notification of agreement to the sale/ transfer, DHB and HealthPac transfer of funding to new owner bank accounts etc.

50. This issue was raised in the 2005/6 review and DHBs agreed to discuss with HealthPac the cause of the delays. We are unaware of

how this issue has progressed. Therefore, until DHB's follow through on their commitments we propose the following amendment to clause A30 inserting a new clause A30.5:

Amendment Eight

"A30.5. Once we have received notification of certification, we shall complete assignment within 30 days."

Epidemic and Pandemic Risk and Cost Sharing

51. Under A20 "Uncontrollable Events" providers are partially insulated from uncontrollable events.

52. We believe this clause need to be more specific to take into account the impacts of epidemics and pandemics. Specifically, we want the ability to reconfigure services to take into account the effects on staffing levels. We also believe the extra costs associated with these types of events needs to be taken into account and a mechanism established between provider and funder to address these uncontrollable financial impacts.

Amendment Nine

Amend clause A 20.1 (b) by adding, "such as reconfiguring services and staffing levels.

Add new clause A 20.5, "We will consider on a case by case basis any financial claims from you based specifically on the uncontrollable event.