



Covid-19

A national health emergency requiring a national co-ordinated response

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Understanding the Australian response to the pandemic cycle

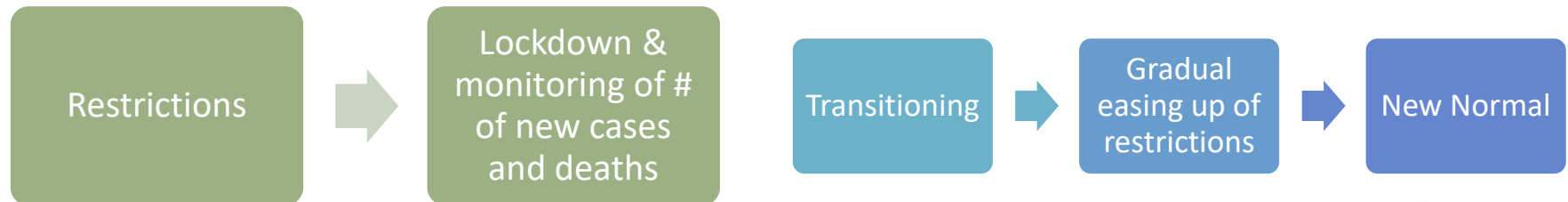


The Hammer (flattening the curve)

- 3 to 7 weeks – late March, April & May 2020
- Characterised by mandatory social distancing – probably leading to virtual lock down of most of country
- Key tools – quarantine, self isolation; social distancing; increase testing and preparing for peak illness sometime late April early May

The Dance

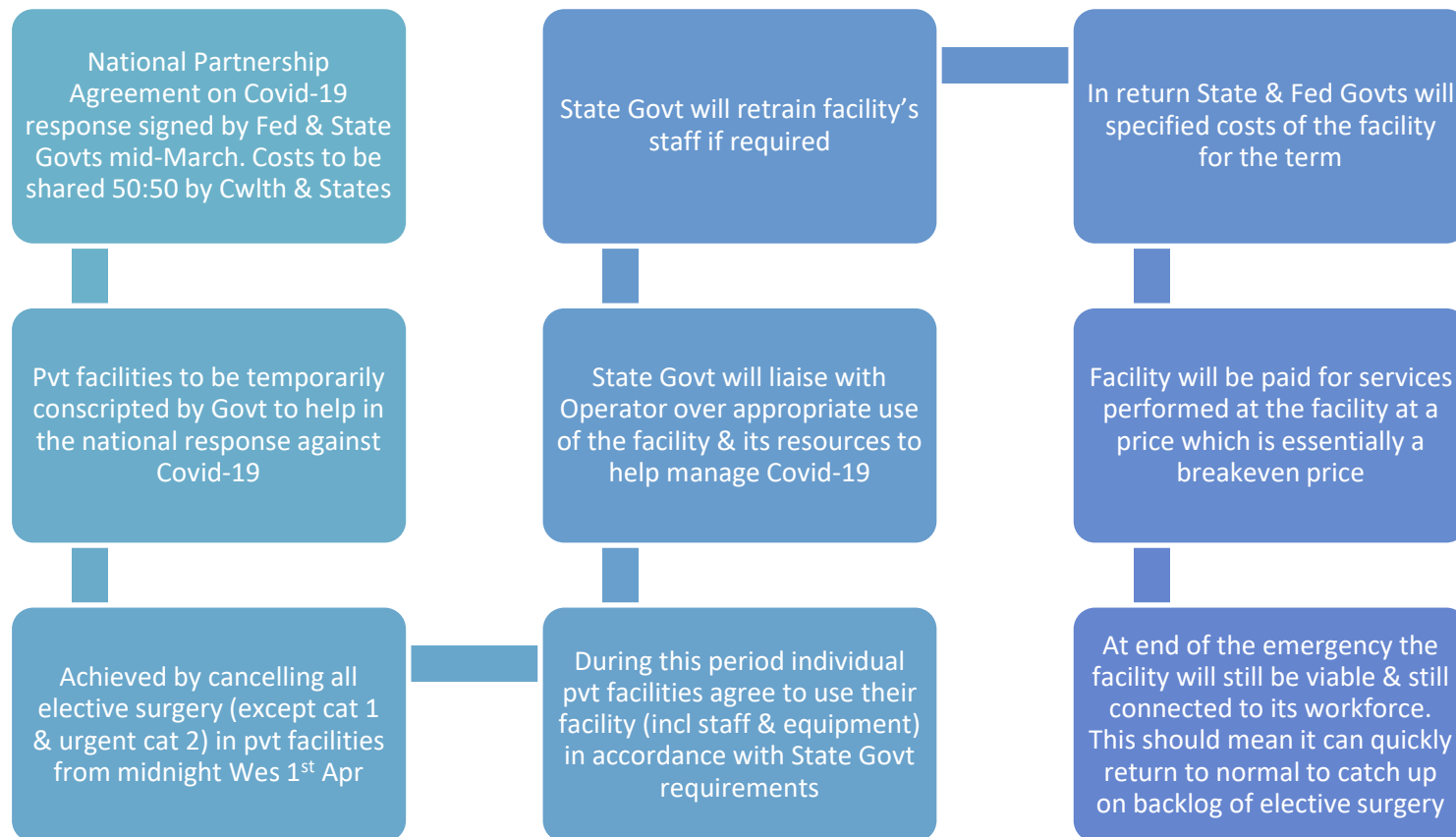
- Week 8 plus 12 months – June 2020 to June 2021
- Characterised by successful flattening of the curve, gradual but cautious relaxation of social distancing measures
- Key tools – testing & tracing; improved treatment protocols; invention of vaccine &/or effective anti-viral treatment protocols



Hospital context – national health emergency requiring co-ordinated national response




How does it work – high level





How might private day hospitals be used?



- 357 facilities, many in rural areas
 - Could take overflow of Covid-19 patients &/or non Covid-19 patients
 - Could take on much of category 1 surgery and all of category 2 surgery
 - Most facilities have anaesthetic machines & could ventilate patients
 - Skilled nursing & administrative staff
 - Many have patient beds with gas & suction capabilities
 - Could house cruise and flight Covid-19 passengers
 - Smaller facilities are unlikely to become hot spots for large contagions
 - Dispersing patients across more facilities reduces contagion risks
 - Lower cost than overnight facilities
 - And anything else the Government might need
- 



The Detail



- No national template (which is a pity)
- Each state will develop their own master template
- This master template will be offered, in theory, to all licensed facilities in that state
- Minimal, if any, individual negotiations with individual facilities
- No compulsion to enter into an agreement with the State, but
 - If you don't, the viability guarantee will not apply
 - The Fed Govt ban on all surgery in private facilities (except for cat 1 and urgent cat 2 elective surgery) will still apply
- But you would be diluting the national response to the national emergency
 - NB – you could continue to perform cat 1 surgery & urgent cat 2 elective surgery but CANNOT do non-urgent cat 2 and any cat 3 surgery

Definitions

Category 1: Procedures that are clinically indicated within 30 days

Category 2: Procedures that are clinically indicated within 90 days

Category 3: Procedures that are clinically indicated within 365 days





SA Agreement



- The original intention was for a HOA to be signed – which would then be followed by a Comprehensive Agreement
- But in practice SA Health have really gone straight to the Comprehensive Agreement
- APHA have been negotiating the draft Private Hospital Funding Agreement direct with SA Health
 - APHA has had no liaison with DHA, apart from today
- DHA now playing catch up
- We have agreed with APHA that DHA will try to develop with SA Health a specific Day Hospital template
- Will be similar to template for overnight hospitals but with specific changes to reflect day hospital requirements
- Haste is order of the day.
- Template needs to be in place by Wednesday of Thursday this week

The SA Private Hospital Funding Agreement template

NB – reflects draft as at 9th April



1. Participation may enable facility to avoid closure (as result of ban on surgery)
2. Funding
 - a. Payment for services performed in facility
 - b. Plus 100% of the difference between the facility's minimum net viability costs and the income it receives for services.
3. Clause 2 - Overarching objectives
 - a. Integration of public and private sectors
 - b. Ongoing viability of the participating facilities
 - c. Govt to have full & total access to all the beds, workforce & equipment of participating facilities
 - d. Amendment to clause 2 (a) (iii) may be required in order to avoid conflicts with EBAs/modern awards
 - e. Subject to specified exceptions, facility will continue to be managed at all times by the current Operator
 - In legal jargon the Minister is the principal and the Operator is a Independent Contractor
 - f. Public patients to be cared for in clinically appropriate settings and to receive the requisite standard of clinical care
 - g. Clause 2 (a) (v). 24/7 access (subject to availability of staff and VMOs). This is a concession Day Hospital facilities can use.
 - h. Both parties to exercise good faith in all their dealings
4. Clause 3 - Term of Agreement
 - a. Commences – 31st March 2020 (retrospective). But clarification required.
 - b. Expires – the later of 30 September and the date the Commonwealth Government lifts the ban on day hospitals being able to perform non-urgent cat 2 & all cat 3 surgeries

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5. Clause 4.3. Services will be provided in 4 phases
 - a. Maintenance phase – minimum activity but maintain all capabilities
 - b. Escalation phase – largely non Covid-19 parties plus private patients channelled from public hospitals
 - c. Peak surge phase – mostly Covid-19 patients plus Cat 1 & Cat 2 surgical patients
 - d. De-escalation phase - servicing of private patients plus back log of public patients.
6. Clause 5 (referrals). Clause 5 (c) may require amendment to allow the Operator to refuse to admit public patients that fall outside its normal admission criteria
7. Clause 8. The Operator cannot engage sub-contractors (excl VMOs) unless get Minister's approval
8. Clause 8 (d). But the Operator cannot be held liable for the acts or omissions of its VMOs
9. Clause 9 (VMOs). I think this states that the Operator will not have to secure relevant contractual arrangements with pathology, medical imaging & pharmacy providers. But this needs to be clarified.
10. The Operator is responsible for agreeing suitable remuneration terms with medical staff (be they employees or VMOs or subcontractors). Medical staff (ie VMOs) will not be separately paid.
11. Clause 11. The Operator must maintain all categories of employees and must, if directed, permit employees to be seconded to Public Hospitals. Clause 11 (f) (i) may require some amendment. See point 3.d above.
12. Clause 12. If the facility has debt, then within 5 days of entering the Agreement the Operator must satisfy the Minister that entering this Agreement does not amount to a default debt under the terms of the loan.
 - a. Operators need to consider whether they need such approvals (including from their landlord) before entering the Agreement.

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13. Clause 14. Financial Viability Payment

- a. An Initial amount (\$ amount to be fixed by agreement) will be payable pretty much as soon as the Agreement is signed
- b. By 15th of each month Operator informs Minister of its estimate of the Operator's Recoverable Costs (less estimate revenue earned for services rendered for the following month
- c. This amount will be paid by the Minister in advance on the 1st business day of each month
- d. On a quarterly basis (and again at the end of the term) the Operator will do a "square up" *on an accruals accounting basis* and a pay adjustment between the parties will then occur
- e. Cost and revenue to be determined on accruals basis (**so beware if you currently account using cash basis**)
- f. Operator must use best endeavours to mitigate any costs it incurs and to receive any revenue to which it is entitled under various Federal, State or Local Government Covid-19 incentives.
- g. Assumes both parties are operating on basis of utmost good faith & trust.
- h. **If you sign the agreement you are NOT entitled to apply for and receive JobKeeper payments.**
- i. **Operator must absolutely avoid double dipping.**

14. Clause 16. Payment for services rendered

- a. The Activity fee – for services rendered to public patients. Activity Fees must be based on the National Efficient Price as set by IHPA. **I doubt whether many day hospitals are familiar with this fee structure.**
- b. The Redeployment fee – relates to any assets, resources of workforce that are redeployed to the Public sector.
- c. The Commonwealth directed Services fee – relates to activities that may be commandeered by Cwlth (eg accommodation for quarantine & self-isolation cases; use by ADF in lieu of them establishing field hospitals; establishment of temp Covid-19 clinics; establishment of temp Covid-19 respiratory clinics etc).

15. Clause 18. Set off & interest

- a. Minister has set-off rights. Operator does not (unless sanctioned by law)

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16. Clause 19. GST

- a. As this is a business to business transaction GST must be included on all the Operators invoices (including fees charged by Operator for medical services rendered)

17. Clause 20. Patient charges & status of public patients.

- a. Public patients cannot be charged any out of pocket costs
- b. But Operator remains in charge of consent, clinical decision making, discharge and liability as set out in clause 22

18. Clause 21. WHS&W

- a. Operator responsible at the facility
- b. Minister responsible at public hospital

19. Clause 22. Liability

- a. Public staff who may be required to work in the Operator's facility will be covered by Govt's worker comp scheme.
- b. Operator's staff who may be required to work in the public sector will be covered by the Operator's worker comp scheme. We need to understand how RTWSA will regard this. Further clarification required

20. Clause 23. Indemnity

- a. The Operator is required to fully indemnify the Minister for any losses incurred by the Minister as a result of negligence, reckless or other wrongful acts by the Operator or its staff. Check with your insurers.
- b. But similar indemnity is not provided by the Minister to the Operator. This needs to be discussed with SA Health.

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21. Clause 24. Insurances

- a. Operator needs to use reasonable endeavours to have in place medical indemnity insurance for all its staff
- b. This includes for the VMOs.
 - i. The inclusion of the words "use reasonable endeavours" gives Operators adequate wriggle room.
 - ii. In addition under clause 24.3 if the Operator cannot secure insurance for its VMOs the Minister will intervene to obtain relevant insurance via SAICORP
- c. The Operator is responsible for insurance arrangements relating to public patients cared for in the facility
- d. The Minister will be responsible for insurance arrangements in respect of the Operator's staff who are seconded to the public sector
- e. But the opposite does not apply – ie the Minister will not be responsible for the insurance arrangements of public sector staff who are required to work in the Operator's facility. So beware before allowing public sector staff to work in your facility (which is unlikely to occur in any event).

22. Clause 25. Records and audits

- a. During the period of the Agreement (and for 7 years afterwards) the Operator's books will be open for inspection by the Minister (subject to 2 days notice)
- b. But will only relate to transaction relating to the Agreement

23. Clause 26. Reporting

- a. Operators should note the required reporting regime
- b. Weekly report specifying what spare capacity it will have in the next 4 weeks and what services it expects to be able to perform

24. Clause 27. Health Records

- a. Operators will be required to make arrangements to transfer the medical records to the public sector of public patients treated at the facility
- b. Not sure how this will be done. Further discussions with SA Health required.

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- 25. Clause 29. Step-in Rights
 - a. These can only be invoked if there is a Major Default by the Operator or an Emergency (as defined in clause 1.1)
- 26. Clause 30. Transition Out Plans
 - a. Operators will need to start thinking about this from early May
- 27. Clause 31. PPE & medical supplies
 - a. Any surplus stock of PPE or other items of P&E should be made available to the Minister. This is easy to say – hard to do.
 - b. Operators will find it difficult to determine how much PPE & other items of P&E they will require to meet their obligations under the Agreement.
 - c. It is impossible to predict demand in the current environment. Further clarification required.
- 28. Clauses 34 - 40
 - a. These are pretty standard
- 29. Clause 41 – interaction of this Agreement and other agreements
 - a. If you have any existing patient panel services agreement with SA Health this Agreement will override that agreement

The SA template

NB – only the HofA has been sighted currently



30. Recoverable Costs

Included	Excluded
Labour costs of employees	Debt servicing costs (ie interest paid)
Consultancy costs (excl legal, accounting & audit consultancies)	GST paid
Consumables & supplies	Fines & penalties
Software licensing costs	Intra-group costs and charges
Insurance costs	Capital expenditure (incl depreciation on new capital expenditure)
Hospital pharmacy	Impairment costs; write-off costs; amortisation of start-up expenses; write-off of goodwill
Pathology, imaging & pharmacy costs	Staff bonuses
VMO costs	Redundancy & severance payments
Utilities	Rent payments
Council rates & State Govt levies	Payments under equipment leases
Depreciation costs on land & buildings	Costs of prostheses
Amortisation of lease costs (including rental) NB – impact of IFRS 16	Bad debts
Contracted in services (like laundry & linen; waste disposal etc)	Advertising & marketing
Repairs & maintenance	Stock obsolescence



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30. Recoverable Costs (continued)

Included	Excluded
Phones & telecommunications	
Head office costs (if directly related to services provided to the Facility)	
Depreciation costs for furniture, plan & equipment	

The SA template

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31. Recoverable costs must be NET of any revenue received by the Operator

Example of revenue amounts that need to be included:

Payments received from Medicare

Payment received from Private Health Insurance Funds

Payments received from patients (self-insured; gaps; co-payments; exclusions)

Payments received from other 3rd party funders – DVA; RTWSA; Legal firms etc

Rental received from tenants

Car parking fees received

Fees it receives for pathology, imaging & pharmacy services

Fees received from on-site gift store; coffee store

Revenue Operator receives from any other Covid-19 related stimulus packages (eg business grants, refund of PAYG, refund of payroll tax, employee wage subsidies (Job Keeper grants)

Example of revenue amounts that may be excluded:

Donations