General Practice Contracted Provider Caucus
c/o GenPro, PO Box 1067, Wellington. 6140

24 November 2021

Michael Howard
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Dear Mike

Draft Pricing Schedule: Managing COVID in the Community

Thank you for your e-mail dated 18 November 2021 inviting feedback on the proposed pricing schedule for managing COVID in the Community. On behalf of the Contracted Provider Caucus, I would like to congratulate you and colleagues on an improved process of engagement and would hope that this can be developed further in the future to include a more representative process of co-design as well as a less challenging consultation timeframe.

I am pleased to provide the following feedback on behalf of the Contracted Provider Caucus and which has been informed by a comprehensive process securing input from all Caucus members, frontline general practice contracted providers and PHO representatives:

1. **High-trust, low-bureaucracy environment:** We believe these arrangements are an opportunity to proactively re-visit the relationship between general practice and crown funding agents. There is scope to support a high-trust, low bureaucracy environment which we believe would better support the cost-effective operation of the whole health system. We are keen to work with the Ministry and DHBs to secure such mutually acceptable working arrangements and underpinning funding frameworks for the future.

2. **Primary Care Clinical Model:** We agree with the need for a risk stratification approach and the intent to protect the secondary care system through community management of COVID positive patients wherever logistically and clinically possible. Such an approach should appropriately incentivise and engage primary care (which is already stretched and has limited capacity under the current funding framework) to ensure early clinical intervention as well as enabling the cost-effective utilisation of our high-cost secondary care infrastructure. We would make the following additional comments:
    a. Clarification is required with regards the co-ordination role to connect with, and oversee social care needs, liaison with Public Health etc
    b. Clarification is required with regards who will be responsible for delivering, collecting and cleaning the pulse oximeters which are to be provided to COVID positive patients
    c. Households where a COVID positive patient is isolating will likely have other residents also in isolation (whether they are COVID positive or not). All residents therefore become high-risk and will require clinical monitoring and support. In order to allow sufficient time and to

respect issues such as patient confidentiality, each patient/resident should be assessed/supported through their own funded virtual consult

d. Follow up check – we know that practices will also be getting discharge summaries from hospital to follow up COVID patients who were admitted – the follow up consult is likely to mirror the initial assessment and should be funded as such.

3. **Medical Complexity:** By definition, COVID positive patients are high-risk and subject to significant clinical deterioration within very short timeframes. Therefore, we would advise that:
    a. The risk to continuity of operations within general practice must be acknowledged and proactively managed – particularly with regards to:
        i. The risk to practice staff and non-COVID patients of potential contact through practice-based face-to-face consultations
        ii. The risk to GPs and their colleagues following a home visit for a COVID positive patient (or a member of their whanau)
        iii. The pressure on business as usual due to capacity and workload pressures upon general practice
    b. The limit of one claim per patient, per day is clinically inappropriate and doesn't acknowledge that the patient's condition may change rapidly and the practice will also receive incoming calls for assistance in addition to the outgoing assessment and surveillance calls
    c. A proportion of the standard virtual monitoring consults will require escalation and additional clinical input (without the need for a high-risk face-to-face consultation). Therefore, an additional fee is required for a same-day escalation consult. We believe this is likely to be a circa 20 minute, GP-led virtual consult.

4. **High-Needs:** There is a significant need for equity of access and service provision for high-needs patients. In this regard, we would advise that:
    a. The high-needs premium should be a minimum of 50% to recognise the additional workload/time commitment required
    b. Where a patient's condition deteriorates and the need for an ambulance is indicated, it is important that the principle of "free care" is maintained, especially for high-needs patients, who may otherwise be deterred due to existing ambulance charges. It would be helpful to clarify how ambulance journeys for COVID positive patients will be funded
    c. We support the in-home consult fee being based on an hourly rate. This is particularly important for those communities where travel times can be excessive – especially rural. In that regard, the provision of an agreed hourly rate would likely negate the need for a rural premium. However, the mileage rate should be at a minimum of the IRD rate of 79c.

5. **Service Alignment:**
    a. It would be helpful to clarify the expectations and associated fees for general practice service provision on behalf of un-registered patients – who will, by definition, require longer consult times due to the lack of an existing relationship as well as the lack of immediate access to the patient's history
    b. The in-hours expectations should be aligned with those of the existing PHO Service Agreement i.e. 8am to 6pm
    c. The suggestion that after-hours arrangements be co-ordinated on a DHB-by-DHB basis is of significant concern. National consistency is required in this regard and is important for many reasons, including clarity for patients, the avoidance of a postcode lottery, minimisation of bureaucracy/administration
    d. Clarity and appropriate funding is required for the provision of ACC care for COVID positive patients isolating in the community – this is particularly important to help avoid all such patients simply presenting at the nearest ED. One option may be for the Ministry of Health to fund all care for COVID positive patients isolating in the community.

6. **Fee Levels:** Several of the fees proposed do not reflect either the time commitment required or the service cost. Based upon feedback from providers already supporting COVID positive patients in the community, as well as clinical opinions of the likely consult content/time, we have re-estimated the consult times and actual costs below.

Group	Consult Type	MOH fee proposal	Consult Time	Minimum Actual Cost (exc. GST)
Initial Assessment	SVA	$ 130.00	40	$ 242.00
Initial Assessment	HNVA	$ 169.00	60	$ 363.00
Care Level 1	SVM	$ 65.00	30	$ 68.00
Care Level 2	SVM	$ 65.00	30	$ 68.00
Care Level 2	HNVM	$ 84.50	45	$ 102.00
Clinical Escalation Level 1/2	(new)		20	$ 121.00
Clinical Discharge and Clearance	SVA	$ 100.00	30	$ 182.00
Clinical Discharge and Clearance	HNVA	$ 130.00	45	$ 273.00
Follow-Up Check	SVC	$ 65.00	30	$ 68.00
In Home Care (Hourly Rate)	IHC	$ 338.00		$ 363.00
In Person Care	IPC	$ 260.00	60	$ 363.00

The following clarification is provided to support the above table/costs:

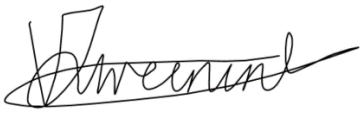
i. Actual costs are calculated using current system settings and "average" practice costs
ii. The hourly cost for GP care is calculated at $363 per hour (exc GST) based upon the benchmark of the ASMS SMO scale point 15 (noting that hourly GP rates vary considerably given current market forces) – please see Appendix A attached
iii. The costs exclude:
    a. Capex premises costs to support COVID related modifications
    b. COVID-risk and business-continuity-risk premiums
    c. Profit / general provider risk premium
    d. Pay parity expectations with secondary care clinical colleagues.

Finally, we would ask that the review process be set out and agreed now – and we would again be happy to work with the Ministry and DHBs to ensure the process proactively includes providers' own appointed representatives and is based upon transparent and mutually agreed evidence.

I would thank you once again for the opportunity to provide this feedback. I would be happy to discuss any of the points we have made in further detail if that would be helpful.

In the meantime, I look forward to our comments being incorporated into an updated set of proposals and would be willing to offer the immediate input of the Contracted Provider Caucus to enable the adoption of a timely co-design process for that purpose.

Yours sincerely



Dr Vanessa Weenink
Caucus Chair

cc: Dr Mark Peterson & Dr Angus Chambers, Contracted Provider Representatives
Philip Grant, Contracted Provider Caucus Secretariat

APPENDIX A

General Practice Costing Model

In-Confidence. Without Prejudice.

Not Policy or Agreed

	Annual Equivalent $
Salary (per ASMS)	245,000
Kiwisaver @ 3% (min)	7,350
ACC @ 3%	7,350
CME	15,000
Premises - Rent @ 10%	24,500
Premises - Power, Light, Insurance, Equip, Car Park, Maintenance, Cleaning etc @ 10%	24,500
Staffing - admin, reception, finance, management, security @ 20%	49,000
Staffing - nursing, healthcare assistants @ 20%	49,000
Consumables, Travel, Subs, Misc @ 5%	12,250
Total Costs	**433,950**

	Hours	Days	Weeks	
Hours				
Total Annual	8	5	52	2,080
Statutory Days	8	-11		-88
Leave	8	5	-6	-240
Sick	8	5	-2	-80
CME	8	5	-2	-80
				1,592
Admin/paperwork at 25%				-398
Total Contact Hours				**1,194**
$ per hour GP (exc GST)				363.44
$ per 15 mins GP (exc GST)				90.86