Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
By email: submissions.ihpa@ihpa.gov.au

Dear Mr Downie,

Re: Pricing Framework for Australian Public Hospital Services 2019-20

Thank you for the opportunity to provide feedback on the IHPA stakeholder consultation paper for the Pricing Framework for Australian Public Hospital Services 2019-20. As you know, Children's Healthcare Australasia's (CHA) membership comprises both specialist children's hospitals and general hospitals providing paediatric services, large and small. We have consulted our members about the questions posed in the consultation paper for the Pricing Framework 2019-20. This submission offers feedback related only to children's health services and for selected questions in the consultation paper.

1. What changes, if any, should be made to the criteria and interpretive guidelines in the *Annual Review of the General List of In-Scope Public Hospital Services* policy?
Nil

2. How could 'Australian Coding Standard 0002 *Additional Diagnoses'* be amended to better clarify what is deemed a significant condition for code assignment?
CHA supports the amendments proposed by ACCD in the Addenda Proposal (TN592_5) to development of the ICD-10-AM Eleventh Edition.

3. Do you support the proposed timeframe to phase out support for AR-DRG classification versions prior to AR-DRG Version 6.X from 1 July 2019?
CHA members confirm that the proposed time frame is sufficient.

4. Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?
In general CHA supports the biennial AR_DRG development cycle. CHA however notes that it could be advantageous to consider a time frame of perhaps 3-4 years to allow more time for harmonisation of data, as some issues will only be uncovered when healthcare facilities adopt classifications for a longer period. This would improve data comparability over time and among healthcare facilities.

5. What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?
CHA encourages inclusion of the functional independence measure (WeeFIM) for children. Currently, FIM is only in the scope of SNAP for adults and including WeeFIM will help to ensure there is complete data available to support the "rehabilitation paediatrics" care type.

6. Should access to the public hospital data held by IHPA be widened? If so, who should have access?
CHA supports IHPAs commitment to transparency. All public hospitals should have access to the IHPA National Benchmarking Portal. Currently, it is not accessible to public hospitals in several jurisdictions. It is vital that hospitals are able to reconcile data in their internal systems with reports provided by IHPA. Hospitals need to be able to predict the impact of funding changes introduced by IHPA as well as plan for future changes. Limitations on this access in some jurisdictions serves only to deprive managers of much needed information to support them to identify opportunities for enhance services and reduce costs.

CHA would also propose that peak not for profit organisations like our own should be granted access to the National Benchmarking Portal. Children's Healthcare Australasia (CHA), and our sister organisation, Women's Healthcare Australasia, have relationships with managers and clinical leaders across the public hospital sector and expertise to assist services to learn from one another's successes, improve outcomes for patients and reduce costs. There could be substantial benefits to health system managers from facilitating access to the Portal for not for profit charity organisations such as ours, not least of which is the efficiency in minimising time spent by data managers providing data to multiple different stakeholders, when one submission of data to IHPA could enable all interested stakeholders to spend less time on duplicating data collection and more time analysing & communicating about the data. Such access could be conditional upon not publishing the resulting analysis publicly if that is what the jurisdictions require.

7. What are the advantages and disadvantages of changing the geographical classification system used by IHPA?
Changing the geographical classification system used by IHPA using a method similar to the one described would provide more granular measures of remoteness than the current ASGS-RA model. Having a continuous remoteness index may help explain cost variations that the split across the 5 ASGS-RA categories are unable to. The ASGS-RA model has the advantage that it directly uses measures of accessibility – the proposed method focuses solely on population density.

8. What areas of the National Pricing Model should be considered as a priority in undertaking the fundamental review?
CHA believes finalising and implementing improved classification systems for emergency, mental health and non-admitted care are priority areas for the national pricing model. Determination of these price weights across care streams is highly dependent on the available end classes within the classification. The current systems for these streams do not allow the true diversity of services and relevant cost drivers to be accurately reflected in activity data.

9. Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2019-20?
Nil

10. What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?
CHA supports the extension of funding adjustments that are applicable in the admitted setting to other settings. Currently there are no adjustments for treatment of paediatric patients in emergency or non-admitted streams and CHA believes investigating this with improved data should be a priority for NEP19.

11. What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.
The inclusion of a measure of comorbidity burden as a relevant risk factor in the HAC model prompts the question if this same measure of comorbidity burden represents a basis for funding adjustment. If these conditions are present but do not manifest as additional LOS or lead to grouping to a more complex DRG then the additional costs of treating these patients may not be reflected.

CHA notes that whilst the consideration of patient comorbidity is supported for the HAC adjustments, the use of the Charlson Index is sub-optimal for paediatric cohorts. See the following papers for some other scores in the literature for which preliminary analysis on paediatric populations has shown a greater ability to predict HAC outcomes (when compared to the Charlson Index).

1. Tai D, Dick, P & To, T et al. 2006, *Development of Paediatric Comorbidity Prediction Model*, University of Toronto and the Research Institute, The Hospital for Sick Children, Toronto
2. Rhee D, Salazar, JH & Zhang, Y et al. 2013, *A Novel Multispecialty Surgical Risk Score for Children*, John Hopkins University School of Medicine, Baltimore

CHA members have completed preliminary analysis on paediatric populations using the Rhee and Tai scores. The preliminary analysis shows that the Rhee score in particular has a significantly improved ability to predict HAC outcomes for paediatric patients when compared with the Charlson Index. CHA suggests that IHPA consider use of these alternative scores for paediatric populations to predict HAC outcomes. CHA can provide further details of this preliminary analysis on request and would encourage IHPA to meet with the relevant CHA members to discuss the work in further depth. CHA would be very happy to facilitate this discussion.

12. Do you support price harmonisation for the potentially similar same-day services which are discussed above?
CHA supports price harmonisation for similar same day services that can be provided in both admitted and non-admitted settings. Currently, the price weights and adjustments that apply in the admitted setting provide a disincentive to transition suitable patients to a non-admitted setting.

CHA supports focusing on the listed services as a priority – especially harmonising same day rehabilitation and non-admitted services.

13. What other services, which can be provided in different settings of care, could benefit from price harmonisation?
Nil

14. When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model?
IHPA should continue to implement shadow periods for changes that require new data items or when new classifications are introduced. Unless it is possible for health services to determine impacts of any changes to the pricing framework 6-18 months ahead of implementation then a shadow period should be implemented.

15. Do you support the proposal to phase out the private patient correction factor for NEP20?
CHA members suggest that the private patient correction factor should only be phased out where evidence supports compliance by hospitals with the business rule 1.1A of the Australian Hospital Patient Costing Standards Part 2: Business rules, Version 4.0. Item 1.1A.3.11 of this rule states that costing practitioners will need to "understand the purpose of expenses in SPA accounts and the various RoPP agreements as to align the appropriate expenses to final cost centres for product costing purposes".

Staying abreast of these arrangements is difficult as they might vary over time. Mapping the SPA funds to the appropriate activity is difficult, in spite of best efforts by costing staff. Full allocation of private patients' costs from SPAs should remain the goal of costing. IHPA's intention to "work with states and territories to better identify the treatment of private patient costs" (NEP Consultation Paper 2018-19 p. 29) is also important. Only when the evidence supports compliance with this rule should the private patient correction factor be removed.

16. What countries have healthcare purchasing systems which can offer value in the Australian context and should be considered as part of the global horizon scan?
CHA has identified that Canada has a number of ABF innovations that may offer value in the Australian context. For example, the Quality Based Procedures (QBP) list used in Ontario – where designated conditions are funded at the cost of the agreed best practice treatment pathway. Another interesting innovation is the Population Grouping Methodology developed by CIHI.

17. Do you agree with the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Hospital Network (either to the same hospital or to another hospital within the same Local Hospital Network)?

CHA agrees with basing readmissions on the same LHN. This ensures that a LHN can proactively manage avoidable readmissions throughout the year as there is zero visibility to episodes admitted to facilities outside of their own LHN. It should also provide higher quality data through the ability to validate unique patient identification and admission details.

The availability of data to monitor and audit HAC rates results in much greater ability to implement measures to address this. Reviewing annual data exceptions and readmissions / representations to other LHDs as part of the NSW process has highlighted some of the data quality issues that can take place when identifying these quality indicators. These data quality issues can only realistically be fixed in a timely manner for episodes within one's own LHN.

18. What are the advantages and disadvantages of use of the Medicare PIN and/or the Individual Healthcare Identifier for the purposes of pricing and funding of hospital readmissions?
CHA members have identified that the IHI would be preferred in identifying unique patients across hospital episodes due to the strategic direction of the IHI's use and planned inclusion in the national dataset collection.

19. What strategies can be used to overcome existing disadvantages for each of these approaches?
CHA encourages continued investment and refinement of the Individual Healthcare Identifier.

20. Do you support the proposal to limit the measurement of readmissions to those occurring within the same financial year?
Yes, CHA agrees that ease of implementation and transparency will be compromised if funding adjustments are incurred significant periods of time after the close of financial year (e.g. up to 90 days for venous thromboembolism). The risk that excluding this small cohort of avoidable readmissions will detract from the overall quality improvement aim of this funding option is low.

21. Do you agree with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions?
CHA agrees with the use of funding options for avoidable hospital readmissions. CHA agrees that an approach which allows for risk adjustment is extremely important, as well as ensuring only those episodes with an avoidable readmission incur any funding impact from the approach.

There is also a need to consider how efforts by hospitals to minimise readmissions are currently inadvertently penalised under ABF. For example, one large member of CHA has recently succeeded in significantly reducing emergency department attendances and inpatient stays for a cohort of children with multiple chronic and complex conditions through investing in care-coordinators to facilitate communication between the family & the multiple sub-specialists involved in the children's care. The children have benefited greatly through improved health, the families are very pleased, and the hospital has saved several millions of dollars that was formerly being required to care for these children. However, without the activity the hospital stood to lose funding under ABF. Unless alternative funding was available they would have needed to discontinue the care coordination roles, which would have increased these children's use of the hospital services again. A grant from the state government made it possible to continue. Consideration needs to be given to how ABF can support rather than impede such innovations, and reward efforts to reduce avoidable readmissions.

22. What patient-specific factors should be examined in a risk-adjustment approach to avoidable hospital readmissions?
CHA supports introducing more granular age groups for children between 0 to 4 to capture the very different patient and treatment characteristics between newborns, babies and toddlers.

CHA reiterates our member's concern with using the Charlson score as a risk adjustment factor for comorbidity burden in children (see Q12).

23. What are the advantages and disadvantages of Option 1?
Option 1 is simple to understand but may be too blunt as a funding model. Such an approach would likely discourage early discharge programs, or models of care which may accept a low level of readmission risk in return for prioritising more complex patients or improving patient flow. Option 1 also does not consider the impact of any high cost readmission episodes – where the reasons for the high cost may not necessarily be related to the initial readmission condition. Such an approach would require a capped funding adjustment.

24. Do you agree with IHPA's assessment of this option (1)?
CHA members disagree with the premise that all events should receive zero funding.

25. What are the advantages and disadvantages of Option 2?
The advantage of Option 2 is that the premise of treating both index and readmission as a single episode but under the DRG of the index episode is intuitive and easy to understand.

There is a risk of using a combined LOS to calculate the NWAU for both episodes that the presence of an avoidable readmission results in no tangible funding penalty e.g.) if the combined LOS was within the short stay per-diem funding period for that DRG and hence the price weight is above average cost.

It is not clear what proportion of NWAU is assigned to the index episode and what proportion is assigned to the readmission episode – for example in the scenario that both the index LOS and the total LOS both fall in the inlier range (so in effect the readmission episode does not add any additional NWAU). Would the NWAU of the index episode remain unchanged and the readmission episode receive no NWAU, or would the index episode receive a lower NWAU with the remaining assigned to the readmission episode?

26. Do you agree with IHPA's assessment of this option (2)?
CHA believes that the difficulties associated with the transparency and ease of implementation assessments are understated.

27. What are the advantages and disadvantages of Option 3?
The key advantage of Option 3 is the balance of encouraging both the minimisation of avoidable readmissions, as well as early discharge programs or models of care involving a low risk of readmissions. These programs or models of care may actually have an overall improvement on patient outcomes and hospital efficiency – but would be highly discouraged if every readmission is penalised. Having a non-zero acceptable/benchmark rate of readmissions addresses this shortcoming of the previous two options.

28. Should benchmarks for avoidable hospital readmissions be measured and calculated at the level of individual hospitals or at the level of Local Hospital Networks?
Benchmarks should be calculated at the level of individual hospitals as there are likely hospital specific characteristics that influence what an acceptable avoidable readmission rate might look like. Using a clearly defined set of *hospital level* risk factors and adjusting of national/state/peer group benchmarks may provide an easy to understand and transparent approach to setting hospital level thresholds.

CHA understands that it is IHPA's intention for the pricing framework to engage health services and influence behaviour. CHA's experience with our members over many years has given us insight into the difficulties for individual hospitals accessing data from the LHN in a timely manner. In addition, both patient characteristics and clinical capability can vary significantly among hospitals within the same LHN. CHA suggests that benchmarking set at the individual hospital level it will enable hospitals participate in this benchmarking and use information readily to change and influence local practices.

29. How should the threshold be set for 'acceptable' rates of avoidable hospital readmissions? How should the funding adjustments be determined for 'excess' rates of avoidable hospital readmissions?
CHA agrees with setting a peer group average / median benchmark and using a more graduated approach so that although more LHNs may experience funding adjustments – the size of the funding adjustment will depend on a specific LHNs deviation from their peer group benchmark. The total funding adjustment should be a function of the number of episodes above the benchmark rate only – it would be unclear exactly which episodes are the "excess" and hence receive 0 NWAU. Perhaps a standard readmission episode NWAU penalty can be used and applied to each of the "excess" readmissions.

30. Do you agree with IHPA's assessment of this option (3)?
Yes

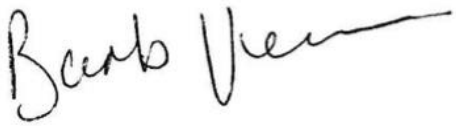
31. Do you agree with IHPA's implementation pathway?
Yes, implementing a shadow period for all three options would provide greater data evidence for assessing which option is most practical and effective.

32. For what period of time should the three proposed funding options be shadowed?
CHA agrees 24 months is appropriate, as it provides one full year of data collection and understanding of results, and hopefully a second full year of data to analyse behavioural change as a result of the collection of this new quality indicator.

33. Do you support an incremental approach to introducing funding adjustments for avoidable hospital readmissions based on one or two clinical conditions from the list of conditions considered to be avoidable hospital readmissions?
An incremental approach will allow hospitals to monitor their own data and reconcile it with the funding adjustments from IHPA. It will also allow IHPA to measure the financial impacts of the funding changes to ensure they are appropriate.

Further information.
CHA would be happy to facilitate further discussion with members about these matters if you require clarification or further explanation for any of the comments provided here. Please don't hesitate to contact me if we can assist further. Thank you again for the opportunity to provide advice on these matters.

Kind regards



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Children's Healthcare Australasia

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