Mr James Downie
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WOMEN'S & CHILDREN'S HEALTHCARE AUSTRALASIA

Dear James,

Re: Pricing Framework for Australian Public Hospital Services 2021-22

Thank you for the opportunity to provide feedback on the IHPA stakeholder consultation paper for the Pricing Framework for Australian Public Hospital Services 2021-22. Children's Healthcare Australasia's (CHA) membership comprises 90 paediatric services, including both specialist children's hospitals and general hospitals providing paediatric services, large and small. While Women's Healthcare Australasia (WHA) represents 139 maternity services across Australia. We have consulted our members about the questions posed in the consultation paper for the Pricing Framework 2021-22. This submission offers feedback related only to the provision of women's and children's healthcare services.

1. What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?

In paediatric services, changes to triage procedures, ward setup and addition of COVID related services have been implemented as a result of COVID-19. Members have seen a significant decrease in emergency department encounters, admissions and elective surgeries, but increase in mental health presentations among children & young people, especially (but not exclusively) related to eating disorders. Members also have seen changes to the overall casemix of patients, with typical high volume low severity admissions from seasonal respiratory infections dropping to comparatively low numbers due to social distancing and better hygiene measures. Use of telehealth for outpatient consultations became commonplace, with both advantages (increased efficiency for OPD clinics & convenience for families) and drawbacks (loss of ability to undertake physical assessments resulting in need for multiple appointments, some families have not regarded telehealth consultations with the same level of commitment and have not even had their child with them when taking the call/joining the web meeting).

In the maternal & newborn services, levels of demand for care have understandably remained the same although our members have also reported increasing prevalence of women experiencing stress and or harm from living with domestic violence, financial insecurity and even homelessness. Key changes in the provision of care have included widespread adoption of telehealth consultations for pregnancy and post-natal care, increased use of Hospital in the Home (HITH) for some newborn care, but reductions in home-visiting initiatives in continuity of care models, due to concerns about potential risks of spreading infection to/by midwives. Antenatal education classes were moved online, which improved attendance & access, but reduced the opportunity to build networks of social support among mothers having babies at similar times.

2. How will these changes affect the costs of these services in the short and long term?

For paediatric services, these changes have increased cost per service for the short term due to reduced activity (ED and inpatient – both surgical & medical) against an existing cost base designed to staff higher usual numbers of presentations/admissions. Paediatric services implemented a range of measures to try to reduce their costs, including redeploying staff to assist adult services where appropriate (in training use of PPE, providing supplementary labour on adult wards, etc) and encouraging/obliging paediatric staff to take accrued leave. But the size of changes in activity levels in the last quarter of 2019-20 and first quarter (at least) of 2020-21 are likely to result in sustained higher per episode costs for paediatric care at many hospitals in the short term.

In the longer term, costs for outpatient services may be reduced per attendance, where use of Telehealth remains a key feature of paediatric specialist clinics, particularly for review patients. However there are also

expected to be significant increases in demand for mental health services beyond the capacity of current services. Mental health services for children & young people were already oversubscribed before the pandemic. Analysis by CHA of data from the children's hospitals indicates that ED presentations for mental health reasons have risen over the past 6 years by more than 60% from 1.3% (n=4,668) to 2.1% (n=8,536) of total presentations. Inpatient numbers have also increased by 40% from lows of 1.5% (3,306) to 2.1% (4,371) of total admissions. This period's effect on the paediatric population will be likely to have long term impacts on service costs.

3. What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

As IHPA has acknowledged, periods where COVID and related policy measure were in place will have impacted on the costing data and therefore will affect the pricing model. There should be clear documentation where appropriate to highlight this and the resulting impact to the model.

CHA members remain interested to see changes to the pricing for newborns & other neonates admitted to specialist children's hospitals, to unbundle the ICU component of the price for these patients.

WHA members remain interested to see changes to the specification of unqualified neonates, many of whom are continuing to be provided with clinical care on postnatal wards with their mothers rather than in a nursery but whose care is not adequately funded by the birth DRG of the mother. Further, there continues to be an unfunded cost related to care of babies who are effectively borders to mothers admitted for mental health reasons following childbirth. Some of our larger members report this care (of the babies) is costing $1m annually.

4. Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

Yes. The pricing guidelines continue to be relevant to the provision of women's and children's healthcare services and to provide a consistent reference point.

5. Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

Not allowing hospitals to 'double dip' on funding where private sector funding are available, and at the same time not to disadvantage facilities that are not able to attract the same level of private sector contributions due to low levels of insurance in the community is understandable. However, CHA members also believe this goal to achieve strict neutrality may bring unintended consequences. The system needs to retain some incentives for hospitals to pursue private sector funding for sustainability and to encourage patients to access their private health insurance. There should be some recognition and support for the resources that are committed to pursuing private income to the overall benefit of the system.

6. What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?

Changes in standards, new standards, new Diagnosis Codes, and new procedure codes should be included in the online education for new editions of ICD-10-AM/ACHI/ACS. It would be beneficial to include paediatric coding scenarios/examples where relevant such as for paediatric mental health, paediatric cardiac surgery, etc. Education should also be standardised nationally and delivered virtually, to efficiently support consistency of education & implementation.

7. How should AR-DRG education be delivered and what should it include?

AR-DRG education can include a one-page summary of changes and examples that identifies diagnoses/ procedures that impact on DRG Assignment. Updates on which DRG have been split or amalgamated, new DRGs and obsolete DRGs should also be included, together with examples of the importance of specificity, as this can alter episode complexity. Clinician engagement resources should also be considered.

8. What improvements to the content and format of the electronic code lists could be made to enhance their utility?

Wider distribution and online access via IHPA, version control, consider access to clinical teams. ie when clinicians require access for database or research requests or documentation improvement education.

9. Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

Yes. A sensible move towards environmental sustainability.

10. Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely?

Members suggest the Australian system needs to consider the issues of education and coder competence in preparation for the introduction of the new system.

ICD-11 has potential impacts on the coding workforce. Coders need to learn to the new classification system and adapt to the changes to feeder systems and established databases and dashboards that rely on ICD-10-AM data. An aging workforce of coders is likely to retire and not be invested in learning a new classification system. New coders currently invested in personal cost of learning ICD-10-AM and gaining coding qualifications are not yet employed. Qualifications in ICD-10-AM will not be valid, and they will be unable to apply for coding positions requiring ICD-11 skill set. As a result, there is potential shortfall of coders.

A transition period would be needed to minimize impact on coding turnaround times and service delivery whilst coders learn and adapt to the new system. Hospitals may need to run dual systems for data access and reference.

Apart from testing the impact on AR-DRG grouping, the ICD-11 system with its expanded scope of concepts, could be tested with regard to its suitability in enhancing the Mental Health, Emergency Department and SNAP classifications. IHPA should consider including both maternity/newborn and paediatric sites for testing or learning reflective of specific diagnosis and procedure codes relevant to these populations of patients.

11. Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?

CHA members welcome these additions. The creation of new clinics should consider the paediatric adjustment and if this accurately reflects the cost of this service. IHPA should also consider incentives for services to move similar services provided in acute or rehabilitation day only to an outpatient setting.

12. How would activity that falls under these proposed new classes previously have been classified?

Members have advised that these activities are currently being coded mainly to Pain Management Allied Health / Nursing Unit (Tier 2 clinic Code 20.03), to Clinic 40:14 Neurpsychology or to occupational therapy or physiotherapy depending on local MOH HIRD definitions.

13. What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?

It provides initiative for better data quality especially for accurate documentation of ED diagnosis.

14. Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

CHA has facilitated active contributions to consultations and workshops on the AECC hosted by IHPA over the past few years. There is support for the principle behind the development of the classification, i.e. that the classification should have a stronger emphasis on patient factors such as diagnosis rather than simply on triage category. The biggest impediment to implementing pricing based on the AECC in the view of members will be having the data systems to capture the relevant information. While most (though not all) children's hospitals now have Electronic Health Records that can be adapted to the new classification, the majority of

children's emergency care is provided in mixed Emergency Departments. Many hospitals are yet to access EMR systems for emergency care. No doubt the proposed pricing will help to stimulate development of appropriate systems to capture the necessary data.

15. How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

CHA members have noted IHPA's intention to shadow price mental health services using the AMHCC version 1.0. There is considerable interest among providers of child & adolescent mental health services in seeing the resulting analysis, and ensuring that mental health services for children and adolescents is appropriately captured & priced before we move from shadow pricing to ABF funding of these services.

16. Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

Some CHA members raised concerns about potential pricing differences between acute and sub-acute services for child & adolescent mental health between higher cost tertiary/quaternary specialist paediatric hospitals and community based CAMH services. Among community services too there are significant ranges of service provision costings, from short term primary consultations through to longer stay residential sub-acute services for chronic mental health issues.

WHA member hospitals are also interested in the development of the AMHCC and shadow pricing. Demand for perinatal mental health care has continued to grow in recent years, with concerns being raised by maternity providers about capacity to fund services with appropriate clinical workforces to care for mothers and their babies, when inpatient mental health care is required before or after childbirth. There continues to be a significant shortfall in services offering inpatient perinatal mental health care that enable babies to co-reside with their mothers to support attachment and breastfeeding while the mother receives mental health care. Pricing of these services must take into account the need to provide care to a baby that is not itself a patient of the mental health service, but whose care is nevertheless important to the recovery of mental health for the mother, as well as to the prevention of mental ill-health through attachment issues) of the infant. Whether this is an issue relevant to the AMHCC or the AR-DRG classification is unclear, but either way there is a need to capture, code and measure the care needed in this important area.

17. Do you support the adjustment IHPA has proposed for NEP21?

Further development and refinement of paediatric adjustments is supported. Consideration is encouraged for a neonate adjustment where the newborn is admitted to a specialist children's hospital (for specialist paediatric surgical or medical care beyond that typically provided in the NICU of a hospital providing birthing care). While overall volumes are low, the clinical complexity of these neonates is by definition different from that of newborns admitted for NICU care in a maternity hospital.

18. What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

CHA recommends IHPA consider unbundling the ICU component of the DRG price for MDC15 Newborns and Other Neonates.

The high cost of treating patients in Intensive Care Units (ICU) is recognised in the NEP20 through the provision of a price adjustment based on the time a patient spends in ICU. This adjustment is applied to all patients utilising ICU except those assigned a Major Diagnostic Category (MDC) of 'Newborns and Other Neonates' (Neonates), where the AR-DRG price is inclusive of a 'Bundled ICU' component.

This differential model for patients requiring treatment in Paediatric Intensive Care Unit (PICU) creates issues in understanding productivity and efficiency as the level of funding is impacted by the proportion of neonates and associated PICU bed utilisation which is subject to variation.

This issue is most evident for long stay, complex patients receiving ventilatory support where age is a prime factor in determining the level of funding received with neonatal patients significantly impacted despite being managed under the same model of care as older (non-neonatal) infants.

Two CHA members, Queensland Children's Hospital (QCH) and Child and Adolescent Health Service (CAHS), have conducted case studies for this issue.

QCH estimates how much funding is received for providing care to a patient with elective admission from NICU at transferring hospital via QCH Operating Theatre to PICU and then discharged home after 226 days in PICU. If the patient is 27 days old on admission, this episode will be coded to P06A (with bundling ICU payment) and the hospital receives $379,670. However, if the same patient is 28 days old on admission, this episode can be coded to A13A (with unbundling ICU adjustment) and QCH can receive additional $848,688 for providing the same care.

CAHS has undertaken a similar analysis. A patient was born pre-term at King Edward Memorial Hospital (KEMH) between 24 and 28 weeks of maturity with a birth weight of 740 grams and was subsequently admitted to special care nursery at KEMH. During the stay at KEMH this patient had several underlying conditions and diagnoses including chronic neonatal lung disease, patent ductus arteriosus, extremely low birth weight and neonatal cardiac dysrhythmia. This patient spent a total of 114 days in hospital with 1,944 bed hours in ICU and 684 hours of Mechanical Ventilation. This episode was coded as P61Z and CAHS received $255,770 in nominal ABF funding for this episode (with bundling of ICU payment). For the same episode, if the ABF ICU payment for MDC15 was unbundled then CAHS would have received an additional $427,680 just for providing the ICU care for this patient which would align with the actual costs of providing the service to the patient.

Their analysis also indicates complex, long stay patients that require significant time in ICU and are typically transferred from other hospitals to specialist paediatric, quaternary facilities are significantly underfunded while less complex patients that do not require treatment in ICU are overfunded.

It is recommended IHPA consider unbundling the ICU component of the DRG price for Newborns and Other Neonates to provide consistency for all patients treated in a PICU and create a more transparent and equitable model.

19. Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?

Price harmonisation is a good initiative by IHPA to reduce and eliminate financial incentives for hospitals to admit patients that could otherwise be treated on a non-admitted basis. It reflects the Pricing Guidelines including Efficiency, Transparency and patient-based care.

However, the complexity of patients paediatric services are looking after should be considered for implementing the harmonisation of prices.

<u>Re Oncology Care</u>

There are significant differences between the oncology care delivery between paediatric and adult services.

1. In paediatrics, procedures like lumbar puncture and intrathecal chemotherapy administration are performed under general anaesthesia (GA) compared to under local anaesthesia or sedation in the adults. This is a very common procedure, for example, at Perth Children's Hospital (PCH) there is an Oncology GA list 3 times a week with around 3-6 patients requiring this procedure on each list. Patients spend 4-6 hours in the unit which requires significant nursing and medical care.
2. Nearly all paediatric patients have a central venous line to facilitate chemotherapy administration. Sometimes accessing these devices is tricky due to patient anxiety. PCH routinely use occupational therapy support and sedation in such cases which also prolongs the duration of hospital visit with significantly higher burden of care.

This clinical model of care at PCH aligns with other paediatric hospitals nationally and is reflected in the activity that is undertaken by those hospitals under the DRG code R63Z. For example, in FY 2019-20 PCH had 1,495 separations under DRG R63Z whilst Royal Children Hospital Melbourne & Queensland Children Hospital had 3,064 & 2,471 separations respectively.

Changing the AR-DRG code R63Z to Tier 2 clinic code 10.11 will not correlate with the intensity of care given to children with cancer and would not reflect the Overarching Pricing Guideline of Fairness. The average cost of admission for intrathecal chemotherapy is $2,003 at PCH. The price weight for the Tier 2 code- 10.11 for FY 2020-21 is 0.1558 (including paediatric loading). Based on the number of chemotherapy admissions in FY 2019-20 (1,495) that equates to a potential loss of approx. $1.5M for PCH, and similar amounts for other large paediatric hospitals across Australia.

CHA is concerned a harmonised price for chemotherapy may not necessarily reflect the true costs of services provided in specialist paediatric hospitals. The current (2020-21) price variation between the current published admitted and non-admitted prices for paediatric hospitals appears unrealistic and requires further investigation.

Re Dialysis

Similar to Chemotherapy, the NWAU and adjustments across admitted and non-admitted (for publicly funded services) are heavily weighted towards admitted care. For L61Z, there is an additional 200% paediatric adjustment that is not in place for non-admitted. When the harmonisation of prices are being implemented, this paediatric adjustment should be considered and priced properly. CHA recommends the harmonised price for Haemodialysis delivered at specialist paediatric hospitals is also further reviewed given the large price variance in the current (2020-21) price weight tables and that all hospitals in the paediatric peer group admit dialysis patients*.

20. Are there other clinical areas where introducing price harmonisation should be considered?

Our members did not nominate any other areas.

21. Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

No objections were shared with us.

22. Are there refinements to the 'fixed-plus-variable' model that IHPA should consider?

Our members did not nominate any refinements for consideration.

23. What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

WHA members remain interested in returning to the development and implementation of bundled pricing for public maternity care.

24. What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?

NA

25. Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?

WHA suggests refining ADRG O66 Antenatal Admissions based on diagnosis. There is only one ADRG (O66) for all antenatal admissions. WHA has recently identified the WHA members have different criteria in admitting women for antenatal care. For example, QLD services have significantly more volume, shorter length of stay, and lower average complexity and costs for ADRG O66. Their lower cost would have significant impact on the national efficient price and NWAU determination. WHA suggest to further develop DRG codes based on the principal diagnosis of women admitted for antenatal care.

26. What other strategic areas should IHPA consider in developing a framework for future funding models?

Models for more accurate funding and quality assessment of family-based services such as child protection, social work, and trauma care should be considered. Anecdotally members are reporting significant increased prevalence of psycho-social risk factors among patients, requiring increasing amounts of planning and coordination work that is not currently funded by ABF. This could undermine these services affecting overall maternal and paediatric care and outcomes.

Proposing a funding model with the flexibility and ability to manage inflow from the districts where paediatrics services are yet to be established. Allowing for more transparent and consistent service sharing and chargebacks, including incentivising virtual care (telehealth) services to support non-specialist regional & rural services to keep women and children close to home at lower cost to both health services and the families.

27. Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

IHPA has previously identified the critical success factors in our experience – a capacity to clearly identify patient groupings who would benefit from innovative models, strong engagement with clinical experts and service managers and funders, increasing commitment to measuring and valuing outcomes not just activity, both in terms of clinically defined health outcomes and patient reported outcomes.

28. Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

IHPA's development of a risk adjustment model for avoidable hospital readmissions is an overall positive initiative which will improve patient health outcomes and decrease avoidable demand on already stretched resources in the public hospital system.

Whilst there is support around a funding adjustment for avoidable readmissions to be applied, there are mixed views among the tertiary paediatric services about the use of funding option 1.

It is not clear how the risk adjustments would be fairly applied under funding option one. The Commission's definition of Avoidable Readmission include that the readmission must be 'clinically related' to the index admission. The 2021-22 pricing framework doesn't state how that will be tested or assured. The 2021-22 pricing framework also lists several risk adjustments are proposed to be applied in the funding model but does not outline how. If funding option one – the preferred IHPA option due to ease of application – is to be applied then risk adjustment is critical, as every case of readmission (as defined) is treated as avoidable and penalised. If the risk adjustment cannot be applied fairly to account for complex and high-risk paediatric patients, then option three should be applied.

Funding option three is preferred by some of our members given that it considers expected rates of readmission compared to actual rates of readmissions provided it compares tertiary paediatric services with their peers and the expected rates of readmissions is risk adjusted for paediatric factors and weighted by case-mix. Funding option three therefore would provide a much more transparent and consistent funding adjustment model for re-admissions instead of option one. Overall, funding option one also has the highest funding adjustment (0.64%) based on IHPA's calculations and this could have a significant material negative impact on Activity Based Funding and result in significant funding shortfalls within certain specialities at tertiary paediatric services.

Others see option 1 as being workable and appropriate, noting the similarity to the HAC adjustment methodology

29. Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

Current list of avoidable hospital readmissions and readmission intervals that is being proposed to be used in the model needs to consider factors specific to paediatric patients.

Whilst age group is considered as a risk factor in the readmission categories (Table 4) it is not clear how this will impact the risk adjustment model and whether this will have a negative impact for paediatric facilities which look after complex paediatric patients and accept referrals from across their respective jurisdictions.

Paediatric patients generally have a lower readmission threshold than adults. Parents are encouraged to bring their child back to the hospital if concerned in a more precautionary approach. Some examples of the variations between adult and paediatric clinical models of care that need to be considered are provided below.

1. Surgical Site infections – 30 days - Post appendectomy wound infection rates

   Wound infection rates are higher in patients with perforated appendicitis. Paediatric patients have a higher rate of perforated appendicitis than young adults[1]. This is primarily due to reasons beyond the health service's control. Penalising paediatric hospitals for this condition which is beyond their control is not in line with the primary outcomes of this re-admission model.

2. Pain Following Surgery – 14 days

   Pain in the paediatric age group has complex underlying aetiologies. Part of the contributing factors to pain is separation anxiety and fear of a new environment. This has led to clinically driven decreased length of stay. Sometimes the analgesic regimes fail and patients require re-admission. Parental anxiety in managing pain is a known factor in readmission[2], parents are encouraged to re-present with pain management concerns with children under 5 years old and hence a family's inability to cope in this situation shouldn't be a factor that drives the funding mechanisms.

3. Readmission Following Neonatal admission
   The most common reason for Neonates to be readmitted to hospital after discharge is for repair of inguinal hernia. If these are identified within a patient's initial inpatient stay, then surgery is undertaken to complete the repair before discharge. Presentation with hernias after discharge is not related to clinical care but is a normal pathological condition.

4. Neonatal patients having thoracotomy
   These neonates need to be handled multiple times per day and by necessity are prone to more wound infections or wound dehiscence.

5. Other surgical complications – 28 days – Tonsillectomy readmission
   Paediatric patients and their parents post tonsillectomy are encouraged as part of discharge planning to re-present to the hospital if they encounter any pain, failure to eat or drink or if the patient has any level of bleeding that causes parental concern. Readmission is less often related to post-surgical bleeding requiring surgical arrest of bleeding but is more likely to be related to families presenting with complex social issues and comorbidities needing readmission due to inability of families to manage the pain relief regimes for their child. Other major reasons that have been highlighted by several studies has been dehydration & general pain[3]. As such, there is an inherent risk that by not funding re-admissions for tonsillectomy, hospitals will be incentivised not to admit children who could go on to have a catastrophic tonsillar bleed and result in preventable mortality.

6. Pressure Injury
   "Age group" does not have pressure injury marked as a readmission category. Neonates and babies are at higher risk for developing complications from mobility related & device related pressures injuries. In SCHN's QIDs data, they have had 161 Pressure injuries reported since 1 Jan 2020, 32% were under 2 years of age, and 71% of those were under 1 (23% of total).

CHA supports a risk adjustment model that takes into consideration the complex and high-risk patients treated in specialist paediatric hospitals. Other risk factors for consideration include:

- Discharge mode (e.g. discharge against medical advice) should not be included in the avoidable readmissions or admissions where the Z code for non-compliance with medical regime has been coded (as the readmission could be due to patient factors).

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6209076/

[2] https://journals.sagepub.com/doi/full/10.1177/1024907918807384

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6560194/

- High risk patients (Charlson Comorbidity flags) - Syndromic patients
- Age (premature/extreme premature or under 1 year of age) and weight (premature/extreme premature or under 1 year of age) should be included for high risk.
- Chronic Conditions flag - Malignancy, Cystic Fibrosis, Inflammatory bowel disease (IBD), immunocompromised patients and Haemophilia patients.

30. What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

As previously proposed by CHA, we recommend use of the Rhee score instead of Charlson score within the risk adjustment model which considers risks related to paediatric hospitals and settings and outperforms the current model with regards to predicting the likelihood of HACs in paediatric patients.

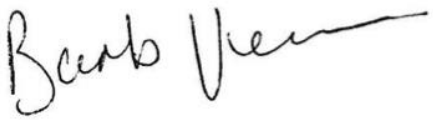
Congenital paediatric conditions while appearing similar in DRGs to adult conditions often have a significant difference in treatment, outcomes and complications that are not related to quality of care.

Parents and society have differing expectations on the level of care, outcomes and type of care provided to children compared to the ageing adult population.

Enhancements to the classification system to determine if the readmission condition is related to the index admission.

Thank you for the opportunity to comment on the design of the 2021-22 pricing framework. We appreciate IHPA's ongoing commitment to consuilting with the women's and children's healthcare sectors and are happy to help facilitate any further discussions IHPA may wish to have with experts in these sectors on any aspect outliend above.

Yours sincerely,



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