Children's Health Queensland Hospital and Health Service

Response to IHPA Consultation Paper on the Pricing Framework for Australian Public Health Services 2021-22

Dated: 8 October 2020

Consultation Question	Feedback
What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?	Children's Health Queensland (CHQ) first identified the impact of COVID-19 on activity in late March 2020 with reduced demand for Emergency Department services and subsequent non-elective admissions. A 35% reduction in ED presentations and 27% reduction in non-elective admissions was recorded in the April to June period compared to the same period in 2018/19. Reduced Paediatric ED demand has continued in the first quarter of 2020/21 with activity 17.4% below the same quarter 2019/20 with Non-Elective admissions 15.1% below Q1 2019/20 activity. Increased mental health presentations continued in the first quarter of 2020/21 with admissions 11.8% above the same quarter 2019/20, most notably for patients with eating disorders/ compromised nutrition. CHQ reduced elective surgery in response to the AHPPC 24 March 2020 recommendation for temporary suspension of all non-urgent elective procedures. The incremental recommencement of elective Surgery in late April resulted in a net reduction of 1,300 cases (-19%) compared the same period 2018/19. Elective Surgery has now largely recovered to pre COVID-19 activity levels. CHQ introduced service model changes for Specialist Outpatients from late March 2020 to replace face to face appointments with Telehealth/Telephone appointments which allowed cancellations to be minimised and resulted in a 3% reduction in activity between April and June compared to the same period 2018/19. Specialist outpatient activity has now recovered to pre COVID-19 levels with a return to face to face contacts, however patient demand for services delivered by Telehealth/ Telephone will result in sustained model of care changes for some services.
How will these changes affect the costs of these services in the short and long term?	The short-term impact of reduced patient volume and increased costs resulting from COVID-19 should largely be identifiable on completion of the 2019/20 Clinical Costing process, however accurate costing of the impact of service model changes introduced in response to COVID-19 is unlikely given the short time frame and confounding factors. The introduction of COVID-19 hand hygiene and social distancing safe practices and resulting reduction in respiratory related infections presenting to ED has significantly impacted paediatric demand for emergency services which is likely to result in sustained higher ED costs above the NEP determination. (Noting Emergency Department has a large fixed cost base).
What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?	CHQ continue to recommend consideration of unbundling the ICU component of the DRG price for Newborns and Other Neonates and note IHPA's response to review ICU pricing for Newborns and Other Neonates ahead of the National Efficient Price Determination 2021-22.

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Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?	Yes, the guidelines provide a consistent reference point.
Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?	Yes.
What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?	Education should be standardised nationally – if face-to-face education is not possible, a series of 'Zoom' style meetings, for people to dial into nationally (or by state) would be ideal. All facilitators/trainers should use the same education material and format, to ensure consistency of education. Include Paediatric component or specialty options such as Paediatric Mental Health, Cardiac Surgery For new editions of ICD-10-AM/ACHI/ ACS- the existing education on ICD-10 and ACHI is well presented. Just include few exclusion (type 1 and 2) and inclusion notes examples. ACS should be simplifying so the interpretation should be consistent, the existing ACS could be perceived differently by different people.
How should AR-DRG education be delivered and what should it include?	Education on DCLs and how the DRGs split and updates provided on any changes in the new DRG version. Education on the importance of specificity as this can alter episode complexity. Include how the ECCS is computed, weight for neonates and ventilation hours – how they can impact the DRG
What improvements to the content and format of the electronic code lists could be made to enhance their utility?	No cost to HHS, access when needed.
Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?	Yes.
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?	Gap analysis identification by mapping ICD-10 to ICD-11 and AR-DRG review. Involvement of Paediatric hospitals in testing and consideration of paediatric age groups so they can find the gap relevant to neonates/paediatric age group.
Are there any other factors that should be considered for the addition of pain management and exercise	Review Paediatric adjustment.

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physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?	
How would activity that falls under these proposed new classes previously have been classified?	Pain Management services currently provided by clinical nurse specialist/ allied health are recorded under 40.14 Neuropsychology.
What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?	None identified by CHQ.
Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?	None identified by CHQ.
How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?	Provide differential pricing for pediatric age groups to better reflect complexity of assessment, treatment and support i.e. 0-5 years, 6-12 years, and 13 – 17 years. It is currently 0 – 17 years.
Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?	Yes, potentially as there will be pricing differences between Acute and Sub-Acute services and higher cost services that are provided through the Tertiary/Quaternary Specialist Paediatric Hospital.
Do you support the adjustment IHPA has proposed for NEP21?	Yes.
What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?	The unbundling of the ICU component of the DRG price for Newborns and Other Neonates as previously recommended.
Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21e	CHQ support the proposed harmonisation of prices for dialysis and chemotherapy to reduce and eliminate financial incentives for hospitals to admit patients that could otherwise be treated on a non-admitted basis but have concerns regarding the significant differences in the care delivery between paediatric and adult services, particularly for chemotherapy. In the specialist paediatric hospitals, the majority* of patients receiving chemotherapy are admitted and recorded clinical coding data provides details of the procedures and complexity of each admitted care episode. Procedures for Chemotherapy patients include Intravenous administration of pharmacological agent, lumbar puncture, general anaesthesia and allied health interventions including pharmacy, occupational therapy and social work. CHQ 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.

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	<table><tr><th>AR-DRG V10.0</th><th>Description</th><th>Paediatric adjustment</th><th>Inlier Price Weight</th><th>Adjusted Paediatric Inlier Price Weight</th><th>Adjusted Paediatric Inlier Price</th></tr><tr><td>R63Z</td><td>Chemotherapy</td><td>127%</td><td>0.2392</td><td>0.3038</td><td>$ 1,616</td></tr><tr><td>10.11</td><td>Chemotherapy treatment</td><td>200%</td><td>0.0779</td><td>0.1558</td><td>$ 829</td></tr><tr><td></td><td></td><td>Variance to IP PW</td><td></td><td>(0.148)</td><td></td></tr><tr><td></td><td></td><td>% Variance to IP PW</td><td></td><td>(48.7%)</td><td></td></tr></table> CHQ recommend 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*. <table><tr><th>AR-DRG V10.0</th><th>Description</th><th>Paediatric adjustment</th><th>Inlier Price Weight</th><th>Adjusted Paediatric Inlier Price Weight</th><th>Adjusted Paediatric Inlier Price</th></tr><tr><td>L61Z</td><td>Haemodialysis</td><td>200%</td><td>0.1051</td><td>0.2102</td><td>$ 1,118</td></tr><tr><td>10.10</td><td>Renal dialysis – hospital delivered</td><td>100%</td><td>0.0522</td><td>0.0522</td><td>$ 278</td></tr><tr><td></td><td></td><td>Variance to IP PW</td><td></td><td>(0.158)</td><td></td></tr><tr><td></td><td></td><td>% Variance to IP PW</td><td></td><td>(75.2%)</td><td></td></tr></table> *IHPA National Benchmarking Portal 2017/18
Are there other clinical areas where introducing price harmonisation should be considered?	None identified by CHQ
Is there any objection to IHPA phasing out the private patient correction factor for NEP21?	No objection by CHQ,
Are there refinements to the ‘fixed-plus-variable’ model that IHPA should consider?	None identified by CHQ.
What comments do stakeholders have regarding the innovative funding models being considered by IHPA?	None identified by CHQ.
What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?	N/a
Are there other factors that IHPA should consider in its	None identified by CHQ.

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analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?	
What other strategic areas should IHPA consider in developing a framework for future funding models?	None identified by CHQ.
Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?	None identified by CHQ.
Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?	Yes, CHQ support proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level noting the similarity to the HAC adjustment methodology. CHQ also note that the funding adjustment for avoidable hospital readmissions is subject to back-casting at implementation which should take into consideration differences between adult and specialist paediatric care. For example, the ENT Service at QCH has a low threshold for readmission relating to post adenotonsillectomy complications including bleeding. Parents are advised to bring their child back to hospital if they are feeling nauseated or vomiting, have frank bleeding into their mouths, are regularly spitting out blood, or if they have uncontrolled pain, and are not eating and drinking. This low threshold is due to the potential for complications in children, such as bleeding, to rapidly worsen.
Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?	CHQ support 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). • 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.
What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?	None identified by CHQ.