



Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22

September 2020

Independent Hospital Pricing Authority



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Glossary

ABF	Activity Based Funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnoses Related Group
AECC	Australian Emergency Care Classification
AHMAC	Australian Health Ministers Advisory Council
AMHCC	Australian Mental Health Care Classification
ANACC	Australian Non-Admitted Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
CAC	Clinical Advisory Committee
CHC	Council of Australian Governments Health Council
COVID-19	Coronavirus Disease 2019
DRG	Diagnosis Related Group
HAC	Hospital Acquired Complication
HCP	Hospital Casemix Protocol
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11	International Classification of Diseases 11th Revision
IHI	Individual Healthcare Identifier
IHPA	Independent Hospital Pricing Authority
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MBUs	Mother and Baby Units
MHPoC	Mental Health Phase of Care
NBP	National Benchmarking Portal
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NWAU	National Weighted Activity Unit
The Addendum	Addendum to the National Health Reform Agreement
The Commission	Australian Commission on Safety and Quality in Health Care



1

Introduction

1

Introduction

The Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22 (the Consultation Paper) is the primary mechanism for providing input to the Pricing Framework for Australian Public Hospital Services 2021–22, the key policy document that underpins the approach that the Independent Hospital Pricing Authority (IHPA) takes to determine public hospital pricing. It provides an opportunity to comment on the development and refinement of the national activity based funding (ABF) system, including data collection, classification systems and policy decisions, which will underpin the national efficient price (NEP) and national efficient cost (NEC) Determinations for 2021–22.

In May 2020, the Commonwealth and all state and territory governments signed an Addendum that amends the National Health Reform Agreement (NHRA) for the period from 1 July 2020 to 30 June 2025 (the Addendum). The Addendum re-affirms IHPA's primary function as an independent, national agency responsible for calculating and determining the NEP for public hospital services in Australia. It also maintains the 6.5 per cent national funding cap. This Consultation Paper will outline the impact of the Addendum on IHPA functions including determining pricing arrangements for private patients in public hospitals, avoidable hospital readmissions and innovative funding models.

The Addendum includes updated arrangements for the funding of private patients in the public hospital system. It specifies that IHPA will adjust the price for privately insured patients in public hospitals to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction, taking into account all hospital revenues. IHPA is developing an approach to implementing clauses in the Addendum relating to private patients as they apply to the national pricing model. This Consultation Paper seeks feedback on this approach.

IHPA is also required to develop a pricing model for avoidable hospital readmissions for implementation from 1 July 2021, following approval from the Council of Australian Governments Health Council. This Consultation Paper outlines IHPA's proposed approach and implementation considerations.

Alternate and value-based funding models continue to be the subject of discussions within the Australian health policy environment and internationally. IHPA is currently evaluating options for pricing and funding approaches that use methodologies differing from ABF, including bundled payments and capitation models. This Consultation Paper provides further detail on these models.

IHPA recognises public hospital services have undergone significant change as a result of responding to the COVID-19 pandemic. Hospital services and models of care have been adapted and it is likely many of these changes will be embedded into care delivery going forward. This presents challenges for IHPA in pricing public hospital services in 2021–22. Stakeholders are able to provide feedback on the impacts of COVID-19 on the NEP Determination for 2021–22 and future NEP Determinations.

This Consultation Paper builds on previous work in this area and should be read in conjunction with the following documents:

- [*Pricing Framework for Australian Public Hospital Services 2020–21*](#) (the Pricing Framework 2020–21)
- [*Pricing Framework for Australian Public Hospital Services 2020–21 Consultation Report*](#) (the Consultation Report 2020–21)
- [*National Efficient Price Determination 2020–21*](#) (NEP20)
- [*National Efficient Cost Determination 2020–21*](#) (NEC20)

Have your say

Submissions close at 5pm AEDT on Friday, 9 October 2020.

Submissions should be emailed to IHPA Secretariat at submissions.ihpa@ihpa.gov.au.

All submissions will be published on [IHPA's website](#) unless respondents specifically identify sections that they believe should be kept confidential due to commercial or other reasons.

The Pricing Framework for Australian Public Hospital Services 2021–22 will be released in March 2021 alongside publication of the National Efficient Price Determination 2021–22 and the National Efficient Cost Determination 2021–22.

A large green graphic consisting of two overlapping shapes. The left shape is a rounded rectangle with a white number '2' inside. The right shape is a larger, more complex shape that tapers to a point on the right side, resembling a stylized arrow or a bracket. Both shapes are filled with a solid green color.

2

Addendum to the National Health Reform Agreement 2020–2025

2

Addendum to the National Health Reform Agreement 2020–2025

In May 2020, the Commonwealth and all state and territory governments signed the [Addendum to the National Health Reform Agreement 2020–2025](#) (the Addendum). The Addendum has a range of policy implications for the Independent Hospital Pricing Authority (IHPA) and the national efficient price (NEP), however the below key points remain from the previous iteration of the National Health Reform Agreement (NHRA):

- The national bodies (including IHPA) and their functions remain independent
- Activity based funding (ABF) remains the basis for Commonwealth funding except where ABF is not appropriate or practical
- The 6.5 per cent national funding cap remains in place
- The pricing approach for safety and quality in relation to both sentinel events and hospital acquired complications has been retained.

Significant changes arising from the Addendum and IHPA's approach to implementing new arrangements are outlined below.

Note: Unless otherwise stated, all references to 'the Addendum' in this Consultation Paper refer to the [Addendum to the National Health Reform Agreement 2020–25](#).

2.1. Working with Australian governments, AHMAC and the CHC

The Addendum has clauses outlining new arrangements for the national funding bodies, and measures to strengthen the links between IHPA, the Australian Health Ministers Advisory Council

(AHMAC) and the Council of Australian Governments Health Council (CHC).¹ These measures include:

- Clause B10, which notes that IHPA will consult with CHC on changes that materially impact the application of the national funding model
- Clauses B37–B40 outline a requirement that IHPA must provide a statement of impact to the Commonwealth, states and territories (via CHC) when material changes are proposed to the national funding model. This includes changes that will have a major impact on any one party or materially redistribute activity between service streams. The statement of impact must be timely in relation to the matter raised and:
 - Include a risk assessment of the proposed changes or adjustments
 - Outline appropriate transition arrangements
 - Be informed by consultation with the parties
 - Have input from the Administrator of the National Health Funding Pool.

IHPA has consulted with all jurisdictions to seek feedback on the interpretation of these new clauses. IHPA intends to implement its updated consultation approach by December 2020, and will utilise this approach to consult on the draft National Efficient Price Determination 2021–22.

¹ The Council of Australian Governments has been disbanded, and the ongoing status of CHC is to be determined at a future time.

2.2. Shadow pricing periods

Clause A42 of the Addendum outlines transitional arrangements when developing new ABF classification systems or costing methodologies. Those transitional arrangements are to last two years or a period agreed with the Commonwealth and a majority of states, and include shadow pricing classification system changes or where pricing is based on a costing study. Where states and territories participate fully in shadow pricing and provide their best available data, there will be no retrospective adjustments to funding (except as a result of service volume reconciliations).

Other changes to the Addendum include a requirement that IHPA develop business rules and a process around retrospective adjustments. That includes ensuring the 45 day consultation period with the Commonwealth, states and territories prior to any decision on retrospective adjustments being made. It also notes the above requirement for provision a statement of impact from IHPA to all impacted parties.

IHPA has consulted with jurisdictions to develop business rules and parameters for determining the significance and impact of classification and costing changes. Areas of consultation included:

- Consideration of what constitutes ‘full participation’ and ‘best available data’
- What constitutes ‘materiality’ and therefore consultation with CHC
- Timeframes for IHPA’s engagement with CHC.

IHPA will develop a new policy to address the shadow pricing and transitional arrangements. IHPA will also undertake a review of its existing policies including the [Back-casting Policy](#), [Materiality Policy](#) and [National Pricing Model Stability Policy](#).

2.3. New high cost, highly specialised therapies

Clauses C11 and C12 of the Addendum contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee.

These arrangements include:

- The Commonwealth will provide a contribution of 50 per cent of the growth in the efficient price or cost (including ancillary services), instead of 45 per cent.
- They will be exempt from the national funding cap for a period of two years from the commencement of service delivery of the new treatment.

IHPA and the National Health Funding Body have a process for funding of chimeric antigen receptor (CAR-T cell) therapy under similar arrangements, which is available on [IHPA’s website](#). This method could be utilised for other new highly specialised therapies.

IHPA will work with jurisdictions to develop an approach for funding new high cost, highly specialised therapies. As part of this process, IHPA will review the [Impact of New Health Technology Framework](#) to outline the process for incorporating new high cost, highly specialised treatments into the classification systems and the pricing model.

2.4. Other issues arising from the Addendum

The Addendum provides direction on issues relating to the funding for private patients in public hospitals. This is discussed in detail in Chapter 6.

The Addendum also stipulates requirements for a pricing model for reducing avoidable hospital readmissions. This is discussed in detail in Chapter 11.

3

Impact of COVID-19

Coronavirus Disease 2019 (COVID-19) has resulted in significant and potentially long lasting changes to models of care and service delivery in Australian public hospitals. It is important that these changes are adequately accounted for in the national pricing model as quickly as possible.

3.1. Implications of COVID-19 on the pricing of public hospital services

IHPA needs to consider the impact of COVID-19 on the overall delivery of all public hospital services in order to ensure the national pricing model reflects current models of care.

IHPA will continue to work with jurisdictions to understand changes occurring in models of care. Challenges include lower patient volumes at many services potentially resulting in cost increases per patient and changes to how patients access services (for example, increased use of telehealth) and service design (for example, using nurse practitioners as triage staff for telehealth).

IHPA already prices care delivered through different models. For example, hospital-in-the-home services are priced under the admitted acute care pricing model. Where non-admitted care is delivered via telehealth, it is priced under the non-admitted care pricing model. The challenge will be identifying whether cost differences exist under models of care adopted or expanded to deliver care during the COVID-19 pandemic and beyond.

Data underpinning a given national efficient price Determination has a three year time lag. For example, for the National Efficient Price Determination 2021–22 IHPA will use costed activity data based on 2018–19 models of care. These costs are indexed forward to 2021–22.

Consultation questions

- What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?
- How will these changes affect the costs of these services in the short and long term?
- What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?



4

The Pricing Guidelines

4

The Pricing Guidelines

4.1. The Pricing Guidelines

The decisions made by the Independent Hospital Pricing Authority (IHPA) in pricing in-scope public hospital services are evidence-based and use the latest costing and activity data supplied to IHPA by states and territories. In making these decisions, IHPA balances a range of policy objectives including improving the efficiency and accessibility of public hospital services.

The Pricing Guidelines signal IHPA's commitment to transparency and accountability as it undertakes its work. They are the overarching framework within which IHPA makes its policy decisions, which are outlined in the annual Pricing Framework for Australian Public Hospital Services.

The Pricing Guidelines comprise the overarching, process and system design guidelines within which IHPA makes its policy decisions.

The Pricing Guidelines are found in **Figure 1**.

IHPA has reviewed the Pricing Guidelines in light of the new Addendum to the National Health Reform Agreement (the Addendum) and found they largely continue to reflect the principles and reforms the Addendum outlines. Examples include:

- **Transparency:** The Addendum calls for IHPA to expand its consultation program to ensure states, territories and the Commonwealth have a clear understanding of the pricing decisions IHPA makes and why.
- **Fostering clinical innovation:** The Addendum calls for IHPA to continue working with all stakeholders to price new and innovative models of care.

IHPA is proposing a change to the public-private neutrality guideline to reflect the requirements of the Addendum. IHPA proposes changing it from:

'Activity based funding (ABF) pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital'

To: *'ABF pricing should ensure that there is funding neutrality for the service provider for treating a person who elects to be treated as a private or a public patient in a public hospital'.*

Consultation questions

- Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?
- Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

Figure 1: The Pricing Guidelines

<hr/> <p>Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising ABF and block grant funding:</p> <ul style="list-style-type: none">– Timely-quality care: Funding should support timely access to quality health services.– Efficiency: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.– Fairness: ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.– Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement: Funding design should recognise the complementary responsibilities of each level of government in funding health services. <hr/>	<hr/> <p>System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none">– Fostering clinical innovation: Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.– Promoting value: Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.– Promoting harmonisation: Pricing should facilitate best practice provision of appropriate site of care.– Minimising undesirable and inadvertent consequences: Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.– ABF pre-eminence: ABF should be used for funding public hospital services wherever practicable.– Single unit of measure and price equivalence: ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
<hr/> <p>Process Guidelines to guide the implementation of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none">– Transparency: All steps in the determination of ABF and block grant funding should be clear and transparent.– Administrative ease: Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.– Stability: The payment relativities for ABF are consistent over time.– Evidence-based: Funding should be based on best available information.	<ul style="list-style-type: none">– Patient-based: Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.– Public-private neutrality: ABF pricing should ensure that there is funding neutrality for the service provider for treating a person who elects to be treated as a private or a public patient in a public hospital.



5

Scope of public hospital services

5

Scope of public hospital services

In August 2011, Australian governments agreed to be jointly responsible for funding efficient growth in public hospital services. The Independent Hospital Pricing Authority (IHPA) was assigned the task of determining whether a service is ruled 'in-scope' as a public hospital service and therefore eligible for Commonwealth funding under the National Health Reform Agreement (NHRA).

Each year, IHPA publishes the General List of In-Scope Public Hospital Services (the General List) as part of the national efficient price (NEP) Determination. The General List defines public hospital services eligible for Commonwealth funding, except where funding is otherwise agreed between the Commonwealth and a state or territory.

This model has been retained by the Addendum to the NHRA 2020–25 (the Addendum). The Addendum notes that IHPA may update the criteria for inclusion on the General List to reflect innovations in clinical pathways (clause A21).

The IHPA [*General List of In-Scope Public Hospital Services Eligibility Policy*](#) (the General List policy) defines public hospital services eligible for Commonwealth funding to be:

- All admitted services, including hospital in the home programs;
- All emergency department services provided by a recognised emergency department service; and
- Other non-admitted services.

The General List policy does not exclude public hospital services provided in settings outside a hospital (for example, whether the service is provided in a hospital, in the community or in a person's home). The Pricing Authority determines whether specific services proposed by a state or territory are 'in-scope' and eligible for Commonwealth funding, based on criteria and empirical evidence provided by that state and territory. These criteria are outlined in the General List policy.

Applications to have a service added to the General List are made as part of the annual process outlined in the General List policy.



6

Classifications used to describe and price public hospital services

6

Classifications used to describe and price public hospital services

Classifications aim to provide the health care sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs to provide better management, measurement and funding of high quality and efficient health care services. Classifications are a critical element of activity based funding (ABF) as they help to group patients with similar conditions and complexity, resulting in groups that are clinically relevant and resource-homogenous.

The Independent Hospital Pricing Authority (IHPA) reviews and updates existing classifications and is also responsible for introducing new classifications. There are currently six patient service categories that have classifications in use or in development in Australia:

- Admitted acute care
- Subacute and non-acute care
- Non-admitted care
- Emergency care
- Mental health care
- Teaching and training.

6.1. Admitted acute care

The Australian Refined Diagnosis Related Group (AR-DRG) classification system is used for admitted acute episodes of care. This system is based on a set of three standards:

- The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) to code diseases and problems
- Australian Classification of Health Interventions (ACHI) to code procedures and interventions

- Australian Coding Standards (ACS), a supplement to ICD-10-AM and ACHI, to assist clinical coders in using the classifications.

IHPA will use AR-DRG Version 10.0 and ICD-10-AM/ACHI/ACS Eleventh Edition to price admitted acute patient services for the National Efficient Price Determination 2021–22 (NEP21).

AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition are currently being developed.

Review of admitted acute care classification systems

In 2019, IHPA commissioned a review of the processes involved in the development of the classifications for acute care. The Final Report on the Consultation and Review of the AR-DRG and ICD-10-AM/ACHI/ACS Classification Systems (the review) was presented to the Pricing Authority and IHPA's advisory groups in early 2020.

The review identified that while the acute care classification development process was functioning well, there are four key opportunities for improvement to provide the most benefit to the health care system and stakeholders that use and implement the classifications. These opportunities are outlined below in **Figure 2**.

The review of acute care classifications found four key opportunities for improvements that will benefit the health care system.

Extending the current development cycle

The review identified that the regularity of the development cycle required significant resources to understand and implement changes to the classifications. While the previous two-year cycle was not problematic in itself, a three-year cycle would relieve some of the burden in implementation costs and provide more time for classification development. **Table 1** shows the implementation dates for the previous and current cycles.

Table 1: New acute care classification implementation dates

Classification	Previous 2 year cycle	Current 3 year cycle
ICD-10-AM/ACHI/ACS Twelfth Edition	1 July 2021	1 July 2022
AR-DRG Version 11.0	1 July 2022	1 July 2023
ICD-10-AM/ACHI/ACS Thirteenth Edition	1 July 2023	1 July 2025
AR-DRG Version 12.0	1 July 2023	1 July 2026

The review also identified a lack of agility in the classifications being able to keep pace with new health technologies due to the rigidity of the deadlines for the development cycle. The electronic code lists are determined for the release of each classification version and there is no ability to add new codes until the next edition is released.

An initial review of potential mechanisms to address this issue identified an option to develop a set of codes inACHI to be used as placeholders for new health technology without having to wait for a subsequent edition ofACHI, or having large impacts on software systems mid-edition. This would ensure that new technologies could be captured with minimal impact to the structure of data collections thus reducing infrastructure and implementation costs.

FromACHI Twelfth Edition, to be released in 2022, these placeholder codes would be embedded within the classification and the electronic code lists in software systems.

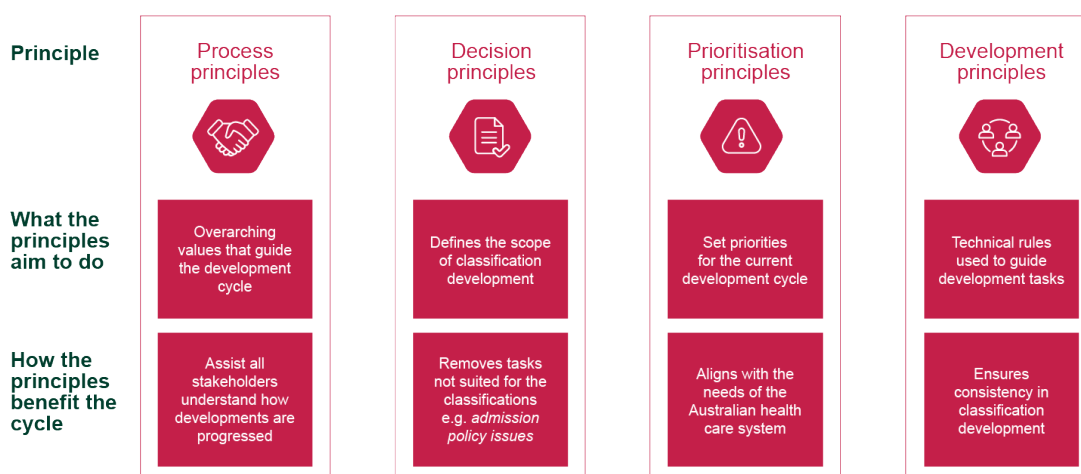
IHPA will develop an approach to determine when a new technology would qualify for a placeholder code and, subsequently, when a placeholder code would be formally integrated intoACHI. IHPA will undertake a review of its [Impact of New Health Technology Framework](#) (the Framework) and update once this approach has been determined.

Embedding principles to focus the development approach

The review highlighted a need to create robust development and priority-setting principles to ensure that the acute care classifications respond to Australian health system needs. IHPA has developed four types of principles and their purpose in the classification development cycle are illustrated in **Figure 2**.

The principles will facilitate rigorous forward planning and approval processes, supported by a set of principles or decision criteria for the initial filtering and triaging of development requests. This will improve the transparency of the acute care classifications work program and improve users' preparedness for adopting changes.

Figure 2: Four types of principles guiding the classification development cycle



Streamlining clinical and technical input into the classifications

The review highlighted a number of administrative burdens related to consultation in the current development cycle. Therefore, IHPA is considering options to streamline consultation processes.

IHPA proposes to redevelop the Australian Classification Exchange (ACE) portal to align with the principles outlined in **Figure 2**. This would include stakeholders being required to provide robust evidence for change requests before a submission is accepted and facilitate a more transparent process for all stakeholders by dynamically displaying the stage and outcome of a submission.

IHPA is also exploring a more streamlined process for obtaining clinical input and is reviewing the acute care classification working groups to explore efficiencies in their governance and operation.

Enhancing education material and other support for implementation

Education on the new edition ICD-10-AM/ACHI/ACS was highlighted as an area for improvement. Face-to-face education was seen as a desirable method however IHPA notes that this method may reach a limited audience. Therefore, IHPA is exploring options for different models of education delivery, including a more comprehensive online education for new editions to ensure quality, standardised education that reaches the entire workforce.

While developing ongoing education for ICD-10-AM/ACHI/ACS is not within IHPA's remit, feedback is sought on what education tools would be useful to stakeholders as new editions of the classification are developed.

IHPA provides other materials that support implementation and use of the acute care classifications, including the electronic code lists for ICD-10-AM and ACHI. IHPA is also seeking feedback on improvements that could be made to the content and format of the electronic code lists to enhance their utility.

Significant resources are invested in providing hard copies of ICD-10-AM/ACHI/ACS and the AR-DRG Definitions Manual. IHPA is exploring the viability of providing an electronic version of

the AR-DRGs Definitions Manual to replace the hard copy manual. Similarly, IHPA is also considering opportunities to provide an electronic version of ICD-10-AM/ACHI/ACS to replace the hard copies.

Consultation questions

- What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?
- How should AR-DRG education be delivered and what should it include?
- What improvements to the content and format of the electronic code lists could be made to enhance their utility?
- Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

Phasing out support for older AR-DRG versions

In the *Pricing Framework for Australian Public Hospital Services 2019–20*, IHPA stated its intention to phase out support for old AR-DRG versions. IHPA remains committed to this approach, and to working with stakeholders to achieve this outcome. IHPA has developed a revised timeline to accommodate the extended three-year development cycle as detailed in **Table 2**.

Table 2: Timeline of AR-DRG phase out

AR-DRG version	Original proposed phase out date	New proposed phase out date	Most current AR-DRG version
Version 5.0, 5.1, 5.2, 6.0, 6.x and 7.0	1 July 2021	1 July 2022	Version 11.0

IHPA notes concerns raised by some stakeholders in the private sector that support for AR-DRG phase out should be based on the availability of private sector costing studies for newer versions, prior to ceasing support for older versions. In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020–21*, some stakeholders

highlighted the cost of implementing any new AR-DRG version. However, IHPA must weigh these concerns against the need to maintain the clinical currency of the classification and to ensure benefits of more recent AR-DRG versions are realised. IHPA will work with private health sector stakeholders to continue to facilitate phasing out of old AR-DRG versions.

Release of ICD-11

The World Health Organization released the eleventh revision of the International Classification of Diseases (ICD-11) in June 2018. ICD-11 was approved by the World Health Assembly in May 2019. The Australian Institute of Health and Welfare has explored the feasibility and potential timeframe for implementation of ICD-11 in Australia, however Commonwealth, state and territory health ministers are yet to make a decision on the implementation of ICD-11.

In the interim IHPA will explore the readiness of ICD-11 for implementation in admitted care by undertaking a gap analysis that includes mapping ICD-10-AM to ICD-11. IHPA will review the impact of moving to ICD-11 on the AR-DRG classification and determine whether remediation is required to use ICD-11 within AR-DRGs. Consideration will also be given to determining whether the new features of ICD-11 may be used to enhance the AR-DRG classification.



Consultation question

- 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?

6.2. Subacute and non-acute care

Subacute care is specialised multidisciplinary care in which the primary need is optimisation of the patient's functioning and quality of life. Subacute care includes rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care types while non-acute care is comprised of maintenance care services.

IHPA will use the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 4.0 classification system to price admitted subacute

and non-acute services for NEP21. Patients are classified on the basis of care type, phase of care, functional impairments, age and other measures.

Subacute and non-acute services which are not classified using AN-SNAP are classified using AR-DRGs.

Developing AN-SNAP Version 5.0

States and territories have made significant progress in their collection of subacute activity and cost data. The *Pricing Framework for Australian Public Hospital Services 2020–21* noted that IHPA is working with its Subacute Care Working Group to continue to progress AN-SNAP Version 5.0. It is anticipated that a draft AN-SNAP Version 5.0 will be released for public consultation in early-2021, separately to this Consultation Paper.

6.3. Non-admitted care

Tier 2 Non-Admitted Services Classification

The [Tier 2 Non-Admitted Services Classification](#) is the existing classification system that categorises a public hospital's non-admitted services into classes, which are generally based on the nature of the service and the type of clinician providing the service.

For NEP21, IHPA intends to continue using the Tier 2 Non-Admitted Services Classification for pricing non-admitted services.

IHPA is committed to undertaking maintenance work to ensure relevancy of Tier 2 for activity based funding purposes while a new Australian Non-Admitted Care Classification (ANACC) is being developed. IHPA has consulted with jurisdictions and stakeholders via its advisory committees on further refinements that could be made to Tier 2. Currently two refinements are being considered. These are the addition of two clinical nurse specialist/allied health led clinics, in pain management and exercise physiology.

Consultation questions

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

Australian Non-Admitted Care Classification

IHPA is developing the ANACC to better describe patient characteristics and the complexity of care in order to more accurately reflect the costs of non-admitted services. The classification will also better account for changes in care delivery as services transition to the non-admitted setting, as new electronic medical records allow for more detailed data capture and as new funding models which span multiple settings are tested.

IHPA commenced a national costing study in 2018 to collect non-admitted (including subacute) activity and cost data and test a shortlist of variables and potential classification hierarchies.

The impact of COVID-19 on hospitals participating in the costing study has resulted in the study being suspended. Data collection was paused in March 2020 with a decision reached in August 2020 to indefinitely suspend the study. IHPA will work with states and territories to understand the impact that the COVID-19 response will have on models of care, particularly where there is a permanent change from existing practice. There will be significant delays to the development and ultimate finalisation of a new non-admitted care classification to replace the Tier 2 Non-Admitted Services Classification.

6.4. Emergency Care

For the National Efficient Price Determination 2020–21 (NEP20), IHPA used Urgency Related Groups Version 1.4 to classify presentations to emergency departments and Urgency Disposition Groups Version 1.3 for presentations to emergency services. IHPA included shadow price weights for emergency department activities using the new Australian Emergency Care Classification (AECC) Version 1.0, with an intent to price using AECC Version 1.0 for NEP21.

IHPA will undertake a review of the shadow year for the AECC Version 1.0, assessing the impacts of the shadow pricing period and the merits of the shadow process.

IHPA is also working with states and territories to determine whether emergency services could collect a subset of diagnosis data using the [Emergency Department Principal Diagnosis Short List](#) to support implementation of the AECC for these services.

The [IHPA Work Program 2020–21](#), published in June 2020 outlined IHPA's intention to continue supporting jurisdictions to improve data collection and reporting. It also noted that the AECC will continue to be refined, including consideration of potential new variables.

IHPA intends to use AECC Version 1.0 to price emergency department activities for NEP21.

Consultation questions

- What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?
- Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

6.5. Mental health care

IHPA commenced shadow pricing admitted mental health services using the Australian Mental Health Care Classification (AMHCC) Version 1.0 for NEP20. The shadow price weights for admitted AMHCC end classes are outlined in the [Australian Mental Health Care Classification Pricing Feasibility Report](#). Pending a review of the 2018–19 activity and cost data, IHPA intends to use AMHCC Version 1.0 to price admitted mental health care for NEP21. The proposed pricing model for admitted mental health care is based on a fixed price for the majority of phases (inliers), with exceptionally short or long phase prices (outliers) adjusted based on the phase length.

In 2017–18, only one jurisdiction provided cost data for community mental health activity for NEP20 and as such, IHPA did not consider the developed price weights adequate for assessment of the impact of pricing these services in the community setting.

On the basis that the volume of data submitted to IHPA for the 2018–19 period appears to be significantly increased and from a range of jurisdictions, IHPA intends to commence shadow pricing community mental health using the AMHCC Version 1.0 for NEP21. The proposed pricing model for community mental health care uses a combination of different pricing models dependent on the type of phase. Assessment only phases are assigned a fixed price for the phase. The acute phases are priced using a per diem due to a shorter length of stay. Functional gain, intensive extended and consolidating gain phases are priced under a bundled monthly model to provide a single fixed price per month due to the longer length of stay.

Mental Health Phase of Care

In the *Pricing Framework for Australian Public Hospital Services 2020–21*, IHPA provided an update on its clinician-rated measure of mental health ‘phase of care’. The [Mental Health Phase of Care \(MHPoC\) Clinical Refinement Project Final Report](#) was published in November 2019. The report outlines the key findings of the project and recommendations to refine MHPoC to improve the consistency and reliability with which clinicians identify the most appropriate phase of care.

IHPA intends to carry out further testing in order to ensure the suitability of the proposed revised MHPoC definitions prior to implementation.

Mother and baby units

In response to the *Consultation Paper on the Pricing Framework for Public Hospital Services 2020–21*, IHPA received feedback from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) highlighting potential cost differences between mother and baby units (MBUs) and other mental health services. IHPA is exploring whether MBUs can be accurately identified to determine whether cost differences exist. Early investigations have highlighted challenges with identifying MBU units in activity data. Of those identified, MBU are generally well priced, however the volume of patients and total cost are likely to fall short of the materiality guidelines for consideration of adjustments for legitimate and unavoidable costs. IHPA will continue to review MBUs using 2018–19 cost data, for consideration in NEP21, in addition to investigating whether this could be addressed by future AMHCC development.



Consultation questions

- How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?
- Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

6.6. Teaching and training

Teaching, training and research activities represent an important role of the public hospital system alongside the provision of care to patients. However, the components required for ABF are not currently available to enable these activities to be priced. As a result, these activities are currently block funded, except where teaching and training is delivered in conjunction with patient care (embedded teaching and training), such as ward rounds. These costs are reported as part of routine care and the costs are reflected in the ABF price.

For NEP21, IHPA will continue to determine block funding amounts for teaching, training and research activity based on states and territories' advice.

IHPA has developed an implementation plan for the Australian Teaching and Training Classification (ATTC), however implementation of the ATTC has not been prioritised by jurisdictions. IHPA will continue to work with jurisdictions on the timeframe for implementation of shadow pricing, and investigating alternative models to block funding until the ATTC can be enabled.

A large orange graphic consisting of two overlapping shapes: a rounded rectangle on the left and a larger, more complex shape on the right that resembles a stylized arrow or a bracket. The number '7' is centered within the rounded rectangle.

7

Setting the national efficient price for activity based funded public hospitals

7

Setting the national efficient price for activity based funded public hospitals

7.1. Technical improvements

The Independent Hospital Pricing Authority (IHPA) has developed a robust pricing model that underpins the national efficient price (NEP) Determination. The model is described in detail in the National Pricing Model Technical Specifications on IHPA's website.

7.2. Adjustments to the national efficient price

Clauses A46 and A47 of the National Health Reform Agreement (NHRA) Addendum (the Addendum) require IHPA to make adjustments to the NEP. Clause A47 of the Addendum requires IHPA to determine adjustments to the NEP while having "regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery".

In developing the National Efficient Price Determination 2021–22 (NEP21), IHPA is assessing the need for an adjustment for patient transport in rural areas, including medical transfers and other inter-service transports in rural areas.

Consultation questions

- Do you support the adjustment IHPA has proposed for NEP21?
- What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

7.3. Harmonising price weights across care settings

The Pricing Guidelines guide policy decisions underpinning the National Pricing Model and were developed following extensive consultation with key stakeholders and the public. The Pricing Guidelines include System Design Guidelines to inform options for the design of activity based funding (ABF) and block funding arrangements, including an objective for price harmonisation whereby pricing should facilitate best practice provision of appropriate site of care.

IHPA already harmonises a limited number of price weights across the admitted acute and non-admitted settings to ensure that similar services are priced consistently across settings. For example, IHPA harmonises price weights for gastrointestinal endoscopes as well as interventional imaging. Harmonisation ensures there is no financial incentive for hospitals to admit patients previously treated on a non-admitted basis due to a higher price for the same service.

Price harmonisation is a method to reduce and eliminate financial incentives for hospitals to admit patients that could otherwise be treated on a non-admitted basis.

IHPA has identified an Australian Refined Diagnosis Related Group (AR-DRG) code for dialysis (L61Z – Haemodialysis) that could potentially be harmonised with a Tier 2 clinic code (10.10 – Dialysis).

IHPA has also identified an AR-DRG code for chemotherapy (R63Z – Chemotherapy) that could be harmonised with a Tier 2 clinic code (10.11 – Chemotherapy).

? Consultation questions

- Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?
- Are there other clinical areas where introducing price harmonisation should be considered?

7.4. Setting the national efficient price for private patients in public hospitals

Public hospitals may receive revenue for delivering patient care from funding sources other than through the NHRA. For example, patients admitted to public hospitals may opt to use their private health cover.

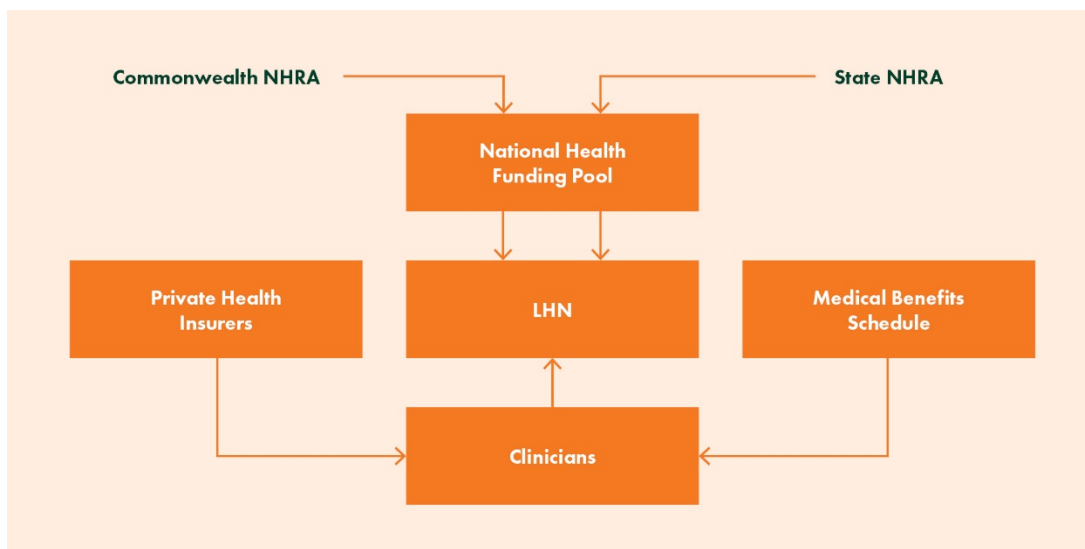
Under the current pricing model, IHPA applies two adjustments for private patients: the Private Patient Service Adjustment and the Private Patient Accommodation Adjustment. IHPA determines a reduced price taking in to account other sources of revenue available to the hospital. These include:

- Commonwealth NHRA funding through the National Health Funding Pool
- Private health insurance payments to hospitals
- Medical Benefits Schedule (MBS) payments to clinicians.

Prior to the Addendum to the NHRA being signed, IHPA has not considered the impact of State NHRA funding through the National Health Funding Pool.

Figure 3 outlines how these funding sources flow through to local hospital networks (LHNs) to fund patient care.

Figure 3: Funding flows to LHNs for private patients



The Private Patient Service Adjustment reduces the price weight by the amounts paid by the Commonwealth and private health insurers on behalf of private patients. This includes MBS payments to medical staff and charges for prostheses. The Private Patient Accommodation Adjustment further reduces the National Weighted Activity Unit (NWAU) for a private patient by accounting for the Default Bed Day benefit paid by the insurer to the hospital. The level is calculated for each state and territory based on a determination made by the Commonwealth Minister for Health under the *Health Insurance Act 1973* (Cwlth). The adjustment is dependent on the length of stay.

Private patients and the new Addendum

The Addendum sets parameters for how funding for private patients in public hospitals should be considered. Clause A13 states the parties agree to the principle that both the Commonwealth, state and territory funding models will be financially neutral with respect to all patients, regardless of whether they elect to be treated as a private or public patient.

Clause A44 specifies that in determining the cost weight for private patients, IHPA will adjust the price to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction. This takes into account all hospital private patient revenues, and notes that any adjustments will be back-cast. Where adjustments are estimated before activity has taken place, the Commonwealth contribution will need to be reconciled based on actual revenue as data becomes available.

In order to do this, IHPA would require an additional data collection to be established to ensure all hospital revenues were captured. States and territories would also be required to submit a complete Hospital Casemix Protocol (HCP) data set to align with the timeframes for annual reconciliation.

IHPA is continuing to refine the new methodology for pricing private patients in public hospitals with assistance from its Technical Advisory Committee and Jurisdictional Advisory Committee.

The final methodology for the new approach will be detailed in the Pricing Framework for Australian Public Hospital Services 2021–22.

Costing private patients in public hospitals and the private patient correction factor

The collection of private patient medical expenses has been problematic in the National Hospital Cost Data Collection (NHCDC). For example, some states and territories use Special Purpose Funds to collect associated revenue (for example, MBS) and reimburse medical practitioners.

The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the NHCDC. The use of the correction factor assumes that all private patient costs are missing and that these costs are spread across both private and public patients, which is not always the case. For example, some hospitals appear to report specialist medical costs for private patients, whilst others may have costs missing from both public and private patients.

The implementation of Australian Hospital Patient Costing Standards Version 4.0 should have addressed the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required. Stakeholders have previously supported phasing out the private patient correction factor when feasible.

Therefore, IHPA intends to phase out the private patient correction factor for NEP21.



Consultation question

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

7.5. A pricing approach for hospital and academic-led clinical trials

IHPA has received advice from stakeholders that academic and hospital-led clinical trials are under considerable strain, due to them being commonly run under cost structures established for commercial clinical-trials. One cited example is that academic-led trials are charged for each additional hospital test, as would normally occur for a commercially-run trial.

Some stakeholders felt strongly that academic-led clinical trials may cease, or become less prevalent in favour of commercially-backed trials with the financial resilience to afford research if the additional costs for academic led trials were not recognised in the national funding model.

IHPA is in the early stages of investigating availability of data to provide evidence on current costs of hospital or academic-led clinical trials.

8

Data collection

8.1. Overview

The Independent Hospital Pricing Authority (IHPA) requires accurate activity, cost and expenditure data from states and territories on a timely basis in order to perform its core determinative functions including the national efficient price (NEP) and national efficient cost (NEC) Determinations. To determine the NEP and NEC, IHPA must first specify the classifications, counting rules, data and coding standards, as well as the methods and standards for allocating costs to hospital activity.

Guided by the concept of ‘single provision, multiple use’, IHPA is committed to the principle of data rationalisation as outlined in the National Health Reform Agreement.

IHPA continues to advocate for the routine collection of the Individual Hospital Identifier (IHI) to provide greater transparency of the patient journey and to support implementation of new funding models. The limitations associated with the current lack of an IHI is addressed in greater detail in Chapter 11.

In the *Pricing Framework for Australian Public Hospital Services 2020–21*, IHPA outlined its intention to make the National Benchmarking Portal (NBP) publicly available. IHPA is continuing to work with jurisdictions and other stakeholders to ensure that a publicly available NBP works to enhance policy decisions and improve patient outcomes, while offering appropriate privacy protections. IHPA will make the NBP public in 2021.

8.2. Phasing out aggregate non-admitted data reporting

States and territories are required to submit public hospital activity data at the patient level wherever possible on a quarterly basis. Only patient level data is used by IHPA to determine the price weights in the NEP Determination.

The Administrator of the National Health Funding Pool (the Administrator) has advised

its intention to phase out aggregate non-admitted activity reporting for funding and reconciliation purposes from 1 July 2021. IHPA supports the Administrator’s proposal.

The move towards patient level data is a crucial step in improving data reliability and embedding the reporting arrangements required for the new patient-centred Australian Non-Admitted Care Classification.

While states and territories have increased the reporting of patient level non-admitted service events since 2012–13, this data has not accounted for all services delivered by states and territories. Previously, aggregate non-admitted data reporting by states and territories has been allowed to ensure that all activity is captured.

IHPA is proposing to establish a national minimum data set for non-admitted patient level data from 2021–22 for activity based funding reporting.



9

Treatment of other Commonwealth programs

9

Treatment of other Commonwealth programs

9.1. Overview

To prevent a public hospital service being funded twice, clause A9 of the Addendum to the National Health Reform Agreement (NHRA) requires the Independent Hospital Pricing Authority (IHPA) to discount Commonwealth funding provided to public hospitals through programs other than the NHRA. The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs including:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme Access Program
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding).

The Australian Hospital Patient Costing Standards Version 4.0 includes a costing guideline related to the consumption of blood products. The objective of Costing Guideline 6 Blood Products is to guide costing practitioners through the steps required to ensure that all blood product consumption and expenses, which contribute to the production of final blood products, are included in the patient costing process.

For 2021–22, IHPA proposes no changes be made to the treatment of other Commonwealth programs.

10

Setting the national efficient cost

Setting the national efficient cost

10.1. Overview

The Independent Hospital Pricing Authority (IHPA) developed the national efficient cost (NEC) for services that are not suitable for activity based funding (ABF), as provided by the Addendum to the National Health Reform Agreement (NHRA). Such services include small rural hospitals, which are funded by a block allocation based on their size, location and the type of services provided.

A low volume threshold is used to determine whether a public hospital is eligible to receive block funding. All hospital activity is included in assessing it against the low volume threshold. This includes admitted acute and subacute, non-admitted and emergency department activity.

IHPA uses public hospital expenditure as reported in the National Public Hospital Establishments Database to determine the NEC for block funded hospitals. IHPA expects that continued improvements to the data collection will lead to greater accuracy in reflecting the services and activities undertaken by block funded hospitals. In addition, work to price classifications for mental health and teaching and training will result in more services being funded through ABF rather than block funded amounts, increasing transparency of costs.

10.2. The ‘fixed-plus-variable’ model

Both ABF and block funding approaches cover services that are within the scope of the NHRA. The key difference is that the ABF model calculates an efficient price per episode of care, while the block funded model calculates an efficient cost for the hospital.

In 2019, IHPA worked with its Small Rural Hospital Working Group to develop a ‘fixed-plus-variable’ model where the total modelled cost of each hospital is based on a fixed component as well as a variable ABF style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.

The new model addresses two key objectives. It removes the potential financial disincentive when shifting services from an ABF hospital to one that is block-funded. It is also more responsive to changes in activity levels in block-funded hospitals.

IHPA introduced the ‘fixed-plus-variable’ model for the National Efficient Cost Determination 2020–21. IHPA will continue to use the ‘fixed-plus-variable’ model for National Efficient Cost Determination 2021–22.

Consultation question

- Are there refinements to the ‘fixed-plus-variable’ model that IHPA should consider?

11

Alternate funding models

11.1. Overview

Activity Based Funding (ABF) has proved to be a very effective funding mechanism since it was introduced to Australian public hospitals in 2012. ABF provides transparency of funding and allows the comparison of variation in cost across public hospitals nationally. This has led to improved technical efficiencies in the delivery of public hospital services.

However, Australian governments and health providers are increasingly recognising the need for integrated health care across the entire health system, with a greater focus on hospital admission-avoidance programs and funding that incentivises improving patient outcomes at an efficient cost.

Systemically, this has been difficult due to the non-integrated nature of the primary and secondary health system in Australia. States and territories are adopting their own approaches to patient-centred care through policies focussing on pathways of care and organisational change. This is particularly evident in New South Wales with its leading better value care initiative. However, the key challenge is adaptation of existing funding models that were not designed with flexibility in mind.

As outlined in the *Pricing Framework for Australian Public Hospital Services 2020–21*, the Independent Hospital Pricing Authority (IHPA) has continued to investigate alternative funding models with a view to explore how the ABF system can incorporate funding options for more innovative patient-centred models of care.

While IHPA does not propose wide scale change to the current funding arrangements through ABF, there is an opportunity to identify specific areas of care that could potentially benefit from funding and payment mechanisms that incentivise providers to focus on outcomes that matter to patients as opposed to volume of services or procedures performed.

11.2. Requirements under the Addendum

The new Addendum to the National Health Reform Agreement (the Addendum) provides the foundation for IHPA to support work in investigating innovative models of care and trialling new funding arrangements.

The Addendum provides that the Commonwealth, states and territory governments will work together to explore trials of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes. Specifically, Australian governments have agreed to:

- Focus on the outcomes that matter to patients
- Improve patient equity
- Improve clinical outcomes
- Deliver best-practice clinical care
- Focus on the entire patient journey.

Under clauses A97–A101, states and territories may enter into a bilateral agreement with the Commonwealth to seek a trial of an innovative funding model. The Addendum requires IHPA to develop a funding methodology for the Council of Australian Governments Health Council (CHC) for approval by April 2021 that does not penalise states undertaking trials of innovative models of care.

Further, should a trial be proposed, IHPA will be required to advise CHC on the application of the above-mentioned funding methodology and any issues it foresees with the proposed trial with regard to the national funding model. This advice would inform CHC consideration on the trial and any CHC decision on the continuation of the model for a further period of trial or translation as a permanent model of care.

11.3. Innovative funding models being explored by IHPA

In March 2019, IHPA conducted a global horizon scan to identify international best practice and alternative approaches to health care funding that could be applied in the Australian context. Following the global horizon scan and feedback received through the *Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2020–21* (the Consultation Paper 2020–21), IHPA has developed a roadmap in consultation with its key advisory committees that sets out different funding models and their applicability to different conditions and care pathways.

ABF remains the most appropriate funding model for one-off acute episodes of care usually in a hospital setting (for example, a tonsillectomy). The other major funding models under consideration are:

– Bundled payments/pricing:

When episodes of care are delivered across multiple settings, or over longer periods, bundled payments may provide increased incentives for providers to address efficiency in innovative ways. The main criteria for identifying where bundled payments may be appropriate is a clear, well-defined care pathway that spans multiple care settings (for example maternity care, stroke or hip replacement).

Bundled payments for hip and knee replacements has consistently received stakeholder support due to the clear pathway of care and good data already available through Clinical Quality Registries. Developing bundles for specific conditions also provides the opportunity to ‘scale up’ once demonstrated to be effective and paves the way for further analysis and discussion.

– Capitation payments:

A per-person funding model pays a provider or fund holder for the care of a patient for a defined period, where the provider is accountable for all services consumed by the patient for that period. Capitation models typically work well for chronic conditions where the care

pathway is not well defined and may extend over many years (for example chronic obstructive pulmonary disease).

IHPA is currently assessing the Victorian HealthLinks program, which uses a capitation model, for inclusion on the *General List of In-Scope Public Hospital Services*. This program aims to provide an alternative funding model to ABF and promotes innovative ways of funding care pathways such as chronic care.

Key concepts to consider in the development of designing a national capitation model include:

- Classification of patients into clinically relevant, resource homogeneous groups;
- Mandatory reporting on programs to ensure patients are not being under-served; and
- Mandatory reporting of outcomes to monitor whether patients are improving as a result of these programs.

IHPA’s approach and initial findings

IHPA has conducted some initial analysis of activity data to identify the patient services that may be suitable under the considered funding models. Selected Adjacent Diagnoses Related Groups (ADRGs) were assigned potential funding models using the following approach:

- A high level literature review was conducted to identify ADRGs where bundling or capitation funding have been applied both within Australia and internationally.
- Findings of the literature review were then supplemented by preliminary advice from classification experts within IHPA to further identify ADRGs where bundling or capitation may be suitable.
- Analysis of 2018–19 data was undertaken to identify reporting patterns within those ADRGs identified through the literature review and classification advice. These reporting patterns were then used to identify other ADRGs where bundling or capitation may be suitable.

IHPA did not identify a potential funding model for all of the investigated ADRGs, however noted some initial findings in regards to the suitability of one of the specified funding models.

As expected, a large number of ADRGs were well suited to ABF. For example, appendectomy was identified as being suited to ABF both by the literature review and advice from classification experts within IHPA, due to the generally urgent, short term, one-off acute care delivered under this ADRG. The predominance of unique patients and minimal activity in other streams were used to identify other ADRGs best suited to ABF.

Initial analysis also identified several ADRGs as being potentially suitable for bundled payments or capitation payments, however further analysis will need to be undertaken to determine which ADRGs are amenable to which funding options. This will include incorporation of additional years' data; refinement of which ADRGs, Australian National Subacute and Non-Acute Patient classes, Tier 2 clinics and/or Urgency Related Groups are relevant to the primary acute episode; analysis of diagnosis and chronic disease codes; and application of the HealthLinks algorithm to the national data set.

11.4. Development of a framework for future funding models

IHPA is developing a framework to guide work to investigate the feasibility of future funding models at a national level. The framework will provide clear guidance to Australian governments as well as the Pricing Authority in determining its approach to trialling different funding models and how IHPA will facilitate this work.

The key objectives of the framework are to:

- Promote consideration of different funding models at the national level
- Determine system design considerations, critical success factors and a pathway to implementation for any proposed funding models under the current ABF framework
- Build on existing work to progress a national capitation model for complex chronic care and identify clinical cohorts and care types that would be amenable to a bundled pricing model
- Guide IHPA's approach in how it works with states, territories and clinicians
- Establish IHPA's remit and responsibilities in setting incentives that encourage better health outcomes and patient experiences as outlined in the Addendum
- Provide reports to CHC as required regarding the outcomes of trials and their applicability to the national funding model.

11.5. Individual Healthcare Identifier

Key barriers to more patient-centred funding models include the way that hospital services are classified and the difficulties in tracking a patient across these different settings (for example, acute care or non-admitted care). In 2016 IHPA undertook a program of work to explore a national bundled pricing model for maternity services (intended to cover antenatal, admission for delivery and postnatal services). However, this model was not able to be implemented due to the absence of a nationally consistent unique patient identifier.

A unique patient identifier such as the Individual Healthcare Identifier (IHI) is one way to enable a patient to be tracked across the different classification system data sets, and more accurately allow for the pathway of care to be classified and costs attributed accordingly. Further, a patient identifier is a key requirement to ensure that the Commonwealth does not contribute for a patient's care multiple times under alternate funding models (for example, through both ABF and the Medicare Benefits Schedule).

IHPA has previously sought comment through the Consultation Paper 2020–21 regarding the provision of the IHI as part of national data sets. Jurisdictions are working through varying issues relating to the provision of the IHI including privacy concerns, information technology system issues and data accuracy concerns.

IHPA will continue to work with jurisdictions individually to address concerns in providing the IHI to find a way forward in the collection of this data.

Consultation questions

- What comments do stakeholders have regarding the innovative funding models being considered by IHPA?
- What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?
- Are there other factors that IHPA should consider in its 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?
- Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

12

Pricing and funding for safety and quality

12

Pricing and funding for safety and quality

12.1. Overview

The Addendum to the National Health Reform Agreement (the Addendum) sees the Commonwealth and state and territory governments recommit to improving Australian health outcomes and decreasing avoidable demand for public hospital services.

The Independent Hospital Pricing Authority (IHPA) and the Australian Commission on Safety and Quality in Health Care (the Commission) have followed a program of collaborative work to consider the incorporation of safety and quality measures into the national efficient price (NEP) Determination.

IHPA was required to advise on an option or options for a comprehensive and risk adjusted model to determine how funding and pricing could be used to improve patient outcomes across three key areas: sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions.

Funding adjustments related to sentinel events were introduced in July 2017, followed by funding adjustments for HACs in July 2018.

As per clause A171 of the Addendum, IHPA is required to develop a pricing model for avoidable hospital readmissions for implementation by 1 July 2021.

12.2. Sentinel events

In 2002, Australian Health Ministers agreed on the Australian Sentinel Events List, a national set of sentinel events. Sentinel events are defined by the Commission as a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

Since 1 July 2017, IHPA has specified that an episode of care including a sentinel event will not be funded. A zero National Weighted Activity Unit (NWAU) is assigned to episodes with a sentinel event. This approach is applied to all hospitals, whether funded on an activity basis or a block funded basis. As sentinel events are not currently reported in national data sets, states and territories submit an additional data file identifying episodes where a sentinel event occurred.

Per the Addendum (clauses A165–A166), IHPA will continue to assign zero NWAU to episodes with a sentinel event for the National Efficient Price Determination 2021–22 (NEP21) using Version 2.0 of the Australian Sentinel Events List published on the Commission's [website](#).

12.3. Hospital acquired complications

HACs are complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

A list of HACs was developed by a Joint Working Party of the Commission and IHPA.

Funding is reduced for any episode of admitted acute care where a HAC occurs. The reduction in funding reflects the incremental cost of the HAC, which is the additional cost of providing hospital care that is attributable to the HAC. This approach recognises that the presence of a HAC increases the complexity of an episode of care or the length of stay, driving an increase in the cost of care.

The HAC funding approach incorporates a risk adjustment model that assigns individual patient episodes with a HAC to a low, medium or high complexity score. This complexity score is used to adjust the funding reduction for an episode containing a HAC on the basis of the risk of that patient acquiring a HAC.

The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant. The Commission also has a range of resources to support local monitoring of HACs and quality improvement strategies. The Commission's [HACs Information Kit](#) outlines activities that health services can implement in order to minimise the occurrence of HACs. There are also groupers and specifications that health services can download to monitor HACs using their administrative data.

IHPA is currently developing a risk adjustment methodology for avoidable hospital readmissions. Following the finalisation of the risk adjustment model for avoidable hospital readmissions, IHPA will consider remodelling the HAC risk adjustment model based on this approach.

As the review of the HAC risk adjustment model is still in early stages, IHPA will provide updates and seek stakeholder feedback in the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23*.

The Commission published Version 3.0 of the HAC list in January 2020. The list is available on the Commission's [website](#). IHPA will use Version 3.0 of the HAC list for NEP21.

12.4. Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission (the index admission). Reducing the number of avoidable hospital readmissions improves patient health outcomes and decreases avoidable demand for public hospital services.

The Commission was tasked with developing and maintaining a list of clinical conditions considered to be avoidable hospital readmissions. In June 2017, the Australian Health Ministers' Advisory Council approved the list of avoidable hospital readmissions and readmission diagnoses.

Table 3 lists the conditions and condition-specific readmission intervals; further detail can be found on the Commission's [website](#).

Table 3: List of avoidable hospital readmissions and readmission intervals

Readmission condition	Readmission diagnosis	Readmission interval
1. Pressure injury	Stage III ulcer	14 days
	Stage IV ulcer	7 days
	Unspecified decubitus and pressure area	14 days
2. Infections	Urinary tract infection	7 days
	Surgical site infection	30 days
	Pneumonia	7 days
	Blood stream infection	2 days
	Central line and peripheral line associated bloodstream infection	2 days
	Multi-resistant organism	2 days
	Infection associated with devices, implants and grafts	90 days
	Infection associated with prosthetic devices, implants and grafts in genital tract or urinary system	30 days
	Infection associated with peritoneal dialysis catheter	2 days
	Gastrointestinal infections	28 days
	3. Surgical complications	Postoperative haemorrhage/haematoma
Surgical wound dehiscence		28 days
Anastomotic leak		28 days
Pain following surgery		14 days
Other surgical complications		28 days
4. Respiratory complications	Respiratory failure including acute respiratory distress syndromes	21 days
	Aspiration pneumonia	14 days
5. Venous thromboembolism	Venous thromboembolism	90 days
6. Renal failure	Renal failure	21 days
7. Gastrointestinal bleeding	Gastrointestinal bleeding	2 days
8. Medication complications	Drug related respiratory complications/depression	2 days
	Hypoglycaemia	4 days
9. Delirium	Delirium	10 days
10. Cardiac complications	Heart failure and pulmonary oedema	30 days
	Ventricular arrhythmias and cardiac arrest	30 days
	Atrial tachycardia	14 days
	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	30 days
Other	11. Constipation	14 days
	12. Nausea and vomiting	7 days

Under the Addendum, IHPA is required to develop a pricing model for avoidable hospital readmissions, for implementation from 1 July 2021, following approval from the Council of Australian Governments Health Council (CHC).

The Addendum requires the use of transitional arrangements when developing new costing methodologies, including shadow pricing and reporting for two years or a period agreed upon by the Commonwealth and a majority of states. The shadow period for avoidable hospital readmissions commenced on 1 July 2019, and will be completed by the required implementation date of 1 July 2021.

IHPA intends to make avoidable hospital readmission rates available in the National Benchmarking Portal to allow hospitals to access and compare cost and activity data relating to readmissions.

IHPA also notes that the funding adjustment for avoidable hospital readmissions is subject to back-casting at implementation, as outlined in the Addendum. In future years, if the number of recorded avoidable hospital readmissions increases compared to the previous year, this will result in a decrease to Commonwealth growth funding, and vice versa.

Funding options

In July 2019, IHPA commenced a shadow period to analyse funding options intended to assist in preventing avoidable hospital readmissions. The shadow period allowed IHPA to assess the activity and funding impacts of the proposed funding options for avoidable hospital readmissions.

The shadow period incorporated the following funding options:

- **Option one:** Deduct the cost of the readmission episode from the index episode.
- **Option two:** Combine the index and readmission episodes and recalculate the funding of the combined episode.
- **Option three:** Adjust funding at the hospital level where actual rates of avoidable readmissions exceed expected rates of avoidable readmissions.

IHPA has developed the following example to assist stakeholders in understanding the three funding options.

Case study:

Joan is a 54 year old woman who underwent an emergency appendicectomy following a diagnosis of appendicitis. Joan is otherwise fit and healthy, with no comorbidities. At the index admission, Joan was assigned to the Diagnosis Related Group (DRG) G07B (Appendicectomy, Minor Complexity) and the hospital received 1.2502 NWAU.

Seven days after Joan was discharged, she presented at the emergency department at the same hospital, as she was experiencing acute pain to her lower right abdomen. As a result, she was readmitted. As this meets the definition of an avoidable readmission, there is a funding impact to the hospital. The price weight for the readmission is 0.8316.

Under option one, a NWAU adjustment is applied to the index episode, based on the total NWAU of the readmission episode. As Joan was considered a low complexity patient, the NWAU for the index episode is reduced by the total NWAU of the readmission episode.

Under option two, the funding adjustment is also applied to the index episode. Firstly, a 'combined episode' is created from the index and readmission episodes for the purpose of calculating the funding adjustment. The 'combined episode' retains the DRG of the index episode but has the total length of stay of the combined index and readmission episodes. The 'combined episode' has an NWAU calculated using the index DRG and the combined length of stay. The NWAU of the index admission is then reduced by the amount equal to the NWAU of the index and readmission episode less the NWAU of the 'combined episode'. As Joan was considered a low complexity patient, the NWAU for the index episode is reduced by the full amount.

Under option three, the hospital's readmission rate for the entire year is calculated and compared to the expected rate of readmissions based on the probabilities output by the risk model. If the actual readmission rate for the hospital is lower than the expected rate (that is, the hospital performed better than expected), then there is no funding adjustment applied to the index episode (it is funded in full). If the actual readmission rate for the hospital is higher than the expected rate, then there is a funding adjustment applied to the index episode based on the ratio between the number of actual and expected readmissions.

The funding options were analysed using activity data from 2015–16, 2016–17, 2017–18 and 2018–19. The funding impact on total Commonwealth funding across all three funding options was shown to be relatively small at 0.15 per cent for funding option three, 0.63 per cent for funding option two and 0.64 per cent for funding option one.

At the completion of the shadow period, IHPA intends to implement the avoidable hospital readmissions funding adjustment under funding option one due to its ease of application, similarity to the HACs methodology, and less disproportionate impact across jurisdictions, particularly smaller states and territories with fewer Local Hospital Networks (LHNs).

Scope options

A patient's readmission episode may not always occur at the same hospital where they had their original (index) admission episode. The patient may be readmitted to a different hospital in the same LHN or they may be readmitted to a different hospital in a different LHN. Throughout the shadow period, IHPA has undertaken analysis of the three funding options under three scope options (readmissions limited to the same hospital, same LHN or same jurisdiction). The analysis of avoidable hospital readmission episodes by location over the four year period indicated that:

- Almost half of all avoidable hospital readmissions (48 per cent) occurred when patients presented to the same hospital within the same LHN.
- 26.0 per cent of readmissions occurred in a different hospital in the same LHN.
- 12.3 per cent of readmissions occurred in a different LHN in the same state or territory.
- 1.5 per cent of readmissions occurred in a different state or territory.

At the completion of the shadow period, IHPA intends to implement the avoidable hospital readmissions funding adjustment to apply where there is a readmission to any hospital within the same jurisdiction.

Exclusion of transfer episodes

In addition to the exclusion criteria and specifications developed by the Commission, available on the Commission's [website](#), IHPA has made the decision to exclude transfer episodes from being classed as a readmission, that is, a transfer from the index admission facility to a secondary facility within the same course of care.

The readmissions criteria provided by the Commission includes transfer episodes, as the specifications were initially developed for a hospital-level approach that did not account for transfers between facilities. Keeping this criteria to identify readmissions at the jurisdiction scope artificially inflates the number of readmissions.

Approach to risk adjustment

The risk adjustment model is constructed on the premise that a patient's likelihood of experiencing a potentially avoidable hospital readmission is the same regardless of the funding option considered. A risk adjustment model has been derived for each readmission condition, which assigns the risk of being readmitted for each episode of care, based on the most statistically significant and best performing risk factors.

IHPA has finalised the risk factors in response to stakeholder feedback, recommendations from the Clinical Advisory Committee (CAC) and advice from the University of Melbourne. A discrete set of risk factors has been developed for the risk adjustment model of each readmission category, using the top performing risk factors based on statistical importance and model contribution. This approach captures the statistically important risk factors, while trimming insignificant risk factors by not adhering to an arbitrary number of included risk factors for each readmission category. **Table 4** below lists the risk factors used in each readmission model.

Table 4: Risk factors for each readmission category

Readmission category	1. Pressure injury	2. Infections	3. Surgical complications	4. Respiratory complications	5. Venous thromboembolism	6. Renal failure	7. Gastrointestinal bleeding	8. Medical complications	9. Delirium	10. Cardiac complications	11. Constipation	12. Nausea and vomiting
Age group		✓	✓	✓	✓	✓		✓	✓	✓	✓	
Major diagnostic category (MDC)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Emergency admission flag		✓	✓	✓	✓			✓	✓	✓	✓	✓
Diagnosis-related group (DRG) type		✓	✓					✓	✓	✓	✓	
Gender					✓		✓				✓	✓
Transfer status				✓								
Patient remoteness	✓	✓		✓	✓	✓	✓				✓	✓
Indigenous status		✓		✓				✓				
Obesity					✓							
Hospital Acquired Complication flag								✓				
ICU hours flag								✓				
Malnutrition				✓								
Short stay outlier flag		✓			✓				✓			
Number of procedures in the index episode		✓	✓		✓						✓	
Number of admissions in the past year		✓									✓	
Charlson comorbidity flags:												
Acute myocardial infarction										✓		
Cerebral vascular accident									✓			
Congestive heart failure										✓		
Dementia				✓					✓			
Diabetes								✓				
Diabetes complications		✓				✓		✓		✓		✓
Peptic ulcer							✓					
Pulmonary disease	✓	✓			✓	✓						
Renal disease						✓						
Chronic condition flags:												
Arthritis and osteoarthritis	✓						✓					
Asthma without COPD						✓						

Readmission category	1. Pressure injury	2. Infections	3. Surgical complications	4. Respiratory complications	5. Venous thromboembolism	6. Renal failure	7. Gastrointestinal bleeding	8. Medical complications	9. Delirium	10. Cardiac complications	11. Constipation	12. Nausea and vomiting
Cerebral palsy				✓							✓	
Chronic heart failure										✓		
Chronic kidney disease	✓						✓					
Chronic respiratory failure				✓								
Emphysema without COPD									✓			
Epilepsy				✓			✓					
Hypertension	✓					✓	✓					✓
Intellectual disorder											✓	
Ischaemic heart disease						✓				✓		
Osteoporosis							✓					
Paralysis conditions	✓								✓			
Severe liver disease									✓			
Systemic lupus erythematosus	✓											
Ulcerative colitis						✓						
Total number of risk factors:	7	11	5	11	9	10	8	9	10	9	10	6

IHPA proposes to implement the avoidable hospital readmissions funding adjustment using the finalised sets of risk factors for the risk adjustment model of each readmission category.

Individual Healthcare Identifier

Throughout the shadow period, IHPA has evaluated the feasibility of implementing the assessed scope and funding options, with the understanding that currently there is not a national patient identifier available in national data sets used by IHPA.

As such, IHPA will use the Medicare PIN in the short term to implement the adjustment for avoidable hospital readmissions, with a view to using the Individual Healthcare Identifier in the long term.

Readmissions across financial years

IHPA recognises the need to accurately capture and adjust for readmission episodes that occur across financial years. In reviewing 2015–16, 2016–17, 2017–18 and 2018–19 data of all avoidable hospital readmissions within or across financial years, the analysis revealed that while the majority of readmissions occurred within the same financial year, approximately 2.8 per cent occurred across financial years.

Therefore, as part of the implementation of a funding adjustment for readmissions, IHPA notes that it may be necessary for the Administrator of the National Health Funding Pool to make minor funding adjustments post-reconciliation to account for any newly identified readmissions with index episodes in the previous financial year.

Implementation of the readmissions funding adjustment

Following feedback to the consultation process and ahead of the 1 July 2021 implementation, IHPA will seek final approval for all aspects of the proposed pricing model from the CHC, as stipulated by the Addendum.

Commercial readmissions software

IHPA has engaged 3M Australia Pty Ltd to develop a readmissions software tool, based on their existing Potentially Preventable Readmissions software. The software tool will be applicable to the nationally admitted patient data set to identify and link avoidable hospital readmissions, and will be used to determine whether a readmission is clinically related to a prior admission based on the patient's diagnosis and procedures in the index admission and the reason for readmission. This will allow investigation of a broader scope of avoidable hospital readmission conditions than the current list.

The project is scheduled for completion at the end of 2021. IHPA will provide updates and seek stakeholder feedback in the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23*.

Consultation questions

- Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?
- Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?
- What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

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