



# **Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23**

June 2021

Independent Hospital Pricing Authority



## **Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23 – June 2021**

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# Table of contents

Glossary.....	1
1 Introduction.....	2
2 Impact of COVID-19 .....	5
3 The Pricing Guidelines .....	7
4 Scope of public hospital services .....	10
5 Classifications used to describe and price public hospital services.....	12
6 Setting the national efficient price .....	18
7 Data collection .....	23
8 Treatment of other Commonwealth programs .....	25
9 Setting the national efficient cost.....	27
10 Future funding models .....	30
11 Pricing and funding for safety and quality .....	34
Appendix A: Consultation questions .....	38

# Glossary

<b>ABF</b>	Activity based funding
<b>ACHI</b>	Australian Classification of Health Interventions
<b>ACS</b>	Australian Coding Standards
<b>AECC</b>	Australian Emergency Care Classification
<b>AMHCC</b>	Australian Mental Health Care Classification
<b>AN-SNAP</b>	Australian National Subacute and Non-Acute Patient Classification
<b>AR-DRG</b>	Australian Refined Diagnosis Related Group
<b>ATTC</b>	Australian Teaching and Training Classification
<b>CHC</b>	Council of Australian Governments Health Council <sup>1</sup>
<b>COVID-19</b>	Coronavirus Disease 2019
<b>HAC</b>	Hospital acquired complication
<b>ICD-10-AM</b>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
<b>ICD-11</b>	International Classification of Diseases Eleventh Revision
<b>IHI</b>	Individual Healthcare Identifier
<b>IHPA</b>	Independent Hospital Pricing Authority
<b>LHN</b>	Local hospital network
<b>MHPoC</b>	Mental Health Phase of Care
<b>NBP</b>	National Benchmarking Portal
<b>NEC</b>	National efficient cost
<b>NEP</b>	National efficient price
<b>NHCDC</b>	National Hospital Cost Data Collection
<b>NHRA</b>	National Health Reform Agreement
<b>NWAU</b>	National weighted activity unit
<b>PPH</b>	Potentially preventable hospitalisation
<b>The Addendum</b>	Addendum to the National Health Reform Agreement 2020–25
<b>The Administrator</b>	Administrator of the National Health Funding Pool
<b>The Commission</b>	Australian Commission on Safety and Quality in Health Care
<b>UDG</b>	Urgency Disposition Group
<b>WHO</b>	World Health Organization

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<sup>1</sup> The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies.



1

# Introduction

# 1

# Introduction

The Pricing Framework for Australian Public Hospital Services (the Pricing Framework) is the Independent Hospital Pricing Authority's (IHPA) key policy document and underpins the approach adopted by IHPA to determine the national efficient price (NEP) and national efficient cost (NEC) for Australian public hospital services. The Consultation Paper on the Pricing Framework for Australian Public Hospital Services (the Consultation Paper) is the primary mechanism for providing input to the Pricing Framework.

The Consultation Paper 2022–23 provides an opportunity for public consultation on the development and refinement of the national activity based funding (ABF) system, including policy decisions, classification systems and data collection, which will underpin the NEP and NEC Determinations for 2022–23.

## 1.1. IHPA's role under the Addendum

In May 2020, the Commonwealth and all state and territory governments signed an Addendum that amends the National Health Reform Agreement for the period from 1 July 2020 to 30 June 2025 (the Addendum).

The Addendum reaffirms IHPA's primary function as an independent national agency responsible for calculating and determining the NEP and NEC for public hospital services in Australia.

The Addendum defines IHPA's role in health funding reform and contains a number of provisions relating to improving efficiency in the health system through a shift in focus from paying for volume of services to paying for value and patient outcomes. IHPA is investigating the feasibility of implementing pricing and funding approaches that use methodologies differing from ABF, including bundled payments and capitation models. The Consultation Paper provides further detail on these models and proposed next steps.

IHPA is also required to provide advice to the Council of Australian Governments Health Council<sup>2</sup> on evaluating existing and new safety and quality reforms, including ways that avoidable and preventable hospitalisations can be reduced. The Consultation Paper includes an update on IHPA's work in this area and the implementation considerations of introducing an approach for reducing avoidable and preventable hospital admissions.

## 1.2. Impact of COVID-19

IHPA received extensive feedback to the Consultation Paper 2021–22 regarding the impact on models of care and service delivery arising from the Coronavirus Disease 2019 (COVID-19) pandemic. IHPA recognises that public hospital services have undergone significant change as a result of the COVID-19 response.

The Consultation Paper seeks feedback on how IHPA proposes to assess the impact of COVID-19 on the cost and activity data used to determine the NEP and the potential resultant changes to the national pricing model.

## 1.3. Changes arising from the Federal Budget

The [Federal Budget 2021–22](#) was delivered on 11 May 2021 and contains two significant measures that impact IHPA's current functions.

The first measure, in response to the [Royal Commission into Aged Care Quality and Safety](#), is the expansion of IHPA to inform Australian government decisions on annual funding increases in residential aged care from 1 July 2023. IHPA will also have a role in home aged care pricing advice from 1 July 2023.

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<sup>2</sup> The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies.

The second measure involves working with the Department of Health and key stakeholders to support reform to the Prostheses List to reduce the cost of medical devices used in the private health sector and streamline access to new medical devices. This is intended to improve the affordability and value of private health insurance for Australians.

This Consultation Paper builds on previous work in IHPA's work program and should be read in conjunction with the following documents:

- [\*Pricing Framework for Australian Public Hospital Services 2021–22\*](#)
- [\*Pricing Framework for Australian Public Hospital Services 2021–22 – Consultation Report\*](#)
- [\*National Efficient Price Determination 2021–22\*](#)
- [\*National Efficient Cost Determination 2021–22\*](#).

## **Have your say**

Submissions close at [5pm AEST on Friday, 9 July 2021](#).

Submissions can be emailed to IHPA Secretariat at [submissions.ihpa@ihpa.gov.au](mailto:submissions.ihpa@ihpa.gov.au).

All submissions will be published on the [IHPA 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 2022–23 will be published in December 2021, ahead of the publication of the National Efficient Price Determination 2022–23 and the National Efficient Cost Determination 2022–23 in March 2022.

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**

## **Impact of COVID-19**

# 2

## 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 the impact of COVID-19 on activity and cost data is adequately and appropriately accounted for in the national pricing model.

### 2.1. Impact of COVID-19 on NEP22

The Independent Hospital Pricing Authority (IHPA) is working with jurisdictions to understand the changes occurring in models of care and the impact on the overall delivery of all public hospital services as a result of the COVID-19 pandemic, to ensure that the national pricing model reflects current models of care.

The challenges identified by IHPA and stakeholders include lower patient volumes at many services, potentially resulting in unit cost increases in the short term, and changes to how patients access services, such as increased use of telehealth and hospital-in-the-home.

IHPA already accounts for some of these changes to how patients access services. For example, non-admitted care delivered via telehealth is priced under the non-admitted care pricing model and hospital-in-the-home services are priced under the admitted acute care pricing model.

All states and territories have reported an initial period of reduced activity, largely stemming from the suspension of elective surgery and reduction in emergency department presentations.

The data underpinning a given national efficient price (NEP) determination has a three year time lag. The NEP Determination 2022–23 (NEP22) will therefore use 2019–20 costed activity data, which includes three months of costed activity data in 2020 impacted by the COVID-19 pandemic response.

IHPA is finalising the collection of activity based funding activity data and the National Hospital Cost Data Collection (NHCDC) Round 24 for the 2019–20 period.

IHPA is analysing the activity and NHCDC data to investigate variations in activity and cost compared to historical trends, including changes in acuity and casemix, changes in length of stay and cost per stay, the impact of reduced ward capacity, changes in funding sources and the activity and costs associated with codes and end-classes which were implemented to record COVID-19 specific activity.

This analysis will allow IHPA and jurisdictions to identify areas where service delivery has been impacted by COVID-19 in the three month period, where activity and cost data may vary significantly to previous years and where there may be longer term impacts.

### 2.2. Impact of COVID-19 on future determinations

IHPA notes that COVID-19 may have significant longer term implications, including:

- The potential for more complex future surgeries as non-critical surgeries were delayed and have now developed into more serious issues
- Additional personal protective equipment and staffing to support COVID-19 social distancing and safety measures.

IHPA will assess the longer term impact of COVID-19 on patient complexity and costs as updated data becomes available.



#### Consultation questions

- What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?
- Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

**3**

# **The Pricing Guidelines**

# 3

## The Pricing Guidelines

### 3.1. 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 and comprise the overarching, process and system design guidelines within which IHPA makes its policy decisions.

In 2020, IHPA reviewed the Pricing Guidelines in light of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) and found that they largely continued to reflect the principles and reforms outlined by the Addendum. The *Activity based funding (ABF) pre-eminence*, *Patient-based* and *Public-private neutrality* guidelines were updated to reflect stakeholder feedback and changes arising from the Addendum.

IHPA has reviewed the Pricing Guidelines again in 2021 and considers that further amendments are not required.

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

**Figure 1: The Pricing Guidelines**

<p><b>Overarching Guidelines</b> 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"><li>- <b>Timely-quality care:</b> Funding should support timely access to quality health services.</li><li>- <b>Efficiency:</b> ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.</li><li>- <b>Fairness:</b> 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.</li><li>- <b>Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:</b> Funding design should recognise the complementary responsibilities of each level of government in funding health services.</li></ul>	<p><b>System Design Guidelines</b> to inform the options for design of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none"><li>- <b>Fostering clinical innovation:</b> 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.</li><li>- <b>Promoting value:</b> Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.</li><li>- <b>Promoting harmonisation:</b> Pricing should facilitate best practice provision of appropriate site of care.</li><li>- <b>Minimising undesirable and inadvertent consequences:</b> Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.</li><li>- <b>ABF pre-eminence:</b> ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.</li><li>- <b>Single unit of measure and price equivalence:</b> 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.</li><li>- <b>Patient-based:</b> Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.</li><li>- <b>Public-private neutrality:</b> ABF pricing should ensure that payments a local hospital network (LHN) receives for a public patient should be equal to payments made for a LHN service for a private patient.</li></ul>
<p><b>Process Guidelines</b> to guide the implementation of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none"><li>- <b>Transparency:</b> All steps in the determination of ABF and block grant funding should be clear and transparent.</li><li>- <b>Administrative ease:</b> Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.</li><li>- <b>Stability:</b> The payment relativities for ABF are consistent over time.</li><li>- <b>Evidence-based:</b> Funding should be based on best available information.</li></ul>	



4

## **Scope of public hospital services**

# 4

## 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).

### 4.1. General List of In-Scope Public Hospital Services

Each year, IHPA publishes the General List of In-Scope Public Hospital Services (the General List) as part of the national efficient price 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).

Clause A17 of the Addendum and the IHPA [General List of In-Scope Public Hospital Services Eligibility Policy](#) (the General List Policy) provide that the scope of public hospital services funded on an activity or grant basis that are eligible for a Commonwealth funding contribution will include:

- all admitted services, including hospital-in-the-home programs;
- all emergency department services provided by a recognised emergency department service; and
- other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service in accordance with clauses A18–A24 of the Addendum.

The General List Policy provides that the listing of in-scope non-admitted services is independent of the service setting in which the service is provided. This means that in-scope services can be provided on an outreach basis (for example, the service can be provided in a hospital, in the community or in a person's home).

Applications to have a service added to the General List are made as part of the annual process outlined in the General List Policy, where 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 or territory. These criteria are outlined in the General List Policy.

Under the Addendum, IHPA is also required to facilitate the exploration and trial of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes.

In 2020–21, IHPA undertook a review of its General List Policy in consultation with jurisdictions to address these requirements under the Addendum. The updated General List Policy will be finalised in July 2021 and include updates to the eligibility criteria around trials of innovative models of care and services for inclusion on the General List.

A large teal graphic consisting of two overlapping shapes: a smaller teal shape on the left and a larger teal shape on the right, both with rounded corners. The number '5' is centered in white within the smaller shape.

5

## **Classifications used to describe and price public hospital services**

# 5

## Classifications used to describe and price public hospital services

Classifications aim to facilitate a nationally consistent method of classifying patients, their treatments and associated costs in order to provide better management and funding of high quality and efficient health care services.

Effective classifications ensure that hospital data is grouped into appropriate classes, which contributes to the determination of a national efficient price (NEP) for public hospital services and allows Australian governments to provide funding to public hospitals based on the activity based funding (ABF) mechanism.

The Independent Hospital Pricing Authority (IHPA) is responsible for reviewing and updating existing classifications, as well as introducing new classifications. There are currently six patient service categories in Australia which have classifications in use or in development:

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

### 5.1. Standard development cycles for all classifications

Under the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), one of IHPA's determinative functions is to develop, specify, refine and maintain the national classifications to ensure that they remain fit-for-purpose, reflect current clinical practice and facilitate continual improvement of the national pricing model.

The admitted acute care classification systems undergo refinements through established three-year development cycles. IHPA is seeking feedback on the feasibility of implementing standard classification development cycles for the other patient service categories. A standard development cycle provides stakeholders with certainty regarding timing of new versions and ensures that classifications maintain clinical currency.

Standard development cycles would require the establishment of a minimum set of measures that would be assessed as part of the review for an updated classification version. Potential measures may include:

- Assessment of classification performance using the latest cost and activity data
- Review and refinement of complexity splits
- Review of variables contributing to complexity
- Review of existing variables and consideration of new variables used for grouping.



#### Consultation questions

- Do you support the proposal to establish standard development cycles for all classification systems?
- Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?
- Do you have any feedback on what measures should be standard as part of the review and development of an updated version of an established classification?

## 5.2. Admitted acute care

The Australian Refined Diagnosis Related Group (AR-DRG) classification is used for admitted acute episodes of care. AR-DRGs are underpinned by a set of classifications and standards used for admitted care:

- 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, collectively known as ICD-10-AM/ACHI/ACS.

The AR-DRG and ICD-10-AM/ACHI/ACS classification systems have been extended from a two to three-year development cycle, to balance currency against the need for stability and reduce the burden of implementation for stakeholders.

These classifications are updated in consultation with IHPA's Technical and Clinical Advisory Committees and subject to public consultation. Following consideration of feedback, the classifications will be finalised and endorsement sought through IHPA's advisory committees prior to seeking approval from the Pricing Authority.

For the NEP Determination 2021–22 (NEP21), IHPA used AR-DRG Version 10.0 and ICD-10-AM/ACHI/ACS Eleventh Edition to price admitted acute patient services.

### 5.2.1. ICD-10-AM/ACHI/ACS Twelfth Edition and AR-DRG Version 11.0

Both ICD-10-AM/ACHI/ACS Twelfth Edition and AR-DRG Version 11.0 are proposed for release from 1 July 2022.

The Twelfth Edition of ICD-10-AM/ACHI/ACS has been informed by updates to the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, upon which ICD-10-AM is based, and updates to the Medicare Benefits Schedule, upon which ACHI is based. Additional refinements are based on stakeholder submissions or have been progressed by IHPA to ensure currency and usability of the classifications.

AR-DRG Version 11.0 has been updated to maintain clinical currency and robustness, and further revised by taking into consideration submissions from stakeholders.

The proposed updates for ICD-10-AM/ACHI/ACS Twelfth Edition and AR-DRG Version 11.0 are outlined in the public consultation paper on the [IHPA website](#).

To price admitted acute patient services for the NEP Determination 2022–23 (NEP22) IHPA proposes to use AR-DRG Version 10.0 and ICD-10-AM/ACHI/ACS Twelfth Edition. It is anticipated that AR-DRG Version 11.0 will be used to price admitted acute patient services for the NEP Determination 2023–24.

### 5.2.2. Enhancing education materials for admitted acute care classification systems

In 2019, IHPA commissioned a review of the processes involved in the development of the classifications for admitted acute care that identified enhancing education materials as a key opportunity for improvement.

IHPA is exploring options to develop an engaging, interactive and responsive online educational program hosted in a centralised online learning environment for new editions and versions of the admitted acute care classifications. This will support the needs of users as it provides consistent delivery of education and allows for flexible, repeatable on-demand access and self-paced learning.

IHPA is also considering supplementing the online education materials with options that support more direct learning, such as webinars or other arrangements that enable jurisdictions and health care organisations to formulate their own learning materials for local application, to complement the national education materials.

IHPA will also explore options to transition hard copies of the AR-DRGs Definitions Manual and ICD-10-AM/ACHI/ACS to electronic versions.

### 5.2.3. Phasing out support for older AR-DRG versions

IHPA remains committed to phasing out support for older versions of the AR-DRG classification and considers that the phase out is required to maintain the clinical currency of the classification and to ensure that the benefits of more recent AR-DRG classification versions are realised.

As cost reports using AR-DRG Version 10.0 are available on the [IHPA website](#), it is recommended that all new agreements between private hospitals and insurers use AR-DRG Version 10.0.

IHPA will continue to work with private health sector stakeholders to discuss the implications of withdrawing support for older AR-DRG classification versions.

### 5.2.4. Release of ICD-11

The Eleventh Revision of the International Classification of Diseases (ICD-11) was released by WHO in June 2018 and 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 this is still under consideration by governments.

IHPA will continue to 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 also plans to review the impact of using ICD-11 on the AR-DRG classification to determine whether remediation is required for use within the AR-DRG classification.

## 5.3. Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services. Subacute and non-acute services not classified using AN-SNAP are classified using AR-DRGs.

For NEP21, IHPA used AN-SNAP Version 4.0 to price admitted subacute and non-acute services.

### 5.3.1. AN-SNAP Version 5.0

A draft AN-SNAP Version 5.0 has been developed through extensive statistical analysis and consultation with jurisdictions, clinicians and other experts and represents a modest refinement of AN-SNAP Version 4.0.

The most significant change is a proposal to recognise frailty as a cost driver for subacute care by incorporating a Frailty Risk Score into the classification of geriatric evaluation and management and non-acute episodes of care. Other proposed refinements include a new impairment type group for joint replacement activity, changes to the complexity thresholds used for splitting episodes and changes to the order that variables are applied.

The draft version of AN-SNAP Version 5.0 was released for a four-week public consultation period in April 2021.

IHPA is currently considering the consultation feedback and, where necessary, will conduct further statistical analysis and expert consultation through its advisory committees to finalise the proposal for AN-SNAP Version 5.0. IHPA will then test the impact of the changes on the national pricing model, with a view to use AN-SNAP Version 5.0 to price admitted subacute and non-acute patients for NEP22.



### Consultation question

- Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?

## 5.4. Emergency care

For NEP21, IHPA used the Australian Emergency Care Classification (AECC) Version 1.0 to price emergency department activities and Urgency Disposition Groups (UDGs) Version 1.3 to price emergency services.

AECC Version 1.0 was introduced for NEP21 following one year of shadow pricing in 2020–21. This was a result of the agreement of the Commonwealth and a majority of states and territories to reduce the shadow pricing period and progress to pricing.

IHPA acknowledges that there is a need for a stabilisation period after the implementation of AECC Version 1.0 and will continue to support jurisdictions to improve data collection and reporting.

IHPA will also continue to explore areas to refine the AECC through considering additional variables collected in the Emergency Care Costing Study to determine whether these are useful measures of complexity for incorporation into future revisions of the AECC. These variables include 'diagnosis modifiers' (conditions or states that contribute to a patient being more complex than expected given their diagnosis) and investigations such as imaging, pathology and diagnostic procedures performed in emergency departments.

IHPA will use AECC Version 1.0 to price emergency department activities for NEP22.

### 5.4.1. Considering the use of AECC for emergency services

IHPA is currently considering the creation of a patient level emergency care services National Best Endeavours Data Set to allow those emergency services capable of reporting patient level data to do so.

IHPA will continue to work with states and territories to determine the feasibility of transitioning emergency services to be priced using the AECC.

IHPA will continue to use UDGs Version 1.3 to price emergency services for NEP22.

## 5.5. Non-admitted care

### 5.5.1. Tier 2 Non-Admitted Services Classification

The Tier 2 Non-Admitted Services Classification is the existing classification system used for pricing non-admitted services. It 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.

IHPA is committed to undertaking maintenance work to ensure relevancy of the Tier 2 Non-Admitted Services Classification for ABF purposes while a new non-admitted care classification is being developed.

For NEP21, IHPA used the Tier 2 Non-Admitted Services Classification Version 7.0 for pricing non-admitted services.

IHPA has consulted with jurisdictions and stakeholders via its advisory committees on additional refinements that could be made to the Tier 2 Non-Admitted Services Classification. No further requests for refinements have been received.

For NEP22, IHPA intends to continue using the Tier 2 Non-Admitted Services Classification Version 7.0 for pricing non-admitted services.

### 5.5.2. A new non-admitted care classification

IHPA is developing a new non-admitted care classification to better describe patient characteristics and care complexity in order to more accurately reflect the costs of non-admitted services.

The new non-admitted care 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.

IHPA commenced a national costing study in 2018 to collect non-admitted activity and cost data and test a shortlist of variables and potential classification hierarchies. The costing study was suspended in 2020 due to the impact of COVID-19, resulting in significant delays to the development timeline of the new non-admitted care classification to replace the Tier 2 Non-Admitted Services Classification.

As the COVID-19 situation and activity and service delivery in the non-admitted setting continues to stabilise, IHPA is seeking feedback on readiness to recommence the non-admitted care costing study.



#### Consultation question

- How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?

## 5.6. Mental health care

### 5.6.1. Admitted mental health care

For NEP21, IHPA used AR-DRG Version 10.0 to price admitted mental health care.

NEP21 included shadow price weights for admitted mental health care using the new Australian Mental Health Care Classification (AMHCC) Version 1.0. NEP21 is the second year of shadow pricing for admitted mental health care using AMHCC Version 1.0.

For NEP22, IHPA intends to price admitted mental health care using AMHCC Version 1.0, following a two-year shadow pricing period as required under the Addendum, subject to assessment of the quality and coverage of admitted mental health data.

Progression to pricing admitted mental health using the AMHCC will impact block funded standalone hospitals providing specialist mental health services. IHPA will consider the feasibility of transitioning these hospitals to ABF. This is discussed in further detail at Chapter 9.

## 5.6.2. Community mental health care

NEP21 also included shadow price weights for community mental health care using AMHCC Version 1.0. NEP21 is the first year of shadow pricing for community mental health care using AMHCC Version 1.0.

IHPA is seeking feedback around readiness to progress to pricing with AMHCC Version 1.0 for community mental health care for NEP22, following one year of shadow pricing in 2021–22.

Community mental health care is currently block funded as part of the national efficient cost (NEC) determination, with jurisdictions advising their community mental health care expenditure each year. IHPA considers that progression to pricing community mental health care with the AMHCC will drive more rapid improvements in the quality of data collected as it will enable a transition of these services to ABF.

## 5.6.3. Mental Health Phase of Care

In November 2019, IHPA published the [\*Mental Health Phase of Care Clinical Refinement Project Final Report\*](#), which outlined the key findings of the project and recommendations to refine the Mental Health Phase of Care (MHPoC) definitions within the AMHCC, in order to improve the consistency with which clinicians apply phase of care.

IHPA has undertaken additional work in the form of the MHPoC Clinical Refinement Testing Project, to test whether refined definitions outperform the existing MHPoC. This project was aimed at identifying the best option for refining MHPoC phase names and definitions in order to improve reliability and clinical meaningfulness.

IHPA is working with jurisdictions and its Mental Health Working Group to finalise minor revisions to MHPoC definitions prior to implementation of the AMHCC.

In terms of future work for the AMHCC, IHPA plans to undertake a review of the classification to identify specific areas for improvement in late 2021. This work will inform the direction of future revisions to the AMHCC.



### Consultation question

- Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?

## 5.7. Teaching and training

Teaching and training activities represent an important aspect 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.

As part of the NEC Determination 2022–23, IHPA will continue to determine block funding amounts for teaching, training and research activity based on advice from states and territories.

IHPA has developed an implementation plan for the Australian Teaching and Training Classification (ATTC) and 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.

6

## Setting the national efficient price

# Setting the national efficient price

The Addendum to the National Health Reform Agreement 2020–25 (the Addendum) specifies that one of the Independent Hospital Pricing Authority's (IHPA) determinative functions is to determine the national efficient price (NEP) for services provided on an activity basis in Australian public hospitals.

## 6.1. National pricing model

IHPA has developed a robust pricing model that underpins the annual determination of the NEP, price weights and adjustments, based on cost and activity data from three years prior. The national pricing model is described in more detail in the [National Pricing Model Technical Specifications](#) on IHPA's website.

### 6.1.1. Consultative requirements for changes to the national pricing model

Under the Addendum, IHPA is required to undertake consultation with all Australian governments for proposed changes to the national funding model. These requirements are outlined below:

- Clause A42 requires IHPA to use transitional arrangements such as shadow pricing when developing new activity based funding (ABF) classification systems or costing methodologies, for two years or a period agreed with the Commonwealth and a majority of states and territories.
- Clause B10 notes that IHPA will consult with the Council of Australian Governments Health Council (CHC)<sup>3</sup> on changes that materially impact the application of the national funding model.

<sup>3</sup> The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to CHC, including matters relating to the national bodies.

- Clauses B37–B40 stipulate that IHPA must seek guidance through its Jurisdictional Advisory Committee and provide a Statement of Impact outlining risks and transition arrangements to the Commonwealth, states and territories when material changes or significant transitions are proposed to the national funding model.

In consultation with jurisdictions, IHPA has developed the [Alterations to the National Pricing Model Framework](#) (the Alterations Framework) to address these consultative requirements.

The Alterations Framework also provides guidelines for the Statement of Impact, which includes risk assessment of the proposed change, transitional arrangements and thresholds for additional CHC consultation. IHPA will use the consultation approach outlined in the Alterations Framework to consult on key pricing decisions for the NEP Determination 2022–23 (NEP22).

IHPA is in the process of developing best practice guidelines in consultation with jurisdictions around the use of shadow pricing for new or changed ABF classification systems.

## 6.2. Adjustments to the national efficient price

Clauses A46 and A47 of the Addendum require IHPA to determine adjustments to the NEP and have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:

- hospital type and size;
- hospital location, including regional and remote status; and
- patient complexity, including Indigenous status.

For the NEP Determination 2021–22 (NEP21), IHPA investigated the need for an adjustment for patient transport in rural areas, however did not implement this adjustment for NEP21, as high travel costs for remote patients were considered to be already adjusted for in the national pricing model with the existing patient residential and treatment remoteness adjustments.

For NEP21, IHPA also removed the emergency care age adjustment with the introduction of the Australian Emergency Care Classification to price emergency department activities.

In developing NEP22, IHPA is investigating the need to review or assess the following existing or new adjustments:

- Reinvestigation of an adjustment for patient transport in rural areas
- Review of the Specified Intensive Care Unit eligibility criteria and adjustment
- Review of the Indigenous adjustment
- Genetic services
- Socioeconomic status.



### Consultation questions

- What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?
- What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment?
- What factors should IHPA consider in reviewing the Indigenous adjustment?
- What evidence is there to support increased costs for genetic services or socioeconomic status?
- What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?

## 6.3. Harmonising price weights across care settings

IHPA's Pricing Guidelines include System Design Guidelines to inform options for the design of ABF and block funding arrangements, including an objective for price harmonisation whereby pricing should facilitate best practice provision of appropriate site of care.

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 harmonises a number of price weights across the admitted acute and non-admitted settings so that similar services are priced consistently across settings (for example, for interventional imaging). Price harmonisation ensures that 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.

For NEP21, IHPA considered but did not progress price harmonisation due to potential unintended consequences, for the following:

- Australian Refined Diagnosis Related Group (AR-DRG) code L61Z – Haemodialysis with Tier 2 Non-Admitted Services Classification (Tier 2) code 10.10 – Dialysis
- AR-DRG code R63Z – Chemotherapy with Tier 2 code 10.11 – Chemotherapy.

IHPA will undertake clinical consultation through its Clinical Advisory Committee and jurisdictional consultation through its Jurisdictional and Technical Advisory Committees to consider further investigation of price harmonisation for dialysis and chemotherapy for NEP22.



### Consultation question

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

## 6.4. Unqualified newborns

IHPA has received feedback from stakeholders detailing concerns around how unqualified newborns are currently accounted for in the national pricing model. A newborn qualification status is assigned to each patient day within a newborn episode of care and a newborn patient day is considered qualified if the infant meets at least one of the following criteria<sup>4</sup>:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care
- is admitted to, or remains in hospital without its mother.

A newborn patient day is considered unqualified if the infant does not meet any of the above criteria. Unqualified newborns are therefore not considered in-scope for admitted patient data collections or ABF. Their costs are assigned to the mother's record and included in the delivery Diagnosis Related Group price.

The qualification status means that hospitals do not receive separate funding for unqualified newborns receiving medical treatment while on a ward with their mothers. This may result in unqualified newborns requiring specialist medical care and nursing attention being separated from their mothers for funding purposes as there is no incentive for providers to keep them together.

For NEP22, IHPA is investigating the current funding model around unqualified newborns and assessing if methodology changes are required.



### Consultation question

- What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns?

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

The Addendum includes parameters around how funding for private patients in public hospitals should be considered, specifically 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.

In addressing clauses A13, A43 and A44 of the Addendum, IHPA developed the following definition of financial neutrality and payment parity in terms of revenue per national weighted activity unit (NWAU) for the given year, excluding private patient adjustments.

The sum of revenue a local hospital network (LHN) receives for public patient NWAU (Commonwealth and state or territory ABF payments) should be equal to payments made for a LHN service for private patient NWAU (Commonwealth and state or territory ABF payments, insurer payments and Medicare Benefit Schedule (MBS) payments).

For NEP21, IHPA implemented an updated private patient methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public. This updated approach involves calculating state-specific Private Patient Service Adjustments prospectively and reconciliation of state funding for public and private patients by the Administrator of the National Health Funding Pool.

IHPA is continuing to work with jurisdictions to refine this approach, in particular addressing any difficulties in data collection and improving the provision of a timely and complete Hospital Casemix Protocol data set.

<sup>4</sup> Newborn qualification status. Available at: <https://meteor.aihw.gov.au/content/index.phtml/itemId/327254>

### 6.5.1. Phasing out 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, the 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 implementation of the 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.

The private patient correction factor was removed for the Northern Territory for NEP21.

For NEP22, IHPA intends to phase out the private patient correction factor in the remaining states and territories.



#### **Consultation question**

- Are there any objections to IHPA phasing out the private patient correction factor for NEP22?



7

## Data collection

## 7.1. Overview

Under the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), the Independent Hospital Pricing Authority (IHPA) is required to develop, refine and maintain systems as necessary to determine the national efficient price (NEP) and national efficient cost (NEC), including classifications, costing methodologies and data collections.

To facilitate the collection of accurate activity, cost and expenditure data for the annual NEP and NEC determinations, IHPA works with states and territories to develop appropriate data specifications and to acquire, validate and maintain data within the IHPA information technology environment.

In developing these data specifications, IHPA is guided by the principle of data rationalisation, including the concept of ‘single provision, multiple use’, as outlined in the Addendum.

IHPA continues to advocate for the routine collection of the Individual Healthcare Identifier (IHI) to provide greater transparency of the patient journey and to support implementation of alternate funding models. The importance of the IHI in implementing future funding models is outlined in Chapter 10.

### 7.1.1. National Benchmarking Portal

In the [\*Pricing Framework for Australian Public Hospital Services 2021–22\*](#) IHPA noted its intention to make the National Benchmarking Portal (NBP) publicly available in 2021.

IHPA is on track to make the NBP publicly available by the end of 2021, pending additional consultation with jurisdictions and broader stakeholders to ensure that a publicly available NBP works to enhance policy decisions and improve patient outcomes, while offering appropriate privacy protections.

IHPA will also consider the level of reporting to be made available and the development of supplementary educational materials to facilitate navigation of a publicly available NBP.



8

## **Treatment of other Commonwealth programs**

# 8

## Treatment of other Commonwealth programs

### 8.1. Overview

To prevent a public hospital service being funded more than once, the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) requires the Independent Hospital Pricing Authority (IHPA) to discount Commonwealth funding provided to public hospitals through programs other than the National Health Reform Agreement.

The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs.

Consistent with clauses A9 and A46(e) of the Addendum, blood expenditure that has been reported in the National Hospital Cost Data Collection by states and territories will be removed in determining the national efficient price (NEP), as Commonwealth funding for this program is provided directly to the National Blood Authority.

The following Commonwealth funded pharmaceutical programs will also be removed prior to determining the underlying cost data for the NEP determination:

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

For 2022–23, IHPA does not propose any changes to the treatment of other Commonwealth programs.



9

## Setting the national efficient cost

# 9

# Setting the national efficient cost

## 9.1. 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) 2020–25 (the Addendum). 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 the hospital 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.

## 9.2. 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.

This 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 activity level changes in block funded hospitals.

IHPA introduced the ‘fixed-plus-variable’ model for the NEC Determination 2020–21. IHPA will continue to use the ‘fixed-plus-variable’ model for the NEC Determination 2022–23.

### 9.2.1. Standalone hospitals providing specialist mental health services

Other block funded hospitals such as standalone hospitals providing specialist mental health services (for example, psychiatric hospitals) are treated separately from the ‘fixed-and-variable’ cost model.

The efficient cost of these hospitals is currently determined in consultation with the relevant state or territory with reference to their total in-scope reported expenditure.

With the proposed implementation of the Australian Mental Health Care Classification for admitted mental health care, IHPA will be able to establish admitted prices for patients treated in these standalone hospitals. IHPA is investigating the feasibility of transitioning these block funded hospitals to ABF and will work with jurisdictions to explore options for an appropriate transition approach.



#### Consultation question

- What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?

### 9.3. New high cost, highly specialised therapies

The annual NEC determination includes block funded costs for the delivery of high cost, highly specialised therapies, as provided by clauses C11–C12 of the Addendum. These clauses contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee.

For 2021–22, the following high cost, highly specialised therapies were recommended for delivery in public hospitals based on advice from the Commonwealth:

- Kymriah<sup>®</sup> – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah<sup>®</sup> or Yescarta<sup>®</sup> – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Qarziba<sup>®</sup> – for the treatment of high risk neuroblastoma
- Luxturna<sup>™</sup> – for the treatment of inherited retinal disease.

The indicative block funded costs for the delivery of these high cost, highly specialised therapies based on the advice of states and territories were included in the NEC Determination 2021–22.

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

**10**

## **Future funding models**

## 10.1. Overview

Activity based funding (ABF) has been an effective funding mechanism since it was introduced to Australian public hospitals in 2012. By setting a national efficient price (NEP) for each ABF funded hospital service, it has contributed to creating a more equitable and transparent system of hospital funding across Australia and enabled a stable and sustainable rate of growth in public hospital costs.

ABF will continue to be the best pricing and funding mechanism for many hospital services, however, the existing ABF system could benefit from the incorporation of alternate funding models that have the potential to create better incentives for improved continuity of care, use of evidence-based care pathways and substitution of the most effective service response. This is consistent with the move towards value based care and a focus on outcomes over volume of services.

The Addendum to the National Health Reform Agreement 2020–25 (the Addendum) provides opportunities for states and territories to trial new funding approaches and outlines the Independent Hospital Pricing Authority's (IHPA) role in supporting these reforms.

Under the Addendum, IHPA is required to develop a methodology to support the trialling of innovative models of care and provide the Council of Australian Governments Health Council (CHC)<sup>5</sup> with advice on continuing proposed trials for a further period or translation into a permanent model of care.

## 10.2. Investigation of alternate funding models

While ABF works well for funding predictable one-off episodes of care, it may not incentivise the provision of health services that are delivered across multiple settings of care or the delivery of more services in the community.

<sup>5</sup> The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to CHC, including matters relating to the national bodies.

For example, a single payment for a bundle of care for a reasonably predictable care pathway may be more suitable than the multiple episodic payments under current ABF arrangements.

For patients with complex and chronic health conditions that lead to frequent use of hospitals (and other services) over an extended time period, capitation payments may work better as the incentive under current ABF arrangements may be to admit patients to a hospital, not to prevent hospitalisation. Preventing hospitalisations often requires alternative treatments and services which can lead to better health outcomes, reduced costs and an improved patient experience.

**Bundled payments:** Bundled payments are made to health providers for a clinically defined episode or bundle of related health care services. Bundled payments may be appropriate for clear, well-defined care pathways spanning multiple care settings or over longer periods (for example, stroke or hip or knee replacement).

**Capitation payments:** Capitation payments are made to health providers or fund holders for the care of a patient over a defined period of time, where the provider is accountable for services consumed by the patient during that period. Capitation models work well for chronic conditions where the care pathway is not well defined and may extend over many years (for example, chronic kidney disease).

Guided by review of national and international literature and advice from clinical experts, IHPA has developed a methodology to categorise patient cohorts that may be amenable to ABF, bundling or capitation payments. Preliminary analysis has shown that around 30 per cent of the patients currently funded under ABF could potentially benefit from alternate funding approaches. This is outlined in **Table 1**.

**Table 1.** Potential distribution of funding under ABF and alternate funding options, following analysis of 2018–19 linked data

Funding type	Patients		Acute admissions		Other events (emergency and non-admitted)		National weighted activity unit (across all streams)	
	n	%	n	%	n	%	n	%
ABF	2,018,109	70.3%	3,212,972	50.4%	11,387,292	51.6%	3,992,426	51.2%
Bundling	529,008	18.4%	1,265,531	19.9%	5,788,939	26.2%	1,644,980	21.1%
Capitation	322,148	11.2%	1,894,176	29.7%	4,880,189	22.1%	2,165,866	27.8%
<b>Total</b>	<b>2,869,265</b>	<b>100%</b>	<b>6,372,679</b>	<b>100%</b>	<b>22,056,420</b>	<b>100%</b>	<b>7,803,272</b>	<b>100%</b>

## 10.3. Next steps for alternate funding models

### 10.3.1. Critical success factors

Reform to pricing and funding models has the potential to alter the incentives in the public hospital system away from acute admitted activity towards community-focused, value based care and a focus on outcomes. However, to achieve this there are a number of critical success factors that need to be addressed.

#### Clinical engagement

The design of new classification and pricing systems will require advice and support from clinical experts, particularly in identifying risk adjustment parameters and ensuring that proposed groupings for bundled payments and capitation models are clinically meaningful.

#### Data linkage and ICT requirements

At present, data linkage is extremely limited between primary, secondary and hospital-based care.

Therefore, the success of introducing any alternate funding model relies on utilisation of the Individual Healthcare Identifier (IHI) in all national data sets. The IHI is a unique number used to identify an individual for health care purposes and would enable a patient to be tracked across the different classification system data sets more accurately. This will allow for the pathway of care to be classified and costs attributed accordingly.

IHPA commenced work on the IHI in 2019 and, pending additional consultation with jurisdictions to address any privacy or information technology concerns, expects to make significant progress on implementing the IHI into national data sets from 1 July 2022.

#### Change management

Successful implementation of alternate funding models will require a significant change in paradigm across the hospital system where hospitals take a broader responsibility (beyond the hospital walls) for the health of the people they serve. IHPA will work closely with all jurisdictions to ensure that changes are well communicated and that adequate time is given for changes in patient pathways to occur.

#### Determining the fund holder

Choosing the appropriate fund holder for any proposed alternate funding model is critical in the funding model's long term success. Potential fund holders for alternate funding models could be the health service provider (for instance, individual health care providers or health service facilities), the local hospital network or the state or territory, with careful consideration required for what works best for each different alternate funding model.

The capacity and capability to take on the risk of bundled and capitation payments will be an important consideration as jurisdictions consider who is best placed to be the fund holder in any new models.

#### Evaluation

Finally, there must be formal evaluation of alternate funding models, which must produce measurable outcomes for patients and continued improvement in efficiency through substitution of the most appropriate service.

Specific funding models require tailored evaluation measures. IHPA will work with jurisdictions, its advisory committees, internal and external working groups, hospital managers, clinicians, patients and broader stakeholders to develop these evaluation measures.

## 10.3.2. Trialling innovative models of care

As provided by the Addendum, IHPA is to facilitate exploration and trial of new and innovative approaches to public hospital funding. Clause A99 of the Addendum stipulates that states and territories can seek to trial innovative models of care, either:

- as an ABF service with shadow pricing, reporting, and appropriate interim block funding arrangements for the trial period; or
- as a block funded service, with reporting against the national model and program outcomes for the innovative funding model.

Consistent with feedback received from states and territories to the [\*Pricing Framework for Australian Public Hospital Services 2021–22\*](#), IHPA notes the preference for states and territories to nominate their own models of care or services for consideration under the innovative funding model clauses of the Addendum, rather than specific models of care or services determined by IHPA.

For the National Efficient Price Determination 2022–23, IHPA is seeking expressions of interest from jurisdictions that wish to nominate alternate funding models such as bundling or capitation to trial.



### Consultation questions

- What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?
- What innovative models of care or services are states and territories intending to trial for NEP22?

11

## **Pricing and funding for safety and quality**

# Pricing and funding for safety and quality

## 11.1. Overview

The Independent Hospital Pricing Authority (IHPA) and the Australian Commission on Safety and Quality in Health Care (the Commission) follow a collaborative work program to incorporate safety and quality measures into determining the national efficient price (NEP), as required under the Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

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

Funding adjustments relating to sentinel events, HACs and avoidable hospital readmissions have been introduced from July 2017, July 2018 and July 2021 respectively.

The Addendum also contains provisions around evaluating the above reforms and provision of advice to the Council of Australian Governments Health Council (CHC)<sup>6</sup> on options for the further development of safety and quality related reforms, including examining ways for reducing avoidable and preventable hospitalisations.

## 11.2. 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 be assigned a national weighted activity unit (NWAU) of zero. This approach is applied to all hospitals, whether funded on an activity or block funded basis.

<sup>6</sup> The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to CHC, including matters relating to the national bodies.

As per the Addendum (clauses A165–A166), IHPA will continue to apply this funding adjustment for episodes with a sentinel event for the NEP Determination 2022–23 (NEP22) using Version 2.0 of the Australian Sentinel Events List published on the [Commission's website](#).

## 11.3. Hospital acquired complications

A HAC is a complication that occurs during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

The funding adjustment for HACs reduces funding for any episode of admitted acute care where a HAC occurs. This approach incorporates a risk adjustment model and 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 Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant. In March 2021, Version 3.1 of the HACs list was released. Version 3.1 of the HACs list includes an update to assist health services in monitoring the HACs in mental health related separations and the following changes:

- HAC 4.5 Other surgical complications requiring unplanned return to theatre: updated additional criteria to avoid double counting of HACs when the 'Unplanned return to theatre' flag is available
- HAC 14.2 Arrhythmias: updated additional criteria to better indicate the additional criteria is only applicable to R00.1 Bradycardia, unspecified.

For NEP22, IHPA will use Version 3.1 of the HACs list on the [Commission's website](#).

## 11.4. 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.

An avoidable hospital readmission occurs when a patient who has been discharged from hospital (the index admission) is admitted again within a certain time interval (the readmission), and the readmission is clinically related to the index admission and has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

The approved list of avoidable hospital readmissions, condition-specific readmission intervals and readmission diagnoses is available on the [Commission's website](#).

From 1 July 2021, IHPA will implement a funding adjustment for avoidable hospital readmissions that involves the application of a NWAU adjustment to the index episode, based on the total NWAU of the readmission episode, to apply where there is a readmission to any hospital within the same jurisdiction.

IHPA has developed a discrete risk adjustment model for each readmission condition, which assigns the risk of being readmitted for each episode of care, based on the most clinically relevant and statistically significant risk factors for that condition.

Further information on the avoidable hospital readmissions funding approach is included in the [NEP Determination 2021–22](#) and the [National Pricing Model Technical Specifications 2021–22](#).

For NEP22, IHPA will continue to implement the avoidable hospital readmissions funding adjustment.

### 11.4.1. Commercial readmissions software

In March 2020, IHPA engaged 3M Australia to develop a readmissions software tool, based on their existing Potentially Preventable Readmissions software. The software tool will be used to identify and link avoidable hospital readmissions and 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 project is ongoing and IHPA will work with the Commission to investigate whether there is potential for the current avoidable hospital readmissions list to be expanded.

## 11.5. Evaluation of safety and quality reforms

Clauses A172 and A174 of the Addendum stipulate that IHPA will provide advice to CHC evaluating the above reforms, to support the consideration of new or additional reforms. IHPA is also required to work with jurisdictions, national bodies and other related stakeholders to establish a framework to evaluate safety and quality reforms against the following principles:

- Reforms are evidence based and prioritise patient outcomes
- Reforms are consistent with whole-of-system efforts to deliver improved patient health outcomes
- Reforms are transparent and comparable
- Reforms provide budget certainty.

IHPA is investigating options for developing an evaluation approach, noting that any evaluation framework will require a comprehensive implementation plan and involve extensive consultation with the Commission, jurisdictions and other national bodies.

IHPA will work with the Commission and jurisdictions to determine the best way to progress work on a safety and quality evaluation framework.



### Consultation question

- What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms?

## 11.6. Avoidable and preventable hospitalisations

Reducing avoidable and preventable hospital admissions can support better health outcomes, improve patient safety and lead to greater efficiency in the health system.

Under the Addendum, IHPA, the Commission and the Administrator of the National Health Funding Pool (the Administrator) is required to provide advice to CHC on options for developing upon the existing safety and quality related reforms, including examining ways that avoidable and preventable hospitalisations can be reduced through changes to the Addendum.

Preliminary review of national and international literature indicates that potentially preventable hospitalisations (PPHs) is a primary focal area for reducing avoidable and preventable hospitalisations through changes in pricing and funding.

PPHs are hospital admissions for a condition where the admission could have potentially been prevented through the provision of appropriate individualised preventative health interventions and early disease management, delivered in primary and community care settings.

Recent data from the Australian Institute of Health and Welfare<sup>7</sup> indicates that there were approximately 745,000 PPHs to public and private hospitals in 2018–19 across three key areas: vaccine-preventable conditions, acute conditions and chronic conditions.

A potential approach for reducing PPHs for chronic conditions is a whole of government approach that focuses on both preventative and reactionary measures through the identification of patient cohorts that present a risk for future PPHs and patient cohorts that are at risk of presenting again with PPH conditions. This can be done through identifying at risk chronic condition groups and development of capitation style funding approaches as discussed in Chapter 10.

IHPA will continue to work with the Commission and the Administrator, as well as jurisdictions individually, to investigate options and determine a way to progress the inclusion of safety and quality reforms for reducing avoidable and preventable hospital admissions.



### Consultation questions

- What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?
- What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?

<sup>7</sup> Available at: <https://www.aihw.gov.au/reports-data/myhospitals/content/data-downloads>

# Appendix A: Consultation questions

Questions	Page number
What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?	6
Are there any recommendations for how IHPA should account for COVID-19 in the coming years?	6
Do you support the proposal to establish standard development cycles for all classification systems?	13
Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?	13
Do you have any feedback on what measures should be standard as part of the review and development of an updated version of an established classification?	13
Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?	15
How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?	16
Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?	17
What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?	20
What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment?	20
What factors should IHPA consider in reviewing the Indigenous adjustment?	20
What evidence is there to support increased costs for genetic services or socioeconomic status?	20
What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?	20
Are there other clinical areas where introducing price harmonisation should be considered?	20
What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns?	21
Are there any objections to IHPA phasing out the private patient correction factor for NEP22?	22
What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?	28

Questions	Page number
What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?	33
What innovative models of care or services are states and territories intending to trial for NEP22?	33
What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms?	36
What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?	37
What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?	37



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