

Independent Hospital Pricing Authority

Three Year Data Plan 2021–22 to 2023–24

June 2021



IHPA

IHPA Three Year Data Plan 2021–22 to 2023–24

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Glossary

ABF	Activity Based Funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
Addendum	Addendum to National Health Reform Agreement
Administrator	Administrator of the National Health Funding Pool
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient classification
AR-DRG	Australian Refined Diagnosis Related Groups classification
COAG	Council of Australian Governments
HAC	Hospital Acquired Complication
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification
IHI	Individual Healthcare Identifier
IHPA	Independent Hospital Pricing Authority
LHN	Local Hospital Network
METeOR	AIHW’s Metadata Online Registry
NBEDS	National best endeavours data set
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHDISC	National Health Data and Information Standards Committee
NHRA	National Health Reform Agreement
NMDS	National minimum data set
NPHEd	National Public Hospital Establishment Database
SDMS	Secure Data Management System
TTR	Teaching, training and research
UDG	Urgency Disposition Groups
URG	Urgency Related Groups

1. Executive summary

The Independent Hospital Pricing Authority (IHPA) is an independent government agency provided for through the National Health Reform Agreement (NHRA) and established under the National Health Reform Act 2011. A major component of these reforms is the implementation of national Activity Based Funding (ABF) for Australian public hospitals.

IHPA's key functions include determining pricing for services funded on an activity basis through the national efficient price (NEP), and determining the efficient cost for services that are block funded through the national efficient cost (NEC).

In determining the NEP and NEC, IHPA must first specify the classifications, counting rules, data and coding standards as well as the methods and standards for costing data. As the provision of timely, accurate and reliable data is vital to IHPA in determining the NEP, IHPA has prepared this ninth edition of the IHPA Three Year Data Plan to communicate these requirements to the jurisdictions in accordance with clauses B66 to B83 of the Addendum to the NHRA 2020–25 (the Addendum).

Clause B66 of the Addendum requires IHPA to develop a rolling three year data plan each year.

For this update, IHPA has worked collaboratively with the Administrator of the National Health Funding Pool (the Administrator) as part of IHPA's commitment to the principle of data rationalisation expressed in the Addendum, particularly the desire to implement the 'single provision, multiple use' concept.

IHPA and the Administrator (collectively the national bodies) have collaborated on the standardisation of the documents and tables used to communicate each agency's data requirements, including clearly defining which data requests are common across the national bodies. This enables simultaneous consideration by all state, territory and Commonwealth governments.

2. Overview

IHPA requires accurate activity, cost and expenditure data from jurisdictions on a timely basis in order to perform its core determinative functions.

IHPA's ninth rolling Three Year Data Plan covers the period 2021–22 to 2023–24.

The data plans of the national bodies have been harmonised to provide a standard document structure and an appendix listing shared data collection.

Supply of the data outlined in this document is required under clause A8 of the Addendum, with details of jurisdictions compliance to be reported on a quarterly basis in line with clause B81.

IHPA will also continue to make de-identified aggregate and patient-level data available to the Commonwealth, states and territories consistent with clause B77 of the Addendum and section 220 of the *National Health Reform Act 2011*.

The objectives of the IHPA Three Year Data Plan are to:

- communicate IHPA's data requirements over the next three years to jurisdictions and other government agencies in accordance with clause B66 of the Addendum
- describe the mechanisms and timelines IHPA will use to collect data from the jurisdictions.

Chapter 3 describes the consultation and development processes associated with this data plan and its implementation.

Chapter 4 describes the security and privacy requirements and protections surrounding the data.

Chapter 5 indicates how this data plan conforms to the principles of the Addendum.

Chapter 6 covers the specific data requirements of IHPA. It identifies the data sources and major data components to be used to support data analysis and reporting in the period covered by this plan.

Chapter 7 details the data submission process and collection schedule.

Appendix A details the data collections utilised by the national bodies.

3. Background

3.1 Legislative basis

The functions of IHPA are specified in section 131 of the *National Health Reform Act 2011* and include:

- determining the NEP for health care services provided by public hospitals where the services are funded on an activity basis
- determining the NEC for health care services provided by public hospitals where the services are block funded
- determining adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services
- developing and specifying classification systems to be used to classify health care and other services provided by public hospitals
- determining data requirements and standards to apply in relation to data to be provided by jurisdictions, including:
 - i. data and coding standards to support uniform provision of data
 - ii. requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions.
- except where otherwise agreed between the Commonwealth and a state or territory – to determine the public hospital functions that are to be funded in the state or territory by the Commonwealth.

Section 226(1) of the *National Health Reform Act 2011* enables the Commonwealth Minister for Health to give directions to the Pricing Authority in relation to the performance of its functions and the exercise of its powers.

In May 2020, Australian governments signed the Addendum to the NHRA which sets out public hospital financing arrangements until 30 June 2025. Under the Addendum, IHPA will work with the Commonwealth, state and territory governments to explore and trial new and innovative approaches to public hospital funding to improve health outcomes. IHPA will continue implementation of pricing and funding approaches for sentinel events and hospital acquired complications and the development of an approach for avoidable hospital readmissions.

The Addendum sets out the requirement for jurisdictions to submit a Statement of Assurance regarding data quality which is discussed in section 7.4.

3.2 National collections

IHPA continues to work closely with the Australian Institute of Health and Welfare (AIHW) and the national data governance processes to ensure that IHPA conforms with existing data development processes and structures to the fullest extent possible. IHPA is a Registering

Authority for METeOR, the Australia's repository for national metadata standards for health statistics and information. All specifications for IHPA's data sets are stored in METeOR.

IHPA has worked with the National Health Data and Information Standards Committee (NHDISC) to incorporate ABF specific data items into existing national minimum data sets (NMDS) and data set specifications where possible.

Data sets designated as 'data set specifications' are distributed into one of two categories:

- National best endeavours data set (NBEDS): This category is for metadata sets that are not mandated for national collection, but where there is a commitment to provide data nationally on a best endeavours basis
- National best practice data set: This category is for metadata sets that are not mandated for collection, but are recommended as best practice.

IHPA will continue to align ABF reporting requirements with existing national data collections where possible.

IHPA supports the 'single provision, multiple use' principle outlined in clause B67d of the Addendum.

IHPA is a signatory to the National Health Information Agreement (NHIA), which involves a commitment to cooperate through the Australian Health Ministers' Advisory Council agreed governance arrangements for information management. The NHIA coordinates the development, collection and dissemination of health information in Australia, including the development, endorsement and maintenance of national data standards.

3.3 Consultation

Advisory committees and working groups have been established to ensure that jurisdictions are consulted and that the national health reforms are implemented efficiently.

IHPA uses these committees and working groups to:

- understand the impact on jurisdictions of collecting data required by IHPA
- consult on timelines to incorporate standardised data collection methodologies
- encourage and facilitate processes that will ensure data accuracy
- review preliminary results from hospitals and provide assistance in quality assurance.

4. Security and privacy

IHPA is tasked with collecting, securing and using information in accordance with relevant legislation and national privacy principles, ethical guidelines and practices.

4.1 Privacy

The privacy of information is of paramount importance. IHPA manages all information in accordance with the Australian Privacy Principles in the *Privacy Act 1988* and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*; the secrecy and patient confidentiality provisions in the *National Health Reform Act 2011* as well as other statutory protections.

The *National Health Reform Act 2011* provides protections for personal information and makes provisions to ensure patient confidentiality.

All IHPA staff are employed under the *Public Service Act 1999*, and are subject to the Australian Public Service Code of Conduct.

4.2 Security

IHPA is committed to the security of data submitted by jurisdictions. Systems and processes used for collection, analysis, storage and reporting are designed to ensure security of information.

To manage its information security risks and responsibilities, IHPA has an internal Protective Security Framework modelled on the Australian Government's Protective Security Policy Framework. IHPA's Protective Security Policy Framework consists of a range of policies that interact and complement each other to provide a comprehensive framework for the handling of information collected by IHPA. The following policies fall under IHPA's Protective Security Framework:

- IHPA Information Security Policy – This policy outlines how IHPA secures its information assets and information processing facilities. Information relating to IHPA is a highly valuable asset, which requires protection from unauthorised use, disclosure, potential theft, alteration, or destruction. Effective information security management enables information to be shared while minimising IHPA's exposure to risk.
- IHPA Cloud Security Policy – This document defines IHPA's approach to the use and procurement of cloud technology services, noting that the public expects IHPA to have a low tolerance for interruption to critical services or to breaches of the confidentiality of protected data. This policy also covers cloud service providers that provide cloud services through a private, public, community or hybrid cloud deployment model.
- IHPA IT Operations Security Policy – This policy outlines how IHPA secures its information assets. It demonstrates how IHPA will ensure the confidentiality, integrity and availability of the information and technology assets it uses.
- IHPA Data Governance Policy – This policy defines the roles and responsibilities of IHPA staff, contractors and consultants with internal/external parties in relation to data access, retrieval, storage, disposal and archiving of data assets.

- IHPA Data Breach Response Plan – This plan is used to ensure that IHPA assesses and responds to actual and suspected data breaches, and that IHPA is able to identify and notify ‘eligible data breaches’ to the Privacy Commissioner in compliance with the Privacy Act 1988.

Requests for release of information by government agencies or research organisations are covered by IHPA’s Data Access and Release Policy, which enacts the relevant provisions with the *National Health Reform Act 2011* and the National Health Reform Agreement.

4.3 Data submission

In 2017, IHPA implemented the Secure Data Management System (SDMS), which complies with the Australian Government Information Security Manual and is hosted on infrastructure that has been approved by the Defence Signals Directorate. IHPA has also implemented a classification grouping module and National Weighted Activity Unit calculator which allows jurisdictions to obtain real-time feedback on the data supplied to IHPA.

5. Governance

5.1. Compliance with the National Health Reform Agreement

Clause B67 of the Addendum specifies the requirements of the Three Year Data Plan. IHPA acknowledges and complies with these requirements, as outlined in [Table 1](#).

Table 1: Addendum to the National Health Reform Agreement compliance matrix

Clause	Compliance principles	Compliance mechanisms
B67 a	Seek to meet its data requirements through existing national data collections, where practical.	IHPA has worked with the national data committees to align ABF reporting with existing NMDS and NBEDS for admitted patient care, subacute, non-acute, emergency care, non-admitted care, mental health care and teaching, training and research.
B67 b	Conform with national data development principles and wherever practical use existing data development governance processes and structures, except where to do so would compromise the performance of its statutory functions.	All new data development work in 2020–21 has been in collaboration with the national data governance processes and groups.
B67 c	Allow for a reasonable, clearly defined timeframe to incorporate standardised data collection methods across all jurisdictions.	IHPA will consult with its Jurisdictional Advisory Committee and the national data committees prior to introducing additional data elements into collections.
B67 d	Support the concept of ‘single provision, multiple use’ of information to maximise efficiency of data provision and validation where practical, in accordance with privacy requirements.	IHPA supports the concept of ‘single provision, multiple use’. Wherever possible, IHPA will apply the same validations as the AIHW and provide data to agencies under clause B77 of the Addendum as requested.
B67 e	Balance the national benefits of access to the requested data against the impact on jurisdictions providing that data.	IHPA is mindful of the need to balance the benefits against the impact on jurisdictions and will continue to review this in 2021.
B67 f	Consult with the Commonwealth and states when determining its requirements.	IHPA will consult with all key stakeholders through its relevant working groups, Technical Advisory Committee, Jurisdictional Advisory Committee and external national data committees prior to introducing additional data elements into collections.

6. Data requirements

IHPA requires accurate activity, cost and expenditure data from jurisdictions on a timely basis in order to perform its core determinative functions. Wherever possible, IHPA uses pre-existing classifications and data set specifications.

6.1. Classifications

IHPA has approved a number of classifications to describe clinical activity in each service category.

6.1.1. Approved ABF classifications

The classifications or lists that will be used to describe activity for the admitted acute, non-admitted, emergency, mental health, subacute and non-acute, teaching, training and research and sentinel events service categories from 1 July 2021 are provided in **Table 2**.

Table 2: Activity Based Funding classifications

Service category	Classification	Collection start date
Admitted acute	ICD-10-AM/ACHI/ACS, Eleventh Edition; in conjunction with Australian Refined Diagnosis Related Groups (AR-DRG) v10.0	1 July 2021
Non-admitted	Tier 2 Non-Admitted Services v7.0	1 July 2021
Emergency (Levels 3B – 6)	Australian Emergency Care Classification (AECC) v1.0	1 July 2021
Emergency (Levels 1 – 3A)	Urgency Disposition Groups (UDG) v1.3	1 July 2021
Subacute & Non-acute	Australian National Subacute and Non-Acute Patient (AN-SNAP) classification v4.0	1 July 2021
Mental Health	Australian Mental Health Care Classification (AMHCC) v1.0	1 July 2021
Teaching, training and research	Australian Teaching and Training Classification (ATTC) v1.0	1 July 2021
Sentinel events	Australian sentinel events list v2.0	1 July 2021

6.2. Data specifications

The NMDS and NBEDS that IHPA will use from 1 July 2021 are divided into two sections, one each for activity data and cost data.

6.2.1. Activity data

IHPA has developed a limited number of data set specifications for use under the ABF framework. Data set specifications that will be used to collect activity data is listed in **Table 3**.

Table 3: Data set specifications to be used in the ABF framework

Service category	Data set specification	Start date
Admitted acute	Admitted Patient Care NMDS 2021–22 (APC NMDS)	1 July 2021
Non-admitted services	Non-Admitted Patient NBEDS 2021–22 (NAP NBEDS)	1 July 2021
Emergency (Levels 3B & above)	Non-Admitted Patient Emergency Department Care NMDS 2021–22 (NAPEDC NMDS)	1 July 2021
Emergency (Levels 3A & below)	Emergency service care NBEDS 2021–22 (ESC NBEDS)	1 July 2021
Admitted subacute and non-acute	Admitted subacute and non-acute hospital care NBEDS 2021–22 (ASNHC NBEDS)	1 July 2021
Mental health	Activity Based Funding: Mental health care NBEDS 2021–22 (ABF MHC NBEDS)	1 July 2021
Teaching, training and research	Hospital teaching, training and research activities NBEDS 2021–22 (HTTRA NBEDS)	1 July 2021

6.2.2. Cost data

IHPA released Version 4.0 of the [Australian Hospital Patient Costing Standards \(AHPCS\)](#) in early 2018.

6.2.3. Process for updating data set specifications

Data set specifications are updated to ensure that they continue to capture the data relevant to a particular service category for ABF purposes. Wherever possible, IHPA uses established national data sets and governance structures. However, the final responsibility for making the change remains with IHPA. Changes can vary in complexity and may subsequently require more time to update.

6.3. Public Hospital Establishments NMDS

The AIHW's [National Public Hospital Establishments Database](#) is compiled from data specified by state and territory health authorities. The database holds a collection of resources, expenditure and services data for all public and repatriation hospitals in Australia. The Local Hospital Networks/Public Hospital Establishments NMDS is one of the primary data sources available to IHPA to determine the NEC for block funded services.

6.4. Commonwealth pharmaceutical program payments

The Addendum requires IHPA to remove costs associated with programs that the Commonwealth funds through other programs, including pharmaceutical program payments. IHPA identifies these payments using patient-level Commonwealth pharmaceutical program payments data which is provided by the Commonwealth Department of Health for in-scope public hospital services. IHPA uses de-identified Medicare PIN and associated information ('Submission B' data file) from the Administrator to undertake episode-level matching between

the National Hospital Cost Data Collection (NHCDC) and pharmaceutical program payment data as provided for by clause B74 of the Addendum. This data is required according to the timelines below:

Table 4: Timeline for Commonwealth in-scope patient-level pharmaceutical program payments data submission

Data reporting period	Data required
2020–21	29 Jul 2022
2021–22	28 Jul 2023
2022–23	28 Jul 2024

6.5. Hospital Casemix Protocol collection

The Addendum, includes clauses which have the intent to neutralise revenue at the hospital level for public and private patients. To implement these clauses IHPA has developed a methodology which utilises Hospital Casemix Protocol (HCP) data. Additional data on the actual state and territory payments to each Local Hospital Network (LHN) for public and private patients will also be required.

As the quality and timeliness of the HCP collection is improved, the requirement for actual payments to LHNs may not be required.

IHPA uses the HCP collection provided by the Commonwealth Department of Health to:

- determine a correction factor for under-attribution of medical costs across all patients as costs associated with medical practitioners are applied equally across public and private patients
- identify payments made by insurers and the Medicare Benefits Schedule for private patients in public hospitals.

Table 5: Timeline for Commonwealth Hospital Casemix Protocol collection data submission

Data reporting period	Data required
2020–21 (Jun – Dec)	29 Apr 2021
2020–21 full year	28 Oct 2021
2021–22 (Jun – Dec)	29 Apr 2022
2021–22 full year	27 Oct 2022
2022–23 (Jun – Dec)	28 Apr 2023
2022–23 full year	27 Oct 2023

6.6. Pricing for safety and quality

The Addendum requires IHPA to collaborate with jurisdictions and national bodies to determine how funding and pricing could be used to improve patient outcomes across three key areas:

- sentinel events
- hospital acquired complications (HACs)
- avoidable hospital readmissions.

6.6.1. Sentinel events

Since 1 July 2017, an episode of care (across all care streams) where a sentinel event occurs is not funded in its entirety. This funding approach will use the national core set of sentinel events agreed to by Australian Health Ministers in 2002.

Under clause A166 of the Addendum, states and territories agree to apply a digital flag to any episode that includes a sentinel event and report the information to IHPA. The Australian Commission on Safety and Quality in Health Care maintains the data specifications for nationally consistent reporting of sentinel events.

6.6.2. Hospital acquired complications

Implementation of the approach for hospital acquired complications does not require states and territories to submit additional data to IHPA.

6.6.3. Avoidable Hospital Readmissions

Implementation of the approach for avoidable hospital readmissions requires a national unique patient identifier to be reported in national data set specifications.

6.7. Inclusion of unique patient identifiers in national data sets

The Individual Healthcare Identifier (IHI) is a personal identifier that was introduced to support the My Health Record system. IHPA has previously detailed the value in introducing the IHI into national data collections. A unique patient identifier would allow IHPA to accurately identify service delivery to patients across different care settings, financial years and hospitals.

IHPA has consulted with jurisdictions on the inclusion of the IHI in national data sets used for ABF through NHDISC and as part of the Pricing Framework for Australian Public Hospital Services 2020–21 and 2021–22 consultation processes. IHPA will continue to work with jurisdictions and national data committees to progress the inclusion of the IHI in the national data collections.

6.8. Ad-hoc data requests

IHPA undertakes ad-hoc data collection and research to inform modelling, reconciliation and verification. All requests for additional data will be considered by IHPA on a case by case basis, in consultation with jurisdictions through the Jurisdictional Advisory Committee and Technical Advisory Committee.

7. Data submission and collection schedule

IHPA has a detailed data submission process and collection schedule, which is essential to obtaining activity and cost data required to determine the NEP and NEC. Submissions will be made through the SDMS.

7.1. Data submission process

The data submission process is illustrated in **Figure 1** and described in **Table 6**.

Figure 1: Data submission process map

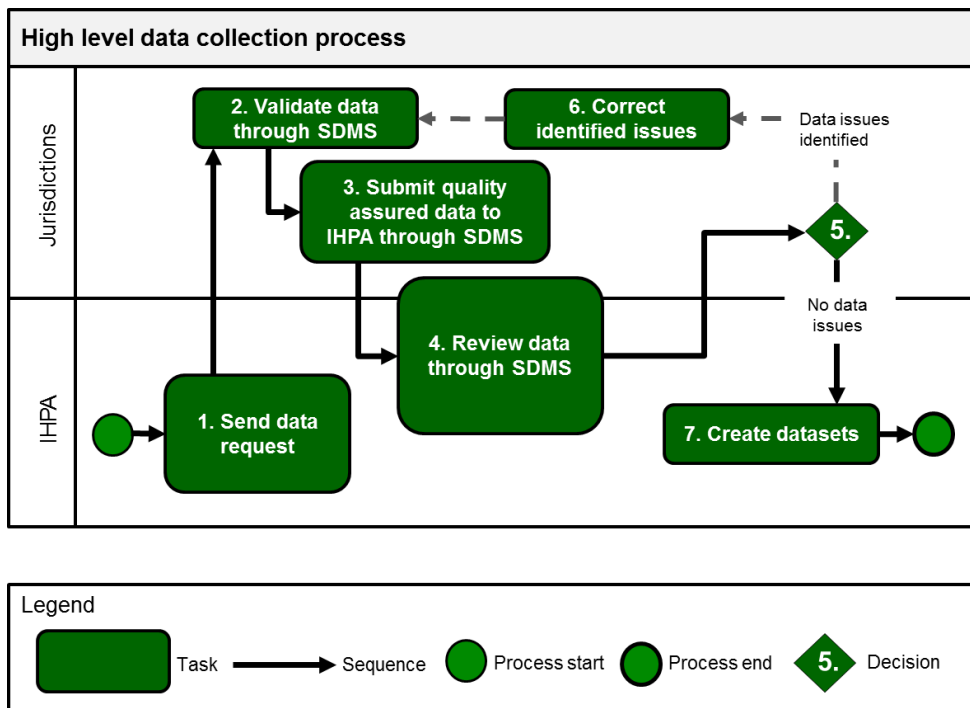


Table 6: Data submission process description

No.	Activity	Description
1.	Send data request	IHPA will send an email to each jurisdiction with the following instructions: <ul style="list-style-type: none"> • method of delivery; • contact person at IHPA; • data request, which will include a spread sheet (or similar) that provides the format in which the data is to be supplied; • validation rules that IHPA will apply to ensure that the submitted data meets the specified requirements; • summary of changes from previous versions of the data set specification; and • due date for submission.
2.	Validate data	Before submission of data, jurisdictions are able to validate data multiple times through the SDMS before submitting. The data will be validated in accordance with the instructions specified in the data request specification. IHPA will ensure that the system is ready for the data validation four weeks before the submission due date.
3.	Submit quality assured data to IHPA	Once jurisdictions are satisfied with the data quality based on the feedback generated by the online validation feature, data can be formally submitted within the SDMS. A confirmation email will be issued by the system following submission.
4.	Review data	Any data anomalies or errors identified by IHPA will be discussed with the relevant jurisdiction to determine how they will be addressed.
5.	Decision	If there are no errors or anomalies, the final datasets are created. Otherwise, jurisdictions will be asked to make appropriate corrections and re-submit the data to IHPA. Where the issues cannot be corrected, jurisdictions will be asked to advise IHPA that the data is to be used with known issues.
6.	Correct identified issues	Jurisdictions correct any errors or anomalies identified by IHPA and resubmit their data.
7.	Create datasets	After all issues are resolved the final datasets are created and made available to agencies under clause B77 of the Addendum.

States and territories are required to report hospital activity data on a quarterly 'year to date' basis to IHPA, while teaching, training and research and hospital cost data provided through the NHCDC is reported on an annual basis. Sentinel events are to be reported every six months as part of the December and June submissions.

Quarterly 'year to date' data collection enables data from previous submissions to be corrected. For example, the end of year submission would be considered final, allowing for any missing or erroneous data in the third quarter submission to be corrected.

7.2. Activity data collection

To provide a draft NEP determination to health ministers by 30 November each year, IHPA collects data from jurisdictions according to the following principles:

- Data requests are sent to jurisdictions in March of each year, three months prior to the start of the next financial year.

- Activity data for service categories (with the exception of teaching, training and research) to be submitted to IHPA quarterly on a year to date basis (i.e. the fourth quarter data submissions will include all activity data for that financial year).
- Sentinel events to be submitted to IHPA biannually as part of the December and June data submissions.
- Activity data for teaching, training and research to be submitted to IHPA on an annual basis.
- Data for each quarter is due by the last working day of the following quarter (e.g. data for the June 2020 quarter period is due on 30 September 2020).
- IHPA validates the submitted data within two weeks and provides feedback to jurisdictions who have two weeks to correct any identified issues and resubmit the data to IHPA.
- The acceptance of any data resubmissions for the purposes of calculating funding entitlements are a matter for the Administrator.

7.2.1 Admitted patient care activity

- Admitted patient care activity data is reported once a separation has occurred.
- Due to 'coding lag' (i.e. elapsed time between the date of service provision and the diagnosis details being coded) previous quarter admitted acute activity data can be revised when the subsequent quarter is submitted.

7.2.2 Emergency patient care activity

- Emergency patient care activity is reported once the patient has physically departed the emergency department and the emergency department stay has been completed.

7.2.3 Non-admitted patient care activity

- Non-admitted patient care activity is reported once the service event has been completed.

7.2.4 Admitted subacute and non-acute patient care activity

- Admitted subacute and non-acute patient care activity is reported once a separation has occurred.

7.2.5 Mental health patient care activity

- Mental health patient care activity will be either admitted, ambulatory or residential episodes.
- Admitted mental health care activity is reported once a separation has occurred.
- Ambulatory and residential mental health activity is reported each quarter it remains open.

7.2.6 Sentinel events

- A sentinel event is reported once a separation has occurred or service event has been completed.

7.2.7 COVID-19

- A supplementary file to identify COVID-19 activity in the ABF data sets eligible for funding under the National Partnership Agreement.
- Where activity relates directly to the COVID-19 response (for example, a COVID-19 hospital admission, emergency department attendance or non-admitted clinic visit), this can be identified in the activity data.
- Where activity does not relate to confirmed or suspected COVID-19 episodes and jurisdictions nominate that it be funded under the National Partnership Agreement, this will be identified through the supplementary file.

The timelines for the submission of activity data between 2021–22 and 2023–24 are shown in **Table 7**.

Table 7: Activity data submission timeline

Financial year	Data reporting period	NBEDS published	Data request sent	Submission date
2021–2022	Sep Quarter	31 Dec 2020	19 Mar 2021	21 Dec 2021
	Dec Quarter	31 Dec 2020	19 Mar 2021	31 Mar 2022
	Mar Quarter	31 Dec 2020	19 Mar 2021	30 Jun 2022
	Jun Quarter	31 Dec 2020	19 Mar 2021	30 Sep 2022
2022–2023	Sep Quarter	31 Dec 2021	18 Mar 2022	23 Dec 2022
	Dec Quarter	31 Dec 2021	18 Mar 2022	31 Mar 2023
	Mar Quarter	31 Dec 2021	18 Mar 2022	30 Jun 2023
	Jun Quarter	31 Dec 2021	18 Mar 2022	29 Sep 2023
2023–2024	Sep Quarter	31 Dec 2022	17 Mar 2023	22 Dec 2023
	Dec Quarter	31 Dec 2022	17 Mar 2023	29 Mar 2024
	Mar Quarter	31 Dec 2022	17 Mar 2023	28 Jun 2024
	Jun Quarter	31 Dec 2022	17 Mar 2023	30 Sep 2024

7.3. National Hospital Cost Data Collection

IHPA uses NHCDC data collected three years earlier to calculate the NEP each year. For example, the NEP Determination 2022–23 will be calculated using cost data from the Round 24 (2019–20) NHCDC. The timeframes for the collection of cost data are shown in **Table 8**.

Table 8: National Hospital Cost Data Collection data submission timeline

NHCDC Round	Data reporting period	Data request sent	Submission date	IHPA review date	Latest resubmission date
25	2020–21	30 Jul 2021	28 Feb 2022	14 Mar 2022	25 Mar 2022
26	2021–22	29 Jul 2022	28 Feb 2023	14 Mar 2023	24 Mar 2023
27	2022–23	31 Jul 2023	28 Feb 2024	15 Mar 2024	29 Mar 2024

7.4. Reporting jurisdictions compliance with data requirements

Jurisdictions are required to submit activity data to IHPA on a quarterly basis with the exception of teaching, training and research data which is submitted on an annual basis. NHCDC data are

also submitted annually, as is Pharmaceutical Benefits Scheme data from the Commonwealth. IHPA reports on jurisdiction compliance as per clause B81 of the Addendum. The process for reporting compliance will be managed in accordance with IHPA's [Data Compliance Policy](#).

Jurisdictions will be judged to have complied with IHPA's data requirements if they:

- have provided the data required as specified in the data request; and
- have provided the data in the timeframes requested.

If a jurisdiction does not meet both of these requirements for any given quarterly period, they will be regarded as being non-compliant. This information will be published on the IHPA website on a quarterly basis.

However, it is also important to note that where a jurisdiction is judged to be non-compliant, it will have an opportunity to communicate the circumstances to IHPA. In this instance IHPA will work with the jurisdiction to improve the data submission process over time.

Clause B82 of the Addendum requires the Commonwealth, states and territories provide IHPA with a Statement of Assurance certifying completeness and accuracy of data submissions or resubmission from a senior health department official biannually on the completeness and accuracy of its data submissions. IHPA will provide these Statements of Assurance to the Administrator for reconciliation purposes.

The provision of the Statement of Assurance does not prevent a jurisdiction from resubmitting data to improve previous submissions, subject to the timing requirement in clause A78. Each approved submission or resubmission of data is accompanied by a Statement of Assurance.

Appendix A - IHPA and the Administrator of the National Health Funding Pool

IHPA has worked collaboratively with the Administrator in revising the IHPA Three Year Data Plan as part of IHPA's commitment to the principle of data rationalisation expressed in the Addendum particularly the 'single provision, multiple use' concept.

The national bodies use cost and expenditure data through the same key collections – the NHCDC, the National Public Hospitals Establishments Database and the Public Hospitals Establishments Data Set Specification.

Table A1 details the activity data collections utilised by the national bodies.

Table A1: Comparative activity data collections utilised by the national bodies

Service category	National agencies			Year of data collection					
	IHPA		NHFP Administrator	2021–22		2022–23		2023–24	
	ABF	Block-funded		Data spec	Classification	Data spec	Classification	Data spec	Classification
Admitted acute	✓	✓	✓	APC NMDS 2021–22	ICD-10-AM Eleventh ed. & AR-DRG v10.0	APC NMDS 2022–23	ICD-10-AM Twelfth ed. & AR-DRG v10.0	APC NMDS 2023–24	ICD-10-AM Twelfth ed. & AR-DRG v11.0
Emergency (Levels 3B – 6)	✓	✓	✓	NAPEDC NMDS 2021–22	Australian Emergency Care Classification v1.0	NAPEDC NMDS 2022–23	Australian Emergency Care Classification v1.0	NAPEDC NMDS 2023–24	Australian Emergency Care Classification v1.0

Service category	National agencies			Year of data collection					
	IHPA		NHFP Administrator	2021–22		2022–23		2023–24	
	ABF	Block-funded		Data spec	Classification	Data spec	Classification	Data spec	Classification
Emergency (Levels 1 – 3A)	✓	✓	✓	ESC NBEDS 2021–22	Urgency Disposition Group v1.3	ESC NBEDS 2022–23	Urgency Disposition Group v1.3	ESC NBEDS 2023–24	Urgency Disposition Group v1.3
Non-admitted services	✓		✓	NAP NBEDS 2021–22	Tier 2 Non-Admitted Services v7.0	NAP NBEDS 2022–23	Tier 2 Non-Admitted Services v7.0	NAP NBEDS 2023–24	Tier 2 Non-Admitted Services v7.0
Mental health	✓	✓	✓	ABF MHC NBEDS 2021–22	AMHCC v1.0	ABF MHC NBEDS 2022–23	AMHCC v1.0	ABF MHC NBEDS 2023–24	AMHCC v1.0
Admitted subacute & non-acute	✓	✓	✓	ASNHC NBEDS 2021–22	AN-SNAP v4.0	ASNHC NBEDS 2022–23	AN-SNAP v5.0	ASNHC NBEDS 2023–24	AN-SNAP v5.0
Teaching, training & research		✓		HTTRA NBEDS 2021–22	ATTC v1.0	HTTRA NBEDS 2022–23	ATTC v1.0	HTTRA NBEDS 2023–24	ATTC v1.0
Sentinel events	✓	✓	✓	Data file which identifies episodes with sentinel events to be provided by jurisdictions	Australian sentinel events list v2.0	Data file which identifies episodes with sentinel events to be provided by jurisdictions	Australian sentinel events list v2.0	Data file which identifies episodes with sentinel events to be provided by jurisdictions	Australian sentinel events list v2.0

Service category	National agencies			Year of data collection					
	IHPA		NHFP Administrator	2021–22		2022–23		2023–24	
	ABF	Block-funded		Data spec	Classification	Data spec	Classification	Data spec	Classification
COVID-19	✓	✓	✓	Supplementary file to identify COVID-19 activity in the ABF data sets eligible for funding under the National Partnership Agreement.	Rules for coding and reporting COVID-19 episodes of care				

Table A2 details other data collections utilised by these two national agencies.

Table A2: Other data collections utilised by the national bodies

Category	National Agencies			Year of data collection		
	IHPA		NHFP Administrator	2021–22	2022–23	2023–24
	ABF	Block-funded		Data collection	Data collection	Data collection
In-scope pharmaceutical program payments	✓	✓	✓	Commonwealth in-scope patient-level pharmaceutical program payments data	Commonwealth in-scope patient-level pharmaceutical program payments data	Commonwealth in-scope patient-level pharmaceutical program payments data
De-identified Medicare number and funding source information	✓	✓	✓	'Submission B' data file provided by jurisdictions to the Department of Human Services	'Submission B' data file provided by jurisdictions to the Department of Human Services	'Submission B' data file provided by jurisdictions to the Department of Human Services
Private Health Insurance payments for private patients in public hospitals	✓	✓	✓	Hospital Casemix Protocol (HCP) Collection	Hospital Casemix Protocol Collection	Hospital Casemix Protocol Collection
State and territory payments to LHNs for public and private patients	✓	✓	✓	State and territory payments to Local Hospital Networks (LHNs) for public and private patients	State and territory payments to LHNs for public and private patients	State and territory payments to LHNs for public and private patients

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