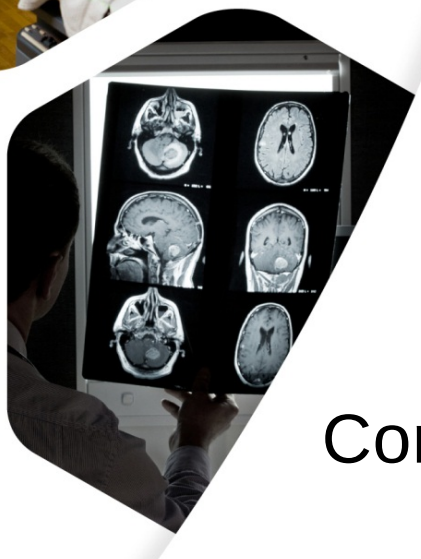
Independent Hospital Pricing Authority

IHPA



Consultation paper on the Pricing Framework for Australian Public Hospital Services 2016-17

June 2015

Independent Hospital Pricing Authority
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Glossary

ABF	Activity Based Funding
ACHI	Australian Classification of Health Interventions
AHPCS	Australian Hospital Patient Costing Standards
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-acute Patient classification
AR-DRG	Australian-Refined Diagnosis Related Groups
ASGS	Australian Statistical Geography Standard
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
DSS	Data Set Specification
ED	Emergency Department
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
JWP	Joint Working Party for Safety and Quality
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MDCC	Multidisciplinary Case Conferences
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
OTA	Organ and Tissue Authority
PBS	Pharmaceutical Benefits Scheme
PHEC	Public Hospital Establishments Collection
The Act	The *National Health Reform Act 2011*
TTR	Teaching, Training and Research
UDGs	Urgency Disposition Groups
URGs	Urgency Related Groups

1. Introduction

The implementation of a national Activity Based Funding (ABF) system is intended to improve efficiency and transparency of funding contributions of the Commonwealth, state and territory governments for each Local Hospital Network (LHN) across Australia.

To achieve this, IHPA is required under the National Health Reform Agreement (NHRA) and the *National Health Reform Act 2011* (the Act) to determine the National Efficient Price (NEP) to calculate Commonwealth ABF payments for in-scope public hospital services and the National Efficient Cost (NEC) covering those services which are block funded. IHPA has completed four rounds of pricing public hospital services under the NHRA.

The Commonwealth Government announced in its 2014-15 Budget that it intended to work with states and territories to create a new Health Productivity and Performance Commission. It was proposed that the Commission would merge the functions of the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare, IHPA, the National Health Performance Authority, the National Health Funding Body and the Administrator of the National Health Funding Pool.

The Commonwealth Government stated in its 2015-16 Budget that it has held consultations with state and territory health officials, entity Chief Executive Officers and Boards on the proposed merger. Whilst the Commonwealth Government continues these consultations, IHPA will deliver the program of work laid out in the IHPA Work Program 2015-16, including the Determination of the 2016-17 NEP (NEP16) and NEC (NEC16).

The *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2016-17* (Consultation Paper) is IHPA's primary consultation mechanism. Feedback received from stakeholders will inform the development of the *Pricing Framework for Australian Public Hospital Services 2016-17* (Pricing Framework) which sets out IHPA's policy intentions for the NEP16 and NEC16 Determinations.

The Pricing Framework will be released in late 2015 prior to releasing the NEP16 and NEC16 Determinations in February 2016. This timing provides an additional layer of transparency and accountability by making available the key principles, scope and approach adopted by IHPA to inform the NEP and NEC Determinations.

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

- Pricing Framework for Australian Public Hospital Services 2015-16
- National Efficient Price Determination 2015-16
- National Efficient Cost Determination 2015-16

Submissions should be uploaded via IHPA's website:
www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/submissions

Submissions close at 5pm, 27 July 2015.

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

2. Pricing Guidelines

2.1 Overview

The Pricing Guidelines signal IHPA's commitment to transparency and accountability in how it undertakes its work (see Box 1). The decisions made by IHPA in pricing in-scope public hospital services are evidence-based and utilise the costing and activity data supplied to IHPA by states and territories.

In making these decisions, IHPA must balance a range of policy objectives including improving the efficiency and accessibility of public hospital services. This role requires IHPA to exercise judgement on the weight to be given to different policy objectives.

Whilst these Pricing Guidelines are used to explain the key decisions made by IHPA in the annual Pricing Framework, they can also be used by governments and other stakeholders to evaluate whether IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

IHPA considers that the Pricing Guidelines are working well. For this reason, IHPA did not make any changes to the Pricing Guidelines for the Pricing Framework 2015-16 and no changes are proposed for the Pricing Framework 2016-17.

Box 1: Pricing Guidelines

The Pricing Guidelines comprise the following overarching, process and system design guidelines.

Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising Activity Based Funding (ABF) and block grant funding:

- **Timely–quality care:** Funding should support timely access to quality health services.
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the NHRA:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

Process Guidelines to guide the implementation of ABF and block grant funding arrangements:

- **Transparency:** All steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Stability:** The payment relativities for ABF are consistent over time.
- **Evidence based:** Funding should be based on best available information.

System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Price harmonisation:** Pricing should facilitate best-practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **ABF pre-eminence:** ABF should be used for funding public hospital services wherever practicable.
- **Single unit of measure and price equivalence:** ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Patient-based:** Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **Public-private neutrality:** ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.

3. Scope of public hospital services

3.1 Overview

Making decisions about what is, or is not, a public hospital service for the purpose of determining eligibility for Commonwealth funding is one of the important tasks assigned to IHPA under the NHRA.

In August 2011 governments agreed to be jointly responsible for funding growth in 'public hospital services'. As there was no standard definition or listing of public hospital services, the Council of Australian Governments (COAG) assigned IHPA the task of determining whether a service is ruled 'in-scope' as a public hospital service, and therefore eligible for Commonwealth Government funding under the NHRA.

The reformed funding arrangements agreed by COAG apply to the scope of 'public hospital services', which is broader terminology than public hospitals or hospital-based care. For example, private hospitals and non-governmental organisations may provide public hospital services when these services are contracted out by governments or public hospitals. However, many public hospitals provide residential aged care services, but these are not regarded as public hospital services under the NHRA.

3.2 Scope of Public Hospital Services and General List of Eligible Services

Each year, IHPA publishes the 'General List of In-Scope Public Hospital Services' which defines public hospital services eligible for Commonwealth funding in the NHRA, except where funding is otherwise agreed between the Commonwealth and a state or territory.

In accordance with Section 131(f) of the Act and Clauses A9-A17 of the NHRA, the General List defines public hospital services eligible for Commonwealth funding to be:

- All admitted programs, including hospital in the home programs. Forensic mental health inpatient services are also included if they were recorded in the 2010 Public Hospital Establishments Collection (PHEC).
- All Emergency Department (ED) services provided by a recognised ED service; and
- Other non-admitted services that meet the criteria for inclusion on the General List.

A public hospital service's eligibility for inclusion on the General List is independent of the service setting in which it is provided (e.g. at a hospital, in the community, in a person's home). This policy decision ensures that the Pricing Framework supports best practice provision of appropriate site of care.

IHPA also publishes an 'A17 List' of public hospital services which would not normally be considered a public hospital service, but are eligible for Commonwealth funding under Clause A17 of the NHRA. The A17 List provides a form of "grand parenting" in that an otherwise ineligible service is eligible for Commonwealth funding in a specific hospital if the service was purchased or provided by that hospital during 2010, as reported to the PHEC.

The Pricing Authority determines whether specific services proposed by states and territories are in-scope and eligible for Commonwealth funding based on decision criteria and through reviewing supporting empirical evidence provided by jurisdictions.

The process IHPA follows in assessing services and the decision criteria and interpretive guidelines used by the Pricing Authority are outlined in the Annual Review of the General List of In-Scope Public Hospital Services policy. The policy was updated in early 2015 to clarify that an eligible service is added to the General List after it is assessed as meeting the criteria and a jurisdiction has provided supporting empirical evidence. Services that meet the criteria but do not have supporting empirical evidence will not be added to the General List.

The criteria and interpretive guidelines are presented in Box 2. The General List and A17 List were published as part of the NEP15 Determination in February 2015.

IHPA considers the criteria and interpretive guidelines fit for purpose. No further changes are proposed for the Pricing Framework 2016-17.

Consultation question

- What additional evidence exists to support the inclusion or exclusion of specific services from the General List in 2016-17?

3.2.1 Pricing posthumous organ procurement activities

Under Clause A6 of the NHRA, the Commonwealth will not fund patient services through the NHRA if the same service, or any part of the same service, is funded through any other Commonwealth program. For this reason, IHPA has previously not priced posthumous organ procurement activities due to advice from the Organ and Tissue Authority (OTA) that these costs were funded by the Commonwealth.

Posthumous organ procurement refers to activities involving the procurement of organs for the purpose of transplantation from a donor who has been declared brain dead and are coded as 'Care Type 9' in the Admitted Patient Care National Minimum Data Set.

At the request of its Clinical Advisory Committee, IHPA has sought clarification from the OTA on whether its funding programs cover all organ donation and retrieval costs. The OTA has advised that it contributes towards the costs which are additional to those normally incurred for providing care for critically ill patients, as well as the costs of transferring intended organ donors from a regional hospital to a metropolitan hospital in order to facilitate donation. This means that posthumous organ procurement costs are not funded by the Commonwealth and can thus be considered for inclusion for funding under the NHRA.

IHPA will now assess whether posthumous organ procurement activities are accurately costed in the National Hospital Cost Data Collection (NHCDC).

Consultation questions

- Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?
- Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?

Box 2: Scope of Public Hospital Services and General List of Eligible Services

In accordance with Section 131(f) of the *National Health Reform Act 2011* (the Act) and Clauses A9–A17 of the National Health Reform Agreement (NHRA), the scope of "Public Hospital Services" eligible for Commonwealth funding under the Agreement are:

- All admitted programs, including hospital in the home programs and forensic mental health inpatient services.
- All Emergency Department (ED) services.
- Non-admitted services as defined below.

Non-admitted services

This listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in scope services can be provided on an outreach basis.

To be included as an in scope non-admitted service, the service must meet the definition of a 'service event' which is:

> An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Consistent with Clause A25 of the NHRA, the Independent Hospital Pricing Authority will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making those services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:

A. Specialist Outpatient Clinic Services
B. Other Non-admitted Patient Services

Category A: Specialist outpatient clinic services – Tier 2 Non-admitted Services Classification – Classes 10, 20 and 30

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

Category B: Other non-admitted patient services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40)

To be eligible for Commonwealth funding as an Other Non-admitted Patient Service or a Class 40 Tier 2 Non-admitted Service, a service must be:

- directly related to an inpatient admission or an ED attendance; or
- intended to substitute directly for an inpatient admission or ED attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

Jurisdictions have been invited to propose services that will be included or excluded from Category B "Other Non-admitted Patient Services". Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the three criteria above.

The following clinics are considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service under this category:

- Commonwealth funded Aged Care Assessment (40.02)
- Family Planning (40.27)
- General Counselling (40.33)
- Primary Health Care (40.08).

Interpretive guidelines for use

In line with the criteria for Category B, community mental health, physical chronic disease management and community based allied health programs considered in-scope will have all or most of the following attributes:

- Be closely linked to the clinical services and clinical governance structures of a public hospital (for example integrated area mental health services, step-up/step-down mental health services and crisis assessment teams);
- Target patients with severe disease profiles;
- Demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum);
- Demonstrate the operation of formal discharge protocols within the program; and
- Demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

Home ventilation

A number of jurisdictions submitted home ventilation programs for inclusion on the General List. The Pricing Authority has included these services on the General List in recognition that they meet the criteria for inclusion, but will review this decision in the future once the full scope of the National Disability Insurance Scheme is known.

4. Classifications used by IHPA to describe public hospital services

4.1 Overview

In order to determine the NEP for services funded on an activity basis, IHPA must first specify the classifications, counting rules, data and coding standards as well as the methods and standards for costing data.

4.2 Classification systems

Classification systems provide the hospital sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs in order to better manage, measure and fund high quality and efficient health care services.

The use of these systems is a critical element of ABF as they group patients who are clinically relevant (i.e. have similar conditions) and resource homogenous (i.e. cost similar amounts per episode) together.

4.3 Australian-Refined Diagnosis Related Groups classification

For NEP15 IHPA used the Australian Refined Diagnosis Related Groups (AR-DRG) Version 7 classification to price admitted acute patient services with the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI) 9th edition used for the underlying diagnosis and procedure coding.

In the Pricing Framework 2015-16, IHPA foreshadowed its intention to price admitted acute patients using AR-DRG Version 8 in NEP16. This version of the classification includes a new approach to case complexity which more accurately quantifies individual patient complexity and better recognises the impact of the principal diagnosis and comorbidities on overall case complexity. IHPA will use AR-DRG Version 8 in NEP16 underpinned by the ICD-10-AM and ACHI 9th edition diagnosis and procedure codes.

4.4 Australian National Subacute and Non-Acute Patient classification

For NEP15 IHPA used the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 3 classification to price admitted subacute and non-acute patients. For NEP15 IHPA also ceased per diem pricing for subacute services not classified using AN-SNAP, except for paediatric subacute per diem pricing as AN-SNAP Version 3.0 did not include paediatric classes.

AN-SNAP Version 4 better reflects current and evolving clinical practice in subacute services such as rehabilitation, palliative care and geriatric evaluation and management services. The new version will also introduce paediatric classes, which will allow IHPA to price paediatric subacute activity using only AN-SNAP grouped services and to cease paediatric per diem payments.

4.5 Tier 2 Non-admitted Patient Services classification

IHPA acknowledges that the existing Tier 2 Non-admitted Patient Services classification is not ideal in the longer term for pricing non-admitted patients as it is not patient centred. However, there are no non-admitted classifications in use internationally which could be suitably adapted to the Australian setting.

For this reason, IHPA is continuing its work to develop a new Australian non-admitted patient care classification that will be better able to describe patient complexity and more accurately reflect the costs of non-admitted public hospital services.

In their responses to the Consultation Papers for 2014-15 and 2015-16, stakeholders strongly supported the counting, costing and classification of non-admitted Multidisciplinary Case Conferences (MDCCs) where the patient is not present. IHPA has commenced developmental work to define MDCCs where the patient is not present for inclusion in the new non-admitted care classification. This work is informed by the MDCCs recently added to the Medicare Benefits Schedule.

For NEP16 IHPA will continue to use the Tier 2 classification for pricing non-admitted services. It is anticipated only minor amendments will be made to the Tier 2 classification as work continues on the new non-admitted classification.

4.6 Emergency care classification

IHPA currently uses the Urgency Related Group (URG) and Urgency Disposition Group (UDG) classifications to describe presentations to emergency departments (EDs) and emergency services for ABF purposes.

IHPA acknowledges that the URG and UDG classification systems require improvement for classifying emergency care in the medium to long term. There is a need for an emergency care classification with a stronger emphasis on patient factors, such as diagnosis, compared to the current focus on triage status in the existing classification. Work has commenced on the redevelopment of the emergency care classification systems in 2015.

For NEP16 IHPA will price emergency activity using the URG Version 1.4 and UDG Version 1.3 classifications.

4.7 Teaching, training and research

Teaching, training and research (TTR) activities represent an important role of the public hospital system alongside the provision of care to patients. However, there is currently no acceptable classification system for TTR, nor are there mature, nationally consistent data collections for activity or cost data which would allow IHPA to price TTR using ABF.

The NHRA requires that IHPA provide advice to the COAG Health Council on the feasibility of transitioning funding for TTR to an ABF system by 30 June 2018. IHPA provided advice to the COAG Health Council in late 2014 that the work IHPA has undertaken to date indicates that the development of systems which underpin ABF are feasible for teaching and training. This view is shared by jurisdictions and clinical, academic and peak body stakeholders. However, IHPA also advised that further work is required to obtain robust data prior to IHPA providing advice on the feasibility of ABF for research.

IHPA has proceeded to the next step of developing a TTR classification through commencing a comprehensive TTR costing study at a representative sample of public hospitals. The study will run until early 2016, after which work will commence on the development of a teaching and training classification system.

IHPA also continues to improve its ongoing data collection of TTR activities, with a Hospital Teaching, Training and Research Data Set Specification (DSS) included in IHPA's *Three Year Data Plan 2015-16 to 2017-18*. The DSS will provide for the reporting of research activity in addition to teaching and training from 1 July 2015.

IHPA will continue to block fund TTR activity in ABF hospitals, including in NEC16, until the classification is developed. The TTR block funding amounts will be determined with advice from jurisdictions and consistent with the Block Funding Guidelines developed for NEC15.

4.8 Australian Mental Health Care Classification

IHPA continues to develop a new mental health care classification for classifying and pricing mental health services on an activity basis across both the admitted and non-admitted settings. This work is guided by a Mental Health Working Group which includes clinicians, consumers and carers, as well as jurisdictional representatives.

The classification is intended to improve the clinical meaningfulness of the way mental health care services are classified, better account for new models of mental health care and enhance the cost predictiveness of the pricing model.

The Australian Mental Health Care Classification (AMHCC) is in its final stages of development. The classification development builds on earlier work to define and cost mental health care.

Current work includes analysing data from the mental health costing study to inform the development of the classification. Data from the study was collected from a broad cross-section of public and private health services across Australia including admitted, community and residential settings in the second half of 2014.

The classification will include a number of variables that describe how a mental health consumer's diagnosis impacts their daily activities.

IHPA intends to pilot the new classification in the second half of 2015 at a small number of sites nationally to test the clinical acceptability and explanatory power of the classification and to identify the data collection and other infrastructure requirements and system changes that are needed.

IHPA also expects to commence the development of the second version of the AMHCC in late 2015. IHPA anticipates that an ongoing refinement process for the AMHCC, similar to the AR-DRG classification, will be implemented following the release of Version 2 of the AMHCC.

4.8.1 Pricing mental health services

In the Pricing Frameworks 2014-15 and 2015-16, IHPA foreshadowed pricing mental health services using the AMHCC from 1 July 2016. However, IHPA now intends to defer implementation of the new classification for pricing purposes until 1 July 2017.

Deferring for one year would provide time to evaluate and incorporate the outcomes of the pilot and provide system managers and clinicians the lead time required to make the system changes to capture the key data elements in the classification. It would also allow time for stakeholders to undertake training and education to support implementation at the local level.

This issue will be further discussed in a second *Public Consultation Paper on the Development of the Australian Mental Health Care Classification* to be released in August 2015.

5. Costing and counting rules

5.1 National Hospital Cost Data Collection (NHCDC)

The NHCDC is the primary data collection that IHPA relies on to develop the NEP and price weights for the funding of public hospital services on an activity basis, as well as to develop the NEC for block funded hospitals. Jurisdictional data submissions to the NHCDC are informed by the Australian Hospital Patient Costing Standards (AHPCS).

In 2015 IHPA will continue to work with stakeholders to address actions from the Strategic Review of the National Hospital Cost Data Collection with the aim of improving the consistency of cost allocation methods across Australian public hospitals.

IHPA published Version 3.1 of the AHPCS in late 2014 which addressed a number of the issues raised in the Strategic Review.

IHPA has now commenced a comprehensive review of the content of the AHPCS which will be used as the basis for AHPCS Version 4 as well as to develop supporting materials to assist system managers in undertaking costing activities in public hospitals.

The comprehensive review is informed by consultation with all jurisdictions and other stakeholders, with IHPA publishing a public consultation paper in early 2015.

The comprehensive review will include a study which will evaluate alternative cost allocation methods and to determine a preference hierarchy of methods for the AHPCS.

IHPA will release AHPCS Version 4 in late 2015 for use in future rounds of the NHCDC. It is intended that the new standards and the accompanying educational materials will deliver greater consistency and improve comparability for future rounds of the collection.

6. The National Efficient Price for Activity Based Funded Public Hospital Services

6.1 Technical improvements

IHPA has developed a sophisticated and robust pricing model that underpins the determination of the NEP. The model is described in detail in the Technical Specifications on IHPA's website.

Some jurisdictions have requested that IHPA consider technical improvements to the cost models underpinning the NEP.

IHPA will consider these technical improvements in its development of NEP16, as well as any additional suggestions received from jurisdictions and other stakeholders.

6.1.1 Alternative geographical classification systems

Remoteness has been shown to be a significant cost driver for the provision of public hospital services. For this reason, it is considered in both the NEP model and the NEC model as one of a variety of factors. IHPA's current approach to determining remoteness is to use the Australian Bureau of Statistics' 2011 Australian Statistical Geography Standard (ASGS) Remoteness Area classification.

IHPA proposes to investigate the Modified Monash Model as an alternative to the ASGS for determining patient and hospital remoteness. Like the ASGS, this model categorises metropolitan, regional, rural and remote areas according to both geographical location, but introduces new categories in regional and rural remoteness areas based on town size. The Commonwealth Department of Health has adopted the Modified Monash Model for use in its District of Workforce Shortage map, which is used to identify medical workforce shortages across Australia. It is possible that this classification will help to better explain the unavoidable costs of service delivery in some areas in Australia where some stakeholders claim the existing ASGS fails to do so.

Consultation questions

- Should IHPA consider any further technical improvements to the NEP pricing model for 2016-17?
- What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

6.2 Adjustments to the National Efficient Price

6.2.1 Overview

Section 131(1)(d) of the Act requires IHPA to determine "adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services". Clause B13 of the NHRA additionally states that IHPA "must 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."

IHPA tests whether there are empirical differences in the cost of providing public hospital services in order to determine whether there are legitimate and unavoidable variations in the costs of service delivery that may warrant an adjustment to the NEP. IHPA's decisions are based on national data sources.

IHPA will examine patient-based characteristics in the cost of providing public hospital services as a first priority before considering hospital or provider-based characteristics. This policy reinforces the principle that funding should follow the patient wherever possible.

IHPA will continue to review its existing adjustments, with the aim of discontinuing adjustments associated with input costs or which are facility-based when it is feasible to do so.

IHPA developed the Assessment of Legitimate and Unavoidable Cost Variations Framework in 2013 to assist state and territory governments in making applications for consideration of whether a service has legitimate and unavoidable cost variations not adequately recognised in the National Pricing Model. If agreed, IHPA then determines whether an adjustment to the NEP is necessary to account for the variation. Jurisdictions may continue to propose potential unavoidable cost variations under the Framework on an annual basis.

6.2.2 Adjustments to be evaluated for NEP16

For NEP15, the Pricing Authority determined to apply these evidence based adjustments:

- Paediatric Adjustment for a person who is aged up to and including 17 years and is admitted to a specialised children's hospital for admitted acute patients or treated in any facility for admitted subacute patients;
- Specialist Psychiatric Age Adjustment for an admitted acute patient who has one or more psychiatric care day during their admission, with the rate of adjustment dependent on the person's age;
- Patient Remoteness Area Adjustment for an admitted acute or subacute patient whose residential address is within an area that is classified as being outer regional, remote, or very remote in the Australian Bureau of Statistics' Australian Statistical Geography Standard, with the rate of adjustment dependent on the person's specific geographical classification;
- Indigenous Adjustment for a person who identifies as being of Aboriginal and/or Torres Strait Islander origin;
- Radiotherapy Adjustment for an admitted acute patient with a specified ICD-10-AM 9th edition radiotherapy procedure code recorded in their medical record;
- Dialysis Adjustment for an admitted acute patient with a specified ICD-10-AM 9th edition renal dialysis code who is not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis; and
- Intensive Care Unit (ICU) Adjustment for patients who were admitted to a specified ICU that met the criteria defined by IHPA (provided more than 24,000 hours of ICU care, at least 20 per cent of which involved mechanical ventilation);
- Private Patient Service Adjustment and Private Patient Accommodation Adjustment for admitted private patients; and

- Multidisciplinary Clinic Adjustment for a non-admitted patient where three or more health care providers (each of a different specialty) are present.

During IHPA's consultation on the Pricing Framework 2015-16, stakeholders requested that IHPA review the costs of treating patients with an intellectual disability to determine whether an adjustment is necessary. IHPA analysed its cost data and determined that the average cost of these patients was not materially above the price paid for their care. However, the diagnosis codes used to identify these patients may not have comprehensively accounted for all admitted patients with an intellectual disability. For NEP16, IHPA will explore alternative approaches for identifying all admitted patients with an intellectual disability and consider whether an adjustment is required.

Some stakeholders have also suggested that IHPA should consider an adjustment for Culturally and Linguistically Diverse (CALD) patients. As national data sets do not capture the variables which allow for CALD patients to be identified, IHPA has used additional data sets held by states and territories to investigate whether an adjustment is warranted. This analysis indicates that the costs of CALD patients are not materially different from other patients at the national level. IHPA recognises that the cost allocations for services specific to CALD patients can be improved, such as for interpreter services, and IHPA has identified this as a priority area for AHPCS Version 4.

Western Australia has requested that IHPA consider the issue of fly-in, fly-out workers and domestic tourists (predominately from metropolitan areas) who are treated in outer regional and remote hospitals. Western Australia states that it's hospitals are at a disadvantage as the patients do not receive a Remoteness Adjustment as this is based on their residential post code. IHPA will undertake further analysis of this issue in preparation for the NEP16 Determination.

IHPA has also identified that age may be a potential cost driver in emergency departments (EDs) and, for NEP16, IHPA will explore whether an age-related adjustment should be introduced for EDs.

IHPA will also consider adjustments proposed by stakeholders in their response to the Consultation Paper.

6.2.3 Stability of adjustments

As advised in the Pricing Framework 2014-15, IHPA has conducted a review of the stability of the adjustments applied to the NEP over previous years. For NEP14 and NEP15 adjustments were determined on a rolling average where up to three years' historical data was available in order to maximise stability of these adjustments. This process is set out in IHPA's National Pricing Model Stability Policy. It is IHPA's intention to continue this approach for NEP16.

Consultation questions

- What are the priority areas for IHPA to consider when evaluating adjustments to NEP16?
- What patient-based factors provide the basis for these or other adjustments? Please provide supporting evidence, where available.

7. Setting the National Efficient Price for private patients in public hospitals

7.1 Overview

The NHRA requires IHPA to set the price for admitted private patients in public hospitals accounting for payments made by other parties including private health insurers (for prosthesis and the default bed day rate) and the Medicare Benefits Schedule (MBS).

Under the NHRA, IHPA is prevented from pricing private non-admitted patient services.

7.2 Costing private patients

The collection of private patient medical expenses is problematic in the NHCDC. For example, there is a common practice in some jurisdictions of using Special Purpose Funds to collect associated revenue (e.g. MBS) and reimburse medical practitioners.

These funds generally do not appear in hospital accounts used for costing in the NHCDC. This leads to an under attribution of total medical costs across all patients as costs associated with medical staff are applied equally across public and private patients.

In NEP15 IHPA corrected for this issue by inflating the cost of all patients by 1.9 percent to account for these missing costs based on data from the Hospital Casemix Protocol that enabled more specific identification of the missing private patients' costs.

In their responses to the Consultation Paper 2015-16, stakeholders broadly supported IHPA phasing out the correction factor when it is feasible to do so. IHPA released Version 3.1 of the AHPCS in late 2014 for states and territories to use in Round 18 of the NHCDC. This version of the standards allows for a significant improvement in the way private patient costs are captured and ultimately may allow for the phasing out of the correction factor.

The use of the correction factor assumes that all private patient costs are missing and that these costs are spread across both private and public patients. However, this may not be the case for all hospitals. For example, IHPA has identified some hospitals which appear to be reporting specialist medical costs for private patients in the NHCDC cost data supplied to IHPA.

IHPA will work with states and territories to better identify the treatment of private patient costs in the NHCDC for Round 18 and ascertain if any revision needs to be made to the existing methodology used to correct for missing costs.

8. Treatment of other Commonwealth programs

8.1 Overview

Under Clause A6 of the NHRA, IHPA is required to discount funding that the Commonwealth provides to public hospitals through programs other than the NHRA to prevent the hospital being funded twice for the service. The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs including:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Benefits Scheme (PBS) – Herceptin: Early Stage Breast Cancer (Section 100 funding)
- Pharmaceutical Reform Agreements – PBS Access Program
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding)

IHPA is not proposing to change the treatment of these programs for NEP16.

IHPA is currently working with jurisdictions to investigate how blood costs can more accurately be captured in the NHCDC.

9. Bundled pricing

9.1 Overview

Like many ABF systems internationally, IHPA has generally adopted an approach to pricing hospital services based on discrete episodes of care. For example, a patient who attends an Emergency Department and is subsequently admitted to hospital with a fractured neck femur may then receive admitted rehabilitation services in a subacute setting. Under the existing approach to pricing, this would be considered as three discrete episodes of care.

IHPA recognises that there is potential to better align pricing incentives across settings for care paths such as those described above by introducing bundled pricing approaches, where a single price across three settings of care is determined. This potentially gives hospital managers greater room to develop innovative models of care for these patient groups, without being deterred by pricing models based around traditional care settings.

IHPA also recognises that for chronic conditions bundled pricing can significantly reduce the bureaucratic overhead associated with reporting activity on a regular basis. Therefore IHPA introduced bundled pricing for a number of home-delivered chronic disease services in NEP15.

9.2 Bundled pricing in future years

IHPA proposes to investigate options for bundled pricing across care settings for future years.

IHPA has identified a number of potential services which could benefit from bundled pricing. IHPA seeks stakeholder feedback on whether these services would benefit from a broader bundling approach, as well as nomination of additional services that IHPA should consider for future years.

Uncomplicated maternity care

IHPA is exploring the feasibility of a bundled price for uncomplicated maternity care services, including antenatal and postnatal services and the admission for birth. Uncomplicated maternity care services are potentially amenable to bundled pricing as they follow a relatively predictable care pathway. They are also high volume services, meaning that small improvements in service delivery can result in significant savings to the health system.

IHPA has completed a baseline review of the literature which has identified potential variation in the service delivery of different jurisdictions. The Commonwealth Clinical Practice Guidelines – Antenatal Care are nationally agreed guidelines for maternity care. They recommend seven (for subsequent pregnancies) to ten (for a first pregnancy) antenatal visits for a maternity care episode. A review of public data sources has indicated that over 86 per cent of pregnant women in South Australia had seven visits or more[1] and 97 per cent had five or more in 2012.[2] However, approximately 15 per cent of women in the Australian Capital Territory had less than five antenatal visits in 2012.[2]

This data suggests that bundled pricing for uncomplicated maternity care could potentially support the implementation of the nationally agreed guidelines.

[1] SA Health (September 2014) *Pregnancy Outcome in South Australia 2012*, p.29
[2] AIHW (December 2014) *Australia's mothers and babies 2012*, p.23

Stroke

IHPA is exploring the feasibility of bundled pricing for stroke patients across the entire episode of care, including admitted acute, subacute and non-admitted settings. Strokes are amenable to bundled pricing as they are common, the care episode generally lasts for a definable period of time, and high costs offer potentially significant savings to the health system.

Due to differences in the severity of strokes, IHPA is considering bundled price weights which are weighted for complexity and notes that there are a range of issues involved in differentiating between stroke bundles.

Joint replacement

IHPA is exploring whether joint replacement (particularly for elective hip and knee replacement surgeries) is amenable to bundled pricing for care across settings (for example non-admitted pre-operative assessment, acute, subacute and follow up).

Joint replacement surgeries already represent a high volume, high cost service which is set to continue growing as the population ages, which has increased the prevalence of osteoarthritis, and with a greater expectation about improved quality of life. This growth indicates the need for a coordinated and sustainable model of service delivery, which bundled pricing may incentivise.

9.2.2 Next steps

IHPA is not proposing additional bundled price weights for NEP16. Based on feedback received from this Consultation Paper, IHPA will include a shortlist of candidate services for bundled pricing in future years in the final Pricing Framework 2016-17.

Consultation questions

- Do you support IHPA's expanded policy intention for bundled pricing in future years?
- What services or patient episodes of care would most benefit from this expanded bundled pricing approach?
- What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?

10. Pricing for safety and quality

10.1 Overview

Under Clause B12(a) of the NHRA IHPA must "have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system" in setting the NEP. The NHRA does not specify or constrain how IHPA might seek to give effect to this broad set of responsibilities. Clause B12(a) also indicates that IHPA have regard to other important policy objectives such as quality and access as it undertakes its price-setting role.

10.2 IHPA and the Commission collaboration

IHPA and the Australian Commission on Safety and Quality in Health Care (the Commission) are working in partnership to explore options for incorporating quality considerations in the NEP in the future. A Joint Working Party (JWP) of senior clinicians nominated by both organisations oversees this week.

Following work completed in late 2014 on high-priority hospital complications, the agencies are seeking to better understand how providing patient-level information to clinicians improves quality.

In 2015 the agencies will conclude a trial of the draft national set of high-priority hospital complications in four hospitals. The trial is assessing whether the draft national set which the agencies have developed is clinically meaningful, clinically useful and feasible to monitor, as well as whether the complications are appropriately captured within administrative data sets.

The JWP established a sub-committee in 2014 to investigate potential approaches to best-practice pricing and the provision of quality and safety data in Australian public hospital services, with an initial focus on the management of hip fracture patients. This work has been informed by clinicians, national and international clinical experts and a consumer representative, reviews of the literature and analyses of Australian data.

Under a best-practice pricing approach, prices are determined based on the health care provider delivering a best-practice package of services or elements of care to patients. This approach has the potential to incentivise best-practice care and if implemented, a best-practice pricing approach would augment the current approach based on the average cost of care.

The sub-committee has identified that the design and implementation of a best-practice pricing scheme should be coupled with, or preceded by, the provision of timely, relevant and comparable clinical information to clinicians, and would require reliable information on the quality of care delivered to determine eligibility for funding.

The sub-committee is now concluding its assessment of the feasibility of a best-practice pricing model for hip fracture care.

IHPA does not propose to price for safety and quality in NEP16.

Consultation questions

- If feasible, would you support a best-practice pricing approach for hip fracture care in future years?
- What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?

11. The Evaluation of the Impact of the Implementation of National Activity Based Funding for Public Hospital Services

11.1 Overview

IHPA is undertaking an evaluation of the impact of the implementation of national ABF for public hospital services. The evaluation's main objective is to understand the impacts of the national ABF system as to allow for its continuous improvement. The evaluation has two phases:

- Phase one is the development of an evaluation framework methodology and establishment of a baseline; and
- Phase two is the undertaking of the evaluation using the criteria and baseline.

Focusing on the first four years of national ABF implementation (2012-13 to 2015-16), the evaluation will assess changes arising from the implementation of ABF such as:

- Efficiency of health services (service delivery costs, activity levels);
- Efficient allocation of resources (resource usage, use of ABF as a management tool);
- Transparency of funding arrangements (publication of information);
- Sustainability of financing (information to support decision making);
- Quality, safety and appropriateness of care (quality of care indicators, length of stay, appropriateness, patient safety);
- Access to public hospital services (access to health care services including in terms of time and equity of access); and
- Identification of possible expected and unexpected incentives (changes in practices, changes in provision of care).

The evaluation will also examine its impact on data collections and the use of data.

In mid-2014 IHPA engaged an independent consortium to undertake phase one of the evaluation. Phase one is expected to be completed in late-2015.

In the draft Evaluation Framework, the consortium recommended a 'difference-in-difference' study design which has been used in other major evaluations of hospital funding arrangements in the United States of America and the United Kingdom. The approach comprises quantitative and qualitative analysis of administrative data and primary data collected from surveys, open forums and state and territory interviews.

The consortium has undertaken preliminary analysis of the baseline work to assess the applicability of the study design and to establish the baseline dataset for the evaluation. The consortium is currently finalising the Evaluation Framework and Baseline Report.

The Pricing Authority is yet to determine when Phase two will be undertaken.

It is noted that Clause 18 of the NHRA refers to a review of the NHRA in 2015-16. IHPA's proposed evaluation is separate to any review referred to in Clause 18 of the NHRA.

Consultation question

- When should IHPA undertake 'Phase two' of the evaluation of the impact of the implementation of national Activity Based Funding for public hospital services?

12. Setting the National Efficient Cost

12.1 National Efficient Cost 2016-17

IHPA announced In the Pricing Framework 2015-16 IHPA introduced new 'low volume' thresholds to determine whether a public hospital is eligible to receive block funding. IHPA considered the underlying data to be sufficiently robust to include all activity in the low volume threshold and not just the admitted acute activity.

In accordance with the NHRA, IHPA provided these new criteria to COAG for approval. Without pre-empting a decision by COAG, IHPA proceeded to implement these revised activity thresholds in NEC15.

In NEC15 IHPA also introduced a new statistical methodology for calculating a small rural block funded hospital's efficient cost based on hospital size, location and type.

These refinements to the NEC model were broadly supported by stakeholders and have improved the model's stability and predictability within and between hospital groupings, as well as across years, and will lead to greater accuracy in determining hospital eligibility for block funding from year to year.

IHPA will evaluate the impact of the Modified Monash Model remoteness classification (discussed earlier in this paper) on the NEC model. Beyond this, IHPA is not proposing any other changes for NEC16, given the significant methodological improvements made to the block funding model in NEC15.

12.2 Teaching, training and research

For NEC15, IHPA determined block funding amounts for TTR activity in ABF hospitals based on jurisdictional advice. IHPA will continue this approach in NEC16 and until such time that an ABF model is implemented for teaching and training or research.

12.3 Non-admitted mental health services

For NEC15, IHPA determined block funding amounts for non-admitted mental health activity in ABF hospitals based on jurisdictional advice. IHPA will continue this approach in NEC16 and until such time that non-admitted mental health services are incorporated into the Australian Mental Health Care Classification.