



Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24

June 2022

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Glossary

ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
COVID-19	Coronavirus disease 2019
eMR	Electronic medical record
HAC	Hospital acquired complication
HMM	Health Ministers' Meetings ¹
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11	International Classification of Diseases 11th Revision
IFR	Independent financial review
IHI	Individual Healthcare Identifier
IHPA	Independent Hospital Pricing Authority
JORDT	Jurisdictional Organ Donation, Retrieval and Transplantation Steering Committee
LHN	Local hospital network
MHPoC	Mental Health Phase of Care
NAPEDC	Non-admitted patient emergency department care
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Set
NWAU	National weighted activity unit
PPH	Potentially preventable hospitalisation
The Addendum	Addendum to the National Health Reform Agreement 2020–25
The Administrator	Administrator of the National Health Funding Pool
The Commission	Australian Commission on Safety and Quality in Health Care
UDG	Urgency Disposition Group
WHO	World Health Organisation

¹ The Health Ministers' Meetings, comprised of all Australian health ministers, has been established to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies. The Health Ministers' Meetings serves as the replacement for the Council of Australian Governments Health Council.



1

Introduction

1

Introduction

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

The Consultation Paper 2023–24 provides an opportunity for public consultation on the development and refinement of the national activity based funding (ABF) system, including policy decisions, classification systems and data collection, which will underpin the NEP and NEC Determinations for 2023–24.

1.1. IHPA's role under the Addendum

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

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

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

IHPA is also required to provide advice to all health ministers on evaluating existing and new safety and quality reforms, including ways that avoidable and preventable hospitalisations can be reduced.

This Consultation Paper outlines the policy implications of the Addendum, the work IHPA has undertaken to address requirements under the Addendum and its impact on IHPA's future work program.

1.2. Impact of COVID-19

IHPA received extensive feedback to the Consultation Paper 2022–23 and the NEP and NEC Determinations for 2022–23 regarding the short and long-term impacts on models of care and service delivery resulting from the Coronavirus disease 2019 (COVID-19) pandemic and how these changes should be accounted for in the national pricing model.

IHPA recognises that public hospital services have undergone significant change as a result of the COVID-19 pandemic response. The Consultation Paper seeks feedback on how IHPA proposes to assess the ongoing impact of COVID-19 on the activity and cost data and the potential resultant changes to the national pricing model.

1.3. Pricing aged care services

The [Federal Budget 2021–22](#) was delivered on 11 May 2021 and contained a measure in response to the [Royal Commission into Aged Care Quality and Safety](#), which would result in the expansion of IHPA, to be renamed the Independent Health and Aged Care Pricing Authority. Under this measure, IHPA will inform Australian government decisions on annual funding increases in residential aged care from 1 July 2023. IHPA will also have a role in providing advice on home aged care pricing from 1 July 2023.

This Consultation Paper will only apply to developing the NEP and NEC Determinations for Australian public hospital services in 2023–24. A separate pricing framework for pricing Australian residential aged care services will be developed and released later in 2022.

1.4. Supporting documents

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

- [*Pricing Framework for Australian Public Hospital Services 2022–23*](#)
- [*Pricing Framework for Australian Public Hospital Services 2022–23 – Consultation Report*](#)
- [*National Efficient Price Determination 2022–23*](#)
- [*National Efficient Cost Determination 2022–23*](#)

Have your say

Submissions close at 5pm AEST on **Friday 8 July 2022**.

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

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

The Pricing Framework for Australian Public Hospital Services 2023–24 will be published in December 2022, ahead of the publication of the National Efficient Price Determination 2023–24 and the National Efficient Cost Determination 2023–24 in March 2023.

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

2

Impact of COVID-19

2

Impact of COVID-19

Coronavirus disease 2019 (COVID-19) has resulted in significant and potentially long-lasting changes to models of care and service delivery in Australian public hospitals. Therefore, it is important that the impact of COVID-19 on activity and cost data is adequately accounted for in the national pricing model.

The national efficient price (NEP) underpins activity based funding for Australian public hospitals. The NEP is based on the average cost of an admitted acute episode of care provided in public hospitals during the relevant financial year. As such, developing the annual NEP Determination relies on accurate activity and cost data.

2.1. Accounting for the impact of COVID-19 on NEP22

The data underpinning a NEP Determination has a three-year time lag. The NEP Determination 2022–23 (NEP22) used costed activity data from 2019–20 which included data impacted by the COVID-19 pandemic response.

The Independent Hospital Pricing Authority's (IHPA) analysis of 2019–20 activity data showed a substantial reduction in the number of daily separations in March to June 2020 compared to the 2018–19 daily average across all states and territories, which coincided with the onset of national lockdowns and the cancellation of elective surgeries. Cost data analysis indicated that hospital expenditure remained relatively stable throughout the COVID-19 impacted period despite the significant reduction in activity.

In developing NEP22, IHPA undertook extensive consultation with the jurisdictions and adopted a set of assumptions to account for the variations in activity and cost data impacting the national pricing model over the 2019–20 period. However, IHPA acknowledges that it is not possible to definitively account for the ongoing impact that COVID-19 may have on hospital service delivery and costs in the future.

2.2. Plan to assess COVID-19 impacts on NEP23

The NEP Determination 2023–24 (NEP23) will use 2020–21 costed activity data, which includes a full financial year of data impacted by the COVID-19 pandemic response. For NEP23, IHPA will work closely with jurisdictions and key stakeholders to ensure that the national pricing model continues to reflect variations in activity and cost, and current models of care.

IHPA is developing a plan for assessing COVID-19 impacts on the 2020–21 data. The plan will set out how IHPA intends to:

- analyse each of the assumptions used in the development of NEP22
- analyse 2020–21 activity data
- quantify the ongoing COVID-19 impacts on cost data
- identify potential implications for the National Hospital Cost Data Collection.

IHPA will consult with jurisdictions in finalising the plan.

The results of these analyses will improve understanding of the impact of COVID-19 on hospital costs and activity, which will inform the development of NEP23.

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

- the potential for more complex future surgeries as non-critical surgeries were delayed and have now developed into more serious issues
- additional personal protective equipment, impact of workforce shortages and staffing to support implementation of COVID-19 safe policies and procedures.

As updated activity and cost data becomes available, these impacts will be assessed in consultation with jurisdictions and key stakeholders.



Consultation question

- Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

3

The Pricing Guidelines

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The Pricing Guidelines

3.1. The Pricing Guidelines

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

The Pricing Guidelines signal IHPA's commitment to transparency and accountability as it undertakes its work and comprise the overarching, process and system design guidelines within which IHPA makes its policy decisions.

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

IHPA has reviewed the Pricing Guidelines again in 2022 and considers that further amendments are not required at this time.

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

Figure 1: The Pricing 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 and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

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.
- **Promoting value:** Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.
- **Promoting harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **Using ABF where practicable and appropriate:** ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.
- **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 based on patient-related rather than provider-related characteristics wherever practicable.
- **Public-private neutrality:** ABF pricing should ensure that payments a local hospital network (LHN) receives for a public patient should be equal to payments made for a LHN service for a private patient.



4

Scope of public hospital services

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Scope of public hospital services

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

4.1. General List of In-Scope Public Hospital Services

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

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

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

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

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

Applications to have a service added to the General List are made as part of the annual process outlined in the General List Policy, where the Pricing Authority determines whether specific services proposed by a state or territory are ‘in-scope’ and eligible for Commonwealth funding, based on criteria and empirical evidence provided by that state or territory. These criteria are outlined in the General List Policy.

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

In May 2022, IHPA updated the General List Policy in consultation with the jurisdictions to refine the eligibility criteria that IHPA will apply when considering trials of innovative models of care and services, and the attributes of those models of care and services that would be eligible for inclusion on the General List. Further information on IHPA’s investigation of innovative funding models is outlined in Chapter 8.

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

5

Classifications used to describe and price public hospital services

5

Classifications used to describe and price public hospital services

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

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

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

- admitted acute care
- subacute and non-acute care
- emergency care
- non-admitted care
- mental health care
- teaching and training.

In the development of the *Pricing Framework for Australian Public Hospital Services 2022–23*, IHPA sought feedback on the feasibility of implementing standard development cycles for all patient service categories, in line with the three-year development cycle for the admitted acute care classifications. Stakeholders were largely supportive of this proposal and IHPA is progressing this program of work.

5.1. Admitted acute care

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

standards used to collect activity data for admitted care, which includes:

- International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI)
- Australian Coding Standards (ACS).

These are collectively known as ICD-10-AM/ACHI/ACS.

The AR-DRG and ICD-10-AM/ACHI/ACS classification systems have a three-year development cycle, to balance currency against the need for stability and to reduce the burden of implementation for stakeholders. These classifications have been developed in accordance with the [Governance Framework for the Development of the Admitted Care Classifications](#) (the Governance Framework) with relevant input from clinicians and other health sector stakeholders represented on IHPA's advisory committees.

For the NEP Determination 2022–23 (NEP22), IHPA used AR-DRG Version 10.0 and ICD-10-AM/ACHI/ACS Twelfth Edition to price admitted acute patient services.

In May 2021, IHPA consulted on the proposed updates for AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition, as outlined on the [IHPA website](#).

5.1.1 AR-DRG Version 11.0

AR-DRG Version 11.0 will be released in July 2022. AR-DRG Version 11.0 contains three new Adjacent Diagnosis Related Groups:

- B08 *Endovascular Clot Retrieval*
- F25 *Percutaneous Heart Valve Replacement with Bioprosthesis*

- G13 *Peritonectomy for Gastrointestinal Disorders*.

Some diagnosis and intervention codes in the AR-DRGs are flagged with a 'sex edit' that indicates whether the code relates to a particular biological sex. IHPA undertook a review of the sex edits in AR-DRG Version 11.0, to limit their use as a classification variable in anticipation of changes in reporting gender rather than sex nationally.

To mitigate risks associated with using sex as a classification variable, IHPA made some changes in the AR-DRG Version 11.0 supported by the development of new codes in ICD-10-AM Twelfth Edition to ensure concepts relating to reproductive systems are able to distinguish male and female reproductive organs without the use of the sex variable.

Further information about all changes in AR-DRG Version 11.0 are available in the AR-DRG Final Report on the [IHPA website](#).

For NEP23 IHPA proposes to use AR-DRG Version 11.0 to price admitted acute patient services, without a shadow pricing period. IHPA is not required to shadow price the implementation of AR-DRG Version 11.0 as it does not include major structural changes, as per the [National Pricing Model Consultation Policy](#).

5.1.2. ICD-10-AM/ACHI/ACS Twelfth Edition

ICD-10-AM/ACHI/ACS Twelfth Edition was released in March 2022 for implementation on 1 July 2022. It includes updates to the classification of sepsis, antimicrobial resistance, Coronavirus disease 2019 (COVID-19), gestational age of newborn, removal of outdated mental health terminology and simplification of ACS 0002 *Additional diagnoses*, without changing its intent. A comprehensive education program outlining the changes for Twelfth Edition was released in May 2022.

For the NEP Determination 2023–24 (NEP23) IHPA will continue to use ICD-10-AM/ACHI/ACS Twelfth Edition to price admitted acute patient services.

5.1.3. ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0

Given the admitted acute care classifications have a three-year development cycle, IHPA will commence the development of

ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 in 2022.

5.1.4. Release of ICD-11

The [11th Revision of the International Classification of Diseases](#) (ICD-11) was released by the World Health Organisation (WHO) in June 2018 and came into effect as the national and international standard for recording and reporting of causes of illness, death and other health-related cases in February 2022.

There has not yet been a decision in Australia to implement ICD-11. The Australian Institute of Health and Welfare is leading work alongside the Australian Bureau of Statistics and IHPA to inform decision making and preparations for the implementation of ICD-11 in Australia.

Previously, IHPA signalled its intention to prepare for ICD-11 by seeking to align updates incorporated for ICD-10-AM Twelfth Edition with ICD-11. In considering the next development cycle for ICD-10-AM Thirteenth Edition, IHPA will refocus some resources to ICD-11 'readiness' projects such as mapping between ICD-10-AM and ICD-11, gap analysis and implementation of clustering.

Clustering would not only leverage some of the new features of ICD-11 but would also enhance data collected using ICD-10-AM through the Admitted patient care National Minimum Data Set. This work will be informed by IHPA's classification working groups and advisory committees.

5.1.5. Streamlining clinical and technical input

Public submissions are received from stakeholders for enhancements or modifications to the classifications and standards used in admitted acute care through the Australian Classification Exchange (ACE) portal on the [IHPA website](#). The public submission process provides ongoing opportunities to propose updates to the AR-DRGs and ICD-10-AM/ACHI/ACS classification systems to ensure they meet the needs of users and continue to be comprehensive and meaningful. These public submissions are reviewed in each development cycle to inform the work programs of the next editions or versions of the admitted care classifications.

In August 2019, IHPA commissioned a review to evaluate the end-to-end processes of the development of the admitted care classifications.

The review identified the need for a principles-based approach to guide the classification development cycle to ensure the classifications are responsive to the needs of the Australian health care system. These principles were developed in consultation with stakeholders and resulted in the Governance Framework.

IHPA intends to redevelop the ACE portal to align with the principles outlined in the Governance Framework, including the requirement for robust evidence for change requests, and greater transparency for stakeholders by displaying the stage and outcome of a submission. These improvements will streamline and quality assure public submissions received in the future.

In the interim, IHPA plans to review and assess existing public submissions against the principles in the Governance Framework, including evaluating public submissions against developments made in the WHO's ICD-11.



Consultation questions

- Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?
- Do you support IHPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation? Please provide suggestions for any specific 'readiness' projects you would like to see progressed.

5.2. Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services.

For NEP22, IHPA used AN-SNAP Version 4.0 to price admitted subacute and non-acute services and AN-SNAP Version 5.0 to shadow price admitted subacute and non-acute services.

5.2.1. AN-SNAP Version 5.0

AN-SNAP Version 5.0 was released in December 2021 and has been developed through extensive statistical analysis and consultation with jurisdictions, clinicians and other experts.

AN-SNAP Version 5.0 represents a modest refinement of AN-SNAP Version 4.0.

The most significant change is a proposal to recognise frailty as a cost driver for subacute care by incorporating the Frailty Related Index of Comorbidities into the classification for geriatric evaluation and management and non-acute episodes of care. In addition, a new impairment type group for joint replacement (shoulder, hip and knee) episodes in the rehabilitation branch has been added, and some existing variables in the classification have been reordered or expanded, including the use of the Health of the Nation Outcome Scales 65+.

As there is minimal change between AN-SNAP Version 4.0 and AN-SNAP Version 5.0, IHPA proposes to progress to pricing admitted subacute and non-acute services using AN-SNAP Version 5.0 for NEP23, following one year of shadow pricing.



Consultation question

- Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?

5.3. Emergency care

For NEP22, IHPA used the Australian Emergency Care Classification (AECC) Version 1.0 to price emergency department activities and Urgency Disposition Groups (UDGs) Version 1.3 to price emergency services.

IHPA is continuing to investigate future refinements of the AECC, including the collection of potential new variables, such as procedures and investigations performed in emergency departments, as well as telehealth delivered as part of emergency care. IHPA intends to work with stakeholders to better understand the feasibility of reporting for these items prior to inclusion in national collections for 2023–24.

IHPA will continue to use AECC Version 1.0 to price emergency department activities for NEP23.

5.3.1. Considering the use of AECC for emergency services

In 2021, IHPA redeveloped the Emergency service care National Best Endeavours Data Set to support patient level reporting for patients

registered for care in emergency services. This will enable the consistent reporting of emergency services from 1 July 2022, to align with future national strategies.

IHPA will continue to use UDGs Version 1.3 to price emergency services for NEP23 and will work with states and territories to determine the feasibility of transitioning emergency services to be priced using the AECC in the future.

5.4. Non-admitted care

5.4.1. Tier 2 Non-Admitted Services Classification

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

For NEP22, IHPA used Tier 2 Version 7.0 to price non-admitted services.

IHPA is committed to undertaking maintenance work to ensure relevancy of Tier 2 for ABF purposes while a new non-admitted care classification is being developed. IHPA has consulted with jurisdictions and stakeholders via its advisory committees on additional refinements that could be made to Tier 2. Proposed refinements include additional Tier 2 classes to better capture violence, abuse and neglect services, exercise physiology services, genetics services and long COVID-19. IHPA will continue to work with stakeholders on the proposed refinements for inclusion in Tier 2 for 2023–24.

For NEP23, intends to continue using Tier 2 to price non-admitted services. The inclusion of any of the proposed refinements may result in the development of a new version of Tier 2. IHPA will consider the suitability for pricing or shadow pricing any new classes in Tier 2 in the development of NEP23.

5.4.2. A new non-admitted care classification

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

The new non-admitted care classification will also

better account for changes in care delivery as services transition to the non-admitted setting, as new electronic medical records (eMRs) allow for more detailed data capture.

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

Stakeholder feedback received to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23* outlined support to recommence the costing study to further progress the development of a new non-admitted care classification.

States and territories have made substantial progress in digitalising health information and implementing eMRs. This provides an opportunity to utilise the significant amount of valuable unstructured data that currently exists within jurisdictional administrative and clinical systems.

IHPA proposes a multi-staged plan to investigate the feasibility of recommencing the costing study which consists of consultation and development of a proof-of-concept and leveraging non-admitted service activity data from jurisdictional eMR systems. This approach would enable the costing study to recommence with a lower impact on clinical service delivery.

IHPA will work with jurisdictions and other key stakeholders on the feasibility of this approach prior to finalisation.

5.5. Mental health care

5.5.1. Mental Health Phase of Care

In July 2021, IHPA published the [*Mental Health Phase of Care Clinical Refinement Project Final Report*](#), which outlined the key findings of the project and recommendations to refine Mental Health Phase of Care (MHPoC) definitions within the Australia Mental Health Care Classification (AMHCC), in order to improve the consistency with which clinicians apply phase of care.

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

MHPoC phase names and definitions in order to improve reliability and clinical meaningfulness. At the conclusion of the project, a decision was made in consultation with the jurisdictions to retain the current MHPoC concept.

A minor update to the Acute MHPoC definition was approved by jurisdictions to align with the clinical reality. Assessment Only changed to a data item based on the clinical feedback that the standalone nature of the activity was different to the other MHPoC in which consumers continue to move through. Education materials are being developed as a project recommendation to further assist with training and improving the consistency of ratings.

5.5.2. Admitted mental health care

For NEP22, IHPA priced admitted mental health care using the AMHCC Version 1.0. This decision followed the completion of a two-year shadow pricing period, assessment of the quality and coverage of admitted mental health data, and consultation with jurisdictions.

For NEP23, IHPA intends to continue to price admitted mental health care using AMHCC Version 1.0.

5.5.3. Community mental health care

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

For 2022–23, community mental health care was block funded as part of the NEC Determination 2022–23 while a second year of shadow pricing is undertaken using AMHCC Version 1.0.

In NEP22, a new pricing model structure was introduced, based on the number of service contacts within a MHPoC. The service contact cost model has significantly better statistical performance in predicting cost variation for community mental health care. It also aims to mitigate the risks of potentially incentivising under-servicing in community mental health care by ensuring that phases with more consumer care activities receive a higher modelled cost than comparable phases with fewer service

contacts. IHPA will review the stability and performance of this model using 2020–21 costed activity data.

After two years of shadow pricing in 2021–22 and 2022–23 as required under the Addendum to the National Health Reform Agreement 2020–25, IHPA proposes to progress to pricing community mental health care using AMHCC Version 1.0 for NEP23.



Consultation question

- Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

5.6. Teaching and training

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

For the NEC Determination 2023–24, IHPA will continue to determine block funding amounts for teaching, training and research activity based on advice from states and territories, and will continue to work with stakeholders to improve data quality.

6

Setting the national efficient price

Setting the national efficient price

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

The [Pricing Framework for Australian Public Hospital Services 2022–23](#) noted that ensuring that the national pricing model adequately accounts for the impact of the Coronavirus disease 2019 (COVID-19) pandemic is the highest priority. As such, IHPA prioritised the investigation of refinements to the pricing model to account for COVID-19 in the development of the NEP Determination 2022–23 (NEP22) and this impacted IHPA’s capacity to undertake other initiatives to refine the national pricing model.

6.1. National pricing model

IHPA has developed a robust pricing model that underpins the annual determination of the NEP, price weights and adjustments, based on the activity and cost data from three years prior. The national pricing model is described in more detail in the [National Pricing Model Technical Specifications 2022–23](#).

For NEP22, IHPA included an adjustment to reflect increases in the superannuation guarantee, as these costs were not in the 2019–20 cost data used to develop NEP22.

Stakeholders have advised that there may be new cost input pressures for 2023–24 that may have an impact on the national pricing model. For the development of the NEP Determination 2023–24 (NEP23), IHPA will consider additional cost input pressures supported by evidence, and that are not reflected in the National Hospital Cost Data Collection (NHCCDC).

IHPA will also investigate the criteria for assessing specialist paediatric hospitals.

6.2. Adjustments to the national efficient price

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

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

In 2021, IHPA outlined its intention to investigate the need to review or assess the following adjustments, based on feedback from stakeholders:

- reinvestigation of an adjustment for patient transport in rural areas
- review of the Specified Intensive Care Unit eligibility criteria and adjustment
- review of the Indigenous adjustment
- consideration of a new adjustment for genetic services
- consideration of a new adjustment for socioeconomic status.

Due to the impact of COVID-19, IHPA deferred investigation of the proposed adjustments for NEP22 to focus on refinements to the pricing model to account for the impact of COVID-19.

IHPA will review 2020–21 activity and cost data to determine whether sufficient data is available to progress investigation of these proposed adjustments, recognising the impact of COVID-19 during this period.



Consultation questions

- Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?
- What cost input pressures that may have an impact on the national pricing model and are not included in the NHCCDC should be considered in the development of NEP23?

6.3. Harmonising price weights across care settings

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

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

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

For NEP22, IHPA did not progress price harmonisation due to the impact of COVID-19 on 2019–20 activity and cost data.

For NEP23, IHPA will review 2020–21 activity and cost data to determine whether sufficient data is available to progress investigation of price harmonisation, recognising the impact of COVID-19 during this period.

6.4. Unqualified newborns

IHPA has received feedback from stakeholders detailing concerns around how unqualified newborns are currently accounted for in the national pricing model. A newborn qualification status is assigned to each patient day within a

newborn episode of care and a newborn patient day is considered qualified if the infant meets at least one of the following criteria:

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

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

Some stakeholders have advised that the current approach to pricing newborn episodes of care does not reflect increased care being provided to newborns outside of the intensive care unit setting. Stakeholders suggested costs associated with both qualified and unqualified newborns should be assigned to separate DRG prices, independent of the mother's admitted episode.

For NEP22, IHPA proposed to investigate the current funding model around unqualified newborns and explore how the national pricing model accounts for unqualified newborns. IHPA deferred this work to focus on refinements to the national pricing model to account for the impact of COVID-19.

For NEP23, IHPA will review 2020–21 activity and cost data to determine whether sufficient data is available to progress investigation of how costs of unqualified newborns are accounted for in the national pricing model. The criteria for determining qualification status which is set out in legislation would be considered out of scope for this review.

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

The Addendum includes parameters around how funding for private patients in public hospitals should be considered, specifically that IHPA will adjust the price for privately insured patients in

public hospitals to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction, taking into account all hospital revenues.

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

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

Since the NEP Determination 2021–22 (NEP21), IHPA has implemented a private patient methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public. This updated approach involves calculating state-specific Private Patient Service Adjustments prospectively and reconciliation of state funding for public and private patients by the Administrator of the National Health Funding Pool.

IHPA proposes to adopt the same methodology for NEP23.

6.5.1. Phasing out the private patient correction factor

The collection of private patient medical expenses has previously been problematic in the NHCDC. For example, some states and territories use Special Purpose Funds to collect associated revenue (for example, the Medicare Benefits Schedule) and reimburse medical practitioners.

The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the NHCDC. The implementation of the Australian Hospital Patient Costing Standards Version 4.0 should have addressed the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required.

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

IHPA will assess 2020–21 cost data and continue to consult with the other states and territories on

phasing out the private patient correction factor.

6.6. Organ donation, retrieval and transplantation

In 2018, the Review of the Australian organ donation, retrieval and transplantation system – Final Report (the Final Report) made two recommendations related to IHPA:

- Recommendation 52: IHPA conduct a costing study and classification review for the classification of organ donation, retrieval and transplantation to take into account the cost impact of the use of donation after circulatory death donated organs and organs from extended criteria donors and to appropriately attribute retrieval costs.
- Recommendation 54: IHPA conduct a costing study and classification review for the classification of non-admitted pre and post organ transplantation care.

The Jurisdictional Organ Donation, Retrieval and Transplantation Steering Committee (JODRT) was established to consider the findings and recommendations from the Final Report, and to develop a National Strategy for Organ Donation, Retrieval and Transplantation (the Strategy). The Strategy is due to be released in 2022 for consultation.

Due to the impact of COVID-19 and the ongoing development of the Strategy, IHPA deferred reviewing the current activity data collection and costing arrangements for organ donation, retrieval and transplantation, and non-admitted pre and post organ transplantation care.

IHPA will work with jurisdictions and the JODRT to consider whether there is capacity to undertake further work to review the classification of organ donation, retrieval and transplantation, and activity and cost data sets.



Consultation questions

- Which initiatives to refine the national pricing model should IHPA prioritise investigating?
- What additional data sources are available to support refinement of the national pricing model in relation to adjustments, price harmonisation, unqualified newborns, private patients or organ donation?



7

Setting the national efficient cost

7

Setting the national efficient cost

7.1. Overview

The Independent Hospital Pricing Authority (IHPA) developed the national efficient cost (NEC) for services that are not suitable for activity based funding (ABF), as provided by the Addendum to the National Health Reform Agreement (NHRA) 2020–25 (the Addendum). Such services include small rural hospitals, which are funded by a block allocation based on their size, location and the type of services provided.

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

Stakeholders have advised that there has been an increase in in-reach models of care that have been established in some regional hospitals whereby clinicians in metropolitan hospitals provide or assist local staff to provide services via telehealth. This approach, which enables block-funded hospitals to undertake greater activity in situ rather than transferring patients to metropolitan hospitals, is intended to alleviate pressure on metropolitan hospitals including bed availability, arising from the Coronavirus disease 2019 (COVID-19) response. IHPA will consider how additional cost pressures on regional hospitals as a result of responses to COVID-19 are taken into account in the national pricing model.

7.2. The ‘fixed-plus-variable’ model

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

For the NEC Determination 2020–21, IHPA

introduced the ‘fixed-plus-variable’ model where the total modelled cost of each hospital is based on a fixed component as well as a variable ABF style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.

IHPA will continue to use the ‘fixed-plus-variable’ model for the NEC Determination 2023–24 (NEC23).

7.2.1. Standalone hospitals providing specialist mental health services

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

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

IHPA introduced pricing admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0 for the National Efficient Price (NEP) Determination 2022–23. IHPA is proposing to price community mental health care using AMHCC Version 1.0 for the NEP Determination 2023–24.

IHPA will work with jurisdictions to investigate the feasibility of transitioning standalone hospitals providing specialist mental health services to ABF in the development of NEC23.

7.3. Quality assurance of public health expenditure data

IHPA uses public hospital expenditure as reported in the National Public Hospital Establishments Database to determine the NEC for block funded hospitals. IHPA is exploring the

development of an independent quality assurance process for the public health expenditure included in Local Hospital Networks and Public Hospital Establishments National Minimum Data Set.

This process will help to ensure high quality input data for cost modelling for the NEC Determination is maintained and aligns with the quality assurance process adopted to inform the NEP Determinations. Each year, IHPA commissions an independent financial review (IFR) to assess whether all participating hospitals have included appropriate costs and patient activity in the National Hospital Cost Data Collection (NHCDC) which is used to calculate the NEP. The IFR also provides recommendations for IHPA and the jurisdictions to consider with the aim of improving the consistency and transparency of the NHCDC submissions and to ensure the NHCDC is robust and fit for purpose.

IHPA expects that continued improvements to the data collection will lead to greater accuracy in reflecting the services and activities undertaken by block funded hospitals. IHPA will work with its advisory committees to refine and progress the new quality assurance process.

Consultation questions

- What cost pressures for regional or remote hospitals should be considered in the development of NEC23?
- What specific areas of the Local Hospital Networks and Public Hospital Establishments National Minimum Data Set would you recommend IHPA focus on when developing its independent quality assurance process?
- What should IHPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?

7.4. New high cost, highly specialised therapies

The annual NEC Determination includes block funded costs for the delivery of high cost, highly specialised therapies, as provided by clauses C11–C12 of the Addendum. These clauses

contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee.

For 2023–24, the following high cost, highly specialised therapies have been recommended for delivery in public hospitals based on advice from the Commonwealth:

- Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah® or Yescarta® – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Qarziba® – for the treatment of high-risk neuroblastoma
- Luxturna™ – for the treatment of inherited retinal dystrophies
- Tecartus® – for the treatment of relapsed or refractory mantle cell lymphoma.

The indicative block funded costs for the delivery of these high cost, highly specialised therapies based on the advice of states and territories will be included in NEC23.

Although IHPA does not play a role in the health technology assessment process or funding decisions for the high cost, highly specialised therapies, the [Impact of New Health Technology Framework](#) outlines the process by which IHPA receives submissions for and reviews the impact of new health technologies on the existing classifications to ensure they are accurately accounted for in the pricing of public hospital services.

IHPA is currently undertaking a comprehensive review of the *Impact of New Health Technology Framework*. In response to previous feedback from jurisdictions and other key stakeholders, IHPA will expand the scope of the *Impact of New Health Technology Framework* to shift away from being focused on the assessment of new health technologies in the admitted patient setting. The updated *Impact of New Health Technology Framework* will also include a streamlined process for the timely assessment of new health technologies and outlines the classification development mechanisms and impact of new health technologies on all patient service categories.

8

Future funding models

8.1. Overview

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

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

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

Under the Addendum, IHPA is required to develop a methodology to support the trialling of innovative models of care and provide advice to the Health Ministers' Meetings (HMM) on continuing proposed trials for a further period or translation into a permanent model of care.

8.2. Investigation of alternate funding models

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

For patients with conditions that lead to frequent use of hospitals (and other services) over an extended time period, capitation payments may work better than current ABF arrangements. That is, ABF may incentivise admitting patients to a

hospital rather than aim to prevent hospitalisation. Preventing hospitalisations often requires alternative treatments and services which can lead to better health outcomes, reduced costs and an improved patient experience.

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

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

Bundling and capitation payment models provide better incentives for the management of patients with chronic health conditions beyond the hospital setting, thereby reducing preventable hospital admissions for those chronic condition groups.

Guided by review of national and international literature and advice from clinical experts, IHPA developed a methodology which identified different patient cohorts that may be amenable to ABF, bundling or capitation payments. IHPA provided these findings as part of the joint advice on behalf of IHPA, the Australian Commission on Safety and Quality in Health Care and the Administrator of the National Health Funding Pool to HMM for consideration in October 2021.

IHPA will continue to work with stakeholders and jurisdictions to investigate options for further developing and implementing alternate funding models.

8.3. Trialling innovative models of care

As provided by the Addendum, IHPA is to

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

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

Consistent with feedback received from states and territories to the [Consultation Paper on Pricing Framework for Australian Public Hospital Services 2022–23](#), IHPA notes the preference for states and territories to nominate their own models of care or services for consideration under the innovative funding model clauses of the Addendum, rather than specific models of care or services determined by IHPA.

States and territories have expressed interest in innovative funding models such as chronic care capitation models, bundled payment cohorts, the use of telehealth in patient settings such as emergency departments, specialist access programs and mental health responder programs.

To assist the states and territories, IHPA has developed draft business rules for a capitation model for chronic kidney disease, Stage 3 to 5, in consultation with its advisory committees. The draft business rules aim to demonstrate a specific chronic care capitation model and provide guidance to states and territories on the types of innovative funding models being considered by IHPA, and potential project requirements and trial parameters.

IHPA is also investigating innovative models of care and services related to virtual care with an initial focus on telehealth video consultations delivered by emergency departments.

Telehealth video consultations in emergency departments provide an equivalent to face-to-face consultation, in the presence of a clinician, where it is not possible for the patient to be physically present at the emergency department. For example, the patient may be in a residential aged care facility or a regional urgent care centre.

This model of care reduces unnecessary transfers to emergency departments, enables patients to be managed closer to home or in the home and supports rural patients where an emergency department is not close by. It also

supports clinicians at urgent care centres where access to a doctor is not always readily available.

The Pricing Authority approved the inclusion of telehealth video consultations delivered by emergency departments on the General List of In-Scope Public Hospital Services 2022–23. At present, telehealth activity is not collected in the Non-admitted patient emergency department care (NAPEDC) National Minimum Data Set (NMDS), as only physical emergency department presentations are considered in-scope.

IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24.

Other examples of virtual care models include remote monitoring of COVID-19 positive patients or patients with chronic conditions in their own homes to help them self-manage or providing specialist consultations virtually to people living in rural and remote areas to address the gap in the availability of specialist services in these areas and minimise the need for patient travel.

As part of the program of work to trial innovative models of care, IHPA will consult and engage with the National Health Reform Agreement Reform Implementation Group, as well as the jurisdictions, to facilitate the development of broader trial principles and guidelines. These would be intended for the jurisdictions and IHPA to apply in considering proposals of innovative funding models by the states and territories for trial under bilateral agreements with the Commonwealth.



Consultation questions

- How is virtual care delivery captured in information systems and data collections?
- IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?
- What changes, if any, to the national pricing model should IHPA consider to account for innovative models of care and services related to virtual care?



9

Pricing and funding for safety and quality

Pricing and funding for safety and quality

9.1. Overview

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

Under the Addendum, IHPA is required to implement:

- an approach whereby any episode of care that includes a sentinel event, across all care settings, will not be funded in its entirety;
- an approach whereby all hospital acquired complications (HACs) across every public hospital will have a reduced funding level to reflect the extra cost of a hospital admission with a HAC and will be risk adjusted; and
- a pricing and funding approach for avoidable hospital readmissions related to a prior HAC, based on a set of definitions developed by the Commission.

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

9.2. Sentinel events

Sentinel events are defined by the Commission as a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

Since 1 July 2017, IHPA has specified that an episode of care including a sentinel event will be assigned a national weighted activity unit (NWAU) of zero. This approach is applied to all hospitals, whether funded on an activity or block funded basis.

As per the Addendum (clauses A165–A166), IHPA will continue to apply this funding adjustment for episodes with a sentinel event for the NEP Determination 2023–24 (NEP23) using Version 2.0 of the Australian Sentinel Events List published on the [Commission's website](#).

9.3. Hospital acquired complications

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

The funding adjustment for HACs reduces funding for any episode of admitted acute care where a HAC occurs. This approach incorporates a risk adjustment model and recognises that the presence of a HAC increases the complexity of an episode of care or the length of stay, driving an increase in the cost of care.

Further information on the HACs funding approach is included in the [NEP Determination 2022–23](#) and the [National Pricing Model Technical Specifications 2022–23](#).

The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant.

For NEP23, IHPA will use Version 3.1 of the HACs list on the [Commission's website](#) to implement the HACs funding adjustment.

9.4. Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission.

An avoidable hospital readmission occurs when a patient who has been discharged from hospital (the index admission) is admitted again within a certain time interval (the readmission), and the readmission is clinically related to the index

admission and has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

From 1 July 2021, IHPA has implemented a funding adjustment for avoidable hospital readmissions and involves the application of a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode, to apply where there is a readmission to any hospital within the same jurisdiction.

IHPA developed a discrete risk adjustment model for each readmission condition, which assigns the risk of being readmitted for each episode of care.

Further information on the avoidable hospital readmissions funding approach is included in the [NEP Determination 2022–23](#), and the [National Pricing Model Technical Specifications 2022–23](#).

For NEP23, IHPA will use Version 1.0 of the avoidable hospital readmissions list on the [Commission's website](#) to implement the avoidable hospital readmissions funding adjustment.

9.5. Evaluation of safety and quality reforms

Clause A174 of the Addendum stipulates that IHPA, the Commission and the Administrator of the National Health Funding Pool (the Administrator) (the national bodies) will work with jurisdictions, and other related stakeholders to establish a framework to evaluate safety and quality reforms against the following principles:

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

IHPA led the development of a proposed approach to evaluate the implemented safety and quality reforms for sentinel events, HACs and avoidable hospital readmissions. This was provided to the Health Ministers' Meetings (HMM) for consideration in October 2021 as part of the joint advice from the national bodies.

9.6. Avoidable and preventable hospitalisations

The Addendum also requires the national bodies to provide advice to HMM on options for the further development of safety and quality-related reforms, including examining ways that avoidable and preventable hospitalisations can be reduced.

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

The Commission's [Fourth Australian Atlas of Healthcare Variation](#) (the Fourth Atlas) identifies that in 2017–18, more than 330,000 PPHs could be attributed to five condition groups: chronic obstructive pulmonary disease, heart failure, diabetes complications, kidney infections and urinary tract infections, and cellulitis.

IHPA contributed to the development of advice on options for further safety and quality-related reforms and ways that avoidable and preventable hospitalisations can be reduced through changes to the Addendum. The advice was provided from the national bodies to the HMM for consideration in October 2021. IHPA will consider feedback and directives from HMM before further progressing this program of work.

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