Pricing Framework for Australian Public Hospital Services 2022–23

Consultation Report

December 2021

Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2022–23 – Consultation Report – December 2021

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1 Introduction

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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.

IHPA conducted a public consultation on key issues to be included in the Pricing Framework 2022–23 through the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23* (the Consultation Paper). The consultation period ran from 9 June 2021 to 9 July 2021 and invited submissions from the Commonwealth, state and territory health departments, professional health organisations, private industry and other interested members of the Australian public.

IHPA received 25 submissions to the Consultation Paper from a diverse range of stakeholders. Key themes arising from the consultation feedback are summarised in this report, corresponding with the chapters in the Pricing Framework. This stakeholder feedback has informed the development of the Pricing Framework, including the decisions that underpin the NEP and NEC Determinations for 2022–23.

IHPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. The key decisions for the NEP and NEC Determinations for 2022–23 are outlined in the Pricing Framework 2022–23.

All submissions have been made available on the IHPA website, unless they were marked confidential due to commercial or other reasons.

2 Impact of COVID-19

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Consultation question

- What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?

Feedback received

Jurisdictions and broader stakeholders were supportive of the Independent Hospital Pricing Authority's (IHPA) proposed approach to assess and account for the impact of Coronavirus Disease 2019 (COVID-19) on the National Efficient Price Determination 2022–23 (NEP22), and recommended consideration of the following areas to inform potential pricing model refinements:

- consider the use of 2018–19 data where 2019–20 data is not adequately robust
- undertake separate analysis for activity based funding and block-funded facilities
- account for the differing impact of COVID-19 across individual states and territories
- consider the implementation of a COVID-19 adjustment or an additional back-casting multiplier
- source additional data from current records such as elective surgery waitlists.

Stakeholders noted that NEP22 would need to account for changes to in-scope activity, volume and casemix (such as reductions in elective surgeries and changing patterns in emergency department presentations), changes to models of care (including increased use and demand for telehealth and hospital-in-the-home services), and ongoing COVID-19 related costs (for example, to comply with COVID-19 safety requirements and to address the more complex health needs of patients with delayed treatment).

IHPA's response

IHPA has finalised the collection of cost and activity data for 2019–20 and undertaken consultation with the jurisdictions through its advisory committees and across a series of COVID-19 workshops in July and September 2021. IHPA's analysis has indicated that although there were significant increases in reported cost per National Weighted Activity Unit and in-scope cost across admitted acute and emergency department activities, the relative costs between classification end-classes have remained reasonably stable. IHPA continues to work with jurisdictions to account for the period impacted by the COVID-19 pandemic.

Increased activity under new and emerging models of care has also been reported. IHPA notes that some of these models of care, such as telehealth and hospital-in-the-home, are already priced under the existing national pricing model. The increased demand and any additional costs associated with delivering these services will be evaluated to ensure that they are captured and priced appropriately.

Stakeholders noted that the varying impact of COVID-19 across states and territories will need to be considered for NEP22, particularly for those with prolonged lockdowns or those impacted as early as 2019. IHPA is working with jurisdictions to ensure that variations in service delivery, volume, casemix and cost are taken into account in refining the national pricing model for NEP22.

IHPA acknowledges the financial and resource impacts on jurisdictions arising from the COVID-19 response, as well as significant variations in data reporting. Ensuring that the pricing model adequately accounts for COVID-19 impacts is IHPA's highest priority.

In the development of NEP22, IHPA will also ensure that any implications from the *National Partnership on COVID-19 Response* and subsequent announcements by National Cabinet concerning public hospital funding arrangements are considered.

Consultation question

- Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

Feedback received

Stakeholders provided a number of considerations in accounting for system changes as a result of COVID-19 in the coming years, including:

- addressing increased patient complexity due to delayed care resulting from suspended elective surgeries, reduced emergency department presentations, decreased health screenings and delayed access to rehabilitation services
- addressing the complications or chronic conditions arising from patients exposed to COVID-19
- remaining responsive to the long term or permanent impact of COVID-19 on costs
- reviewing new and emerging models of care to ensure that pricing accurately reflects the resources required to deliver care.

New South Wales (NSW) noted that IHPA needs to ensure that costing standards and costing data can identify COVID-19 related costs specifically.

The Australian Medical Association (AMA) recommended that suspended elective surgeries during the impacted periods should be eligible for the National Partnership on COVID-19 Response agreement and the 50:50 COVID-19 cost share arrangements.

The Australasian College for Emergency Medicine (ACEM) noted the need to consider the ongoing mental health impacts of the pandemic and increased drug and alcohol use on future emergency department presentations.

IHPA's response

IHPA will review updated cost and activity data as it becomes available to ensure that long term or permanent impacts of COVID-19 on costs and changing models of care are accounted for in the national pricing model for future determinations.

The impacts of COVID-19 on patient complexity due to delayed treatment or the yet unknown longer term complications or chronic conditions arising from patients exposed to COVID-19 will also be assessed as updated data is received.

3 The Pricing Guidelines

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The Independent Hospital Pricing Authority (IHPA) did not ask any specific consultation questions on the Pricing Guidelines but received feedback from a small number of stakeholders.

Feedback received

Victoria (Vic) noted that there may be opportunity for the Pricing Guidelines to be consolidated, particularly in consideration of the role of activity based funding (ABF) in the development of innovative models of care and funding approaches.

The Northern Territory (NT) recommended the introduction of a new system design guideline, '**Promoting equitable access:** Pricing should support funding solutions that facilitate equitable access to healthcare', to address inequities in health status and access for disadvantaged groups.

Tasmania (Tas) requested that the **ABF pre-eminence** guideline is updated to reflect the requirement of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) for ABF to be not only practical, but also appropriate.

IHPA's response

In 2020, IHPA undertook a comprehensive review of the Pricing Guidelines in light of the Addendum. The **ABF pre-eminence**, **Patient-based** and **Public-private neutrality** guidelines were updated to reflect changes arising from the Addendum and stakeholder feedback.

IHPA has undertaken detailed consideration of the feedback from Vic in addressing the role of ABF and the incorporation of innovative models of care and funding approaches. IHPA considers that no further amendments are required at this time as the Pricing Guidelines provide adequate flexibility for the development and implementation of new and innovative funding approaches.

As this work evolves, IHPA will further consider the Pricing Guidelines to ensure they accommodate the introduction of innovative funding approaches and reflect the policy intent of the Addendum.

In response to NT's recommendation for the introduction of a new guideline, IHPA notes that the existing guidelines adequately promote equitable access to health care within IHPA's remit of pricing public hospital services.

In response to the request from Tas, IHPA notes that the **ABF pre-eminence** guideline stipulates that ABF should be 'compatible with delivering value in both outcomes and cost', which provides an adequate signal for appropriateness of use.

4 Scope of public hospital services

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The Independent Hospital Pricing Authority (IHPA) did not ask any specific consultation questions on the scope of public hospital services but received feedback from a small number of stakeholders.

Feedback received

NSW supported further revisions to the General List of In-Scope Public Hospital Services (the General List) criteria to support innovative funding approaches that deliver efficient, high quality, patient centred care.

Vic noted that the scope of the General List needs to be reviewed to ensure that it reflects the changes in the provision of services introduced during Coronavirus Disease 2019 and supports the funding of services in all settings.

IHPA's response

In July 2021, following consultation with all jurisdictions, IHPA finalised and published the latest version of the *General List of In-Scope Public Hospital Services Eligibility Policy* (the General List Policy). The updated General List Policy incorporates expanded criteria to support innovative models of care and services delivered outside of the hospital setting.

IHPA will consider further refinements to the General List Policy as part of its annual review process.

5 Classifications used to describe and price public hospital services

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Standard development cycles for all classifications

Consultation questions

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

Feedback received

Stakeholders supported the establishment of standard development cycles for all classification systems to ensure classification currency, provide greater certainty for the timing of new versions and assist jurisdictions in planning for implementation costs and education programs.

Stakeholders were also supportive of a three-year development cycle and the minimum set of measures developed by the Independent Hospital Pricing Authority (IHPA).

Additional recommendations included:

- flexibility within the development cycles to allow for urgent or unexpected updates
- staggered implementation of admitted and non-admitted classification changes across separate years
- shorter initial stabilisation and review periods for new classifications
- consideration of a 12 to 18 month standard development cycle in line with IHPA's assessment of new health technologies
- incorporation of clinician consultation and user acceptance testing into developing a minimum set of measures
- reviewing the potential impact of changes to coding practices.

IHPA's response

IHPA notes the broad stakeholder support for the establishment of standard development cycles and the feedback regarding preferred development cycle lengths and standard development measures.

IHPA notes that with the introduction of the Australian Classification of Health Interventions (ACHI) Twelfth Edition from July 2022, placeholder codes will enable the mid-cycle capture of new health technology.

IHPA will work with jurisdictions and broader stakeholders to consider the next steps for implementing standard development cycles for all classifications.

Admitted acute care

IHPA did not ask any specific consultation questions on the admitted acute care classifications but received feedback from a small number of stakeholders.

Feedback received

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

NT requested that IHPA prepare a Statement of Impact, as required under the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), to assess the funding impacts of introducing the Australian Refined Diagnosis Related Group (AR-DRG) classification Version 11.0 for the National Efficient Price (NEP) Determination 2023–24 (NEP23).

Enhancing education materials

NSW noted that the availability of comprehensive education and training materials is critical to enable a standardised approach to content and delivery of education.

Older versions of AR-DRGs

NSW supported phasing out older versions of AR-DRGs, however suggested retaining support for a minimum of two prior versions to ensure continuity for research and minimise the financial burden of change.

Catholic Health Australia (CHA) noted concerns with the previously proposed timeframes and suggested that as some health fund contracts cover a three-year period, all older versions of AR-DRGs should be supported for at least five years to allow providers and health funds sufficient time to update funding models and contracts.

ICD-11 preparedness

NSW noted that the International Classification of Diseases 11th Revision (ICD-11) represents a major change compared to the previous version of the classification and would require a more definitive timeframe and implementation plan for its introduction, given the potential burden and cost for jurisdictions.

IHPA's response

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

IHPA notes the request from NT for the provision of a Statement of Impact for introducing AR-DRG Version 11.0 without shadow pricing for NEP23. IHPA will undertake impact analysis and prepare a Statement of Impact for consultation with the jurisdictions, as outlined in the *Alterations to the National Pricing Model Framework* (the Alterations Framework), for pricing AR-DRG Version 11.0 for NEP23.

Enhancing education materials

IHPA notes the importance of comprehensive and accessible education and training materials and will continue to work with stakeholders to develop a centralised online educational program for new versions of the admitted acute care classifications.

Older versions of AR-DRGs

IHPA notes the recommendations from NSW and CHA to retain support for a minimum number of prior AR-DRG versions. IHPA has worked extensively with private health sector stakeholders to discuss the timeframes and implications of withdrawing support for older versions of the AR-DRG classification.

Cost reports using AR-DRG Version 10.0 are available on the IHPA website and IHPA recommends that all new agreements between private hospitals and insurers use AR-DRG Version 10.0.

ICD-11 preparedness

IHPA notes NSW's concerns regarding the implementation of ICD-11 in Australia. IHPA notes that any decision to move to ICD-11 will be a joint government decision, as will the broad framework for infrastructure changes and educational requirements as part of that transition.

IHPA is working to conduct a gap analysis that includes mapping the International Statistical Classification for Diseases and Health Related Problems, Tenth Revision, Australian Modification to ICD-11. Further work will involve considering the impact of ICD-11 on AR-DRGs, determining the new features of ICD-11 that may be useful in AR-DRGs and assessing what would be required to ensure compatibility between the two classification systems.

Subacute and non-acute care

Consultation question

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

Feedback received

NSW, Vic, South Australia (SA), NT and CHA recommended a shadow pricing period for the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 in line with clause A42 of the Addendum, to assess the funding impacts and address any issues prior to implementation.

Queensland (Qld) and Tas supported the introduction of a frailty measure for geriatric evaluation and management and non-acute episodes of care. Qld was also supportive of IHPA's investigation of suitable measures to further refine and validate the proposed frailty measure into future classification updates.

Western Australia (WA), the Queensland Nurses & Midwives' Union (QNMU) and the Victorian Healthcare Association (VHA) supported using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for the NEP Determination 2022–23 (NEP22).

IHPA's response

IHPA has undertaken further statistical analysis and consultation prior to the decision to progress to shadow pricing using AN-SNAP Version 5.0 for admitted subacute and non-acute services for NEP22. Pricing decisions following the shadow pricing period will be made in line with the Addendum and the criteria outlined in the Alterations Framework. Further analysis has been provided to jurisdictions for consultation, within the Statement of Impact.

Emergency care

IHPA did not ask any specific consultation questions on emergency care but received feedback from a small number of stakeholders.

Feedback received

Australian Emergency Care Classification

NSW noted that IHPA should better capture shifts in provision of care, particularly the increased use of virtual care in emergency departments.

ACEM recommended that IHPA consider tracking and mapping 'diagnostic modifiers' as drivers of investigation costs to more accurately reflect patient complexity within the Australian Emergency Care Classification (AECC). ACEM also recommended that IHPA consider incorporating frailty as a cost driver, to account for transfers from aged care facilities and other community presentations.

Pricing emergency services

SA noted its support for the continued improvement of data collection for all hospital services and, in principle, the use of the AECC for emergency services, noting that some smaller sites may have difficulty in collecting robust diagnosis codes.

IHPA's response

Australian Emergency Care Classification

IHPA notes the increased use of virtual care in emergency departments and will work with jurisdictions to assess the impact of this.

For future refinements of the AECC, IHPA is analysing diagnosis modifiers, investigations and procedures as potential variables, noting that a period of stabilisation is required following its implementation.

Pricing emergency services

IHPA notes that it will undertake thorough funding and impact analysis in consultation with the jurisdictions prior to any decision on pricing emergency services using the AECC.

Non-admitted care

Consultation question

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

Feedback received

Stakeholders welcomed the development of a new non-admitted care classification and provided the following recommendations to support recommencement of the costing study:

- determine scope and data submission requirements to ensure adequate volume and quality of information is collected, including on new and changed services
- assess the extent to which existing jurisdiction clinical and administrative systems can be used to link information
- provide adequate notification of the commencement date and additional support to site participants to assist in resource allocation.

Vic, NT, CHA and VHA recommended that longer timeframes for recommencement are explored as states and territories will unlikely be in a position to allocate resources to participate at this stage due to the impact of Coronavirus Disease 2019.

IHPA's response

IHPA is committed to developing a new non-admitted care classification and will continue to work with its Non-Admitted Care Advisory Working Group, jurisdictions and other key stakeholders to assess the feasibility of undertaking a non-admitted care costing study to inform the new classification.

Future work will include consideration of whether methodology changes are required and monitoring of site and jurisdiction capacity for recommencement, noting the ongoing impact of COVID-19 on jurisdiction readiness and changing models of care in the non-admitted setting.

Mental health care

Consultation question

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

Feedback received

Admitted mental health care

NSW, Vic, WA and the Royal Australian & New Zealand College of Psychiatrists (RANZCP) noted that a thorough review of the admitted mental health cost and activity data from the two-year shadow period is required prior to supporting pricing of the Australian Mental Health Care Classification (AMHCC) Version 1.0 for NEP22.

Qld, Tas and NT did not support pricing admitted mental health care using AMHCC Version 1.0 due to concerns regarding the quality and quantity of the AMHCC data and phase of care definitions.

SA, the Grattan Institute and VHA supported pricing admitted mental health care using AMHCC Version 1.0 for NEP22.

In the pricing of admitted mental health care, NSW recommended that IHPA consider mental health intensive care units and recognise same-day or short stay episodes of less than three days. NSW also noted that Mental Health Legal Status (MHLS) is only recognised as a variable AMHCC split for the acute phase of care between the ages of 18 to 64 and recommended the extension of the MHLS across all age groups and phases of care.

Community mental health care

NSW, Vic, Qld, SA, WA, Tas, NT, the Grattan Institute and RANZCP recommended that community mental health care be shadow priced for a second year for NEP22 using AMHCC Version 1.0, noting the following concerns:

- additional time is required to address gaps in data collections
- inter-rater reliability issues with three of the five mental health phases of care
- a number of community mental health services do not fit the proposed model as they are delivered to de-identified clients, triage only or secondary support services.

IHPA's response

Admitted mental health care

IHPA has undertaken a thorough review of the available admitted mental health care cost and activity data, in consultation with jurisdictions. IHPA recognises the concerns raised regarding progressing to pricing admitted mental health care for NEP22. However, there have been significant improvements in the quality and volume of admitted mental health care data since 2017–18.

Pricing admitted mental health care using AMHCC Version 1.0 will also result in more accurate pricing of services, with adjustments in the pricing model to capture and account for legitimate and unavoidable variations in the costs of delivering these services.

Following the completion of a two-year shadow pricing period, IHPA will progress to pricing admitted mental health care using AMHCC Version 1.0 for NEP22.

IHPA will continue to investigate where refinements can be made for future versions of the AMHCC.

Community mental health care

IHPA acknowledges the concerns raised by jurisdictions regarding the pricing of community mental health care, however also notes that the volume and coverage of community mental health care data has improved substantially in 2018–19 and 2019–20.

IHPA will continue to block fund community mental health care while undertaking a second year of shadow pricing using AMHCC Version 1.0 for NEP22.

IHPA will continue to work with jurisdictions to improve data collection and assess the feasibility of pricing community mental health care for NEP23.

Teaching and training

IHPA did not ask any specific consultation questions on teaching and training but received feedback from several stakeholders.

Feedback received

NSW recommended that IHPA review in-scope teaching and training activities to ensure that it reflects contemporary practice, including consideration of whether COVID-19 related training costs need to be embedded.

For the development of the Australian Teaching and Training Classification (ATTC), CHA recommended the inclusion of genomics training and QNMU requested that nursing and midwifery research costs be included.

The Royal Australasian College of Physicians (RACP) noted the need for continued investigation of funding for local research and recommended that IHPA incorporates this into future work.

IHPA's response

IHPA notes that limited progress has been made towards pricing using the ATTC due to the small amount of data available. IHPA will continue to investigate alternatives with jurisdictions until the ATTC can be implemented and priced.

Teaching and training will continue to be block funded in 2022–23.

6 Setting the national efficient price

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For the National Efficient Price (NEP) Determination 2022–23 (NEP22), the Independent Hospital Pricing Authority (IHPA) has deferred consideration of proposed refinements to the national pricing model outlined in the Consultation Paper, in order to prioritise refinements to the national pricing model to adequately account for Coronavirus Disease 2019 (COVID-19). These include adjustments to the NEP, price harmonisations and refining the private patient neutrality methodology. IHPA will review jurisdictional capacity to support these refinements for future NEP Determinations.

Adjustments to the national efficient price

Consultation question

- What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?

Feedback received

NSW, Vic, Qld, SA, WA, Tas, Austin Health, QNMU, RACP and VHA supported IHPA's investigation into costs associated with patient transport in rural areas and noted a number of issues with how patient transport is currently captured in the national pricing model:

- equitable access to care is restricted by the need to travel large distances and the high cost of travel and accommodation
- data collection and linkage issues as patient transport services often commence prior to the admission and may be associated with non-government organisations such as the Royal Flying Doctor Service
- at present, patient transport is not feasible for activity based funding due to the lack of resource homogeneity.

Stakeholders also provided recommendations for supporting the progression of this work:

- review the existing patient residential and treatment remoteness adjustments
- review the existing state and territory based Patient Assisted Travel Schemes
- undertake a costing study into patient transport costs
- consider the incorporation of escorts to accompany patients from their rural homes to specialist care.

NT noted that it faces unique challenges in the delivery of health care services as patients are often transferred thousands of kilometres from regional and remote hospitals to other facilities to receive critical or specialist services that are not available locally. In the interim, NT has proposed that these patient transport costs could be block funded within the national efficient cost determination.

IHPA's response

IHPA acknowledges the challenges and the additional costs associated with patient transport that are captured inconsistently by the current national pricing model and existing adjustments.

Following a review of stakeholder feedback, IHPA has determined that further investigation is required to support the development of a new adjustment for patient transport, due to the current lack of patient level data and significant variation in cost reporting across jurisdictions.

IHPA is undertaking in-depth analysis to address the additional costs associated with patient transport and will work with jurisdictions to consider the feasibility of a new adjustment for the NEP Determination 2023–24 (NEP23).

Consultation question

- What factors should IHPA consider in reviewing the Specified Intensive Care Unit (ICU) eligibility criteria and adjustment?

Feedback received

Jurisdictions provided feedback that the current eligibility criteria may preclude smaller facilities delivering ICU services from being adequately funded if they fall below the threshold as they incur significant costs to deliver ICU capability.

Tas noted that the ICU eligibility criteria lacked consideration of the impact of obesity on patient complexity, cost of care and length of stay. Tas also recommended that IHPA review Critical Care Unit (CCU) component costs, as CCUs can be more resource intensive than general wards.

Jurisdictions provided the following considerations in reviewing the ICU eligibility criteria:

- extension of the mechanical ventilation thresholds and consideration of broadening the criteria to include other ICU services
- review changes in state and territory ICU capability and capacity arising from the COVID-19 pandemic response
- review the bundling of ICU hours in neonatal care
- consider a two-tier ICU adjustment defined by clinical need to provide ICU services and differentiated by observed cost and volume.

IHPA's response

IHPA reviews the ICU eligibility criteria annually, and considers that the current adjustment is adequately robust to capture additional costs associated with ICU utilisation.

IHPA will undertake further consultation with the jurisdictions and review the ICU eligibility criteria and adjustment for NEP23 to determine if refinements are required.

Consultation question

- What factors should IHPA consider in reviewing the Indigenous adjustment?

Feedback received

Stakeholders noted that the Indigenous adjustment should account for geographical, socioeconomic and cultural barriers to accessing care, potentially longer consultation times and higher rates of patients leaving against medical advice or being discharged at their own risk.

Feedback indicated the following potential amendments to the Indigenous adjustment:

- application of safety and quality adjustments to the base weight and not the final weight, to prevent incentives for the Indigenous adjustment being removed
- consideration of a tiered adjustment based on patient acuity, complexity, admission type and resource use, including the prevalence of chronic conditions.

Several stakeholders recommended further investigation into the additional cost and benefits associated with Aboriginal and Torres Strait Islander Health Practitioners, Aboriginal Liaison Officers and interpreter services, and consideration of whether these are appropriately accounted for in the national pricing model.

IHPA's response

IHPA acknowledges the variance in health care access experienced by Aboriginal and Torres Strait Islander patients, which needs to be appropriately adjusted for to incentivise provision of best care and promote funding equity.

IHPA notes that difficulties may arise from under-reporting of Indigenous status within health service patient level records and data sets. IHPA will undertake a thorough review of the adjustment for NEP23 and provide the findings to its advisory committees for consideration.

Consultation question

- What evidence is there to support increased costs for genetic services or socioeconomic status?

Feedback received

Genetic services

Stakeholders identified several factors contributing to increased costs for genetic services that are not adequately accounted for in the national pricing model, including:

- use of expensive highly specialised pathology for genetic and genomic tests
- significant time and resources are required for genetic consultations, including pre-clinic and post-clinic work which is not reflected in funding
- data linkage issues failing to capture service delivery by multidisciplinary teams, complex testing performed over several months and other ancillary costs
- under-pricing of costs associated with send-away genetic testing.

Tas, Australian Genomics and the Human Genetics Society of Australasia (HGSA) recommended the establishment of a new Tier 2 Non-Admitted Services Classification 40 series for use by genetic counsellors, which may assist in data reporting and capture.

Socioeconomic status

Stakeholders provided varying feedback on the consideration of an adjustment for socioeconomic status. Socioeconomically disadvantaged patients tend to be more complex and incur higher hospital costs, longer length of stay and greater incidence of adverse outcomes. The University of Melbourne (UoM) also noted that socioeconomic status has an important effect on hospital utilisation and costs, independent of other factors such as age, gender and comorbidities.

However, accounting for socioeconomic status represents a challenge in that approximations using traditional area indicators may not be appropriate as they are not patient centric and only suitable for population level adjustments.

Similarly, a potential admission-based loading may also not adequately capture the higher costs associated with servicing low socioeconomic status patients, including non-patient specific costs such as hiring of trained personnel or establishing specialty facilities.

Some stakeholders noted that socioeconomic status may already be captured within the national pricing model and the development of a new adjustment will overlap with the existing NEP adjustments that account for patient complexity.

IHPA's response

Genetic services

IHPA will work with jurisdictions and key stakeholders to further investigate a possible adjustment for genetic services for future determinations, noting the need for improved data reporting and capture, as prices for genetics services are set using the cost and activity data submitted by the states and territories.

Future work in this area may involve conducting a costing study to better understand cost drivers and determine what changes are required to standardise data collections for genetic services across and within jurisdictions.

Socioeconomic status

IHPA notes the extensive feedback on increased costs associated with socioeconomic status and acknowledges the potential difficulties of capturing socioeconomic status using area indicators as they may not adequately account for patient level disadvantages and impacts.

IHPA notes that some socioeconomic factors are collected in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, however these are not in-scope to contribute to the Australian Refined Diagnosis Related Group complexity model. Previous analysis has also indicated that admitted episodes with these codes are not more costly, aside from mental health care episodes.

IHPA will undertake further work to investigate whether an adjustment for socioeconomic status is feasible, or whether refinements are needed to the existing residential and treatment adjustments. As part of this work, IHPA will also consider undertaking longitudinal analysis of cost and hospital utilisation patterns for patients with chronic conditions to compare socioeconomically disadvantaged and non-disadvantaged patients.

Consultation question

- What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?

Feedback received

Stakeholders proposed the following additional adjustments and areas for consideration:

- percentile-based approach to setting Diagnosis Related Group (DRG) length of stay inlier bounds
- an adjustment to account for costs associated with providing services to patients with disabilities
- age adjustment for paediatric emergency department presentations under the Australian Emergency Care Classification
- increased costs associated with mental health Mother and Baby Units
- telehealth and other technology-enhanced care, particularly for rural areas
- unbundling the Neonatal ICU component of the DRG price for Newborns (qualified) and Other Neonates
- older patients with cognitive impairment and Behavioural and Psychological Symptoms of Dementia.

Stakeholders also recommended that IHPA examine opportunities to consolidate existing adjustments where they concurrently explain the same variation in costs.

IHPA's response

IHPA will work with jurisdictions through its advisory committees and broader stakeholders to assess whether these proposed adjustments are feasible for incorporation into the national pricing model. IHPA notes that for some of these proposals, there may be insufficient volume of available data to facilitate the development of a robust adjustment.

Harmonising price weights across care settings

Consultation question

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

Feedback received

Price harmonisation for haemodialysis and chemotherapy

Stakeholders supported the investigation of price harmonisation for haemodialysis and chemotherapy, noting the need for a thorough review of cost and activity data and analysis on variations in service delivery across jurisdictions and service settings. Stakeholders also noted the importance of considering patient comorbidity risk profiles and paediatric-specific factors.

Other areas for price harmonisation

Stakeholders recommended the following areas for consideration:

- surgical specialties where there is activity variously recorded as admitted and non-admitted (for example, cataract surgery)
- surgical procedures where no other ongoing care is required (for example, colonoscopy or nasendoscopy)
- same day gastroenterology activity
- violence, abuse and neglect services including Family and Domestic Violence, Sexual Assault and Abuse
- treatment of anaemia with blood transfusions and infusions of blood products
- mechanical hysteroscopy performed in a non-admitted setting
- services provided in ambulatory care (for example, treatment of cellulitis, deep vein thrombosis or pneumonia and ambulatory rehabilitation services).

IHPA's response

Price harmonisation for haemodialysis and chemotherapy

IHPA will consider price harmonisation for haemodialysis and chemotherapy for NEP23. IHPA will consult further with jurisdictions to undertake analysis on the stability of the underlying data, the suitability of these services for harmonisation and the potential unintended consequences of pursuing price harmonisation for haemodialysis and chemotherapy.

IHPA notes that haemodialysis may potentially be captured under the innovative models of care currently in development, such as IHPA's proposed chronic condition capitation model.

IHPA also notes that there will be changes to same-day chemotherapy codes from July 2022, which may impact the parameters for price harmonisation of chemotherapy services.

Other areas for price harmonisation

IHPA will prioritise the development of harmonisation methodologies for haemodialysis and chemotherapy before assessing the other proposed harmonisations. IHPA currently harmonises the price for same-day scopes. IHPA notes that cataract extraction, same-day endoscopy, blood transfusions and infusions, and mechanical hysteroscopy are often performed in the non-admitted setting.

IHPA will undertake further consultation with jurisdictions, classification experts and clinical experts to determine whether price harmonisation is feasible and appropriate for the areas proposed by stakeholders.

Unqualified newborns

Consultation question

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

Feedback received

Stakeholders supported IHPA undertaking further investigation of funding arrangements for unqualified newborns, noting that the separation of newborns from mothers does not reflect contemporary best practice.

Stakeholders noted that the current bundling of unqualified newborns within the maternal DRG does not adequately reflect the cost of care, which could drive adverse resource allocation.

The following recommendations were provided to assist in driving methodology changes:

- review the definition and criteria for the 'qualification' of newborns
- develop a costing standard to capture cost differentials for different clinical care
- record all newborns as admitted patients with a separate but linked record to the maternal record, with allocation of a separate adjustment per DRG.

IHPA's response

Methodology changes for unqualified newborns represents a relatively new area in IHPA's investigation of pricing model refinements. As such, IHPA will undertake further consultation with jurisdictions and stakeholders to determine the feasibility of methodology changes for future determinations.

IHPA notes that definition changes around qualification status would require legislative changes.

Setting the national efficient price for private patients in public hospitals

Consultation question

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

Feedback received

NSW and Tas did not support phasing out the private patient correction factor for NEP22, citing non-compliance with Business Rule 1.1A of the Australian Hospital Patient Costing Standards (AHPCS) Version 4.1 and the potential bias against jurisdictions with low private patient rates.

Vic, Qld, SA, WA, Stryker South Pacific and QNMU supported phasing out the private patient correction factor where feasible and within an adequate timeframe for compliance with the AHPCS Version 4.1.

Qld sought the provision of a Statement of Impact to assess the change by jurisdiction, including the back-casting implications when not applied.

IHPA's response

IHPA will undertake analysis to understand whether the private patient correction factor as it is currently applied is still required, and continue to support the remaining states and territories in phasing out the private patient correction factor.

7 Data collection

7 Data collection

The Independent Hospital Pricing Authority (IHPA) did not ask any specific consultation questions on data collection, but received feedback from two jurisdictions.

Feedback received

NSW and Tas noted concerns with the National Benchmarking Portal (NBP) becoming publicly available due to comparability issues across states and territories, lack of specified patient privacy measures and safeguards, and the potential for public misinterpretation and commercial misuse.

NSW recommended that IHPA undertake a risk assessment to assess the impact and potential unintended consequences associated with making the NBP publicly available.

Separately, Tas recommended the inclusion of subacute clinical scores into activity based funding classifications to enable transition from two data collection systems into a single data collection process.

IHPA's response

IHPA notes the concerns raised by NSW and Tas regarding the NBP, and will continue to work with jurisdictions to address any patient privacy concerns, prior to the NBP becoming publicly available in 2022.

8 Treatment of other Commonwealth programs

8 Treatment of other Commonwealth programs

The Independent Hospital Pricing Authority (IHPA) did not ask any specific consultation questions on the treatment of other Commonwealth programs, but received feedback from a small number of stakeholders.

Feedback received

Qld noted that some Tier 2 Non-Admitted Services Classification clinics have a Pharmaceutical Benefits Scheme (PBS) price weight due to allocating residual PBS costs. Qld recommended that this practice should exclude non-admitted clinics that would not receive funding for PBS-listed medications.

Tas supported the review and refinement of the PBS and Medicare Benefits Schedule (MBS) rebate systems, noting that many private health insurers may not have had time to update their schedules. Tas noted that this could lead to the situation where the casemix and revenue amount in the Hospital Casemix Protocol (HCP) will be significantly different than the base data used for back-casting.

IHPA's response

In response to the feedback provided by Qld, IHPA's PBS matching methodology will be reviewed and refined in the development of the National Efficient Price Determination 2023–24 (NEP23).

For NEP23, IHPA will also review the potential impact of the PBS and MBS rebate systems on the casemix and revenue amount in the HCP data.

9 Setting the national efficient cost

9 Setting the national efficient cost

Consultation question

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

Feedback received

NSW, Vic, Qld, WA, Tas, ACEM and QNMU noted the following concerns regarding the transition of block-funded standalone hospitals that provide specialist mental health services to ABF:

- potentially significant impact on the acute stream due to funding redistribution
- transitioning to ABF may not reflect the true cost of care, particularly for patients with complex conditions and facilities treating very long stay patients
- risks associated with a new classification where phase of care is still being refined
- potential under-pricing leading to exacerbation of existing resource issues.

SA and the Grattan Institute supported the transition of block-funded standalone hospitals to ABF using the Australian Mental Health Care Classification (AMHCC) Version 1.0.

IHPA's response

IHPA acknowledges the concerns raised by stakeholders that premature transition to ABF for block-funded standalone hospitals may not adequately capture the costs associated with service delivery, which could lead to a negative impact on funding. IHPA notes that more time may be required for stabilisation of the AMHCC model and improvement in data integrity and coverage following progression to pricing of admitted mental health care for the National Efficient Price Determination 2022–23.

IHPA will work with jurisdictions to facilitate the transition of block-funded standalone hospitals providing specialist mental health services to ABF.

IHPA will also work with jurisdictions and its Mental Health Working Group to undertake further analysis, including recalculation of AMHCC price weights, assessing the impact on acute streams and shadowing to compare ABF allocations with actual costs.

10 Future funding models

10 Future funding models

Consultation question

- What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?

Feedback received

Stakeholders provided a range of considerations and recommendations for the Independent Hospital Pricing Authority (IHPA) to support the investigation and trial of new and innovative models of care and funding approaches.

General recommendations from stakeholders included the use of clinician-led, evidence-based and data-driven approaches to inform modelling, funding and risk adjustment methodologies. Feedback from stakeholders also highlighted the importance of utilising a value based approach to incentivise delivery of care in the most appropriate setting and incorporating patient reported experience and outcome measures.

Stakeholders also advocated for developing and implementing flexible and mixed models of care across care settings with blended payment models. This would assist in developing a collaborative presence between health services and jurisdictions to encourage data sharing and reduce fragmentation of the health care system.

Jurisdictional feedback focused on consideration of state and territory capacity and capability in undertaking pilots and trials of innovative models of care, with potential impacts on infrastructure and data collection.

Finally, new models of care and funding approaches will need robust evaluation measures with clinical input to assess the impact on patient outcomes and hospital efficiency.

IHPA's response

The feedback received from stakeholders aligns with IHPA's proposed approach of incorporating patient reported measures, clinical involvement and flexibility in service delivery and setting.

IHPA will consider the recommendations and considerations provided by stakeholders to facilitate the exploration and trial of innovative models of care and funding approaches.

IHPA has incorporated this feedback as part of the joint advice provided to Australian health ministers from the national bodies.

IHPA will continue to work with jurisdictions and clinical experts to guide the implementation pathway for trialling state and territory nominated innovative models of care and funding approaches.

Consultation question

- What innovative models of care or services are states and territories intending to trial for the National Efficient Price Determination 2022–23?

Feedback received

Jurisdictions provided details of innovative models of care and funding approaches being implemented or in development at the state and territory level:

- NSW outlined programs to support coordinated care and improve patient outcomes under its Leading Better Value Care initiatives
- Vic intended to leverage its HealthLinks Chronic Care Program into the investigation of other innovative models such as the use of telehealth in emergency departments, urgent care, aged care and correctional facilities
- Qld noted its priorities as kidney disease and diabetes in the chronic disease category, and ophthalmology, ear, nose and throat, gastroenterology and orthopaedic joint replacement in the bundled payment cohort
- SA has commenced investigating models of care such as My Home Hospital and the Mental Health Co-Responder program
- WA intended to explore options to drive the initiatives outlined in the recommendations from the WA Sustainable Health Review
- Tas noted it was developing and implementing a Rapid Access In-reach Service that provides primary care health providers with rapid access to specialists.

IHPA's response

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.

IHPA is in the process of developing pilot parameters, business rules and evaluation methodology to facilitate trialling state and territory nominated innovative models of care and services for 2022–23 to inform translation into the national pricing model, pending jurisdiction capability and capacity.

11 Pricing and funding for safety and quality

11 Pricing and funding for safety and quality

Evaluation of safety and quality reforms

Consultation question

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

Feedback received

Stakeholders provided the following feedback for the development of evaluation measures for safety and quality reforms, noting that the evaluation measures should:

- be meaningful, transparent, actionable and assessable at the clinician, health service and jurisdiction levels
- prioritise patient outcomes and experiences
- be risk adjusted to account for patient factors such as age, gender, comorbidities, Indigenous status, socioeconomic status and health factors (for example, exercise, smoking and diet)
- be developed in consultation with clinicians, health services, jurisdictions and the national bodies.

Feedback from stakeholders also included recommendations for undertaking the evaluation process:

- target specific outcomes, such as the number, proportion and likelihood of sentinel events, hospital acquired complications and avoidable hospital readmissions in hospitals pre- and post-intervention
- aim to understand if the reforms have been effective, if refinements are required and whether the reforms have caused any unintended consequences
- consider data availability and potential data linkage issues
- consider the reallocation of ‘savings’ for further safety and quality reforms.

UoM recommended that the unit of analysis should be at the hospital level rather than at the local hospital network (LHN) or jurisdiction level, as generally reform targeted policies and procedures are implemented by hospitals.

Some stakeholders noted that the evaluation process should be carried out by an independent party.

IHPA’s response

The Independent Hospital Pricing Authority (IHPA) has incorporated the feedback from stakeholders regarding evaluation measures into the development of its Safety and Quality Evaluation Framework (the Evaluation Framework).

The Evaluation Framework has undergone consultation with jurisdictions through IHPA’s advisory committees and been progressed as part of the joint advice to health ministers from the national bodies, as required under the Addendum to the National Health Reform Agreement 2022–25 (the Addendum).

IHPA will continue to refine the methodology for the evaluation of the implemented safety and quality reforms, based on the feedback from stakeholders, in consultation with jurisdictions and clinical experts.

Avoidable and preventable hospitalisations

Consultation questions

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

Feedback received

Stakeholders provided extensive feedback on considerations for reducing avoidable and preventable hospitalisations.

A common theme in the feedback was the need to consider patients with frequent hospitalisations arising from chronic and complex health needs. Stakeholders noted the importance of ensuring that these patients are appropriately risk adjusted for and adequately funded, and also to avoid penalising hospitals for patient-related factors beyond their control.

Feedback from stakeholders highlighted areas where gaps in preventative and secondary care could be addressed through exploring models of care that integrate hospitals and LHNs with general practice and Primary Health Networks.

Stakeholders also recommended undertaking a review of the admissions policies for specific patient cohorts, as admission criteria may vary substantially between jurisdictions, LHNs, hospitals and even clinicians. This variation could have significant impacts on rates of avoidable and preventable hospitalisations and would need to be accounted for.

Finally, stakeholders noted that IHPA could consider a benchmarking approach where funding is incentivised or reduced based on expected versus actual rates of avoidable and preventable hospitalisation.

Stakeholders provided the following recommendations for evaluating pricing and funding approaches to reduce avoidable and preventable hospitalisations:

- measures should be reproducible and implementable by hospitals, and include consideration of clinician acceptance
- consider factors such as socioeconomic status and access to primary health care, particularly in patients with chronic and complex conditions
- provide appropriate alignment of incentives with achieving the desired outcome.

3M Health Information Systems noted that ‘pay for performance’ systems can assist in reducing health care inefficiency across five categories of potentially preventable events: complications, readmissions, admissions, emergency room visits and ancillary services.

IHPA’s response

IHPA notes the extensive feedback for options to reduce avoidable and preventable hospitalisations. IHPA notes the recurring theme among the feedback received is targeting hospitalisations arising from patients with chronic and complex health needs and consideration of integration between care settings.

This feedback aligns with the joint advice provided to health ministers, as required under the Addendum, from IHPA and the national bodies.

IHPA will continue to work with the national bodies and jurisdictions to investigate options for reducing avoidable and preventable hospitalisations.

Appendix A: List of stakeholders

The stakeholders that made submissions in response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23* have been outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Abbreviation
New South Wales Ministry of Health	NSW
Victorian Department of Health and Human Services	Vic
Queensland Health	Qld
South Australian Department for Health and Wellbeing	SA
Western Australian Department of Health	WA
Tasmanian Department of Health	Tas
Northern Territory Department of Health	NT
3M Health Information Systems	3M
Austin Health	
Australasian College for Emergency Medicine	ACEM
Australian Genomics Health Alliance	Australian Genomics
Australian Medical Association	AMA
Catholic Health Australia	CHA
Grattan Institute	
Human Genetics Society of Australasia	HGSA
Medical Technology Association of Australia	MTAA
Palliative Care Nurses Australia	PCNA
Queensland Nurses & Midwives' Union	QNMU
Royal Australasian College of Physicians	RACP
Royal Australian & New Zealand College of Psychiatrists	RANZCP
Stryker South Pacific	Stryker
University of Melbourne	UoM
Victorian Healthcare Association	VHA

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