IHACPA

New Health Technology Policy

December 2022

New Health Technology Policy
Version 5.0 December 2022

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Glossary

Abbreviation	Full term
ABF	Activity based funding
ACE	Australian Classification Exchange
ACHI	Australian Classification of Health Interventions
CAC	Clinical Advisory Committee
CATAG	Council of Australian Therapeutic Advisory Groups
CCAG	Classifications Clinical Advisory Group
HTA	Health Technology Assessment
HST	High cost, highly specialised therapy
IHACPA	Independent Health and Aged Care Pricing Authority
IHPA	Independent Hospital Pricing Authority
JAC	Jurisdictional Advisory Committee
LHN	Local hospital network
MSAC	Medical Services Advisory Committee
NEC	National efficient cost
NEP	National efficient price
NHRA	National Health Reform Agreement
NHCDC	National Hospital Cost Data Collection
PBAC	Pharmaceutical Benefits Advisory Committee
PLAC	Prostheses List Advisory Committee
TGA	Therapeutic Goods Administration
The Addendum	Addendum to the National Health Reform Agreement 2020–25
The Administrator	Administrator of the National Health Funding Pool
The NHR Act	*National Health Reform Act 2011* (Cwlth)
This Policy	*New Health Technology Policy*

Definitions

Term	Definition
Activity based funding	Refers to a system for funding public hospital services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Health and Aged Care Pricing Authority (IHACPA), as outlined in the Addendum to the National Health Reform Agreement 2020–25. An activity based funding (ABF) activity may take the form of a separation, presentation or service event.
Australian Classification Exchange	The IHACPA Australian Classification Exchange is an online portal that provides registered users with access to submit public submissions for classification enhancements or modifications, including public submissions for the consideration of new health technologies.
Classifications Clinical Advisory Group	An advisory group that includes members from medical, nursing and allied health professions and representatives from IHACPA's Clinical Advisory Committee. Members of this group have significant knowledge of the classifications used in Australia and provide expert clinical advice on development proposals across the admitted care classifications.
Clinical Advisory Committee	Established under the *National Health Reform Act 2011* (Cwlth) (the NHR Act) to assist IHACPA in the development of a national ABF system through the provision of timely and quality clinical advice. Members are drawn from a range of clinical specialities and backgrounds to ensure the committee represents a wide range of clinical expertise. Through this committee, IHACPA reviews new health technologies that may not be adequately accounted for in the classification and costing of public hospital services.
Health technology	A health technology is defined as an intervention developed to prevent, diagnose or treat medical conditions; promote health; provide rehabilitation; or organise health care delivery[1]. Health technologies include tests, devices, medicines, vaccines, procedures, programs and systems[1,2]. The scope of new health technology considered by IHACPA under the *New Health Technology Policy* includes procedures, interventions, devices and pharmaceuticals.

[1] As defined by the International Network of Agencies for Health Technology Assessment, available at: https://www.inahta.org

[2] As defined in the Addendum to the National Health Reform Agreement 2020–25, available at: https://www.federalfinancialrelations.gov.au

Term	Definition
Health Technology Assessment	Health Technology Assessment refers to the systematic evaluation of the properties and effects of a health technology, addressing direct and intended effects, as well as indirect and unintended consequences, aimed mainly at informing decision making[3].
National pricing model	The national pricing model is produced annually by IHACPA and defines the national efficient price, price weights and adjustments based on the activity and cost data from three years prior. For more detail, refer to the link below for the National Pricing Model Technical Specifications. https://www.ihacpa.gov.au/health-care/pricing/national-pricing-model-technical-specifications
New health technology placeholder codes	Placeholder codes for new health technologies have been established as part of the update to the Australian Classification of Health Interventions (ACHI) Twelfth Edition, implemented from 1 July 2022. The update to ACHI Twelfth Edition includes 100 placeholder codes, which will facilitate the capture of new health technology and enable the flexibility of ACHI to respond to emerging trends that require counting in admitted patient care during the three-year period between classification releases.
Pricing Authority	The governing body of IHACPA established under the NHR Act.
The Pricing Guidelines	In undertaking its legislated functions, IHACPA balances a range of policy objectives, including improving the efficiency and accessibility of public hospital services. The Pricing Guidelines[4] signal IHACPA's commitment to transparency and accountability in making its policy decisions. The Pricing Guidelines may also be used by governments and other stakeholders to evaluate whether IHACPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

[3] As defined in the Addendum to the National Health Reform Agreement 2020–25, available at: https://www.federalfinancialrelations.gov.au

[4] The Pricing Guidelines can be found within the *Pricing Framework for Australian Public Hospital Services*, available at: https://www.ihacpa.gov.au/health-care/pricing/pricing-frameworks

1. Executive summary

1.1 Background

The Independent Hospital Pricing Authority (IHPA) was established under the *National Health Reform Act 2011* (Cwlth) (the NHR Act), as part of the National Health Reform Agreement (NHRA) signed in August 2011.

On 12 August 2022 amendments to the NHR Act came into effect changing IHPA's name to the Independent Health and Aged Care Pricing Authority (IHACPA) and expanding its role to include the provision of aged care costing and pricing advice to the Commonwealth Government.

One of IHACPA's determinative functions is to develop, refine and maintain systems as necessary to determine the national efficient price (NEP) and national efficient cost (NEC) for Australian public hospital services. This includes consideration of the extent to which classifications are reflective of new health technology and changing models of care.

It may take time for new health technology to be adopted more broadly, and for their impact on costs to become routinely captured in national cost data. Additionally, although the NEP partially accounts for new health technology through the indexation methodology, the data underpinning a given NEP Determination has a three year time lag. Therefore, changes to the uptake and implementation of new and emerging health technologies may take place between the collection of cost data and the period for which IHACPA is pricing.

In assessing new health technology, IHACPA is guided by the Pricing Guidelines, specifically '**Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes'.

1.2 Purpose

The *New Health Technology Policy* (this Policy) outlines the process by which IHACPA receives submissions and reviews the impact of new health technologies on the existing classifications to ensure they are adequately accounted for in the pricing of public hospital services.

In consultation with its advisory committees and classification working groups, IHACPA will:

- review submissions on new health technologies from jurisdictions, advisory bodies and other stakeholders;
- assess the impact of new health technologies on the national classification systems; and
- where required, refer new health technologies for classification development.

IHACPA recognises there are existing national and state and territory processes to evaluate new health technologies. IHACPA does not intend to duplicate these mechanisms and notes that states and territories may wish to fund new health technology outside existing activity based funding (ABF) arrangements.

1.3 Review

The Pricing Authority and Chief Executive Officer of IHACPA will review this Policy, including associated documentation, annually or as required.

This Policy was reviewed in December 2022.

2. Overview

IHACPA, in consultation with its advisory committees and classification working groups, will assess new health technologies for incorporation into the ABF classifications where they are not adequately accounted for in the pricing of public hospital services, based on submissions received from jurisdictions, advisory bodies and other stakeholders.

Organisations that provide submissions to IHACPA under this Policy should be mindful that accounting for new health technologies within the classifications may be a lengthy process. Additionally, submitters should note that the submission of a new health technology under this Policy does not constitute a recommendation for funding.

2.1 Scope of new health technologies

This Policy defines new health technology as an intervention developed to prevent, diagnose or treat medical conditions; promote health; or provide rehabilitation. The scope of new health technology considered by IHACPA under this Policy includes procedures, interventions, devices and pharmaceuticals[5].

IHACPA has identified three types of new health technologies that may impact the cost of public hospital service delivery. These are new health technologies that:

- impact the efficiency of hospital service delivery (for example, new health technologies that contribute to reduced workforce load)
- impact the quality of patient care (for example, new health technologies for reducing patient pain)
- represent new capability (for example, new health technologies that enable treatments not previously available).

The potential impact of the first type of new health technology is accounted for through the broader national pricing model methodology underpinning the NEP and NEC Determinations, which reflects the average increase in cost over the previous five years. IHACPA does not assess submissions for these types of new health technologies.

Under this Policy, IHACPA will consider submissions for new health technologies that represent major advances in the quality of patient care and new capability as they may not be adequately captured by the broader national pricing model methodology underpinning the NEP and NEC Determinations. Additionally, they could include significant cost impacts for services that do not fit into the underlying classifications. The process for the submission and assessment of new capability health technologies is outlined in Chapter 3.

[5] The administration of pharmaceuticals is not routinely coded in the classifications and the costs are not disaggregated within the National Hospital Cost Data Collection. Under this Policy, IHACPA will only consider submissions for pharmaceuticals where the new health technology may be eligible for Commonwealth funding as advised by the Medical Services Advisory Committee under Schedule C of the Addendum to the National Health Reform Agreement 2020–25. The eligibility criteria and funding arrangements for high cost, highly specialised therapies is discussed in further detail at Chapter 4.

2.2 Agencies, advisory committees and groups

In its assessment of new health technologies, IHACPA will have consideration of the roles and processes of the external agencies and advisory groups that investigate new health technologies, regulate the market, and manage reimbursement and post-implementation management. The organisations involved in investigating the impact of new health technologies in Australia are outlined below.

- **Council of Australian Therapeutics Advisory Groups (CATAG):**

  CATAG includes representatives from all state and territory health departments and aims to standardise and improve medicines used in the hospital sector and provide advice on medicine governance issues.

- **Health Technology and Genomics Collaboration:**

  The Health Technology and Genomics Collaboration, effective from 1 July 2022, is responsible for developing and implementing a nationally cohesive approach to the coordination of the assessment, implementation, monitoring and evaluation of new health technology, as required under the NHR Act.

- **Medical Services Advisory Committee (MSAC):**

  MSAC is an independent non-statutory committee established to appraise new medical services and provide advice to the Commonwealth on whether a new medical service should be publicly funded.

- **Pharmaceutical Benefits Advisory Committee (PBAC):**

  PBAC is an independent statutory body established to make recommendations and provide advice to the Commonwealth on assessment of pharmaceuticals for inclusion on the Pharmaceutical Benefits Scheme.

- **Prostheses List Advisory Committee (PLAC):**

  PLAC includes industry experts, consumer representatives and hospital advisory members and functions to provide recommendations and advice on the clinical and cost effectiveness of prostheses products and other matters related to the Prostheses List.

- **Therapeutic Goods Administration (TGA):**

  TGA is the regulatory authority in Australia for the quality, supply, regulation and advertising of therapeutic goods such as medicines, biologicals, medical devices and diagnostic tests.

In considering submissions for new health technologies received through this Policy, IHACPA will seek advice from its classification working groups and consult with its Clinical and Jurisdictional Advisory Committees (CAC and JAC). IHACPA notes that if a new health technology cannot be uniquely identified in the Australian Classification of Health Interventions (ACHI), significant work would be required to accurately classify and account for the technology. Therefore, it is important that new health technologies, irrespective of the setting of service delivery, are able to be captured in ACHI. As such, IHACPA's assessment of submissions for new health technologies may include advice received from its Classifications Clinical Advisory Group (CCAG).

Where submissions for new health technologies involve interventions provided through subacute and non-acute care, emergency care, mental health care, non-admitted care or teaching and training, IHACPA may receive additional advice from its other classification working groups.

3. Assessment process

In consultation with its classification working groups, CAC, JAC and the Pricing Authority, IHACPA will assess on an ongoing basis whether submissions for new health technologies should be referred as a priority for classification development.

The key stages and timeframes for the identification, assessment and referral of new health technologies are outlined in **Table 1**.

Table 1. Overview of assessment process

Stage	Process
Stage 1: Identify new health technologies	(1a) IHACPA receives submissions from jurisdictions, advisory bodies and other stakeholders
	(1b) Review and shortlisting of submissions
Stage 2: Clinical consultation	(2a) IHACPA seeks clinical advice from classification working groups on the shortlisted submissions
	(2b) IHACPA undertakes quarterly consultations with CAC
	(2c) Incorporation of clinical feedback to finalise recommendations
Stage 3: Quarterly updates on new health technologies	(3a) IHACPA provides quarterly updates to JAC and the Pricing Authority on new health technology submissions, assessments and referrals for classification development
	(3b) Consideration of JAC and Pricing Authority feedback
Stage 4: Referral for classification development	(4a) Implementation of new health technology placeholder codes where applicable
	(4b) Notification to submitters and publication of outcomes
	(4c) Referral for formal classification development

Stage 1: Identify new health technologies

(1a) IHACPA receives submissions from jurisdictions, advisory bodies and other stakeholders

IHACPA will receive submissions for new health technologies from jurisdictions, advisory bodies (for example, the Medical Technology Association of Australia) and other stakeholders (for example, medical device companies) on an ongoing basis through the IHACPA Australian Classification Exchange (ACE). This will facilitate timely identification and assessment of new health technologies and reduce duplication of processes.

Submissions for new health technologies through the ACE will be guided by the criteria outlined at Appendix A.

The following information is requested to facilitate the review and shortlisting of submissions:

- description of the new health technology, including details of the intervention, the proposed or actual setting of service delivery and information on the treatment cohort
- MSAC status and/or details of MSAC application, if applicable
- uptake in Australia (anticipated and actual) by state and territory and by year
- details of TGA approval, if applicable[6]
- costs associated with the technology (estimated or actual), including the average cost per episode of care and the difference in costs between the technology and the most frequently mapped code or class within existing classifications, where possible
- details of any alternatives to the technology, including alternative procedures, interventions, devices or pharmaceuticals currently in use and the costs and benefits of these alternatives
- benefits associated with the technology, including completed or planned studies, impact on service delivery, impact on patient care (including patient reported outcome and experience measures, if applicable), cost benefit and cost effectiveness analysis and risk assessment
- international experience of the technology
- actual or proposed implementation schedule of the technology.

Prior to making a submission, submitters should ensure that they have reviewed the current editions and versions of the classifications to ascertain whether the new health technology is already accounted for with an existing code or class, where possible. If a submission does not include adequate detail or lacks sufficient supporting evidence, the new health technology may not be considered for progression to the next stage.

Submitters should also note that the submission of a new health technology does not constitute direct referral for classification development or a recommendation for funding.

(1b) Review and shortlisting of submissions

IHACPA will review the submissions and determine a shortlist of new health technologies for progression to clinical consultation based on the following considerations:

- uptake – the anticipated or actual uptake in Australian public hospitals
- materiality – the total cost of the mapped code or class and the estimated or actual volume of patients
- feasibility of classification development – the potential administrative, financial or reporting burden on jurisdictions, the maturity of the classification of the proposed patient service category and whether classification development to account for the new health technology is possible[7].

Where a new health technology cannot be readily classified in the existing classification system, IHACPA will consider the implementation of a placeholder code to temporarily codify the new health technology to facilitate data capture and inform classification development decisions. IHACPA's assessment and recommendations for classification development will be provided to its classification working groups for clinical advice at Stage 2 of the process under the Policy.

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[6] TGA approval is not required for new medical procedures, as they do not constitute therapeutic goods. TGA approval is required for submissions pertaining to therapeutic goods.

[7] Assessment of feasibility of classification development and consideration of placeholder codes will be guided by the principles outlined in the *Governance framework for the development of the admitted care classifications*.

IHACPA's recommendation for implementation of a placeholder code will be based on the new health technology meeting all or most of the following criteria:

- the intervention is unable to be captured uniquely within the current edition of ACHI
- a code for the intervention exists in ACHI, however a new technique or approach cannot be distinguished (for example, where the intervention can now be performed using a minimally invasive approach or other technique)
- the intervention is delivered in Australia, with assessable patient and service delivery volume (this is intended to assess actual uptake)
- the intervention has applicability in the Australian health system (this is intended to assess anticipated uptake)
- the intervention will result in benefits to patient outcomes or patient experiences.

In its review, IHACPA will also consider whether the new health technology is already funded through research or grant funding sources or programs other than the NHRA, such as under the National Blood Agreement or Commonwealth pharmaceutical programs. New health technologies already funded through these sources are out-of-scope under this Policy.

Stage 2: Clinical consultation

(2a) IHACPA seeks clinical advice from classification working groups on the shortlisted submissions

IHACPA will seek clinical advice on the shortlisted technologies and proposals for classification development from its classification working groups. Clinical advice will be sought from IHACPA's classification working groups in alignment with their scheduled meeting dates within the calendar year. Where a matter is urgent, requests for advice may occur out-of-session.

As outlined in Chapter 2 of this Policy, significant work would be required for a new health technology that cannot be uniquely identified in ACHI. As such, where IHACPA is considering placeholder code implementation for a new health technology that is not classifiable within ACHI, IHACPA will seek advice from CCAG on the following:

- use and uptake of the new health technology submission
- whether the new health technology submission is eligible for placeholder code activation in ACHI for admitted care
- recommendations for ongoing classification development
- review and refinement of the criteria for placeholder code activation.

Where a new health technology is applicable to one of the other patient service categories, IHACPA will seek specific advice from the relevant classification working group.

(2b) IHACPA undertakes quarterly consultations with CAC

IHACPA will provide an update on the shortlisted new health technologies to CAC on a quarterly basis, in alignment with its scheduled meeting dates within the calendar year. This update will encompass the proposed course of action regarding placeholder code implementation and classification development for shortlisted new health technologies. IHACPA will also seek clinical feedback from CAC on the uptake, materiality and delivery of shortlisted new health technologies.

(2c) Incorporation of clinical feedback to finalise recommendations

Incorporating advice received through its classification working groups and CAC, IHACPA will finalise the shortlisted submissions and prepare its recommendations for classification development. These recommendations will be provided to JAC and the Pricing Authority for comment as part of IHACPA's quarterly updates on new health technologies.

Stage 3: Quarterly updates on new health technologies

(3a) IHACPA provides quarterly updates to JAC and the Pricing Authority on new health technology submissions, assessments and referrals for classification development

Under Stage 3 of the process, IHACPA will provide JAC and the Pricing Authority with quarterly updates on the following:

- submissions received for the assessment of new health technologies
- IHACPA's review and shortlisting of submissions
- any clinical feedback received through CCAG, the other classification working groups and CAC
- IHACPA's recommendations for placeholder code implementation and classification development.

This will provide an opportunity for JAC and the Pricing Authority to comment on the shortlisted new health technologies and IHACPA's recommendations for referral for classification development. The quarterly updates will also allow jurisdictions to provide feedback on whether the shortlisted new health technologies are in use across the states and territories, and whether there is support for progressing the technology for classification development.

(3b) Consideration of JAC and Pricing Authority feedback

Where required, IHACPA may write to jurisdictions to request additional supporting evidence (for example, local hospital network (LHN) service level agreements) to assist the assessment process. Based on the advice from JAC and the Pricing Authority, and any feedback received from the jurisdictions, IHACPA may undertake additional analysis and consultation as required to complete its assessment and finalise its recommendations.

Stage 4: Referral for classification development

(4a) Implementation of new health technology placeholder codes where applicable

If IHACPA's assessment of a new health technology determines that an appropriate ACHI code or combination of codes already exists, then a Coding Rule may be published as part of the quarterly release of National Coding Advice to confirm correct code assignment.

If IHACPA's assessment of a new health technology determines that it cannot be readily classified and represents a significant gap in the existing classification systems, it may require temporary codification through placeholder code activation. Following endorsement of placeholder code activation by CCAG, IHACPA will publish a Coding Rule in an upcoming release of National Coding Advice to enable data capture and facilitate future consideration of classification development in the ABF classifications.

New health technology placeholder codes will be implemented on a quarterly basis following the completion of Stage 3 under this Policy and the incorporation of any additional feedback from JAC and the Pricing Authority.

The placeholder code will act as a flag to enable timely data capture for the new health technology until such time as it is deemed appropriate to formally incorporate a code for the new health technology within ACHI. This placeholder code will be in effect until a decision is made to implement a new code in ACHI.

(4b) Notification to submitters and publication of outcomes

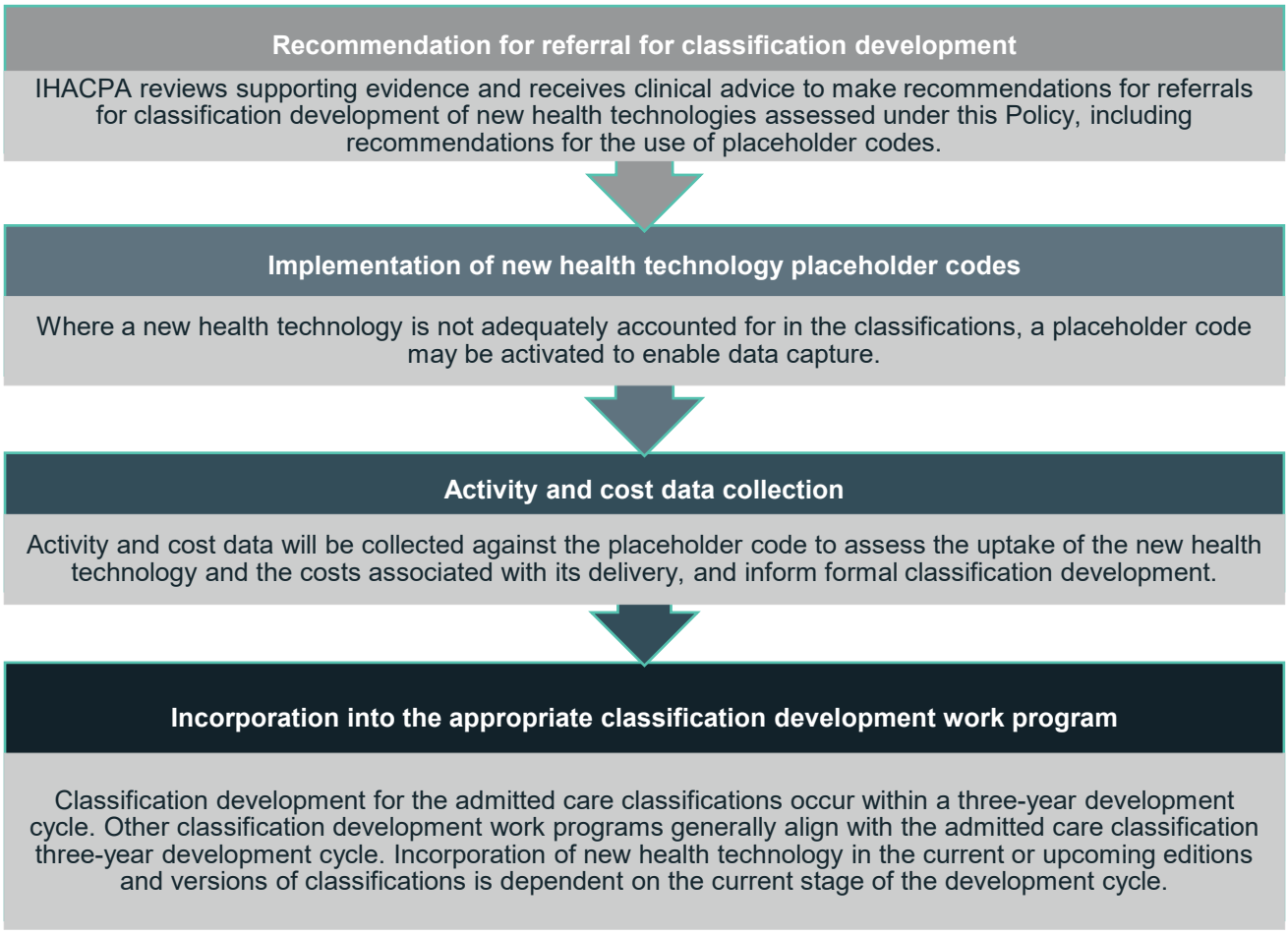
IHACPA will notify the organisations that provided submissions for new health technologies under this Policy to advise them of the outcome of the assessment process. IHACPA will also publish the outcome on its website.

(4c) Referral for formal classification development

Jurisdictions, advisory bodies and other stakeholders that provide submissions to IHACPA under this Policy should be mindful that classification development from a placeholder code to formal inclusion into ACHI and the other classifications may be a lengthy process. This is due to the need to align with the three-year development cycle for the admitted care classifications and the other classification development cycles.

The process for formal classification development is illustrated at **Figure 1**. This process will occur in consultation with IHACPA's classification working groups and, where required, IHACPA's advisory committees.

Figure 1. Process for formal classification development



Formal classification development in ACHI or the Australian Refined Diagnosis Related Groups (AR-DRGs) classification is subject to the development principles within the *Governance framework for the development of the admitted care classifications*. A new health technology that has been assigned a placeholder code and approved for formal classification development may be incorporated into the current ACHI work program or held over for the next work program depending on the current stage of the three-year development cycle.

Prior to classification development in the AR-DRG classification, a minimum amount of activity and cost data is required.

Classification development in the other patient service categories may be considered as part of the planned updates to classification editions and versions. Where possible, these classification development cycles will align with the three-year development cycle for the admitted care classifications. Those classifications that don't currently align with the admitted care classifications, such as the non-patient based Tier 2 Non-Admitted Services Classification, may be considered for classification development through a separate review process as necessary.

4. High cost, highly specialised therapies

4.1 Provisions under the Addendum

The Addendum to the NHRA 2020–25 (the Addendum) outlines specific arrangements for the funding of new high cost, highly specialised therapies (HST). These arrangements are as follows:

- the Commonwealth, for these types of therapies, will provide a contribution of 50 per cent of the growth in the efficient price or cost (including ancillary services), instead of 45 per cent; and
- they will be exempt from the funding cap at clause A56 of the Addendum for a period of two years from the commencement of service delivery of the new treatment.
- Upon commencement of service delivery of the new treatment in a state or territory, the state or territory may request advice from the Administrator of the National Health Funding Pool (the Administrator) on the operation of the cap exemption for that treatment in that state or territory.

4.2 Referral for classification development

The Addendum stipulates that there will be joint decision making by the Chairs of MSAC and PBAC and a nominated health minister representative, on the referral for Health Technology Assessments (HTA) of applications for a new HST likely to be offered within public hospitals.

IHACPA does not play a role in the HTA process for assessment of HST. IHACPA receives advice from the Commonwealth when a HST has been recommended for delivery in a public hospital setting by MSAC, for inclusion in the annual NEC Determination and the *Pricing Framework for Australian Public Hospital Services*. The funding and reconciliation process for HST recommended for delivery in public hospitals is discussed in further detail at Section 4.5.

Where IHACPA is advised that a HST has been recommended for delivery in a public hospital setting and it is identified that the HST is not adequately accounted for in the national classification systems, this will constitute an automatic referral for classification development.

4.3 Eligibility criteria

As stated above, IHACPA is not involved in the HTA process for assessment of HST. In line with the provisions under the Addendum, IHACPA's remit is to establish eligibility, scope and reporting criteria for in-scope services for the Commonwealth funding cap exemption.

IHACPA has determined that the following prerequisites will apply for HST considered in-scope for Commonwealth funding cap exemption under the HST clauses of the Addendum:

- MSAC and Commonwealth recommendation for the delivery of the HST, according to the approved indications;
- states and territories confirm the treatment centre/s delivering the HST;

- states and territories demonstrate the patient specifications meet the approved indications for the HST; and
- states and territories commit to reporting activity and cost data through ABF activity data submissions and the National Hospital Cost Data Collection (NHCDC).

4.4 Scope

In-scope activity

To be considered in-scope for the Commonwealth funding cap exemption under the specific arrangements outlined in Schedule C of the Addendum, the treatment centre must be accredited to provide the HST. In-scope activity for the Commonwealth funding cap exemption associated with the accredited treatment centre, as advised by the state or territory, is defined as the following:

- activity related to the establishment and ongoing accreditation of the treatment centre, including activity related to the delivery of a new HST at an existing treatment centre
- services related to the approved indications for the delivery of a HST to registered patients, where costs are incurred by the treatment centre.

Activity that is in-scope for the Commonwealth funding cap exemption may include patient referral processes and associated tests and diagnostic procedures, consultations, treatments, monitoring and community-based or other non-admitted care. Accommodation and transport of the patient, and carer if required, where those costs are incurred by the treatment centre are also considered in-scope for the Commonwealth funding cap exemption.

Out-of-scope activity

Activity that is out-of-scope for the Commonwealth funding cap exemption under the specific arrangements outlined in Schedule C of the Addendum is defined as the following:

- services provided to patients by treatment centres not accredited to provide the HST
- services provided to patients in contraindication of the approved indications for the HST
- services provided to patients after a treatment centre has been registered for more than two years, as per the funding cap exemption.

As outlined in the Addendum, HST recommended for delivery in a public hospital setting by MSAC will be exempt from the Commonwealth funding cap for a period of two years from the commencement of service delivery of the new treatment. Services provided after a treatment centre has been registered for more than two years will no longer be eligible for the Commonwealth funding cap exemption. However, upon commencement of service delivery of a new HST in a state or territory at a treatment centre that has been registered for more than two years, the state or territory may request advice from the Administrator on the operation of the funding cap exemption for that treatment in that state or territory.

IHACPA notes that where the two-year funding cap exemption period has been exceeded, HST will still be funded under block funding or ABF but no longer exempt from the 6.5 per cent funding cap calculation.

IHACPA notes that any activity relating to HST that is out-of-scope for block funding under the HST clauses in the Addendum will be funded through the ABF pool and be priced under the national pricing model.

4.5 Reporting requirements

To enable funding reconciliation, states and territories are required to submit activity and cost data, to include the following data items:

- the treatment centre/s and LHN/s providing the HST;
- the dates on which HST services were provided;
- the volume of patients receiving the HST; and
- the costs incurred, including the breakdown of fixed and variable costs for the HST.

Activity data submissions

Activity data for the HST patients will be included in the ABF data files as part of the quarterly ABF submissions, including reporting of the 'Funding Source / Program Indicator' data item as part of the ABF data request specifications for 'Alternative Funding Source'.

Cost data submissions

Cost data for the HST patients is required to be provided to the Administrator within three months of the completion of the relevant financial year and reported in the NHCDC. Fixed costs are defined as those associated with the establishment and ongoing accreditation of the treatment centre, including minimum staffing requirements. Variable costs are defined as those directly or indirectly attributable to a registered patient over the course of their treatment.

Funding and reconciliation

States and territories eligible for the Commonwealth funding cap exemption will be required to provide IHACPA with the estimated cost of each HST (including ancillary services) and the anticipated volume of patients as part of the development of the annual NEC Determination. Updated cost estimates will be published as part of the Supplementary NEC Determination.

Activity and cost data identified through the ABF activity data submissions and the NHCDC will be used by the Administrator to determine the actual HST costs for each state and territory, for exclusion from the Commonwealth funding calculation.

Appendix A: Submission form – New Health Technology Policy

Submission form – New Health Technology Policy	
The *New Health Technology Policy* outlines the process by which IHACPA, in consultation with its advisory committees and classification working groups, will review the impact of new health technologies on the existing classifications in order to adequately account for them in the pricing of public hospital services. Prior to making a submission, submitters should ensure that they have reviewed the current editions and versions of the classifications on the IHACPA website to determine whether the new health technology is already accounted for with an existing code or class. If a submission is made with incomplete fields or lacks sufficient supporting evidence, the new health technology may not be considered for progression to clinical review. Submissions may be made at any time through the IHACPA Australian Classification Exchange by registered users.	
New health technology	
Submitter	
Date of submission	
New health technology	
Description of technology • Details of intervention • Proposed or actual setting of service delivery • Information on the treatment cohort • Confirmation that the technology is not currently captured in the classifications	
Contact details for further information	
Submission details	
MSAC status and/or details of MSAC application (if applicable)	
Details of TGA approval (if applicable)	

Uptake in Australia (anticipated and actual patient and service delivery volume): • By LHN/state/territory • By year	
Details of existing research, grant or other funding sources (if applicable)	
Costs associated with the technology: • Estimated or actual • Average cost per episode of care • Difference in costs between the technology and the most frequently mapped code or class (where possible)	
Alternatives to the technology: • Alternative procedures, interventions, devices or pharmaceuticals currently in use • Cost of alternative procedures, interventions, devices or pharmaceuticals • Benefit of alternative procedures, interventions, devices or pharmaceuticals	
Benefits associated with the technology: • Completed or planned studies • Impact on service delivery • Impact on patient care • Cost benefit analysis • Cost effectiveness analysis • Risk assessment	
International experience	
Implementation schedule	

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