IHACPA

Pricing Framework for Australian Public Hospital Services 2023–24

December 2022

Independent Health and Aged Care Pricing Authority

Pricing Framework for Australian Public Hospital Services 2023-24 – December 2022

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Abbreviations

Abbreviations	Full term
ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
COVID-19	Coronavirus disease 2019
eMR	Electronic medical record
ESC	Emergency service care
HAC	Hospital acquired complication
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11	International Classification of Diseases 11th Revision
IHACPA	Independent Health and Aged Care Pricing Authority
IHPA	Independent Hospital Pricing Authority
LHN	Local hospital network
MHPoC	Mental Health Phase of Care
NAPEDC	Non-admitted patient emergency department care
NBEDS	National best endeavours data set
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NMDS	National minimum data set
NWAU	National weighted activity unit
The Addendum	Addendum to the National Health Reform Agreement 2020–25
The Commission	Australian Commission on Safety and Quality in Health Care
UDG	Urgency Disposition Group

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Introduction

1. Introduction

1.1 About IHACPA

The Independent Hospital Pricing Authority (IHPA) was established under the *National Health Reform Act 2011* (NHR Act) to improve health outcomes for all Australians.

Its primary responsibility has been to enable the implementation of national activity based funding (ABF) of public hospital services through the annual determination of the national efficient price (NEP) and national efficient cost (NEC). These determinations play a crucial role in calculating the Commonwealth funding contribution to Australian public hospital services and offer a benchmark for the efficient cost of providing those services as outlined in the National Health Reform Agreement.

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.

1.2 About this Pricing Framework

The Pricing Framework for Australian Public Hospital Services (the Pricing Framework) is one of IHACPA's key policy documents and underpins the approach adopted by IHACPA to determine the NEP and NEC for Australian public hospital services.

The Pricing Framework is published prior to the release of the NEP and NEC Determinations in early March each year. This provides an additional layer of transparency and accountability by making available the principles, decisions and approach used by IHACPA to inform the Determinations.

IHACPA released the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* (the Consultation Paper) for a 30-day public consultation period on 8 June 2022. The Consultation Paper sets out the major issues for the development and refinement of the national ABF system, including policy decisions, classification systems and data collection. Development of the Pricing Framework has been informed by stakeholder feedback to the Consultation Paper.

This year, IHACPA received 36 submissions to the Consultation Paper, including responses from the majority of jurisdictions. These submissions are available on the IHACPA website. A Consultation Report that includes commentary on how IHACPA reached its decisions for 2023–24 is also available.

Stakeholders provided valuable feedback regarding IHACPA's proposed approach for using the 2020–21 activity and cost data to assess the short-term pricing impacts of the coronavirus disease 2019 (COVID-19) pandemic response on the NEP Determination 2023–24 (NEP23). Stakeholders provided feedback on changes to in-scope activity, volume, casemix and models of care, ongoing workforce impacts and differences in reporting and public health policies across states and territories reflecting the varying impact of COVID-19, which may impact the application of the national pricing model for NEP23.

IHACPA 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 the highest priority.

IHACPA will continue to work with jurisdictions to investigate where refinements can be made to the national pricing model to account for the impact of COVID-19 on future NEP Determinations.

2

Impact of COVID-19

2. Impact of COVID-19

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

2.1 Impact of COVID-19 on NEP23

The National Efficient Price (NEP) Determination 2023–24 (NEP23) will use 2020–21 costed activity data, which includes a full financial year of data impacted by the COVID-19 pandemic response. In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* (the Consultation Paper), the Independent Health and Aged Care Pricing Authority (IHACPA) outlined its plan for assessing COVID-19 impacts on the 2020–21 data.

Stakeholders were supportive of the proposed plan and provided a number of considerations for cost modelling and refinements to the national pricing model to account for the impact of COVID-19 on NEP23:

- account for the differing impact of COVID-19 between states and territories
- consider inconsistent national reporting of COVID-19 costs and the potential limitations of relying on historical data
- consider cost increases resulting from increased demand and waiting times for emergency department and non-admitted services
- balance how activity and cost data is 'normalised' to approximate the volume of services that would have been delivered without the impact of COVID-19.

Stakeholders also provided feedback about changes to in-scope activity, volume and casemix; changes to models of care; workforce impacts; and ongoing costs resulting from COVID-19 which may impact the development of NEP23.

To support the development of NEP23, IHACPA worked with the states and territories to understand how the *National Partnership on COVID-19 Response* funding was allocated in the NHCDC and how changes in activity levels, service delivery and models of care have impacted NHCDC reporting.

IHACPA undertook extensive analysis of 2020–21 activity and cost data in consultation with the jurisdictions to understand the impact of COVID-19. IHACPA's analysis indicates that for the admitted acute stream, at a national level in 2020–21, activity returned to a level that is not significantly different from pre-COVID-19 trends. At the jurisdictional level, activity in Victoria in the admitted acute stream is below trend, with substantially higher costs in 2020–21 in comparison to historical trends. IHACPA's analysis also indicated that activity for all other streams in 2020–21 is consistent with pre-COVID-19 trends.

Additionally, IHACPA's analysis indicated that the cost of treating COVID-19 patients, and their length of stay in hospitals is substantially higher when compared to non-COVID-19 patients in the same Australian Refined Diagnosis Related Group.

IHACPA's decision

IHACPA is working with jurisdictions to develop pricing model refinements to account for the impact of the COVID-19 pandemic response and inform the development of NEP23. IHACPA is exploring refinements to account for jurisdiction-specific changes in activity compared to historical trends, the legitimate and unavoidable cost variations associated with treating patients for COVID-19, and the implications from the *National Partnership on COVID-19 Response* and associated funding arrangements.

Next steps and future work

IHACPA will continue to work with jurisdictions to understand the ongoing impact of COVID-19 on service delivery, activity levels and models of care, noting that any changes to the national pricing model for future determinations will require accurate cost and activity data.

IHACPA will also review the need for ongoing pricing model refinements to account for the impact of COVID-19 for future NEP Determinations.

2.2 Impact of COVID-19 on future Determinations

IHACPA notes that COVID-19 may have significant longer term implications. In response to the Consultation Paper, stakeholders noted the following potential impacts of COVID-19 on the development of future NEP Determinations:

- more complex future surgeries as non-critical surgeries were delayed and have now developed into more serious issues
- provision of care to patients with long COVID, particularly in regional and remote communities
- account for the potential cessation of the *National Partnership on COVID-19 Response* from 1 January 2023.

Further detail on stakeholder feedback on these impacts is provided in the Consultation Report.

Next steps and future work

IHACPA will monitor and review updated activity and cost data as it becomes available to ensure that these are accounted for in future NEP Determinations.

3

The Pricing Guidelines

3. The Pricing Guidelines

3.1 The Pricing Guidelines

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

The Pricing Guidelines, outlined in **Figure 1**, signal IHACPA's commitment to transparency and accountability in making its policy decisions. The Pricing Guidelines comprise of Overarching, Process and System Design Guidelines.

In 2022, IHACPA reviewed the Pricing Guidelines and made minor amendments to the 'Activity based funding (ABF) pre-eminence' pricing guideline, updating it to 'Using ABF where practical and appropriate'.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, stakeholders recommended refinements to the Pricing Guidelines to promote equitable access to health care for populations with differing care needs and to support refinement to the ABF model to promote a sustainable and integrated model. Further detail on this feedback is provided in the Consultation Report.

IHACPA's decision

IHACPA has determined that the current Pricing Guidelines adequately advocates for equitable access to health care and integration with other tiers of the health system within IHACPA's remit of pricing public hospital services.

IHACPA considers that amendments to the Pricing Guidelines are not required at this time.

Next steps and future work

IHACPA will continue to use the Pricing Guidelines to inform its decision making. IHACPA will also continue to review the Pricing Guidelines to ensure they support ongoing improvement to the efficiency and accessibility of public hospital services.

Figure 1. The Pricing Guidelines

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

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

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

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

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

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Promoting value**: Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.
- **Promoting harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **Using ABF where practicable and appropriate:** ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.
- **Single unit of measure and price equivalence**: ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Patient-based**: Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.
- **Public-private neutrality**: ABF pricing should ensure that payments a local hospital network (LHN) receives for a public patient should be equal to payments made for a LHN service for a private patient.

4

Scope of public hospital services

4. Scope of public hospital services

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

4.1 General List of In-Scope Public Hospital Services

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

Clause A17 of the Addendum to the NHRA 2020–25 (the Addendum) and the IHACPA *General List of In-Scope Public Hospital Services Eligibility Policy* (the General List Policy) outlines the scope of public hospital services eligible for Commonwealth funding under the Addendum and the process used by IHACPA to determine whether specific services proposed by a state or territory are 'in-scope' for inclusion on the General List.

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

In May 2022, IHACPA refined the General List Policy to provide guidance for IHACPA's assessment of the eligibility criteria and key attributes, and to provide clarity on IHACPA's consideration of trials of innovative models of care and services for inclusion on the General List.

Further information on IHACPA's investigation of innovative funding models is outlined in Chapter 8.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, stakeholders provided feedback that IHACPA consider accepting submissions under the General List Policy on a more flexible basis.

Stakeholders also provided feedback that urgent care centres should be considered in-scope for funding under the NHRA. IHACPA notes that urgent care centres are captured under activity based funding where an urgent care centre meets the definition for emergency services and under the National Efficient Cost Determination where facilities do not have the capacity to enable activity based funding reporting.

IHACPA's decision

IHACPA will review the submission process as part of its 2023 review of the General List Policy, noting that the inclusion of services determined to be in-scope will still need to align with the annual NEP Determination development cycle.

5

Classifications used to describe and price public hospital services

5. Classifications used to describe and price public hospital services

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

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

The Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for reviewing and updating the following six classifications:

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

5.1 Admitted acute care

The Australian Refined Diagnosis Related Group (AR-DRG) classification is used for admitted acute episodes of care. AR-DRGs are underpinned by the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI), and Australian Coding Standards (ACS). These are collectively known as ICD-10-AM/ACHI/ACS.

ICD-10-AM/ACHI/ACS Twelfth Edition was released in March 2022 alongside a comprehensive education program outlining its changes.

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

AR-DRG Version 11.0

AR-DRG Version 11.0 was released in July 2022 alongside education modules to support its implementation, available on the IHACPA Learn platform.

AR-DRG Version 11.0 has been updated to maintain clinical currency and robustness including the introduction of three new Adjacent Diagnosis Related Groups and changes to using biological sex as a classification variable. Further detail on updates to AR-DRG Version 11.0 is available on the IHACPA website.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* (the Consultation Paper), stakeholders were supportive of IHACPA's proposal to use AR-DRG Version 11.0 to price admitted acute services for the NEP Determination 2023–24 (NEP23) and recommended further refinements to inform AR-DRG Version 12.0. Further detail on these refinements is provided in the Consultation Report.

IHACPA's decision

For NEP23, IHACPA will use AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition to price admitted acute patient services, without a shadow pricing period.

Next steps and future work

IHACPA will consult with stakeholders in undertaking development of AR-DRG Version 12.0 and ICD-10-AM/ACHI/ACS Thirteenth Edition, in line with the three-year development cycle.

Release of ICD-11

The Consultation Paper outlined IHACPA's intention to prepare for the implementation of the 11th Revision of the International Classification of Diseases (ICD-11) in consultation with the Australian Institute of Health and Welfare and the Australian Bureau of Statistics.

Stakeholders were supportive of IHACPA's proposal to refocus resources to ICD-11 'readiness' projects such as mapping between ICD-10-AM and ICD-11 and gap analysis. Stakeholders also recommended other projects to prepare for ICD-11 implementation. Further detail on these recommendations is provided in the Consultation Report.

Next steps and future work

IHACPA will work with its advisory committees and classification working groups to develop a work program to inform and support the implementation of ICD-11.

5.2 Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services. For NEP22, IHACPA used AN-SNAP Version 4.0 to price admitted subacute and non-acute services and AN-SNAP Version 5.0 to shadow price admitted subacute and non-acute services.

AN-SNAP Version 5.0

AN-SNAP Version 5.0 was released in December 2021 and has been developed through statistical analysis and consultation with jurisdictions, clinicians and classification experts and represents a modest refinement of AN-SNAP. The most significant refinement is the recognition of frailty as a cost driver, which has received support from clinicians and broader stakeholders.

The Consultation Paper outlined IHACPA's intention to price admitted subacute and non-acute services using AN-SNAP Version 5.0 for NEP23 following the completion of one year of shadow pricing. The Addendum to the National Health Reform Agreement 2020–25 requires the completion of a two year shadow pricing period, unless agreed by the Commonwealth and a majority of states and territories.

A majority of jurisdictions requested that IHACPA undertake the full two-year shadow pricing period for the change.

IHACPA's decision

Following a review of jurisdictional feedback, for NEP23 IHACPA will price admitted subacute and non-acute services using AN-SNAP Version 4.0 and shadow price admitted subacute and non-acute services using AN-SNAP Version 5.0 for a second year.

5.3 Emergency care

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

In response to the Consultation Paper, stakeholders provided feedback that IHACPA should consider refining certain areas in the AECC such as reviewing the mappings between Systematized Nomenclature of Medicine Clinical Terms and ICD-10-AM codes, progressing the diagnosis short list and considering tracking and mapping 'diagnostic modifiers' as drivers of investigation costs. Further detail on this feedback is provided in the Consultation Report.

IHACPA's decision

IHACPA will use AECC Version 1.0 to price emergency department activities and UDGs Version 1.3 to price emergency services for NEP23.

Next steps and future work

IHACPA is currently investigating emergency care interventions as a potential variable for future refinements of the AECC and will assess the feasibility of incorporating refinements proposed by stakeholders as part of its classification development work program, noting IHACPA continually refines the Emergency Department Principal Diagnosis Short List and associated mappings in consultation with stakeholders as part of the standard work program.

As part of this process, IHACPA will undertake thorough impact analysis and consultation with jurisdictions and health stakeholders.

5.4 Non-admitted care

Tier 2 Non-Admitted Services Classification

The Tier 2 Non-Admitted Services Classification is the existing classification system used to price non-admitted services.

For NEP22, IHACPA used the Tier 2 Non-Admitted Services Classification Version 7.0 to price non-admitted services.

In response to the Consultation Paper, stakeholders indicated support for refinements to the Tier 2 Non-Admitted Services Classification proposed by IHACPA to maintain the classification's relevancy while a new non-admitted care classification is being developed. These refinements included the introduction of new clinics for violence, abuse, and neglect services, and long coronavirus disease 2019 (COVID-19), and new classes for exercise physiology and genetic counselling - allied health/clinical nurse counselling. Stakeholders also recommended additional areas for refinement as part of IHACPA's maintenance work, outlined in the Consultation Report.

IHACPA intends to introduce four new classes for '20.58 Long COVID', '40.65 Violence, Abuse, and Neglect Services', '40.66 Genetic Counselling', and '40.67 Long COVID' to better account for the activity being reported against existing Tier 2 class and to collect applicable activity and cost data to inform price weight refinement.

The addition of these classes have been incorporated as part of the update to the Tier 2 Non-Admitted Services Classification Version 8.0.

IHACPA's decision

For NEP23, IHACPA will use the Tier 2 Non-Admitted Services Classification Version 8.0 for pricing non-admitted services.

For NEP23, IHACPA will also price the Tier 2 '40.62 Multidisciplinary case conference - patient not present' class, following two years of shadow pricing.

Next steps and future work

In its analysis of activity and cost data for future Determinations, IHACPA will consider whether the additional refinements recommended by stakeholders to the Tier 2 Non-Admitted Services Classification are required, while a new non-admitted care classification is being developed.

A new non-admitted care classification

In 2018, IHACPA commenced a national costing study to inform the development of a new non-admitted care classification. The costing study was suspended in 2020 due to the impact of COVID-19.

The Consultation Paper outlined IHACPA's proposed plan to recommence the costing study using jurisdictional electronic medical records systems and linking this to costing data.

Stakeholders supported the recommencement of the non-admitted costing study, pending jurisdictional capacity and recommended areas for focus in the costing study. Further detail on these recommendations is provided in the Consultation Report.

Next steps and future work

IHACPA will work with states, territories, and its advisory committees and working groups to recommence the non-admitted care costing study. This includes assessing data limitations in the proposed methodology using electronic medical records systems, identifying areas for focus in the costing study, ethical and privacy considerations related to electronic medical records data and the impact of COVID-19 on service delivery and models of care.

5.5. Mental health care

Admitted mental health care

For NEP22, IHACPA priced admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0.

In response to the Consultation Paper, stakeholders proposed areas for refinement to AMHCC Version 1.0 such as reviewing age restrictions in the Health of the Nations Outcomes selection, reviewing the indicator for patients treated on an involuntary basis, and considering an admitted class for electroconvulsive therapy. Further detail on these areas is available in the Consultation Report.

IHACPA's decision

IHACPA will continue to price admitted mental health care using AMHCC Version 1.0 for NEP23.

Next steps and future work

IHACPA will assess the feasibility of incorporating the proposed refinements as part of its classification development work program for the AMHCC.

Community mental health care

Community mental health care is currently block funded as part of the National Efficient Cost (NEC) Determination, with states and territories advising their block funded expenditure each year.

NEP22 was the second year of shadow pricing for community mental health care using AMHCC Version 1.0. In NEP22, a new pricing model structure was introduced, based on the number of service contacts within a Mental Health Phase of Care (MHPoC). IHACPA has developed MHPoC education materials in consultation with jurisdictions, clinicians, consumer and carer representatives to assist with the consistency of MHPoC application.

IHACPA notes that volume and coverage of community mental health data has improved substantially since the introduction of the AMHCC. However, stakeholders provided feedback that additional time was required to improve the quality and quantity of activity and cost data for community mental health care, and to analyse the impact of the pricing model structure prior to progressing to pricing.

IHACPA's analysis of the available activity and cost data indicates that although data collections and model performance show improvements, an additional year of shadow pricing community mental health care using AMHCC Version 1.0 will enable better understanding of the impact of transitioning from block funding to ABF for community mental health care. The additional year of shadow pricing will also facilitate the further development of arrangements to support this transition and enable stable funding flows within the states and territories.

IHACPA's decision

For 2023–24, IHACPA will continue to block-fund community mental health care under the NEC Determination 2023–24 (NEC23) while undertaking an additional year of shadow pricing using AMHCC Version 1.0.

During this year of shadow pricing, IHACPA will work with jurisdictions to continue to improve data collections and jurisdictional preparedness to progress to pricing.

Next steps and future work

IHACPA intends to progress to pricing community mental health services using AMHCC Version 1.0 for the NEP Determination 2024–25 (NEP24).

IHACPA notes that progression to pricing community mental health care using AMHCC Version 1.0 for NEP24 will continue to incentivise improvements in the volume and coverage of community mental health data and provide greater funding transparency.

Education materials to further assist with training and improving the consistency of MHPoC ratings will be released in late 2022.

5.6. Teaching and training

Teaching and training activities are currently block funded as part of the NEC Determination except where teaching and training is delivered in conjunction with patient care (embedded teaching and training), such as ward rounds. These costs are reported as part of routine care and are reflected in the ABF price. This is due to the unavailability of teaching and training components required for ABF.

IHACPA has developed the Australian Teaching and Training Classification (ATTC) as a national classification for teaching and training activities which occur in public hospitals. The ATTC aims to provide a nationally consistent approach to how teaching and training activities are classified, counted and costed.

IHACPA's decision

For NEC23, IHACPA will continue to determine block-funding amounts for teaching, training and research activity based on advice from states and territories.

Next steps and future work

IHACPA will continue to work with jurisdictions on investigating alternative models to block funding until the ATTC can be enabled.

6

Setting the national efficient price

6. Setting the national efficient price

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

6.1 National pricing model

IHACPA has developed a robust pricing model that underpins the annual determination of the NEP, price weights and adjustments, based on the activity and cost data from three years prior. The national pricing model is described in further detail in the National Pricing Model Technical Specifications on the IHACPA website.

6.2 Adjustments to the national efficient price

Clauses A46 and A47 of the Addendum require IHACPA to determine adjustments to the NEP and have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:

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

Patient transport costs

The *Consultation Paper on the Pricing Framework for Australian Public Hospitals 2022–23* signalled IHACPA's intention to reinvestigate the need for an adjustment for patient transport in rural and remote areas, although this was deferred in 2022 due to the prioritisation of making refinements to the national pricing model to account for the impact of coronavirus disease 2019 (COVID-19).

For the NEP Determination 2023–24 (NEP23), IHACPA has reinvestigated the need for an adjustment for patient transport in rural and remote areas, including aeromedical ambulances and inter-hospital transfers.

IHACPA notes that although patient travel costs are highest for patients in rural and remote areas, the existing patient residential and treatment remoteness adjustments are intended to account for the legitimate and unavoidable cost variations in rural and remote areas.

IHACPA's decision

Following a review of stakeholder feedback and available data, IHACPA has determined that an additional adjustment for patient transport costs in rural and remote areas is not required.

Next steps and future work

IHACPA has included updates to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2, which were developed in consultation with jurisdictions to assist in improving data quality related to patient transport costs. AHPCS Version 4.2 is due to be released in mid-2023.

Refinement of existing adjustments and development of new adjustments

In the *Consultation Paper on the Pricing Framework for Australian Public Hospitals 2023–24* (the Consultation Paper), IHACPA signalled its intention to review 2020–21 activity and cost data to determine whether sufficient data is available to progress investigation of the following adjustments, recognising the impact of COVID-19 during this period: review of the Indigenous status adjustment, the Specified Intensive Care Unit and specialised children's hospitals eligibility criteria, and investigate the need for new adjustments for genetic services and socioeconomic status.

Stakeholders supported investigation of all of these adjustments and proposed additional areas for exploration of refinement to the national pricing model. Further detail on this feedback is provided in the Consultation Report.

Instability was introduced into activity and cost data during 2019–20, 2020–21 and 2021–22 due to COVID-19. The development and review of adjustments to address specific areas in the national pricing model needs to be supported by stable data over multiple years to ensure the proposed area requiring adjustment is sustained over time. Stable data is also required to inform the application of the adjustment, for example whether a single national adjustment is required or whether the adjustment should be applied to specific end-classes or target specific cohorts.

IHACPA will prioritise national pricing model refinements to account for COVID-19 impacts for NEP23 and further consider these adjustments for future NEP Determinations based on the availability of stable data.

IHACPA's decision

For NEP23, IHACPA has deferred further consideration of developing new adjustments or reviewing existing adjustments to future NEP Determinations to prioritise national pricing model refinements to account for COVID-19 impacts.

Next steps and future work

IHACPA intends to work with its advisory committees to undertake a program of work to investigate and implement these proposed refinements, to inform future NEP Determinations.

6.3 Cost pressures

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

In the Consultation Paper, IHACPA sought feedback on what cost pressures may have an impact on the national pricing model and are not included in the National Hospital Cost Data Collection (NHCDC) and should be considered in the development of NEP23.

Stakeholders noted the following cost pressures that are likely to impact the national pricing model:

- further increases in the superannuation guarantee, indemnity and insurance premiums
- workforce shortages, wage increases, award wages and conditions financial incentives
- increased infrastructure, commodity and utility prices due to inflation and supply chain disruption
- increased responsibilities from legislative changes relating to work, health and safety and digital security.

IHACPA notes that ongoing costs associated with staffing are captured in the NHCDC and therefore reflected in the reference cost for NEP23. IHACPA also accounts for the superannuation guarantee and the effect of inflation through the indexation methodology and the incorporation of year-on-year cost growth amounts within the broader national pricing model methodology.

Costs associated with system management of public hospitals including planning, funding and delivering capital and managing industrial relations are the responsibility of the states and territories and not in-scope under the National Health Reform Agreement.

Next steps and future work

IHACPA will work with jurisdictions to review the indexation methodology for future NEP Determinations.

6.4. Harmonising price weights across care settings

IHACPA's Pricing Guidelines include an objective for price harmonisation whereby pricing should facilitate best practice provision of appropriate site of care.

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

In response to the Consultation Paper, states, territories, and broader stakeholders supported IHACPA undertaking work to harmonise price weights across care settings. Stakeholders also noted concerns regarding the impact of COVID-19 on data, the potential need for transitional arrangements and price stabilisation and consideration of unintended consequences for future models of care. Further detail is provided in the Consultation Report.

IHACPA notes progressing price harmonisation requires analysis on the stability of the underlying data, the suitability of services for harmonisation and the potential unintended consequences of pursuing price harmonisation. IHACPA notes that instability was introduced into activity and cost data for the years 2019–20, 2020–21 and 2021–22 as a result of COVID-19. This limits the ability to progress price harmonisation based on the data available.

IHACPA's decision

For NEP23, IHACPA has deferred consideration of price harmonisation to prioritise national pricing model refinements to account for COVID-19.

Next steps and future work

IHACPA acknowledges the importance of progressing refinements to the national pricing model. IHACPA intends to work with its advisory committees to develop a proposed approach and timeframes for progressing price harmonisation, noting further consultation with states and territories is required to undertake analysis on the stability of the underlying data, the suitability of services for harmonisation and the potential unintended consequences of pursuing price harmonisation for future Determinations.

6.5. Unqualified newborns

In the Consultation Paper, IHACPA noted its intention to investigate how costs for unqualified newborns are accounted for in the national pricing model and assessing whether methodology changes are required.

At present, a newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is considered qualified if the infant meets at least one of the following criteria[1]:

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

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

[1] Newborn qualification status. Available at: https://meteor.aihw.gov.au/content/index.phtml/itemId/327254

In response to the Consultation Paper, stakeholders noted that the current approach to pricing newborn episodes of care does not reflect increased care being provided to newborns outside of the intensive care unit setting, and that bundling of unqualified newborns within the maternal DRG may not adequately reflect the cost of care. Stakeholders recommended costs associated with both qualified and unqualified newborns should be assigned to separate DRG prices, independent of the mother's admitted episode. Stakeholders also recommended reviewing the definitions and business rules for unqualified newborns.

IHACPA's decision

IHACPA will work with its advisory committees to review the funding methodology of unqualified newborns for future NEP Determinations, noting available cost data is limited and changes may be required to jurisdictional costing practices to support refinements to the methodology.

Next steps and future work

IHACPA notes that the criteria for determining qualification status which is set out in legislation would be considered out-of-scope for this review. However, IHACPA will consult with the Commonwealth Department of Health and Aged Care regarding the feasibility of undertaking legislative changes related to the qualification status of newborns.

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

The Addendum specifies that IHACPA will adjust the price for privately insured patients in public hospitals to the extent required to achieve overall payment parity between public and private patients in the relevant state or territory, taking into account all hospital revenues.

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

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

IHACPA implements a private patient methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public. Stakeholders provided feedback regarding the limits and consistency of data used in the methodology, and the methodology's potential impact on the growth of public NWAU.

IHACPA's decision

IHACPA will continue to implement the private patient neutrality methodology for NEP23.

Next steps and future work

IHACPA will consider reviewing the private patient methodology on the basis of alternative, evidence-based methodologies proposed by the states and territories.

Phasing out the private patient correction factor

The collection of private patient medical expenses has previously been problematic in the NHCDC, which led to the introduction of the private patient correction factor as an interim solution for the issue of missing private patient costs in the NHCDC.

The implementation of the Australian Hospital Patient Costing Standards Version 4.0 aimed to address the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required.

The private patient correction factor was removed for the Northern Territory for the NEP Determination 2021–22.

IHACPA's decision

IHACPA will continue to work with the remaining states and territories to phase out the private patient correction factor.

6.7. Organ donation, retrieval and transplantation

In 2018, the *Review of the Australian organ donation, retrieval and transplantation system – Final Report* made two recommendations for IHACPA to conduct a costing study and classification review of organ donation, retrieval and transplantation and of non-admitted pre and post organ transplantation care.

In response to the Consultation Paper, stakeholders supported the proposed investigation of costs associated with organ donation, retrieval and transplantation services, noting that changes to the National minimum data set requirements may be necessary.

Stakeholders also provided feedback on other costs associated with organ donation, retrieval and transplantation and sources of data for IHACPA to consider in undertaking a costing study. Further information is available in the Consultation Report.

IHACPA's decision

IHACPA will review available activity and cost data, and develop a project plan to investigate the feasibility of progressing this work in consultation with advisory committees.

IHACPA will also work with its advisory committees, the Commonwealth Department of Health and Aged Care and the Australian Institute of Health and Welfare to progress the development of the Posthumous organ procurement national best endeavours data set.

7

Setting the national efficient cost

7. Setting the national efficient cost

7.1 Overview

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

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

7.2 Cost pressures on regional hospitals

In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* (the Consultation Paper), IHACPA acknowledged that there has been an increase in in-reach models of care that have been established in some regional hospitals to alleviate pressure on metropolitan hospitals arising from the coronavirus disease 2019 (COVID-19) response.

In response to the Consultation Paper, stakeholders proposed the following cost pressures for consideration in the development of the NEC Determination 2023–24 (NEC23):

- rural-specific contract or award conditions
- rural workforce shortages, high cost of locum and contract staff, recruitment and retention costs, fly-in fly-out arrangements and absences due to COVID-19
- regional and remote specific costs, including patient transport costs, cost of living and high cost of specialised services and medications due to limited access.

IHACPA notes that some of the additional costs associated with the delivery of health services in regional or remote areas are accounted for through the existing patient residential and patient treatment remoteness adjustments developed for the national efficient price (NEP).

IHACPA also applies an additional loading to the NEC Determination for 'very remote' hospitals that is targeted at addressing the additional costs associated with the delivery of regional and remote health services. Ongoing staffing costs due to the impact of COVID-19 are captured in the National Hospital Cost Data Collection and reflected in the reference cost for NEC23.

Costs associated with system management of public hospitals including planning, funding and delivering capital and managing industrial relations are the responsibility of the states and territories and not in-scope under the NHRA.

IHACPA's decision

IHACPA has considered the feedback received from stakeholders and considers that the current remoteness adjustments and loadings adequately account for additional cost pressures within IHACPA's remit of pricing public hospital services.

7.3 The 'fixed-plus-variable' model

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

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

IHACPA's decision

IHACPA will continue to use the 'fixed-plus-variable' model for NEC23.

Standalone hospitals providing specialist mental health services

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

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

IHACPA introduced pricing admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0 for the NEP Determination 2022–23. In the Consultation Paper, IHACPA outlined its intention to investigate the feasibility of transitioning standalone hospitals providing specialist mental health services to ABF in the development of NEC23.

Stakeholders noted concerns with transitioning standalone hospitals to ABF due to the significant differences in patient profiles, service models, length of stay and resources that may not be accounted for in the AMHCC model. Stakeholders also provided feedback that given some standalone hospitals report limited or incomplete activity and cost data, the current AMHCC model may not adequately capture the costs associated with service delivery, which could negatively impact funding for standalone hospitals. Further detail is available in the Consultation Report.

IHACPA's decision

IHACPA acknowledges the concerns provided by stakeholders and considers that additional consultation is required prior to transitioning block-funded standalone hospitals to ABF to mitigate the risk of incurring unintended consequences. As such, IHACPA will continue to block fund standalone hospitals providing specialist mental health services for NEC23.

7.4 Quality assurance of public health expenditure data

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

In the Consultation Paper, IHACPA noted that it is exploring the development of an independent quality assurance process for the public health expenditure included in Local Hospital Networks and Public hospital establishments national minimum data set. This process will help to ensure high quality input data for cost modelling for the NEC Determination is maintained and aligns with the quality assurance process adopted to inform the NEP Determinations.

Stakeholders suggested a range of areas in the Local Hospital Networks and Public hospital establishments national minimum data set to focus on when developing IHACPA's independent quality assurance process. These included the inclusion of non-patient products in the National Hospital Cost Data Collection, data relating to demand for local services in rural areas such as cancer treatment and emergency department services, and data related to patients with complex needs. Further detail is available in the Consultation Report.

Following consultation with the Australian Institute of Health and Welfare, IHACPA has developed a plan for undertaking additional quality assurance of the Local Hospital Networks and Public hospital establishments national minimum data set.

Next steps and future work

IHACPA will work with its advisory committees to refine and implement the quality assurance process for the public health expenditure included in the Local Hospital Networks and Public hospital establishments national minimum data set to inform NEC23.

8

Future funding models

8. Future funding models

The Addendum to the National Health Reform Agreement 2020–25 (the Addendum) provides opportunities for states and territories to trial new funding approaches and outlines the Independent Health and Aged Care Pricing Authority's (IHACPA) role in supporting these reforms. Clause A99 of the Addendum stipulates that states and territories can seek to trial innovative models of care, either:

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

8.1 Telehealth video consultations delivered by emergency departments

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, stakeholders indicated their support for IHACPA to investigate innovative models of care and services related to virtual care with an initial focus on telehealth video consultations delivered by emergency departments. Stakeholders also supported investigation of the inclusion of emergency department telehealth video consultations in the Non-admitted patient emergency department care national minimum data det (NAPEDC NMDS), and the Emergency service care national best endeavours data set (ESC NBEDS) for 2023–24.

Stakeholders noted the delivery of some virtual care services are currently being captured in the admitted and non-admitted data collections, although these systems and processes vary across states and territories.

Stakeholders provided examples of innovative models of care related to virtual care across different settings including remote monitoring, telehealth services, hospital-in-the-home, virtual general practitioner and specialist consultations, pharmacy or outpatient services, asynchronous healthcare, virtual ward rounds, virtual midwifery and nurse-led models of care, and other virtual bundled payment and capitation models.

Stakeholders also proposed a range of factors IHACPA should consider when implementing changes to the national pricing model to account for innovative models of care and services related to virtual care such as ensuring pricing and data collection adequately reflects the resources required and potential variation in costs between virtual and face to face care. Further detail is available in the Consultation Report.

Next steps and future work

IHACPA has commenced consultation with the states and territories through its advisory committees to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and ESC NBEDS and consider the necessary changes to the national pricing model to account for innovative models of care and services related to virtual care. IHACPA proposes to undertake a staged implementation approach to minimise implementation burden and ensure sufficient time to develop an approach to capturing virtual care data across all care types in the future.

IHACPA has engaged with the National Health Reform Agreement Reform Implementation Group and the states and territories to facilitate the development of broader trial principles and guidelines for considering proposals of innovative funding models for trial under bilateral agreements with the Commonwealth.

9

Pricing and funding for safety and quality

9. Pricing and funding for safety and quality

9.1 Overview

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

Under the Addendum, IHACPA is required to incorporate safety and quality into the pricing and funding of public hospital services to improve patient outcomes across three key areas: sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions.

The funding adjustments applied as part of the safety and quality reforms not only act as a price signal, but also aim to improve awareness of areas that clinicians and hospital managers can work on to address and improve patient care.

9.2 Sentinel events

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

IHACPA's funding approach for sentinel events is to assign a national weighted activity unit (NWAU) of zero to an episode of care with a sentinel event, applicable to all hospitals, whether funded on an activity or block funded basis.

IHACPA's decision

For the National Efficient Price Determination 2023–24 (NEP23), IHACPA will continue to assign zero NWAU to episodes with a sentinel event using Version 2.0 of the Australian Sentinel Events List, available on the Commission's website.

9.3 Hospital acquired complications

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

IHACPA's funding approach for HACs incorporates a risk adjustment model that reduces funding for any episode of admitted acute care where a HAC occurs. Further information on the HACs funding approach is included in the National Pricing Model Technical Specifications on the IHACPA website.

The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant. The Commission released Version 3.1 of the HACs list in March 2021.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* (the Consultation Paper), stakeholders indicated concerns with the use of condition onset flags to identify HACs and the flow on impact of resourcing constraints in primary care and aged care in contributing to HACs and sentinel events. Stakeholders also provided feedback about the opportunities for new technologies to reduce HACs.

IHACPA's decision

For NEP23, IHACPA will use Version 3.1 of the HACs list, available on the Commission's website.

Next steps and future work

IHACPA will consider stakeholder feedback alongside feedback or directives received from health ministers to inform refinements to the HAC adjustment if required.

9.4 Avoidable hospital readmissions

An avoidable hospital readmission occurs when a patient has been discharged from hospital (the index admission) and has a subsequent unplanned admission that is related to the index admission and was potentially preventable.

IHACPA's funding approach to avoidable hospital readmissions involves the application of a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode, to apply where there is a readmission to any hospital within the same jurisdiction. IHACPA applies a discrete risk adjustment model for each readmission condition, which assigns the risk of being readmitted for each episode of care. Further information on the avoidable hospital readmissions funding approach and risk adjustment model is available within the National Pricing Model Technical Specifications on the IHACPA website.

This approach uses the list of avoidable hospital readmission conditions developed by the Commission. Version 2.0 of the avoidable hospital readmissions list and specifications was released in May 2022 and included new diagnosis categories for the following avoidable hospital readmissions: "pressure injury', 'infections', 'respiratory complications; 'medical complications' and 'cardiac complications'.

In response to the Consultation Paper, stakeholders provided feedback for IHACPA to consider reviewing the application of the adjustment to ensure the index episode is clinically related to the readmission episode.

Stakeholders also suggested IHACPA consider providing incentivisation for the use of technologies that proactively reduce avoidable and preventable hospitalisation.

IHACPA notes the list of avoidable hospital readmissions and associated condition-specific time intervals was developed in consultation with clinical experts and jurisdictions. The Commission has an ongoing work program to ensure the accuracy and currency of the avoidable hospital readmission conditions to ensure they are related to the index admission.

IHACPA's decision

For NEP23, IHACPA will implement the avoidable hospital readmissions funding adjustment using Version 2.0 of the avoidable hospital readmissions list, available on the Commission's website.

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