IHACPA

Pricing Framework for Australian Public Hospital Services 2024–25

Consultation Report

December 2023

Independent Health and Aged Care Pricing Authority

Pricing Framework for Australian Public Hospital Services 2024-25 – Consultation Report December 2023

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Introduction

1. Introduction

1.1 About IHACPA

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

IHACPA enables 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 (NHRA).

1.2 About this Consultation Report

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

IHACPA conducted a public consultation on key issues to be included in the Pricing Framework 2024–25 through the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper).

The consultation period ran from 14 June 2023 to 14 July 2023 and invited submissions from the Commonwealth, state and territory health departments, professional health organisations, private health industry and other interested members of the Australian public.

IHACPA received 27 submissions to the Consultation Paper 2024–25 from a diverse range of stakeholders. Key themes arising from the consultation feedback are summarised in this report, corresponding with the chapters in the Pricing Framework 2024–25. This stakeholder feedback has informed the development of the Pricing Framework 2024–25, including the decisions that underpin the NEP and NEC Determinations for 2024–25.

IHACPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. The key decisions for the NEP Determination 2024–25 and the NEC Determination 2024–25 are outlined in the Pricing Framework 2024–25.

All submissions have been made available on IHACPA's website, unless they were marked confidential for commercial or other reasons.

The feedback included in this Consultation Report relates to IHACPA's remit of pricing public hospital services only. IHACPA released the *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25* in July 2023 which will inform a separate Consultation Report and the Pricing Framework for Australian Residential Aged Care Services 2024-25.

2

Pricing Guidelines

2. Pricing Guidelines

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the Pricing Guidelines but received feedback from a small number of stakeholders.

Feedback received

New South Wales (NSW) recommended the 'Evidence-based' Process Guideline include a caveat for exemptions to trial innovative models of care and services, or include new services on the General List of In-Scope Public Hospital Services (the General List): "Funding should be based on the best available information, **that as a general principle** is both nationally applicable and consistently reported".

The Australian College of Rural and Remote Medicine (ACRRM) noted the 'Fairness' Overarching Guideline may lead to perverse outcomes if activity based funding (ABF) payments are based on the same price for the same service, given the differences in scale, logistics, workforce and other supporting services that impact rural hospital service delivery.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommended the Pricing Guidelines are further refined to ensure all stakeholders are adequately informed of the funding process for hospitals.

The Centre for Aboriginal Economic Policy Research (CAEPR) recommended inclusion of an overarching principle to pursue equity of access and outcomes for Aboriginal and Torres Strait Islander peoples beyond financial equity and reference within the Pricing Framework for Australian Public Hospital Services (the Pricing Framework) about how IHACPA will meet the policy goals of the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* and the *Closing the Gap Agreement 2020–2025.*

CAEPR further noted an absence of Aboriginal and Torres Strait Islander representation in the Pricing Authority and IHACPA's broader advisory committees, and a lack of tailored consultation that accounts for cultural protocols. CAEPR recommended inclusion of organisations and researchers involved in the delivery of public hospital services to Aboriginal and Torres Strait Islander peoples as partners in the development of the Pricing Framework.

IHACPA's response

IHACPA notes that the Pricing Guidelines provide a principles-based approach to guide policy decision making and provide sufficient flexibility to ensure IHACPA continues to fulfill its functions outlined in the *National Health Reform Act 2011*.

In response to the feedback provided by NSW, ACRRM and RANZCP, IHACPA considers these issues are sufficiently accounted for in the existing Pricing Guidelines. For example, the 'Fairness' Overarching Guideline includes a caveat that ABF payments also recognise the legitimate and unavoidable costs faced by some providers of public hospital services, such as rural hospitals. Similarly, the 'Transparency" Process Guideline encourages that the process of determining ABF and block funding should be clear and transparent.

In response to feedback regarding the incorporation of equity in the Pricing Guidelines, IHACPA has updated the 'Timely-quality care' Overarching Guideline to include the following bolded text: 'Funding should support timely **and equitable** access to **high** quality health services **and reduce disadvantage for all Australians, especially for Aboriginal and Torres Strait Islander peoples**'. This approach aligns with the residential aged care pricing principles in the Pricing Framework for Residential Aged Care Services, as well as the intent of the principles for reform and IHACPA's remit, both outlined in the Addendum to the National Health Reform Agreement (NHRA) 2020–25 (the Addendum).

IHACPA intends that the application of the pricing principles in pricing development is nationally consistent, and therefore does not reference policies or targets relating to particular populations. While IHACPA does not have remit over the policy or service delivery of the activities within the *Closing the Gap Agreement 2020–2025* and the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031*, IHACPA notes that ABF and the Indigenous adjustment are intended to provide appropriate price signals that support the provision of care to Aboriginal and Torres Strait Islander peoples in line with these government commitments, where data is available in national collections. IHACPA will consider opportunities to contribute to the associated reporting and monitoring of the goals within the data sharing parameters set out in the Addendum, in consultation with the jurisdictions as the data owners and other government agencies.

3

Classifications used to describe and price public hospital services

3. Classifications used to describe and price public hospital services

3.1 Admitted acute care

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the admitted acute care classifications due to the advanced stage in the development cycle of the next iterations of the admitted acute care classifications. However, IHACPA received feedback from a number of stakeholders on this area.

Feedback received

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

The Australian Refined Diagnosis Related Group (AR-DRG) classification is used to price admitted acute patient services. AR-DRGs are underpinned by a set of classifications and standards used to collect activity data for admitted care, which includes:

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

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

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper), stakeholders proposed the following areas for refinement in the admitted acute care classifications:

- review of different models of care including virtual care, primary care embedded models and technology-assisted care
- inclusion of separate codes for consultation liaison for all clinical specialties, and patients with superficial partial thickness burns and deep partial thickness burns to support more accurate capture of activity and costs
- rapid whole genome trio testing in the admitted acute setting, including the frequency and mode of funding across states and territories to facilitate equitable access across Australia
- review and refine the AR-DRGs A40Z *Extracorporeal Membrane Oxygenation* and D40Z *Dental Extractions and Restorations* to recognise different costs within the services reported against those AR-DRGs.

IHACPA's response

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

IHACPA is undertaking a broader investigation into how virtual care can be appropriately accounted for in the classifications and national pricing model and prioritising the exploration of new data items for virtual care delivered in emergency departments (EDs). This investigation will inform future considerations relevant to ICD-10-AM/ACHI/ACS and AR-DRG development.

AR-DRG Version 12.0 development will include a review of Adjacent Diagnosis Related Groups (ADRGs) A40 *Extracorporeal Membrane Oxygenation* and ADRG D40 *Dental Extractions and Restorations* as part of IHACPA's standard complexity model review. IHACPA notes that in previous reviews, both ADRGs have not met IHACPA's refinement principles for splitting these ADRGs into end classes.

As the development cycle and work program for ICD-10-AM/ACHI/ACS Thirteenth Edition is in an advanced stage, IHACPA will assess the remainder of the proposed refinements against the classification development principles, outlined in the *Governance framework for the development of the admitted care classifications*, in developing its work program for future versions of ICD-10-AM/ACHI/ACS and AR-DRGs.

3.2 Subacute and non-acute care

Consultation question

- Are there any significant barriers to pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for NEP24?

Feedback received

AN-SNAP Version 5.0

Queensland (Qld), Western Australia (WA) and Tasmania (Tas) supported using the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 for the National Efficient Price (NEP) Determination 2024–25 (NEP24), particularly the recognition of frailty as a cost driver.

New South Wales (NSW), Victoria (Vic), South Australia (SA), the Northern Territory (NT) did not indicate support nor objection to pricing subacute and non-acute care using AN-SNAP Version 5.0 for NEP24.

SA noted concerns regarding the potential for significant changes to coded data related to frailty diagnosis codes as clinicians gain a better understanding of the Frailty Related Index of Comorbidities (FRIC), despite the possibility that codes may not be clinically appropriate and may contradict the application of other ICD-10-AM codes.

SA requested assurance that retrospective penalties will not be applied following improvements to clinical documentation and coding. SA also recommended IHACPA lead a workshop with clinicians and clinical coders to work through their concerns and removing this barrier from using AN-SNAP Version 5.0.

Tas noted limitations in extracting relevant assessment data from local source systems as a consideration for implementing AN-SNAP Version 5.0 for NEP24.

General comments

The Queensland Nursing and Midwifery Union (QNMU) and the Royal Australian College of Physicians (RACP) proposed refinements to AN-SNAP Version 5.0 to better account for patient complexity and higher costs of care due to factors including substance misuse, homelessness, mental health, physical and intellectual disability, aged care, and custodial status.

NSW recommended the alignment of Australasian Rehabilitation Outcomes Centre (AROC) Paediatric impairment codes within their local system's code set to establish a unified set of impairment codes, simplify data collection and promote consistency in capturing impairment information.

IHACPA's response

AN-SNAP Version 5.0

AN-SNAP Version 5.0 introduces a new variable, derived from diagnosis codes, to recognise the impact of frailty related comorbidities as cost drivers for geriatric evaluation and management and non-acute care – the FRIC.

The FRIC is the product of a research project that adapted the Hospital Frailty Risk Score through the mapping and refinement of ICD-10 codes to ensure the index was fit-for-purpose as part of an ABF classification in Australia. Further information about the development of the FRIC is available in the *Development of the Australian National Subacute and Non-acute Patient Classification Version 5.0 - Final Report*.

IHACPA intends to price subacute and non-acute services using AN-SNAP Version 5.0 for NEP24 following two years of shadow pricing.

IHACPA will work with its advisory committees and working groups to monitor and mitigate concerns regarding any changes to coded data that may occur following pricing of AN-SNAP Version 5.0 for NEP24. IHACPA notes shadow pricing has been undertaken for two years as per the requirements of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) to mitigate these risks.

General comments

IHACPA will assess the feasibility of incorporating the proposed refinements as part of the work program for future versions of AN-SNAP. IHACPA notes that codes included in the FRIC will also be subject to review through ongoing classification refinement to ensure it remains fit-for-purpose

In addition, IHACPA recognises frailty as a key driver of higher complexity and costs across all care streams. IHACPA will work with jurisdictions to investigate opportunities to capture frailty as a measure of patient complexity through classification development programs including a review of the literature.

The inclusion of the Australasian Rehabilitation Outcomes Centre (AROC) Paediatric impairment codes is part of the data development work program of the subacute and non-acute care classification. To inform this, IHACPA is proposing updates to the Admitted subacute and non-acute hospital care national best endeavours data set for 2024–25 to include the AROC paediatric impairment codes for classification of paediatric episodes of care and new AROC adult impairment codes to classify COVID-19 rehabilitation episodes.

3.3 Emergency care

Consultation questions

- Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?
- What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition?

Feedback received

Refinement of the AECC

In response to the consultation questions, stakeholders recommended that, to better account for patient complexity, future Australian Emergency Care Classification (AECC) refinement should consider social determinants, rurality and transport costs, paediatric and geriatric complexity, comorbidities and additional diagnoses, as well as interventions such as those given and delivered via virtual care or telehealth.

NSW and the QNMU recommended IHACPA consider the changing practices in emergency care due to coronavirus disease 2019 (COVID-19) and an increase in patients seeking emergency treatment in place of general practice care in future refinements of the classification. In addition, NSW requested that new versions of the AECC are implemented with an appropriate lead time.

SA recommended the following areas be reviewed:

- intubation of patients, use of resuscitation bays and other complex procedures
- need for some patients to have one-on-one security.

EPD Short List Thirteenth Addition

NSW, QLD, the NT and Tas recommended that the following areas are explored in the development of the Emergency Principal Diagnosis Short List (EPD Short List) Thirteenth Edition:

- additional pain management and vaping codes
- advice on mapping external cause codes
- additional codes to better capture emergency care in rural and remote locations
- education on selecting principal diagnosis and improvements to searchable terms.

IHACPA's response

Refinement of the AECC

Many of the refinements recommended by stakeholders are part of the work program for the development of future AECC versions. IHACPA will work with its advisory committees and working groups to assess and incorporate the other proposed refinements into the work program.

EPD Short List Thirteenth Edition

IHACPA will consider incorporating these recommendations in the EPD Short List Thirteenth Edition and has produced a fact sheet designed for clinicians as a guide to select principal diagnoses. IHACPA is considering the development of an electronic version of the EPD Short List that will address issues on searchable terms for the EPD Short List in the future.

3.4 Non-admitted care

Consultation question

- Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25?

Feedback received

Tier 2 Non-Admitted Services Classification

NSW, Qld and SA supported the proposed refinements to the Tier 2 Non-Admitted Services Classification (Tier 2) for home-based infusion therapies related to subcutaneous immunoglobulin for NEP24.

NSW also supported refinements to capture activity for the supervised administration of opioid agonist therapy and requested an additional 20 series Tier 2 class for NEP24 to minimise the impact on price weights for the existing 20.52 Addiction medicine clinic.

Stakeholders proposed the following refinements to Tier 2 for 2024–25:

- improvement in capturing complexity for patients who identify as homeless, Aboriginal and Torres Strait Islander, victims of sexual assault, have a disability, receive palliative care or anaesthesia, or have other complex needs or vulnerabilities
- improvements to support data collection and pricing of virtual and innovative of care, such as remote patient monitoring
- inclusion of classes for violence, abuse and neglect services for forensic examinations and medical consultations, exercise physiology and ophthalmology procedures
- consideration of a pricing mechanism for the Tier 2 classes 40.08 Primary health care and 40.11 Social work
- incorporating a tiered funding structure for hospital pharmacy outpatient consultation services
- greater accuracy in capturing costs for multi-disciplinary case conferencing, the multiple healthcare provider indicator, complex services for anaesthesia, medical procedures and palliative care, and simulation and planning for radiation therapy
- account for greater differentiation between genetic counsellors working in different settings and inclusion of a specialisation qualification of a Human Genetics Association registered genetic counsellor in class 40.66 Genetic counselling.

Stakeholders noted reductions in the price weights for the Tier 2 clinics 10.17 Total parenteral nutrition - home delivered (PN) and 10.16 Renal dialysis - peritoneal dialysis - home delivered (PD) since the NEP Determination 2019–20 (NEP19) and that cost data in the National Benchmarking Portal is inaccurate. Stakeholders noted the most recent price weights do not reflect the costs for administering these services and may present a disincentive for offering these services in hospitals despite their clinical benefits. The Australian and New Zealand Society of Nephrology (ANZSN) raised concerns that the changes may particularly affect Aboriginal and Torres Strait Islander peoples, and culturally and linguistically diverse populations living in rural and remote locations. Stakeholders recommended the following:

- review and restoration of the price weights to those from NEP19
- review of the costing practices of hospitals for PN and PD across jurisdictions
- ensure transparency and awareness of the impact of price weight changes
- application of the same methodologies as other changes to the national pricing model such as shadow pricing.

The Human Genetics Society of Australasia Professional Issues for Genetic Counsellors Committee (HGSA PIGC) recommended a costing study to ensure the ancillary costs of providing genetics services are being captured, including in clinical genetics services, familial cancer clinics and mainstream settings in public hospitals.

New non-admitted care classification

NSW, Qld and the Australian Medical Association (AMA) supported the commencement of the Australian Non-Admitted Patient Classification Project (ANAPP) and the utilisation of health information within jurisdictional electronic medical record (eMR) systems. Qld noted the importance of a patient-based approach to classification development.

The QNMU suggested consideration be given to how data will be captured in settings that do not use electronic medical records as part of the ANAPP.

IHACPA's response

Tier 2 Non-Admitted Services Classification

For NEP24, IHACPA has consulted with its advisory committees and working groups to include two new classes in Tier 2 for '10.22 Subcutaneous immunoglobulin (SCIg) infusion therapy - home delivered' and '40.68 Supervised administration of opioid substitution therapy'. The inclusion of these new classes has resulted in a new version of the classification, Version 9.0.

IHACPA notes that currently remote patient monitoring would be considered out-of-scope, as it does not meet the definition of a non-admitted patient service event, except where it is part of the service delivery for in-scope admitted and non-admitted care. IHACPA is exploring potential improvements in activity and cost data collections for virtual care beyond the emergency care setting to inform classification refinement and changes to the national pricing model. IHACPA will consult with jurisdictions to understand the cost data currently being collected. This will inform development of costing guidelines to facilitate improvements in the collection of virtual care cost data in all settings for future Determinations.

IHACPA also notes that the Tier 2 class 40.08 Primary health care is considered out-of-scope for Commonwealth funding, and activity associated with in-reach community services in inpatient

settings is captured in the admitted acute and admitted subacute care classifications.

IHACPA considered the introduction of a new class for exercise physiology as part of the refinements to Tier 2 Version 8.0 for NEP Determination 2023–24 (NEP23), however this was not supported.

IHACPA will work with its advisory committees and working groups to assess and review the other proposed refinements for the future work programs to better capture non-admitted activity data, including implementation of innovative models of care.

In response to the concerns raised around accurate pricing for the delivery of PN and PD, IHACPA notes that price weight changes have resulted from an annual and ongoing program of work to refine the national pricing model, based on data driven, evidence-based methodologies, in consultation with jurisdictions. For the NEP Determination 2022–23 (NEP22), it was determined that there was sufficient stability and availability of National Hospital Cost Data Collection (NHCDC) data to support the transition of the Tier 2 class 10.17 Total parenteral nutrition - home delivered to being priced using actual activity and cost data reported by jurisdictions. Similarly, the Tier 2 class 10.16 Renal dialysis - peritoneal dialysis - home delivered transitioned to using actual activity and cost data for NEP23 on the basis of sufficient and stable cost data. These changes mean that pricing is more responsive to changes in the actual costs associated with the delivery of this service over time.

IHACPA notes that preliminary analysis indicates that the Tier 2 class 10.15 Renal dialysis - haemodialysis - home delivered is a candidate to transition to being priced using actual activity and cost data reported in the NHCDC for NEP24. Aside from updates based on the latest cost and activity data, there is no intention to specifically review the pricing of these clinics for NEP24.

New non-admitted care classification

In 2023, IHACPA commenced the Australian Non-Admitted Patient Classification Project (ANAPP), a multi-staged project to explore the feasibility of developing a new non-admitted care classification through the utilisation of the health information available in state and territory eMR systems. This approach enables the classification development process to minimise the administrative burden on states and territories and the impact on clinical service delivery associated with a traditional costing study.

IHACPA has completed Stage One of the ANAPP which includes a series of consultations with state and territory health departments and other relevant stakeholders to better understand eMR and other systems and the data elements available. Following this, IHACPA commenced Stage Two of ANAPP, the development of a proof-of-concept.

3.5 Mental health care

Consultation questions

- Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?
- Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

Feedback received

Pricing community mental health care using AMHCC Version 1.0

NSW, Vic and Qld did not support pricing community mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0 for NEP24, citing concerns over underfunding of these services. Jurisdictions also noted the following considerations:

- limited quality and quantity of available activity and cost data
- limitations with the definition, data linkage, grouping and cases where consumers refused to disclose their date of birth and name
- the need for clarification on how activity is linked to phases where a consumer is seen by multiple teams at the same time
- small sample size used to develop shadow price weights
- classification limitations and potentially premature implementation prior to the release of AMHCC Version 1.1, which will address known issues such as by allowing up to two missing Health of the Nation Outcome Scales (HoNOS) scores
- appropriateness of using the activity based funding (ABF) criteria for establishments that have only one stream such as specialist mental health services.

Qld recommended another year of shadow pricing and Vic recommended using AMHCC Version 1.1 for pricing, rather than Version 1.0.

SA, WA, Tas and the NT did not indicate support nor an objection to pricing of community mental health care using AMHCC Version 1.0 for NEP24, however, noted the following considerations:

- improvements are required in the accuracy and robustness of activity and cost data
- assurance of funding stability for jurisdictions not currently reporting this data and which may have different cost profiles to other jurisdictions, ensuring states and territories are not financially worse off due to the transition to ABF
- clarification regarding reporting of outpatient services provided in hospital to community mental health consumers.

Tas noted it will continue to develop its cost data for community mental health care to enable benchmarking against other jurisdictions, noting improvements will not be available until cost data for 2022–23 is finalised.

SA provided in-principle support for the transition to ABF subject to improvements in data collection.

Transition to ABF for community mental health care

Stakeholders provided the following recommendations to assist in the transition of community mental health from block funding to ABF:

- clarification and safeguards around how the transition will inform or impact the Commonwealth funding contribution growth cap to ensure funding stability in the long-term, and exemption of community mental health activity from the calculation of the funding cap
- provision of control to jurisdictions to determine which services transition to ABF within the transitional arrangements
- provision of block funding as part of transitional arrangements until health services can adequately report activity
- inclusion of detailed guidelines in the *Activity based funding: Mental health care national best endeavours data set Technical Specifications 2023–24 for Reporting* to reflect the complexity of different support teams involved in community mental health care.
- price weights are assigned to unknown end classes
- provision of phase of care, activity and cost data with error flags to jurisdictions and ensure phase of care reflects the services provided and resources required to provide services
- improvements to information technology systems to support the transition to ABF and the data collection requirements associated with it.

Refinements to AMHCC

Stakeholders recommended the following refinements to the AMHCC Version 1.1:

- standardisation and alignment between AMHCC and Australian Mental Health Outcomes and Classification Network data requirements
- improvement in capturing complexity for consumers who identify as homeless, Aboriginal and Torres Strait Islander or who have comorbidities
- recognition of a same day class with or without electroconvulsive therapy (ECT)
- removal of age restrictions in HoNOS selection
- removal of the requirement for HoNOS for any same day activity to reduce administrative burden.

IHACPA's response

Pricing community mental health care using AMHCC Version 1.0

Community mental health care is currently block funded as part of the National Efficient Cost (NEC) Determination, with jurisdictions advising IHACPA of their community mental health care expenditure each year. Since inception in 2012, IHACPA has worked to develop the AMHCC to transition community mental health care services to ABF in line with the intent of the National Health Reform Agreement and the Addendum and to improve the transparency by enabling funding to be based directly on the volume, type and complexity of care provided to consumers.

IHACPA shadow priced community mental health care services using AMHCC Version 1.0 for three years as part of the NEP Determination 2021–22, 2022–23, and NEP23 to provide sufficient time to prepare for implementation of ABF.

IHACPA acknowledges the concerns raised by jurisdictions regarding progression to pricing community mental health care using AMHCC Version 1.0, and that these risks were also noted in the development of NEP23, namely the:

- potential for a significant funding impact due to the transition from block funding to ABF
- funding implications arising from issues with phase level reporting and data collection.

Throughout 2023, IHACPA has worked extensively with jurisdictions to facilitate jurisdictional readiness for the transition within its remit. IHACPA has also published a set of educational materials to assist in clinician understanding of the AMHCC and assessment and assignment of the Mental Health Phase of Care, and consistent application of the classification.

IHACPA intends to progress to pricing community mental health care using AMHCC Version 1.0 for NEP24. IHACPA considers that progression to pricing in NEP24 for community mental health care with the AMHCC Version 1.0 will contribute to more accurate pricing of community mental health care services into the future.

In preparing for the transition to ABF, IHACPA will continue to engage with all jurisdictions, the National Health Funding Body and the Administrator of the National Health Funding Pool (the Administrator) to mitigate any potential financial risks arising from the transition, within its remit. While IHACPA notes the proposed AMHCC Version 1.1 presents a modest but beneficial refinement to the classification, it will not be finalised in time for implementation in NEP24.

Transition to ABF for community mental health care

In 2022, IHACPA considered transitional arrangements for establishments ineligible for ABF due to being unable to report patient-level community mental health care activity data. However, in feedback provided through its advisory committees in early 2023, jurisdictions reported that all establishments are reporting patient-level activity, and therefore did not provide any establishment level activity data.

To inform the development of pricing transition arrangements and NEP24, IHACPA engaged closely with all jurisdictions to address the concerns raised within its remit. However, the proposed pricing transition arrangements did not receive jurisdictional support, with concerns noted that proposed arrangements were impractical and did not adequately reflect the variation in service structures nationally. Based on this advice, these arrangements were not progressed to avoid introducing unwarranted pricing complexity to the transition. Any decisions on funding transition arrangements would involve Parties to the NHRA and the Administrator.

IHACPA will continue to determine block funding amount for residential mental health services and standalone hospitals providing specialist mental health services through the NEC Determination 2024–25 (NEC24).

In response to the request for the provision of phase of care activity and cost data, IHACPA has not previously provided jurisdictions this information but has provided national weighted activity unit calculators to support jurisdictions to conduct their own impact assessment on the grouped data provided to them through IHACPA's ABF Data Collection Portal. IHACPA has produced a range of analysis at the jurisdictional level and presented this to its advisory committees. IHACPA notes that price weights are assigned to unknown end classes 291Z, 292Z and 293Z in AMHCC Version 1.0.

Refinements to AMHCC

IHACPA notes refinement areas such as a new class for same day ECT and updated age related groupings in HoNOS selection require significant structural change to the classification. These changes are out-of-scope for AMHCC Version 1.1 and will be considered in the development of AMHCC Version 2.0.

The AMHCC Version 1.1 refinement is inclusive of alignment to National Outcomes and Casemix Collection guidelines in allowing up to two missing HoNOS items and complexity model recalibration based on updated national data.

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

3.6 Teaching and training

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

Feedback received

NSW supported the continuation of block funding for teaching, training and research (TTR) and requested IHACPA provide an approximate timeline for progressing to pricing TTR using the Australian Teaching and Training Classification (ATTC).

The Australian College of Rural and Remote Medicine and the QNMU recommended the inclusion of nursing and midwifery research, and rural and regional based training for medical students and junior doctors in teaching and training activities.

IHACPA's response

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

For the NEC24, IHACPA will continue to determine block funding amounts for TTR activity based on advice from states and territories.

4

Setting the national efficient price

4. Setting the national efficient price

4.1 Impact of COVID-19

Consultation questions

- How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the National Efficient Price and National Efficient Cost Determinations for 2024–25?
- For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis, including patients in an ICU, to support retention of the:
  - COVID-19 treatment adjustment
  - temporary ICU measure for COVID-19 patients
  - temporary HAC and AHR measures for COVID-19 patients?

Feedback received

Impact of COVID-19 on NEP24

Stakeholders noted the following impacts resulting from the coronavirus disease 2019 (COVID-19) pandemic response for consideration in the development of the National Efficient Price (NEP) Determination 2024–25 (NEP24):

- changes to models of care and demand such as increased provision of health care in non-admitted settings provided by clinical staff and flow-on impacts on cost profiles and patient complexity due to delayed or deferred care, including elective surgeries
- changes to in-scope activity, volume and casemix including a reduction in hospital and emergency department (ED) presentations due to changes in models of care and an increase in the average lengths of stay
- workforce and resourcing impacts associated with COVID-19 including equipment and services for infection prevention and control and enduring structural changes to support new models of care for patients, such as information communication technology (ICT) systems and devices to support the delivery of virtual care, workforce capacity constraints and inflationary pressures on expenditure such as insurance.

Queensland (Qld) noted that lockdowns in previous years had enduring impacts on service delivery in 2021–22.

Stakeholders noted the following considerations in the development of NEP24:

- the need for flexibility of the model to classify and price new models of care, including improvements in data collection, classification of long COVID, and other sub-specialties such as public health physicians who provide non-patient specific input
- the impact of the expiration of the *National Partnership on COVID-19 Response* (NPA) which funded certain costs such as personal protective equipment (PPE)
- quantification of the cost of delayed or deferred care
- variation in impact across states and territories including the challenges in isolating health system changes and their associated costs directly to the COVID-19 pandemic response.

Western Australia (WA) noted that the national pricing model should not be artificially adjusted to address temporary disruptions without clear and obvious benefits to all states and territories.

Review of the COVID-19 treatment adjustment

New South Wales (NSW), South Australia (SA), WA, Tasmania and the Australian Medical Association (AMA) supported retainment of the COVID-19 treatment adjustment. Stakeholders noted the high volume of COVID-19 cases requiring hospitalisation in 2021–22, including ICU services such as ventilation, or use of extracorporeal membrane oxygenation (ECMO) and the complexities of managing patients with long COVID-19 compared to other respiratory viruses.

Stakeholders noted the following considerations in determining whether to retain the COVID-19 treatment adjustment for NEP24:

- inclusion of E62 Infections and Inflammations in the review process for the COVID-19 treatment adjustment if retained
- use of 2022–23 cost data to inform the level of adjustment applied for NEP24
- extension of the COVID-19 treatment adjustment beyond the admitted acute setting.

SA recommended consideration of the impact of long COVID-19 on outpatient services and whether an adjustment is required.

Review of the temporary pricing measures in the *COVID-19 Response – Costing and Pricing Guidelines*

Qld and the AMA supported the retention of the temporary intensive care unit (ICU), hospital acquired complication (HAC) and avoidable hospital readmission (AHR) measures for COVID-19 patients for NEP24, noting the high volume of COVID-19 cases in 2021–22. Some stakeholders also noted the need to ensure sufficient funding and staffing to provide care to prevent an increase in HACs and infection rates.

IHACPA's response

Impact of COVID-19 on NEP24

The Independent Health and Aged Care Pricing Authority (IHACPA) acknowledges that the COVID-19 pandemic resulted in significant changes to models of care and service delivery in Australian public hospitals.

IHACPA notes the variation in impacts across states and territories in 2021–22 and the challenges this presents for a national pricing model. IHACPA also notes that costs associated with the health workforce are accounted for at a national level through reporting in the National Hospital Cost Data Collection (NHCDC) and thus, cost impacts of changes to the workforce will be accounted for where reported in national data collections.

In consultation with jurisdictions, IHACPA has undertaken detailed analysis to understand and account for the impact of COVID-19 on 2021–22 activity and cost data, including significant disruptions such as lockdown periods, to ensure any sustained changes in service delivery, models of care or cost profiles are accounted for in the national pricing model.

IHACPA's analysis indicated that at a national level, admitted acute care activity in 2021–22 was below trend across the year and in particular during January and February 2022, which coincided with the outbreak of the Omicron subvariant of COVID-19.

With respect to costs, IHACPA's analysis indicated a substantial increase in average costs in 2021–22 compared to 2020–21. This is partly explained by the fixed costs hospitals incur, which do not change based on movements in activity. That is, lower levels of admitted acute care activity in 2021–22 did not result in a commensurate drop in average costs.

Through its analysis, IHACPA has concluded that the presence of fixed costs and low levels of admitted acute activity in public hospitals partially explain the rise in average costs in 2021–22. Furthermore, payments under the minimum funding guarantee, that were not directly linked to activity, were made to all jurisdictions except for South Australia and Tasmania.

Modification of the 2024–25 national pricing model for NEP24 is required to ensure the NEP closely reflects the efficient price of public hospital services for the 2024–25 financial year, rather than the product of these extraordinary, and time-specific factors.

Additionally, IHACPA has identified a number of end-classes as potentially requiring an exemption under the *National Pricing Model Stability Policy*, where there is a legitimate change in the costs of care, for example, changes in models of care due to COVID-19. The *National Pricing Model Stability Policy* aims to minimise year-on-year instability in price weights and adjustments to ensure funding stability and predictability for local hospital networks and hospital managers. It caps year on year changes in price weights at 20 per cent. An exemption mitigates the risk of systematic under or over pricing of specific public hospital services year on year, which are the result of significant changes to clinical care and service delivery.

To account for the impact of COVID-19 on the national pricing model for NEP24, IHACPA intends to:

- modify admitted acute activity and cost data nationally in 2021–22
- exempt specific end-classes from the *National Pricing Model Stability Policy*.

Review of the COVID-19 treatment adjustment

IHACPA introduced the COVID-19 treatment adjustment in the NEP Determination 2023–24 (NEP23) for 11 selected Australian Refined Diagnostic Related Groups (AR-DRGs) on the basis that patients being treated for COVID-19 experienced a longer length of stay and higher costs than patients classified in the same end-classes but without a positive COVID-19 diagnosis.

IHACPA's analysis shows this trend persisted in the 2021–22 financial year with patients being treated for COVID-19 continuing to have a longer length of stay and increased costs compared to non-COVID-19 patients within the same AR-DRG end-classes.

The criteria to select the AR-DRGs for the adjustment was as follows:

- the AR-DRG was clinically relevant to the treatment of COVID-19, informed by advice from IHACPA's Clinical Advisory Committee and that at least 20 per cent of admissions within that end-class were for patients with COVID-19; and
- evidence showed that COVID-19 patients in that AR-DRG had at least 50 per cent longer length of stays compared to their non-COVID-19 patients in the same AR-DRG.

For NEP24, IHACPA applied the same criteria to assess whether the COVID-19 treatment adjustment was necessary. IHACPA's analysis showed this trend persisted in the 2021–22 financial year with patients being treated for COVID-19 continuing to have a longer length of stay and increased costs compared to non-COVID-19 patients within the same AR-DRG end-classes. However, due to a higher concentration of COVID-19 patients in fewer end-classes, and reductions in costs and lengths of stay between COVID-19 patients, and non-COVID-19 patients, there was a smaller number of end-classes that met the criteria for the adjustment.

To reflect the most recent evidence, IHACPA will continue to implement the COVID-19 treatment adjustment for NEP24 for a smaller set of AR-DRGs, using an updated flagging methodology to identify COVID-19 treatment episodes more accurately. IHACPA will review the need for the COVID-19 treatment adjustment to account for the impact of COVID-19 for future NEP Determinations.

IHACPA notes it is not practicable to extend the COVID-19 treatment adjustment to the non-admitted and ED settings due to a lack of appropriate data to identify patients receiving COVID-19 treatment and to demonstrate a cost data or length of stay differential.

Review of the temporary pricing measures in the *COVID-19 Response – Costing and Pricing Guidelines*

The *COVID-19 Response – Costing and Pricing Guidelines* published in 2020, specified IHACPA's process for the costing and pricing of activity for the duration of the NPA. These measures were designed to be temporary arrangements to address significant uncertainty in the early stages of the pandemic around the clinical management of COVID-19 and its impact on ICU capacity for the duration of the NPA.

For NEP24, IHACPA will continue to implement the following temporary measures outlined in the *COVID-19 Response – Costing and Pricing Guidelines*

- application of the ICU adjustment to any patient with a COVID-19 diagnosis code in a non-level 3 ICU
- exemption of the AHR and HACs adjustment is necessary for episodes of care with a COVID-19 diagnosis.

In October, Australia's Chief Medical Officer declared that COVID-19 is no longer a Communicable Disease Incident of National Significance. This followed the expiration of the NPA in December 2022. As such, IHACPA intends to phase out the application of the temporary measures in the *COVID-19 Response – Costing and Pricing Guidelines* for future NEP Determinations. IHACPA will continue to critically review the need to apply these measures in consultation with jurisdictions and stakeholders as more updated data becomes available.

4.2 Adjustments to the national efficient price

Consultation questions

- To inform the review of the ICU adjustment:
  - what available evidence demonstrates the underlying drivers of cost variation for complex ICUs?
  - what additional or alternative measures, other than mechanical ventilation hours, should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?
- To inform the review of the paediatric adjustment:
  - what available evidence demonstrates the underlying drivers of cost variation between specialised and non-specialised children's hospitals?
  - what additional or alternative measures should IHACPA consider for inclusion in the eligibility criteria for a specialised children's hospital?

Feedback received

Intensive Care Unit adjustment

Stakeholders noted the following factors driving cost variations for complex ICUs:

- fixed costs such as costs required to maintain suitable and sufficient staffing and maintenance of advanced medical equipment
- patient characteristics such as age, presence of comorbidities, primary diagnosis and length of stay
- severity of illness and complexity of the treatments administered such as high-cost, high-intensity interventions and range of services such as retrieval teams
- hospital characteristics such as geographic location and regional differences in wages, cost of living, and the availability of resources.
- interactions with high dependency units (HDU) including the ability to move patients to step-down HDU care, and separating costs between co-located HDUs and ICUs.

NSW, Qld, the Northern Territory (NT) and the Australian and New Zealand Intensive Care Society (ANZICS) noted the clinical shift away from mechanical ventilation because of variability in practice across ICUs as other therapies or interventions are increasingly used, and the potential adverse effect of incentivising longer ventilation times.

Stakeholders proposed the following additional or alternative measures for inclusion in the eligibility criteria for a specified ICU:

- patient acuity scores or advanced health or respiratory failure management
- proportion of patients ventilated either through mechanical ventilation or non-invasive ventilation (NIV)
- use of high-cost, high-intensity interventions such as renal replacement therapy (RRT) or continuous RRT, ECMO, vasopressor support and haemodynamic monitoring or vasoactive medications as indicators of complexity
- use of other complex therapies, interventions or monitoring such as prone positioning while mechanically ventilated, complex blood purification, inhalation therapies or monitoring, or repeated patient transfers
- location and type of ICU as data suggests there are differences in patient complexity and service provision between rural/regional, metropolitan, tertiary, and private ICUs
- minimum standards for ICUs published by the College of Intensive Care Medicine of Australia and New Zealand
- predictors of ICU mortality.

ANZICS noted that NIV, RRT and ECMO may only be delivered in ICUs.

Qld recommended an assessment matrix which may include mechanical ventilation as one of a range of measures.

NSW, Qld, SA, WA and ANZICS recommended the review consider a broader range of ICUs other than 'complex ICUs' such as regional ICUs and HDUs to reduce the need for patient transfer to metro hospitals, networked ICUs, neonatal ICUs (NICU) or tertiary and quaternary paediatric centres with a NICU, for their eligibility for the ICU adjustment.

NSW noted that international ICU funding models could be considered, including bundled payments and additional Diagnosis Related Group (DRGs) for intensive care instead of per diem payments.

ANZICS recommended that:

- all ICUs meeting jurisdictional role delineation requirements be considered for the ICU adjustment, regardless of specific ICU hours or other quantitative measures, to acknowledge the importance of ensuring equitable access to funding for all ICUs, irrespective of their size or location
- the ICU adjustment should be appropriately modified to account for the complexity and case-mix of each ICU to accurately reflect the unique challenges and resource needs of different ICUs.

Paediatric adjustment and eligibility criteria for specialised children's hospitals

A number of stakeholders supported a review of the criteria for specialised children's hospitals, noting the adjustment could incorporate a sliding scale model dependent on patient age as opposed to the current model, which is determined at the site level.

NSW and Qld noted the following additional or alternative measures for inclusion in the eligibility criteria for a specialised children's hospital:

- provision of virtual care or advice from specialist staff in one hospital to patients in other hospitals
- inclusion of paediatric subacute and non-acute rehabilitation episodes
- presence of paediatric-specific services such as a paediatric ICU (PICU), Paediatric Critical Care Unit or paediatric surgery service, ED, diagnostic or radiology services
- a minimum of five or more subspecialist services related to paediatrics, specialist paediatric allied health teams, designated ambulatory and inpatient child and adolescent medical, surgical or mental health services or eating disorder services
- accreditation with non-paediatric medical colleges for paediatric training within that college's speciality.

Stakeholders recommended broadening the review to consider application of the adjustment in other settings such as major referral centres for paediatric patients and regular review of the specialised children's hospital list.

Stakeholders noted the following considerations in relation to the paediatric adjustment and the specialised children's hospital eligibility criteria:

- increased costs associated with the specialised workforce, higher nursing ratios and paediatric-specific governance procedures
- higher volume and costs of equipment resourcing to treat patients across a broad age range
- incorporation of a tiered loading methodology to better reflect the costs and range of advanced services provided by dedicated paediatric sites
- challenges in splitting ICU hours of co-located neonatal ICU and PICU sites for the purposes of demonstrating the hospital meets the eligibility criteria.

General comments

NT did not support IHACPA's decision in the *Pricing Framework for Australian Public Hospital Services 2023–24* that patient transport costs are accounted for in the national pricing model and the Commonwealth Grants Commission's goods and services tax distribution model.

The NT recommended travel costs be block-funded while appropriate data items are developed to inform ABF.

WA, the Centre for Aboriginal Economic Policy Research (CAEPR) and the QNMU noted the following considerations in relation to the Indigenous adjustment:

- the current approach does not address the issue of unmet need and underservicing which requires resourcing beyond current funding arrangements in order to achieve health equity
- lack of accountability measures to ensure additional funding provided through the adjustment is allocated to services or areas of priority for Aboriginal and Torres Strait Islander peoples.

Some jurisdictions noted the flow-on costs associated with 'maintenance' care provided to patients waiting for residential aged care services, disability services or community-based mental health services. The NT considered costs resulting from this maintenance care as cost-shifting from the Commonwealth to states and territories and recommended investigation of:

- a mechanism to recognise patients receiving 'maintenance' care
- the equity of the Commonwealth paying the full cost of increases in maintenance care days.

IHACPA's response

Intensive Care Unit adjustment

IHACPA notes stakeholder comments on the breadth of drivers of cost variation for complex ICUs including fixed and variable costs associated with staffing, capital, location, patient characteristics and treatments administered. IHACPA also notes the range of alternative models of care delivered in ICUs, other than mechanical ventilation, as additional or alternative measures for inclusion in the eligibility criteria for a specified ICU.

Given the significant range of considerations proposed by stakeholders, a larger program of work is required to ensure the ICU adjustment and its eligibility criteria reflect current practice.

IHACPA undertook analysis to investigate the feasibility and impact of some amendments to the eligibility criteria for NEP24, using available evidence. Proposed options for potential NEP24 refinements did not demonstrate clear benefits to justify implementation and consultation with IHACPA's advisory committees indicated support for deferring refinements until a more comprehensive review could be undertaken.

For NEP24, IHACPA will maintain the existing eligibility criteria for the ICU adjustment. IHACPA will develop a plan for a larger program of work to review the eligibility criteria and adjustment methodology to inform future Determinations. This review and potential refinement will be carried out in consultation with IHACPA's advisory committees and the jurisdictions.

Paediatric adjustment and eligibility criteria for specialised children's hospitals

IHACPA notes the range of feedback on the underlying drivers of cost variation between specialised and non-specialised children's hospitals, particularly the higher costs associated with treating paediatric patients.

Given the diverse considerations raised, a larger program of work with longer lead time for implementation may be required to review the eligibility criteria and the paediatric adjustment. This approach also provides additional time for jurisdictions to refine data reporting systems for innovative models of care and virtual care pertaining to paediatric services which may contribute to costs for specialised children's hospitals, to ensure activity and cost data from these new models of care are captured and reflected in the national pricing model.

For NEP24, IHACPA will maintain the existing eligibility criteria and develop a plan to review the eligibility criteria and adjustment methodology to inform future Determinations, based on the feedback provided.

IHACPA will review the available activity and cost data in consultation with jurisdictions and key stakeholders to investigate the underlying drivers of cost variation between specialised and non-specialised children's hospitals, the materiality of the variation and whether it is unavoidable, and to assess the suitability of the proposed alternatives for inclusion in the eligibility criteria. The review will also consider whether the variations in costs are best addressed through classification refinement to ensure consistency across all care streams, and alignment with the Pricing Guidelines, noting that many underlying cost drivers identified are based on provider rather than patient characteristics.

General comments

In response to the feedback on IHACPA's decision regarding patient transport costs, IHACPA notes that improvement in the accuracy of incorporation of costs in the national pricing model relies on accurate reporting through national data collections. Through the review of the Australian Hospital Patient Costing Standards (AHPCS), IHACPA engaged with all states and territories to develop refinements that improve cost data reporting for patient transport costs. These changes, reflected in the updated AHPCS Version 4.2, which was released in September 2023, will ensure all reported patient transport costs are accurately reflected in the national pricing model.

IHACPA notes the request for block funding of patient transport costs was considered in its investigation of this area in 2022. At the time, block funding was not progressed due to limitations in identifying relevant cost data in the NHCDC for removal from the cost models, and the potential for significant impacts on the ABF cost model. This can be reviewed again should additional information or evidence be provided.

In response to feedback received on the Indigenous adjustment, IHACPA notes its remit under the *National Health Reform Act 2011* (NHR Act) and Addendum to the National Health Reform Agreement 2020–25 (the Addendum) constrains its ability to provide advice or incorporate analysis on unmet need or underservicing as these costs are not reported in national data collections.

The Indigenous adjustment is calculated using actual costs reported by hospitals for patients who identify themselves as Aboriginal and Torres Strait Islander peoples and allocated accordingly. IHACPA does not have the remit to track allocations of funding once distributed by the Administrator of the National Funding Pool (the Administrator).

In response to the feedback related to flow-on costs associated with maintenance care provided to patients in admitted settings, IHACPA notes that non-acute episodes of care are priced using the AN-SNAP classification and based on the costs reported for this type of care in the NHCDC. IHACPA notes that the process to investigate a cost-shifting dispute is outlined in the *Cost-Shifting and Cross-Border Dispute Resolution Policy*.

4.3 NEP Indexation methodology

Consultation question

- To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

Feedback received

Stakeholders supported the review of the NEP indexation methodology, noting the following considerations and drivers of cost growth:

- staffing costs associated with leave liabilities and workforce shortages
- ongoing costs associated with the COVID-19 pandemic response
- increase in patient transport costs and associated contracts
- increase in operational costs such as utility, commodity and ICT costs
- development of options to utilise updated and targeted measures that include known forward impacts such as wage increases
- pay parity with outsourced providers not allowing for contracting out efficiencies.

NSW requested clarity on the applicability of shadow pricing to any new indexation methodology.

Stakeholders proposed the following alternative indices or metrics to inform the review:

- indices published by the Australian Bureau of Statistics such as the Producer Price Index, Consumer Price Index, Wage Price Index and Selected Living Cost Index
- statistics on actual or projected Australian inflation, unit labour cost growth, commodity prices published by the Reserve Bank of Australia
- development of a composite index that incorporates multiple indices
- trends in the Federal Enterprise Bargaining Report published by the Department of Employment and Workplace Relations to determine changes in wages.

The AMA recommended re-baselining the NEP in light of inflationary pressures and costs associated with the COVID-19 pandemic response, particularly in the absence of wider health system reform.

IHACPA's response

IHAPCA notes that many of the alternative indices or metrics proposed by stakeholders have been incorporated in its assessment of the current methodology and literature review of existing methodologies.

IHACPA has considered the alternative metrics proposed by stakeholders as well as those identified through a literature review of existing methodologies. IHACPA has tested a range of proposed options individually and in combination, and in both stable and volatile inflationary environments to analyse the accuracy of their predictions and compared these to the existing indexation methodology. Preliminary review outcomes have highlighted that alternative indexation options do not have a clear advantage over the existing indexation methods in terms of predictive accuracy in forecasting inflation. However, the review does recommend that some options are worthy of future testing once more data becomes available.

For NEP24, IHACPA will maintain the existing indexation methodology and will consult with its advisory committees as it undertakes further testing of options identified in the review, particularly for volatile scenarios as more data becomes available for the years impacted by COVID-19.

4.4 Refinements to the national pricing model

Consultation questions

- What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?
- Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

Feedback received

Harmonising the price of chemotherapy and dialysis

Jurisdictions and broader stakeholders noted analysis is required to support progression of price harmonisation of chemotherapy and dialysis to understand and account for:

- the impact of COVID-19 and potential differences in costs between inpatient and outpatient chemotherapy and dialysis to set a price that incentivises the lower cost modality while maintaining standards of care
- other factors that explain price and cost variance such as the size, resources, multiple episodes of care and geographic location of the service
- higher costs and care needs for paediatric chemotherapy services compared to adults and the safety implications of providing chemotherapy in outpatient settings
- price weights for different modalities that are representative of service costs, noting refinement of acute care classifications may be required
- potential transition arrangements and price stabilisation where price harmonisation is deemed appropriate.

Qld recommended that chemotherapy and dialysis are considered as a focus for new classification or innovative funding models rather than price harmonisation.

SA supported price harmonisation, particularly for chemotherapy and recommended detailed analysis of activity and cost data used to determine the admitted and non-admitted price weights, including the Pharmaceutical Benefits Scheme (PBS) cost component, to explain differences in price weights for providing the same service.

Candidates for harmonising price weights across care settings

Qld, SA and the Society of Hospital Pharmacists of Australia recommended a range of potential candidates for price weight harmonisation across settings such as:

- surgical procedures with limited clinical practice variations and not requiring ongoing care
- provision of novel, high-cost and off-label medicines prior to listing on the PBS
- majority of classes in the 10 series (procedures and interventions) in Tier 2, where the service delivery setting is determined by local policies.

Unqualified newborns

NSW, SA and the NT supported the review of the proposed investigation into the pricing methodology for unqualified newborns and recommended:

- consideration of a revised approach to the pricing of care provided in Mothers and Babies Mental Health Units
- review of the definition of a qualified newborn that supports clinical innovation in tandem with development of a new pricing approach for separate identification of all newborn costs
- undertaking broad specialist consultation and engagement with NHCDC Advisory Committee as part of the review process.

Qld noted the state has introduced a different funding arrangement for unqualified neonates at a jurisdictional level that apportions the costs of mothers and neonates and discounts the mother's AR-DRG accordingly.

Setting the national efficient price for private patients in public hospitals

NSW noted that the private patient neutrality adjustment does not appear to achieve its stated aims as, when combined with the approach of the Administrator, may encourage differentiation between public and private patients.

NSW further noted it did not support phasing out the private patient correction factor for NEP24.

General comments

The AMA noted the following concerns regarding the annual consultation process and NEP Determination, that the:

- funding model does not adequately reflect the growing complexities of the population's health needs, amplified by the impact of the COVID-19 pandemic
- Pricing Framework does not appropriately take into consideration the views of external stakeholders, particularly medical professionals

- NEP Determination functions as a cost saving exercise rather than an actual reflection.

IHACPA's response

Harmonising the price of chemotherapy and dialysis

IHACPA notes the additional considerations provided by stakeholders generally relate to ensuring price harmonisation does not disincentivise appropriate care for patients who require admission due to clinical risk factors, as well as concerns with the underlying cost data that would be used for price harmonisation.

In consultation with jurisdictions, IHACPA will commence work on resolving data linkage issues to mitigate the risks identified. This is a key step towards progressing price harmonisation across settings.

Candidates for harmonising price weights across care settings

IHACPA will work with its advisory committees and working groups to investigate the appropriateness of the proposed services as potential candidates for price weight harmonisation and identify other opportunities to harmonise prices for similar services across settings for future Determinations.

Unqualified newborns

To inform the review of the pricing methodology, IHACPA has engaged with stakeholders and noted its intention to review the available activity and cost data for newborns to identify variations in patient characteristics, diagnoses and interventions provided outside the neonate ICUs. This will include engagement with the Commonwealth Government regarding whether the definition of qualification status requires revision for the purposes of pricing.

Setting the national efficient price for private patients in public hospitals

IHACPA has discussed the jurisdictional feedback with the NHFB for their consideration in the application of the adjustment in future Determinations. For NEP24, IHACPA will continue to implement the private patient neutrality methodology as required by clause A44 of the Addendum.

Phasing out of the private patient correction factor is based on analysis of cost data and jurisdictional advice on whether privately funded medical costs are included as part of the NHCDC submission. IHACPA does not intend to phase out the private patient correction factor for NEP24. IHACPA will continue to evaluate the private patient correction factor and remove it where appropriate.

General comments

IHACPA notes that the NHR Act states the object of the Pricing Authority is to promote improved efficiency in, and access to, public hospital services by providing independent advice to governments in relation to the efficient costs of such services. IHACPA notes that in some instances, this may differ from the actual costs of public hospital services particularly with respect to costs out-of-scope for Commonwealth funding under the NHRA.

In carrying out its functions, IHACPA consults with clinicians and jurisdictions regularly through its advisory committees on the classification, pricing and policy proposals that inform the Pricing Framework and Determinations. The Pricing Authority approves the NEP and NEC Determinations each year based on the available national activity and cost data, advice from IHACPA's advisory committees, feedback received through public and ministerial consultations and alignment with the Pricing Guidelines.

5

Setting the national efficient cost

5. Setting the national efficient cost

5.1 Standalone hospitals providing specialist mental health services

Feedback received

New South Wales (NSW) recommended that the Independent Health and Aged Care Pricing Authority (IHACPA) allow sufficient time for robust analysis to be completed prior to transitioning standalone psychiatric hospitals from block funding to activity based funding (ABF).

IHACPA's response

IHACPA notes stakeholder concerns that the current Australian Mental Health Care Classification model may not adequately capture costs as some standalone hospitals report limited or incomplete activity and cost data.

In the 2021–22 financial year, some standalone hospitals providing specialist mental health services reported admitted mental health care activity as part of the Activity based funding: Mental health care national best endeavours data set.

IHACPA has reviewed reported activity and cost data from standalone hospitals providing specialist mental health services that received block funding in the *National Efficient Cost (NEC) Determination 2023–24* (NEC23) to identify hospitals that exceeded the 'low-volume' threshold. Based on eligibility criteria used to determine whether a public hospital is eligible to receive block funding, as well as consideration of the breadth of services provided, these hospitals may have sufficient activity to warrant transition to ABF.

IHACPA will continue to block fund standalone hospitals providing specialist mental health services that meet the low volume threshold for the NEC Determination 2024–25 (NEC24). IHACPA intends to transition a small number of standalone hospitals providing specialist mental health services that have significantly exceeded the low volume threshold for NEP24, in consultation with jurisdictions.

IHACPA will continue working with jurisdictions to investigate the feasibility of transitioning block-funded standalone hospitals that exceeded the low volume threshold in NEC23 as candidates for ABF for the National Efficient Price (NEP) Determination 2024–25 (NEP24) or future Determinations.

5.2 NEC indexation methodology

Consultation question

- To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?

Feedback received

Stakeholders supported the indexation review and noted the following for consideration:

- incorporation of costs not yet included in the National Hospital Cost Data Collection (NHCDC) but published in service agreements and budgets at the district or local health network level, consistent with the 'Evidence-based' Process Guideline
- workforce shortages and additional costs of recruiting and relocating doctors, locums and nurses
- shortage of rural accommodation and attracting staff to rural locations

- use of ABF data to measure hospital and regional differences in price indexes
- cost pressures faced by regional and remote hospitals.

IHACPA's response

As mentioned in Chapter 4, IHACPA has considered many of the alternative metrics proposed by stakeholders in its literature review of existing methodologies, and review of the current methodology. However, given the lack of data maturity for block-funded hospitals, the proposed options were not considered feasible using current data collections. Unlike the NEP methodology, the NEC indexation rate is already based on a broader range of activity and is not only based on admitted acute patient care data

For NEP24, IHACPA will maintain its existing indexation methodology.

6

Data collection

6. Data collection

6.1 Assurance of cost data

Consultation question

- What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

Feedback received

Stakeholders recommended the following assurance approaches to ensure the National Hospital Cost Data Collection (NHCDC) data is prepared in line with the Australian Hospital Patient Costing Standards (AHPCS):

- the inclusion of mandatory questions to ensure jurisdictional compliance and clarity and clarification on the level of assurance required
- identification of the gaps between self-assessments and quality statements
- focused analysis to understand cost drivers among patient cohorts requiring increased community support.

The Northern Territory (NT) and Tasmania (Tas) recommended IHACPA provide training to jurisdictions in applying the AHPCS.

IHACPA's response

IHACPA is committed to developing quality assurance reporting that provides mutual value for jurisdictions and the agency. Following stakeholder feedback received and review of the Data Quality Statement (DQS), the Independent Health and Aged Care Pricing Authority (IHACPA) has updated the DQS template for the 2021–22 NHCDC to include reporting against AHPCS compliance and financial reconciliation.

IHACPA notes the additional administrative burden associated with inclusion of mandatory questions to ensure compliance with the standards and considers the current approach to confirm areas where data does not comply with the standards to be proportionate.

IHACPA is currently undertaking a quality assurance project in consultation with jurisdictions to provide assurance that the 2020–21 NHCDC is complete to inform the national pricing model. This includes consideration of historical adherence to the standards, areas for improvement and the potential scope, value and purpose of the independent financial year for consideration in future rounds.

Separately, IHACPA is also developing a quality assurance report dashboard to provide flexible and timely data insights to jurisdictions regarding their NHCDC submission.

While IHACPA does not intend to undertake a focused analysis for NHCDC Public Sector 2021–22 data, IHACPA understands the importance of this process in identifying cost drivers among patient cohorts and will consider the most appropriate mechanism to continue conducting such analysis in future.

6.2 Virtual models of care

Consultation questions

- Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?
- Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?

Feedback received

Virtual care areas and care streams

Stakeholders recommended IHACPA define the strategy for classifying virtual care and proposed focusing on a wide range of virtual care activities for further investigation including:

- virtual care delivered in non-admitted or community settings such as hospital in the home or remote patient monitoring, emergency departments (EDs) telehealth, aged care settings or walk-in centres
- virtual care that enables early supported discharge or ED diversion such as acute patient transport and state-wide services
- virtual care delivered by multidisciplinary teams such as mental health co-responder programs or genetic services.

Capacity to submit data under the emergency care virtual care data specification

Queensland (Qld) and South Australia (SA) noted they have capacity to submit emergency care virtual care data, while New South Wales (NSW) and Tas noted they did not have the capacity to support the data collection due to the administrative burden on clinicians and jurisdictions. NT noted that their EDs are not currently delivering virtual care.

General comments

Vic noted an increase in digital and Information Communication Technology (ICT) costs and requested to work with IHACPA to improve data collections by separating costs associated with devices, server or 'cloud' storage and processing, and applications or application licences from oncosts in the NHCDC.

IHACPA's response

Virtual care areas and care streams

The feedback received reflects IHACPA's analysis that there is significant variation in the delivery of virtual care across jurisdictions, and a lack of consistency nationally in the understanding of the definition and scope of virtual care services in Australia, and the way these services are being captured in activity and cost data collections.

IHACPA is undertaking a program of work to gain a better understanding of virtual care activity, costs, modes of service delivery and models of care in Australia, including variations across jurisdictions and international virtual care funding arrangements in similar health systems. The project will include a horizon scan to facilitate the development of a national strategy for improved integration of virtual care into the pricing and funding for public hospital services.

IHACPA notes that the mental health co-responder program was included on the General List of In-Scope Public Hospital Services for the *National Efficient Price Determination 2022–23* and that a new class for genetic counselling was included in Tier 2 Non-Admitted Care Classification Version 8.0 for the National Efficient Price (NEP) Determination (NEP23).

Capacity to submit data under the emergency care virtual care data specification

IHACPA will work with jurisdictions on improving the reporting of cost and activity data in the emergency care virtual care data specifications and planning for future developments in this area.

General comments

IHACPA notes that the general ledger cost data associated with ICT are already captured in the NHCDC, and ICT operating costs will be reflected in the NEP. Capital costs are considered out-of-scope for Commonwealth funding under the National Health Reform Agreement with the responsibility for planning, funding and delivery of capital resting with the states and territories.

7

Treatment of other Commonwealth programs

7. Treatment of other Commonwealth programs

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the treatment of other Commonwealth programs but received feedback from a small number of stakeholders.

Feedback received

The Society of Hospital Pharmacists of Australia recommended extension of the Pharmaceutical Benefits Scheme (PBS) funding to apply to all hospital medications to address the inefficiencies, wastage and increased cost-shifting onto hospitals when patients present for admission without their PBS-listed medications.

IHACPA's response

The Commonwealth Department of Health and Aged Care are responsible for the policy framework and parameters of the PBS including the services where PBS funding applies.

In addition, to prevent a public hospital service being funded more than once, the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) requires IHACPA to discount Commonwealth funding provided to public hospitals through programs other than the National Health Reform Agreement. Should PBS funding apply to all hospital medications, this funding would then be removed from the national pricing model, as required by the Addendum.

8

Future funding models

8. Future funding models

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the treatment of other Commonwealth programs but received feedback from a small number of stakeholders.

Feedback received

New South Wales recommended IHACPA review the submission process for trialling innovative models of care to reduce the time needed to finalise submissions.

The Australian College of Rural and Remote Medicine recommended development of funding models designed to meet the needs and challenges of rural, remote and Aboriginal and Torres Strait Islander communities which includes representation from each of these communities in the design and decision making of these models, incentivisation for rural-based investment in resourcing and training that complements rural models of care.

Medtronic and the Royal Australian College of Physicians recommended consideration of the following innovative models of care:

- mechanical hysteroscopy – a technology that provides an additional treatment option for patients, delivered in a non-admitted rather than admitted setting
- Model of Chronic Management – a service bridging primary and specialist care for people with comorbidities.

IHACPA's response

IHACPA does recognise the different cost profile associated with rural and remote hospitals through the application of the fixed-plus-variable model for small rural hospitals in the National Efficient Cost Determination and through the patient remoteness residential and treatment adjustments to the national pricing model.

In response to the proposed innovative models of care, IHACPA notes that the Commonwealth and a state or territory are required to agree to trial an innovative model of care for a fixed period of time through a bilateral agreement in accordance with Schedule C of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

IHACPA remains committed to work in partnership with jurisdictions to develop and provide advisory support for the trialling of innovative models of care under bilateral agreements between states and territories and the Commonwealth and encourages stakeholders to approach their jurisdictional representatives to pursue this.

Should jurisdictions seek to explore, develop and trial innovative models of care or alternative funding models for rural and remote care delivery, IHACPA would support this wherever possible, in line with the requirements set out in the Addendum and the *General List of In-Scope Public Hospital Services Eligibility Policy.*

9

Pricing and funding for safety and quality

9. Pricing and funding for safety and quality

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on pricing and funding for safety and quality but received feedback from a small number of stakeholders.

Feedback received

The Northern Territory recommended an evaluation for sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions (AHRs) to assess whether the penalties applied as part of the adjustments have achieved their intended outcomes, including:

- improved patient outcomes
- incentivised provision of timely-quality care
- decreased demand for public hospitals
- created signals to reduce instances of preventable poor quality care, while improving data quality and information to inform clinicians.

New South Wales noted support for the inclusion of incentives for high quality, safe and effective care delivery in place of funding penalties.

IHACPA's response

IHACPA notes the approach to sentinel events, AHRs and the HACs adjustments were developed according to the requirements of clauses A165, A171 and C168b(i) of Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

IHACPA led the development of a proposed approach to evaluate the implemented safety and quality reforms for sentinel events, HACs and AHRs. This was provided to the Health Ministers' Meetings for consideration in October 2021 as part of the joint advice from IHACPA, the Australian Commission on Safety and Quality in Health Care and the Administrator of the National Health Funding Pool, as required by clause A174 of the Addendum.

Appendix

Appendix A: List of stakeholders

The stakeholders that made submissions in response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* have been outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Abbreviation
Jurisdictions	
New South Wales Health	NSW
Victorian Department of Health and Human Services	Vic
Queensland Health	Qld
South Australian Department for Health and Wellbeing	SA
Western Australian Department of Health	WA
Tasmanian Department of Health	Tas
Northern Territory Department of Health	NT
Organisations	
Australian and New Zealand Intensive Care Society	ANZICS
Australian and New Zealand Society of Nephrology	ANZSN
Australian College of Rural and Remote Medicine	ACRRM
Australian Dental Association	ADA
Australian Genomics	Australian Genomics
Australian Medical Association	AMA
Australasian Society for Parenteral and Enteral Nutrition	AuSPEN
Baxter Healthcare	Baxter
Centre for Aboriginal Economic Policy Research	CAEPR
Human Genetics Society of Australasia	HGSA
Human Genetics Society of Australasia Professional Issues for Genetic Counsellors (PIGC) Committee	HGSA PIGC
Intestinal Failure Team, Royal Prince Alfred Hospital (RPA)	Intestinal Failure Team, RPA
Medtronic	Medtronic
Queensland Nurses and Midwives Union	QNMU
Royal Australasian College of Physicians	RACP
Royal Australian and New Zealand College of Psychiatrists	RANZCP
Society of Hospital Pharmacists of Australia	SHPA

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