Pricing Framework for Australian Public Hospital Services 2019–20

December 2018

Independent Hospital Pricing Authority

IHPA

Pricing Framework for Australian Public Hospital Services 2019–20 — December 2018

The Hon. Roger Cook MLA
Chair, COAG Health Council
GPO Box 3410
Rundle Mall,
Adelaide, SA, 5000

IHPA

Dear Minister,

On behalf of the Independent Hospital Pricing Authority (IHPA), I am pleased to present the *Pricing Framework for Australian Public Hospital Services 2019–20*.

The Pricing Framework is the key strategic document underpinning the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the financial year 2019–20. The NEP Determination will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis, whilst the NEC Determination covers the services which are block funded.

This is the eighth Pricing Framework issued by IHPA. The nature of the comments received in response to the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2019–20* demonstrates that IHPA has developed a clear and stable methodology that guides the annual determination of the NEP and NEC. IHPA will continue to develop and refine its classification systems, counting rules, data, coding and costing standards which underpin the national Activity Based Funding system.

The *Pricing Framework for Australian Public Hospital Services 2019–20* includes stakeholder feedback that will inform an independent review of the National Pricing Model in 2018. As the pricing model has now been in operation for a number of years, IHPA considers it an appropriate time to review the methodology underpinning the National Pricing Model. The review will question the assumptions and technical approaches, which were adopted early in the development of the NEP and whether they remain best practice.

IHPA has continued to progress work to develop and implement funding and pricing approaches for safety and quality. Funding adjustments related to sentinel events were introduced in July 2017, followed by funding adjustments for hospital acquired complications in July 2018. This year's Pricing Framework includes the final stage of this work with progress to develop a funding approach for avoidable hospital readmissions.

I would like to affirm IHPA's commitment to transparency and continuous improvement in how it undertakes its functions, grounded in an open and consultative approach to working with the health sector in the implementation of activity based funding for public hospital services.

Yours sincerely

Shane Solomon
Chair
Pricing Authority

Table of contents

Glossary

ABF	Activity Based Funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AHMAC	Australian Health Ministers' Advisory Council
AHPCS	Australian Hospital Patient Costing Standards
AIHW	Australian Institute of Health and Welfare
ANACC	Australian Non-Admitted Care Classification
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient classification
AR-DRG	Australian Refined Diagnosis Related Groups
ATTC	Australian Teaching and Training Classification
COAG	Council of Australian Governments
DRG	Diagnosis Related Group
HAC	Hospital Acquired Complication
ICD-10-AM	*International Statistical Classification of Diseases and Related HealthProblems, Tenth Revision, Australian Modification*
IHPA	Independent Hospital Pricing Authority
IHI	Individual Healthcare Identifier
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MDCC	Multidisciplinary Case Conferences
NBP	National Benchmarking Portal
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NWAU	National Weighted Activity Unit
Pricing Framework	*Pricing Framework for Australian Public Hospital Services*
The Addendum	Addendum to the National Health Reform Agreement
The Commission	Australian Commission on Safety and Quality in Health Care

1

Introduction

1 Introduction

The *Pricing Framework for Australian Public Hospital Services* is the key strategic document underpinning the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the financial year. The *Pricing Framework for Australian Public Hospital Services* is released prior to the NEP and NEC which are released in early March to provide an additional layer of transparency and accountability by making available the key principles, scope and approach adopted by the Independent Hospital Pricing Authority (IHPA) to inform the NEP and NEC Determinations.

The implementation of a national Activity Based Funding (ABF) system is intended to improve the efficiency and transparency of funding contributions of the Commonwealth and state and territory governments for each Local Hospital Network (LHN) across Australia. To achieve this, IHPA is required under the National Health Reform Agreement and the *National Health Reform Act 2011* to determine the NEP to calculate Commonwealth ABF payments for in-scope public hospital services and the NEC covering those services which are block funded.

IHPA released the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2019–20* for a 30–day public comment period on 12 June 2018. The Consultation Paper set out the key issues for consideration in preparation of the *Pricing Framework for Australian Public Hospital Services 2019–20*.

Stakeholder feedback has informed the development of the *Pricing Framework for Australian Public Hospital Services 2019–20* which sets out the policy rationale and decisions regarding IHPA's program of work and the decisions in the NEP and NEC Determinations for 2019–20, as well as considerations for the improvement of future Pricing Frameworks.

Submissions on the Consultation Paper were received from 19 organisations including all states and territories and the Commonwealth government. These submissions are available on the IHPA website.

IHPA has continued to progress work to develop a funding approach for avoidable hospital readmissions. The Addendum to the National Health Reform Agreement sets out public hospital financing arrangements until 1 July 2020 and requires implementation of pricing and funding approaches for sentinel events and hospital acquired complications (HACs) and the development of an approach for avoidable readmissions. This work and IHPA's policy decisions are outlined in Chapter 11.

As part of this year's consultation process, IHPA sought feedback on work to review a number of a policy decisions made when the agency was established in 2011. This includes the methodology underpinning the National Pricing Model, the General List of In-scope Public Hospital Services and a review of block funded services. Feedback will assist in guiding the key priorities to be addressed in the review process. The results and further discussion will be provided in the Consultation Paper on *Pricing Framework for Australian Public Hospital Services 2020–21*.

The *Pricing Framework for Australian Public Hospital Services 2019–20* builds on the Pricing Frameworks available on the IHPA website. For simplicity, where IHPA has reaffirmed a previous principle, the supporting argument has not been restated.

2

Pricing Guidelines

2 Pricing Guidelines

2.1 Overview

The Pricing Guidelines signal IHPA's commitment to transparency and accountability in how it undertakes its work (see **Box 1**). The decisions made by IHPA in pricing in-scope public hospital services are evidence-based and use the latest costing and activity data supplied to IHPA by states and territories.

In making these decisions, IHPA must balance a range of policy objectives including improving the efficiency and accessibility of public hospital services. This role requires IHPA to exercise judgement on the weight to be given to different policy objectives.

Whilst these Pricing Guidelines are used to explain the key decisions made by IHPA in the annual *Pricing Framework for Australian Public Hospital Services*, they can also be used by governments and other stakeholders to evaluate whether IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

Feedback received

South Australia (SA) provided feedback regarding the pricing guideline 'Administrative ease'. SA supports the refinements to the classifications and the funding model, however questioned if IHPA has considered the resource requirements for the changes that are expected, relative to benefit. SA noted that refinements need to take into account the full range of data and reporting burden and amount of change required of data providers at any one time.

IHPA's decision

IHPA will continue to use the Pricing Guidelines (**Box 1**) to guide its decision making where it is required to exercise policy judgement in undertaking its legislated functions. IHPA has not made changes to the Pricing Guidelines for 2019-20.

Next steps and future work

IHPA notes SA's concerns regarding consideration of resourcing related to data requirements. IHPA will continue to consult through its jurisdictional and technical advisory committees with regard to ensuring adherence to the Pricing Guidelines specifically relating to 'Administrative ease: Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.' The introduction of the new mental health classification has required significant investment in training and systems by jurisdictions. IHPA notes that this is the most significant change to data collection since the national Activity Based Funding (ABF) commenced in 2012 and is widely supported by all Australian Governments.

IHPA will continue to monitor changes in the mix, distribution and location of public hospital services, consistent with its responsibilities under Clause A25 of the National Health Reform Agreement. IHPA will continue to work with its Jurisdictional Advisory Committee and Clinical Advisory Committee to analyse any changes evident in the data.

Box 1: Pricing Guidelines

The Pricing Guidelines comprise the following overarching, process and system design 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-forprofit providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

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

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

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

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Price 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.
- **ABF pre-eminence:** ABF should be used for funding public hospital services wherever practicable.
- **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, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **Public-private neutrality:** ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient ina public hospital.

3

Scope of Public Hospital Services

3 Scope of Public Hospital Services

3.1 Overview

In August 2011 governments agreed to be jointly responsible for funding efficient growth public hospital services'. As there was no standard definition or listing of public hospital services, the Council of Australian Governments (COAG) assigned IHPA the task of determining whether a service is ruled 'in-scope' as a public hospital service, and therefore eligible for Commonwealth Government funding under the National Health Reform Agreement.

3.2 Scope of public hospital services and General List of eligible services

Each year, IHPA publishes the 'General List of In-Scope Public Hospital Services' (the General List). 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.

In accordance with Section 131(f) of the National Health Reform Act 2011 and Clauses A9-A17 of the National Health Reform Agreement, the General List defines public hospital services eligible for Commonwealth funding to be:

- All admitted programs, including hospital in the home programs and forensic mental health inpatient services;
- All emergency department services; and
- Other non-admitted services that meet the criteria for inclusion on the General List.

The eligibility of a public hospital service for inclusion on the General List is independent of the service setting in which it is provided (e.g. whether the service is provided at a hospital, in the community or in a person's home). This policy decision ensures that the *Pricing Framework for Australian Public Hospital Services* supports best practice provision of appropriate site of care.

The Pricing Authority determines whether specific services proposed by states and territories are in-scope and eligible for Commonwealth funding based on decision criteria and through reviewing supporting empirical evidence provided by jurisdictions.

The process IHPA follows in assessing services and the decision criteria and interpretive guidelines used by the Pricing Authority are outlined in the Annual Review of the General List of In-Scope Public Hospital Services policy. Services which are not yet in operation or which meet the criteria but do not have supporting empirical evidence will not be added to the General List.

3.2.1 Review of the General List of In-Scope Public Hospital Services policy

Recent applications by jurisdictions for the inclusion of services on the General List have demonstrated the need for a review of the decision criteria and application process. As a first step, IHPA has replaced Appendix B of the General List policy with a simpler application form to improve the assessment process and allow IHPA to better analyse submissions.

In 2018–19, IHPA will undertake a comprehensive review of the General List decision criteria and the process of applying to have a service considered for inclusion on the list to inform future years.

The current criteria and interpretive guidelines are presented in **Box 2**. The General List and A17 List were last published as part of the National Efficient Price 2018–19 (NEP18) in early March 2018.

Feedback received

Stakeholders were generally supportive of IHPA undertaking a review of the General List decision criteria and the process of applying to have a service considered for inclusion on the list.

South Australia and Qld recommend that IHPA review the scope of public hospital services to ensure greater consistency between jurisdictions, particularly in relation to which services are deemed eligible under Clause A17 of the National Health Reform Agreement.

Qld and Catholic Health Australia recommend that IHPA expand the scope of services to include developments in non-bed based specialised health care through investment in community treatment models. Victoria (Vic) also recommend changes to allow more flexibility in the criteria in order to encourage innovative clinical and funding models.

IHPA's decision

IHPA does not propose any changes to the criteria which it uses to determine whether in-scope public hospital services are eligible for Commonwealth funding under the National Health Reform Agreement in 2019–20. Full details of the public hospital services determined to be in-scope for Commonwealth funding will be provided in the National Efficient Price 2019–20 (NEP19) Determination.

Next steps and future work

IHPA recognises that the current General List criteria and assessment process creates challenges for jurisdictions when making an application for inclusion of services on the General List. Work will commence in 2018 to progress a comprehensive review of the current criteria and assessment process.

IHPA will consider stakeholder feedback received through the *Pricing Framework Consultation Paper 2019–20* in undertaking this review and will work with its Technical Advisory Committee and Jurisdictional Advisory Committee members over the course of 2018–19 with the aim of providing an updated General List criteria and assessment process for consultation in the 2020–21 pricing process.

Box 2: Scope of public hospital services and General List of eligible services

In accordance with Section 131(f) of the National Health Reform Act 2011 and Clauses A9–A17 of the National Health Reform Agreement, the scope of "Public Hospital Services" eligible for Commonwealth funding under the Agreement are:

- All admitted programs, including hospital in the home programs and forensic mental health inpatient services;
- All Emergency Department services; and
- Non-admitted services as defined below.

Non-admitted services

This listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in-scope services can be provided on an outreach basis.

To be included as an in scope non-admitted service, the service must meet the definition of a 'service event' which is:

> An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Consistent with Clause A25 of the Agreement, IHPA will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making those services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:

A. Specialist Outpatient Clinic Services
B. Other Non-admitted Patient Services and Non-Medical Specialist Outpatient Clinics

Box 2 (continued): Scope of public hospital services and General List of eligible services

Category A: Specialist outpatient clinic services — Tier 2 Non-Admitted Services Classification — Classes 10, 20 and 30

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

Category B: Other non-admitted patient services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40)

To be eligible for Commonwealth funding as an Other Non-admitted Patient Service or a Class 40 Tier 2 Non-admitted Service, a service must be:

- directly related to an inpatient admission or an Emergency Department attendance; or
- intended to substitute directly for an inpatient admission or Emergency Department attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

Jurisdictions have been invited to propose services that will be included or excluded from Category B "Other Non-admitted Patient Services". Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the three criteria above.

The following clinics are considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service under this category:

- Commonwealth funded Aged Care Assessment (40.02)
- Family Planning (40.27)
- General Counselling (40.33)
- Primary Health Care (40.08)

Interpretive guidelines for use

In line with the criteria for Category B, community mental health, physical chronic disease management and community based allied health programs considered in-scope will have all or most of the following attributes:

- Be closely linked to the clinical services and clinical governance structures of a public hospital (for example integrated area mental health services, step-up/step-down mental health services and crisis assessment teams);
- Target patients with severe disease profiles;
- Demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum);
- Demonstrate the operation of formal discharge protocols within the program; and
- Demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

Whilst a service may meet the criteria specified above, it must also be operational in order to be considered in-scope for the purposes of inclusion on the General List.

4

Classifications used by IHPA to describe public hospital services

4 Classifications used by IHPA to describe public hospital services

4.1 Overview

In order to determine the National Efficient Price (NEP) for services funded on an activity basis, IHPA must first specify the classification systems, counting rules, data and coding standards, as well as the methods and standards for costing data.

Classification systems provide the hospital sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs in order to better manage, measure and fund high quality and efficient health care services.

Classification systems are a critical element of Activity Based Funding (ABF) as they group patients who have similar conditions and cost similar amounts per episode (i.e. the groups are clinically relevant and resource homogenous).

4.2 Australian Refined Diagnosis Related Groups classification

For NEP18 IHPA used the Australian Refined Diagnosis Related Groups (AR-DRG) Version 9 classification system to price admitted acute patient services. AR-DRG Version 9 uses the Tenth Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI) for the underlying diagnosis and intervention coding.

IHPA will continue to use AR-DRG Version 9 to price admitted acute patient services for NEP19 underpinned by ICD-10-AM/ACHI Eleventh Edition.

IHPA commenced development of the Eleventh Edition of ICD-10-AM/ACHI and AR-DRG Version 10 in 2017. AR-DRG Version 10 is being developed in-house by IHPA to leverage and build upon existing capabilities of IHPA's workforce. The Australian Consortium for Classification Development remains responsible for updates to the Eleventh Edition of ICD-10-AM and ACHI.

Major work on the AR-DRG classification for Version 10 has included a clinical review of the diagnoses that contribute to complexity scoring within the complexity model. Other areas include differentiation of caesarean section deliveries according to whether they are performed prior to the commencement of labour or following the commencement of labour, a review of new health technology submissions and other updates sourced through public submissions.

4.2.1 Recording of additional diagnoses

The Australian Coding Standards (ACS) provides guidance to clinical coders to ensure that sound coding convention is applied when assigning diagnosis and intervention codes. ACS 0002 *Additional diagnoses* is a standard which aims to ensure that clinical coders are reporting data on patients' additional diagnoses consistently and that only conditions which are significant to the episode of care are assigned as additional diagnoses and reported in national data sets.

Despite the national standard and regular revision, determining significance can be relatively subjective. The implementation of ABF coincided with improved capture of diagnosis and procedural information for public hospital care. The increased reporting of additional diagnoses may not always be consistent with the principle of ACS 0002 to assign codes for conditions that are 'significant' to the episode of care. In some circumstances, this may lead to an increase in the complexity level assigned to an episode of care in the AR-DRG classification system.

IHPA and the Australian Consortium for Classification Development are revising ACS 0002 *Additional diagnoses* for the Eleventh Edition to make the standard more explicit as to what deems a condition to be 'significant' for code assignment in an admitted acute episode of care.

4.2.2 Phasing out support for older classification versions

In the Consultation Paper on the *Pricing Framework for Australian Public Hospitals 2018-19*, IHPA sought feedback on an intention to phase out support for old AR-DRG classification versions with sufficient lead time for the private sector. This reflected the complexity and difficulty of mapping across older versions and classification improvements not being realised by hospitals or health funds using older versions.

IHPA has also undertaken targeted consultation with representatives from private hospital and health insurer groups on an intention to cease support for previous versions of the AR-DRG classification system from 1 July 2019, which is the release date of AR-DRG Version 10.

IHPA ceasing support for older AR-DRG would mean IHPA would no longer:

- Implement mapping fixes, or provide amended grouper specifications or grouper certification for old versions to adjust for coding changes that have a significant impact on Diagnosis Related Group (DRG) grouping.
- Undertake impact analysis of coding or DRG changes on old versions.
- Accept public or other submissions specific to an old version.
- Publish cost reports that contain old versions.
- Provide grouper specifications for old versions to grouper vendors.
- Provide manuals or publications for old versions.

Phasing out support will not preclude hospitals from using older AR-DRG versions to classify patient care.

4.2.3 AR-DRG development cycle

AR-DRG development currently occurs on a biennial basis, with an updated AR-DRG version released every two years. Updates ensure the AR-DRG classification remains clinically relevant, maintains currency with clinical terminology and practice and is fit for purpose for the ABF system.

Development of a new AR-DRG version commences immediately after the release of the previous version. This means that changes in the previous version are not able to be assessed when a new version is being developed. It also means that the data used to develop the new AR-DRG version is based on data which is reported using the previous ICD-10-AM/ACHI edition.

While this may suggest that the development cycle is fast paced, the timeframe for classification changes to be implemented and to flow from ICD 10 AM/ACHI to the AR-DRG classification can be lengthy.

A balance is required between updating the AR-DRG and ICD 10 AM/ACHI classifications, in light of changes to clinical practice and terminology, and the stability of the classifications for health services and those who use the data.

Feedback received

AR-DRG Version 10

Australian Medical Association (AMA) notes concerns regarding the proposal to differentiate caesarean sections that result in reduced funding for pre-labour caesarean sections when this treatment decision is patient choice or based on the clinical judgement of the treating doctor. AMA notes there are many valid clinical reasons to arrange a caesarean section prior the onset of labour.

Recording of additional diagnoses

The majority of stakeholders recognised there was variation in the interpretation of what is a 'significant' condition in terms of diagnosis code assignment. New South Wales (NSW), Victoria (Vic), Queensland (Qld), Northern Territory (NT), Western Australia (WA), Tasmania (Tas), Australian Capital Territory (ACT), South Australia (SA), the Commonwealth (Cth), Children's Healthcare Australasia, Australian Health Service Alliance (AHSA) and Catholic Health Australia were supportive of refinements to ACS 0002 *Additional diagnoses* to clarify what is deemed a significant condition for code assignment. They noted there is a need for comprehensive guidelines and supporting material with case examples in order to educate clinical coders on the changes. Qld recommended interactive education workshops be considered.

NSW, Qld, SA, Tas and NT provided feedback on factors that make a condition significant, including those that delay discharge or require consultation, diagnostic or surgical interventions. These jurisdictions also commented that the aim of the refinements should not be to reduce the reporting of additional diagnoses, and there was a risk important clinical information may not be captured if the criteria were too strict.

NT and Biotronik recommended IHPA undertake an impact assessment or shadowing exercise to identify the potential change to reported activity prior to implementing a change to the codes that underpin the classification.

Phasing out support for older classification versions

NSW, Vic, WA, SA, ACT, the Cth, Children's Healthcare Australasia, and Queensland Nurses and Midwives' Union (QNMU) were supportive of the proposed timeline for phasing out AR-DRG Version 6.X and all previous versions from 1 July 2019.

AHSA and Catholic Health Australia were supportive of phasing out AR-DRG Version 4 from 1 July 2019. AHSA supports phasing out AR-DRG Version 5 from 1 July 2021, however Catholic Health Australia suggested a longer lead time was required before phasing out Version 5.

AR-DRG development cycle

NSW, VIC, Qld, WA, AHSA and Catholic Health Australia support the current biennial development cycle, although noted that stability and the pace of change could be better managed through focusing on essential updates to incorporate new diagnosis and intervention codes every two years and limiting major methodological changes to less frequent 'major' AR-DRG versions.

SA, ACT and Children's Healthcare Australasia suggested that a three or four year development cycle would be sufficient. NT and the Cth recommended that IHPA not have a set timing for the AR-DRG development cycle, but rather making an assessment on when a new version is required based on robust evidence that clinical practice has changed.

IHPA's decision

- IHPA has determined that the ICD-10-AM and ACHI Eleventh Edition diagnosis and procedure codes and the Australian Refined Diagnosis Related Groups Version 9 classification will be used for pricing admitted acute services in NEP19.
- IHPA will no longer support AR-DRG Versions 4, 4.1 and 4.2 from 1 July 2019.

Next steps and future work

Following feedback received through the Consultation Paper on the *Pricing Framework for Australian Public Hospitals 2019–20* IHPA will continue to consult with jurisdictions in regards to the implementation of the revised ACS 0002 *Additional diagnoses*.

IHPA intends to phase out older versions of AR-DRGs as new versions are developed. IHPA will phase out multiple AR-DRG versions at a time in order to reduce the gap between the current version and older versions. A timeline is outlined in Table 1.

These dates are contingent on there being suitable cost data available to support the use of newer versions of the DRG system prior to phase out. IHPA will work closely with the private sector to assess the readiness for phase out at each stage.

Table 1: Timeline for phasing out AR-DRG versions

AR-DRG version	Proposed phase out date	Most current AR-DRG version
AR-DRG Versions 4, 4.1, 4.2	1 July 2019	AR-DRG Version 10
AR-DRG Versions 5, 5.1, 5.2, 6.0, 6.X, 7.0	1 July 2021	AR-DRG Version 11
AR-DRG Versions 8, 9	1 July 2023	AR-DRG Version 12
AR-DRG Version 10	1 July 2025	AR-DRG Version 13

IHPA will continue to work with stakeholders on the optimum development process and cycle for AR-DRG development in order to balance the need to maintain clinical currency with stability of the classification.

The World Health Organization has released the 11th revision of their International Classification of Diseases, known as ICD-11. A version of ICD-11 was released by the World Health Organization in June 2018. The Australian Institute of Health and Welfare (AIHW), on behalf of the Australian Government Department of Health, has been asked to review the potential for implementation of ICD-11 in Australia. No decision has been made regarding ICD-11 implementation, and exploratory work is soon to commence to discuss ideas, considerations and consultation requirements were there to be an implementation of ICD-11 in Australia.

4.3 Australian National Subacute and Non-Acute Patient classification

For NEP18 IHPA used the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 4 classification system to price admitted subacute and non-acute services. However, per diem prices were retained for paediatric palliative care due to insufficient cost and activity data.

IHPA will continue to use AN-SNAP Version 4 to price subacute services for NEP19. Subacute and non-acute services which are not classified using AN-SNAP will be classified using DRGs.

IHPA will also continue to review whether there is sufficiently robust activity and cost data to price paediatric palliative care services using the AN-SNAP classification for NEP19, noting that there has historically been a very low volume of costed paediatric palliative care episodes.

4.3.1 Developing AN-SNAP Version 5

IHPA is continuing to develop the next version of the AN-SNAP classification. The AN-SNAP Version 4 final report highlighted a key limitation to developing prior versions which has been a lack of data to assess options for making major structural changes to the classification. Considerable progress has since been made by states and territories in the collection of subacute activity and cost data which may support improvements for AN-SNAP Version 5.

Feedback received

NSW, Vic, Qld, WA, Tas, ACT, the Cth, Royal Australasian College of Physicians (RACP), Children's Healthcare Australasia, Catholic Health Australia and AHSA all support the development of the new version of the AN-SNAP classification. A number of areas were identified for consideration in the development of AN-SNAP Version 5, including:

- Review of the geriatric evaluation and management (GEM) branch of AN-SNAP as a priority.
- Consideration of boundary issues between rehabilitation and GEM patients and psychogeriatric and mental health patients.
- Investigating alternative measures for capturing cognitive impairment, such as the Mini Mental State Examination or the Rowland Universal Dementia Assessment Scale for culturally and linguistically diverse patients.
- Consideration of comorbid and complicating conditions.
- Greater clarity around the allocation of rehabilitation impairment codes.
- Development of a more comprehensive usable classification for same-day rehabilitation.
- Consideration of non-admitted and community palliative care classification.
- Consideration of the setting of care, such as hospital in the home.
- Inclusion of the weeFIM as a measure of dependence for paediatric rehabilitation.

SA and Tas note concerns with the burden of data collection. SA recommends more time was needed to embed the subacute data collection before using the data for classification development.

RACP note there are benefits for retaining the psychogeriatric care type within the AN-SNAP classification rather than merging it with the Australian Mental Health Care Classification for the following reasons:

- The older patient with behavioural and cognitive symptoms related to delirium and dementia is primarily under the care of specialist geriatricians and other physicians rather than psychiatrists.
- The psychogeriatric care type patient may have very different lengths of stay and assessment requirements and may require different kinds of hospital and post hospital support resources (e.g. they are unlikely to be managed in a mental health ward or by mental health clinicians and staff).

NSW recommends paediatric palliative care pricing using AN-SNAP should be investigated for NEP19, as they of the view that there is enough cost data to develop an ABF pricing system for these services.

IHPA's decision

IHPA has determined that the AN-SNAP Version 4 classification will be used for pricing admitted subacute and non-acute services in NEP19. IHPA will investigate whether per diem prices should be retained for paediatric palliative care services for NEP19.

Subacute and non-acute services not classified using AN-SNAP Version 4 will be classified using Diagnosis Related Groups.

Next steps and future work

IHPA will continue to work with the Subacute Care Advisory Working Group, Clinical Advisory Committee and other advisory groups on the development of AN-SNAP Version 5.

4.4 Tier 2 Non-Admitted Services classification

4.4.1 Refinement of the Tier 2 Non-Admitted Services classification

The Tier 2 Non-Admitted Services classification system categorises a public hospital's non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service.

For NEP19, IHPA will continue to use the Tier 2 Non-Admitted Services classification for pricing non-admitted services as work on a new non-admitted care classification continues.

IHPA is working with jurisdictions to consider a proposal in response to the Consultation Paper on the *Pricing Framework for Australian Public Hospitals 2018–19* to include a 'first service event' indicator in the non-admitted data collections. Initial analysis using prior costing study data indicates a cost difference between initial and subsequent service events. The indicator could support service planning, analysis and classification development. However, IHPA notes stakeholder feedback regarding the administrative burden of new reporting requirements.

4.4.2 Multidisciplinary case conferences where the patient is not present

For NEP18, IHPA introduced new Tier 2 Non-Admitted Services classes and shadow price weights for multidisciplinary case conferences (MDCCs) where the patient is not present. The change was made to better account for the important role of MDCCs in clinical care and given strong stakeholder support.

A shadow price weight for the medical-led MDCC class (20.56) was included in the NEP18 Determination. The shadow price was determined based on cost data from a 2016 costing study on MDCCs where the patient is not present. The shadow price is intended to provide an indicative cost for service planning purposes.

IHPA was unable to determine a shadow price weight for the nursing or allied health-led MDCC class (40.62) due to insufficient cost information in the 2016 study to model an indicative cost. IHPA will work with jurisdictions to obtain the data to determine a shadow price for the allied health-led MDCC class for 2019–20.

In the meantime, IHPA intends to continue to shadow price the medical-led MDCCs where the patient is not present.

4.4.3 Development of the Australian Non-Admitted Care Classification

IHPA is developing a new Australian Non-Admitted Care Classification (ANACC) that will better describe patient characteristics and the complexity of care in order to more accurately reflect the costs of non-admitted services. The new classification would account for changes in how care is delivered as services transition to the non-admitted setting, as new electronic medical records allow for more detailed data capture and as funders test new funding models which span multiple settings.

IHPA's analysis of existing national data and prior costing studies indicates that there is the potential to use diagnosis-type and intervention-type variables to classify non-admitted care in the future. However, there is currently limited patient diagnosis and intervention information reported for non-admitted patients as outpatient information systems are immature in many centres and reporting is inconsistent.

IHPA undertook public consultation from February to April 2018 to inform ANACC development. The consultation paper described the non-admitted care landscape, changes to the types of services provided across settings, innovations in models of care and the impacts of digital transformation on data reporting. The consultation paper also canvassed classifying variables informed by an initial review of cost drivers including patient presenting problem, diagnoses and intervention groupings. Complexity variables were also canvassed including age, comorbidities, multidisciplinary care, first or follow-up visit and provider type. There were 27 submissions received, including from jurisdictions, peak bodies and clinicians.

A national costing study is planned for 2019 to collect non-admitted (including non-admitted subacute) activity and cost data and test the shortlist of variables and potential classification hierarchies. IHPA will work closely with its advisory committees to define the scope and select a representative sample of outpatient clinics and other non-admitted services in Australia. The outcomes of the costing study will underpin the development of a final hierarchy and end classes for the classification.

Alongside the costing study, new data specifications will be discussed with IHPA's advisory committees to start capturing patient-centred variables within national non-admitted data sets.

Informed by the public consultation, IHPA intends to develop a strategic plan in 2018 that will outline the path for ANACC development, implementation and pricing.

Feedback received

NSW supports the shadow pricing of MDCCs where the patient is not present and recommends that further work is done to establish a flag in the cost data collection to identify these case conferences within the electronic medical record system. Qld comments that clinicians spend significant time planning patient care and treatment in the absence of the patient, and queried why all services provided for patients without them being present were not priced.

WA and Qld support IHPA's work program to develop ANACC, although Qld has reservations regarding the capacity of clinicians and information systems to capture diagnosis and procedure data in the non-admitted setting.

IHPA's decision

IHPA has determined that the Tier 2 Non-admitted Services classification Version 5.0 will be used for pricing non-admitted services in NEP19.

IHPA will continue to shadow price medical led MDCC service events in NEP19. IHPA will investigate shadow pricing for nursing or allied health led MDCC service events for NEC19.

Next steps and future work

IHPA will continue to develop the new Australian Non-Admitted Care Classification, undertaking a costing study commencing in 2019 to collect activity and cost data to inform the new classification.

4.5 Emergency care classification

IHPA currently uses the Urgency Related Groups and Urgency Disposition Groups classification systems to classify presentations to emergency departments and emergency services for ABF purposes. IHPA acknowledges that the classification of emergency care should have a stronger emphasis on patient factors, such as diagnosis, compared to the current focus on triage category. IHPA therefore commenced work on the Australian Emergency Care Classification (AECC) in 2015.

A costing study was conducted in 2016 in ten Australian emergency departments, representative of the different sizes and roles of emergency departments, to inform development of the AECC. The activity and cost data collected from the study have enabled the development of a version of the AECC that was subsequently refined following internal and external stakeholder consultation.

IHPA undertook public consultation on the draft classification system and data requirements in late 2017. The draft AECC introduced major diagnostic groupings as the basis for classifying emergency presentations, with further splits by complexity based on a combination of factors including diagnosis, episode end status, triage category and transport mode.

Feedback on the public consultation paper supported the move towards a diagnosis-based classification that incorporates patient complexity and regarded the draft classification structure as appropriately representing emergency care.

IHPA is finalising Version 1 of the AECC, with the final report to be published on IHPA's website in early 2019. The pricing of emergency department care for NEP19 is discussed in Chapter Six.

The application of the diagnosis-based AECC to emergency services remains under consideration. Emergency services are usually located in small rural and remote hospitals and collect limited patient information. IHPA is working with jurisdictions to determine whether emergency services could collect a subset of diagnosis data using the Emergency Department Principal Diagnosis Short List (the Short List) to support implementation of the AECC for these services.

Improvements in the reporting of diagnosis information in emergency department and emergency services will support future versions of the AECC. Introduction of the Short List from 2018–19 is intended to drive consistency in diagnosis reporting and replace inconsistencies whereby states and territories have developed localised short lists and use different classifications. IHPA has finalised its interoperability tool between the ICD-10-AM and SNOMED CT-AU classifications which will also support greater consistency in the reporting of emergency department principal diagnosis data nationally.

Feedback received

WA supports the implementation of the Short List. Qld advised that restricting the diagnosis data reported by jurisdictions may cause issues with jurisdictional data submission. Vic notes that ten of their local health services still report aggregate data and would not be able to report patient level diagnosis data.

WA and NT support IHPA shadow pricing the AECC prior to a full implementation to understand the impact of the introduction of the AECC.

IHPA's decision

IHPA has determined that Urgency Related Groups Version 1.4 and Urgency Disposition Groups Version 1.3 will be used for pricing emergency activity in NEP19.

Next steps and future work

IHPA will update the Short List to reflect ICD-10-AM Eleventh Edition, which is due for implementation from 1 July 2019.

IHPA will finalise Version 1 of the AECC in late 2018 in consultation with the Emergency Care Advisory Working Group, Clinical Advisory Committee and other advisory groups. The first version of the AECC uses variables that are already collected and reported by emergency departments. Therefore, unlike the new mental health and teaching and training classifications, a significant lead time prior to pricing is not required. The AECC will be released in early 2019.

4.6 Teaching, training and research

4.6.1 Australian Teaching and Training Classification

Teaching, training and research activities represent an important role of the public hospital system alongside the provision of care to patients. However, there is currently no acceptable classification system for teaching, training and research to allow for the activities to be priced.

Teaching and training activities are therefore currently block funded except where teaching and training is in conjunction with patient care (embedded teaching and training), such as ward rounds. These costs are reported as part of routine care and the costs are reflected in the ABF price.

IHPA has investigated whether the key technical requirements for ABF could be met for teaching, training and research, including through a comprehensive costing study in 2015–16. The study concluded that it was feasible to develop a teaching and training classification.

IHPA has since undertaken a program of work to develop the first version of the Australian Teaching and Training Classification (ATTC). The ATTC will assist health services with the administrative management of teaching and training in hospitals, improve statistical reporting, enable quality improvement initiatives and improve the transparency and efficiency of funding.

ATTC development has been informed by the costing study and stakeholder consultation. The major classification variables have been identified as profession and training stage. Public consultation on a draft ATTC occurred in late 2017 and stakeholders were broadly supportive, but requested a greater level granularity for specialties within each profession.

While the costing study did identify other variables which were predictors of costs, small sample sizes meant that stable classes could not be determined. Classification refinement to incorporate these variables will require further activity and cost data collection by jurisdictions.

A key challenge in the implementation of the ATTC is the availability of activity and cost data. Teaching and training activity has been collected on a best endeavours basis since 2014–15, with research data included in the data set from 2016–17. There has been a substantial increase in data reported by jurisdictions over this time and these improvements are expected to continue.

Version 4 of the *Australian Hospital Patient Costing Standards* (the AHPCS) was published in February 2018 and includes a Costing Guideline outlining how to identify and record expenses relating to direct and indirect teaching and training activities. It is intended that the Costing Guideline will support states and territories in improving the collection and reporting of these costs to support future refinement of the ATTC and an appropriate timeline for pricing these activities. IHPA will work with jurisdictions during 2018 to determine an implementation schedule for reporting cost data.

4.6.2 Classifying research activities

Research activities are block funded given the absence of an appropriate ABF classification system. Research activities which are reportable for IHPA's purposes refer to a public health service's contribution to maintain research capability rather than research which is funded from another source.

Determining the feasibility of ABF for research has not been straightforward due to an absence of available research data. The teaching, training and research costing study in 2015–16 did not collect sufficient information on research capability to support classification development.

IHPA intends to put work to develop a research classification on hold given insufficient data at this stage and the relatively low expenditure associated with these activities relative to teaching and training in public hospitals.

Feedback received

NSW, Qld, RACP and QNMU broadly supported the teaching and training classification and continuing to investigate ABF for teaching and training to ensure better management, measurement and funding. RACP commented that remuneration for hospital time expended on teaching and training should not just be aimed at allowing hospitals to recover their costs but also to incentivise the healthcare system to invest sustainably in an activity that has ongoing long-term benefits to the general population.

Qld, WA and SA commented on the challenges of the teaching and training activity data collection. Qld suggested IHPA consider obtaining data on students and trainees directly from universities or medical colleges.

IHPA's decision

In 2019-20 IHPA will determine block funding amounts for teaching, training and research activity based on jurisdictional advice.

Next steps and future work

IHPA will work with stakeholders on implementation of the AHPCS and further development of the activity data collection in order to determine a realistic pathway and timeframe for pricing using the ATTC. Further work on teaching, training and research may be influenced by directions to IHPA in the 2020 National Health Agreement.

4.7 Australian Mental Health Care Classification

IHPA has developed the Australian Mental Health Care Classification (AMHCC) to classify and price mental health services across admitted and non-admitted settings. The classification provides a clinically meaningful way of classifying mental health care to better predict the actual cost of delivering mental health services than the previous AR-DRG classification. A key aspect of the classification is the inclusion of a new clinician-rated measure of 'mental health phase of care'.

Classification development was informed by the outcomes of a 2014–15 costing study, two public consultation processes in early and late 2015, clinical advice and an expert reference group of mental health care and data specialists. The proposed classification was also piloted in late 2015 at a small number of sites nationally to test the clinical acceptability, explanatory power and to identify the system changes which were necessary to support implementation.

Version 1 of the AMHCC was finalised in early 2016. It was implemented for data collection on a best endeavours basis from 1 July 2016.

4.7.1 Refining Mental Health Phase of Care

IHPA undertook an inter-rater reliability study in 2016 to test the rate of agreement amongst clinicians in assigning the concept of 'phase of care' to people with similar mental health care needs. The study found that the 'phase of care' instrument had poor to fair inter-rater reliability in its current form. However, clinicians did find the instrument to be useful in clinical practice and advised that it provides an opportunity to ensure consistency in service provision. The study's report recommended a comprehensive review and refinement of the 'phase of care' instrument to improve the clarity and decrease ambiguity in the application and reporting of 'phase of care'.

IHPA has engaged a number of mental health clinicians to undertake a clinical refinement project to review and enhance the 'phase of care' instrument. The project aims to improve the usability, applicability and exclusivity of each 'phase of care' to support implementation of the AMHCC. The project includes interviews and focus groups with clinicians across a broad range of settings and specialties to seek advice on how the instrument can be improved.

The clinical refinement project will conclude in early 2019.

4.7.2 Consultation-liaison psychiatry

In response to the *Pricing Framework for Australian Public Hospital Services 2018–19*, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) requested consideration of how the ABF classification systems can better account for consultation-liaison psychiatry services. These services are provided in hospitals, such as on the ward or in the emergency department, to patients receiving treatment for physical conditions.

Identifying consultation-liaison psychiatric care is challenging using admitted hospital data, which is largely centred on patient characteristics. The reporting of mental health comorbidities may suggest that consultation-liaison care was provided, however this cannot be confirmed in the absence of an intervention code. Codes for mental health interventions were significantly revised and expanded from 1 July 2017. While their use is encouraged in specialist mental health care facilities and units, and their use is not restricted solely to mental health episodes of care, their assignment is not mandatory in either context.

The NEP Determination includes an adjustment for admitted acute patients who have a principal diagnosis which is not mental health-related and have one or more Total Psychiatric Care Days (the Specialist Psychiatric Age Adjustment). However, consultation-liaison psychiatric care would commonly be provided in a general ward (instead of designated psychiatric unit) which would not be eligible.

IHPA intends to analyse national data sets to determine whether the delivery of mental health care to patients admitted for a non-mental health diagnoses is adequately accounted for in the ABF classification systems and National Pricing Model.

ACHI Tenth Edition (implemented from 1 July 2017) categorises information about initial and follow-up psychiatric assessment as well as therapies for patients in hospital with physical illness and should provide a richer source of information for understanding liaison services in the activity data sets.

Feedback received

Vic, Qld and NT were broadly supportive of the further development work on the AMHCC, in particular the 'phase of care' clinical refinement project.

NSW and RANZCP were supportive of pricing considerations for consultation-liaison psychiatric care. NSW supported expanding this from psychiatry services to include all consultation services delivered.

RANZCP commented that mother and baby units, which have been established to care for mothers with severe to moderate mental illness without separation from their baby (i.e. the baby is admitted with the mother), are not recognised in current pricing models, which are based on costs of adult mental health units. RANZCP also requested a review of the classifications related to caring for elderly patients in mental health units, as elderly patients have complex medical issues and comorbidities which affect length of stay.

Vic, Qld and NT did not support pricing mental health services using the AMHCC, including shadow pricing, until there was robust, nationally representative cost data. Vic recommended that AMHCC shadow pricing should occur for two years and not only a single year.

IHPA's decision

- The Australian Mental Health Care Classification will continue to be implemented for data collection in 2019–20.
- IHPA intends to release indicative price weights for the AMHCC in early 2019 and will seek to price mental health services using the AMHCC in 2020–21.

Next steps and future work

IHPA is investigating the identification of consultation-liaison psychiatric care in the admitted patient data in order to consider a pricing adjustment for NEP19.

As part of the development of AN-SNAP Version 5, IHPA is investigating the cost impact of complications and comorbidities on all of the care types, including GEM and psychogeriatric patients. Comorbidities have also been flagged for investigation in Version 2 of the AMHCC. Preliminary analysis on the impact of comorbidities on mental health patients has already been undertaken.

The 'phase of care' clinical refinement project will conclude in early 2019. IHPA will work with stakeholders on an implementation timeframe for recommendations from the clinical refinement project. These recommendations will inform Version 2 of the AMHCC.

5

Data collection

5 Data collection

5.1 Activity Data

5.1.1 Phasing out aggregate non-admitted data reporting

Jurisdictions are required to submit public hospital activity at the patient level wherever possible. IHPA uses the patient level data to determine the price weights in the National Efficient Price (NEP) Determination. While jurisdictions have increased the reporting of patient level non-admitted service events since 2012–13, it has not accounted for all services delivered by jurisdictions. IHPA has allowed for aggregate non-admitted data reporting by jurisdictions to ensure that all activity is captured.

The move towards patient level data is a crucial step in improving data reliability and embedding the reporting arrangements required for a new patient-centred non-admitted care classification.

In the latest *Three Year Data Plan* IHPA proposed to phase out the collection of aggregate non-admitted data as reported through the Non-Admitted Patient Care Aggregate National Minimum Data Set (for hospital services) and National Best Endeavours Data Set (for Local Hospital Network (LHN) services) from 1 July 2019.

Feedback received

Victoria (Vic) supports the transition towards patient level reporting, so long as there is a methodology to ensure that from 2019–20 the non-admitted funding model and the calculation of efficient growth in activity adequately accounts for the changed reporting requirement.

Vic notes that it may not be possible to phase out the Non-Admitted Patient Care Aggregate National Minimum Data Set from 2019–20 for all health services, and suggests flexibility in reporting to accommodate the capacity of smaller agencies to provide data.

IHPA's decision

IHPA will begin to phase out the collection of aggregate non-admitted data as reported through the Non-Admitted Patient Care Aggregate National Minimum Data Set from 1 July 2019.

Next steps and future work

IHPA notes that some agencies may require more flexibility in achieving this deadline; however IHPA is committed to transitioning to patient level data only. Work will continue through committees and working groups to ensure that a process is in place to continue to capture data where patient level is not yet possible.

5.1.2 Individual Healthcare Identifier

The Individual Healthcare Identifier (IHI) is an existing person identifier that could be included in national data sets. A robust person identifier would allow IHPA to accurately identify service delivery to patients across settings of care, financial years and hospitals.

Linked patient data would provide broad benefits to the health system, allowing hospitals to review care pathways and develop value-based healthcare proposals. The IHI would support IHPA's existing work including:

- Analysis to support a pricing or funding approach for avoidable hospital readmissions as discussed in Chapter 11.
- Development of the Australian Non-Admitted Care Classification, by allowing consideration of a unit of count which is broader than one patient attendance.
- Implementation of the Australian Mental Health Care Classification, by providing a more robust identifier for service delivery to mental health consumers within a phase of care.
- Consideration of innovative funding models, such as bundled pricing (IHPA's work to develop a bundled pricing approach for maternity care concluded that a single person identifier was a precondition to implementation).

IHPA is undertaking consultation with jurisdictions, national data committees, the Australian Digital Health Agency and other national bodies to determine the feasibility of including the IHI in national data sets with a target date for implementation of 1 July 2019.

Feedback received

New South Wales (NSW) supports the introduction of the IHI in 2019–20 to support the identification of service delivery. NSW recognises the significant benefit that a linked patient data set would provide to the health system. NSW noted privacy implications and recommends that an assessment of data quality is undertaken prior to the use of the IHI.

Vic also supports the inclusion of the IHI in the national data sets, but notes there are implementation risks due to the lead time and costs associated with this initiative.

The Australian Medical Association would only support the inclusion of the IHI in hospital datasets if the release of public hospital services data for secondary purposes is governed under the same release conditions applied to My Health Record data and managed by Australian Institute of Health and Welfare (AIHW).

IHPA notes that the IHI is an existing person identifier governed by the Department of Human Services and being used by the Australian Digital Health Authority to underpin My Health Record. IHPA does not intend to access any data from the My Health Record system.

IHPA's decision

IHPA will work with jurisdictions to progress the inclusion of the IHI in national data collections used for Activity Based Funding (ABF) purposes.

Next steps and future work

IHPA will continue to work with jurisdictions and national data committees to progress the inclusion of the IHI in the national data collections used for ABF purposes and ensure that there are appropriate protections and safeguards for consumers.

5.2 National Hospital Cost Data Collection

IHPA primarily relies on the National Hospital Cost Data Collection (NHCDC) to develop the NEP and the price weights for the funding of public hospital services on an activity basis and to develop the NEC for block funded hospitals.

5.2.1 Australian Hospital Patient Costing Standards

Data submissions by jurisdictions to the NHCDC are informed by the *Australian Hospital Patient Costing Standards* (the AHPCS). The AHPCS provide direction for hospital patient costing and are intended to improve consistency in the reporting of hospital costs. The AHPCS are evolving guidelines that will continue to be updated as new costing processes develop.

AHPCS Version 4.0 was published in February 2018. This version has been restructured to incorporate a set of overarching principles to guide the costing process and to include business rules which provide detailed guidance from the costing practitioners' perspective on how a costing standard can be translated into action, while taking into account practical and operational constraints within organisations. It is intended that the changes to the AHPCS will result in greater consistency in activity based costing for future rounds of the NHCDC.

AHPCS Version 4.0 has also sought to address stakeholder issues which were raised in response to previous Pricing Framework Consultation Papers. These include accounting for the costs of interpreter services, private patient medical expenses, teaching and training and posthumous care.

Feedback received

NSW note they will be implementing Version 4 of the AHPCS in 2018–19 and will work with IHPA on an implementation schedule for cost data submission.

Western Australia and South Australia note they will require more time, and that there is additional burden in implementing the revised the AHPCS.

IHPA's decision

AHPCS Version 4.0 will inform the costing of public hospital services from financial year 2017–18 (Round 22) of the NHCDC which will inform the NEP and NEC for 2020–21.

Next steps and future work

IHPA is working with its NHCDC Advisory Committee and jurisdictions to implement AHPCS 4.0. Once implemented, IHPA intends to evaluate compliance with the new aspects of the AHPCS through its annual NHCDC Independent Financial Review.

5.3 Access to public hospital data

IHPA is committed to the open access to information as well as obligations to protect the privacy of individuals and the confidentiality of other information.

A significant amount of public hospital data and related information is accessible via IHPA's website. This includes the NHCDC Cost Report and NEP and NEC Determinations. IHPA cost data is also available on the AIHW MyHospitals website. This information has informed work and publications by research organisations, peak bodies and governments regarding trends in the average cost of public hospital care.

IHPA can also release public hospital data to government agencies and researchers under the *National Health Reform Act 2011*. IHPA may release data to specified government agencies where it would assist them in performing their functions, as well as to other third parties where it would benefit the conduct of research. In deciding to release data, IHPA always ensures adequate steps are taken to protect patient privacy. Further information is contained in the Information Release Policy. The releases have led to research publications which have added value to public discussion on health policy as well as policy making.

5.3.1 Benchmarking

The National Benchmarking Portal (NBP) was developed in 2016 as a secure web-based application allowing users to analyse hospital activity and cost information around the country and compare against similar hospitals, including for hospital acquired complications (HACs). Jurisdictions control access to the NBP, and in many cases have granted access to clinicians, and hospital managers in Local Hospital Networks to enable benchmarking against similar hospitals nationally.

IHPA continues to improve the capabilities of the NBP. In 2018, IHPA will include the HAC Adjustment in the NBP to highlight the risk-adjusted impact of HACs on hospital costs. The NBP will also include HAC rates for hospitals and compare performance on both a risk and adjusted raw basis. This information will support system and hospital managers in identifying areas for improvement in safety and quality.

5.3.2 Increasing access to public hospital data

IHPA considers that broadening access to its data and greater publication of analysis using the data would benefit work to develop and evaluate health policy and programs by researchers, clinical groups and peak bodies and would serve the interests of transparency.

IHPA is considering a range of options to broaden access to its data, including:

- Public access to the NBP: The NBP includes extensive hospital-level information on hospital activity and its costs, as well as safety and quality indicators. IHPA could broaden access to the NBP beyond its current users which are public hospitals and state and territory health departments. Rigorous safeguards would be required to ensure that the data is appropriately managed and the data is used only for research purposes.
- Publications using IHPA data: IHPA publishes a limited number of reports annually which include or analyse hospital data, such as the NHCDC Cost Report or costing studies informing classification development. IHPA could undertake and publish research analysing different aspects of the data to what is currently available. For example, IHPA could report on the cost of HACs and avoidable hospital readmissions at the hospital level or report on the drivers of cost variation in emergency departments.

Feedback received

Increasing access to public hospital data

South Australia, NSW, Vic and Tasmania broadly support the idea of increasing data access but do not support amending the current approval process.

Stakeholder feedback is varied regarding the best approach to increasing access to data held by IHPA. In general there is strong support for increasing access; however, there is strong support from most jurisdictions for centralising the information release processes with other agencies such as the AIHW and ensuring the data custodians within each jurisdiction continue to be involved in access approvals.

WA notes that access could be expanded to various stakeholders including but not limited to the health sector, private sector and education institutions on the proviso that appropriate governance and approval processes are established.

WA and SA raise concerns about how data will be interpreted and used. WA suggests the governance and approval processes to providing access should canvas these considerations.

SA notes that while it is important to utilise data sets to their full potential, data needs to be quality-assured and presented with appropriate contextual information. Similarly, Queensland (Qld) notes the importance of including caveats over the comparability of the data.

Australian Health Service Alliance (AHSA), AMA, Catholic Health Australia, Queensland Nurses and Midwives' Union (QNMU), Medtronic, Children's Healthcare Australasia and Biotronik generally support broadening access to hospital data held by IHPA although most specify the need for ensuring that safeguards are in place around patient privacy and appropriate use of the data.

Publications using IHPA data

Vic and Tas do not support IHPA producing ad-hoc analysis using public hospital data, as they suggest it is outside the scope of IHPA's direct responsibilities. Vic supports the existing process for research requests for public hospital data.

Vic, Tas and NSW suggest that conducting analysis and producing reports on health-related information is the function of the AIHW, not IHPA.

Qld is generally supportive of IHPA publishing additional research and analysis including the publication of all third party analysis of IHPA data, facility level analysis on high volume surgical and medical AR-DRGs and standardised costs for the most common operations nationally.

AMA welcome additional published reports by IHPA noting it has potential to increase transparency and broaden the public's understanding of the quantum of Commonwealth funding per LHN under the activity-based funding model.

AHSA suggests that IHPA publish the results of its analysis on a wide range of issues, particularly safety and quality with a long term view of benchmarking all hospitals to increase transparency but that care is needed to ensure there is no duplication of work with other agencies such as the AIHW and Australian Commission on Safety and Quality in Health Care (the Commission).

QNMU supports the publication of analysis of the public hospital data, provided it is evidence-based and founded on rigorous research methods.

Public access to the National Benchmarking Portal

Both the Australian Capital Territory (ACT) and Northern Territory (NT) support public access to the NBP. However, ACT would require an in-depth review and approval process by IHPA's Jurisdictional Advisory Committee, while NT note that a number of safeguards, including compliance with state and territory law and the ethical release of data would need to be in place to facilitate this.

Vic states that the decision to release data lies with the originating state or territory and not IHPA as per the Clause B100 of the National Health Reform Agreement. Vic also has concerns that the NBP is not a complete dataset to the extent that not all hospitals report cost data.

NSW and Tas are of the view that only health departments should retain access to the NBP as was originally agreed by all jurisdictions. Access to the data in the NBP should remain limited to those using health department IT systems.

Children's Healthcare Australasia notes that the NBP is currently not accessible to public hospitals in several jurisdictions and that limitations on this access in some jurisdictions serves only to deprive managers of much needed information to support them to identify opportunities for enhance services and reduce costs.

Children's Healthcare Australasia also proposes that peak not for profit organisations like themselves and Women's Healthcare Australasia should be granted access to the NBP as these organisations have relationships with managers and clinical leaders across the public hospital sector and expertise to assist in providing services to learn from one another's successes, improve outcomes for patients and reduce costs. They note there could be substantial benefits to health system managers from facilitating access to the NBP not least of which is the efficiency in minimising time spent by data managers providing data to multiple different stakeholders. Such access could be conditional upon not publishing the resulting analysis publicly.

Catholic Health Australia supports IHPA's consideration to allow public access to the NBP and produce benchmarking reports transparently for the public system, particularly around HACs and avoidable hospital readmissions. This will assist hospitals in improving their capabilities to address safety and quality issues. Catholic Health Australia also recommends publishing data for patient homelessness to analyse where there might be areas for potential improvement in the pricing model to service this cohort of patients.

IHPA's decision

- IHPA will develop a list of publications in consultation with its stakeholders.
- IHPA will ensure that access to the National Benchmarking Portal is available to all Local Hospital Networks and public hospitals and will explore mechanisms to allow this.

Next steps and future work

IHPA will continue to work with stakeholders to improve access to hospital data, including developing appropriate safeguards and identifying opportunities that all parties are agreeable to in the release of data and/or publications to third parties.

Specifically, IHPA will ensure that access to the NBP is available to all LHNs and public hospitals, and will explore appropriate mechanisms to allow this without compromising the security of the system.

IHPA will also develop a list of research areas for analysis and publication in consultation with stakeholders including the AIHW and jurisdictions with the intention of publishing research and analyses on the IHPA website.

6

Setting the National Efficient Price for activity based funded public hospitals

6 Setting the National Efficient Price for activity based funded public hospitals

6.1 Technical improvements

IHPA has developed a robust pricing model that underpins the National Efficient Price Determination (NEP). The model is described in detail in the National Pricing Model Technical Specifications on IHPA's website.

In the Consultation Paper for the *Pricing Framework for Australian Public Hospital Services 2019–20* IHPA did not propose any significant modifications to the National Pricing Model for 2019–20, however, IHPA will consider any new technical improvements suggested by jurisdictions and other stakeholders in the development of NEP19.

6.1.1 Pricing of emergency care

IHPA foreshadowed in the *Pricing Framework for Australian Public Hospital Services 2018–19* an intention to price or shadow price emergency department services using the Australian Emergency Care Classification (AECC) for NEP19.

The AECC will be finalised in late 2018. While new data items may be required for the AECC in the future, Version 1 of the classification can be implemented using existing data collections.

A quality assurance process will be undertaken in December 2018 and January 2019 to check and validate Version 1 of the AECC including the complexity model in the classification.

Following this process, IHPA will use available cost data with a view to shadow pricing emergency department services using the AECC for that National Efficient Price 2020–21 (NEP20).

6.1.2 Pricing of mental health care

IHPA foreshadowed in prior Pricing Frameworks an intention to price mental health services using the Australian Mental Health Care Classification (AMHCC) as it more accurately reflects the costs and care delivered to mental health consumers. This requires that cost and activity data is reported at the 'phase of care' level.

The 2017–18 and 2018–19 Consultation Papers advised that IHPA was investigating a proxy for 'phase of care' to price mental health services using the AMHCC prior to phase level cost data being reported by states and territories.

IHPA has investigated a number of potential proxies including episode care type, length of stay, the 'program type' data item collected in the National Outcomes and Casemix Collection and the number of times that the Health of the Nation Outcome Scales (HoNOS) was undertaken or significant changes in HoNOS as indicative of multi-phase episodes.

No robust proxy for 'phase of care' has been identified to price even a subset of mental health consumers. Clinical and other stakeholders are not supportive of further investigating proxies, therefore, IHPA does not intend to continue to investigate proxies for 'phase of care'.

IHPA will also seek to align the pricing and classification of mental health with other policy frameworks and initiatives by Australian governments. For example, IHPA will be mindful of developments regarding the National Mental Health Service Planning Framework and associated documents which guide strategic planning and future investment in the mental health system.

6.1.3 Alternative geographical classification systems

Remoteness has been shown to be a significant cost driver for the provision of public hospital services and is considered in both the NEP model and the NEC model as one of a variety of factors. IHPA's approach to determining remoteness is to use the Australian Bureau of Statistics' 2011 Australian Statistical Geography Standard Remoteness Area (ASGS-RA) classification.

Northern Territory (NT) has proposed an alternative approach for determining patient and hospital remoteness. The simplified methodology is based on population density and spatial distance and is outlined in a 2008 research paper.[1] It has been suggested this more intuitive and statistically straightforward approach could better account for the fixed costs incurred due to geographic remoteness than the current ASGS-RA model.

1 Zhao Y & Guthridge S (Dec 2008). 'Rethinking remoteness: a simple and objective approach', Geographical research, 46(4): 413–420.

Feedback received

Stakeholders were supportive of IHPA exploring alternative geographical classification systems.

NT notes that the proposed remoteness classification increases the granularity of what the current classification considers 'very remote', which more appropriately relates the measure of remoteness and the associated service delivery and accessibility requirements.

Australian Capital Territory (ACT) suggests that IHPA considers the impact and comparability of using a different geographical classification to that used by other reporting agencies such as the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics.

South Australia (SA) notes that any new system must be critically analysed to determine its accuracy, improvement and relevance, and consideration given to whether the administrative burden, and education, which accompanies a change in classification is justified.

New South Wales (NSW) recommended that IHPA continue using the existing geographical classification system and undertake separate analysis to assess whether the method of determining patient and hospital remoteness based on population density and spatial difference is a better fit for the NEP model. Catholic Health Australia also requested further analyses around how the model will be reviewed to account for changes in population density and the transient nature of many indigenous communities.

NSW also notes that all adjustments should be applicable to all jurisdictions and not favour one particular state or territory and that IHPA should review the implementation of such an adjustment to ensure that all jurisdictions would benefit from its introduction.

Children's Healthcare Australasia notes that the proposed NT approach would provide more granular measures of remoteness than the current ASGS-RA model, however, the proposed method focuses solely on population density. They note the advantage of that ASGS-RA model is that it directly uses measures of accessibility.

Queensland (Qld), Australian Medical Association (AMA) and the Queensland Nurses and Midwives' Union (QNMU) recommend that IHPA consider the use of the Modified Monash Model as it is the most current and commonly used index for measuring rurality.

IHPA notes that previous analysis found that the Modified Monash Model does not result in any improvement in identifying costs associated with patient and hospital remoteness compared to the ASGS-RA classification and may have the unintended consequence of disadvantaging small hospitals in outer regional areas.

IHPA's decision

– IHPA will continue to use the 2011 Australian Statistical Geography Standard Remoteness Area (ASGS-RA) classification for NEP19 while undertaking separate analysis of the NT proposed option.

Next steps and future work

IHPA is committed to prioritising the pricing of mental health services using the AMHCC. IHPA will continue to work with jurisdictions to accelerate the collection of 2017–18 mental health cost data in order to enable shadow pricing for NEP20.

IHPA will provide the results of any shadow pricing and further analyses and seek further stakeholder feedback in next year's Consultation Paper on the *Pricing Framework for Public Hospital Services*.

IHPA will continue to use the 2011 Australian Statistical Geography Standard Remoteness Area (ASGS-RA) classification for NEP19 whilst continuing to analysing alternative remoteness classifications, including the proposed NT option. IHPA will work through its committees and working groups with the intention of providing a more informed discussion in next year's Consultation Paper on *Pricing Framework for Public Hospital Services*.

6.1.4 Fundamental review of the National Pricing Model

In response to previous Pricing Frameworks, stakeholders have repeatedly recommended that IHPA consider alternative approaches to calculating the NEP, which may better deliver on the objectives in the National Health Reform Agreement.

This issue was last considered in the *Pricing Framework for Australian Public Hospital Services 2015–16* where different approaches were canvassed including continuing to set the NEP at the average cost, excluding high cost hospitals or excluding 'avoidable costs'.

As public hospital funding arrangements from 2020 are yet to be finalised, IHPA considers it an appropriate time to review the methodology underpinning the National Pricing Model. IHPA has therefore commenced a 'first principles' independent review of the National Pricing Model. The review will question the assumptions and technical approaches, which were adopted early in the development of the NEP and whether they remain best practice.

The review will involve:

- A comprehensive literature review of current data analysis and statistical modelling techniques, focusing on the suitability and applicability for pricing public hospital services.
- A review of the processes used in the development of pricing models underpinning the NEP.
- Recommendations to improve the processes and statistical techniques used in the NEP development.

Feedback received

Stakeholders strongly support IHPA undertaking a fundamental review of the National Pricing Model and agree with the list of proposed focus areas; particularly indexation, back-casting, price weights, calculation of the reference cost and emerging technology.

NSW and Qld support the inclusion of the calculation of the initial reference cost for the National Pricing Model. NSW suggests the reference cost should be updated with recent cost data.

Qld also recommends that the review considers pricing for patient travel and more robust statistical techniques for setting the AR-DRG acute trim points.

Western Australia (WA) recommends that IHPA further investigate private patient adjustments and child and adolescent mental health services to better understand the impact and variance of these patient cohorts on the model.

ACT recommends a number of comparisons across jurisdictions including the price and cost for each jurisdiction over time, qualitative and quantitative assessment of the efficiencies the NEP has delivered in each jurisdiction and an assessment of the benefits and impacts at a jurisdictional level of setting a true efficient price when compared against the current methodology of setting the price at a national average. ACT also recommends the review considers adjustments for differing hospital sizes and varying economic conditions.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends a review of pricing models for mother and baby units which would include a loading to cover the costs of ensuring the safety and care of the baby, similar to precedents that already exist in pricing for rural services.

The Royal Australasian College of Physicians (RACP) supports the investigation of technological and device based advances in clinical assessment and diagnostic care such as new device technologies and telehealth.

Setting the price at the 'average' cost

Stakeholder feedback varies on this issue. The Commonwealth (Cth) strongly advocates for IHPA exploring alternative approaches to calculating the National Pricing Model suggesting options explored should attempt to strengthen the price signal provided by the NEP.

WA does not support a move away from the current process of setting a NEP based on the weighted mean cost of admitted services.

AMA notes that while Activity Based Funding provides greater transparency, focusing on the average cost of a hospital service does not necessarily demonstrate a high quality service. The AMA would like to see more focus on timely access to public hospital treatments and best practice pricing.

IHPA's decision

IHPA will incorporate stakeholder feedback received through the *Pricing Framework Consultation Paper 2019–20* in finalising the focus of the independent fundamental review of the National Pricing Model.

Next steps and future work

Findings from the literature review as well as stakeholder feedback will inform the fundamental review of the processes used in the development of pricing models underpinning the NEP. The review will conclude in 2019 and stakeholders given the opportunity to comment on the findings as part of the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2020–21*.

6.2 Adjustments to the National Efficient Price

6.2.1 Overview

Section 131(1)(d) of the *National Health Reform Act 2011* requires IHPA to determine "adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services". Clause B13 of the National Health Reform Agreement additionally states that IHPA "must 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; and patient complexity, including Indigenous status".

IHPA tests whether there are empirical differences in the cost of providing public hospital services at the national level in order to determine whether there are legitimate and unavoidable variations in the costs of service delivery that may warrant an adjustment to the NEP.

IHPA examines patient-based characteristics in the cost of providing public hospital services as a first priority before considering hospital or provider-based characteristics. This policy reinforces the principle that funding should follow the patient wherever possible.

IHPA will continue to review these existing adjustments, with the aim of discontinuing adjustments associated with input costs or which are facility-based when it is feasible.

IHPA developed the Assessment of Legitimate and Unavoidable Cost Variations Framework in 2013 to assist state and territory governments in making applications for consideration of whether a service has legitimate and unavoidable cost variations not adequately recognised in the National Pricing Model. If agreed, IHPA considers whether an adjustment to the NEP is warranted. Jurisdictions may propose potential unavoidable cost variations on an annual basis.

IHPA will consider adjustments proposed by stakeholders in their responses to Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2019–20* or by jurisdictions as part of the annual *Assessment of Legitimate and Unavoidable Cost Variations Framework* process.

6.2.2 Adjustments to be evaluated for NEP19

Extension of admitted acute adjustments to other care settings

NT has recommended that IHPA standardise adjustments between settings of care where the service is the same, such as renal dialysis and chemotherapy, as outlined in the *Pricing Guidelines* in Chapter 2. For example, it is proposed that the Patient Residential Remoteness Area Adjustment should also apply to non-admitted and emergency care as transferring services to these settings currently has a negative financial impact.

Currently adjustment proposals are considered on the basis of empirical evidence. No cost difference had previously been identified based on remoteness for non-admitted or emergency care. In finalising the NEP18 Determination, IHPA did identify a material cost difference for emergency department presentations where the patient lives in a remote or very remote area. To this end the Patient Residential Remoteness Area Adjustment was extended from admitted acute care to include emergency department and emergency services presentations in the NEP18 Determination.

IHPA will continue to investigate whether existing adjustments for admitted acute care can be extended to other care settings, with a particular focus on the non-admitted service stream. It is hoped that improvements in the quality of cost data for other streams, particularly for non admitted services, may provide new evidence to support this work for NEP19.

Harmonising price weights across care settings

The *Pricing Guidelines* guide the policy decisions underpinning the National Pricing Model and were developed following extensive consultation with key stakeholders and the public. The Pricing Guidelines include 'System Design Guidelines' to inform options for the design of ABF and block grant funding arrangements, including an objective for 'price harmonisation' whereby pricing should facilitate best-practice provision of appropriate site of care.

IHPA 'harmonises' (i.e. equalises) a limited number of price weights across the admitted acute and non-admitted settings, for example those for gastrointestinal endoscopes, to ensure that similar services are priced consistently across settings. Harmonisation ensures that there is no financial incentive for hospitals to admit patients previously treated on a non-admitted basis due to a higher price for the same service. IHPA seeks advice from its Clinical Advisory Committee when considering whether classes across settings of care are providing a similar type and level of care. IHPA will continue to explore opportunities to harmonise price weights between settings in 2019, for possible implementation in NEP20.

Feedback received

Priority areas for IHPA to consider when evaluating adjustments to NEP19

WA suggests that IHPA consider an extension of the adjustments to facility location costs for admitted acute episodes to subacute and outpatient service delivery as this would provide better consistency in the model across settings and equitable compensation for the costs of this service delivery.

Tasmania (Tas) supports the expansion of the dialysis adjustment to all admitted patients, not just acute.

NT recommends that IHPA prioritise the application of adjustments to sub-acute and non-admitted patients as these care types generally treat complex comorbid patients.

ACT recommends that IHPA consider adjustments to the NEP to address the disconnect between cost and price for smaller jurisdictions. This could include a review and adjustment of the grouping of peer hospitals.

IHPA notes that according to the *Pricing Guidelines* in Chapter 2 adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.

Patient-based factors for consideration for new or existing adjustments

NSW, Vic, and Tas recommend that IHPA prioritise the review of the Intensive Care Unit (ICU) Adjustment for NEP19. NSW recommends that IHPA consider using patient based factors, such as clinical measures, to determine the ICU Adjustment, Vic recommends that IHPA investigate replacing the current adjustment for ICU (based on ICU hours) with an adjustment based on a combination of invasive mechanical ventilation hours and non-invasive ventilation hours that are delivered in an ICU and Tas believes that the ICU component should be reviewed, as a priority, and particularly for invasive ventilated patients, to develop a weighting if an invasive ventilated patient is managed in a regional centre critical care unit.

Children's Healthcare Australasia notes that currently there are no adjustments for the treatment of paediatric patients in emergency or non-admitted streams and believes investigating this with improved data should be a priority for NEP19.

WA recommends that IHPA considers the impact of episode costs of patients with a mental health condition receiving treatment where the care type is not mental health, the presence of drugs (such as methamphetamine), the inclusion of parents/guardians or other services that increases costs required to provide child and adolescent mental health services.

Tas recommends a review of the impact of obesity on the cost of care. WA and Catholic Health Australia recommend that IHPA re-consider an adjustment for homeless patients.

QNMU re-iterates the importance of including nursing and midwifery-led programs when evaluating adjustments. QNMU also suggests that IHPA should consider palliative care as a priority area when evaluating adjustments to the NEP.

Price harmonisation for the potentially similar same-day services

Most stakeholders support price harmonisation for potentially similar same-day services. ACT, AHSA and Catholic Health Australia support IHPA's approach to harmonising price weights across the admitted acute and non-admitted settings to avoid perverse incentives to admit patients in some cases.

WA and Vic are supportive subject to consultation on a case by case basis through IHPA's advisory committees and an assessment of cost compatibility.

A number of stakeholders noted further evidence was required before they would support the approach.

NSW would support the harmonisation of price weights across care settings if there was best practice evidence available to support its use. QNMU cannot support price harmonisation for similar same-day services unless all key stakeholders are consulted and further investigation shows price harmonisation is warranted.

AMA notes that price harmonisation will only benefit patients if it is nuanced and sophisticated enough to elevate/emphasise clinical judgement above financial incentive as the determinate of appropriate setting.

Services to investigate for price harmonisation

NSW would support the IHPA's investigation into the price harmonisation for:

- Same day models for rehabilitation compared to outpatient models for rehabilitation
- Non-admitted and subacute psychogeriatric same day services
- Cataract surgery across the admitted and non-admitted settings
- Gastrointestinal endoscopy
- Renal dialysis, chemotherapy and non-chemotherapy infusions.

Vic recommends that price harmonisation should be applied across same-day chemotherapy services in order to support the significant changes that have occurred in recent times in the administration of chemotherapy agents.

Tas supports IHPA undertaking investigating price harmonisation of angioplasty and angiography procedures.

WA suggests gastrointestinal scopes, transfusions and infusions as candidates for initial review.

Qld recommends that the endoscopy, interventional cardiology and radiation oncology could benefit from price harmonisation.

IHPA's decision

- IHPA will expand the extension of existing admitted acute adjustments to non-admitted, emergency care and subacute streams, where appropriate for NEP19.
- IHPA will continue to investigate price harmonisation for potentially similar same-day services such as non-admitted and admitted same-day chemotherapy services, renal dialysis and sleep disorders on a case-by-case basis.

Next steps and future work

IHPA will continue to investigate and revisit a number of suggested adjustments as priority for NEP19 including paediatric patients, palliative care, homelessness and obesity.

IHPA will also include a comprehensive investigation of adjustments for ICU, patient remoteness, and travel costs further as part of the fundamental review of the National Pricing Model (see section 6.1.4).

Mental health as a comorbidity is already considered in AR-DRGs, however, IHPA will consider the impact of episode costs of patients with a mental health condition receiving treatment where the care type is not mental health to assess whether it is adequately accounted for in the ABF classification systems and National Pricing Model. IHPA is also investigating whether consultation-liaison psychiatric care is captured as part of its work to develop the AMHCC (see section 4.7.2 for more detail).

The presence of drugs, the inclusion of parents/guardians or other services that increases costs required to provide child and adolescent mental health services are included as part of IHPA's work to develop a mental health care classification.

IHPA will consider patient comorbidities and complexities for subacute patients as part of the development of AN-SNAP Version 5.0.

IHPA will continue to investigate price harmonisation across different settings of care working with its Clinical Advisory Committee. In time this may extend to investigating harmonising prices to health services delivered outside the hospital setting.

6.3 Shadow implementation periods

The Pricing Framework 2018–19 advised that IHPA will shadow major changes to the ABF classification systems. A shadow implementation period provides Australian governments with the lead time to assess the impact on funding, including for specific population and peer hospitals, and implement system changes to data reporting and clinical information systems.

A shadow implementation period involves determining prices for activity, but with funding implications only in a later year. For example, the non-admitted class for medical-led multidisciplinary case conferences where the patient is not present was shadow priced in NEP18 with the aim of establishing a baseline activity measure for this new Tier 2 clinic.

Major changes to the National Pricing Model can also be shadow priced. For example, the funding approach to hospital acquired complications underwent a shadow implementation period in 2017–18 to assess its expected impact and to allow for its refinement before it was implemented.

Examples of changes that IHPA intends to shadow price include:

- Changes that require new data items: The quality and completeness of reporting for new data items cannot be determined prior to evaluating the first year of collection. IHPA also recognises that the introduction of new data items may require a lead time to be implemented into the information technology systems of health services.
- New Tier 2 Non-Admitted Services classes: IHPA will shadow new Tier 2 Non-Admitted Services classes to reduce the risk of unintended consequences and to collect activity and cost data to assess its impact. For example, IHPA has shadowed the class for medical-led multidisciplinary case conferences where the patient is not present.

Examples of changes that IHPA does not intend to shadow include:

- Adjustments that utilise existing data items, where the historic data is robust: IHPA will introduce adjustments to account for legitimate and unavoidable costs as identified using robust national data. The impact of new adjustments can be determined using existing data and be considered by jurisdictions prior to the release of the NEP Determination.
- New admitted acute care classification versions: The implementation of new ICD-10-AM editions or new AR-DRG versions are generally incremental in nature. However, when significant updates are made (for example the redesign of the case complexity methodology for AR-DRG Version 8.0) any changes that result from this can only be measured when the system is live. That is, in a shadowing implementation, the new DRG system would effectively be ignored. In these situations back casting may be required once data is collected.

In response to the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2018–19*, some stakeholders recommended that IHPA apply shadow implementation periods to all changes to the ABF classification systems and National Pricing Model. IHPA notes that shadowing changes may minimise the risk of unintended consequences, but would also delay necessary improvements to the national ABF system such as improved accuracy in the classification and pricing of services.

Feedback received

In general, all stakeholders support a shadow implementation period based on a set of criteria to provide the parameters around when it is appropriate and when it is not appropriate to shadow price. The majority of stakeholders also agree that any criteria and assessment against the criteria should be made and agreed through IHPA's Jurisdictional Advisory Committee.

NSW and Vic recommend the implementation of a shadow period of at least 12 months before introducing any new ABF classification system or changes to the National Pricing Model.

NSW is of the view that a shadow period should be implemented for the following scenarios:

- When data robustness or volume is not enough to support the implementation;
- To build a year of baseline data when there is no historical data;
- To trial new models of care;
- To implement new data elements; and
- To trial potential changes in clinical practice.

Vic agrees that not all changes to the National Pricing Model should necessitate shadowing. Vic suggests IHPA consider the implementation of a shadow period in instances where:

- Changes represent intended permanent changes where there is insufficient data to provide robust analyses.
- Changes are profound and potentially materially significant.
- Changes require amendments to data specifications, collections or reporting systems.

ACT notes that a shadow period should be implemented for any change that would need to be back-cast for the efficient growth funding formula or that may have a financial impact.

SA notes that agreement is also required that when shadow funding is not implemented, there is an understanding that no retrospective adjustments are to be applied in the assessment of activity growth funding.

WA recommends that new classification systems should always be shadow funded, even where there is robust existing data, unless otherwise agreed to by jurisdictions. An example of this would be the new Australian Emergency Care Classification system. The Cth is also of the view that shadow pricing of ABF classification systems should apply to all changes, in order to ensure consistency and stability across financial years.

Qld recommends that any that changes that require additional investment in IT systems be shadowed for longer periods of time and that shadowed data be made available as soon as possible to allow comprehensive impact analysis.

NT recommends that IHPA apply a shadow implementation period to all changes to the ABF classification systems and National Pricing Model, unless otherwise agreed by states and territories. NT also recommends that criteria is developed to provide the parameters around when it is appropriate to consider not applying a shadow implementation period.

Tas recommends that for structural changes to classification systems, the shadow period should be two annual data submission cycles and two NHCDC costing cycles. For implementation of new classification systems the shadow period should be longer than three annual data submission cycles and two NHCDC costing cycles. For structural changes to the model like the avoidable hospital readmissions the shadow period should be three annual data submission cycles and two NHCDC costing cycles.

Children's Healthcare Australasia notes that IHPA should continue to implement shadow periods for changes that require new data items or when new classifications are introduced.

Biotronik considers where major changes occur to AR-DRG's especially around the engagement of health technology that the changes be shadowed before implementation.

IHPA's decision

IHPA will develop criteria for the parameters around when shadow pricing should be applied based on stakeholder feedback with the intention to implement the criteria from July 2019.

Next steps and future work

IHPA will work with stakeholders to develop criteria that provide the parameters around whether to apply and when not to apply a shadow implementation period and for how long the shadow period should apply. IHPA will provide the draft criteria to its Jurisdictional Advisory Committee for comment and provide a final version to the Pricing Authority with a view of implementation from July 2019.

7

Setting the National Efficient Price for private patients in public hospitals

7 Setting the National Efficient Price for private patients in public hospitals

7.1 Overview

Public hospitals may receive revenue for delivering care from funding sources other than through the National Health Reform Agreement. For example, patients admitted to public hospitals may opt to use their private health cover or pay for their own hospital stay.

The National Health Reform Agreement requires IHPA to set the price for admitted private patients in public hospitals accounting for these payments by other parties, particularly private health insurers (for prostheses and the default bed day rate) and the Medicare Benefits Schedule (MBS).

Under Clauses A6 and A7 of the Agreement, IHPA does not price private non-admitted patient services.

7.2 Costing private patients in public hospitals

The collection of private patient medical expenses has been problematic in the National Hospital Cost Data Collection (NHCDC). For example, there is a common practice in some jurisdictions of using Special Purpose Funds to collect associated revenue (e.g. MBS) and reimburse medical practitioners.

The Australian Hospital Patient Costing Standards (the AHPCS) Version 3.1 state that public hospitals are to report the full costs incurred in the treatment of public and private patients in the NHCDC. While full compliance with the current AHPCS would allow for phasing out the correction factor, private patient costs have not been consistently captured across public hospitals to date. These funds generally do not appear in hospital accounts used for costing in the NHCDC. This leads to an under attribution of total medical costs across all patients as costs associated with medical staff are applied equally across public and private patients.

For the National Efficient Price (NEP) 2018–19 IHPA corrected for this issue by inflating the cost of some patients (the 'private patient correction factor') to account for costs not reported in the NHCDC. The Hospital Casemix Protocol (HCP) data set was used to identify the missing medical costs of private patients.

The use of the correction factor assumes that all private patient costs are missing and that these costs are spread across both private and public patients, which is not always the case. For example, some hospitals appear to report specialist medical costs for private patients, whilst others may have costs missing from both public and private patients.

This aspect of the pricing model will be reviewed as part of the fundamental review of the NEP.

7.2.1 Phasing out the private patient correction factor

The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the NHCDC. Submissions in response to previous Consultation Papers on the *Pricing Framework for Australian Public Hospital Services* have supported phasing out the correction factor when feasible.

The implementation of AHPCS Version 4.0 will address this issue for future NEP Determinations. AHPCS Version 4.0, which was published in February 2018, includes a Business Rule relating to the treatment of medical and other expenses found in Special Purpose Funds which manage Rights of Private Practice arrangements. It is intended that the Business Rule will support states and territories in accounting for all expenses contributing toward hospital activities, regardless of their funding source. The Business Rule will inform the costing process for Round 22 (2017–18) of the NHCDC.

Feedback received

The consultation paper sought feedback on longer term reform, including phasing out the private patient correction factor for NEP20.

Queensland and Victoria support the proposal to phase out the private patient correction factor, however, Vic does not consider this feasible for NEP20.

New South Wales, South Australia, Australian Capital Territory and the Northern Territory (NT) support the phasing out of the private patient correction factor following a review of the 2017–18 NHCDC data to ensure the accuracy and national consistency in the implementation of the AHPCS Version 4.0.

Western Australia and Tasmania do not support the phasing out the private patient correction factor for NEP20.

NT recommends that the phasing out of the private patient correction factor be subject to implementation of a shadow period. NT also recommends that this change should be back-cast to understand effect to 2017–18 data of removing the private patient correction factor.

IHPA's decision

IHPA will work towards phasing out the private patient correction factor for NEP20.

Next steps and future work

IHPA will work with states and territories to better identify the treatment of private patient costs in the 2016-17 NHCDC data (Round 21) used for NEP19 and ascertain if any revision needs to be made to the existing methodology used to correct for missing costs.

IHPA considers that jurisdictions have been given sufficient lead time to ensure that private patient medical costs are captured in the NHCDC. The 'Business Rule for Special Purpose

Funds' in the AHPCS Version 4.0 will provide additional guidance to costing managers.

IHPA will work with its NHCDC Advisory Committee to assess the accuracy and national consistency in the implementation of AHPCS Version 4.0 and provide feedback with further opportunity to comment in the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2020–21*.

7.3 Private patient adjustments

IHPA deducts payments made by insurers and the MBS for services delivered to private patients in developing the National Pricing Model. This revenue is deducted to prevent the hospital being paid twice for each private patient — once by the revenue source and a second time by the Commonwealth under the Agreement.

IHPA will continue to apply the Private Patient Service Adjustment, to deduct revenue received for medical hospital services and prostheses, and the Private Patient Accommodation Adjustment, to deduct revenue received for accommodation, for NEP19.

Feedback received

The Commonwealth notes that in considering any changes to the private patient adjustment, IHPA should ensure that costs are accurately identified and consistently reported and captured, and that any changes do not introduce adverse or unintended financial consequences and that all changes are appropriately back cast.

IHPA will also continue to consider proposals to refine the adjustments. For example, IHPA will give further consideration to a NSW proposal in response to the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2018–19* to split the Private Patient Service Adjustment into two components — prosthesis and medical, to recognise the different characteristics of these costs.

IHPA will continue to investigate whether its private patient adjustments are accurately deducting other sources of revenue. IHPA has compared the total benefits paid on behalf of private patients in 2015–16 (as recorded in the HCP data set) with the deductions included in the NEP15 Determination for private patients. The sample of patients reviewed accounted for around 72.3% of private patients in public hospitals in 2015–16. This analysis showed that the total benefits received in 2015–16 for the sample considered was $838 million and the total deductions applied for the sample considered was $823 million. This analysis suggests that the approach to private patient pricing in NEP15 was accurate. IHPA will repeat this exercise once 2016–17 HCP data is available.

IHPA will also undertake investigations to ensure that the adjustments are not having a perverse impact on the delivery of public hospital services to public and private patients. IHPA commissioned a study to consider this issue in 2016–17, which concluded that the private patient adjustments were not a driver of private health insurance utilisation in public hospitals.

IHPA's decision

IHPA will assess any changes to the private patient adjustment as part of the fundamental review of the NEP.

8

Treatment of other Commonwealth programs

8 Treatment of other Commonwealth programs

8.1 Overview

Under Clause A6 of the National Health Reform Agreement, IHPA is required to discount funding that the Commonwealth provides to public hospitals through programs other than the National Health Reform Agreement to prevent the hospital being funded twice for the service. The two major programs are blood products (through the *National Blood Agreement*) and Commonwealth pharmaceutical programs including:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Reform Agreements — Pharmaceutical Benefits Scheme Access Program
- Pharmaceutical Reform Agreements — Efficient Funding of Chemotherapy (Section 100 funding)

The Australian Hospital Patient Costing Standards (AHPCS) Version 4.0 include a costing guideline related to the consumption of blood products. The objective of "Costing guideline 6 Blood products" is to guide costing practitioners through the steps required to ensure that all Blood Product consumption and expenses which contribute to the production of final Blood Products are included in the patient costing process.

IHPA's decision

IHPA proposes that there be no changes made to the treatment of other Commonwealth programs in the NEP19.

Next steps and future work

IHPA is working with jurisdictions through its National Hospital Cost Data Collection Advisory Committee to implement AHPCS Version 4.0. It is intended that AHPCS Version 4.0 will provide a consistent approach to the treatment of blood and blood products costs.

9

Setting the National Efficient Cost

9 Setting the National Efficient Cost

9.1 Overview

IHPA developed the National Efficient Cost (NEC) for hospitals with activity levels which are too low to be suitable for funding on an activity basis, such as small rural hospitals. These hospitals are funded by a block allocation based on their size, location and the type of services provided.

IHPA introduced new 'low volume' thresholds in 2015–16 to determine whether a public hospital is eligible to receive block funding. All activity by the hospital is included in the low volume threshold, rather than just admitted acute activity. IHPA will retain this approach for NEC19.

IHPA uses public hospital expenditure as reported in the National Public Hospital Establishments Database to determine the NEC for block funded hospitals. IHPA expects that continued improvements to the data collection will lead to greater accuracy and granularity in reflecting the services and activity undertaken by block funded hospitals.

9.1.1 Consideration of alternative NEC methodologies

While Activity Based Funding (ABF) and block funding approaches both cover services that are within the scope of the National Health Reform Agreement, a 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. This split in approaches reflects the wide range of hospital sizes across Australia meaning that a National Efficient Price (NEP) based approach would not scale well across smaller hospitals in remote locations and larger hospitals in metropolitan locations.

While activity reported for ABF hospitals is directly priced through the NEP, block funded hospitals are clustered into volume groups based on set thresholds of activity. The efficient cost of a small rural hospital is determined based on these volume groups and other factors including remoteness and whether the hospital provides surgical or obstetric services.

However, the block funded model does not increase block funding to a hospital commensurate to the increase in activity where it does not lead to a change in the volume grouping. This can occur where services are relocated from metropolitan to regional and remote areas.

Last year, in response to the Pricing Framework Consultation Paper 2018–19, IHPA received strong stakeholder support for consideration of alternative methodologies for calculating the efficient cost of block funded hospitals. Since then a number of alternative methodologies have been put to jurisdictions through IHPA's Small Rural Hospital Working Group for their consideration including:

- A modified ABF approach with additional adjustments to account for the additional costs of service delivery in small rural hospitals.
- A 'fixed plus variable' model where each hospital receives a fixed funding amount (determined using a number of variables) and a variable ABF style amount. Under this approach, the fixed amount could be determined after taking a number of factors into account.

Subsequent discussions have been supportive of the 'fixed plus variable' approaches, which have been adopted in some jurisdictions. The benefit of these models is that block funding would increase to reflect additional activity volumes more continuously.

Feedback received

Victoria (Vic), Queensland (Qld), Western Australia (WA), Royal Australasian College of Physicians (RACP) and Catholic Health Australia support further investigation by IHPA into alternative funding models for small rural and remote hospitals.

Vic notes that there is a significant level of activity and National Weighted Activity Unit (NWAU) movement from year to year at many small health services and hospitals covered by the NEC. The activity movements go down as well as up. This contrasts to the situation at the majority of larger ABF funded services, where overall NWAU increases from year to year. Therefore if an alternative NEC model is intended to be a model for funding individual services, that consideration needs to be given that with a component linked to activity could move down as well as up. Vic expressed concerns that the proposed model may not align with the Pricing Guidelines; in particular those relating to Transparency, Administrative Ease and Stability.

Qld and RACP support the proposed 'fixed plus variable' model. Qld recommended some proposed refinements such as an adjusted baseline that considers the additional costs for service provision. Qld also recommends that IHPA evaluate both weighted and unweighted activity measure to inform the variable funding component.

Qld also recommends that IHPA consider transitioning from using the Public Hospitals Establishment Collection as the source data for the NEC determination to the NHCDC and applying the published provisional weights for very long stay patients to work in progress activity; these changes will improve the accuracy of the NEC and NWAU attributable to small rural and remote hospitals.

Catholic Health Australia suggests a funding model that links age related adjustments to include an age weighting as the rural communities that these hospitals serve tend to have older cohorts of residents that require additional resources. Catholic Health Australia also recommends that IHPA conduct further reviews in how to address the high costs of delivering supplies to these locations as this is a major issue for hospitals.

IHPA's decision

IHPA will use the existing model for NEC19 however, work will continue through the Small Rural Hospital Working Group to develop and finalise a 'fixed plus variable' model with the aim to implement this for NEC20 subject to stakeholder support.

Next steps and future work

IHPA will work with its Small Rural Hospital Working Group to shadow a 'fixed plus variable' model to trial in NEC20. IHPA will consult with stakeholders in the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020–21* with the aim to implement this for NEC20.

9.2 Block funded services

Public hospital services in ABF hospitals are eligible for block funding where the Pricing Authority has determined that they are not able to meet the technical requirements for applying ABF or where they lack the economies of scale which would mean that the service would not be financially viable under ABF.

For NEC18, IHPA determined block funding amounts for teaching, training and research, and non-admitted mental health services in ABF hospitals based on jurisdictional advice. IHPA will continue to block fund these services in NEC19 and until such time that ABF classification systems are implemented and used for pricing for these services.

As discussed in Chapter 10, the Pricing Authority determined that specified hospital avoidance programs which are funded on a capitation basis may be eligible for block funding on application.

9.2.1 Review of block funded services

Expenditure for block funded services in ABF hospitals is determined based on jurisdictional advice in accordance with the National Health Reform Agreement. As state and territory budgets are not finalised prior to publication of the NEC Determination, jurisdictions have the opportunity to revise their block funded amounts later in the year through a Supplementary NEC Determination.

IHPA requires evidence where the growth rate for services exceeds the NEC indexation rate. Evidence can include measures outlined in budget papers, policy and funding guidelines, Local Hospital Network service agreements or other documents which identify specific new programs and investments.

IHPA has commissioned an external party with appropriate expertise to undertake a review of the block funded services (excluding for small rural hospitals) to determine whether the process can be improved. The review will consider the actual costs incurred by states and territories for block funded services and compare these to the amounts submitted as part of the NEC Determination process.

Next steps and future work

The Pricing Authority will consider the recommendations from the review of block funded services to see if the NEC Determination process can be improved and establish a timeframe for any recommendations.

10

Innovative funding models

10 Innovative funding models

10.1 Overview

The *Pricing Guidelines and the National Health Reform Agreement* include provisions for IHPA to consider the impact on its work of evidence-based, effective new technologies and innovations in models of healthcare. IHPA maintains a watching brief on emerging trends in healthcare to ensure that the national Activity Based Funding (ABF) model can accommodate new and innovative approaches to public hospital funding and service delivery.

IHPA has consulted on innovative funding models in the last two Consultation Papers on the *Pricing Framework for Australian Public Hospital Services* and received positive stakeholder feedback for continued investigation.

As ABF models for hospital care are bedded down in Australia and overseas, new value-based approaches have been trialled and are being gradually implemented. These models include bundled and capitation payments, best practice tariffs, pay for performance and hospital avoidance programs.

These approaches aim to refocus health financing arrangements away from payments based on the type and volume of services delivered and towards payments which are based on the value of care which is actually provided to patients. However, these trends have implications for how IHPA will count, classify, cost and price public hospital services.

The February 2018 Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding provides IHPA with an opportunity to explore new developments in health funding on a global scale and opportunities to explore their impact on providing efficiency and transparency in public health systems.

10.2 Block funding for innovative funding programs

Some state and territory governments are developing funding models for some patient groups to drive the adoption of patient-centred models of care. The amount of funding per patient usually reflects the existing cost of delivering hospital services to these patients and allows health services the flexibility to use the funding in primary and community services to reduce per patient expenditure over time. Examples include bundled payments or capitation funding models.

The *Pricing Framework for Australian Public Hospital Services 2018–19* advised that IHPA will consider jurisdictional proposals to block fund patients at the national level to support the introduction of new innovative funding models.

The Victorian 'HealthLinks: Chronic Care' program was included on the General List of In-Scope Public Hospital Services for 2018–19 and IHPA is block funding the program on a trial basis with a number of conditions specified by the Pricing Authority for NEP18. The program is a capitation funding model for patients with chronic disease and aims to reduce avoidable readmissions and presentations to emergency departments.

10.3 International funding models

Healthcare systems around the world are facing rising costs and growing demand for services and policy makers are refocusing health financing arrangements away from payments based on the type and volume of services delivered and towards payments based on the value of care. IHPA is aware of innovative funding systems for healthcare being adopted across Europe and North America which may be relevant to the Australian context.

IHPA will undertake a 'global horizon scan' in 2018 to identify issues, solutions and innovations in health funding across the globe that could be incorporated into the Australian system.

The global horizon scan will include a comprehensive review of international health funding systems and initiatives, identify international initiatives and innovations that may add value and insight into IHPA's work, and advise on the outcomes of funding initiatives that have been trialled overseas. A report which summarises the learning from this project will be finalised in early 2019 and will inform the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2020–21*.

Feedback received

Responses to the Consultation Paper for the *Pricing Framework for Australian Public Hospital Services 2019–20* continue to be supportive of IHPA investigating how the national ABF system can better accommodate innovative and value-based approaches to public hospital funding in Australia.

Victoria supports the review of international models of value-based care, noting that any adverse or negligible outcomes experienced through different models of care should be considered.

Queensland (Qld), Western Australia and Queensland Nurses and Midwives' Union (QNMU) support further investigation of models for bundled payments, noting the need to consider the availability and quality of data. Qld also noted the need to consider the use of technology to both provide and support patient care needs to be analysed in relation to funding.

QNMU also recommends investigating a bundled model for maternity care that could be the driver for incentivising a DRG that is woman-based and one that is not wholly an obstetrics model but encompasses midwife-led models of care.

Children's Healthcare Australasia note that Canada has a number of ABF innovations that may offer value in the Australian context including the Quality Based Procedures (QBP) list used in Ontario and the Population Grouping Methodology developed by Canadian Institute for Health Information.

Medtronic supports IHPA's commitment to exploring new opportunities to improve the ABF system that can better accommodate innovative funding approaches including value-based health care models. Medtronic also suggests that the concept of add-on payments for funding new technologies implemented as part of Germany's Diagnosis Related Group system be considered as part of the global horizon scan.

Biotronik recommends the scope of the global horizon scan be limited to nations that achieve close to or better health outcomes than Australia and that consideration is given to what the drivers are for that country when seeking "value".

IHPA's decision

- IHPA will include stakeholder feedback in the development of the global horizon scan.

Next steps and future work

IHPA will continue to work with stakeholders to ensure that the national pricing model does not act as a barrier to system and hospital-level change to the benefit of patients. A jurisdictional workshop is planned for late 2018 that will include discussions around General List inclusion criteria. This will include consideration of hospital avoidance programs, their current funding arrangements and appropriate criteria against which these services can be assessed for inclusion on the General List.

The global horizon scan will include a literature review to be published in late 2018. This along with stakeholder feedback will inform the global horizon scan which will be completed in 2019.

11

Pricing and funding for safety and quality

11 Pricing and funding for safety and quality

11.1 Overview

In 2017, all Australian governments signed the Addendum to the National Health Reform Agreement (the Addendum). Through this, parties committed to improve Australians' health outcomes and decrease avoidable demand for public hospital services through reforms including the development and implementation of funding and pricing approaches for safety and quality. These reforms are designed to improve patient outcomes in the public health system.

The commitment by Australian governments to safety and quality follows a four-year program of collaborative work between IHPA and Australian Commission on Safety and Quality in Health Care (the Commission) to consider the incorporation of safety and quality measures into the determination of the National Efficient Price (NEP).

Under the Addendum, IHPA is required to advise on an option or options for a comprehensive and risk adjusted model to determine how funding and pricing could be used to improve patient outcomes across three key areas: sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions.

The implementation of pricing and funding for safety and quality is being rolled out on a staged basis. Funding adjustments related to sentinel events were introduced in July 2017, followed in July 2018 by funding adjustments for HACs. In the *Pricing Framework for Australian Public Hospital Services 2019–20*, the focus has moved to the staged implementation of funding adjustments for avoidable hospital readmissions.

Pricing and funding approaches are one element of a comprehensive strategy to improve safety and quality in health care. Pricing and funding approaches should complement other existing strategies to improve safety and quality under the leadership of the Commission and with the active participation of many other groups including clinical colleges, clinicians, state governments and health services.

Feedback received

Stakeholders are generally supportive of the staged implementation of funding and pricing approaches to safety and quality. New South Wales (NSW) notes its broad support for IHPA's work in accordance with the Addendum to the National Health Reform Agreement, while also offering specific support for a 'slow and steady' approach to the development of funding options for avoidable hospital readmissions.

NSW, Northern Territory (NT), the Melbourne Institute of Applied Economic and Social Research (MIAESR) and Children's Healthcare Australasia continue to note that IHPA should broaden its approach beyond funding penalties to also implement positive funding incentives.

The Australia Medical Association (AMA) continues to be critical of safety and quality financial penalties citing issues including: the lack of evidence of their effectiveness; the risk of penalties promoting a culture of blame; and its preference for instead using robust patient outcomes data to improve patient safety. The AMA also expressed its concern at the pace and number of substantial reforms affecting public hospitals.

11.2 Sentinel events

In 2002 Australian Health Ministers agreed on the Australian Sentinel Events List, a national set of eight sentinel events. Sentinel events are adverse events that result in death or serious harm to patients. Since 2007, states and territories have reported annually on sentinel events in the Productivity Commission's *Report on Government Services*. Public reporting of sentinel events is intended to facilitate a safe environment for patients by reducing the frequency of these events.

11.2.1 Approach to funding of sentinel events

Since 1 July 2017, the Pricing Framework has specified that an episode of care including a sentinel event is not funded. As sentinel events are not currently reported in national data sets, states and territories submit an additional data file identifying episodes where a sentinel event occurred. A zero National Weighted Activity Unit (NWAU) is then assigned to episodes with a sentinel event. This approach is applied to all hospitals, comprising services funded on an activity basis or a block funded basis.

For NEP19, IHPA will continue to assign zero NWAU to episodes with a sentinel event.

Next steps and future work

A review of the Australian Sentinel Events list has been completed by the Commission and version 2.0 is expected to be published on its website in early 2019. IHPA intends to adopt Version 2.0 of the list once published by the Commission, and will provide final advice in the NEP and NEC Determinations when published in early March 2019.

11.3 Hospital acquired complications

HACs are complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

A list of 16 HACs was developed by a Joint Working Party of the Commission and IHPA.

Table 2: List of nationally agreed HACs

No.	Hospital acquired complications
1	Pressure injury
2	Falls resulting in fracture or intracranial injury
3	Healthcare-associated infection
4	Surgical complications requiring unplanned return to theatre
5	Unplanned intensive care unit admission
6	Respiratory complications
7	Venous thromboembolism
8	Renal failure
9	Gastrointestinal bleeding
10	Medication complications
11	Delirium
12	Persistent incontinence
13	Malnutrition
14	Cardiac complications
15	Third and fourth degree perineal laceration during delivery
16	Neonatal birth trauma

The Commission is responsible for the ongoing curation of the HAC list to ensure it remains clinically relevant. It has also developed a range of tools to support local monitoring of HACs and quality improvement strategies. The HACs Information Kit outlines activities that health services can implement in order to minimise the occurrence of HACs. There are also specifications and groupers that health services can download to monitor HACs using their administrative data.

In August 2018 the Commission published Version 1.1 of the HACs list. The specifications have been updated to broaden the scope of eligible patients to include those admitted for mental health and drug and alcohol conditions.

11.3.1 Approach to funding of HACs

The *Pricing Framework for Australian Public Hospital Services 2018–19* indicated that funding is reduced for any episode of admitted acute care where a HAC occurs. The reduction in funding reflects the incremental cost of the HAC, which is the additional cost of providing hospital care that is attributable to the HAC. This approach recognises that the presence of a HAC increases the complexity of an episode of care or the length of stay, driving an increase in the cost of care.

The HAC funding approach incorporates a risk adjustment model that assigns individual patient episodes with a HAC to a low, medium or high complexity score. This complexity score is used to adjust the funding reduction for an episode containing a HAC on the basis of the risk of that patient acquiring a HAC. Each HAC is separately risk-adjusted based on risk factors including patient age, gender, diagnosis related group type (medical, surgical, other), major diagnostic category, Charlson score[2], intensive care unit status, admission status and transfer status.

IHPA has added the risk adjusted HAC rates to its National Benchmarking Portal (NBP) to enable hospitals to benchmark and assist in driving improvements to patient outcomes.

IHPA's decision

- For NEP19 IHPA will apply Version 1.1 of the Commission's HACs list.
- For NEP19 IHPA will continue to apply the HAC Adjustment to all acute episodes where a HAC occurs.

Next steps and future work

The HACs list will be reviewed regularly by the Commission's HACs Curation Clinical Advisory Group (HACs CCAG). The HACs CCAG is completing a review of the pressure injury and delirium HACs. Any resulting changes will be incorporated into the pricing model for NEP20. Work has also commenced to consider the inclusion of mental health specific conditions on the HACs list. The Commission's website provides information on this work including opportunities for public feedback on refinements to the HACs list.

2 The Charlson score is a comorbidity index that predicts the one-year mortality for a patient who may have a range of comorbid conditions.

11.4 Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their original hospital admission (the index admission). The objective of interventions targeting avoidable readmissions is to provide incentives for hospitals and clinicians to identify areas for quality improvement.

IHPA recognises that pricing and funding approaches to reduce avoidable hospital readmissions should be part of a comprehensive strategy that also includes non-financial interventions such as the provision of benchmark information to hospitals and clinicians, improvements in care coordination across hospital and community care, and the dissemination of case studies on successful clinical practice changes.

11.4.1 Defining avoidable hospital readmissions

The Commission was requested by the Australian Health Ministers' Advisory Council (AHMAC) to develop:

> *A list of clinical conditions that arise from complications of the management of the original condition, that can be considered avoidable hospital readmissions, including identifying suitable condition-specific timeframes for each of the identified conditions.*

This focus on readmissions arising from complications experienced in the index admission resulted in the Commission including many conditions that overlap with HACs in its list of avoidable hospital readmission conditions. To develop its list, the Commission undertook cycles of analysis and clinical review using the Admitted Patient Care National Minimum Data Set to identify avoidable readmissions. The criteria used by the Commission were that clinical conditions had to be:

- **Related** to the index admission;
- **Avoidable** by improved clinical management in the index admission and/or suitable discharge planning and follow-up; and
- **Measurable** through coded data generated from the patient medical record.

In June 2017, AHMAC approved the list of avoidable hospital readmissions developed by the Commission. Table 3 presents the AHMAC approved list of 11 avoidable hospital readmissions and readmission diagnoses, together with the condition-specific readmissions intervals. The first 10 avoidable hospital readmission conditions are also included in the HAC list. The 'other' avoidable hospital readmission conditions — constipation and nausea and vomiting — were included as they satisfied the specified criteria and they had high prevalence rates among readmissions.

It is important to note that while there is overlap with the list of avoidable hospital readmissions conditions and the conditions on the HAC list, an avoidable hospital readmission is not equivalent to a HAC due to differences in their timing and their impact on a hospital admission.

Table 3: List of Avoidable Hospital Readmissions

Readmission condition	Readmission diagnosis	Readmission interval
1. Pressure injury	Stage III ulcer	14 days.
	Stage IV ulcer	7 days
2. Infection	Unspecified decubitus and pressure area	14 days
	Urinary tract infection	7 days
	Surgical site infection	30 days
	Pneumonia	7 days
	Blood stream infection	2 days
	Central line and peripheral line associated bloodstream infection	2 days
	Multi-resistant organism	90 days
	Infection associated with prosthetic devices, implants and grafts in genital tract or urinary system	30 days
	Infection associated with peritoneal dialysis catheter	2 days
	Gastrointestinal infections	28 days
3. Surgical complications	Postoperative haemorrhage/haematoma	28 days
	Surgical wound dehiscence	28 days
	Anastomotic leak	28 days
	Cardiac vascular graft failure	28 days
	Pain following surgery	14 days
	Other surgical complications	28 days
4. Respiratory complications	Respiratory failure including acute respiratory distress syndromes	21 days
	Aspiration pneumonia	14 days
5. Venous thromboembolism	Venous thromboembolism	90 days
6. Renal failure	Renal failure	21 days
7. Gastrointestinal bleeding	Gastrointestinal bleeding	2 days
8. Medication complications	Drug related respiratory complications/depression	2 days
	Hypoglycaemia	4 days
9. Delirium	Delirium	10 days
10. Cardiac complications	Heart failure and pulmonary oedema	30 days
	Ventricular arrhythmias and cardiac arrest	30 days
	Atrial tachycardia	14 days
	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	30 days
11. Other	Constipation	14 days
	Nausea and vomiting	7 days

Next steps and future work

IHPA will use the Commission's AHMAC approved list of avoidable hospital readmissions as the basis for shadowing the implementation of funding adjustments for avoidable hospital readmissions.

Concurrently, IHPA is exploring the potential use of commercial grouping software. This software determines whether a readmission is clinically related to a prior admission based on the patient's diagnosis and procedures in the index admission and the reason for readmission. This software would allow investigation of a broader scope of avoidable readmission conditions than the current list of avoidable hospital readmissions.

11.4.2 Measuring avoidable hospital readmissions

The Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2019–20* identified four key elements of an approach to measuring avoidable hospital readmissions as follows:

Readmission intervals

The use of these condition-specific readmission intervals (see table 3) has been recommended by the Commission, with input from a panel of clinical and consumer experts. If patients with a readmission condition present at hospital in a timeframe that exceeds the condition-specific readmission interval, these episodes are not considered to be avoidable hospital readmissions.

Scope of included and excluded services

IHPA has taken advice from the Commission as to exclusions required to increase the likelihood that readmissions are, in fact, avoidable. Only episodes that satisfy the criteria in relation to included and excluded services are considered to be avoidable hospital readmissions. IHPA has developed the following table based on the Commission's advice.

Table 4: Scope of included and excluded services for avoidable hospital readmissions

	Service scope for avoidable hospital readmissions
Included services	All relevant[3] acute admitted episodes in activity based funded hospitals comprising: – Episodes with an urgency status of emergency.
Excluded services	Exclusions comprise: – Any readmissions where the index admission had a separation mode of discharged against medical advice. – Index admissions and readmissions for oncology, haematology, chemotherapy, dialysis, neonatal care and palliative care. – Readmissions for child birth.

3 Relevant acute admitted episodes comprise episodes with one or more of the readmission conditions in the List of Avoidable Hospital Readmissions and the readmission interval is less than or equal to the condition-specific timeframes specified in this List.

Readmissions to the same or different hospital

Patients with avoidable hospital readmissions can present to the same or a different hospital, relative to the hospital in which they were originally treated. IHPA does not have access to private hospital data, so it can only measure avoidable hospital readmissions across public hospitals.

Analysis by IHPA of the distribution of avoidable hospital readmissions in 2015–16 indicates that:

- About 67% of these episodes are to the same hospital in which the index admission occurred; and
- A further 18% of avoidable hospital readmissions are to another hospital in the same Local Hospital Network (LHN); and
- Another 13% of avoidable hospital readmissions are to another LHN in the same state; and
- The final 2% of avoidable hospital readmissions are to a hospital in another state.

Funding adjustments for avoidable hospital readmissions are intended to target the original hospital in which the index admission occurred. The aim is to ensure that the original treating hospital effectively manages any complications, does not discharge patients prematurely and ensures that patients are referred to necessary post-discharge services in the hospital or community settings.

This needs to be balanced against the capacity to identify episodes of avoidable hospital readmissions to hospitals that are not the same as the hospital providing the index admission. There is generally the capacity to identify if a patient presents with an avoidable hospital readmission to the same or another hospital within the LHN. However, an individual LHN is not currently readily able to identify if an avoidable hospital readmission episode occurs to a hospital outside their LHN.

The only way an avoidable readmission could be tracked to a different LHN or a different state or territory is by using a unique patient identifier to provide data back to each LHN on patients with avoidable hospital readmissions that presented to hospitals in different LHNs.

Currently IHPA uses the Medicare PIN to identify avoidable hospital readmissions, but jurisdictions do not have access to the Medicare PIN. An option of including the Individual Health Identifier (IHI), an existing unique patient identifier, in national datasets would provide states and territories with the capacity to readily identify avoidable hospital readmissions. (The IHI is discussed in more detail in Chapter 5).

Readmissions within or across financial years

Patients with avoidable hospital readmissions can present in the same year or in the subsequent year to their index admission. Consideration is required as to whether funding adjustments for avoidable hospital readmissions should be limited to those occurring in the same financial year or extend to those occurring early in the next financial year.

Analysis by IHPA of the timing of avoidable hospital readmissions in 2014–15 and 2015–16 indicated that expanding the measurement of readmissions across financial years resulted in a 1.7% increase in the number of readmissions identified.

Feedback received

Readmission intervals

NSW requires further information on the basis of the readmission intervals to assist in discussions between system managers and clinicians.

Catholic Health Australia queries the administrative ease of implementing condition-specific readmission intervals.

Royal Australian College of Physicians (RACP) supports the use of condition-specific readmission intervals. It notes recent literature suggesting that for three common chronic conditions, readmissions after seven days were generally due to community and household factors, rather than attributable to the hospital providing care during the index admission.

Scope of included and excluded services

NSW notes that urgency status may be an imperfect proxy for distinguishing between planned and unplanned readmissions, and that it may be necessary to develop a more sophisticated measure. Qld suggests that hospital transfers be excluded from the scope of avoidable hospital readmissions.

Queensland Nurses and Midwives' Union proposes that measurement of the scope of avoidable hospital readmissions should extend to other factors (such as breastfeeding rates) that may influence readmission rates. It proposed a broad approach to tracking health outcomes and an expanded collection of data in order to reduce avoidable hospital readmissions.

Biotronik suggests that there may be value in focussing on readmissions related to complex disease states, such as heart failure, and the appropriateness of the setting to which readmissions were triaged.

Readmissions to the same hospital or other hospitals

Stakeholder views were mixed on the geographic basis that should be used to measure avoidable hospital readmissions.

NSW and NT support measuring readmissions only to the same hospital in which the index admission occurred. NSW suggests that this would foster local real-time reporting mechanisms and is necessary in the absence of linked data.

In contrast, the Commonwealth (Cth), Australian Capital Territory (ACT), RACP and Children's Healthcare Australasia support a broader approach that involves measuring readmissions within the same LHN.

Tas favours an even broader approach, arguing that funding adjustments could readily be made across LHNs or states. Its rationale is that limiting the measurement of readmissions to within LHNs discriminates based on the size of jurisdictions, the proximity of hospitals and diverse policy choices made on the scope of LHNs between jurisdictions. WA has similar concerns about potential inequities due to differences in the size or number of LHNs across states and territories.

NSW, South Australia (SA), Victoria (Vic) and Queensland (Qld) propose further analysis (and post-implementation monitoring) of geographic distribution issues. This could include analysis of; any differences in measured readmissions between metropolitan, regional and rural hospitals within jurisdictions; the impact of cross-border activity; and the extent to which agreed geographic definitions of avoidable hospital readmissions resulted in any adverse behavioural responses.

In relation to the options of using either the Medicare PIN or the IHI to measure readmissions, a large majority of stakeholders prefer the IHI.

There are multiple concerns about the use of the Medicare PIN including: constraints on secondary use of data; views that it was not a strong identifier; and the current lack of access by states and territories to the Medicare PIN.

SA, Qld, Tasmania (Tas) raise caution about some issues that would need to be managed across any type of unique patient identifier including the IHI. This includes ensuring that there is equal access to the required data, with jurisdictions supported to boost their coverage of the IHI.

Vic and Qld note that it is necessary to recognise that some patients may not have a unique patient identifier including refugees and overseas tourists and to clearly specify how these patients would be treated in the funding model.

WA and Qld note the importance of resolving whether there is legal authority to use the IHI for funding purposes and clarifying governance processes related to third party data provision incorporating the IHI.

Other broad concerns about the use of the IHI include the Australian Medical Association's views on potential threats to security and privacy of sensitive health data associated with the use of the IHI. These issues are covered in more detail in Chapter 5.

Readmissions within or across financial years

The Cth, NSW, Vic, Qld, ACT, NT, RACP, Children's Healthcare Australasia all support limiting the measurement of readmissions to within the same financial year. Reasons include: funding stability and simplicity, the avoidance of delays to Commonwealth Government reconciliation funding; and the marginal gains associated with moving to measurement across financial years.

However, SA, WA and MIAESR note the need to regularly monitor readmissions across financial years in order to promote practice improvement and avoid unintended consequences. In particular, WA suggests that there would be value in such analysis being regularly provided to jurisdictions through IHPA's advisory committees.

Tas does not want to limit measurement of readmissions to the same financial year, noting that the distribution of index admissions may fall randomly across hospitals, LHNs and states.

IHPA's decision

- IHPA will shadow avoidable hospital readmissions using the Commission's list including the condition-specific intervals and the specified scope of included and excluded services.
- IHPA will define and measure avoidable hospital readmissions as those that occur in the same LHN and the same financial year as the index admission.

Next steps and future work

IHPA will continue to analyse and provide data to jurisdictions through its advisory committees, both before and during the shadowing period that examines the distributional issues raised by stakeholders including:

- The extent of any differences between metropolitan, rural and remote regions related to the geographic basis used for measuring avoidable hospital readmissions.
- The extent of any differences between jurisdictions in the measured level of avoidable hospital readmissions if readmissions are limited to the same hospital, the same LHN, the same jurisdiction or nationally.
- The impact of measuring avoidable hospital readmissions across financial years.

The above analyses will examine the activity and funding impact at an aggregate and at a condition-specific level for each of the 11 avoidable hospital readmissions.

As a separate piece of work, IHPA will commence investigation of a grouping software that may provide an alternative approach to defining avoidable hospital readmissions.

11.4.3 Overview of pricing, funding and risk adjustment issues

Three broad issues relevant to the incorporation of safety and quality into pricing and funding were canvassed.

Pricing and funding approaches

Pricing approaches to safety and quality result in changes to the NEP that lead to lower 'quality-adjusted' prices being applied across all episodes (including those with an avoidable hospital readmission and episodes without these readmissions). In contrast, funding approaches impact how the NEP is implemented through, for example, changes to the assignment and calculation of the NWAU or other approaches. This means that funding approaches only affect the funding of episodes with a quality and safety event such as an avoidable hospital readmission.

To date, IHPA has implemented funding (but not pricing) approaches for sentinel events and HACs.

Episode-level and hospital-level funding approaches

Funding approaches can be applied at the level of individual episodes or at hospital-level through funding adjustments for hospitals with higher than expected rates of safety and quality events.

IHPA has implemented episode-level approaches to funding for sentinel events and HACs.

Approach to risk adjustment

The equitable risk adjustment criterion used by IHPA states that:

> *Pricing and funding approaches should balance the likelihood that some patients will be at higher risk of experiencing an adverse event while recognising that all hospitals have scope to improve safety and quality.*

IHPA has implemented a staged approach to the development of funding adjustments based on risk factors for HACs. (No risk adjustment has been included for sentinel events due to their serious nature). The approach to risk adjustment for HACs has included commissioning expert advice and undertaking multiple rounds of analysis and modelling to assign complexity scores that were linked to a range of patient-specific risk factors.

Feedback received

Pricing and funding approaches

There is unanimous support for the use of funding, rather than pricing, approaches to avoidable hospital readmissions. Stakeholders note that this would ensure consistency with the approach used for sentinel events and HACs, result in a targeted approach and avoid penalising all hospitals, regardless of their performance on avoidable hospital readmissions.

Approach to risk adjustment

Similar to the previous feedback received on risk adjustment for HACs, there is a wide range of views on factors that might be relevant to risk adjustment for avoidable hospital readmissions.

NSW and NT note that adequate access to primary care and post-discharge services in the community were relevant to reducing avoidable hospital readmissions.

QNMU caution that risk adjustment should not create incentives to cherry pick or avoid treating complex patients.

Royal Australian and New Zealand College of Psychiatrists (RANZCP) suggest that patients with depression may be at increased risk of hospital readmission. In relation to children, NSW proposes a paediatric adjustment for children's hospitals, while Children's Healthcare Australasia proposes the use of more granular age groups for children between 0–4 years.

MIAESR identify five categories of risk factors that are potentially outside the control of hospitals comprising: underlying clinical factors, demographics, socioeconomic status, health behaviours and activities, and attitudes and perceptions. It proposes that IHPA should supplement existing administrative data sets with survey data on health behaviours, socioeconomic status, and personal attitudes and preferences. Similarly, Vic notes that there may be data limitations for risk factors relating to social determinants and the family/carer circumstances.

SA, WA, Tas and ACT note that IHPA should adopt a similar approach to risk adjustment for avoidable hospital readmissions as it has used for HACs.

NSW suggests that age adjustment would not be needed in a risk adjustment model for avoidable hospital readmissions as this was already included in the risk adjustment model for HACs.

IHPA notes that risk factors for avoidable hospital readmissions need to be examined independently of risk factors already included in the funding model for HACs as there is very limited overlap of episodes that include both types of events.

IHPA's decision

IHPA will implement funding (rather than pricing) approaches for avoidable hospital readmissions, consistent with its approach for sentinel events and HACs.

Next steps and future work

IHPA will commence examination of risk factors for avoidable hospital readmissions through commissioning expert advice and the conduct of analysis and modelling and provide feedback through its advisory committees.

11.4.4 Assessment of funding options for avoidable hospital readmissions

The Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2019–20* identified three alternative funding options:

- **Option 1:** Under this episode-level approach, an episode with an avoidable hospital readmission would not be funded. Instead, these episodes would be assigned zero NWAU. However, this funding adjustment would always be applied to impact on the hospital responsible for the index admission (even when the avoidable hospital readmission occurred in a different hospital to the index admission). This means that the hospital providing care for an episode with an avoidable hospital readmission will continue to be funded for this episode on an unchanged basis if the index admission occurred in a different hospital.
- **Option 2:** Under this episode-level approach, the index admission and the readmission would be combined for funding purposes. This means that the two merged episodes would retain the DRG of the initial admission but also include the additional length of stay days that occur during the readmission. The funding adjustment would always be applied to the hospital responsible for the index admission (even when the avoidable hospital readmission occurred in a different hospital to the index admission). Again, this means that the hospital providing care for an episode with an avoidable hospital readmission will continue to be funded for this episode on an unchanged basis if the index admission occurred in a different hospital.
- **Option 3:** Under this hospital-level approach, funding would be adjusted on the basis of differences in rates of avoidable hospital readmissions compared either at the level of hospitals or at the level of LHNs. This would involve setting benchmark rates of avoidable hospital readmissions. The impact would be that not all avoidable hospital readmissions would be penalised. Instead, funding adjustments might apply only to avoidable hospital readmissions in excess of an agreed benchmark.

Feedback received

Most jurisdictions do not express a clear preference for a particular funding option, instead commenting on the relative benefits and risks of each option.

Option 1 is considered to be the simplest approach with relative ease of implementation by the Cth, SA and WA. However, Children's Healthcare Australasia suggest that the perceived trade-offs are that this option results in a blunt funding model, and Tas and Children's Healthcare Australasia suggest it has the potential to create disincentives for early discharge of patients. NSW has concerns that it could be too strong a funding penalty.

Option 2 is viewed as reasonable by SA and WA, with the combination of index and readmission episodes allowing an improved comparison between hospitals. However, there are some concerns from Qld about its administrative complexity. Questions are also raised by SA about the methodologies that would be used for bundling of codes and by Children's Healthcare Australasia regarding sequencing and the approach to calculating length of stay.

Option 3 receives support as the Cth and RACP note, it allows for peer review, the provision of data back to each hospital on their relative performance, and audit and feedback processes that could support improvements to clinical practice and policies. WA and MIAESR support the potential to include rewards, as well as financial penalties, under a hospital-level benchmarking approach. RACP strongly support option 3, noting that a more nuanced funding approach is required for avoidable hospital readmissions than HACs, as the preventability of HACs is more clear-cut than is the case for avoidable hospital readmissions. However, Biotronik suggest that benchmarking would introduce greater complexity and remove direct incentives to improve practice for individual episodes of care.

NSW recommends a new option that merges options 2 and 3 through combining the index and readmission episodes to calculate funding for the combined episode, followed by benchmarking with funding adjustments made on the basis of threshold rates.

ACT, SA, Qld, Tas advocate for additional data and analysis to better understand the impact of each of the options. ACT proposes impact analysis modelling to identify the financial impact at the level of individual hospitals and LHNs.

There is also considerable feedback on the approach to benchmarking and setting threshold rates under a hospital-level approach (option 3) to funding adjustments for avoidable hospital readmissions. Most stakeholders prefer that benchmarks be set at the level of individual hospitals, rather than LHNs. There were diverse views as to how benchmarks should be set.

The Cth supports setting benchmarks at the top quartile or top 10% of hospitals with the highest rates of avoidable hospital readmissions and then not funding the entire cost of selected readmissions above the threshold.

In contrast, WA proposes that benchmarks should be risk-adjusted, condition-specific and set with regard to best practice. WA suggests the use of a graduated approach with partial funding penalties and lower benchmarks. MIAESR favour a two-stage approach comprising a first stage of risk adjustment and a second stage of analysis to derive benchmarks for levels of expected and excess avoidable hospital readmissions.

IHPA's decision

IHPA will commence a shadowing period for all three options from July 2019 for 24 months and provide analysis through quarterly reports to its advisory committees and inclusion of avoidable hospital readmission rates in the National Benchmarking Portal. IHPA will provide an update and opportunity for further stakeholder input in next year's consultation paper.

Next steps and future work

IHPA agrees with the implications of the stakeholder feedback that it is premature to reach a decision on a preferred funding approach prior to the outcomes of a shadowing period. Accordingly, IHPA has not included a final assessment against its assessment criteria (preventability, equitable risk adjustment, proportionality, transparency and ease of implementation). This assessment will occur at the conclusion of the shadowing period.

Recognising the considerable interest in funding approaches that allow benchmarking of avoidable hospital readmissions across hospitals, IHPA will undertake further technical work on issues involved in the setting, administration and outcomes monitoring of benchmarks. This will include consideration and analysis of:

- The impact of setting benchmarks at hospital, LHN, jurisdiction and national level.
- The impact of setting benchmarks at an aggregate or condition-specific level.
- The impact of options using fixed (for example, top quartile) or derived benchmarks (for example, expected rates) for avoidable hospital readmissions.
- The interaction between the 'severity' of the benchmarks and the use of partial or full funding adjustments.

IHPA will undertake this work, in consultation with its advisory committees, prior to the proposed implementation of the shadowing period on 1 July 2019. The objective will be to narrow down and more clearly specify the parameters of Option 3 in advance of its measurement during the shadowing period.

11.4.5 Implementation pathway for funding adjustments for avoidable readmissions

IHPA has proposed that all three potential funding options are shadowed for a 24–month period commencing 1 July 2019. Over this time, data and analysis on avoidable hospital readmissions would be provided to jurisdictions, clinicians and health services. An annual report would identify the costs of readmissions and the funding impact at the hospital level of each of the three funding options.

The *Pricing Framework Consultation Paper 2019–20* also indicated that IHPA would investigate the value of an incremental approach to introducing funding adjustments for avoidable hospital readmissions. This would involve commencing with funding adjustments for one or two clinical conditions rather than the complete list of 11 avoidable hospital readmission conditions.

Feedback received

ACT, Vic, NT, WA, Qld, Children's Healthcare Australasia, Catholic Health Australia support a shadowing period of a full two years. However, Tas believes that two years may not be sufficient time and NSW proposes a three-year shadow period.

Vic and the NT propose that data be provided quarterly to jurisdictions in the first two years to allow regular review and benchmarking of avoidable hospital readmissions. Qld suggests there would be value in a national modelling tool to allow jurisdictions to measure the impact of funding changes.

There are mixed views on the value of an incremental approach whereby funding adjustments would first be introduced for one or two clinical conditions. This approach is supported in principle by the Cth, Vic and NT.

However, ACT express uncertainty about the practical implications of such an approach including instability around financial impacts. Qld prefer a non-national implementation of all avoidable hospital readmission conditions at selected sites, rather than a national implementation of one or two conditions. WA prefer a national 'all at once approach' to avoid successive disruption to management process. It also suggests that incremental implementation is not be required if there is an effective shadowing period.

IHPA's decision

IHPA has determined that it will implement a benchmarking approach to all three funding options for all avoidable hospital readmissions conditions for a two-year period commencing 1 July 2019.

Next steps and future work

IHPA will regularly provide detailed analyses to jurisdictions of the activity and funding impacts of the funding options for avoidable hospital readmissions throughout the shadowing period. Where possible, this will be provided on a quarterly basis to facilitate timely review and identification of any emerging issues by jurisdictions, health services and clinicians.

11.5 Evaluation of safety and quality in health care

The June 2017 Addendum to the National Health Reform Agreement requires that IHPA provide advice to the Council Of Australian Governments Health Council (CHC) by December 2018 on evaluating the incorporation of safety and quality into hospital pricing and funding.

In February 2018 the Jurisdictional Advisory Committee agreed that an evaluation should be broadly-based, building upon analysis of safety and quality initiatives being undertaken in all states and territories. The draft evaluation framework comprises two key stages: the setting of a comprehensive baseline, and a set of proposed evaluation questions assessing the impact of national funding models for safety and quality.

Feedback received

NSW, SA, WA and Tas support the key elements of the draft evaluation framework — including its breadth and inclusion of a baseline.

WA recommends that the evaluation framework should cover both quantitative measures (measurement of change in the incidence of sentinel events, HACs and avoidable readmissions) and qualitative measures (assessment of the extent of service/clinical practice improvements and clinician engagement in the reforms).

The ACT and NT highlight the value of understanding the relative effectiveness of, and interaction between, funding penalties and other non-punitive reforms targeted at improving safety and quality. However, NSW notes that it may be challenging to isolate the specific impact of IHPA's funding reforms as jurisdictions may have implemented variations of IHPA's pricing and funding approach and there may also be local performance initiatives in place.

Qld and WA identify a wide range of specific questions for potential inclusion in the Evaluation Framework. A key issue raised by Qld was the need to ensure that the evaluation was undertaken independently with external expertise.

Next steps and future work

In accordance with direction from AHMAC's Health Services Principal Committee, IHPA is progressing the development of the evaluation framework as an 'implementation' evaluation framework. This includes an initial focus on a comprehensive baseline, with further consultation to develop the next stage of the evaluation process. In September 2018 AHMAC approved the progression of the evaluation framework to the CHC for a decision by December 2018 in line with the requirements of the Addendum.

Independent Hospital Pricing Authority

Level 6, 1 Oxford Street
Sydney NSW 2000

Phone 02 8215 1100
Email enquiries.ihpa@ihpa.gov.au
Twitter @IHPAnews

www.ihpa.gov.au