Pricing Framework for Australian Public Hospital Services 2021–22

Consultation Report

March 2021

Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2021–22 — Consultation Report — March 2021

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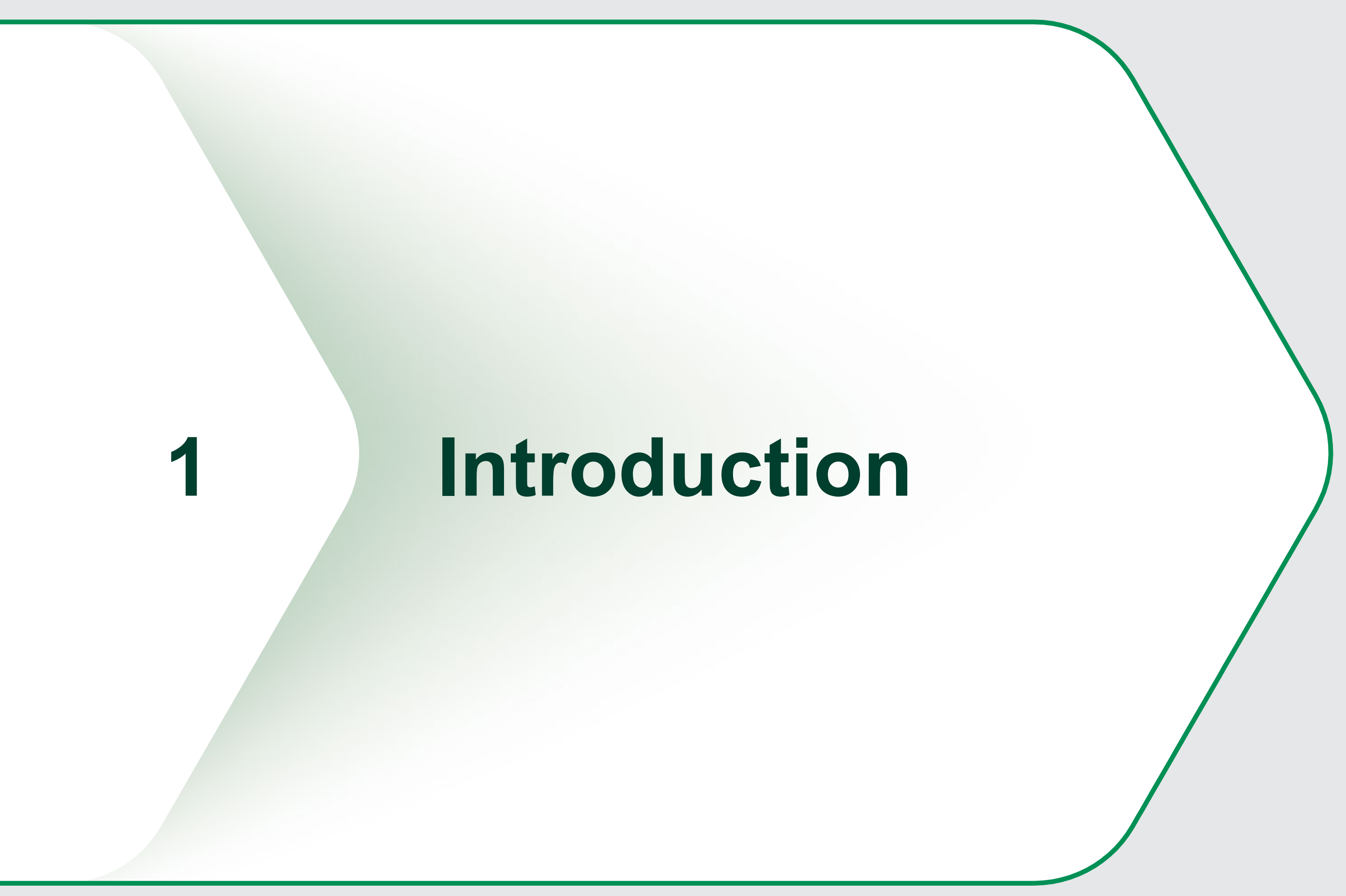

1 Introduction

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The Independent Hospital Pricing Authority (IHPA) conducted a public consultation on key issues to be included in the Pricing Framework for Australian Public Hospital Services 2021–22 (the Pricing Framework). Consultation was based on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22 (the Consultation Paper). The consultation ran from 9 September 2020 to 9 October 2020, and invited submissions from Commonwealth, state and territory (jurisdictions) health departments, professional health organisations, private industry and any other interested members of the Australian public.

IHPA received 35 submissions from a diverse range of stakeholders. Key themes from the consultation feedback are summarised in this report, corresponding with the chapters in the Pricing Framework. Stakeholder feedback has informed the development of the Pricing Framework, which sets out the policy rationale and decisions regarding IHPA's program of work, including the decisions that underpin the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for 2021–22.

IHPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. The key decisions for the NEP Determination 2021–22 and the NEC Determination 2021–22 are stated in the Pricing Framework.

All submissions are available on IHPA's website, unless they were marked confidential.

2

Addendum to the National Health Reform Agreement 2020-2025

2 Addendum to the National Health Reform Agreement 2020–2025

IHPA did not ask any specific questions on the Addendum to the National Health Reform Agreement 2020–2025 (the Addendum).

Feedback received

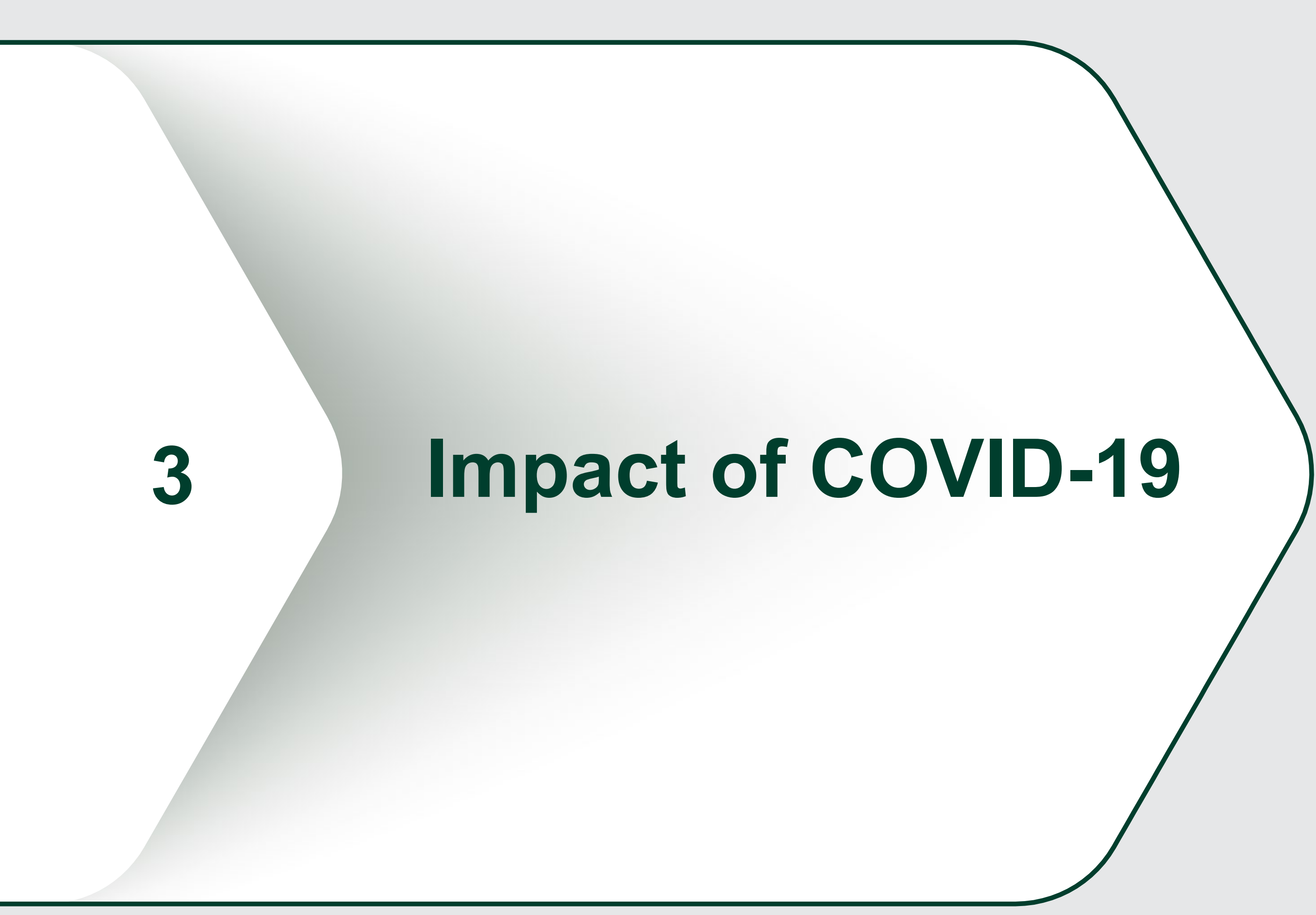
Jurisdictions reinforced the importance of the new requirements in the Addendum, in particular specifying that IHPA adopt shadow pricing for a minimum two year period for any material changes to the national pricing model.

New South Wales (NSW) requested that highly specialised therapies be excluded from safety and quality pricing adjustments such as hospital acquired complications and avoidable hospital readmissions. Western Australia (WA) commented the Addendum makes no provision for what happens to Commonwealth funding for highly specialised therapies following the initial two years, noting cost and activity data collection often takes longer than two years to implement.

IHPA's response

IHPA has developed a new 'Alterations to the National Pricing Model Framework' (the Alterations Framework) which outlines the process for assessing changes to the national pricing model. The Alterations Framework notes that jurisdictions will receive Statements of Impact for material changes to the national pricing model, in advance of IHPA presenting changes to the Council of Australian Government's Health Council.

IHPA notes that highly specialised therapies are not currently funded through activity based funding and therefore are not subject to safety and quality pricing adjustments. IHPA notes the Addendum refers to exemption for highly specialised therapies from the 6.5 per cent Commonwealth funding growth cap for a period of two years, after which services revert to usual National Health Reform Agreement arrangements.



3 Impact of COVID-19

3 Impact of COVID-19

Consultation questions

- What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?
- How will these changes affect the costs of these services in the short and long term?
- What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

Feedback received

Stakeholders noted an initial period of reduced activity due to a range of factors, such as:

- suspension of elective surgery and other services
- reduced emergency department presentations, including for paediatric emergency services
- the need to deliver COVID-19 safe health care.

Some elective non-admitted services were also halted or delivered via telehealth. The Northern Territory (NT) noted delays to elective surgery have led to greater and more complex emergency surgeries.

Stakeholders noted an increase in virtual health care/telehealth and hospital-in-the-home. There were increases in COVID-19 diagnostics, certain types of complex cases such as adolescent mental health issues, drug and alcohol intoxication and multidisciplinary case conferencing was also highlighted.

New services have been created to address COVID-19 including the ‘Statewide Intensive Care Unit Model of Care for COVID-19’ in South Australia (SA), WA’s ‘Telehealth Inpatient Physician Service’ and COVID-19 linked pathology testing across Australia.

Stakeholders noted changes in the way technology is used to deliver care, interruptions to some functions of the health care system such as teaching and training activities, as well as the reduction in activity and increased patient complexity.

A common theme was that costs are likely to remain higher over the short term and possibly the long term.

Capacity costs have increased, with NT noting it has additional staff and clinicians in remote areas to prevent potentially infectious patients being moved between locations. Catholic Health Australia (CHA) and the Royal Australasian College of Physicians (RACP) noted that in addition to a broad increase in capacity costs, additional burdens such as increased personal protective equipment are contributing to this increase in costs. The Australian Medical Association (AMA) identified that even where healthcare workers do not contract COVID-19, the necessary precautions they take to protect themselves and others reduce the treatment capacity of public hospitals and therefore increase per patient cost.

Stakeholders recommended that work be undertaken to fully assess the activity and financial impacts of COVID-19. Recommendations included:

- consideration of a period where pre-COVID-19 data is indexed, rather than attempting to apply COVID-19 period data to any post-COVID-19 years
- consideration of new adjustments to account for changes due to COVID-19 (for example, an urgency of admission adjustment, to account for increased complexity in emergency surgeries resulting from delayed or cancelled elective surgeries)
- consideration of the impact of COVID-19 on teaching and training, with Universities Australia (UA) noting significant interruption to these activities is ongoing.

IHPA's response

IHPA notes that models of care such as telehealth and hospital-in-the-home are already priced under the existing national pricing model. Some of the other short term cost increases, such as reduced hospital activity due to suspended elective surgery, are addressed in the National Partnership Agreement on COVID-19.

While stakeholders identified a number of areas for consideration, there is currently no data to support changes to the national pricing model for the National Efficient Price Determination 2021–22. IHPA will continue to finalise the collection and review of 2019–20 activity based funding activity data and will receive the National Hospital Cost Data Collection for this period in early 2021.

IHPA will work with jurisdictions to analyse cost and activity data from the period covered by the COVID-19 pandemic. The impacts of COVID-19 on patient complexity longer term can be assessed as updated data is received.

4 Pricing Guidelines

4 Pricing Guidelines

Consultation questions

– Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

– Does the change to the public-private neutrality pricing guideline accurately reflect the intent of Addendum to the National Health Reform Agreement 2020–25 (the Addendum)?

Feedback received

Stakeholders were generally supportive of the Pricing Guidelines as a tool to provide consistency in IHPA's approach to policy decisions, and their inclusion in the Pricing Framework.

NSW, Queensland (QLD) and NT requested changes to the following guidelines to reflect the Addendum and ensure flexibility to adopt new funding approaches:

– Fostering clinical innovation

– Paying for Value and Outcomes

– Activity based funding (ABF) pre-eminence

– Patient-based

– Stability.

QLD further noted that any significant changes to the pricing and funding model should be accompanied by explicit reference to the Pricing Guidelines and how any proposed change meets the guidelines.

Responding to IHPA's proposed change to the *Public-private neutrality* guideline, SA, WA, Tasmania (TAS) and Children's Health Queensland (CHQ) noted the proposed change accurately reflects the intent of the Addendum. NSW and QLD each recommended alterations to the revision to the *Public-private neutrality* guideline proposed by IHPA in the Consultation Paper.

Victoria (VIC) did not agree the *Public-private neutrality* guideline reflected the intent of the Addendum, due to an apparent assumption in the model that there will always be a minimum 45 per cent downward adjustment to the Commonwealth contribution. VIC noted this does not allow for a jurisdiction to achieve financial neutrality on its own.

VIC recommended IHPA consider the application of no adjustment if a state or territory demonstrates its funding model is financially neutral with respect to patients.

IHPA's response

IHPA developed the Pricing Guidelines as an overarching framework within which it makes its policy decisions. IHPA assesses changes to the national pricing model against the Pricing Guidelines.

IHPA has updated the Pricing Guideline *ABF pre-eminence* incorporating stakeholder feedback as follows:

– ***ABF pre-eminence:*** *'ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.'*

IHPA has updated the Pricing Guidelines *Patient-based* incorporating stakeholder feedback as follows:

- ***Patient-based:*** *'Adjustments to the standard price should be~~, as far as is practicable,~~ based on patient-related rather than provider-related characteristics <u>wherever practicable</u>.'*

IHPA has updated the Pricing Guideline *Public-private neutrality* to reflect the proposed wording in the Consultation Paper as follows:

- ***Public-private neutrality:*** *'ABF pricing should ensure that payments a local hospital network (LHN) receives for a public patient should be equal to payments made for a LHN service for a private patient.'*

In response to VIC's concern that the model does not allow for a state or territory to achieve financial neutrality on its own, IHPA notes that the price designated under the national efficient price is the base price and a further adjustment is only made where the state model does not fully neutralise any revenue received by the hospital.

5 Scope of public hospital services

5 Scope of public hospital services

IHPA did not ask any specific consultation questions on the scope of public hospital services but received feedback from a small number of stakeholders.

Feedback received

Stakeholders recommended a review of the *General List of In-Scope Public Hospital Services Eligibility Policy* (General List Policy) to ensure:

- Changes in the provision of services introduced due to COVID-19 and funding of services in all settings are appropriately covered
- Eligibility criteria are reviewed as IHPA develops innovative models of care (covered further in Chapter 11) in order to reflect the *Fostering clinical innovation* Pricing Guideline.

IHPA's response

IHPA will continue to consider services to be included or excluded from the General List of In-Scope Public Hospital Services as part of its annual review process which gives jurisdictions with the opportunity to nominate services they consider in-scope for Commonwealth funding. IHPA will consider stakeholder feedback and changes resulting from the Addendum to the National Health Reform Agreement 2020–25 in its annual review of the General List Policy.

6 Classifications used to describe and price public hospital services

6 Classifications used to describe and price public hospital services

Admitted acute care

Consultation questions

- What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?
- How should AR-DRG education be delivered and what should it include?
- What improvements to the content and format of the electronic code lists could be made to enhance their utility?
- Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

IHPA received a large volume of feedback to the consultation questions on admitted acute care. IHPA appreciates the feedback provided on the best methods to deliver online education for new editions of the International Statistical Classification for Diseases and Health Related Problems, Tenth Revision, Australian Modification (ICD-10-AM) / Australian Classification of Health Interventions (ACHI) / Australian Coding Standards (ACS) (ICD-10-AM/ACHI/ACS) and the Australian Refined Diagnosis Related Group (AR-DRG) and to improve the content and format of electronic code lists.

Feedback received

NSW, VIC, QLD, SA, CHA and Northwestern Mental Health — Royal Melbourne Hospital (Northwestern MH) noted a preference for the continued provision of hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS. Stakeholders noted hard copies are particularly important in the hospital setting as they provide definitive proof of code choice and pathways, which can be referred to retrospectively. Additionally, there was concern electronic copies often require multiple licenses and can be a cost burden.

WA is supportive of both hard copies and an electronic format, NT supported hard copies of ICD-10-AM/ACHI/ACS with a shift to electronic formats for the AR-DRG Definitions Manual and TAS supported electronic formats for both resources, noting apps should be available for both mobile devices and desktops. Other stakeholders that supported a shift to electronic versions included 3M Australia, Austin Health, Australian Private Hospital Association (APHA), CHQ, Eurofield Information Solutions, Janssen Pharmaceutical, Stryker South Pacific (Stryker) and Women's Healthcare and Children's Healthcare Australasia (WCHA).

IHPA's response

IHPA will continue to work with stakeholders to understand the obstacles to implementing electronic versions of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS. IHPA considers that an electronic version of these resources would provide identical information to hard copies, be easier to reference and easier to update.

IHPA intends to progress towards providing an electronic version of these resources in parallel to hard copies as an interim measure as IHPA considers whether to phase out hard copies.

ICD-11 and older AR-DRG versions

Consultation question

- Are there other suggestions for approaches or measures to assess impact and readiness of the International Classification of Diseases (ICD-11) for use in the classifications used in admitted care, or more widely?

Feedback received

IHPA received a range of suggestions from stakeholders for methods to assess the impact and readiness of ICD-11 for use in classifications and admitted care.

Stakeholders made the following recommendations:

- that IHPA pursue a study in which sites undergo testing implementation of ICD-11 using real examples, assessing the changes and impact
- that IHPA develop a national plan addressing education and trial implementations
- that IHPA work with jurisdictions to address IT issues in the implementation if ICD-11. WA gave the example of needing to conduct readiness assessments around the ability of health services to incorporate ICD-11 into electronic medical records.

IHPA did not ask any specific consultation questions on the phasing out of older AR-DRG versions but received feedback from some private sector stakeholders.

Some stakeholders expressed concern on the planned phase out of older AR-DRG versions. Private Healthcare Australia (PHA) noted that the private sector has virtually achieved the phase out of AR-DRG Version 4.0, and will phase out AR-DRG Version 5.0 by July 2020. PHA advised the private sector is unable to meet the proposed timeframe to phase out AR-DRG Version 6.0, but could achieve this by 2025.

IHPA's response

IHPA notes that any decision to move to ICD-11 will be a government decision, as will the broad framework for IT and educational requirements as part of that transition.

The Australian Institute of Health and Welfare is progressing this discussion through the Australian Health Classifications Advisory Committee.

IHPA is working to map ICD-10-AM and ICD-11 so that it can conduct a gap analysis. Further work may also consider the impact of ICD-11 on AR-DRGs, determine the new features of ICD-11 that may be useful in AR-DRGs and also determine what would be required to ensure compatibility between the two classifications.

IHPA notes that it is important the benefits of the newer, current versions of AR-DRGs are realised, which requires phasing out older versions. Noting concerns that phase out timeframes are not achievable, IHPA will meet with relevant private sector stakeholders to discuss the implications of IHPA withdrawing support for older AR-DRG versions.

IHPA recommends that any new agreements between private hospitals and health funds use the most recent AR-DRG version rather than moving to an older unsupported version.

Non-admitted care

Consultation questions

- Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?
- How would activity that falls under these proposed new classes previously have been classified?

Feedback received

NSW, VIC, SA, TAS, AMA and WCHA were generally supportive of the inclusion of new classes for exercise physiology and clinic nurse specialist/allied health led pain management services.

NSW, VIC and QLD opposed phasing out aggregate non-admitted data for the National Efficient Price Determination 2021–22 (NEP21), with QLD noting the transition from a National Best Endeavours Data Set (NBEDS) to a National Minimum Data Set would require agreement from all jurisdictions through the National Health Data and Information Standards Committee. NSW and VIC noted there are circumstances where collection of patient level data is not currently feasible, such as in rural health services with limited resources.

IHPA's response

IHPA will price one additional clinical nurse specialist/allied health led class in pain management. The proposed additional exercise physiology class will not be introduced for NEP21 as IHPA has determined that further investigation into the pricing rationale for including the class is required.

Jurisdictions are required to submit public hospital activity data at the patient level wherever possible on a quarterly basis. Only patient level data is used by IHPA to determine the price weights in the NEP Determination.

The Administrator of the National Health Funding Pool (the Administrator) has advised his intention to phase out aggregate non-admitted activity reporting for funding and reconciliation purposes from 1 July 2021. IHPA supports the Administrator's proposal and will only use the patient level data reported through the non-admitted patient NBEDS for activity based funding (ABF) purposes from 1 July 2021.

Emergency care

Consultation questions

- What has been the impact on emergency department data since IHPA commenced shadow pricing using the Australian Emergency Care Classification (AECC) Version 1.0?
- Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

Feedback received

NSW, VIC, TAS and Austin Health noted either no or a small noticeable impact on emergency department (ED) practice since IHPA commenced shadow pricing using AECC Version 1.0. However, some stakeholders noted the reasons for no or low impacts, including not yet having data from shadow pricing using AECC, or inadequate available resources to observe impacts due to COVID-19.

NT noted that the AECC inadequately accounts for cost drivers like socioeconomic status. NT further noted that the cost impact of homelessness and overcrowding on NT EDs has been exacerbated by COVID-19.

A number of jurisdictions noted pricing emergency departments using AECC Version 1.0 for NEP21 was not supported due to the Addendum requiring a two year shadow period, concerns regarding data quality in principal diagnosis reporting and the impacts of COVID-19. It was recommended that IHPA agree through its Jurisdictional and Technical Advisory Committees what shadow pricing should involve and provide a Statement of Impact to jurisdictions.

WCHA noted its possible not all children's hospitals and EDs treating children have an appropriate electronic medical record system to capture the required information to implement AECC Version 1.0.

IHPA's response

IHPA notes concerns raised by NT, regarding the adequacy of the AECC Version 1.0 in capturing all cost drivers. In order to address these issues IHPA will require sufficient national data collection to support further consideration of specific cost drivers. Currently, only a single diagnosis is reported by most jurisdictions. IHPA is working with its Emergency Care Advisory Working Group to broaden the national ED data collection.

IHPA notes that its analysis demonstrates that the AECC cost model was stable between 2017–18 and 2018–19, which was previously of concern to jurisdictions. While the impact of COVID-19 needs to be considered, in IHPA's view the introduction of AECC Version 1.0 does not present an additional risk in this regard. A full Statement of Impact has been developed and provided to jurisdictions.

IHPA notes WCHA's concerns around the capacity of electronic medical records in paediatric EDs to capture the data required for the AECC Version 1.0. IHPA has undertaken analysis and confirmed that children's hospitals have similarly complete ED data than that of other hospitals.

Mental health care

Consultation questions

- How can IHPA further support development of pricing for community mental health services using the Australian Mental Health Care Classification (AMHCC) Version 1.0 to transition to shadow pricing?
- Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

Feedback received

NSW, VIC, QLD, WA, TAS and NT noted that the shadow pricing of community mental health services using AMHCC Version 1.0 should be deferred beyond NEP21. Feedback included concern around the variable quality of cost and activity data, the need for refinements to the Mental Health Phase of Care (MHPoC) and a requirement under the Addendum for a two year shadow period. VIC noted the high proportion of mental health episode data that is in 'Unknown Phase' or 'Unknown HoNoS (Health of the Nation Outcome Scale)' classes, and unresolved inter-rater reliability issues with three of five MHPoC categories.

Other stakeholders addressed specific concerns on the pricing of community mental health services using AMHCC Version 1.0 for NEP21 including:

- The Royal Australian & New Zealand College of Psychiatrists (RANZCP) noted that for consultation-liaison psychiatry challenges remain in implementing ABF in mental health services based in regional and rural Australia
- CHQ recommended differential pricing be used for paediatric age groups to better reflect complexity of assessment, treatment and support for this demographic
- Northwestern MH noted diagnosis is not included in AMHCC Version 1.0 and

recommends its inclusion. Northwestern MH also noted that mapping between Victorian Focus of Care and MHPoC is not one-to-one.

For admitted mental health services, NSW, VIC, QLD, SA, WA, TAS, NT, Austin Health and the Queensland Nurses & Midwives Union (QNMU) supported continued shadow pricing for NEP21 due to:

- data quality
- MHPoC inter-rater reliability
- the impact of COVID-19.

In addition to feedback on AMHCC Version 1.0, IHPA received feedback from NSW, WA and WCHA that supported the review of the pricing of specialist mother and baby units. WA noted that while the total cost of mother and baby units is small, the viability of the model of care is reliant on appropriate pricing.

IHPA's response

IHPA notes the comments raised by stakeholders regarding shadow pricing of community mental health care. However, the volume and coverage of community mental health data has improved substantially in 2018–19, with costed data now supplied by four jurisdictions (NSW, VIC, QLD and TAS).

As a result, IHPA intends to proceed with shadow pricing community mental health care services using the AMHCC Version 1.0 for NEP21.

IHPA notes the comments from jurisdictions on the transition to pricing of admitted mental health care services for NEP21. In response to feedback from jurisdictions, IHPA intends to continue shadow pricing admitted mental health care services using AMHCC Version 1.0 for NEP21. Given the improved quality of the data available and stability in the proposed pricing model, IHPA intends to use AMHCC Version 1.0 to price admitted mental health care services for NEP22. This is expected to drive more rapid improvements in the quality of mental health care data in the admitted setting.

IHPA appreciates feedback on the pricing of mother and baby units. The identification of costed data for mother and baby units is extremely limited, with significant variation in cost per weighted separation. Therefore, it is not robust enough to set any adjustments at this stage.

IHPA notes RANZCP's feedback on consultant-liaison psychiatry. IHPA is working to include intervention codes for consultation-liaison psychiatry to accurately identify this activity for admitted hospital services.

IHPA notes CHQ's recommendation for differential pricing for paediatric age groups. The AMHCC classes are split based on age categories. IHPA will consider any further adjustments as the data collection matures.

Teaching, training and research

IHPA did not ask any specific consultation questions about the teaching and training classification.

IHPA notes feedback from UA highlighting significant interruptions to teaching and training activities for pre-registration students in public hospitals since COVID-19 began. IHPA notes UA's recommendation that these interruptions and the costs they will impose be considered when formulating teaching and training block funding.

IHPA will continue to assess the need for any adjustments relating to teaching and training as activity and cost data becomes available in future.

7 Setting the national efficient price for activity base funded public hospitals

7 Setting the national efficient price for activity based funded public hospitals

Adjustments to the national efficient price

Consultation questions

- Do you support the adjustment IHPA has proposed for the National Efficient Price (NEP) Determination 2021–22 (NEP21)?
- What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

Feedback received

IHPA proposed an adjustment to the national efficient price for patient transport in rural areas, including medical transfers and other inter-service transport. There was broad support among stakeholders for this adjustment. Some stakeholders recommended further alterations to the adjustment to expand its scope.

In addition to the adjustment for patient transport in rural areas, stakeholders proposed other adjustments. These included:

- an alternative proxy measure of intensive care unit (ICU) complexity that is more precise than hours in ICU or hours on a mechanical ventilator
- a neonate adjustment where the newborn is admitted to a specialist children's hospital. It was also recommended that IHPA consider unbundling the ICU component of the diagnosis related group price for 'Newborns and Other Neonates'
- inclusion of weightings based on measures of social determinants of health (for example, socioeconomic status).

The RACP requested IHPA examine whether the NEP for genetics services appropriately covers the cost, given the complex and lengthy nature of its consultation and the AMA asked IHPA to ensure the growth in public hospital wages is indexed in the NEP each year.

IHPA's response

Patient travel costs are highest for remote patients, and high patient travel costs for these patients are already adjusted for in the national pricing model with the existing patient residential and treatment remoteness adjustments.

While IHPA does not intend to proceed with the patient transport adjustment for NEP21, it will continue to assess whether these costs can be refined to more accurately identify patients who attract high travel costs.

IHPA will examine other proposed adjustments including reassessing ICU eligibility criteria, pricing for genetic services and socioeconomic status as part of the NEP development cycle.

It is notable that some of the recommended adjustments are already covered by the national pricing model. For example, neonates are nominally eligible for the specialist paediatric loading applied for admission to specialist hospitals.

Harmonising price weights across service settings

Consultation questions

- Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?
- Are there other clinical areas where introducing price harmonisation should be considered?

Feedback received

QLD, SA, TAS and Austin Health were supportive of harmonising dialysis and chemotherapy prices for NEP21. TAS noted concern that clinical information will be lost as outpatient reporting systems do not contain some diagnosis and comorbidity information that underpins Diagnosis Related Group classification. TAS also recommended that the classes concerned be split into two end classes. SA recommended that prior to harmonisation IHPA should identify any cost differences between jurisdictions and explain these differences.

NSW and WA supported harmonisation in-principle, but highlighted issues including higher comorbidity risk profile of inpatients and associated cost variation, paediatric-specific concerns, and the need for greater consultation with clinicians.

NSW, VIC and NT did not support harmonisation of either dialysis or chemotherapy at this stage, with NT noting it opposes harmonisation if it results in a financial penalty for hospitals that admit patients for clinical reasons.

CHQ and WCHA supported harmonisation but noted some concerns specific to paediatrics as there are significant differences between the delivery of paediatric and adult oncology services. WCHA recommended IHPA consider the complexity of paediatric services when implementing price harmonisation.

QLD and WA recommended price harmonisation for minor surgical procedures such as colonoscopy or nasendoscopy, treatment of anaemia with blood transfusions and infusions of blood products and mechanical hysteroscopy performed in a non-admitted setting.

IHPA's response

IHPA will not be progressing with harmonising dialysis and chemotherapy for NEP21.
IHPA notes that in principle if the same service is being delivered in the admitted and non-admitted setting then price harmonisation is appropriate. However, in this instance IHPA will consult further with jurisdictions on potential unintended consequences of pursuing price harmonisation for dialysis and chemotherapy.

IHPA notes the price for the Tier 2 class covering colonoscopy is already harmonised to the admitted acute price. Nasendoscopy will be considered when harmonisation is reassessed for the NEP Determination 2022–23.

Setting the national efficient price for private patients in public hospitals

IHPA did not ask any specific consultation questions on pricing for private patients in public hospitals but received feedback from some stakeholders.

Feedback received

NSW noted that adjustments to account for variations in jurisdiction funding contributions would undermine the state or territory's role as system managers. NSW noted that as a party to the Addendum to the National Health Reform agreement 2020–25 (the Addendum) it is a jurisdictions' role to ensure financial neutrality, and recommends IHPA's pricing act as an enabler to allow jurisdictions to achieve this. NSW noted that the *Public-private neutrality* pricing guideline focuses on payment reductions – as opposed to cost variation – and was concerned that it could result in services being underfunded.

VIC noted its concern that IHPA's proposed methodology does not allow for no adjustment in the event that a state achieved financial neutrality with its own model and recommended IHPA apply no adjustment if a state or territory demonstrates that its funding model is financially neutral with respect to patients.

QLD noted concerns around IHPA's proposed methodologies to implement private patient neutrality clauses in the Addendum including the QLD Efficient Price being different to the NEP, the added complexity of the proposed methodology, and Hospital Casemix Protocol data not being available to jurisdictions

WA noted concern at the ambiguity in the Addendum as to the meaning of 'funding neutrality for the service provider', with potentially significant impacts on how the WA health system manages private patients.

TAS noted concerns that the price weights that underpin the national weighted activity unit do not accurately describe the projected cost of treating private patients. For example, in hospitals where third-party providers are contracted to provide medical practitioner, imaging and pathology services, the hospital does not always have oversight of the costs.

APHA and PHA recommended IHPA take note of all private patient revenues, giving the examples of income derived from prostheses and charges made for private patients (even when these charges have not been paid).

The QNMU recommended against the potential for the national pricing model to create incentives for public hospitals to admit private patients, as this could interfere with public patients having adequate access to health care. QNMU recommended IHPA consider incentives that improve health service delivery.

IHPA's response

IHPA's Technical (TAC) and Jurisdictional (JAC) Advisory Committees are involved in ongoing discussions on the implementation of private patient neutrality as required under the Addendum. IHPA notes that it is required by the Addendum to provide a funding neutral model for private patients in public hospitals. In consultation with JAC and TAC the methodology IHPA intends to use has been further developed since the Consultation Paper was released.

As required by the Addendum, IHPA will monitor the methodology as it is implemented to ensure financial neutrality, and work with jurisdictions to account for all revenue hospitals receive for private patients.

Costing private patients in public hospitals and the private patient correction factor

Consultation question

- Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

Feedback received

Stakeholders had diverging views on the retention of the private patient correction factor (PPCF) for NEP21. VIC, QLD and SA supported phasing out the PPCF, with VIC noting that any phase out timeframe should allow jurisdictions to comply with the Australian Hospital Patient Costing Standards (AHPCS) Version 4.0. In a similar vein, SA noted that privacy rights of private practice earnings, private pathology income and third party radiology contracts all limit data collection and/or attributing costs to an individual patient. Therefore, SA needs to be able to allow for adjustments to the costs for SA pathology.

WA supports a phase out only if it can be demonstrated all material missing costs are included in the National Hospital Cost Data Collection. NT recommended IHPA shadow phasing out of the PPCF, including back-casting as well as conducting an impact assessment on the application of the AHPCS Version 4.0 in addressing the issue of missing private patient costs.

NSW and TAS recommend the PPCF be retained for NEP21.

IHPA response

IHPA will retain the PPCF for NEP21 in all states and territories except the NT, where it will be removed. IHPA is undertaking analysis to understand whether the PPCF as it is currently applied is still required in remaining jurisdictions.

8 Data collection

8 Data collection

IHPA did not ask any specific consultation questions on data collection, but received feedback from a small number of stakeholders relating to phasing out aggregate non-admitted data reporting. This feedback is addressed under non-admitted care in Chapter 6.

9 Treatment of other Commonwealth programs

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IHPA did not ask any specific consultation questions on treatment of other Commonwealth programs, but received feedback from a small number of stakeholders.

Feedback received

WA noted that the Pharmaceutical Benefits Scheme (PBS), Highly Specialised Drugs and Efficient Funding of Chemotherapy Medicines programs are excluded from the national efficient price (NEP) and that in 2019 the Commonwealth reduced the wholesale mark up on these items. The Commonwealth committed to a correction in National Health Reform funding, to eventually flow through to the NEP. Due to the funding formula, WA notes this correction would only account for part of the reduced funding.

QLD noted some Tier 2 clinics which in practice would not receive funding for PBS-listed medications, still have a PBS price weight due to allocating residual PBS costs. QLD recommended this practice should exclude non-admitted clinics that would not receive funding for PBS-listed medications.

IHPA's response

IHPA notes the October 2019 change to wholesale mark up for section 85 medicines has been accounted for in setting the price for the NEP Determinations 2020–21 and 2021–22 (NEP21).

IHPA's PBS matching methodology has been reviewed for NEP21, and further consultation and refinement will take place in development of the NEP Determination 2022–23.

10 Setting the National Efficient Cost

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Consultation question

– Are there refinements to the ‘fixed-plus-variable’ model that IHPA should consider?

Feedback received

VIC and WA did not recommend further refinements to the ‘fixed-plus-variable’ model, but noted that it should be monitored. WA recommended monitoring to ensure remoteness costs are captured so as to reflect the true cost of service delivery. VIC recommended the model be reviewed after functioning for two years prior to further changes being considered.

TAS and Austin Health were generally supportive of the ‘fixed-plus-variable’ model. TAS recommended caution in considering any changes before the impact of COVID-19 is fully understood. Austin Health noted that while the ‘fixed-plus-variable’ model is based on a sound formula, the impact of reduced activity due to COVID-19 spanning two financial years should be considered.

UA proposed consideration of the ‘fixed-plus-variable’ model being applied to teaching and training costing and funding over the next few years, with the variable component potentially directed to clinical placement ‘catch-up’.

IHPA’s response

IHPA notes feedback from VIC, WA, TAS and Austin Health.

Teaching, training and research will be block funded for the National Efficient Price Determination 2021–22. IHPA is investigating alternative models to block funding until the Australian Teaching and Training Classification can be implemented and priced.

11 Alternative funding models

11 Alternative funding models

Consultation questions

- What comments do stakeholders have regarding the innovative funding models being considered by IHPA?
- What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum to the National Health Reform Agreement 2020–25?

Feedback received

Stakeholders provided detailed feedback on the challenges they foresee in implementing the innovative funding models IHPA is considering.

Feedback included general support for the development of a funding methodology to promote value-based care, with a focus on a reward-based incentive system, rather than punitive financial measures. The Australian Healthcare and Hospitals Association (AHHA) recommended that funding models allow flexibility and pooling of funds at the local level, incentivising integration of care across state/territory and Commonwealth government areas of healthcare responsibility.

It was noted that financial risk needs to be shared between parties (namely the relevant state or territory and the Commonwealth), with VIC noting that under the current model a program needs to be demonstrating successful operation to be eligible for Commonwealth funding. By that stage, significant development costs have already been incurred by the jurisdiction in question. In addition, while some bundles to improve adherence to best practice or patient outcomes may create efficiencies, it was noted that overall costs may still increase.

Stakeholders such as AHHA and Stryker supported including adoption of new technologies in innovative funding models to support improved efficiencies and health outcomes.

Jurisdictions provided details of innovative funding models they are developing, trialling or intending to trial through bilateral agreements. Examples of models being considered include:

- QLD is developing an advanced kidney collaborative, as well as bundled payments for orthopaedics, gastroenterology and ophthalmology
- WA is developing an initiative to address low value care in conjunction with Curtin University
- VIC is working to ensure the reinstatement of Healthlinks to the General List, and also interested in trialling models focused on stroke and orthopaedics
- TAS is working on several programs, including hospital-in-the-home, non-admitted outreach and in-reach programs.

IHPA’s response

IHPA will consider all feedback in developing its innovative funding model approach.

Consultation question

- Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or Australian Diagnosis Related Groups (ADRGs) are amenable to certain funding models?

Feedback received

IHPA received feedback from jurisdictions, as well as private industry and professional associations including AHHA, Biotronik, Johnson and Johnson, RACP and WCHA. It was recommended IHPA consider a variety of factors in determining which patient cohorts are amenable to innovative funding models.

IHPA was asked to recognise the role of jurisdictions in bringing innovative funding models to IHPA for consideration (rather than IHPA imposing funding methodologies on jurisdictions). There was support for engaging clinicians early and consistently in determining where and how to use innovative funding models

It was recommended that IHPA include a focus on environmental, geospatial (for example, commercial/industrial areas) and public health factors when developing innovative funding models.

It was also recommended IHPA consider how a focus on specific patient groups could be aligned with the National Clinical Quality Registry Strategy and whether alternative funding models can help address any equity of access gaps for specific patient cohorts.

IHPA's response

IHPA will consider the range of factors provided by stakeholders in undertaking its analysis of patient cohorts and ADRGs.

Consultation question

- What other strategic areas should IHPA consider in developing a framework for future funding models?

Feedback received

Stakeholders including jurisdictions, Johnson and Johnson, QNMU, Stryker and WCHA noted a range of strategic areas that IHPA should consider in developing its future funding models framework.

Some of the strategic areas IHPA was asked to consider include:

- the role of new and emerging technologies, including what constitutes a 'service event' in a virtual context
- how funding models can be designed to integrate primary healthcare
- utilising classification systems and funding models that respect the cost impact of the burden of disease and chronic illness on the hospital system
- development of models for more accurate funding and quality assessment of family-based services (for example, child protection, social work).

IHPA's response

IHPA will consider the feedback received in developing its future funding models framework.

Consultation question

- Apart from the Individual Healthcare Identifier (IHI), what other critical success factors are required to support the implementation of innovative funding models?

Feedback received

Stakeholders including jurisdictions, Austin Health, QNMU and WCHA suggested a number of critical success factors that IHPA should consider to support the implementation of an innovative funding model.

Examples included:

- a nationally agreed best practice pathway, as well as a fund-sharing and risk-adjustment arrangements for bundled services
- the ability to measure outcomes and to link and access data, sophisticated risk adjustment and governance across care settings and safeguards against selecting low acuity patients
- the need for effective information and communication technology (ICT) and the consideration of the large ICT investment required by jurisdictions and health services
- the importance of appropriate evaluation mechanisms.

There were varied views among jurisdictions as to the importance of the IHI for delivering innovative funding models.

NSW noted that it does not support the collection of the IHI by IHPA at this time. VIC noted it does not consider the IHI to be a critical success factor in implementing innovative funding models.

TAS supported the use of the IHI, but notes it cannot routinely collect it at this time. SA acknowledged the importance of the IHI in jurisdictions' ability to link episodes and track readmissions.

IHPA's response

IHPA will consider the feedback received to support the implementation of an innovative funding model.

12 Pricing and funding for safety and quality

12 Pricing and funding for safety and quality

Avoidable hospital readmissions

Consultation question

- Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

Feedback received

Funding Option one

Several stakeholders including QLD, TAS, CHA, CHQ and QNMU supported IHPA's proposed pricing model, *'Option one: Deduct the cost of the readmission episode from the index episode'* as it focuses on transparency and practicality. SA noted it would consider implementing either Option one or Option three.

Some stakeholders noted challenges to implementing Option one, despite supporting it. For example, the requirement to link patient episodes across a given jurisdiction, with IHPA's efforts to resolve this issue using the Medicare PIN to link admissions representing only a partial solution. While IHPA has committed to providing as much data as possible to jurisdictions they remain concerned about the lack of transparency around avoidable hospital readmissions at a local hospital network (LHN) level. There was recognition from some jurisdictions that comprehensive reporting at an LHN level will not be possible until the Individual Healthcare Identifier is routinely collected.

Stakeholders also noted that a commitment to transparency should include ensuring health services are clear on how readmissions will be identified, and the nature of the deduction to be applied from the index episode.

Funding Option three

Several stakeholders including NSW, VIC, SA, WA, NT and Austin Health preferred *'Option three: Adjust funding at the hospital level where actual rates of avoidable readmissions exceed expected rates of avoidable readmissions'*, given its goal of applying funding adjustments at a hospital level, where they are perceived to be more visible to clinicians.

NT noted that Option three should be augmented by continuing to refine risk adjustment and exclusion rules to eliminate disproportionate funding impacts between funding options for small remote hospitals.

The AMA noted there is no credible international or Australian evidence to 'demonstrate a causal link between funding penalties and few hospital patient complications' and recommended any financial penalties be subject to an independent review. Of the funding options presented AMA viewed Option three as the most workable.

IHPA's response

IHPA proposes to use funding Option one due to its ease of application, similarity to the hospital acquired complications (HACs) methodology already in use, and less disproportionate in its impact across jurisdictions.

IHPA notes that some stakeholders support Option three, given its hospital-level approach.

This approach is based on 'expected' versus 'actual' rates of readmissions. The 'expected' rate of readmissions for each hospital is derived from a national average of readmission rates. Smaller remote hospitals that experience higher than average rates of readmissions in the first instance are likely to proportionately experience a higher funding impact.

IHPA notes concern from some stakeholders that a funding approach to avoidable hospital readmissions may have punitive ramifications for hospitals, but notes the Addendum to the National Health Reform Agreement 2020–25 requires IHPA to develop a funding approach for avoidable hospital readmissions for implementation from 1 July 2021.

Consultation question

- Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

Feedback received

Stakeholders including jurisdictions, AMA, Biotronik, CHQ, Peter Mac National Centre for Infections in Cancer and Stryker provided feedback on refinements to the risk adjustment model and risk factors IHPA should consider.

Priorities included a focus on transparency in the design of the risk adjustment model. Proposals for improvements included:

- investigation of the number of readmissions following a patient being in the care of other organisations, including disability and aged care
- further consideration of sociodemographic factors
- further consideration of paediatric clinical factors
- modifications to the HAC risk adjustment methodology for healthcare associated infections for cancer admissions
- consideration of long-term readmissions for implants
- an independent review of the pricing model for avoidable readmissions to occur at a point agreed by IHPA and the jurisdictions to evaluate outcomes and catalogue any unintended consequences.

IHPA's response

IHPA notes that some of the refinements stakeholders suggested are already accounted for in the risk adjustment model. IHPA will consider those proposals not already accounted for as it continues to refine the risk adjustment model.

Consultation question

- What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

Feedback received

IHPA received suggestions for additional considerations when implementing an avoidable hospital readmission funding adjustment from stakeholders including jurisdictions, Austin Health, Johnson and Johnson, QNMU and WCHA. Recommendations included:

- managing the risk of using the Medicare PIN for data linkage
- implementing a process to reverse the adjustment if needed
- ensuring transparency at a hospital and LHN level
- implementing a reporting tool services can leverage to recognise and replicate best practice
- consideration of information and communications technology limitations faced by hospitals and jurisdictions
- consideration of the appropriateness of an adjuster that is applied across different LHNs where each hospital has no knowledge of how well the other is coding or documenting related variables.

IHPA's response

IHPA notes the quality of Medicare PIN data reporting has been of sufficient quality nationally on a consistent basis over 2015–2019. Where IHPA considers the Medicare PIN is of poor quality, these data points are removed. IHPA intends to provide data pertaining to identified readmission episodes to jurisdictions.

IHPA notes that any mechanism to reverse the adjustment would need to be agreed by jurisdictions.

Appendix 1 — List of stakeholders

The following stakeholders made submissions in response to the Pricing Framework for Australian Public Hospital Services 2021–22 Consultation Paper. Individual and private submissions are not listed.

Where an abbreviation has been used to refer to a stakeholder in this report it is also listed below.

Abbreviation	Stakeholder	Abbreviation	Stakeholder
NSW	New South Wales Ministry of Health		Eurofield Information Systems
VIC	Victoria Department of Health and Human Services		Human Genetics Society of Australia
QLD	Queensland Department of Health		Janssen Pharmaceutical
SA	South Australia Department of Health and Wellbeing	Johnson and Johnson	Johnson and Johnson Medical
WA	Western Australian Department of Health		New Zealand Ministry of Health
TAS	Tasmanian Department of Health	Northwestern MH	Northwestern Mental Health, Royal Melbourne Hospital
NT	Northern Territory Department of Health		Peter Mac National Centre for Infections in Cancer
AHHA	Australian Healthcare and Hospitals Association	PHA	Private Healthcare Australia
AMA	Australian Medical Association	QNMU	Queensland Nurses & Midwives Union
APHA	Australian Private Hospital Association	RACP	Royal Australasian College of Physicians
	Austin Health	RANZCP	Royal Australian and New Zealand College of Psychiatrists
CHA	Catholic Health Australia	Stryker	Stryker South Pacific
	Council of Australian Therapeutic Advisory Groups	UA	Universities Australia
CHQ	Children's Health Queensland		

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