Independent Hospital Pricing Authority

Three Year Data Plan 2018-19 to 2020-21

June 2018

IHPA

IHPA Three Year Data Plan 2018-19 to 2020-21

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Glossary

ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient classification
AR-DRG	Australian Refined Diagnosis Related Groups classification
COAG	Council of Australian Governments
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification
IHPA	Independent Hospital Pricing Authority
The Administrator	Administrator of the National Health Funding Pool
NBEDS	National Best Endeavours Data Set
NEC	National Efficient Cost
NEP	National Efficient Price
NHISSC	National Health Information Standards and Statistics Committee
NMDS	National Minimum Data Set
SDMS	Secured Data Management System
TTR	Teaching, training and research
UDG	Urgency Disposition Groups
URG	Urgency Related Groups

1. Executive summary

The Independent Hospital Pricing Authority (IHPA) is an independent government agency provided for through the National Health Reform Agreement and established under the National Health Reform Act 2011. A major component of these reforms is the implementation of national activity based funding for Australian public hospitals.

IHPA's key functions include determining pricing for services funded on an activity basis, through the National Efficient Price (NEP), and determining the efficient cost for services which are block funded, through the National Efficient Cost (NEC).

In determining the NEP and NEC, IHPA must first specify the classifications, counting rules, data and coding standards as well as the methods and standards for costing data. As the provision of timely, accurate and reliable data is vital to IHPA in determining the NEP, IHPA has prepared this sixth edition of the IHPA Three Year Data Plan to communicate these requirements to the Commonwealth, states and the territories in accordance with Clauses B85 to B104 of the National Health Reform Agreement.

Clause B88 of the National Health Reform Agreement requires IHPA to develop a rolling three year data plan each year.

For this update, IHPA has worked collaboratively with the Administrator of the National Health Funding Pool (the Administrator) as part of IHPA's commitment to the principle of data rationalisation expressed in the National Health Reform Agreement, particularly the desire to implement the 'single provision, multiple use' concept.

Working in a coordinated fashion has involved the standardisation of the documents and tables used to communicate each agency's data requirements, including clearly defining which data requests are common across the Agencies. This also enables simultaneous consideration by the Council of Australian Governments (COAG) Health Council.

This process aims to provide greater clarity of their combined data requirements for jurisdictions for coming years. It will also help highlight further potential areas to implement the 'single provision, multiple use' principle of the National Health Reform Agreement, over and above the work completed by IHPA and the Administrator for activity data submissions.

During 2017, IHPA invested in a new Secured Data Management System (SDMS) to improve the speed and utility of the data submission portal for states and territories. IHPA will continue to work with states and territories to refine this in 2018.

IHPA has also worked with the Australian Institute of Health and Welfare to coordinate the data plans. The Institute has had responsibility for reporting against the indicators in the Performance and Accountability Framework following the transfer of these responsibilities from the National Health Performance Authority.

2. Overview

IHPA requires accurate activity, cost and expenditure data from jurisdictions on a timely basis in order to perform its core determinative functions.

This data plan sets out IHPA's sixth rolling Three Year Data Plan, covering the period 2018-19 to 2020-21.

The data plans of IHPA and the Administrator have been harmonised to provide a standard document structure and an appendix listing shared data collection.

Supply of the data outlined in this document is required under Clause A8 of the National Health Reform Agreement, with details of Commonwealth and state compliance to be reported on a quarterly basis in line with Clause B102.

IHPA will also continue to make de-identified aggregate and patient-level data available to the Commonwealth, states and territories consistent with Clause B97 of the National Health Reform Agreement and Section 220 of the *National Health Reform Act 2011*.

The objectives of the IHPA Three Year Data Plan are to:

- communicate IHPA's data requirements over the next three years to jurisdictions and other government agencies, in accordance with Clause B85 of the National Health Reform Agreement; and
- describe the mechanisms, including timelines, that IHPA will use to collect data from the jurisdictions.

Section 3 describes the background to the development of this data plan, including the objectives, the consultation and development processes associated with this data plan and its implementation.

Section 4 describes the security and privacy requirements and protections surrounding the data.

Section 5 indicates how this data plan conforms to the principles of the National Health Reform Agreement.

Section 6 covers the specific data requirements of IHPA. It identifies the data sources and major data components to be used to support data analysis and reporting in the period covered by this plan.

Section 7 details the data submission process and collection schedule.

Appendix A details the data collections utilised by IHPA and the Administrator.

3. Background

3.1. Legislative basis

The functions of IHPA are specified in Section 131 of the *National Health Reform Act 2011* and include:

- determining the NEP for health care services provided by public hospitals where the services are funded on an activity basis;
- determining the NEC for health care services provided by public hospitals where the services are block funded;
- determining adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services;
- developing and specifying classification systems to be used to classify health care and other services provided by public hospitals for activity based funding purposes;
- determining data requirements and standards to apply, for activity based funding purposes, in relation to data to be provided by jurisdictions, including:
    i. data and coding standards to support uniform provision of data; and
    ii. requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions; and
- except where otherwise agreed between the Commonwealth and a state or territory – to determine the public hospital functions that are to be funded in the state or territory by the Commonwealth.

Section 226(1) of the *National Health Reform Act 2011* enables the Commonwealth Minister for Health to give directions to the Pricing Authority in relation to the performance of its functions and the exercise of its powers.

In June 2017, Australian governments signed an Addendum to the National Health Reform Agreement which sets out public hospital financing arrangements until 1 July 2020. The Addendum requires implementation of pricing and funding approaches for sentinel events and hospital acquired complications (HACs) and the development of an approach for avoidable hospital readmissions. The implications of the new pricing and funding approaches for data collection are discussed in Section 6.6. The Addendum also introduced a new requirement for jurisdictions to submit a Statement of Assurance regarding data quality which is discussed in Section 7.4.

3.2. National collections

IHPA continues to work closely with the Australian Institute of Health and Welfare and the national data governance processes to ensure that IHPA conforms with existing data development processes and structures to the fullest extent possible. IHPA is a Registering

Authority for METeOR, the Australian Institute of Health and Welfare's repository for metadata standards for health statistics and information. All of the specifications for IHPA's data sets are stored in METeOR.

IHPA has worked with the National Health Information Standards and Statistics Committee to incorporate activity based funding specific data items into existing national minimum data sets (NMDS) and data set specifications.

This has resulted in the retirement of a number of activity based funding data specifications in previous years and has reduced the burden of multiple submissions for states and territories.

In March 2016, the decision was made that all current data sets designated as 'data set specifications' will be distributed into one of two categories from 1 July 2016:

- **National best endeavours data set (NBEDS):** This category is for metadata sets that are not mandated for national collection, but where there is a commitment to provide nationally on a best endeavours basis; and
- **National best practice data set:** This category is for metadata sets that are not mandated for collection, but are recommended as best practice.

To reflect the new naming convention, national data collections for some care streams (such as for mental health and non-admitted services) were recategorised as NBEDS.

IHPA will continue to align activity based funding reporting requirements with existing national data collections where possible.

IHPA supports the 'single provision, multiple use' principle outlined in the National Health Reform Agreement.

The National Health Information Agreement was updated in October 2013 and IHPA is a signatory to the Agreement. The Agreement coordinates the development, collection and dissemination of health information in Australia, including the development, endorsement and maintenance of national data standards. This includes a commitment to co-operate through the Australian Health Ministers' Advisory Council agreed governance arrangements for information management.

3.3. Consultation

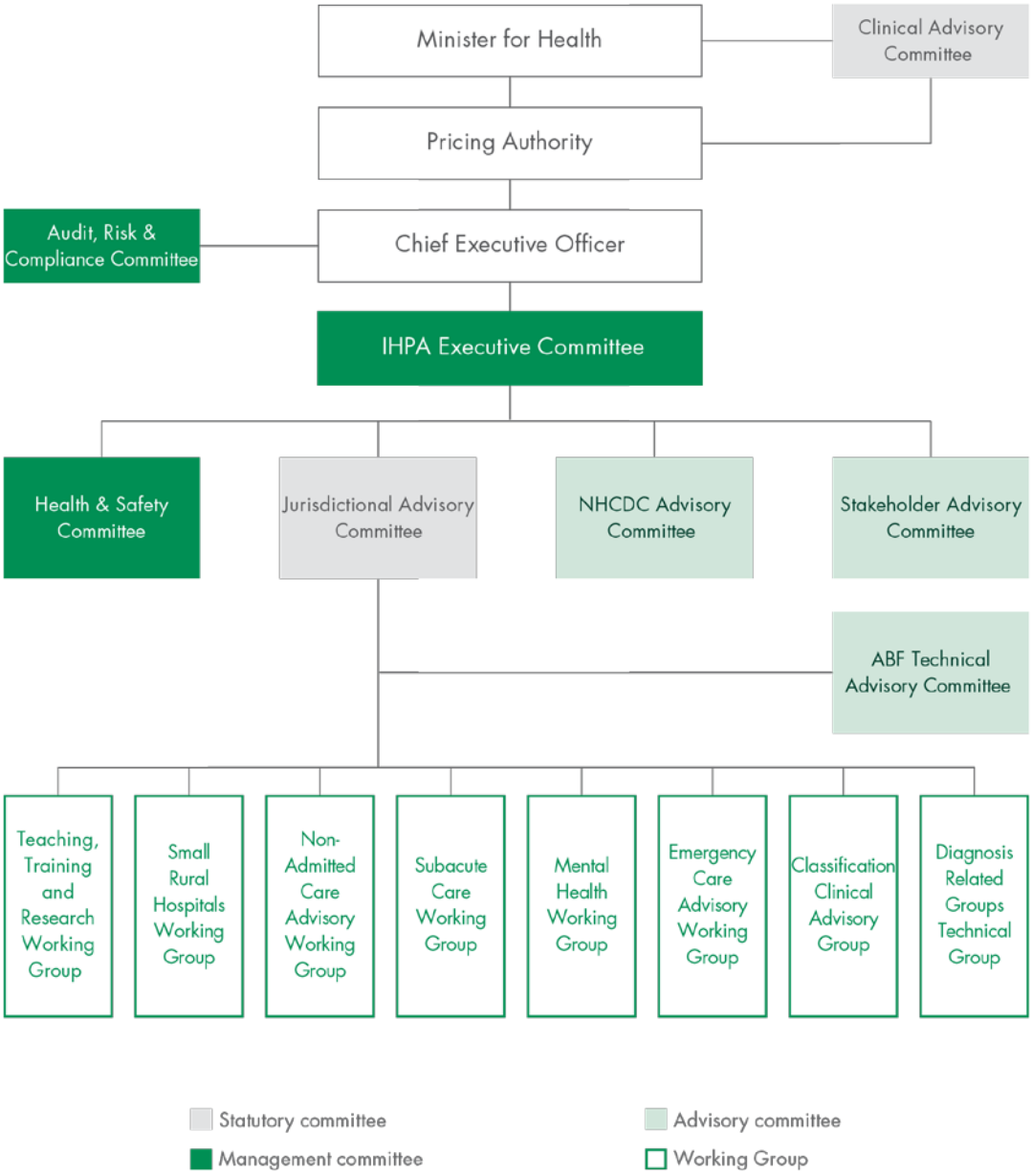
Several advisory committees and working groups have been established to ensure that jurisdictions are consulted and that the national health reforms are implemented efficiently.

Figure 1 provides an overview of the committee structure that has been established to facilitate consultation regarding the specification and collection of IHPA's data requirements.

In particular, IHPA uses these committees and working groups to:

- understand the impact on jurisdictions of collecting data required by IHPA;
- consult on timelines to incorporate standardised data collection methodologies;
- encourage and facilitate processes that will ensure data accuracy; and
- review preliminary results from hospitals and provide assistance in quality assurance.

Figure 1. IHPA Committee Structure



4. Security and privacy

IHPA is tasked with collecting, securing and using information in accordance with relevant legislation and national privacy principles, ethical guidelines and practices.

4.1. Privacy

The privacy of information is of paramount importance. IHPA manages all information in accordance with the Australian Privacy Principles in the *Privacy Act 1988* and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*; the secrecy and patient confidentiality provisions in the *National Health Reform Act 2011;* and other statutory protections.

The *National Health Reform Act 2011* provides protections for personal information and makes provisions to ensure patient confidentiality.

All IHPA staff are employed under the *Public Service Act 1999*, and are subject to the *APS Code of Conduct*. Further, IHPA's Privacy Policy has been substantially revised with regard to the Commonwealth privacy legislation in effect from 12 March 2014.

4.2. Security

IHPA is committed to the security of data submitted by jurisdictions. Systems and processes used for collection, analysis, storage and reporting are designed to ensure security of information.

IHPA's Information Security Policy takes account of particular risks that arise when handling information to perform its functions and activities. It sets out the responsibilities for anyone handling information collected by IHPA including how information is classified, handled and released, and when classified information is transferred internally or sent externally. It also sets out the process for secure disposal of classified information.

To manage its information security risks and responsibilities, IHPA has an internal Protective Security Framework modelled on the Australian Government's Protective Security Policy Framework. IHPA's Protective Security Policy Framework consists of a range of policies which interact and complement each other so that they provide a comprehensive framework for the handling of information collected by IHPA. The following policies are relevant to IHPA's information security policy:

- Physical Security – Physical security controls are those measures that protect IHPA's people, information and assets. In effect they are protective security measures which help to prevent unauthorised access to IHPA's assets, information or other official resources.
- Personnel Security – To ensure that the information IHPA holds is protected from misuse or compromise, IHPA must satisfy itself that people who have been given access to classified resources have been appropriately identified and authorised.
- Security Incident and Investigation – Security Incident Policy applies to all IHPA employees, contractors, and third parties and is the primary source of guidance for identifying and reporting a security incident.

Requests for release of information by government agencies or research organisations are covered by IHPA's Information Release Policy, which enacts the relevant provisions with the *National Health Reform Act 2011* and the National Health Reform Agreement.

4.2.1. Data submission

In 2017 IHPA implemented a new Secured Data Management System (SMDS). This dynamic tool built specifically for IHPA includes a new data submission portal, data validation process, data storage and data analytics platform. The new system has introduced greater flexibility of file upload specifications, faster validation and reporting, and enhanced capabilities for jurisdictions to track and manage their submission process. IHPA has also implemented a classification grouping module and National Weighted Activity Unit calculator in the new system which allows jurisdictions to get real-time feedback on the data supplied to the national health reform agencies, minimising discrepancies.

The SDMS complies with Australian Government Information Security Manual top 35 controls, and is hosted on infrastructure that has been approved by the Defence Signals Directorate. The system implementation was independently reviewed and tested by a third party IT security provider.

The revised process has resulted in higher quality data being provided to the Administrator in a timelier manner. The importance of timely and accurate data supply is underscored in the Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding signed by First Ministers in April 2016 and the Addendum to the National Health Reform Agreement, signed by First Ministers in June 2017, and is even more important with the introduction of a funding cap from 1 July 2017.

The portal was implemented for all data submissions from February 2017. IHPA has developed user guides, held workshops, and provided phone and email support to assist jurisdictions when using the new system.

5. Governance

5.1 Compliance with the National Health Reform Agreement

Clause B86 of the National Health Reform Agreement specifies the requirements of the Three Year Data Plan. IHPA acknowledges and complies with these requirements, as demonstrated in **Table 1**.

Table 1: National Health Reform Agreement compliance matrix

Clause	Compliance principles	Compliance mechanisms
B86 a	Seek to meet its data requirements through existing national data collections, where practical	IHPA has worked with the national data committees to align activity based funding reporting with existing NMDS and NBEDS for admitted patient care, emergency care, non-admitted care and mental health care.
B86 b	Conform with national data development principles and wherever practical use existing data development governance processes and structures, except where to do so would compromise the performance of its statutory functions	All new data development work in 2017 has been in collaboration with the national data governance processes and groups.
B86 c	Allow for a reasonable, clearly defined timeframe to incorporate standardised data collection methods across all jurisdictions	IHPA will consult with its Jurisdictional Advisory Committee and the national data committees prior to introducing additional data elements into collections.
B86 d	Support the concept of 'single provision, multiple use' of information to maximise efficiency of data provision and validation where practical, in accordance with privacy requirements	IHPA supports the concept of 'single submission, multiple use'. Wherever possible, IHPA will apply the same validations as the Australian Institute of Health and Welfare, and will provide data to agencies under Clause B97 of the National Health Reform Agreement as requested.
B86 e	Balance the national benefits of access to the requested data against the impact on jurisdictions providing that data	IHPA is mindful of the need to balance the benefits against the impact on jurisdictions and will continue to review this in 2018.
B86 f	Consult with the Commonwealth and states when determining its requirements.	IHPA will consult with all key stakeholders through its relevant working groups, the Technical Advisory Committee, the Jurisdictional Advisory Committee and the external national data committees prior to introducing additional data elements into collections.

6. Data requirements

IHPA requires accurate activity, cost and expenditure data from jurisdictions on a timely basis in order to perform its core determinative functions. In collecting this data, a number of data collections are used. Wherever possible, IHPA uses pre-existing classifications and data specifications.

6.1. Classifications

This section provides an overview of the classifications approved by IHPA to describe clinical activity in each service category.

6.1.1. Approved activity based funding classifications

The classifications which will be used to describe activity for the admitted acute, non-admitted, emergency, mental health and subacute service categories from 1 July 2018 are listed in **Table 2**.

Table 2: Activity based funding classifications

Service category	Classification	Collection start sate
Admitted acute	ICD-10-AM/ACHI/ACS, Tenth Edition; in conjunction with Australian Refined Diagnosis Related Groups (AR-DRG) v9.0	1 July 2018
Non-admitted	Tier 2 Non-Admitted Services v5.0	1 July 2018
Emergency (ED Levels 3B – 6)	Urgency Related Groups (URG) v1.4	1 July 2018
Emergency (ED Levels 1 – 3A)	Urgency Disposition Groups (UDG) v1.3	1 July 2018
Subacute & Non-acute	Australian National Subacute and Non-Acute Patient classification (AN-SNAP) v4.0	1 July 2018
Mental Health	Australian Mental Health Care Classification v1.0	1 July 2018

6.1.2. Process for classification development

Under the Act, IHPA is authorised to develop and introduce new classifications for activity based funding purposes where it is deemed appropriate.

IHPA has completed development of Version 9 of the Australian Refined Diagnosis Related Groups (AR-DRG) classification system which will be used for pricing admitted acute patients from 2018-19. IHPA has commenced development of ICD-10-AM / ACHI / ACS Eleventh edition and AR-DRG Version 10 for completion in late 2018 and to price admitted acute patients from 2020-21.

IHPA has refined the Tier 2 Non-Admitted Services classification and counting rules to accommodate the counting, costing and classifying of multidisciplinary case conferences where the patient is not present. This includes the creation of two Tier 2 non-admitted classes, a new

data item which identifies the non-admitted service type, and an exception rule to the definition of a non-admitted service event to allow for the reporting of the activity.

The IHPA Three Year Data Plan for 2016-17 to 2018-19 advised that emergency care would be classified using a new Australian Emergency Care Classification in future years. The new classification is expected to be completed in early 2018 and it will be used to price emergency department care from NEP19. IHPA has also completed the Emergency Department ICD-10-AM Principal Diagnosis Short List to improve the consistency of diagnosis reporting and underpin the new classification. The list will be included for national data collection from 2018-19. The reporting of Principal and Additional Diagnosis will only be reported using ICD-10-AM Tenth Edition in the existing emergency data collection from 2018-19 to improve consistency.

IHPA is also developing a mapping tool between the ICD-10-AM and SNOMED CT-AU classifications to improve consistency in the reporting of a patient's principal diagnosis and improve the usefulness of the data. The tool is expected to support the introduction of the new emergency care classification which is intended to have a larger role for principal diagnosis in classifying patients. The project will be completed by the end of 2017 for use from 2018-19.

The IHPA Three Year Data Plan for 2016-17 to 2018-19 advised that mental health services would be classified using the Australian Mental Health Care Classification (AMHCC) from 1 July 2016 on a best endeavours basis and foreshadowed an intention its use for pricing from 1 July 2017. Pricing mental health services using the AMHCC has been deferred until such time as sufficient cost and activity data is available.

IHPA is also continuing to develop the Australian Teaching and Training Classification which is intended to be implemented for pricing purposes from 2019-20.

6.2. Data specifications

This section provides an overview of the NMDS and NBEDS that IHPA will use from 1 July 2018. It is divided into two sections, one each for activity data and cost data.

6.2.1. Activity data

IHPA has developed a limited number of data set specifications for use under the activity based funding framework. An overview of the data specifications that will be used to collect activity data is depicted in **Table 3**.

Table 3: Data specifications to be used in the activity based funding framework

Service category	Data Set Specification	Start date
Admitted acute	Admitted Patient Care NMDS 2018-19 (APC NMDS)	1 July 2018
Non-admitted Services (Aggregate data)	Non-Admitted Patient Care Hospital Aggregate NMDS 2018-19 (NAPC Aggregate NMDS) – for hospital services Non-Admitted Patient Care Local Hospital Network Aggregate NBEDS 2018-19 (NAPC Aggregate NBEDS) – for Local Hospital Network services	1 July 2018
Non-admitted Services (Patient-level data)	Non-Admitted Patient NBEDS 2018-19 (NAP NBEDS)	1 July 2018
Emergency (Category 3B & above)	Non-Admitted Patient Emergency Department Care NMDS 2018-19 (NAPEDC NMDS)	1 July 2018

Service category	Data Set Specification	Start date
Emergency (Category 3A & below)	Activity based funding: Emergency service care NBEDS 2018-19 (ABF ESC NBEDS)	1 July 2018
Admitted Subacute & Non-acute	Admitted Subacute and Non-Acute Hospital Care NBEDS 2018-19 (ASNHC NBEDS)	1 July 2018
Mental health	Activity based funding: Mental health care NBEDS 2018-19 (ABF MHC NBEDS)	1 July 2018
Teaching, Training & Research	Hospital teaching, training and research activities NBEDS 2018-9 (HTTRA NBEDS)	1 July 2018

Jurisdictions are required to submit non-admitted activity at the patient level wherever possible. IHPA uses patient level data to determine the non-admitted price weights in the NEP Determination. Aggregate non-admitted data is also reported by jurisdictions to ensure that all non-admitted service delivery is captured. IHPA considers the move towards patient level data as a crucial step in improving data reliability and supporting the development of a new patient-centred non-admitted care classification. IHPA therefore intends to phase out the collection of aggregate non-admitted data in 2019-20 as the reporting of patient level data improves. IHPA notes that as of June 2017, all jurisdictions supply patient non-admitted level data, with this data used for payment reconciliation in four out of eight jurisdictions.

6.2.2. Cost data

Working with jurisdictions and other stakeholders, IHPA developed Version 3.1 of the Australian Hospital Patient Costing Standards in 2014. IHPA will release Version 4 of the Standards in early 2018 for use in future rounds of the National Hospital Cost Data Collection. It is intended that the Standards and the accompanying educational materials will result in greater consistency and improve comparability for future rounds of the collection. IHPA will make an assessment of the magnitude of system changes required for Version 4 once they are finalised. This will inform the final implementation timeline.

6.2.3. Process for updating data set specifications

Data specifications are updated from time to time to ensure that they continue to capture the data that is relevant to a particular service category for activity based funding purposes. Wherever possible, IHPA utilises established national data sets and governance structures. However, the final responsibility for making the change remains with IHPA. Changes can vary in complexity, with corresponding implications for the time required to make the change.

6.3. Public Hospital Establishments NMDS

The Australian Institute of Health and Welfare's National Public Hospital Establishments Database, specified by the Local Hospital Networks / Public Hospital Establishments NMDS, is one of the primary data sources available to IHPA to determine the NEC for block funded services. As the data collection predated the introduction of activity based funding nationally, IHPA commissioned the Institute in 2013 to redevelop the data collection to allow for the clearer reporting of in-scope expenditure by care stream. This work was completed and is reflected in the 2014-15 National Public Hospital Establishments Database.

6.4. Commonwealth pharmaceutical program payments

The National Health Reform Agreement requires IHPA to remove costs associated with programs that the Commonwealth funds through other programs, including pharmaceutical program payments. IHPA identifies these payments by using patient-level Commonwealth pharmaceutical program payments data which is provided by the Department of Health for in-scope public hospital services. IHPA uses de-identified Medicare PIN and associated information ('Submission B' data file) from the Administrator to undertake episode-level matching between the National Hospital Cost Data Collection and pharmaceutical program payment data as provided for by Clause B94 of the National Health Reform Agreement.

6.5. Hospital Casemix Protocol collection

The collection of private patient medical expenses is problematic in the National Hospital Cost Data Collection due to the use of Special Purpose Funds to collect associated revenue and reimburse medical practitioners. This can lead to an under-attribution of medical costs across all patients as costs associated with medical practitioners are applied equally across public and private patients. IHPA uses the Hospital Casemix Protocol collection which is provided by the Commonwealth Department of Health to determine a correction factor for this.

The National Health Reform Agreement requires that IHPA set the price for admitted private patients in public hospitals accounting for payments made by other parties. IHPA also uses Hospital Casemix Protocol data to identify actual payments made by insurers and the Medicare Benefits Schedule.

6.6. Pricing for Safety and Quality

First Ministers at the 1 April 2016 COAG meeting signed a Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding which commits that the Parties, in conjunction with IHPA and the Australian Commission on Safety and Quality in Health Care, will develop "a comprehensive, risk adjusted model to integrate quality and safety into hospital pricing and funding". The three measures of safety and quality which were identified in the Agreement were sentinel events, preventable hospital acquired complications and avoidable hospital readmissions.

The Commonwealth Minister for Health gave IHPA a Direction on 16 February 2017 which sets out the pricing and funding approaches for safety and quality, as well as the additional work which IHPA is to undertake to support these approaches.

These new pricing and funding approaches for safety and quality were formalised in the Addendum to the National Health Reform Agreement which was signed by First Ministers in June 2017.

From 1 July 2017, an episode of care (across all care streams) where a sentinel event occurs will not be funded in its entirety. This funding approach will use the national core set of eight sentinel events agreed to by Australian Health Ministers in 2002.

As sentinel events are not currently reported in national data sets, states and territories will be required to submit an additional data file identifying those episodes in which a sentinel event occurred. The Australian Commission on Safety and Quality in Health Care is developing a data set specification for nationally consistent reporting of sentinel events in future years.

The Addendum to the National Health Reform Agreement also specified requirements in relation to preventable hospital acquired complications and avoidable hospital readmissions. Implementation of these does not require states and territories to submit additional data to IHPA at this stage.

6.7. Inclusion of unique patient identifiers in national data sets

In 2016 and 2017, IHPA and an advisory group which included jurisdictions and other key stakeholders investigated whether bundled pricing for maternity care was feasible at the national level. The absence of unique patient identifiers in national data collections was identified as the principal barrier to implementation as service utilisation by patients cannot be reliably identified across settings of care. The advisory group noted that linked patient data could provide broad benefits to the health system, including public health research, allowing hospitals to review care pathways and develop value-based healthcare proposals. IHPA notes that Clause I54 of the Addendum to the National Health Reform Agreement states that new bilateral agreements on coordinated care reforms may include arrangements for sharing of patient information between Australian governments to support a better understanding of patients and service utilisation.

The Individual Healthcare Identifier has been identified as an existing person identifier which could be included in national data sets. All Australians with a Medicare number have an Individual Healthcare Identifier which underpins the My Health Record program which is administered by the Australian Digital Health Agency. This will provide a rich dataset across settings of hospital and primary care in future years.

Given the benefits to the health system and stakeholder support, IHPA proposes to include the Individual Healthcare Identifier in its national data sets in future years, subject to further consultation on appropriate lead time with jurisdictions, national data committees and the Commonwealth. IHPA will work with the Australian Digital Health Agency and other national bodies on this proposal. The Individual Healthcare Identifier will be added as an additional data item in each of the relevant data set specifications.

6.8. Ad-hoc data requests

IHPA also undertakes ad-hoc data collection and research to inform modelling, reconciliation and verification. All requests for additional data will be considered by IHPA on a case by case basis, in consultation with jurisdictions through the Jurisdictional Advisory Committee and Technical Advisory Committee.

7. Data submission and collection schedule

This section outlines the data submission process and the detailed collection schedule that IHPA considers essential to obtaining activity and cost data required to determine the NEP and NEC. From 2017-18 submissions will be made through IHPA's new Secured Data Management System (SDMS).

7.1. Data submission process

The data submission process is illustrated in **Figure 2** and described in **Table 4**.

Figure 1: Data submission process map

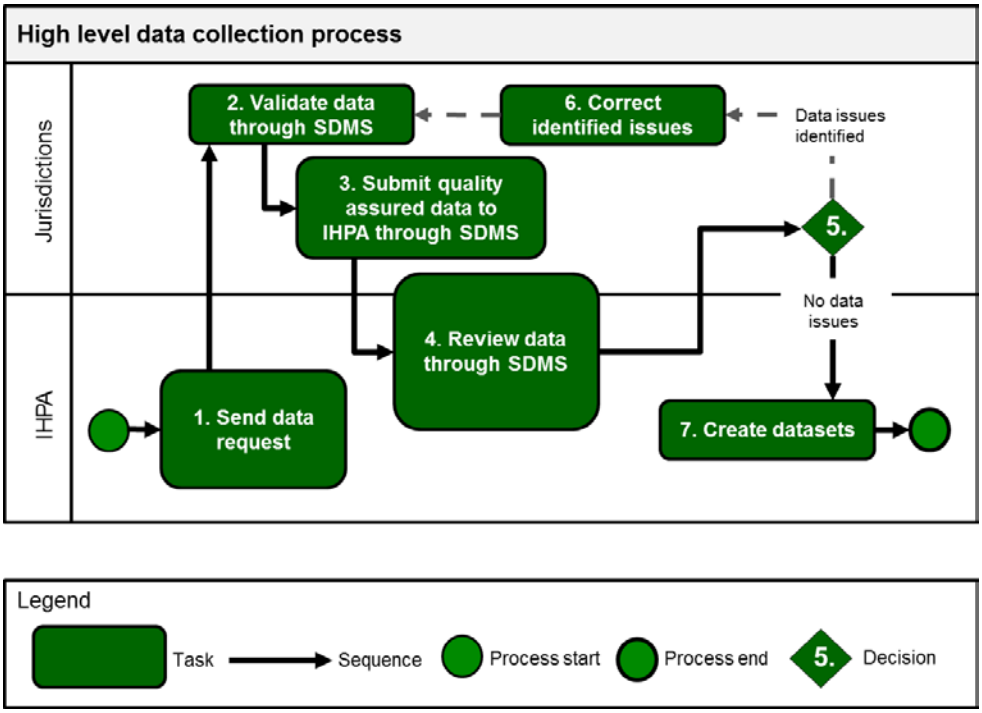


Table 4: Data submission process description

No.	Activity	Description
1.	Send data request	IHPA will send an email to each jurisdiction with the following instructions: • the method of delivery; • contact person at IHPA; • a data request, which will include a spread sheet (or similar) that provides the format in which the data is to be supplied; • the validation rules that IHPA will apply to ensure that the submitted data meets the specified requirements; • summary of changes from previous versions of the data specification; and • the due date for submission.
2.	Validate data	Before submission of data, jurisdictions are able to validate data multiple times through IHPA's online SDMS. The data will be validated in accordance with the instructions specified in the data request specification. IHPA will ensure that the system is ready for the data validation four weeks before the submission due date.
3.	Submit quality assured data to IHPA	Once jurisdictions are satisfied with the data quality based on the feedback generated by the online validation feature, data submitters can formally submit the data within the SDMS. A confirmation email will be issued by the system to acknowledge the submission.
4.	Review data	Based on the validation result, any data anomalies or errors identified by IHPA will be discussed with the relevant jurisdiction to determine how they will be addressed. As part of this process, jurisdictions will have an opportunity to identify the circumstances associated with any anomalies or errors identified. This will in turn assist IHPA to improve the data submission process over time.
5.	Decision	If there are no errors or anomalies, the final datasets are created. Otherwise, jurisdictions will be asked to make appropriate corrections and re-submit the data to IHPA. Where the issues cannot be corrected, jurisdictions will be asked to advise IHPA that the data is to be used with known issues.
6.	Correct identified issues	Jurisdictions correct any errors or anomalies identified by IHPA and resubmit their data.
7.	Create datasets	After all issues are resolved, the final datasets are created, and made available to agencies under Clause B97(f) of the National Health Reform Agreement.

IHPA proposes that data is submitted on a year to date basis that will allow for the previous data to be corrected in the event that coding reviews and the like have occurred in the intervening period. That is, the end of year submission would be considered final, allowing for any missing or erroneous data in the third quarter submission to be corrected.

7.2. Activity data collection

To meet IHPA's commitments to provide a draft NEP Determination to health ministers by 30 November each year IHPA collects data from jurisdictions according to the following principles:

- data requests are sent to jurisdictions in March of each year, three months prior to the start of the next financial year;
- activity data for aggregate level collections are required to be submitted to IHPA each quarter in a submission that contains data for each of the quarters elapsed in that year (e.g. the third quarter data submission would include a resubmission of the first and second quarter data sets), noting that IHPA intends to phase out aggregate level reporting in 2019-20;
- activity data for all other service categories is required to be submitted to IHPA quarterly on a 'year to date' basis (i.e. the third quarter data submissions will include all activity data for that financial year);
- activity data for teaching, training and research is required to be submitted to IHPA on an annual basis;
- due to 'coding lag' (i.e. elapsed time between the date of service provision and the diagnosis details being coded), June quarter admitted acute activity data can be revised when the September quarter is submitted;
- data for each quarter is due by the last working day of the following quarter (e.g. data for the September 2018 quarter period is due on 31 December 2018);
- IHPA will validate the submitted data and provide feedback to jurisdictions no later than two weeks after submission; and
- Jurisdictions have two weeks to correct any identified issues and resubmit the data to IHPA.

The timelines for the submission of activity data for all service categories between 2018-19 and 2020-21 are shown in **Table 5**.

Table 5: Activity data submission timeline

Financial year	Data reporting period	NBEDS published	Data request sent	Submission date	IHPA review date	Resubmission date (if required)
2018-19	Sep Quarter	31-Dec-17	16-Mar-18	21-Dec-18	14-Jan-19	28-Jan-19
	Dec Quarter	31-Dec-17	16-Mar-18	29-Mar-19	15-Apr-19	29-Apr-19
	Mar Quarter	31-Dec-17	16-Mar-18	28-Jun-19	15-Jul-19	29-Jul-19
	Jun Quarter	31-Dec-17	16-Mar-18	30-Sep-19	14-Oct-19	28-Oct-19
2019-20	Sep Quarter	31-Dec-18	15-Mar-19	23-Dec-19	13-Jan-20	27-Jan-20
	Dec Quarter	31-Dec-18	15-Mar-19	31-Mar-20	14-Apr-20	28-Apr-20
	Mar Quarter	31-Dec-18	15-Mar-19	30-Jun-20	14-Jul-20	28-Jul-20
	Jun Quarter	31-Dec-18	15-Mar-19	30-Sep-20	14-Oct-20	28-Oct-20
2020-21	Sep Quarter	31-Dec-19	20-Mar-20	21-Dec-20	11-Jan-21	25-Jan-21
	Dec Quarter	31-Dec-19	20-Mar-20	31-Mar-21	14-Apr-21	28-Apr-21
	Mar Quarter	31-Dec-19	20-Mar-20	30-Jun-21	14-Jul-21	28-Jul-21
	Jun Quarter	31-Dec-19	20-Mar-20	30-Sep-21	14-Oct-21	28-Oct-21

7.3. National Hospital Cost Data Collection

In calculating the NEP each year, IHPA uses NHCDC cost data collected three years earlier. For example, the 2019-20 NEP will be calculated using cost data from the Round 21 (2016-17) NHCDC. The timeframes for the collection of cost data are shown in **Table 6**.

Table 6: National Hospital Cost Data Collection data submission timeline

NHCDC Round	Data reporting period	Data request sent	Submission date	Quality Assurance Reports complete date	Final dataset created
22	2017-18	31 Jul 18	28 Feb 19	30 April 19	31 May 19
23	2018-19	31 Jul 19	28 Feb 20	30 April 20	29 May 20
24	2019-20	31 Jul 20	1 Mar 21	30 April 21	31 May 21

7.4. Reporting jurisdictions compliance with data requirements

Jurisdictions are required to submit activity data to IHPA on a quarterly basis with the exception of teaching, training and research data which is submitted on an annual basis. NHCDC data is also submitted annually. As per Clause B102 of the National Health Reform Agreement, IHPA must report on jurisdictions' compliance with these requirements.

Jurisdictions will be judged to have complied with IHPA's data requirements if they:

- have provided the data required as specified in the data request; and
- have provided the data in the timeframes requested.

If a jurisdiction does not meet both of these requirements for any given quarterly period, they will be regarded as being non-compliant. This information will be published on the IHPA website on a quarterly basis.

However, it is also important to note that where a jurisdiction is judged to be non-compliant, it will have an opportunity to communicate the circumstances to IHPA. In doing this, IHPA and the jurisdictions will work together to improve the data submission process over time.

From 1 July 2017, Clause I40 of the Addendum to the National Health Reform Agreement requires that jurisdictions provide IHPA with a Statement of Assurance from a senior health department official on the completeness and accuracy of its data submissions. IHPA will provide these Statements of Assurance to the Administrator for reconciliation purposes.

The provision of the Statement of Assurance will not prevent a jurisdiction from resubmitting data to improve previous submissions, subject to the timing requirement in Clause I28. Each approved submission or resubmission of data will be accompanied by a Statement of Assurance.

IHPA and the Administrator of the National Health Funding Pool

For this rolling update, IHPA has worked collaboratively with the Administrator of the National Health Funding Pool in revising the IHPA Three Year Data Plan as part of IHPA's commitment to the principle of data rationalisation expressed in the National Health Reform Agreement, particularly the desire to implement the 'single provision, multiple use' concept.

IHPA and the Administrator utilise cost and expenditure data through the same key collections – the National Hospital Cost Data Collection, the National Public Hospitals Establishments Database and the Public Hospitals Establishments Data Set Specification.

Table A1 details the activity data collections utilised by these two national agencies.

Table A1: Comparative activity data collections utilised by IHPA and the Administrator

	National Agencies			Year of data collection					
	IHPA		NHFP Administrator	2018-19		2019-20		2020-21	
Service category	ABF	Block-funded		Data spec	Classification	Data spec	Classification	Data spec	Classification
Admitted acute	✓	✓	✓	APC NMDS 2018-19	ICD-10-AM Tenth ed. & AR-DRG v9.0	APC NMDS 2019-20	ICD-10-AM Eleventh ed. & AR-DRG v9.0	APC NMDS 2020-21	ICD-10-AM Eleventh ed. & AR-DRG v10.0
Emergency (ED Levels 3B – 6)	✓	✓	✓	NAPEDC NMDS 2018-19	URG v1.4	NAPEDC NMDS 2019-20	Australian Emergency Care Classification	NAPEDC NMDS 2020-21	Australian Emergency Care Classification

	National Agencies			Year of data collection					
	IHPA		NHFP Administrator	2018-19		2019-20		2020-21	
Service category	ABF	Block-funded		Data spec	Classification	Data spec	Classification	Data spec	Classification
Emergency (ED Levels 1 – 3A)	✓	✓	✓	ABF ESC NBEDS 2018-19	UDG v1.3	ABF ESC NBEDS 2019-20	Australian Emergency Care Classification	ABF ESC NBEDS 2020-21	Australian Emergency Care Classification
Non-admitted (Aggregate data)	✓	✓	✓	NAPC Aggregate NMDS and NBEDS 2018-19	Tier 2 Non-Admitted Services v5.0	N/A	Tier 2 Non-Admitted Services v5.0	N/A	N/A
Non-admitted (Patient-level data)	✓		✓	NAP NBEDS 2018-19	Tier 2 Non-Admitted Services v5.0	NAP NMDS 2019-20	Tier 2 Non-Admitted Services v5.0	NAP NMDS 2020-21	Australian Non-Admitted Care Classification
Mental health	✓	✓	✓	ABF MHC NBEDS 2018-19	Australian Mental Health Care Classification v1.0	ABF MHC NBEDS 2019-20	Australian Mental Health Care Classification v2.0	ABF MHC NBEDS 2020-21	Australian Mental Health Care Classification v2.0
Admitted subacute & non-acute	✓	✓	✓	ASNHC NBEDS 2018-19	AN-SNAP v4.0	ASNHC NBEDS 2019-20	AN-SNAP v5.0	ASNHC NBEDS 2020-21	AN-SNAP v5.0
Teaching, training & research	✓			HTTRA NBEDS 2018-9	N/A	HTTRA NBEDS 2019-20	Australian Teaching and Training Classification	HTTRA NBEDS 2020-21	Australian Teaching and Training Classification

Table A2 details other data collections utilised by these two national agencies.

Table A2: Other data collections utilised by IHPA and the Administrator

	National Agencies			Year of data collection		
	IHPA		NHFP Administrator	2018-19	2019-20	2020-21
Category	**ABF**	**Block-funded**		**Data collection**	**Data collection**	**Data collection**
In-scope pharmaceutical program payments	✓		✓	Commonwealth in-scope patient-level pharmaceutical program payments data	Commonwealth in-scope patient-level pharmaceutical program payments data	Commonwealth in-scope patient-level pharmaceutical program payments data
De-identified Medicare number and funding source information	✓	✓	✓	'Submission B' data file provided by jurisdictions to the Department of Human Services	'Submission B' data file provided by jurisdictions to the Department of Human Services	'Submission B' data file provided by jurisdictions to the Department of Human Services
Sentinel events	✓	✓	✓	Data file which identifies episodes with sentinel events to be provided by jurisdictions	Data file which identifies episodes with sentinel events to be provided by jurisdictions	Data file which identifies episodes with sentinel events to be provided by jurisdictions

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