IHACPA

Pricing Framework for Australian Public Hospital Services 2024–25

December 2023

Independent Health and Aged Care Pricing Authority

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

Table of Contents

Abbreviations

Abbreviation	Full term
ABF	Activity based funding
ABF MHC NBEDS	Activity based funding: Mental health care national best endeavours data set
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AHR	Avoidable hospital readmission
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
COVID-19	Coronavirus disease 2019
DRG	Diagnosis Related Group
eMR	Electronic medical record
HAC	Hospital acquired complication
HMM	Health Ministers' Meetings
HoNOS	Health of the Nation Outcome Scales
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11	International Classification of Diseases 11th Revision
ICU	Intensive care unit
IHACPA	Independent Health and Aged Care Pricing Authority
LHN	Local hospital network
MHPoC	Mental Health Phase of Care
NBEDS	National Best Endeavours Data Set
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NPA	National Partnership on COVID-19 Response Agreement
NWAU	National weighted activity unit
The Addendum	Addendum to the National Health Reform Agreement 2020–25
The Commission	Australian Commission on Safety and Quality in Health Care
UDG	Urgency Disposition Group

1

Introduction

1. Introduction

1.1 About IHACPA

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

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

1.2 About this Pricing Framework

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

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

IHACPA released the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper) for a 30-day public consultation period on 14 June 2023. The Consultation Paper sets out the major issues for the development and refinement of the national ABF system, including policy decisions, classification systems and data collection. The Pricing Framework benefits immensely from the contributions of jurisdictions, academic institutions, and other stakeholders to the Consultation Paper.

This year, IHACPA received 27 submissions to the Consultation Paper, including responses from the majority of jurisdictions. These submissions are available on the IHACPA website. A Consultation Report that includes commentary on how IHACPA reached its decisions for 2024–25 is also available.

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

Stakeholders provided valuable feedback regarding IHACPA's proposals to use the Australian Subacute and Non-Acute Patient Care Classification Version 5.0 to price subacute and non-acute care, and to transition community mental health care from block funding to activity based funding using the Australian Mental Health Care Classification Version 1.0 for the NEP Determination 2024–25 (NEP24).

Stakeholders also provided extensive feedback on a range of areas related to setting the NEP. This includes the various impacts arising from the coronavirus disease 2019 (COVID-19) pandemic response in the 2021–22 financial year, considerations for how these should be accounted for in the national pricing model, and evidence to support the continued application of the COVID-19 treatment adjustment for NEP24. Stakeholders also provided valuable feedback on alternative measures to use in IHACPA's review of the NEP and NEC indexation methodologies, and the review of the eligibility criteria for specified intensive care units (ICU) for use in the ICU adjustment and specialised children's hospitals for use in the paediatric adjustment.

IHACPA will continue to work with jurisdictions and stakeholders to progress investigations in these areas and determine whether refinements to the national pricing model are required for NEP24, in line with the Pricing Guidelines outlined in Chapter 2.

In 2023, the Australian Government undertook the Mid-Term Review of the Addendum to the NHRA 2020–25, due for completion at the end of 2023. IHACPA will consider the outcomes of the review and any recommendations that impact the delivery of the NEP and NEC Determinations for 2024–25, in its application of the Pricing Framework, and in consultation with jurisdictions and IHACPA's advisory committees.

2

Pricing Guidelines

2. Pricing Guidelines

2.1 The Pricing Guidelines

The decisions made by the Independent Health and Aged Care Pricing Authority (IHACPA) in pricing in-scope public hospital services are evidence-based and use the latest activity and cost data supplied to IHACPA by the states and territories. In making these decisions, IHACPA balances a range of policy objectives provided by the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

The Pricing Guidelines outlined in Figure 1, signal IHACPA's commitment to transparency and accountability as it undertakes its work and comprise the overarching, process and system design guidelines within which IHACPA makes its policy decisions.

IHACPA reviewed the Pricing Guidelines prior to the release of the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper) and made minor amendments to the 'Evidence-based' Process Guideline, based on stakeholder feedback to the National Efficient Price Determination 2023–24.

In response to the Consultation Paper, the Centre for Aboriginal Economic Policy Research recommended inclusion of a guideline to pursue equity of access and outcomes for Aboriginal and Torres Strait Islander peoples.

Some stakeholders also recommended refinements to the 'Fairness', 'Evidence-based" and 'Transparency' guidelines to account for differences in operating costs and models in rural areas and ensure transparency of hospital funding decisions processes. Further detail on this feedback is provided in the Consultation Report.

IHACPA's decision

IHACPA has updated the 'Timely-quality care' Overarching Guideline to include the following bolded text 'Funding should support timely **and equitable** access to **high** quality health services **and reduce disadvantage for all Australians, especially for Aboriginal and Torres Strait Islander peoples**'. This approach aligns with the residential aged care pricing principles in the Pricing Framework for Residential Aged Care Services, the intent of the principles for reform and IHACPA's remit, outlined in the Addendum.

IHACPA considers the existing Fairness', 'Evidence-based" and 'Transparency' guidelines sufficiently account for the issues raised.

Next steps and future work

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

Figure 1: The Pricing Guidelines

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

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

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

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

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

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

3

Classifications used to describe and price public hospital services

3. Classifications used to describe and price public hospital services

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

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

The Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for reviewing and updating existing classifications, as well as introducing new classifications.

There are currently six public hospital service categories in Australia which have classifications in use or in development:

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

3.1 Admitted acute care

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

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

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

The AR-DRG and ICD-10-AM/ACHI/ACS classification systems have a three-year development cycle, to balance currency against the need for stability and to reduce the burden of implementation for stakeholders.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper), stakeholders proposed a range of areas for refinement as part of the work program for the admitted care classifications development cycle including a review of care types and models of care such as virtual care. Further information is available in the Consultation Report.

IHACPA's decision

For the NEP Determination 2024–25 (NEP24), IHACPA will continue to use AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition to price admitted acute patient services.

Next steps and future work

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

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

3.2 Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services.

3.2.1 AN-SNAP Version 5.0

AN-SNAP Version 5.0 was released in December 2021 and has been developed through extensive statistical analysis and consultation with jurisdictions, clinicians and other experts. Version 5.0 introduces a new variable, derived from diagnosis codes, to recognise the impact of frailty related comorbidities as cost drivers for geriatric evaluation and management and non-acute care – the Frailty Related Index of Comorbidities (FRIC). This research-based approach uses comorbidities commonly found in frail people as a proxy to better predict costs associated with frailty.

FRIC was developed through the adaptation of the Hospital Frailty Risk Score which included mapping ICD-10 codes to ICD-10-AM and refining the list of codes included to ensure the index was fit-for-purpose as part of an ABF classification in Australia. Further information about the development of the FRIC is available in the *Development of AN-SNAP Version 5.0 – Final Report*.

IHACPA shadow priced admitted subacute and non-acute services using AN-SNAP Version 5.0 for the *NEP Determination 2022–23* (NEP22) and the *NEP Determination 2023–24* (NEP23).

In response to the Consultation Paper, stakeholders did not indicate any significant barriers to using AN-SNAP Version 5.0 to price subacute and non-acute patient services for NEP24. However, some jurisdictions did note the potential for changes in clinical coding related to identifying frailty complexity through the FRIC and limitations in extracting relevant assessment data from source systems. Stakeholders also proposed refinements to AN-SNAP to better account for patient complexity and higher costs of care. Further information is available in the Consultation Report.

IHACPA's decision

For NEP24, IHACPA intends to progress to pricing admitted subacute and non-acute patient services using AN-SNAP Version 5.0, following two years of shadow pricing, as required by the Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

IHACPA will work with its advisory committees and working groups to monitor any coded data changes that may occur following pricing of AN-SNAP Version 5.0.

Next steps and future work

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

In addition, codes included in FRIC will be subject to review over time through ongoing classification refinement programs to ensure it remains fit for purpose.

IHACPA will consider the proposed refinements, such as further investigations into patient complexity, as part of the development of the work program for the next iteration of AN-SNAP.

3.3 Emergency care

IHACPA used the Australian Emergency Care Classification (AECC) Version 1.0 to price ED activities and Urgency Disposition Groups (UDG) Version 1.3 to price emergency services for NEP23.

IHACPA's decision

IHACPA will continue to use AECC Version 1.0 to price ED activities and UDG Version 1.3 to price emergency services for NEP24.

Next steps and future work

IHACPA notes that many of the proposed refinement areas are part of the work program for the development of future AECC versions. IHACPA will work with its advisory committees and working groups to assess and incorporate these recommendations into the work program for future iterations of the AECC and Emergency Care ICD-10-AM Principal Diagnosis Short List.

3.4 Non-admitted care

3.4.1 Tier 2 Non-Admitted Services Classification

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

IHACPA undertakes an ongoing program of classification refinement to ensure the relevancy of Tier 2 for ABF purposes, while a new non-admitted care classification is developed.

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

In response to the Consultation Paper, stakeholders proposed a range of areas for consideration in the refinement of Tier 2 for 2024–25 including improvements in data collection to capture patient complexity, virtual and innovative models of care, in-reach community services in inpatient settings and other specific clinical areas. Further information is available in the Consultation Report.

IHACPA's decision

For NEP24, IHACPA will use the Tier 2 Non-Admitted Services Classification Version 9.0 to price non-admitted services.

Next steps and future work

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

3.4.2 A new non-admitted care classification

IHACPA is developing a new non-admitted care classification to better describe patient characteristics and care complexity, and more accurately reflect the costs of non-admitted services. The new non-admitted care classification will also better account for changes in care delivery and models of care as services transition to the non-admitted setting.

In 2023, IHACPA commenced the Australian Non-Admitted Patient Classification Project (ANAPP), a multi-staged project with stage gates at the completion of each stage. The ANAPP stages are as follows:

- Stage One: Investigation and consultation
- Stage Two: Proof-of-concept
- Stage Three: Data collection and final data sets
- Stage Four: Analysis and classification development.

The ANAPP proposes to take a novel approach to collecting activity and cost data to underpin the development of a new classification and aims to leverage health information available in jurisdictional electronic medical record (eMR) systems and other relevant information systems and applicable cost data to develop a comprehensive activity and cost data set. Rigorous statistical analysis will then be conducted to develop a new non-admitted patient classification.

This approach enables the classification development process to minimise the administrative burden on states and territories and the impact on clinical service delivery associated with a traditional costing study.

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

3.5 Mental health care

3.5.1 Admitted mental health care

For NEP23, IHACPA priced admitted mental health care using AMHCC Version 1.0.

As part of the work program for the development of AMHCC Version 1.1, IHACPA has made refinements to update the classification using the most recent activity and cost data.

In response to the Consultation Paper, stakeholders proposed a range of areas for refinement in future iterations of the AMHCC including standardisation and alignment between AMHCC and Australian Mental Health Outcomes and Classification Network data requirements and improvement in capturing patient complexity. Further information is available in the Consultation Report.

IHACPA's decision

For NEP24, IHACPA will continue using AMHCC Version 1.0 to price admitted mental health care services.

Next steps and future work

IHACPA notes a number of the proposed refinement areas are addressed in AMHCC Version 1.1, due to be released at the end of 2023. IHACPA will continue to work with its advisory committees to assess the feasibility of incorporating other proposed refinements as part of the AMHCC classification development work program for AMHCC Version 2.0. IHACPA intends to commence the work program for the development of AMHCC Version 2.0 in 2024.

3.5.2 Community mental health care

Clause A3 of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) and the Pricing Guidelines outline that Commonwealth funding is to be provided on the basis of ABF except where it is neither practicable nor appropriate.

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

IHACPA shadow priced community mental health care services using AMHCC Version 1.0 for three years as part of the NEP Determination 2021–22, NEP22 and NEP23. This has enabled time to prepare for implementation of ABF.

In response to the Consultation Paper, jurisdictions noted concerns regarding the quality of activity and cost data contributing to the potential funding difference between block funding and ABF estimates, and limitations associated with the classification such as circumstances where consumers refuse to disclose their name or date of birth or are treated by multiple teams.

Throughout 2023, IHACPA has worked extensively with jurisdictions to facilitate jurisdictional readiness for the transition within its remit. IHACPA has also developed nationally consistent education materials to assist clinicians in understanding of the AMHCC and assessment and assignment of the Mental Health Phase of Care, released in December 2022.

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

IHACPA's decision

For NEP24, IHACPA intends to progress to pricing community mental health care services using AMHCC Version 1.0, following three years of shadow pricing.

IHACPA will continue to engage with all jurisdictions, the NHFB and the Administrator to support the transition to ABF and to mitigate any potential financial risks arising from the transition, within its remit.

IHACPA will continue to determine block funding amounts for residential mental health services and standalone hospitals providing specialist mental health services for which ABF is not considered practicable, through the NEC Determination 2024–25 (NEC24).

3.6 Teaching and training

Teaching and training activities represent an important aspect of the public hospital system alongside the provision of care to patients. However, the components required for ABF are not currently available to enable these activities to be priced. As a result, these activities are currently block funded, except where teaching and training is delivered in conjunction with patient care (embedded teaching and training), such as ward rounds. These costs are reported as part of routine care and the costs are reflected in the ABF price.

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

IHACPA's decision

For NEP24, IHACPA will continue to determine block funding amounts for teaching, training and research activity based on advice from states and territories and will continue to work with stakeholders to improve the volume and quality of activity and cost data being reported.

4

Setting the national efficient price

4. Setting the national efficient price

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

4.1 Impact of COVID-19

4.1.1 Impact of COVID-19 on NEP24

The data underpinning an NEP Determination has a three-year time lag. The development of the NEP Determination 2024–25 (NEP24) will use 2021–22 costed activity data, which also represents the second full financial year of activity that has been impacted by the coronavirus disease 2019 (COVID-19) pandemic response which resulted in significant changes to models of care and service delivery in Australian public hospitals.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper), stakeholders noted the following impacts of the COVID-19 pandemic response and that these varied across states and territories:

- changes to models of care and demand such as increased patient complexity due to delayed or deferred care including elective surgeries
- changes to in-scope activity, volume and casemix such as reductions in hospital presentations due to changes in models of care
- ongoing costs associated with infection prevention and control
- workforce-related capacity constraints and costs and inflationary pressures.

Further information on the feedback received is available in the Consultation Report.

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

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

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

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

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

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

IHACPA's decision

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

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

4.1.2 Review of the COVID-19 treatment adjustment

In response to the observed clinical impacts of COVID-19 on cost and activity data, IHACPA introduced a COVID-19 treatment adjustment in the *NEP Determination 2023–24* (NEP23). This adjustment aimed to recognise and account for legitimate and unavoidable increased costs associated with COVID-19 patients within certain Australian Refined Diagnosis Related Groups (AR-DRGs) compared to patients who did not have COVID-19.

For NEP23, IHACPA applied the COVID-19 treatment adjustment to 11 selected AR-DRGs. The criteria to select the AR-DRGs for the adjustment was as follows:

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

In response to the Consultation Paper, stakeholders supported retention of the COVID-19 treatment adjustment and noted the high volume of COVID-19 cases in 2021–22, and requested IHACPA consider inclusion of additional AR-DRGs in the adjustment, and whether the impact of long COVID requires an adjustment.

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

IHACPA's decision

To reflect the most recent evidence, IHACPA will continue to implement the COVID-19 treatment adjustment for a more limited set of AR-DRGS for NEP24 using an updated flagging methodology to identify COVID-19 treatment episodes more accurately.

Next steps and future work

IHACPA will review the need for the COVID-19 treatment adjustment to account for the impact of COVID-19 for future NEP Determinations.

4.1.3 Review of the COVID-19 Response – Costing and Pricing Guidelines

In 2020, IHACPA published the *COVID-19 Response – Costing and Pricing Guidelines*, to specify IHACPA's process for the costing and pricing of activity for the duration of the NPA. The NPA provided financial assistance from the Commonwealth to states and territories for the additional costs incurred by health services in responding to the COVID-19 pandemic.

The *COVID-19 Response – Costing and Pricing Guidelines* includes the following measures that were reflected in the national pricing model:

- for the purpose of COVID-19 activity funded through the NPA, the intensive care unit (ICU) loading will apply to any patient with a COVID-19 diagnosis code and ICU hours reported in the admitted patient care activity data set

- the hospital acquired complications (HAC) adjustment and the avoidable hospital readmissions (AHR) adjustment[1] will not be applied to activity with a COVID-19 diagnosis.

These measures were implemented in the development of the NEP Determinations for 2021–22, 2022–23 and 2023–24. They were designed to be temporary arrangements to address significant uncertainty in the early stages of the pandemic around the clinical management of COVID-19 and its impact on ICU capacity for the duration of the NPA.

In response to the Consultation Paper, some stakeholders supported retention of the temporary ICU, HAC and AHR measures for COVID-19 patients for NEP24 noting the high volume of COVID-19 cases in the 2021–22 financial year. Some stakeholders also noted the need to ensure sufficient funding and staffing levels to provide care and prevent an increase in HACs and infection rates. Further information is available in the Consultation Report.

IHACPA's decision

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

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

Next steps and future work

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

4.2 Adjustments to the national efficient price

Section 131(1)(d) of the *National Health Reform Act 2011* (the NHR Act) allows IHACPA to determine 'loadings' or adjustments to the NEP to reflect legitimate and unavoidable cost variations in the delivery of public hospital services that affect the costs of service delivery such as:

- hospital type and size
- hospital location, including regional and remote status
- patient complexity, including Indigenous status, which is not captured by the classification system.

Development and application of adjustments to the NEP is the method that IHACPA applies to address legitimate and unavoidable cost variations in the delivery of public hospital services. Information about the eligibility criteria for legitimate and unavoidable cost variations and IHACPA's process to assess them is available in the *Assessment of Adjustments to the National Pricing Model Policy.*

A list of all the adjustments IHACPA applies to the national pricing model is available in the *NEP Determination 2023–24* on IHACPA's website.

[1] The avoidable hospital readmissions adjustment was introduced in the *NEP Determination 2021–22* (NEP21). Whilst not explicitly included in the *COVID-19 Response – Costing and Pricing Guidelines*, as part of its introduction in NEP21, the decision was made that the avoidable hospital admissions adjustment would also not be applied to activity with a COVID-19 diagnosis.

4.2.1 Intensive Care Unit adjustment

Since the *NEP Determination 2012–13* (NEP12), IHACPA has applied an ICU adjustment for specified ICUs, listed in Appendix D of the NEP Determination each year.

The ICU adjustment was introduced to address legitimate and unavoidable cost variations associated with treating patients in specified ICUs compared to other admitted patients that were not reflected in patient casemix or characteristics in data collections and could not otherwise be adequately addressed through classification.

Currently, hospitals that consistently report more than 24,000 ICU hours and have more than 20 per cent of those hours reported with the use of mechanical ventilation are generally considered to be eligible for the ICU adjustment.

Stakeholders recommended undertaking a review to consider ICUs other than 'complex ICUs' and noted the following underlying drivers of cost variation for ICUs:

- fixed costs such as costs required to maintain suitable and sufficient staffing and for maintenance of advanced medical equipment
- patient characteristics, severity of illness and complexity or resource intensity of the treatments administered
- hospital characteristics such as geographic location.

Stakeholders noted the shift away from mechanical ventilation in many ICUs and proposed the following alternative or additional measures, which reflect contemporary clinical practice, for use in the eligibility criteria:

- patient acuity scores or other indicators of complexity including use of high-cost interventions
- proportion of patients ventilated either through mechanical ventilation or non-invasive ventilation
- minimum standards for ICUs published by the College of Intensive Care Medicine of Australia and New Zealand.

Further information on the feedback provided is available in the Consultation Report.

IHACPA's decision

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

For NEP24, IHACPA will maintain the existing eligibility criteria for the ICU adjustment.

Next steps and future work

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

4.2.2 Paediatric adjustment and eligibility criteria for specialised children's hospitals

Since NEP12, IHACPA has also applied a paediatric adjustment to reflect the legitimate and unavoidable cost variations associated with treating patients who are 17 years of age or less that are treated in a specialised children's hospital, as specified in Appendix E of the *NEP Determination 2023–24*. Hospitals with a Level 3 ICU or Paediatric ICU that undertake a substantial number of mechanical ventilation procedures on paediatric patients (on average, greater than one patient per week) are deemed as specialised children's hospitals, in consultation with states and territories.

Stakeholders provided examples of the underlying drivers of cost variation between specialised and non-specialised children's hospitals. This included increased costs associated with the specialised workforce required and the virtual care provided by specialist staff to other hospitals, higher volume and costs of equipment resourcing and presence of a paediatric ICU. Stakeholders also recommended broadening the review to consider application of the paediatric adjustment in other settings such as major referral centres for paediatric patients.

Stakeholders proposed alternative methods to account for these costs in the paediatric adjustment such as incorporation of a sliding scale model to increase the loading based on patient age or a tiered loading methodology to better reflect the costs and range of advanced services provided by dedicated paediatric sites.

IHACPA's decision

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

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

Next steps and future work

IHACPA will review the available activity and cost data in consultation with jurisdictions and key stakeholders to investigate the underlying drivers of cost variation between specialised and non-specialised children's hospitals, the materiality of the variation and whether it is unavoidable, and to assess the suitability of the proposed alternatives for inclusion in the eligibility criteria.

The review will also consider whether the variations in costs are best addressed through classification refinement to ensure consistency across all care streams, and alignment with the Pricing Guidelines, noting that many underlying cost drivers identified are based on provider rather than patient characteristics.

4.3 NEP indexation methodology

The data underpinning each NEP Determination has a three-year time lag. As part of the NEP development, IHACPA indexes costs from the latest available data to estimate those in the year of funding. IHACPA uses the five most recent years of available patient costed admitted acute activity data to calculate an indexation rate. In 2023, IHACPA commenced a review of the NEP and national efficient cost (NEC) indexation methodology to ensure it remains fit for purpose.

In response to the Consultation Paper, stakeholders proposed a range of economic indices that they suggested demonstrated input costs increasing at a faster rate than what is reflected in the available historical cost data captured in the National Hospital Cost Data Collection (NHCDC). These included indices managed by the Australian Bureau of Statistics and Reserve Bank of Australia.

Stakeholders also provided examples of cost drivers, which included staffing costs associated with leave liabilities, use of locum staff, and increased utility, commodity and information communication technology costs. Further information is available in the Consultation Report.

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

IHACPA's decision

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

4.4 Harmonising price weights across care settings

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

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

In response to the Consultation Paper, stakeholders supported IHACPA undertaking work to harmonise price weights across care settings.

IHACPA notes that progressing price harmonisation requires further analysis of the stability of the underlying data, the suitability of services for harmonisation and the potential unintended consequences of pursuing price harmonisation. In particular, data linkage challenges and unexplained differences in reported costs across settings have hindered progression of price harmonisation for chemotherapy and dialysis in past years, despite stakeholder support and feedback recommending harmonisation of these services.

In response to the Consultation Paper, stakeholders noted analysis is required to support progression of price harmonisation of chemotherapy and dialysis to understand and account for:

- a price that incentivises the lower cost modality while maintaining standards of care,
- price weights for different modalities that are representative of service costs
- other factors that explain price and cost variance.

Stakeholders also proposed a range of other potential candidates for price weight harmonisation across settings such as surgical procedures with limited clinical practice variations and that do not require ongoing care and the provision of novel, high-cost and off-label medicines prior to listing on the Pharmaceutical Benefits Scheme.

IHACPA's decision

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

Next steps and future work

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

4.5 Unqualified newborns

At present, a newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is considered qualified if the infant meets at least one of the following criteria[2]:

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

A newborn patient day is considered unqualified if the infant does not meet any of the above criteria.

[2] The newborn qualification status outlined by the Australian Institute of Health and Welfare notes that the criteria for qualification is only applied when the baby is nine days old or less. Available at: https://meteor.aihw.gov.au/content/index.phtml/itemId/327254

Previously, stakeholders noted that the current approach to pricing newborn episodes of care does not reflect the care being provided to newborns outside of the special care nursery, and that bundling of unqualified newborns within the maternal AR-DRG may not adequately reflect the cost of care. Stakeholders recommended costs associated with unqualified newborns should be used to develop the neonate AR-DRG price, independent of the price of the mother's episode. Stakeholders also recommended reviewing the definitions and business rules for unqualified newborns.

Episodes with unqualified newborns are coded and reported separately to the mother record. Costs for the unqualified newborn episode are combined with the costs of the mother's episode and included in the AR-DRG price for the delivery. Costs for the qualified newborn are used in the development of prices for AR-DRG related to neonate admissions.

Next steps and future work

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

4.6 Setting the national efficient price for private patients in public hospitals

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

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

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

IHACPA determines a private patient adjustment methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public.

In fulfilling its functions under clause A44 of the Addendum, IHACPA intends to adopt the same methodology for NEP24.

IHACPA's decision

For NEP24, IHACPA will continue to implement the private patient neutrality methodology as required by clause A44 of the Addendum.

IHACPA will continue to engage with the NHFB regarding jurisdictional concerns with the current methodology, for their consideration in the application of the adjustment in future Determinations.

4.6.1 Phasing out the private patient correction factor

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

The Australian Hospital Patient Costing Standards Version 4.1 aims to address the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required.

At present, the private patient correction 'adds back' costs of private patients which are met through alternative funding sources, for example, where a jurisdiction does not report private patient costs within their NHCDC submissions. IHACPA will assess 2021–22 cost data and continue to consult with jurisdictions on phasing out the private patient correction factor.

IHACPA's decision

IHACPA does not intend to phase out the private patient correction factor for NEP24. IHACPA will continue to evaluate the private patient correction factor and remove it where appropriate.

5

Setting the national efficient cost

5. Setting the national efficient cost

5.1 Overview

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

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

5.2 The 'fixed-plus-variable' model

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

Since the *NEC Determination 2020–21*, IHACPA has used a 'fixed-plus-variable' model where the total modelled cost of each hospital is based on a fixed component as well as a variable ABF style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.

IHACPA's decision

IHACPA will continue to use the 'fixed-plus-variable' model for the NEC Determination 2024–25 (NEC24).

5.3 Standalone hospitals providing specialist mental health services

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

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

IHACPA priced admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0 for the National Efficient Price (NEP) Determinations for 2022–23 and 2023–24. In the 2021–22 financial year, some standalone hospitals providing specialist mental health services reported admitted mental health care activity as part of the Activity based funding: Mental health care national best endeavours data set.

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

In response to the *Consultation Paper on Australian Public Hospital Services 2024–25* (the Consultation Paper), stakeholders recommended IHACPA allow sufficient lead time for analysis prior to transitioning standalone hospitals providing specialist mental health services from block funding to ABF.

IHACPA's decision

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

5.4 NEC indexation methodology

Similar to the NEP indexation methodology, the NEC indexation methodology is based on historical data, however it is developed using expenditure data that incorporates both costs and activity volumes. The purpose of the NEC indexation rate is to account for growth in volume and growth in unit costs.

In response to the Consultation Paper, stakeholders advised of a range of ongoing cost pressures for regional or remote hospitals that may not be reflected in the cost data such as costs associated with rural workforce shortages, accommodation and transportation. Stakeholders also suggested alternative metrics that are publicly available to demonstrate cost increases in the expenditure of small rural hospitals such as published service agreements or budgets at the district or local health network level.

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

IHACPA's decision

For NEC24, IHACPA will maintain its existing indexation methodology.

6

Data collection

6. Data collection

6.1 Overview

Under the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), the Independent Health and Aged Care Pricing Authority (IHACPA) is required to develop, refine and maintain systems as necessary to determine the national efficient price (NEP) and national efficient cost (NEC), including classifications, costing methodologies and data collections.

To facilitate the collection of accurate activity, cost and expenditure data for the annual NEP and NEC determinations, IHACPA works with states and territories to develop appropriate data specifications and to acquire, validate and maintain data within the IHACPA information technology environment.

In developing these data specifications, IHACPA is guided by the principle of data rationalisation, including the concept of 'single provision, multiple use', as outlined in the Addendum.

6.2 Assurance of cost data

In past years, IHACPA commissioned an independent financial review (IFR) of the National Hospital Cost Data Collection (NHCDC) to ensure that the quality of NHCDC data is robust, fit-for-purpose, and includes in-scope costs in accordance with the Australian Hospital Patient Costing Standards (AHPCS).

Based on stakeholder feedback and IHACPA's review of all information collected through the NHCDC quality assurance activities and the IFR, IHACPA made the decision not to undertake the IFR on the NHCDC Public Sector 2021–22 data. Instead, IHACPA is holding bilateral meetings with each jurisdiction to review their NHCDC submission and data quality statement to understand how the NHCDC data has been prepared and if it is consistent with the AHPCS.

The *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25* (the Consultation Paper) sought input on what assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories.

Stakeholders recommended inclusion of mandatory questions to demonstrate compliance with the AHPCS, identification of the gaps between self-assessments and data quality statements (DQS) and focused analysis to understand cost drivers among patient cohorts.

IHACPA's decision

Following stakeholder feedback received and review of the DQS, IHACPA has updated the DQS template for the 2021–22 NHCDC to include reporting against AHPCS compliance and financial reconciliation.

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

Next steps and future work

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

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

While IHACPA does not intend to undertake a focused analysis for NHCDC Public Sector 2021–22 data, IHACPA will consider appropriate approaches to conducting such analysis in the future.

6.3 Virtual models of care

In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, IHACPA outlined its intention to investigate innovative models of care and services related to virtual care, with an initial focus on virtual care delivered by emergency departments.

For 2023–24, IHACPA has developed data request specifications in consultation with jurisdictions for the voluntary collection of emergency virtual care activity data from 1 July 2023. This is part of an initial project to collect virtual care data to inform future data collection refinements.

The Consultation Paper sought input on the specific virtual care areas and care streams that IHACPA should prioritise for further investigation to inform future data collection, classification and pricing refinement.

Stakeholders provided feedback demonstrating the diversity of activities related to virtual care including:

- virtual care delivered in non-admitted or community settings such as Hospital in the Home or remote patient monitoring
- virtual care that enables early supported discharge or emergency department diversion
- virtual care delivered by multidisciplinary teams.

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

Next steps and future work

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

6.4 Organ donation, retrieval and transplantation

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

In 2023, IHAPCA sought feedback from jurisdictions on the gaps identified by IHACPA in existing activity and cost data collections for organ donation, retrieval and transplantation services, the current Commonwealth funding contribution for organ procurement services through DonateLife and other sources and options to improve activity and cost data collections, including analysis of risks and benefits.

Based on this feedback, IHACPA has finalised a project plan for progressing the work to facilitate better capture of organ donation, retrieval and transplantation activity and costs in the admitted setting, which has been supported by jurisdictions. This includes a staged approach to undertaking the project, proposed scope and timeframes to progress this program of work.

Next steps and future work

In 2024, IHACPA will commence Stage One of the project, to facilitate improvements in capturing organ procurement activity through classification refinement and investigate opportunities for improvements in cost data reporting for activity that is already being collected. This will include:

- development of a schema to identify gaps in reporting and provide an overview of the entire organ procurement journey from initial potential donor screening through to post-transplantation care; and
- work on the development of a Data Request Specification for collection of organ procurement activity data to support future collection of additional data.

IHACPA is also exploring classification refinement for the Australian Refined Diagnosis Related Groups classification for Version 12.0 and the Australian Classification of Health Interventions Thirteenth Edition, which would be supported by improved patient cost data collection.

7

Treatment of other Commonwealth programs

7. Treatment of other Commonwealth programs

7.1 Overview

To prevent a public hospital service being funded more than once, the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) requires the Independent Health and Aged Care Authority (IHACPA) to discount Commonwealth funding provided to public hospitals through programs other than the National Health Reform Agreement.

The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs.

Consistent with clauses A9 and A46(e) of the Addendum, blood expenditure that has been reported in the National Hospital Cost Data Collection (NHCDC) by states and territories will be removed in determining the national efficient price (NEP), as Commonwealth funding for this program is provided directly to the National Blood Authority.

The following Commonwealth funded pharmaceutical programs will also be removed prior to determining the underlying cost data for the NEP determination given that they are already funded separately:

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

IHACPA's process to remove PBS payments from the NHCDC involves linking the benefits to the corresponding hospital episodes where possible, as well as removing aggregate amounts where payments cannot be linked.

In 2023–24, IHACPA intends to commence a review of this linking process and explore potential process improvements to ensure the amounts deducted from individual hospital episodes better reflect the associated PBS payments and in turn, improve the representativeness of resulting prices.

In 2023, changes to some PBS listed medicines were introduced to allow prescribers to prescribe a two-month supply of some PBS medicines used in chronic conditions for eligible patients. This allows for these patients to receive two months of these medicines for a single PBS co-payment fee. IHACPA has reviewed the changes against the eligibility criteria in the *Assessment of Adjustments to the National Pricing Model Policy* to check if this policy change resulted in a legitimate and unavoidable cost variation in the delivery of public hospital services. IHACPA also reviewed whether these changes impacted the method IHACPA applies in removing PBS costs from NHCDC data so they do not inform the national pricing model resulting in double payment. Based on these reviews, IHACPA has determined that no changes are required to the national pricing model for the NEP Determination 2024–25.

8

Future funding models

8. Future funding models

8.1 Overview

Activity based funding (ABF) has been an effective funding mechanism since it was introduced to Australian public hospitals in 2012 in creating a more equitable and transparent system of hospital funding across Australia through the national efficient price (NEP).

While ABF will continue to be the best pricing and funding mechanism for many hospital services, the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) stipulates that the Independent Health and Aged Care Pricing Authority (IHACPA) will support the exploration and trial of new and innovative approaches to public hospital funding through:

- developing a funding methodology that does not penalise states and territories undertaking trials of innovative models of care
- advising the Commonwealth and states and territories on the application of the aforementioned methodology and any issues with the proposed trial, with regard to the national funding model
- providing advice to Health Ministers' Meetings (HMM)[3] on any proposal to translate an innovative funding model to the national funding model.

8.2 Trialling of innovative models of care

Clause A99 of the Addendum stipulates that states and territories can seek to trial innovative models of care, either:

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

IHACPA's role as outlined in the Addendum, is to provide advice and facilitate exploration and trial of new and innovative approaches to public hospital funding.

As part of the *Update to the National Efficient Cost Supplementary Determination 2022–23*, IHACPA included block-funded expenditure amounts for a number of innovative models of care proposed by New South Wales (NSW), based on a pending interim agreement with the Commonwealth to trial these models under clause A97 of the Addendum.

IHACPA is considering whether refinements to existing classifications or pricing models are required to support the translation of these innovative models of care to the national pricing model.

In response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25*, some stakeholders recommended development of funding models designed to meet the needs and challenges of rural, remote and Aboriginal and Torres Strait Islander communities. They proposed the development of these models include representation from each of these communities, and that funding models incentivise rural-based investment in resourcing and training.

Next steps and future work

IHACPA remains committed to work in partnership with jurisdictions to develop and provide advisory support for the trialling of innovative models of care under bilateral agreements between states and territories and the Commonwealth, particularly for specific patient cohorts or provider types, as recommended by stakeholders.

[3] The Council of Australian Governments has been dissolved. The Health Ministers' Meeting, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies.

9

Pricing and funding for safety and quality

9. Pricing and funding for safety and quality

9.1 Overview

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

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

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

9.2 Sentinel events

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

Since 1 July 2017, IHACPA has specified that an episode of care including a sentinel event will be assigned a national weighted activity unit (NWAU) of zero. This approach is applied to all hospitals, whether funded on an activity or block funded basis.

IHACPA's decision

As per the Addendum (clauses A165–A166), IHACPA will continue to apply this funding adjustment for episodes with a sentinel event for the NEP Determination 2024–25 (NEP24) using Version 2.0 of the Australian Sentinel Events List published on the Commission's website.

9.3 Hospital acquired complications

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

The funding adjustment for HACs reduces funding for any episode of admitted acute care where a HAC occurs. This approach incorporates a risk adjustment model and recognises that the presence of a HAC increases the complexity of an episode of care or the length of stay, driving an increase in the cost of care.

Further information on the HACs funding approach is included in the *NEP Determination 2023–24* and the *National Pricing Model Technical Specifications 2023–24*.

The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant.

IHACPA's decision

For NEP24, IHACPA will use Version 3.1 of the HACs list on the Commission's website to implement the HACs funding adjustment.

9.4 Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission.

An avoidable hospital readmission (AHR) occurs when a patient who has been discharged from hospital (the index admission) is admitted again within a certain time interval (the readmission), and the readmission is clinically related to the index admission and has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

From 1 July 2021, IHACPA has implemented a funding adjustment for AHRs and involves the application of a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode, to apply where there is a readmission to any hospital within the same jurisdiction.

IHACPA developed a discrete risk adjustment model for each readmission condition, which assigns the risk of being readmitted for each episode of care.

Further information on the AHRs funding approach is included in the *NEP Determination 2023–24*, and the *National Pricing Model Technical Specifications 2023–24*.

IHACPA's decision

For NEP24, IHACPA will use Version 2.0 of the AHRs list on the Commission's website to implement the avoidable hospital readmissions funding adjustment.

Independent Health and Aged Care Pricing Authority

Eora Nation, Level 12, 1 Oxford Street
Sydney NSW 2000

Phone: 02 8215 1100
Email: enquiries.ihacpa@ihacpa.gov.au

www.ihacpa.gov.au