Prof. Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority

Dear Professor Pervan,

Thank you for the opportunity to provide feedback on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26. Please find enclosed our feedback which we have limited to mental health care, and is informed by the delivery of admitted, residential, community, outpatient, specialist and forensic services across three large designated mental health services (DMHS) in the Northern and Western metropolitan regions of Melbourne.

Our Community of Practice looks forward to working with IHACPA on the ongoing refinement of the Framework. We also look forward to supporting the role of the Pricing Framework in contributing to the contemporary, sustainable, flexible, efficient, responsive, transparent, and values-based health financing system envisioned within the National Health Reform Agreement - Long Term Health Reforms roadmap.
With kindest regards

Health Information Manager Community of Practice,
Mental Health Services
NWMetro-MHHIMCoP@mh.org.au

Consultation Question:

Section 3.5 Mental Health Care Qu. 5 What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification Version 1.1 for NEP25?

Admitted Activity:
Based on the modest refinements of AMHCC v1.1, we don't anticipate any significant barriers to pricing admitted activity using v1.1 for NEP 25. In particular, we welcome the inclusion of phases with up to two missing HoNOS items in our classifiable data.

Although we do not think AMHCC v1.1 creates any new barriers to pricing activity, we would like to flag the possible ongoing effect differing reporting rules (such as those related to treatment leave) may have on matching admitted episodes between different datasets.

We also look forward to exploring the insights the different complexity threshold splits each mental health legal status value in v1.1 provides. With regard to legal status splits, we would like to raise for IHACPA's consideration a review of pricing activity for secure extended care units, where admitted episodes do not fall into an acute phase of care.

Community Mental Health (CMH) Activity:

Recognising a modest change between AMHCC v1.0 and v1.1, we anticipate the current barriers to pricing community mental health activity will translate across into v1.1 for NEP25.

Similarly to previous feedback, these current barriers exist at the health service level and are caused by a combination of CMI/ODS system constraints and business reporting rule limitations. In particular, we would like to flag the following influences on reported data:

- 'layered'/concurrent community episodes with overlapped start and end dates (outcomes activity is attributed to the first community episode only)
- Community teams that are not required to report Outcomes (for example court liaison services)
- type B (unregistered) contact activity generated by intake/duty/triage services
- outcomes where the clinical measure does not align with the consumers age are grouped to an 'unknown' HoNOS (particularly at the cross over age thresholds for youth and aged services)

The resulting gaps/inconsistencies in reporting to both the State and Commonwealth make it difficult for us to comment fully on the impact of pricing CMH activity. We welcome the change to v1.1 and the ongoing move to implement activity-based funding for CMH, however are concerned that further transition arrangements are needed to mitigate any unintended pricing effects upon this service setting. Additionally, the opportunity to shadow CMH with AMHCC v1.1 for NEP25 will allow an opportunity to review pricing data, and better inform the impact of inter-rater reliability on Phase of Care, HoNOS, and LSP-16 without significant detriment to services. This would align us with the two-year shadow period as outlined in the IHACPA Shadow Pricing Guidelines.

With the outcomes of the Royal Commission into Victoria's Mental Health System also in mind, we would like to suggest that further transition arrangements for CMH may assist in scaffolding any inadvertent reporting challenges that may arise from imminent replacement of the CMI/ODS, and implementation the new state-wide mental health client management system.

To better support the pricing of CMH, our Community of Practice welcomes the move to AMHCC v1.1. We do however, recommend that shadow pricing continues for CMH with AMHCC v1.1 for NEP25 to mitigate the current barriers to reporting and pricing this service setting.