

SCHEDULE I – ADDENDUM TO THE NATIONAL HEALTH REFORM AGREEMENT: REVISED PUBLIC HOSPITAL ARRANGEMENTS

Preliminaries

11. Notwithstanding Clauses 19 and 20 of the National Health Reform Agreement (the Agreement), the Parties agree to amend the Agreement with this Schedule.
12. This schedule:
 - a. reiterates the shared commitment of Parties to improve health outcomes for all Australians and ensure the sustainability of the Australian health system;
 - b. implements the arrangements outlined in the Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding (the Heads of Agreement) as agreed by COAG in April 2016;
 - c. affirms the Parties agreement to the Medicare principles at Clause 4 of the Agreement;
 - d. sets out the shared commitment of Parties to develop and implement reforms to improve health outcomes for patients and decrease potentially avoidable demand for public hospital services;
 - e. acknowledges the Roles and Responsibilities of the Parties outlined in the Agreement;
 - f. supersedes the Heads of Agreement agreed by COAG in April 2016;
 - g. builds on and complements the policy and reform direction in the National Healthcare Agreement (agreed by COAG in 2008 and amended in July 2011) and the *National Health Reform Act 2011* (Cth); and
 - h. is subject to the Intergovernmental Agreement on Federal Financial Relations.
13. This Schedule is divided into two parts:
 - a. Part A (Clause 15 to 16) outlines the agreed amendments to the Agreement and schedules; and
 - b. Part B (Clauses 17 to 192) outlines time-limited arrangements that supplement and to the extent of any inconsistency take precedence over the remainder of the Agreement (including Schedules A – H and Part A of Schedule I) from 1 July 2017 to 30 June 2020, recognising any adjustments arising from Reconciliation will occur in the 2020-21 financial year.
14. The Parties acknowledge this Schedule anticipates the development of a longer-term public hospital funding agreement to commence 1 July 2020. This agreement will be developed by the Commonwealth and all jurisdictions and be agreed by COAG in 2018.

Part A: Variations to the Agreement

15. Parties agree to amend the Agreement and schedules as follows:

Former clause	Varied clause
<p>Clause 1</p>	<p>Clause 1 –addition of:</p> <p>(i) is subject to Schedule I, which sets out variations to this Agreement and arrangements for public hospital funding for the period 1 July 2017 to 30 June 2020. In the event of inconsistency between Part B of Schedule I and the remainder of this Agreement during this period, Part B of Schedule I will take precedence.</p>
<p>Clause 12</p> <p>The Commonwealth and States will implement public hospital governance and financing arrangements as set out by this Agreement in line with the timeframes identified in this Agreement. In recognition of the implementation by the States of these reforms, the Commonwealth will provide at least an additional \$16.4 billion in growth funding between 2014-15 and 2019-20 through meeting 45 per cent of efficient growth between 2014-15 and 2016-17 and 50 per cent of efficient growth from 2017-18 onwards; in the event the additional growth funding is less than \$16.4 billion, the Commonwealth will provide the remainder to States as top-up funding.</p>	<p>Clause 12 – amended:</p> <p>The Commonwealth and States will implement public hospital governance and financing arrangements as set out by this Agreement in line with the timeframes identified in this Agreement. In recognition of the implementation by the States of these reforms, the Commonwealth will provide growth funding between 2014-15 and 2019-20 through meeting 45 per cent of efficient growth.</p>
<p>Clauses 15, A5, A67-A79</p>	<p>Clauses omitted</p>

<p>Clause B61</p> <p>The annual adjustment will be conducted in arrears once actual volumes have been validated by the service volume Reconciliations to ensure the Commonwealth meets its agreed contribution to the funding of efficient growth and to effect any payment arising from the funding guarantee, as detailed in clauses A67-A79.</p>	<p>Clause B61 – amended:</p> <p>The annual adjustment will be conducted in arrears once actual volumes have been validated by the service volume Reconciliations to ensure the Commonwealth meets its agreed contribution to the funding of efficient growth.</p>								
<p>Schedule H</p>	<p>Schedule H – amended row:</p> <table border="1" data-bbox="715 703 1406 1301"> <thead> <tr> <th>Task</th> <th>Process for resolution</th> <th>Timing</th> <th>By whom (indicative)</th> </tr> </thead> <tbody> <tr> <td>\$16.4 billion top-up payment guarantee</td> <td>Heads of Treasuries (HOTS) will review the need for payment of any top up funding against the national guarantee. The Commonwealth will provide top-up funding to meet any shortfall against the \$16.4 billion guarantee.</td> <td>July 2017, July 2018 and July 2019 30 June 2021</td> <td>Commonwealth</td> </tr> </tbody> </table>	Task	Process for resolution	Timing	By whom (indicative)	\$16.4 billion top-up payment guarantee	Heads of Treasuries (HOTS) will review the need for payment of any top up funding against the national guarantee. The Commonwealth will provide top-up funding to meet any shortfall against the \$16.4 billion guarantee.	July 2017, July 2018 and July 2019 30 June 2021	Commonwealth
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<p>Appendix A – definition of Administrator</p> <p>Means the Administrator of the National Health Funding Pool, who is appointed in accordance with clause B24, and performs the functions set out in clauses B26-B27.</p>	<p>Appendix A – definition of Administrator (amended)</p> <p>Means the Administrator of the National Health Funding Pool, who is appointed in accordance with Clause B24, and performs the functions set out in Clauses B26-B27 <u>and Schedule I</u>.</p>								
<p>Appendix A – definition of Australian Commission on Safety and Quality in Health Care</p> <p>Means the authority performing the functions set out in Schedule B.</p>	<p>Appendix A – definition of Australian Commission on Safety and Quality in Health Care (amended)</p> <p>Means the authority performing the functions set out in Schedule B <u>and Schedule I</u>.</p>								

<p>Appendix A – definition of Independent Hospital Pricing Authority</p> <p>Means the authority established by Commonwealth legislation in accordance with clause B1 to perform the functions set out in clauses B3 to B8.</p>	<p>Appendix A – definition of Independent Hospital Pricing Authority (amended)</p> <p>Means the authority established by Commonwealth legislation in accordance with clause B1 to perform the functions set out in clauses B3 to B8 <u>and Schedule I</u>.</p>
<p>Appendix A – definition of National Health Funding Body</p> <p>Means the body established by Commonwealth legislation to assist the Administrator in carrying out his or her functions under Commonwealth and State legislation, in accordance with Schedule B of this Agreement.</p>	<p>Appendix A – definition of National Health Funding Body (amended)</p> <p>Means the body established by Commonwealth legislation to assist the Administrator in carrying out his or her functions under Commonwealth and State legislation, in accordance with Schedule B <u>and Schedule I</u> of this Agreement.</p>

16. Add new defined terms to Appendix A of the Agreement as follows:

ABF Service	Means a Public Hospital Service funded under ABF.
Avoidable Hospital Readmission	Means a clinical condition identified by the ACSQHC for the purpose of Clause 171.
Commonwealth Funding Entitlement	Means, in respect of a State, its Uncapped Commonwealth Funding Entitlement, adjusted for the imposition of the Soft Cap and any Redistribution Amount that may be payable. It may be expressed on an estimated basis prior to annual Reconciliation or a final basis after annual Reconciliation and Redistribution.
Data Conditional Payment (DCP)	Means the mechanism described at Clause 135 to provide an incentive for the prompt provision of hospital activity data to enable timely Reconciliation.
HAC List	Means the Hospital Acquired Complication List maintained by the ACSQHC, as amended from time to time.
Hospital Acquired Complication (HAC)	Means a condition set out on the HAC List and approved by the COAG Health Council.

national bodies	Means the functions and bodies established and existing from time to time for the purposes of the Agreement, including, without limitation, the Administrator, the National Health Funding Body (NHFB), the Independent Hospital Pricing Authority (IHPA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC).
National Funding Cap	Means the limit in growth in Commonwealth funding for Public Hospital Services for all States of 6.5 per cent per annum and where the context so requires includes the operation of the Funding Cap as provided in this Agreement.
Parties	Means the signatories to this Agreement, being the Commonwealth and each State and Territory.
Public Hospital Services	Means the services, functions and activities funded by the Commonwealth under this Agreement, including service subject to Activity Based Funding, Block Funding or public health activities.
Reconciliation	Means the Reconciliation of actual ABF Service delivery volume undertaken within a State to the estimate of ABF Service delivery volumes provided by a State in accordance with Clauses B59 to B64.
Redistribution	Means the allocation of remaining funding under the National Funding Cap to States whose Uncapped Commonwealth Funding Entitlement exceeded their respective Soft Funding Cap in accordance with Clause I27.
Redistribution Amount	Means an amount paid by the Commonwealth to a State that is entitled to additional funds as a result of the Redistribution.
relevant financial year	Means a specific financial year for which data is submitted by the Parties so that the Administrator can calculate the Commonwealth funding and payments for that financial year.

Required Data	Means each of: <ul style="list-style-type: none"> a. the data specified as being required for Reconciliation in the data plan issued by the Administrator for the relevant financial year; b. data necessary to enable the Administrator to operate the pricing and funding models agreed by the Parties to calculate Safety and Quality Adjustments; c. data necessary to identify Sentinel Events; and d. the duly completed Statement of Assurance.
Safety and Quality Adjustment	Means a reduction in funding payable to a State by the Commonwealth for Public Hospital Services, funded either under ABF or Block Funding, following the occurrence of a HAC or an Avoidable Hospital Readmission in accordance with the pricing and funding models to be developed by the Parties for this purpose.
Sentinel Event	Means an event set out on the Sentinel Events List.
Sentinel Events List	Means events set out on the Australian Sentinel Events List maintained by the ACSQHC and approved by the COAG Health Council.
Soft Cap	Means the limit in growth in Commonwealth funding for Public Hospital Services in a State of 6.5 per cent per annum.
Statement of Assurance	Means the statement as to the completeness and accuracy of data submitted, issued in accordance with Clauses I40 and I41.
Uncapped Commonwealth Funding Entitlement	Means in respect of a State in a relevant financial year, its entitlement to Commonwealth funding for Public Hospital Services in that State under the Agreement, excluding the impact of the National Funding Cap or any relevant Soft Cap.

Part B: Revised arrangements for 2017-18 to 2019-20

Scope

17. This Part amends the Agreement to detail public hospital funding arrangements between the Parties from 1 July 2017 to 30 June 2020.

Public hospital funding arrangements

18. Consistent with Clause A1 of the Agreement, the Parties agree the Commonwealth's contribution to hospital services from 1 July 2017 until 30 June 2020 will comprise funding relating to:
 - a. Public Hospital Services provided to public patients in a range of settings, and eligible private patients in public hospitals and a range of settings on an activity basis;
 - b. Block Funding for Public Hospital Services better funded through block grants, including relevant services in regional and rural communities and teaching, training and research functions; and
 - c. public health activities.
19. Consistent with Schedule A of the Agreement, Commonwealth funding will be provided on the basis of activity through ABF wherever practicable.
110. Growth in annual Commonwealth funding for national Public Hospital Services, will not exceed 6.5 per cent a year (the National Funding Cap) while this Part is operational. Details on the operation of the National Funding Cap are outlined below.
111. Parties agree to improve the accuracy of NWAU estimates by allowing States to provide non-binding advice to the Commonwealth and the Administrator on expected services to be delivered, without the need to vary Service Agreements. The provision of this advice will not affect Commonwealth payments or cash flows to LHNs.

National health funding pool

112. Consistent with Schedules A and B of the Agreement, the Administrator will continue to calculate and advise the Commonwealth Treasurer of the monthly Commonwealth payments into the National Health Funding Pool. The States, in consultation with the National Health Funding Body (NHFB), will continue to determine when State payments are made into the National Health Funding Pool and State managed funds.
113. The National Health Funding Pool, the NHFB, and the Administrator will continue to operate as set out in the Agreement, subject to the additional responsibilities conferred on the Administrator in this Schedule.

Activity based funding

114. The Parties reiterate their commitment to funding Public Hospital Services under ABF and confirm the ongoing operation of the arrangements and calculation processes contained in Schedule A of the Agreement, subject to modification in the Clauses below, including:
 - a. the operation of the National Funding Cap and Soft Caps;
 - b. the incorporation of a Data Conditional Payment to promote the prompt provision of the Required Data; and
 - c. changes in the proportion of efficient growth met by Commonwealth contributions.

- I15. From 1 July 2017 to 30 June 2020, the Commonwealth will fund 45 per cent of the efficient growth of ABF Service delivery, subject to the operation of the National Funding Cap. References in the Agreement to a Commonwealth contribution of 50 per cent of efficient growth are not operational for the life of this Part.
- I16. Consistent with Clause A34 of the Agreement and subject to the operation of the National Funding Cap, for the period 1 July 2017 to 30 June 2020 the Commonwealth's funding for each category of ABF Service will be calculated individually for each State by summing:
- a. *previous year amount*—the Commonwealth's percentage funding rate for the relevant State in the previous year, multiplied by the volume of weighted ABF Services provided in the previous year, multiplied by the National Efficient Price (NEP) in the previous year;
 - b. *price adjustment*—the volume of weighted services provided in the previous year, multiplied by the change in the NEP relative to the previous year, multiplied by 45 per cent; and
 - c. *volume adjustment*—the net change in volume of weighted services to be provided in the relevant State (relative to the volume of weighted ABF Services provided in the previous year), multiplied by the NEP, multiplied by 45 per cent.
- I17. The Commonwealth's contribution to funding Public Hospital Services on an ABF basis (including efficient growth) will be calculated at the start of each financial year, and may be updated or revised based on advice from the Administrator, including a final Reconciliation of Public Hospital Services, consistent with current arrangements under the Agreement.

Block funded services funding

- I18. The Commonwealth will continue to provide funding to States for Public Hospital Services or functions that are more appropriately funded through Block Funding in accordance with Schedule A and will fund 45 per cent of the growth in the efficient cost of providing these services or performing these functions. References in the Agreement to a Commonwealth contribution of 50 per cent of the growth in the efficient cost are not operational for the life of this Part.
- a. Commonwealth payments for block funded services for the life of this Part will continue to be calculated consistent with the process outlined in Schedule A of the Agreement, with the exception that the Commonwealth will fund 45 per cent of the growth in the efficient cost.

Public health activity funding

- I19. Commonwealth payments for public health activities for the life of this Part will continue to be calculated in accordance with Schedule A of the Agreement.

Funding cap

- I20. The Parties agree to give effect to a cap in overall growth in Commonwealth funding of 6.5 per cent a year (the National Funding Cap) for the period 2017-18 to 2019-20. In doing so, it is the intention of the Parties that:

- a. A Soft Cap will be applied to the Commonwealth Funding Entitlement of each State throughout the relevant financial year;
- b. Any funding remaining under the National Funding Cap will be subject to proportionate Redistribution as part of the annual Reconciliation under Clause I27;
- c. while the National Funding Cap applies to Commonwealth contributions to Public Hospital Services in aggregate, any adjustments to funding as a result of the National Funding Cap will be applied to the Commonwealth funding contribution for ABF Services only;
- d. should the growth in Commonwealth funding under this Agreement not exceed 6.5 per cent at a national level, each State will receive its Uncapped Commonwealth Funding Entitlement for that State; and
- e. no State will receive more than its Uncapped Commonwealth Funding Entitlement for Public Hospital Services delivered in a relevant financial year.

Role of the Administrator

- I21. The Administrator will apply the National Funding Cap and Soft Cap in calculating and delivering advice to the Commonwealth Treasurer in respect of the Commonwealth contribution to the National Health Funding Pool under the Agreement.

Determining preliminary Commonwealth funding

- I22. Prior to the commencement of a relevant financial year covered by this Part, the Administrator will calculate a State's estimated Commonwealth Funding Entitlement as the lower of:
- a. 106.5 per cent of the State's most recent estimated Commonwealth Funding Entitlement for the State for the previous financial year, excluding any adjustments relating to prior year activities; or
 - b. That State's estimated Uncapped Commonwealth Funding Entitlement for the relevant financial year.
- I23. Estimated Commonwealth Funding entitlements can be updated during the course of the year as outlined in Clause B57 of the Agreement. Adjustments to payments remain subject to the Soft Cap.
- I24. For the avoidance of doubt, a State will not receive any Commonwealth funding in excess of the Soft Cap until after annual reconciliation, at which time it may be entitled to payment of a Redistribution Amount.

Determining final Commonwealth funding

- I25. The Administrator will undertake annual Reconciliation for each State following the receipt of Required Data from all States. The Administrator will not finalise an annual Reconciliation for individual States that have provided the Required Data until all other States have provided Required Data.

126. In undertaking the annual Reconciliation the Administrator will calculate any Sentinel Event or Safety and Quality Adjustment that applies to a State in a relevant financial year.
127. Following the completion of the annual Reconciliation, the Administrator will calculate the final Commonwealth Funding Entitlements for a State for that year as follows:
- a. Where a State has an Uncapped Commonwealth Funding Entitlement less than or equal to the Soft Cap, then the State's Commonwealth Funding Entitlement will equal its Uncapped Commonwealth Funding Entitlement.
 - b. Where a State has an Uncapped Commonwealth Funding Entitlement that is more than its Soft Cap and the sum of all of the States Uncapped Commonwealth Funding Entitlements is less than or equal to the National Funding Cap, then the State's Commonwealth Funding Entitlement will equal its Uncapped Commonwealth Funding Entitlement.
 - c. Where a State has an Uncapped Commonwealth Funding Entitlement that is more than its Soft Cap, and the sum of all of the States Uncapped Commonwealth Funding Entitlements is more than the National Funding Cap, then the State's Commonwealth Funding Entitlement is its Soft Cap, plus a Redistribution Amount, calculated by the following formula:

National funding available for redistribution	X	$\frac{\text{Individual State's funding shortfall}}{\text{National funding shortfall}}$
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Where:

- The 'national funding available for redistribution' is the sum of the difference of each State's Uncapped Commonwealth Funding Entitlement and the Soft Cap where the State's Uncapped Commonwealth Funding Entitlement's is less than the Soft Cap.
- The 'individual State's funding shortfall' is the amount by which its Uncapped Commonwealth Funding Entitlement exceeds the Soft Cap.
- The 'national funding shortfall' is the sum of all the 'individual State's funding shortfall'.

Certainty of Reconciliation

128. The Parties agree that the final Commonwealth Funding Entitlement of a State will not be adjusted unless a Party has notified the Administrator of an issue affecting its accuracy within 12 months of the end of the relevant financial year. The Administrator will not make any further adjustments to funding relating to that financial year, unless it is to resolve an issue raised within that 12 month period.
- a. This does not restrict the Administrator's ability to identify issues including inaccuracies or errors within 12 months of the end of the relevant financial year.
129. A notice for the purpose of Clause 128 must be issued in writing by a senior officer of the relevant health department and provide full particulars of the nature and extent

of the issue and the likely impact on the State's Commonwealth Funding Entitlement. A Statement of Assurance must accompany any further submission of data by a State to remedy an identified issue.

- I30. If an issue is identified or raised with the Administrator, the Administrator will notify the Commonwealth and States of the issue and how the Administrator plans to resolve the issue.
- I31. The Administrator will calculate the impact on the Commonwealth Funding Entitlement of each State, including any applicable Redistribution Amounts, following the assessment of the issue by the Administrator.
- I32. The Administrator will assess and advise whether adjustments to the Commonwealth Funding Entitlement of the States should be made. Following resolution of the issue, the Administrator will notify the Commonwealth and States of the outcome.

Disputes with the Administrator

- I33. The Parties agree that in the event of a dispute with the Administrator:
 - a. Officials will work with the Administrator to resolve the dispute in the first instance.
 - b. If the dispute cannot be resolved by officials and the Administrator, it may be escalated in accordance with the process for dispute resolution for the Parties outlined at Clauses 22 and 23 of the Agreement.

Data quality and integrity

- I34. Consistent with Clause B95, jurisdictions will work together and with the national bodies to share and work towards best practice approaches to data quality and integrity.

Data Conditional Payment

- I35. The Parties agree to incorporate a Data Conditional Payment (DCP) to encourage the prompt provision of the Required Data in order to facilitate timely Reconciliation and payment of any Redistribution Amounts due to States. The DCP will be a variation to the timing of payments under Clause B46 of this Agreement.
- I36. If a state has not provided the Required Data for annual Reconciliation within three months of the end of the Reconciliation period the Administrator will, in calculating the Commonwealth contribution to the National Health Funding Pool for that state, advise the Treasurer to defer payment of 10 per cent of the amount payable to the State in November of the current year, until the Required Data is provided.
- I37. If a state has not provided the Required Data for the annual Reconciliation within four months of the end of the Reconciliation period, the Administrator will, in calculating the Commonwealth contribution to the National Health Funding Pool for that state, advise the Treasurer to defer a further 15 per cent of the amount payable to the States in December of the current year, until the Required Data is provided.
- I38. If an amount is deferred under Clauses I36 or I37
 - a. the Administrator will advise the affected State of that fact; and

- b. any funds deferred will be repaid in the next available monthly payment once the Required Data is provided.
- I39. The Administrator will be responsible for applying the DCP and providing advice to jurisdictions as to its operation.

Statement of Assurance

- I40. From 1 July 2017, States will provide the IHPA with a Statement of Assurance from a senior health department official on the completeness and accuracy of approved data submissions provided under clauses B63, B95 and B97 of the Agreement.
 - a. Consistent with Clause B97, the IHPA will provide statements of assurance to the Administrator.
 - b. Jurisdictions will work with the national bodies to determine the manner and form of the Statement of Assurance, for approval by the Australian Health Ministers' Advisory Council (AHMAC).
 - c. The provision of the Statement of Assurance does not prevent a State 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.
- I41. Data provided to the Administrator under clauses A6 and A8 by the Commonwealth will also require a statement of assurance on completeness and accuracy of data submitted by the relevant data custodian(s).

Reporting

- I42. Further to Clause B102 of the Agreement, in publishing information on compliance with data requirements, the Administrator will publish additional information including:
 - a. dates on which each State provided data under clauses B63, B73 and B74;
 - b. dates on which resubmissions of data were provided; and
 - c. dates on which Reconciliation was completed.

Other arrangements

- I43. The Parties agree that where a State may receive less funding under the arrangements outlined in this Part than it would have received under block grant arrangements outlined in the 2014-15 Commonwealth Budget, the Commonwealth will work with any affected jurisdiction to consider whether there is a case to provide additional funding to that jurisdiction for that year.
 - a. Any additional payments provided under Clause I43 should not be considered as 'other funding streams' for the purpose of Clause B63 of this Agreement.
 - b. Any additional funding provided under Clause I43 will be paid outside of the National Health Funding Pool and will not be considered in the determination of Commonwealth Funding Entitlements for a State or the application of the National Funding Cap or Soft Cap.

144. States agree to, at a minimum for the period of 2017-18 to 2019-20, maintain 2015-16 levels of funding for Public Hospital Services, while having regard to new, appropriate models of care that may change the setting in which care is delivered.
145. Parties acknowledge that the Australian Capital Territory, Tasmania and the Northern Territory have separate bilateral arrangements with the Commonwealth regarding public hospital funding. These bilateral arrangements operate separately to this Agreement and will not affect the Commonwealth funding of other States under this Agreement.

Reforms to decrease avoidable demand for public hospital services

146. All Parties commit to implement reforms to improve outcomes for patients and decrease potentially avoidable demand for Public Hospital Services. This Part does not preclude pursuing other reforms to improve health outcomes and the efficiency of public hospitals in the future.

Coordinated care for patients with chronic and complex disease

147. The Parties acknowledge that Australia's health system is high performing but that patients with chronic and complex conditions can experience the system as fragmented and difficult to navigate.
148. The Parties will develop a range of coordinated care reforms to complement existing national and local measures to deliver better care for patients with chronic and complex conditions and reduce avoidable demand for health services.
149. These reforms will be implemented from 1 July 2017, with progress reported to COAG through the COAG Health Council in early 2019, to inform further consideration of a joint national approach to enhanced coordinated care for people with chronic and complex conditions.
150. These coordinated care activities will complement reforms articulated within this Schedule in relation to safety and quality and Commonwealth funding mechanisms.

Bilateral Agreements on Coordinated Care

151. The Parties agree to develop and finalise bilateral agreements that set out jurisdiction-specific coordinated care reform activities that will be implemented from 1 July 2017. The activities identified within the bilateral agreements will build on and support the existing investments in infrastructure, governance systems, and service programs and initiatives that already support patients with chronic and complex conditions.
152. The Parties agree that coordinated care reforms for patients with chronic and complex conditions are central to a strong and sustainable health system, through reducing avoidable demand for health services and improving health outcomes. The Parties agree that the bilateral agreements will be guided by the following principles:
 - a. Patient centred:
 - i. Engage patients with chronic and complex conditions, estimated to comprise up to 20 per cent of the population, and their carers, as active partners with clinicians and broader health care team to improve patient health care experience and outcomes; and

- ii. Empower patients to maximise their knowledge, skills and confidence to manage their health, with the support of their health care team.
 - b. Evidence based:
 - i. Based on evidence, and/or seek to contribute to the evidence base for improving patient care;
 - ii. Target patients that have multiple chronic and complex conditions and can most benefit from enhanced coordinated care; and
 - iii. Include evaluation processes to assess the reforms, including where possible, impact on patient outcomes and experiences.
 - c. Consistent with whole-of-system efforts to deliver improved patient health outcomes:
 - i. Complement existing national and local measures to deliver better care and reduce avoidable demand for health services; and
 - ii. Complement other reforms agreed in this Schedule in relation to safety and quality and Commonwealth funding mechanisms.
 - d. Flexible and sustainable:
 - i. Be flexible to enable jurisdictions and regional delivery structures to test different approaches and to tailor care coordination solutions to local circumstances, available funding, and service availability;
 - ii. Encourage flexible and sustainable funding arrangements which may include collaborative, joint and/or pooled funding arrangements, including between Primary Health Networks and LHNs.
 - iii. Encourage partnerships with other sectors (e.g. non-government and private sectors); and
 - iv. Seek cost effective and efficient targeting of available resources, while ensuring continuity of care for patients.
153. The bilateral agreements will support the development of a joint national approach to enhanced coordinated care, and will provide flexibility to address local needs and priorities through core common characteristics and priority areas.
- a. Common core characteristics to be included in all agreements are:
 - i. Data collection and analysis;
 - ii. Care coordination services; and
 - iii. System integration.
 - b. Examples of priorities that could be a focus for activities implemented under bilateral agreements include:
 - i. Aged care integration;

- ii. Multidisciplinary team based approach;
 - iii. End of life care;
 - iv. Mental health; and
 - v. Rural and remote service delivery.
154. The bilateral agreements will include arrangements to support the implementation of actions in common and priority areas. These arrangements may include:
- a. Arrangements for the sharing of patient information between States and the Commonwealth, with patient consent, including relevant hospitalisation, Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) data to support a better understanding of patients and service utilisation across the system and to potentially identify patients or patient characteristics that would benefit from better care co-ordination; and
 - b. Education and information for relevant state health funded health service providers that work with stage one Health Care Homes in participating regions (see Clause 155 for details of Health Care Homes).

Health Care Homes implementation

155. The bilateral agreements will complement the implementation by the Commonwealth of the first stage of the Health Care Home (HCH) model in primary health care, to commence in selected Primary Health Network regions from 1 July 2017. Commonwealth implementation of HCH stage one includes:
- a. Recruitment and training of general practices and Aboriginal Medical Services to become a 'home base' for the ongoing care and management of patients with multiple complex and chronic disease;
 - b. Patient identification through a model that predicts future risk of hospital admission, and their enrolment with HCHs;
 - c. A new blended payment mechanism to provide practices with flexibility in how they deliver care and to incentivise delivery of high quality care;
 - d. Data collection and associated quality improvement processes within participating general practices, including:
 - i. Progress activities towards establishment of a National Minimum Data Set of de-identified information to help benchmark primary health care performance at a local, regional and national level to inform policy and identify region-specific issues and areas for improvement;
 - ii. Supporting HCHs and other primary care clinicians, such as allied health professionals, to have electronic medical record capability and encouraging uplift of patient records to My Health Record; and
 - iii. Progress care plan templates that can capture comprehensive information about patients and which can be accessed via My Health Record.

- e. A comprehensive evaluation to determine impact on patient outcomes, hospitalisations and overall cost effectiveness of the model.

Evaluation of coordinated care reform activities

- I56. Evaluation of the bilateral agreement activities will be undertaken by States and Territories and the Commonwealth in accordance with an agreed evaluation framework. Where State reforms build on or directly support the HCH model, the evaluation of bilateral agreement activities may be undertaken in partnership with the Commonwealth as agreed.
- I57. Evaluation of stage one of the HCH model will be undertaken by the Commonwealth.
- I58. The results of the bilateral agreement activity evaluations and the HCH evaluation will be drawn together to inform advice to COAG through the COAG Health Council in early 2019, for further consideration of a joint national approach to enhanced care coordination for patients with chronic and complex conditions.

Incorporating quality and safety into hospital pricing and funding

Context and intent

- I59. Australia's public hospitals deliver safe, high quality care but there remain opportunities for improvement. Reducing Sentinel Events, Hospital Acquired Complications (HACs) and Avoidable Readmissions will deliver better health outcomes, improve patient safety and support greater efficiency in the health system.
- I60. The Parties agree to develop reforms to integrate safety and quality into the pricing and funding of Public Hospital Services in a way that:
 - a. Improves patient outcomes;
 - b. Provides an incentive in the system to provide the right care, in the right place, at the right time;
 - c. Decreases avoidable demand for public hospital services; and
 - d. Signals to the health system the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.
- I61. The Parties agree that development of pricing and funding adjustments for Sentinel Events, HACs and Avoidable Readmissions is part of a multifaceted, system-wide approach to safety and quality, which includes national standards, accreditation, and workforce development.
 - a. The Parties recognise that safety and quality reforms are connected to wider health system reforms, particularly better coordinated care.
 - b. Together, these reforms will establish better system capability and culture to support the reduction of ineffective interventions and procedures known to be harmful in the longer term, beyond the immediate focus on Sentinel Events, HACs and Avoidable Readmissions.

162. For the avoidance of doubt, the Parties agree that Sentinel Events and Safety and Quality adjustments will be subject to back-casting under Clause A40.

Sentinel events

163. The Parties agree that any episode of care that gives rise to a Sentinel Event will not be funded by the Commonwealth from 1 July 2017. The episode will be assigned a NWAU of zero.
164. States agree to apply a digital flag as soon as practicable to any episode that includes a Sentinel Event and report this information to IHPA as part of data submissions under Clauses A8 and B93 of this Agreement. The Parties will consider development of a linkable dataset as a longer-term solution by 30 June 2020.

Hospital Acquired Complications

165. The Parties agree to develop, in consultation with the ACSQHC, IHPA and the Administrator, a comprehensive pricing and funding model, that:
- a. Is rigorous, fair and transparent;
 - b. Does not incentivise under reporting, or adversely affect service delivery; and
 - c. Is significant enough to be an effective overall price signal from the Commonwealth through to hospitals.
166. The Parties agree to shadow the preferred pricing and funding option for HACs from 1 July 2017 in order to:
- a. Improve data quality and identify any significant issues that need to be addressed prior to implementation;
 - b. Monitor any changes in the incidence of HACs in public hospitals;
 - c. Refine data and reporting requirements for HACs occurring in public hospitals;
 - d. Engage with the health system to ensure readiness for the implementation of the agreed model;
 - e. Confirm the suitability of complications on the HAC List for inclusion in a pricing and funding model;
 - f. Engage broadly with clinician groups on the proposed approach to ensure efficacy; and
 - g. Refine the HAC risk and complexity adjustment methodology in consultation with the Commonwealth and States in 2017, including a peer review process to ensure that it is fit for purpose.
167. IHPA will develop a preliminary report assessing the shadow implementation, including the impact of the preferred model on funding, data reporting, clinical information systems, and specific population and peer hospital groups. The preliminary report will be publicly consulted on, with the final report to be submitted to COAG Health Council by 30 November 2017.

- a. To assess shadow implementation, IHPA will use available activity data and the most recent available cost data from the National Hospital Cost Data Collection.
168. The Parties intend to introduce a pricing and funding model for HACs from 1 July 2018, subject to the results of the shadow implementation to be considered by COAG Health Council.
169. To confirm the suitability of the complications on the HAC List in a pricing and funding model, the Parties will use the following four criteria:
- a. Preventability:
 - i. Clinical evidence is available to demonstrate that the HAC can be prevented with 'best clinical practice'.
 - ii. Evidence supports that individual LHNs (including single campus and specialist hospitals) are able to prevent the HAC and that the causes of such condition are within the control of the hospital.
 - iii. The strength of external influences (e.g. patient factors) does not unduly impact the LHN's ability to avoid the HAC.
 - iv. There is sufficient evidence to inform / instruct health services on how to avoid the HAC.
 - i. The development of the HAC measure has been subjected to valid construction. The inferences used to test the HAC have been made on the basis of appropriate measurements and occurrences can be easily defined, identified and adequately measured.
 - b. Impact:
 - i. The introduction of the financial adjustments related to specific HAC will result in a significant enough change to funding at the hospital level to drive the intended clinical practice outcome, impact appropriately on patients and improve patient outcomes.
 - ii. Unintended consequences as a result of practice or reporting changes are not likely to be to the detriment of individual and hospital-wide patient care.
 - iii. The rate of HAC by LHN (giving consideration to size and type of hospital) is sufficient to warrant introduction of a financial mechanism.
 - c. Feasibility:
 - i. Reporting mechanisms are sufficiently robust to ensure that any benefit obtained through under reporting is minimised.
 - ii. Sufficient information is available to other bodies, such as the National Health Funding Body, to monitor the impact of the financial mechanism on the prevalence of the HAC across the system.

- iii. Sufficient processes, systems, policies, feedback mechanisms and data collections are in place to support the reduction of the HAC across each LHN.
 - iv. The introduction of the HAC is prioritised to obtain maximum benefit.
- d. Equity:
- i. The application of pricing and funding adjustment does not unfairly impact any one, or group, of providers as a result of characteristics beyond their control (e.g. size, location and type of hospital).

Avoidable Hospital Readmissions

- I70. The Parties recognise that there is variation in the way States currently define Avoidable Hospital Readmissions, presenting challenges to the immediate development of a pricing and funding model.
- I71. The ACSQHC will develop a list of clinical conditions that arise from complications of the management of the original condition, which can be considered Avoidable Hospital Readmissions, including identifying suitable condition-specific timeframes for each of the identified conditions.
- I72. The Parties agree to work in conjunction with the ACSQHC and IHPA to provide advice to COAG Health Council by November 2017 on:
- a. a nationally consistent definition for Avoidable Hospital Readmissions; and
 - b. refining the risk adjustment methodology and undertaking a peer review process in 2017 to ensure the methodology is fit for purpose.
- I73. The Parties agree that the further work outlined in Clauses I71 and I72 is required before a pricing or funding model can be agreed.
- I74. The Parties agree to determine an appropriate model for Avoidable Hospital Readmissions for implementation not before 1 July 2018, taking into account advice to COAG Health Council.

Evaluation

175. The Parties agree that IHPA will provide advice to COAG Health Council by December 2018 evaluating these reforms against the principles outlined at Clause I69, to support COAG consideration of a longer-term funding agreement from 1 July 2020.
176. IHPA will work with the Parties, national bodies and other related stakeholders to establish a framework to evaluate the reforms against the following principles:
- a. Reforms are evidence based and prioritise patient outcomes:
 - i. Better patient health outcomes underpin the design and implementation of reform
 - ii. The design and implementation of pricing and funding models for safety and quality, and reducing avoidable readmissions, are based on robust evidence
 - iii. Adjustments are based on evidence of a causal link to the condition or complication, and are commensurate with the additional care required as a result of the complication
 - iv. Adjustments relate to conditions or complications which clinicians and other health professionals are reasonably able to take action to reduce their incidence or impact
 - v. Pricing and funding models add to the evidence base for strategies to address safety and quality, with robust monitoring of the effectiveness of implementation and ultimately, their impact on patient outcomes.
 - b. Reforms are consistent with whole-of-system efforts to deliver improved patient health outcomes:
 - i. Adjustments complement existing national and state measures to improve patient health outcomes and reduce avoidable hospital demand, including but not limited to the ACSQHC's goals, national benchmarking, data reporting, and accreditation.
 - ii. The design and implementation of pricing and funding models acknowledge that mechanisms other than pricing and funding have a role in achieving the reform intention and that complementarity of all mechanisms is desirable.
 - iii. The design and implementation of pricing and funding models should not compromise State system financial sustainability and quality and should therefore be focused on system level performance improvement.
 - c. Reforms are transparent and comparable:
 - i. As far as practicable, the financial levers are designed to ensure there is transparency between the approach and the intended outcome.
 - ii. Pricing and funding models use an appropriate risk adjustment methodology to consider different patient complexity levels or specialisation across jurisdictions and hospitals.

- d. Reforms provide budget certainty
 - i. Any downward adjustment to an individual State is not deducted from the available pool of funding under the overall cap of 6.5 per cent.

Interaction with the funding cap

- 177. Adjustments to Commonwealth funding for an individual State resulting from Sentinel Events, HACs and Avoidable Hospital Readmissions will be incorporated in the calculation and determination of the State's Commonwealth Funding Entitlement. The Commonwealth Funding Entitlement for a given year, incorporating these adjustments, will form the base for the calculation of the State's soft cap in the following year.
- 178. Any downward adjustment to an individual State for Sentinel Events, HACs and Avoidable Hospital Readmissions will not be deducted from the total available pool of Commonwealth funding under the National Funding Cap and will be available for Redistribution.

Transparency

- 179. States agree to implement a pricing approach for sentinel events and safety and quality adjustments, to give effect to the model developed by the IHPA, within their funding and purchasing arrangements (including in Service Level Agreements and Purchasing Agreements) for public hospital services at the episode of care level.
- 180. States agree to each provide an annual report to AHMAC, within nine months from the end of the financial year, on the outcomes of the implementation of the pricing approach for safety and quality. These reports will include information on:
 - a. the financial impacts at the LHN level; and
 - b. any relevant safety and quality programmes.

Roles and responsibilities

- 181. COAG Health Council will oversee the continuing development, implementation and the ongoing refinement of reforms to integrate safety and quality into the pricing and funding of public hospital services, including:
 - a. advising national bodies of pricing and funding approaches, including any shadow approaches, for HACs and avoidable readmissions for implementation from 1 July 2018; and
 - b. final approval of the Sentinel Events and HAC lists for funding and pricing purposes.
- 182. States will seek to refine and improve public hospital activity monitoring and reporting capability to support the system in making safety and quality improvements.
- 183. The Commonwealth will work collaboratively with States and national bodies to support the introduction of pricing and funding reforms for public hospital services, and advise on how these reforms intersect with private hospital services and primary health care services.

184. In relation to the safety and quality reforms described in this Part and in addition to its normal functions described in the Agreement, the IHPA will:
- a. implement an approach whereby any episode of care that includes a Sentinel Event, across all care settings, will not be funded in its entirety;
 - b. shadow implement an approach whereby all HACs across every public hospital will have a reduced funding level to reflect the extra cost of a hospital admission with a HAC and will be risk adjusted;
 - c. Develop a preliminary report assessing the impact of the preferred model on funding, data reporting, clinical information systems, and specific population and peer hospital groups. The preliminary report will be subject to public consultation, with the final report to be submitted to COAG Health Council by 30 November 2017, and
 - d. Undertake further public consultation on a pricing and funding approach for avoidable hospital readmissions related to a prior HAC, based on a set of definitions developed by the ACSQHC.
185. In relation to the safety and quality reforms described in this Part and in addition to its normal functions described in the Agreement, the ACSQHC will:
- a. curate the Sentinel Events and HAC lists for the purposes of ensuring they remain robust and relevant for clinical improvement purposes, within its existing governance arrangements and in conjunction with IHPA Technical Advisory Committee advice;
 - b. establish a HAC Curation Clinical Advisory Group (HCCAG) to advise on new and existing complications on the HAC list. The HCCAG will have regard to the recommendations of specialty Clinical Panels established by the ACSQHC where necessary;
 - c. develop rates of preventability for each HAC to inform a risk adjustment methodology developed by IHPA;
 - d. lead development of a nationally consistent definition for avoidable hospital readmissions associated with a HAC; and
 - e. advise on clinician engagement.
186. The Administrator will:
- a. calculate Commonwealth Funding Entitlement of States with reported Sentinel Events, from 1 July 2017;
 - b. calculate Safety and Quality Adjustments to be made using the pricing and funding models nominated for this purpose by the Parties, from 1 July 2018 or such later date as the Parties nominate; and
 - c. advise the Commonwealth Treasurer of a) and b) during annual Reconciliation and a) during six monthly Reconciliation.

187. National bodies will regularly engage with the Parties and other relevant stakeholders through existing consultation mechanisms.

Reforms to primary care to reduce potentially avoidable hospital admissions

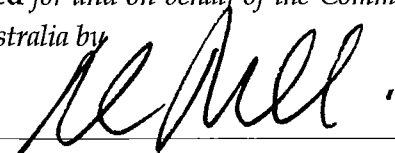
188. The Commonwealth will continue to invest in programmes designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control including:
- a. integrating the planning, co-ordination and commissioning of services at a regional level through Primary Health Networks, with a specific focus on the interface between primary health care, and hospital services;
 - b. investments in national implementation of co-ordination of care models for persons with complex, chronic conditions, including Health Care Homes, and flexible funding model to better support persons with severe mental health conditions, consistent with the November 2015 response to the National Mental Health Commission Report - *Contributing Lives, Thriving Communities*;
 - c. accelerating national rollout of My Health Records with legislative change to enable opt out provisions, with ongoing patient safety and efficiency benefits;
 - d. implementation of the 6th Community Pharmacy Agreement to enhance primary health care management of medications and avoidance of errors; and
 - e. partnering with jurisdictions, where appropriate, in relation to primary health care, for example in remote and Indigenous communities.

Miscellaneous arrangements

189. Parties note that as of 1 July 2016, the functions of the National Health Performance Authority have transferred to the Australian Institute of Health and Welfare, the ACSQHC and the Commonwealth Department of Health.
190. Parties note that as of 1 July 2016, the IHPA will comprise an independent board and chief executive officer, supported by officials from the Commonwealth Department of Health operating at the direction of the IHPA Chief Executive Officer.
- a. IHPA's functions, including setting the National Efficient Price and National Efficient Cost, will continue as set out in the Agreement and existing legislation.
 - b. The ongoing costs of the IHPA will continue to be met by the Commonwealth.
191. Parties note that Medicare Locals have been discontinued. The Commonwealth has established Primary Health Networks with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.
192. Parties note that references in the Agreement to the 'Standing Council on Health' will be taken to refer to the COAG Health Council and references to the 'Standing Council on Federal Fiscal Relations' should read as references to the COAG Council on Federal Financial Relations.

The Parties have confirmed their commitment to this schedule as follows:

Signed for and on behalf of the Commonwealth of Australia by



The Honourable Malcolm Turnbull MP
Prime Minister of the Commonwealth of Australia

June 2017

Signed for and on behalf of the State of New South Wales by

The Honourable Gladys Berejiklian MP
Premier of the State of New South Wales

[Day] [Month] [Year]

Signed for and on behalf of the State of Queensland by

The Honourable Anastacia Palaszczuk MP
Premier of the State of Queensland

[Day] [Month] [Year]

Signed for and on behalf of the State of South Australia by

The Honourable Jay Weatherill MP
Premier of the State of South Australia

[Day] [Month] [Year]

Signed for and on behalf of the Australian Capital Territory by

Andrew Barr MLA
Chief Minister of the Australian Capital Territory

[Day] [Month] [Year]

Signed for and on behalf of the State of Victoria by

The Honourable Daniel Andrews MLA
Premier of the State of Victoria

[Day] [Month] [Year]

Signed for and on behalf of the State of Western Australia by

Premier of the State of Western Australia

[Day] [Month] [Year]

Signed for and on behalf of the State of Tasmania by

The Honourable Will Hodgman MP
Premier of the State of Tasmania

[Day] [Month] [Year]

Signed for and on behalf of the Northern Territory by

The Honourable Michael Gunner MLA
Chief Minister of the Northern Territory of Australia

[Day] [Month] [Year]

The Parties have confirmed their commitment to this schedule as follows:

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The Honourable Malcolm Turnbull MP
Prime Minister of the Commonwealth of Australia

March 2017

Signed for and on behalf of the State of New South Wales by



The Honourable Gladys Berejiklian MP
Premier of the State of New South Wales

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March 2017

Signed for and on behalf of the State of Queensland by

The Honourable Anastacia Palaszczuk MP
Premier of the State of Queensland

March 2017

Signed for and on behalf of the State of South Australia by

The Honourable Jay Weatherill MP
Premier of the State of South Australia

March 2017

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Andrew Barr MLA
Chief Minister of the Australian Capital Territory

March 2017

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The Honourable Daniel Andrews MP
Premier of the State of Victoria

March 2017

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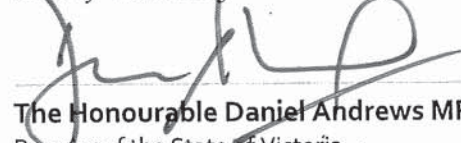
March 2017

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Andrew Barr MLA
Chief Minister of the Australian Capital Territory

March 2017

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The Honourable Daniel Andrews MP
Premier of the State of Victoria

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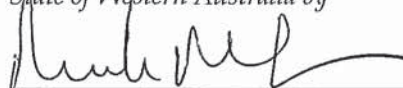
March 2017

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The Honourable Daniel Andrews MP
Premier of the State of Victoria

March 2017

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Premier of the State of Queensland

March 2017

Signed for and on behalf of the State of South Australia by

The Honourable Mark McGowan MP
Premier of the State of Western Australia

7 March 2017
April

Signed for and on behalf of the State of Tasmania by

The Honourable Jay Weatherill MP
Premier of the State of South Australia

March 2017

Signed for and on behalf of the Australian Capital Territory by

The Honourable Will Hodgman MP
Premier of the State of Tasmania

March 2017

Signed for and on behalf of the Northern Territory by

Andrew Barr MLA
Chief Minister of the Australian Capital Territory

March 2017

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Chief Minister of the Northern Territory of Australia

March 2017

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Premier of the State of New South Wales

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Premier of the State of New South Wales
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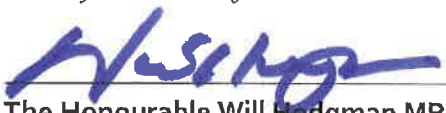
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March 2017

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Premier of the State of Tasmania
March 2017 16 June 2017

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The Honourable Michael Gunner MLA
Chief Minister of the Northern Territory of Australia
March 2017

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Andrew Barr MLA
Chief Minister of the Australian Capital Territory

27 March 2017

The Honourable Will Hodgman MP
Premier of the State of Tasmania

March 2017

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March 2017

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March 2017

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Chief Minister of the Northern Territory of Australia

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