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National Health
Funding Pool

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2026-27

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Approval

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1 BACKGROUND

In August 2011, the then Council of Australian Governments (now National Cabinet) agreed to major changes in how public hospitals were to be funded by Commonwealth, State and Territory governments, including the move from block grants to an 'activity-based' funding system (ABF).

These changes included establishing the Administrator of the National Health Funding Pool (the Administrator) and the National Health Funding Body (NHFB) to improve transparency of public hospital funding arrangements.

The *National Health Reform Agreement 2011* (NHR Agreement) outlines the shared responsibility of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

This document sets out the approach and processes used by the Administrator to calculate Commonwealth NHR funding paid to States and Territories (hereafter, the States).

The calculation policy includes calculation methodology for ABF, Block and Public Health funding categories as well as the approach to reconciliation activities.

The policy has been updated to reflect the revised funding arrangements resulting from the *Addendum to National Health Reform Agreement 2026-2031* signed on 27 February 2026. It undergoes annual updates to reflect the calculations for the upcoming year, with the current iteration focusing on financial year 2026-27 calculations.

Modifications for the *Addendum to National Health Reform Agreement 2026-2031* include:

- Transition from a growth formula to a glide path formula
- Base Year for 2025–26 to include additional funding (i.e. Schedule K), with subsequent base years reflecting the prior year's funding cap
- An increase in the funding cap from 6.5% to 10.25% in the first year, and 8% in following years
- Introduction of a minimum funding guarantee (additional $15 billion)
- Introduction of a new funding stream for Service Model Reform Funding (SMRF) commencing 2027-28
- Continuation of existing Public Health Funding arrangements until Public Health Funding is incorporated into the Block Funding stream
- Transition from no reconciliation of Block Funding to reconciling Block Funding against actual payments from State Managed Funds.

2 LEGISLATIVE AND POLICY FRAMEWORK

Legislative Framework

The framework for Commonwealth public hospital funding as well as the functions and responsibility of the Administrator are underpinned across a legislative framework. The components of the framework are listed:

- *National Health Reform Act 2011*
- *National Health Reform Agreement 2011*
- Addendum to the National Health Reform Agreement 2017-18 to 2019-20
- Addendum to the National Health Reform Agreement 2020 to 2026 *(inclusive of Schedule K extension)*
- Addendum to the National Health Reform Agreement 2026-2031
- Federal Financial Relations
- Intergovernmental Agreement on Federal Financial Relations

The legislative instruments and agreements can be found on the websites

- Federal Register of Legislation
- Federal Financial Relations

Administrator's Policy Framework

The Administrator's policies make transparent the approach taken to perform the Administrator's functions. This includes the provision of data, data quality and management, calculation of initial payments, reconciliation of final entitlements, funding integrity, and guidance on the operation of the National Health Funding Pool.

THREE-YEAR DATA PLAN

The Administrator's Three-Year Data Plan describes the Administrator's determination of the minimum level of data required from the Commonwealth and States, to calculate the Commonwealth's national health reform funding to public hospital services, conduct reconciliation activities, undertake funding integrity and report publicly on NHR funding and payments. The Administrator's Three-Year Data Plan is developed in close coordination with IHACPA's Three-Year Data Plan.

DATA COMPLIANCE POLICY

The Data Compliance Policy comprises the Administrator's policy on jurisdictional compliance with data provision as required in the Administrator's Three-Year Data Plan. The NHFB, on behalf of the Administrator, publishes a quarterly Data Compliance Report on jurisdictional compliance with the Data Plan and Data Compliance Policy.

DATA GOVERNANCE POLICY

The Data Governance Policy covers both the Administrator and the NHFB and details the information collected, the purpose for the collection, its use, storage, disclosure, security, and disposal, by the Administrator.

CALCULATION OF COMMONWEALTH NATIONAL HEALTH REFORM FUNDING

This document sets out the approach and process used by the Administrator to calculate Commonwealth NHR funding paid to States. The calculation policy includes funding for ABF, Block and Public Health funding categories as well as the approach for reconciliation activities.

BUSINESS RULES FOR DATA MATCHING

The business rules outline the business and data matching rules in relation to clause A218 of the NHR Agreement, where assessment is undertaken to ensure the Commonwealth does not fund activities twice, through ABF and through MBS and/or PBS funding.

NATIONAL HEALTH FUNDING POOL PAYMENTS SYSTEM MANUAL

The Manual covers the procedures for authorised NHFB and State staff to process Pool deposits and payments through the Payments System.

3 ROLES

Role of the Administrator

The Administrator of the National Health Funding Pool (the Pool) is a statutory office holder, independent from Commonwealth and State Governments and is appointed to the position under Commonwealth and State legislation.

The position was established by the NHR Act (2011) and relevant legislation of each State. The Administrator is supported by the NHFB, which is also independent of all governments. The key functions of the Administrator, with the support of the NHFB, are to:

- Accurately calculate and advise the Commonwealth Treasurer on Commonwealth funding contributions.
- Undertake best practice financial administration of the Pool, ensuring:
  - The integrity of the payments system
  - Commonwealth and State payments are correct and timely
  - Payments to Local Hospital Networks (LHNs) from the Pool follow government directions
  - Reconciliation between estimated and actual volumes of services and payments every six months
- Provide effective reporting on the monthly and annual funding arrangements to ensure transparency in the operation of the Pool.
- Maintain productive and effective relationships with stakeholders and strategic partners, including all Australian Governments, the Independent Health and Aged Care Pricing Authority (IHACPA), the Australian Institute of Health and Welfare (AIHW) and the Australian Commission on Safety and Quality in Health Care (ACSQHC).

Role of the Commonwealth and the States

Under the NHR Agreement, the Commonwealth and States are jointly responsible for:

- funding public hospital services in Australia, using ABF where appropriate and Block funding in other cases
- funding in public hospital services and variations in the cost of public hospital services
- establishing and maintaining nationally consistent standards for health care and reporting to the community on the performance of health services
- collecting and providing data to support comparability and transparency, and data sharing arrangements to promote better health outcomes.

The NHR Agreement recognises the States as the system managers of the public hospital system. A core element of being the system manager of public hospitals is to ensure services are appropriately funded. Therefore, each State determines the amount they pay for public hospital services and functions, and the mix of those services and functions, and meets the balance of the cost of delivering public hospital services and functions over and above the Commonwealth NHR funding.

In determining the mix of services and functions provided, States work with LHNs to develop Service Agreements (clause E7 of the Addendum) and estimates of activity to be delivered. These Service Agreements are provided to the Administrator for funding purposes and are updated throughout the year as needed.

The States are responsible for hospital data quality, integrity and timeliness. To enable the calculation of Commonwealth NHR funding, States collect and provide data as specified in the Administrator's Three-Year Data Plan. The data submitted to the Administrator for Reconciliation activities is required to be timely, complete, and accurate, meeting appropriate assurance requirements.

The Commonwealth is also responsible for system management, policy and funding for GP, primary and aged care services. Its role is to promote coordinated, equitable and timely access to GP and primary health care service delivery, work with States on system-wide policy and state-wide planning for GP and primary health care, policy planning, funding, management and delivery of aged care system.

4 FUNDING AND PAYMENTS

Components of National Health Reform Funding

The Administrator's calculation of 2026-27 Commonwealth NHR funding includes the following major components:

- Activity Based Funding (ABF) (See **Section 6**), which is used to fund public hospital services based on the number of services provided and the price to be paid for delivery
- Block funding (See **Section 7**), which is provided to support teaching, training and research undertaken in public hospitals and public hospital services and functions that are more appropriately funded through block grants
- Public Health Funding (See **Section 8**), which covers amounts relating to national public health initiatives (service delivery).

Additionally, adjustments are made to Commonwealth NHR funding (ABF and Block) for:

- Funding Cap, if exceeded (See **Section 9**)
- Data Conditional Payments, Safety and Quality adjustments, Private Patient Neutrality and for Data Matching adjustments in specified circumstances (See **Section 10**)
- Annual Reconciliation (See **Section 11**)

National Health Funding Pool

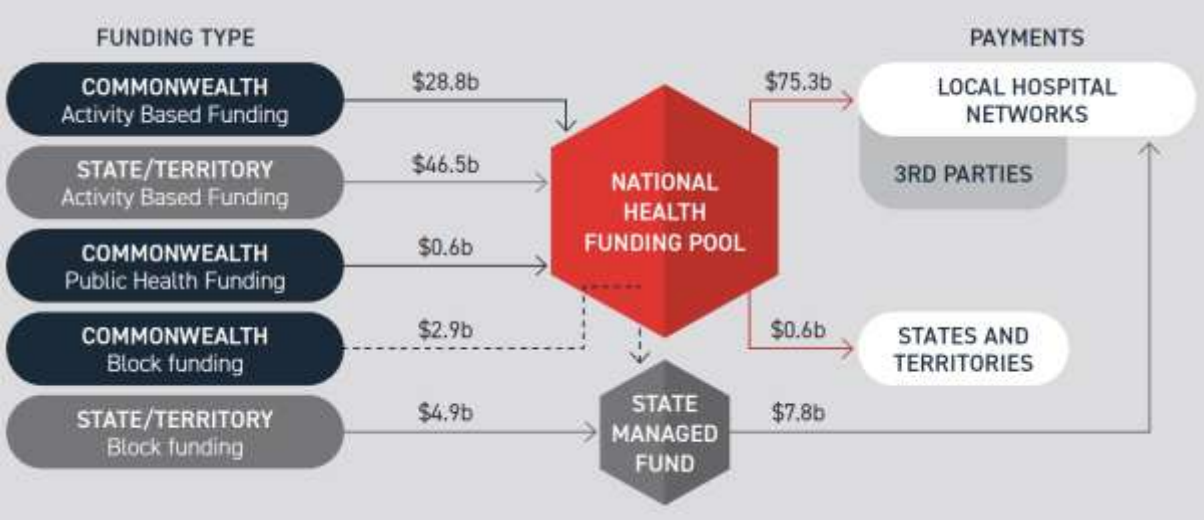
The National Health Funding Pool (the Pool) was established to receive all Commonwealth (ABF, Block and Public Health) and State (ABF) public hospital funding. The Pool comprises of a Reserve Bank of Australia (RBA) account for each State, with each State also having established a State Managed Fund (SMF) to manage Block funding.

The Pool and SMF provide a line-of-sight mechanism to trace each jurisdiction's contribution to LHNs and third parties. The funding in the Pool is paid to States (including public health, cross border, interest and over deposits).

Figure 1 highlights the source, types and amount of funding and payments that flowed through the Pool and SMFs in 2025-26.

The NHR Agreement also allows for additional streams of funding to be paid through the Pool if agreed by Government.

FIGURE 1 2025-26 Public Hospital Funding Payment Flows



5 COMMONWEALTH CONTRIBUTION MODEL

Commonwealth funding for ABF and Block categories is calculated using the Commonwealth Contribution Model (CCM), an accurate, transparent and independently reviewed methodology. Public Health funding is indexed and calculated by the Commonwealth Department of Health, Disability and Ageing.

The CCM calculations form the basis of the Administrator's payment advice to the Commonwealth Treasurer. This advice is also provided to Commonwealth and State Health Ministers and their Departments.

There are two broad types of funding calculated using the CCM, ABF and Block funding. Under the NHR Agreement, the scope of public hospital services that are funded on an ABF or Block funding basis is determined by IHACPA and in accordance with section 131(1)(f) of the *National Health Reform Act 2011 (Cth) (*NHR Act) and clauses A100–A110 of the Addendum to the NHR Agreement. Broadly the services eligible for a Commonwealth funding contribution currently includes:

- Emergency department services provided by a recognised emergency department.
- Admitted and non-admitted services (including community mental health services).
- Other outpatient, mental health, sub-acute services and other services that could reasonably be considered a public hospital service.

Public hospitals also receive funding from other sources, including the Commonwealth, States and third parties for the provision of other specific functions and services outside the scope of the NHR Agreement (e.g. pharmaceuticals, primary care, home and community care, dental services, residential aged care and disability services).

Calculation Inputs

To calculate NHR funding, relevant inputs are required from the IHACPA, Commonwealth Department of Health, Disability and Aged Care, and State Health Departments.

THE IHACPA

The IHACPA's determination of the National Efficient Price (NEP) and National Efficient Cost (NEC) are important inputs for calculating Commonwealth NHR funding, providing the price for ABF funding (NEP) and the cost for Block funding (NEC).

COMMONWEALTH DEPARTMENT OF HEALTH, DISABILITY AND AGEING

Commonwealth Department of Health, Disability and Ageing provides the annual figures for Public Health funding, which are calculated using the growth factor for Commonwealth Health Specific Purpose Payments (pre NHR Agreement).

STATES AND TERRITORIES

SERVICE CATEGORY ACTIVITY ESTIMATES

States are required to provide the Administrator with estimates of expected activity, expressed as National Weighted Activity Units (NWAU) for ABF funded services. These are used by the Administrator to calculate the formal forecast of Commonwealth NHR Agreement ABF and advise the Commonwealth Treasurer. Both Commonwealth and State payments are made prospectively based on the estimated service activity that is negotiated between the States and their LHNs.

Estimates can be provided both prior to and during the relevant financial year, formally (binding) and informally (non-binding). Binding estimates result in a change to the forecast level of activity and a corresponding adjustment to Commonwealth NHR funding, while non-binding estimates are simply for information and do not trigger a funding adjustment.

FORMAL ACTIVITY ESTIMATES (BINDING)

States must provide, at a minimum, two formal service activity estimates prior to the commencement of the relevant financial year:

- Aggregate State activity by service category, due by **31 March** of the preceding financial year (A179); and
- LHN activity by service category, due by **31 May** of the preceding financial year (A180).

Service activity estimates are underpinned by the Service Agreements. Clause A169 requires States to provide the Administrator with a copy of the Service Agreement for each LHN once agreed between the State and the LHN. States must provide Service Agreements as set out in clause E7 within 14 calendar days of finalisation and no later than **15 December** of the relevant financial year.

As per Clause A116, if States do not provide Service Agreements or service volume statements by the agreed timeframes set out in clause A169, or do not meet the requirements as set out in Schedule A or Schedule E, the Administrator may use the previous financial years' Service Agreement to calculate the formal forecast, amended by the change in the published NEP for the relevant year.

In accordance with clauses A114 and A122, States and LHNs can vary Service Agreements during the financial year as required and formal updated estimates of activity can be provided to the Administrator for funding purposes during the financial year.

The Administrator encourages States to provide updated service estimates in November and March of the relevant financial year to assist with the accuracy of Commonwealth and State Budget calculations. Updated service estimates should align with LHN Service agreements.

Adjustments advised to the Administrator by the last business day on or before the 15th of a month, take effect in the Commonwealth NHR funding in the following month. If advised later than the 15th of the month, the change takes effect in the second following month. It is expected that States provide their updated LHN Service Agreements prior to or within 14 days of formally revising estimated activity.

The use of these estimates for ABF purposes and the need to avoid significant cash flow variations for LHNs reinforces the need for States to have estimates that are as robust as possible and that reflect actual activity to the greatest extent possible.

INFORMAL ACTIVITY ESTIMATES (NON-BINDING)

To assist jurisdictions with budget certainty, clause A181 allows States to provide non-binding advice of service estimates to the Commonwealth and the Administrator, without the need to vary Service Agreements.

Confidential budget planning advice may be provided by jurisdictions at any time prior to or during the relevant financial year. States are encouraged to provide non-binding estimate advice throughout the relevant financial year, to inform Commonwealth and State Budget calculations and assist States with internal planning processes.

Non-binding advice provided to the Administrator will be shared with the Commonwealth. The advice will not be used in the calculation of Commonwealth NHR funding for the purpose of payments or cash flows to LHNs within the current year.

6 ACTIVITY BASED FUNDING

ABF is a funding method for public hospital services based on the number of weighted services provided to patients and the price to be paid for delivering those services.

The IHACPA's NEP Determination and Pricing Framework, issued prior to the commencement of the relevant financial year, determines the hospital services in scope for Commonwealth NHR funding. States provide data detailing these in scope hospital services for confirmation of eligibility by the Administrator.

The following service categories are funded through ABF in 2026-27:

- Emergency department services.
- Acute admitted services.
- Admitted mental health services
- Sub-acute and non-acute services
- Non-admitted services
- Community mental health services

Outlined in the Addendum to the National Health Reform 2026-2031, the Commonwealth will fund ABF service delivery at an increasing contribution rate, as per clause A36 of the Addendum (see **Table 1**).

TABLE 1 Commonwealth contribution glide path for ABF, 2026-27 to 2030-31

2026-27	2027-28	2028-29	2029-30	2030-31
40.5%	41.0%	41.5%	42.0%	42.5%

Commonwealth NHR funding is calculated as per clause A22, for all ABF service categories, individually for each State by calculating the product of:

- **Activity** – the volume of weighted ABF services provided in the current year for that State, measured in National Weighted Activity Units (NWAUs)
- **Price** – the National Efficient Price for that year, as determined by the IHACPA; and
- **Input Contribution Rate** – the contribution rate for the relevant financial year, the minimum as determined in Table 1

The input CCR for ABF funding for each year is the **greater of**:

- The CCR specified in clause A36, or
- The State's 2025-26 ABF CCR calculated in accordance with clause A32.

If a service category is moved from another funding stream to ABF, the CCR for that service category will be that of the higher funding stream (up to a maximum of 45.0 per cent). This ensures there is no funding disadvantage due to a change in CCR caused by a change in funding stream.

As per clause A32, each State's 2025-26 ABF CCR (or base year ABF CCR) will be calculated as follows:

$$2025-26\ ABF\ CCR = \frac{\text{ABF entitlement for 2025-26}}{\text{Total volume of weighted services for 2025-26} \times NEP \text{ for 2025-26}}$$

With Tasmania's 2025-26 ABF CCR accounting for Mersey Community Hospital calculated by

$$2025-26\ ABF\ CCR = \frac{\text{TAS ABF entitlement for 2025-26} + \$32{,}858{,}722}{\text{Total volume of weighted services for 2025-26} \times NEP \text{ for 2025-26}}$$

As the 2025-26 annual reconciliation will not be completed until after the commencement of this Addendum, each State's ABF and Block CCR for 2025-26 will be provisionally calculated based on the most recent payment advice provided by the Administrator to the Commonwealth Treasurer. The CCR for these streams will be recalculated once the 2025-26 annual reconciliation is completed.

Under the previous Addendum, Commonwealth ABF calculations incorporated back-casting of changes to the classifications, counting rules or pricing methodology between the base year and the growth year. As of 2026-27 back-casting has been removed and is no longer a required component to calculate Commonwealth ABF funding.

Calculating ABF

There are two stages in the calculation and determination of ABF:

- Stage 1. Based on estimated activity for the relevant financial year (see **Appendix E: Calculation example 1**);
- Stage 2. Based on actual activity for the relevant financial year (see **Appendix E: Calculation example 2**).

These milestones are highlighted in the Timeline in **Section 12: Timeline**.

The ABF calculation process is the same for each calculation stage; however, the calculation basis may alter between stages due to the inclusion of annual actual hospital activity data. The 2026-27 ABF calculation is shown in **Figure 2** below.

FIGURE 2 2026-27 ABF calculation

Activity National Weighted Activity Unit	x	**NEP26** National Efficient Price 2026-27	x	**Input CCR** ABF Cwlth Contribution Rate	=	**ABF** 2026-27 Activity Based Funding

The NEP is the same for all ABF service categories, and the volume (in NWAU) is based on a State aggregation of LHN service category activity for all ABF service categories. The Input CCR for ABF is determined by the greater of a State's 2025-26 ABF CCR or the glide path as per clause A36 of the Addendum. Service category Commonwealth ABF for each State is calculated by multiplying the State's NWAU for the relevant service category by the relevant financial year's NEP, and by the CCR for that State.

TABLE 2 ABF calculation for each service category

Calculation Example for Acute Admitted						
2026-27 ABF Acute Activity for State	x	2026-27 National Efficient Price	x	2026-27 ABF Cwlth Contribution Rate	=	2026-27 ABF Acute Cwlth funding for State

Commonwealth ABF for each LHN service category is determined by multiplying the LHN's NWAU for the relevant service category by the relevant financial year's NEP, and by the CCR for that State.

TABLE 3 ABF calculation for each LHN and each Service Category

Calculation Example						
2026-27 ABF Acute service volume for LHN	x	2026-27 National Efficient Price	x	2026-27 ABF Cwlth Contribution Rate	=	2025-26 ABF Acute Cwlth funding for LHN

The Commonwealth ABF for each LHN (being the sum of the amounts for each service category) is paid via the NHFP in equal monthly amounts (clauses A153 and A157 of the Addendum).

Commonwealth ABF payment

Estimated Commonwealth NHR funding paid during the financial year to States (excluding prior year Reconciliation see below) is subject to the Funding Cap (clause A38, A41).

Final Commonwealth Funding Entitlement is subject to the Funding Cap as well as other items such as the Minimum Funding Guarantee (clause A53) and the Sentinel Event safety and quality adjustment (A91). These are applied when Annual Reconciliation of actual annual hospital activity data is undertaken in the following financial year.

The Addendum establishes a mechanism to redistribute unspent cap funding in 2030-31, including a top-up for States below 42.5% ABF CCR (clauses A48-A52). SMRF unspent amounts are excluded from redistribution (clause A29(b)). The operation of this mechanism will be included in future calculation policy updates.

Clause A197 states that Commonwealth cross-border funding is to flow to the provider State (where the service occurred). The quantum of services provided for interstate residents is included in each State's LHN NWAU and reflected in the Commonwealth NHR funding for ABF (for both estimates and Annual Reconciliation). This ensures each State's entire ABF service levels (including cross-border services) are included in the ABF calculation. Commonwealth funding for patients identified in Non Self Governing Territories will not contribute towards the NHR Funding Cap for the States and that those residents are 100% funded in the reconciliation outcome.

7 BLOCK FUNDING

Block funding supports training and research in public hospitals, mental health (not covered by ABF activities) and other public health programs. It is also used for certain public hospital services where Block funding is more appropriate, particularly for smaller rural and regional hospitals.

Categories of Block funding in 2026-27 include:

- Teaching, training and research (TTR)
- Small rural hospitals (SRH)
- Other mental health
- Non-admitted home ventilation
- Other non-admitted services
- Other hospital programs
- Highly specialised therapies (HST)

Note: 'Small rural hospitals' also includes major city and other standalone hospitals. As of 2024-25, standalone hospitals providing specialist mental health services (Appendix B of the NEC determination) have been moved from SRH to Other Mental Health.

For 2026-27, the Commonwealth funds a fixed per cent of the cost of providing Block funded services as defined in the CCR glide path at A36 in the Addendum (except for HSTs where the Commonwealth funds 50 per cent of the cost).

The IHACPA determines which hospital services and functions are eligible for Commonwealth funding on a block basis (clause A68), the Administrator then calculates the Commonwealth's funding (clause A24). The IHACPA determines the efficient cost of block funded hospitals using a fixed-plus-variable cost model.

In accordance with the new Addendum (clauses A130 and A132) the Administrator will work in consultation with the IHACPA to reconcile block funding amounts during the Administrator's Annual Reconciliation. Any changes to the Commonwealth funding and its subsequent impact will be communicated with stakeholders.

For HSTs, provider States are required to submit actual cost data at patient level to facilitate the calculation of incurred HST costs. This will allow the NHFB to incorporate HSTs into the annual reconciliation of the relevant financial year.

Block Funding Inputs

Under the Agreement, the Administrator calculates the Commonwealth NHR funding for eligible Block services and functions using IHACPA's NEC Determination.

The Block funding amounts contained in the NEC Determination are total figures (i.e. inclusive of both Commonwealth and State components) for each Block funded service category. Therefore, the Administrator is required to determine the Commonwealth NHR Agreement component of this total figure.

Calculating Block Funding

Block funding is calculated at a service category level for each State as per the IHACPA NEC Determination and Pricing Framework.

The Commonwealth's funding contribution for each block service category will be calculated for each State by multiplying:

- Cost – the National Efficient Cost for each State in the current year for that block service category as determined by the IHACPA.
- Input Contribution Rate – the greater of the glide path rate specified in clause A36 or the State's 2025-26 block CCR.

A State's block CCR can be defined as per the formula

$$State\ Block\ CCR\ = \frac{\text{Block Funding entitlement for Year X in State}}{\text{National Efficient Cost for Year X in State}}$$

Application of the input contribution rate to determine Commonwealth block funding is provided in **Table 4**.

TABLE 4 Commonwealth block funding calculation

Block Funding calculation				
2026-27 Input CCR for block funding	x	2026-27 NEC for Block Category	=	2026-27 Commonwealth Block funding

For more detailed calculation steps for Block funding see **Appendix B.**

Commonwealth Block Payment

Block funding is paid at an aggregate State level via the Pool to State Health Departments in equal monthly amounts (clause A153 of the Addendum). Payments flow through pool accounts to State Managed Funds and from there to LHNs.

Small Rural Hospitals

Small Rural Hospitals as defined in the Administrator's payment advice are derived from the appendices of the relevant IHACPA NEC determination year below:

- Appendix A – Block funded small rural hospitals
- Appendix C – Standalone major city hospitals providing specialist services
- Appendix D – Other standalone hospitals

The costs per establishment (provided by IHACPA) are aggregated to the State level and input into the Commonwealth Contribution Model. Hospitals or establishments listed in Appendix B of IHACPA's NEC determination are funded under 'Other Mental Health' in the Administrator's payment advice.

Previously where a block funded establishment transitioned from block funding arrangements to activity-based funding, the base funding for ABF and Block as well as the activity growth for ABF calculations were adjusted accordingly to account for the transition. For transitions in 2026-27 onward, any establishments transitioning to ABF will need to report their NWAU as part of the ABF estimate submissions.

As per clause A73c of the Addendum, if an establishment is listed in IHACPA's NEC determination but is activity-based funded by the State(s), the establishment will be removed from the Administrator's Commonwealth block funding calculations. Identification and removal of establishments from block funding will be done in consultation with affected States.

Other Mental Health

As of 2024-25, all mental health block funding services will be consolidated and reported under a single service category in the Administrator's payment advice.

For 2026-27 calculations, the transitional community mental health is not included in NEC26. 'Other Mental Health' has been revised to fund the following mental health services from the following block service categories:

- Standalone facilities providing mental health services as listed in the NEC26 determination (Appendix B of the National Efficient Cost Determination)
- Residential Mental Health
- Block funded Community Mental Health LHNs (as identified in Appendix E of IHACPA's NEC determination)
- Other non-admitted services where funding is used for mental health activities (amounts advised by States)

The NEC amounts will be combined and the calculation applied to the new service category. Calculations for the new service category will be distributed to States.

Highly Specialised Therapies

The Commonwealth will fund contribution for HSTs at 50 per cent of the determined cost. Further, Commonwealth funding for HSTs will be exempt from the Funding Cap (See **Section 9 Funding Cap**) for a period of two years from the commencement of service delivery of the new treatment.

HSTs eligible to receive Commonwealth NHR funding are recommended by the Medical Services Advisory Committee (MSAC) for delivery in public hospitals under the HST clause.

The IHACPA determines the costs for delivering HSTs through the NEC Determination based on advice from the States. The NHFB will reconcile the actual costs and the associated number of patients treated (NWAU is excluded from ABF), in consultation with the IHACPA and provider and resident States as part of the annual reconciliation process.

TREATMENT OF HST FUNDING DURING THE FINANCIAL YEAR

During the financial year and prior to the Annual Reconciliation, the Funding Cap (see **Section 9**) is applied to the total State uncapped funding entitlement (the sum of the State's Activity Based Funding, Block, including HST funding, and Public Health Commonwealth funding entitlements).

The HST block funding for the State will not be exempt from establishing whether the Funding Cap has been exceeded or not. That is, should total State funding entitlement exceed the Funding Cap, State's activity-based funding will be adjusted down. The amount of the individual State's funding is applied equitably to LHNs through a proportional reduction in the calculated CCR.

This approach to funding during a financial year is consistent with prior year calculations. The Administrator will not apply Funding Cap exemptions in excess of the Funding Cap until Annual Reconciliation when the actual cost data supporting the calculation becomes available.

TREATMENT OF HST FUNDING AT ANNUAL RECONCILIATION

Pursuant to Clause A235b of the Addendum, the Commonwealth contribution to HST funding, that fits within the two-year exemption from the Funding Cap, will not be taken into account when determining whether total Commonwealth NHR funding exceeds the Funding Cap at Annual Reconciliation.

There are three parts to implementing the exemption from the Funding Cap:

- Determining the scope of the exemption
- Measuring the two-year exemption period
- Implementing the HST funding exemption at Annual Reconciliation

SCOPE OF THE HST EXEMPTION PERIOD

The funding cap exemption for HSTs will apply for each new facility providing a new MSAC approved HST treatment within each State for a two-year period. The examples below provide further information on the application of the scope

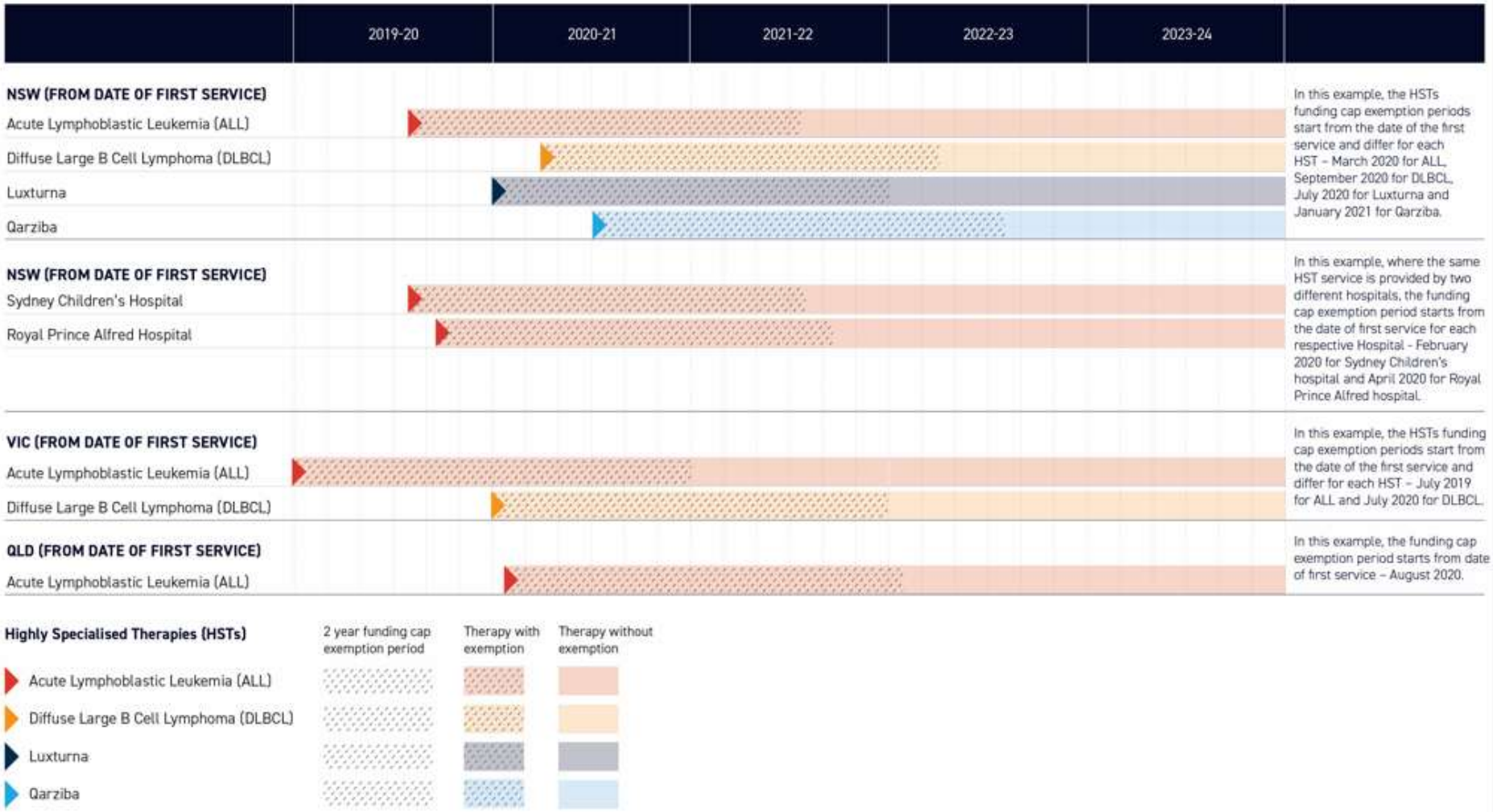
Facility	Treatment	HST exemption
Facility A	Treatment A (MSAC approved, first application at Facility A)	In scope. As this is the first instance of this MSAC approved treatment at Facility A.
Facility A	Treatment B (no MSAC approval, first application at Facility A)	Out of scope. Treatment is not MSAC approved.
Facility B	Treatment A (MSAC approved, provided 6 months after Facility A)	In scope. First instance of a MSAC approved treatment at Facility B. Receives full 2-year exemption starting at date of first service at this facility. Exemption scope is facility based.
Facility A	Treatment C (MSAC approved, first application at Facility A)	In scope. As this is the first instance of this MSAC approved treatment at Facility A.

MEASURING THE TWO-YEAR EXEMPTION PERIOD

The exemption implementation approach is to apply the two-year exemption from the date of service commencement for each new facility delivering an approved HST.

For example, if State A delivered their first Kymriah HST on 15 July 2021, the exemption for State A would be applied from 15 July 2021 to 15 July 2023. An implication of this approach is that if the HST does not commence on the first day of a financial year, then the two-year exemption period will overlap three financial years rather than two financial years. In this case, during the third financial year the Funding Cap exemption will only apply for a fraction of the HST costs for the financial year. Determining the fraction of the HST cost that will be exempt from the Funding Cap at Annual Reconciliation will be determined by apportioning the cost based on the period the exemption falls within a financial year.

FIGURE 3 Illustrated two-year exemption period, by State



IMPLEMENTATION OF THE HST FUNDING EXEMPTION AT ANNUAL RECONCILIATION

Consistent with the previous Addendum, the HST exemption to the Funding Cap will be applied at the annual reconciliation. The impact of the HST block funding for the State on their activity-based funding will be removed at annual reconciliation. This will only need to be done for States that exceed their Funding Cap and are entitled to funding above the Cap. In the case a State is below their Funding Cap, the State will be paid their uncapped entitlement.

Applying the exemption to the Funding Cap will require States to provide information supplementary to Submission A files on patients and activity receiving HST. This will assist with ensuring a State does not inadvertently receive both block and ABF funding for a HST.

During the reconciliation process the exemption will be applied in accordance with a three-step approach.

- **Step 1** — Annual reconciliation of HST funding: apply an adjustment in the CCM to convert estimates of block funded HST amounts into actual HST costs. The reconciliation adjustment will be based on actual HST costs determined and estimated payments based on the NEC amounts issued by IHACPA.
- **Step 2** — Determine the amount of HST Block funding eligible for Funding Cap exemption.
- **Step 3** — Remove the HST funding impact on the Funding Cap and State ABF.

Step 1 – Annual Reconciliation of HST Funding

To enable the IHACPA and the NHFB to undertake the reconciliation activities, States providing HST services are required to submit actual activity and cost data following the completion of the relevant financial year. As of the Administrator's November 2025 JAC, a data request specification (DRS) sheet was provided to States to standardise HST cost submissions. The DRS captures information such as:

- Record level activity associated with providing HSTs (stateids, estids)
- Actual costs incurred with breakdown of fixed / variable costs for each HST (provided by product and treatment);
- LHNs and establishments providing HST services
- Dates on which the HST services were provided

The actual HST cost data will be used by the NHFB to determine the actual HST funding for each State providing HST services. The reported cost should correspond to the expenses incurred in the relevant financial year for patients treated in that year. If a patient has not completed their final treatment stage by the end of the relevant financial year, then costs incurred up to the end of the financial year should be reported. In this instance, the remaining costs up to the final treatment should be reported in the following financial year and will be reconciled as part of the following financial year's reconciliation.

The NHFB will utilise the actual HST costs to determine the actual HST Block funding entitlement for the relevant financial year.

For example, the estimated 2026-27 Commonwealth Block funding calculation for HST is calculated as follows:

Block Funding				
50% contribution rate	X	2026-27 National Efficient Cost for State as per IHACPA NEC determination	=	Estimated 2026-27 Cwlth Block funding for HSTs

Subsequently, the actual 2026-27 HST Commonwealth Block funding will be calculated using the below formula by incorporating the actual total costs submitted by provider States to the Administrator for HST reconciliation:

Block Funding				
50% contribution rate	X	Final determined costs by the Administrator as per annual reconciliation submissions	=	Actual 2026-27 Cwlth Block funding for HSTs

Similar to ABF, the Annual Reconciliation adjustment is calculated as the difference between the HST Commonwealth Block Funding based on the estimated NEC allocation and the actual cost incurred for the relevant financial year. Subsequently, subject to the Commonwealth Treasurer's Determination, the adjustment is spread evenly over the relevant adjustment period with any rounding differences made up in the final month of the adjustment period.

Separately, the NHFB will utilise the actual HST activity data to ensure hospital activities relating to HST patients are excluded from the ABF reconciliation. States are required to identify records in the alternative funding source (AFS) data submissions which relate to HST patients. The corresponding records in the hospital activity file will be assigned an NWAU of zero as part of the NWAU calculations.

Step 2 – HST amount eligible for Funding Cap exemption

Depending on when the HST exemption period ends, only a proportion of the State's actual HST Commonwealth Block funding for the relevant financial year may be eligible for the Funding Cap exemption. The proportion is calculated for each State and each HST based on the number of days exempt in the relevant financial year:

$$HST\ Proportion\ =\ (Exemption\ End\ Date - Start\ day\ of\ financial\ year)/365.25$$

In the event where the exemption period ends after the end of the relevant financial year, the HST proportion applied at Annual Reconciliation will be 100 per cent. On the other hand, if the exemption period has ended prior to the start of the relevant financial year, then the HST proportion applied will be 0 per cent.

This then provides a ratio that is multiplied by the HST NEC amount for each HST and the CCR for all HSTs to determine the HST amount eligible for exemption from the Funding Cap.

$$HST\ amount\ eligible\ for\ exemption\ =\ \sum HST\ NEC\ \times HST\ CCR\ \times\ HST\ Proportion$$

The State's HST CCR for all HSTs is calculated as per below:

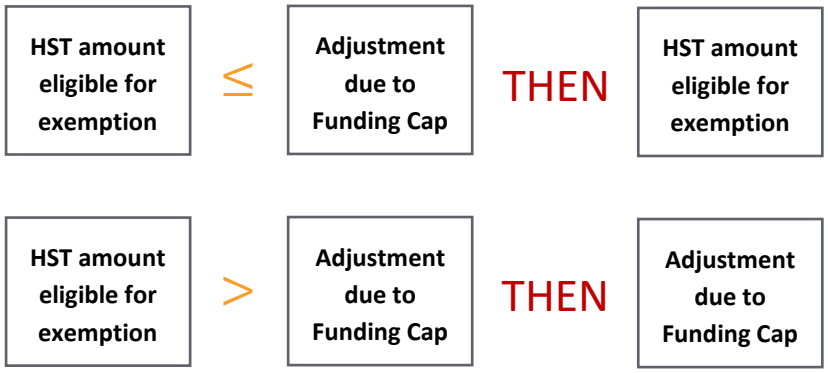
$$HST\ CCR\ =\ \frac{HST\ Commonwealth\ Block\ funding}{HST\ National\ Efficient\ Cost}$$

Step 3 – Removing the impact of the HST funding cap exemption from State ABF

Based on the HST amount eligible for exemption from the Funding Cap we can determine the impact of HST funding on the Funding Cap for the State. The total funding adjustment for the State due to the Funding Cap is calculated as follows:

$$Adjustment\ due\ to\ Funding\ Cap = \ Uncapped\ ABF - Funding\ Cap\ ABF$$

Given that the impact of HST funding on the Funding Cap can only be up to the total funding adjustment due to the Funding Cap, the HST Funding Cap impact can be determined as the lower of the HST amount (eligible for exemption from the Funding Cap), and the total funding adjustment due to the Funding Cap. Specifically, the steps to determine the HST Funding Cap Impact is as follows:



Finally, to exclude the impact of HST on the State's ABF entitlement, the calculated HST impact on the Funding Cap is reversed by adding it back to ABF resulting in a higher ABF entitlement for the State.

$$ABF\ after\ Exemption = \ ABF\ post\ Funding\ Cap\ application + HST\ Funding\ Cap\ Impact$$

8 PUBLIC HEALTH FUNDING

States have full discretion over the application of Public Health funding to the outcomes as set out in the National Healthcare Agreement 2012 per clause A26b. The Public Health funding amount for each State grows by the National Healthcare Specific Purpose Payment (SPP) growth factor (clause A26a), which is advised to the Administrator by the Commonwealth Department of Health, Disability and Ageing. The SPP growth factor is made up of:

- five-year rolling average of the health price index;
- growth in population estimates weighted for hospital utilisation (nationally); and
- a technology factor (Productivity Commission derived index of technology growth).

Changes in the SPP growth factor may occur for any financial year (for example arising from the Mid-Year Economic and Financial Outlook (MYEFO)) and may lead to an adjustment to the Public Health funding.

If an adjustment occurs during the year, reflecting variations in the above indexation factors, the Commonwealth Department of Health, Disability and Ageing advises the Administrator of the updated Public Health amounts, which may lead to a consequential change in the overall calculated Commonwealth NHR funding amount.

Any adjustment to Commonwealth NHR funding is calculated as if the change related to the entire financial year. The resultant funding adjustment is spread evenly over the remaining months of the financial year (with any remainder from rounding applied to the last month). All stakeholders are advised of the change and its subsequent impact.

Commonwealth Public Health Payment

Public Health funding is paid at an aggregate State level via the NHFP to State Health Departments in equal monthly amounts (clause A153 of the Addendum).

9 FUNDING CAP

The Funding Cap determines, at an aggregate State level, the maximum Commonwealth NHR funding payable based on estimated activity (clause A38) for the relevant financial year.

The Addendum to National Health Reform Agreement 2026-2031 introduces a cumulative cap which is underpinned by specified base year entitlement. Clause A40 specifies that the funding cap amount for each State for each year of the Addendum will be calculated as a percentage of the State's funding entitlement for 2025-26, with the 2025-26 funding entitlement, or funding base, being determined as:

$$\text{2025-26 NHRA entitlement} + \text{2025-26 additional amount}$$

Where:

- **2025-26 NHRA entitlement** relates to the 2025-26 estimated funding amounts prior to the completion of the 2025-26 annual reconciliation process or if 2025-26 annual reconciliation has been finalised, the final 2025-26 funding entitlements.
- **2025-26 Additional Amount** refers to the additional funding of states under Schedule K – Addendum to the National Health Reform Agreement: Revised public hospital funding and health reform arrangements for 2025-26, FFA payment amount (as per clause K7(c))

For the avoidance of doubt, the 2025-26 additional amount is as per the table below:

TABLE 5 2025-26 additional top up amount

State	2025-26 additional funding ($ millions)
NSW	407.000
Vic	402.000
Qld	414.000
WA	158.134
SA	169.198
Tas	50.000
ACT	50.000
NT	51.000
National	**1,701.332**

The cumulative cap increases relative to the sum of the total 2025-26 NHRA entitlement and 2025-26 additional amount and is provided below rounded to two decimal places:

TABLE 6 Cumulative cap percentage increase across the agreement[1]

Year	2026-27	2027-28	2028-29	2029-30	2030-31
All States	110.25%	119.07%	128.60%	138.88%	149.99%

[1] *For the purposes of funding calculations, unrounded cumulative percentages will be used*

The Administrator applies the Funding Cap in calculating and advising the Commonwealth Treasurer in respect of the Commonwealth's contribution to the Pool under the Addendum (A112a). If the growth in Commonwealth funding does not exceed 10.25 per cent at a State level in 2026-27, each State will receive its uncapped Commonwealth Funding Entitlement.

The uncapped entitlement is a State's entitlement to Commonwealth NHR funding for Public Hospital Services (including ABF, Block and Public Health) under the Agreement, excluding the impact of the Funding Cap. **Table 7** outlines the possible outcomes in relation to the Funding Cap.

TABLE 7 Summary of possible funding outcomes

Scenario	Funding Cap	Commonwealth NHR Funding Entitlement	Commonwealth NHR Funding Payable (cash payable to the State)
A	Not Exceeded	Full funding of activity	Full entitlement paid
B	Met	Full funding of activity upon Annual Reconciliation	Funding up to Funding Cap paid through the financial year Up to the full entitlement paid in following financial year upon Annual Reconciliation
C	Exceeded	Funding Cap entitlement PLUS any additional funding amounts exempt from the cap	Funding up to Funding Cap paid through the financial year Up to the full entitlement paid in following financial year upon Annual Reconciliation as well as additional exempt funding

Adjustments to funding stemming from the Funding Cap are applied equitably to LHNs through a proportional adjustment in the calculated single CCR. The calculation steps required to allocate the funding to LHNs are described in **Section 9 Funding allocation when Funding Cap is exceeded**.

The Funding Cap is applied by the Administrator to any calculation of Commonwealth NHR funding during the relevant financial year to reflect amendments to input parameters. This may include updates to NWAU estimates, NEP and NEC determination or changes to Public Health amounts, with changes pro-rated across the remaining monthly payments in the relevant financial year.

States will not receive any Commonwealth NHR funding in excess of the Funding Cap except for provisions for funding related to the exemptions for services referenced in clause A39 of the 2026-2031 Addendum.

To identify if the Funding Cap is exceeded, the growth in the uncapped Commonwealth Funding Entitlement (sum of ABF, Block and Public Health) is then compared to the state-based Funding Cap for each State. The quantum of the State's funding that exceeds the Funding Cap is represented in **Table 8**.

TABLE 8 Application of the Funding Cap to State Commonwealth NHR Funding

Scenario	Funding Growth	Result
Scenario A	Greater than 10.25%	Funding Cap **Exceeded**
Scenario B	Less than 10.25%	Uncapped Commonwealth Funding Entitlement Paid
Where the Funding Cap is exceeded: State Funding Cap Excess = Uncapped Commonwealth Entitlement – Capped Commonwealth Funding Entitlement		

For more detailed calculation steps for the Funding Cap, see **Appendix C**.

Should a State exceed its Funding Cap, the calculation steps required to allocate the Funding Cap to LHNs are described in **Section 9 Funding allocation when Funding Cap is exceeded.**

Funding allocation when Funding Cap is exceeded

The Funding Cap is applied over the uncapped Commonwealth Funding Entitlement (the sum of ABF, Block and Public Health Commonwealth Funding Entitlements).

If the Funding Cap is exceeded, any adjustments to funding because of the Funding Cap are applied to the Commonwealth NHR funding contribution for ABF services only. The capped amount of the individual State's funding is applied equitably to LHNs through a proportional redistribution in the calculated CCR.

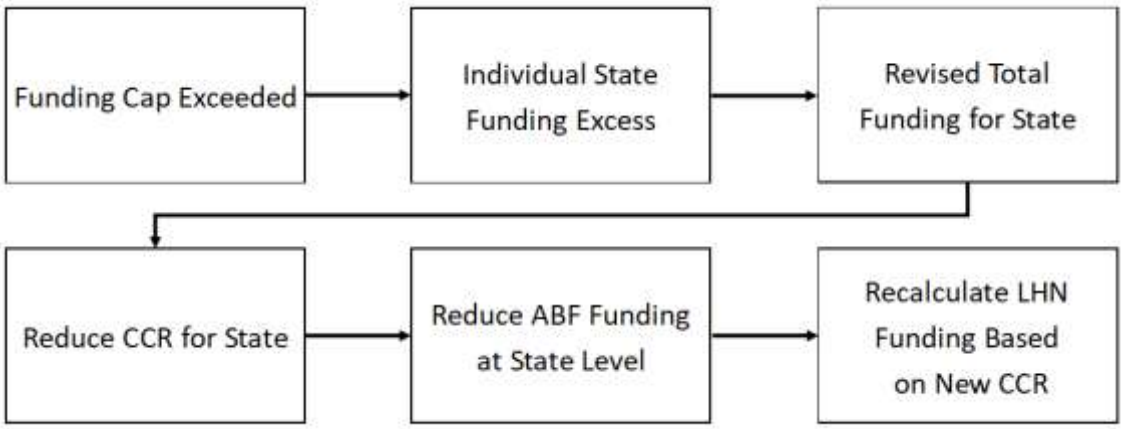
The funding to a State is:

a) Based on estimates, the difference between the uncapped Commonwealth Funding Entitlement and the Funding Cap (i.e. the Funding Excess); or

b) Based on actuals, the difference between the uncapped Commonwealth Funding Entitlement and the Commonwealth Funding Entitlement

The Administrator's calculation process for allocating the funding to LHNs is summarised in **Figure 4**. This process applies to the reallocation of funds when the Funding Cap is exceeded.

FIGURE 4 Summary of calculation process for allocating the funding to LHNs; redrawn to align with single CCR



The Commonwealth NHR funding for ABF for each LHN by service category is determined by multiplying the LHN's NWAU by the relevant financial year's NEP, and by the relevant CCR for that State, which is described in **Section 6 Calculating ABF**.

To distribute the funding cap to the LHNs, the CCR is recalculated using the revised funding amounts incorporating a proportional reduction. The recalculated CCR is then multiplied by each LHN's NWAU and NEP to determine the funding allocation for each LHN. For more detailed calculation steps for the allocation of ABF subject to the Funding Cap, see **Appendix C**.

An example of the reallocation of a funding is shown in **Table 9**.

Any changes to the input parameters require the calculation process to be repeated, resulting in updated advice to the Commonwealth Treasurer and Health Ministers.

TABLE 9 Allocation of a Funding Cap under 2026-27 funding arrangements

$m	2025-26 base	2026-27 Uncapped	Growth	Funding Cap	Funding Cap Exceeded?	Funding Excess	Capped Entitlement
State A	7,850.1	9,002.3	14.7%	8,654.0	Yes	347.6	8,654.7
State B	5,236.5	5,750.4	9.8%	5,773.2	No	0.0	5,750.4
State C	2,560.1	2,724.1	6.4%	2,822.5	No	0.0	2,724.1
Total	15,646.7	17,476.8	11.7%	17,250.5	-	347.6	17,129.2

- State A growth is above the Funding Cap with a funding excess of $347.6m (i.e. uncapped funding entitlement less Funding Cap for States impacted by Funding Cap). The growth for States B and C is below the Funding Cap with no funding adjustment applied.
- Continuing from **Table 9**, State A has a funding adjustment of $347.6m ($9,002.3m - $8,654.0m) or 3.9%.
- The $347.6m funding adjustment is allocated to each ABF service category by distributing the reduction in proportion with uncapped service category funding. For Acute admitted, this means a reduction of $208.3m ($347.6m x 59.9%), with the total state-level funding for Acute admitted being $4,950.6m.
- In **Table 22 (Appendix E),** the single CCR for the State as per the glide path was 40.5%. This can be checked via the calculating the CCR: $8,608.3m / (2,865,342, x $7,418) = 40.5%.
- Following the reallocation of the funding to service categories, the recalculated Funding Cap CCR is: $8,260.1m / (2,865,342 x $7,418) = 38.9%. The complete allocation of the $347.6m funding adjustment is described in the tabled below.

TABLE 10 Service category allocation Funding Cap adjustments to State A's ABF.

Service Category	Uncapped Funding ($m)	Uncapped CCR (%)	Proportion of State's ABF (%)	Funding above Cap ($m)	Funding adjustment (%)	Capped Funding ($m)	Capped CCR (%)
Emergency	1,149.3	40.5	13.4	46.4	-3.9	1,102.9	38.9
Acute Admitted	5,158.9	40.5	59.9	208.3	-3.9	4,950.6	38.9
Admitted Mental Health	378.4	40.5	4.4	15.3	-3.9	363.1	38.9
Sub-Acute	536.2	40.5	6.2	21.7	-3.9	514.6	38.9
Non-admitted	880.3	40.5	10.2	35.5	-3.9	844.7	38.9
Community Mental Health	505.2	40.5	5.9	20.4	-3.9	484.8	38.9
Total	8,608.3	40.5	100.0	347.6	-3.9	8,260.7	38.9

The funding reduction is proportionally allocated to each LHN through the recalculation of the Funding Cap CCR. The recalculated CCR is then applied to each LHN's relevant NWAU and NEP to determine the funding allocation for each LHN.

The allocation of the Acute admitted amount to LHNs A, B and C is described in the table below.

TABLE 11 LHN estimated funding entitlement allocation

Acute Admitted	Acute Admitted NWAU	Uncapped Funding ($m)	Capped Funding using revised CCR ($m)	Funding adjustment ($m)	Proportion of States Acute NWAU (%)
LHN A	894,563	2,687.5	2,579.0	-108.5	52.1
LHN B	433,836	1,303.4	1,250.7	-52.6	25.3
LHN C	388,771	1,168.0	1,120.8	-47.2	22.6
Total	1,717,170	5,158.9	4,950.6	-208.3	100

10 ADJUSTMENTS TO COMMONWEALTH NHR FUNDING

There are two forms of adjustment undertaken by the Administrator to the Commonwealth NHR funding throughout the year. These can be grouped as

- Adjustments relating to estimates, which are those that occur prior to or during the funding period (i.e. the relevant financial year), and
- Adjustments relating to reconciliation, these occur once the period has concluded (i.e. adjustments relating to prior financial years).

Adjustments Relating to Estimates

The adjustments relating to estimates are listed below and are applied in the following order:

a) Commonwealth Budget and MYEFO (e.g. update to Public Health amounts by Commonwealth Department of Health, Disability and Aged Care);

b) changes to LHN NWAU estimates (e.g. increase/decrease to activity estimates by States);

c) revisions of the IHACPA NEP and NEC determination; and

Adjustments relating to estimates are calculated as if the factors giving rise to them related to the entire financial year. The resultant funding adjustment is spread evenly over the remaining months of the financial year (with any remainder from rounding applied to the last month).

Where the change results in a downward adjustment for a particular LHN that cannot be fully applied within the relevant financial year (due to insufficient Commonwealth NHR funding available), the method of recouping any remaining funds owing is discussed with the relevant State on a case-by-case basis.

Adjustments advised to the NHFB, on behalf of the Administrator, via nhfa.administrator@nhfa.gov.au by the last business day on or before the 15th of a month, take effect in the Commonwealth NHR funding in the following month. If advised later than the 15th of the month, the change takes effect in the second following month.

The Administrator advises each State of any revised schedule of contributions at least five days prior to the first affected Commonwealth NHR funding payment.

Reconciliation Related Adjustments

Reconciliation related adjustments are distinct and separate from reconciling the variance between estimated and actual public hospital activity or costs. These are adjustments which are only actionable upon the receipt of actual activity data.

a) Reconciliation related adjustments as listed below

- Data Conditional Payment
- Private Patient Neutrality
- Safety and Quality Adjustments (Sentinel Event funding adjustments)
- Minimum Funding Guarantee top up amounts for eligible States

b) Adjustments for prior year issues affecting accuracy of the Commonwealth NHR funding (e.g. omission or correction of hospital activity data); subject to application of the Funding Cap.

DATA CONDITIONAL PAYMENT

The Administrator is responsible for applying the Data Conditional Payment, a temporary adjustment to Commonwealth NHR funding resulting from late submission of the required data to the national bodies as described in their 3-Year Data Plans (clauses A222 to A229 of the Addendum).

If it is identified by a national body that a State has not provided the required data as per the deadline listed in the relevant 3-Year Data Plan:

- The Administrator engages cooperatively with the State and relevant national body. Exploration of alternative or temporary measures is undertaken. A record of engagement actions and outcomes is taken.
- The Administrator, after consultation and advice from the relevant national body, determines that the State has failed to provide Required Data and that the DCP should be initiated.
- the Administrator advises the Treasurer to defer payment of 10 per cent of the monthly amount payable to the State until the required data is provided (clause A226a of the Addendum), for each month up to 3 months. The deferred payment is calculated as 10 per cent of amount paid to the State including ABF, Block and Public Health funding.
- If a State has not provided the required data within the initial 3 months of the data deadline, the Administrator advises the Treasurer to defer a further 15 per cent of the amount payable to the State, until the required data is provided (clause A226b of the Addendum). The deferred payment is calculated as 15 per cent of the amount paid to the State including ABF, Block and Public Health funding for a total deferral of 25 per cent of the monthly payment.

Following receipt of the required data, the Administrator advises the Treasurer that all withheld funds be paid to the State in the next available monthly payment (clause A227b of the Addendum).

Note: Required data is the data requested by the Administrator in the rolling Three-Year Data Plan for the purpose of Annual Reconciliation. The Administrator's assessment process for compliance for the Data Conditional Payment is detailed in the Administrator's Data Compliance Policy.

PRIVATE PATIENT NEUTRALITY

Private Patient Neutrality (PPN) came into effect from 1 July 2021 with the intent to achieve overall payment parity between public and private patients in public hospitals.

The IHACPA has developed a definition for payment neutrality and a methodology for determining an adjustment to Commonwealth ABF contribution. This has remained unchanged and is included in pricing under the NEP26 Determination. Due to the removal of back-casting, the current iteration of PPN will be reworked in consultation with IHACPA and the States.

The IHACPA and the Administrator, in consultation with the Parties, will review the methodology for calculating funding adjustments for private patient neutrality established by clause A44 of the 2020-2025 Addendum (A30). A completed review will be provided to Health Ministers Meeting by December 2027.

Until this review is completed and actioned, there will be development of a revised PPN adjustment methodology which is considerate of the removal of back-casting and the base plus growth model. This will be subject to consultation with IHACPA and the States. Pending finalisation, the revised methodology will be provided to JAC members and actioned for the 2026-27 annual reconciliation.

SAFETY AND QUALITY ADJUSTMENT

As set out in clause A87 of the Addendum, there is agreement to continue to retain the existing Safety and Quality adjustments that have been integrated into the pricing of public hospital services. A Safety and Quality Adjustment applies to services that:

- are identified as a Sentinel Event;
- include a Hospital Acquired Complication (HAC) event; or
- include an Avoidable Hospital Readmission (AHR).

SAFETY AND QUALITY REVIEW IN RELATION TO FUNDING ADJUSTMENTS

A90 denotes that whilst ACSQHC undertakes a review of existing Safety and Quality measures (A87a), pricing penalties for HACs and AHRs will not be applied to States and will only be shadow priced during this period. Identified occurrences of HACs or AHRs will not incur a NHR funding adjustment.

For Sentinel Events, A91a states that any episode of care that gives rise to a Sentinel Event will not be funded by the Commonwealth and will be given an assigned NWAU of zero should State be below the Funding Cap in the relevant year. Should a State be in excess of the Funding Cap the contribution for the calculation number of Sentinel Event NWAU will be applied as an absolute funding penalty after the Funding Cap.

The Safety and Quality Adjustment is calculated as part of a State's actual NWAU during the Reconciliation process and incorporated into the Commonwealth NHR funding through the revised Commonwealth NHR funding calculation.

SENTINEL EVENTS

Sentinel Event Adjustments assigns an NWAU weight of zero (i.e. no funding) to services that result in the occurrence of a Sentinel Event (A91). States apply a digital flag to any episode that includes a Sentinel Event and report this information as part of their data submissions to the IHACPA (clause A92 of the Addendum).

HOSPITAL ACQUIRED COMPLICATION

HAC Adjustments assign a reduced NWAU to public hospital services that result in the occurrence of a HAC.

AVOIDABLE HOSPITAL READMISSION

The Avoidable Hospital Readmission Adjustment are public hospital services that result in an avoidable hospital readmission and are assigned a reduced risked adjusted NWAU based on the total NWAU of the associated readmission.

MINIMUM FUNDING GUARANTEE

Clause A53 of the Addendum outlines that the Commonwealth will provide a minimum additional $15.0 billion in NHR funding over the period 2026-27 to 2030-31 when compared to the maximum amount that States would have received if the 2020-2025 Addendum funding arrangements applied.

A54 outlines the methodology for the calculation of the funding guarantee and is provided below

Step 1

Calculate the maximum amount that all States would have received if the 2020-2025 Addendum funding arrangements applied to the 2026-27 to 2030-31 period as per the formula below

$$\text{Total National Final Entitlement 2025-26} \sum_{k=1}^{5} (1.065)^k + \text{Mersey adjustment 2026-27} \sum_{k=1}^{4} (1.065)^k$$

Where:

- the 'Total National Final Entitlement 2025-26' is the sum of all the individual States' Final Entitlements for 2025-26
- the 'Mersey adjustment 2026-27' is the funding adjustment for 2026-27 as set out in Table 1 of the National Partnership on Transfer of the Mersey Community Hospital

Step 2

Calculate the total national MFG amount of the 2026-27 to 2030-31 period as below

Max payable as per calculation Step 1 + $15,000,000,000.00.

Step 3

Calculate the annual State cumulative funding cap proportion for each State for each year as following

$$\frac{\text{Funding Cap Amount for State A for that year}}{\text{Five year total funding cap for all States}}$$

Where:

- the funding cap amount for each State for each year of the Addendum will be calculated as per clauses A41
- the five-year total funding cap will be calculated as the sum of all the individual States' funding cap amounts for each of the five years from 2026-27 to 2030-31
- the sum of the annual state funding cap per cent for all States over the five years equals 100 per cent

Step 4

Calculate the annual state specific MFG as per the formula

$$\text{Total national MFG 2026-27 to 2030-31 (Step 2)} \times \text{Annual State funding cap \% (Step 3)}$$

The 2026-27 preliminary funding guarantee amounts as based on the Administrators June 2026 payment advice are provided in **Table 12** below. These amounts are subject to revision pending 2025-26 Annual Reconciliation.

TABLE 12 Preliminary Minimum Funding Guarantee Amounts

State	Funding Guarantee amount
NSW	$10.456
VIC	$8.648
QLD	$8.405
WA	$3.831
SA	$2.482
TAS	$0.797
ACT	$0.665
NT	$0.568

A55 denotes the timing of the minimum funding guarantee calculation and payment. Funding Guarantee amounts will be calculated during the annual reconciliation process and paid out as a prior year adjustment in the next practicable Administrator payment advice.

11 RECONCILIATION OF ESTIMATED AND ACTUAL SERVICE VOLUME

Reconciliation of actual activity to estimated service volumes primarily relates to ABF public hospital services (clauses A124 to A133) and is the process through which the Administrator determines the actual volume of services delivered by LHNs (and thereby States) for Commonwealth NHR funding purposes. As of the *2026-2031 Addendum to the National Health Reform Agreement*, clause A130 denotes the requirement to reconcile Block funding with payments through the SMF.

Clauses A124 to A133 of the Addendum set out the requirements relating to the reconciliation of actual hospital activity on an annual basis. The NWAU attributable to the hospital activity data is calculated and reconciled to the Commonwealth NHR funding for the relevant period. Adjustments are made to the Commonwealth's NHR funding to LHNs (and therefore to States) for any difference between the actual and estimated NWAU.

To enable the Administrator to conduct Reconciliation activities in a complete and timely manner, States must provide all relevant data (clause A127 of the Addendum) in the following timeframes as indicated in clause A134 of the Addendum:

- annual data (July to June of the relevant financial year) by 15 September of the following financial year.

To support the reconciliation of Commonwealth Block contributions occurring through State Managed Funds, States will provide the Administrator an annual State Managed Fund acquittal and a Statement of Assurance from a senior health department official on the completeness and accuracy of the acquittal (clause A132). These must be in a format specified by the Administrator and be provided within annual reconciliation timeframes.

Calculation of NWAU

Data on actual patient level services delivered, as provided by States, is used as the basis for the calculation of NWAUs. NWAUs are calculated in two broad stages outlined below, within each Reconciliation period, with results communicated to States for each stage.

CALCULATION STAGES

STAGE ONE – NWAU FOR ALL ELIGIBLE SERVICES IN HOSPITAL ACTIVITY DATASETS

NWAUs are calculated based on the hospital activity datasets provided by States, after appropriate validations and data preparation steps and before any adjustments are made based on eligibility of hospital services due to data matching exercises with other Commonwealth datasets, based on clauses A12 and A169.

STAGE TWO – NWAU FOR ELIGIBLE SERVICES AFTER DATA MATCHING ACTIVITIES

NWAU are calculated for the hospital services considered eligible for Commonwealth NHR funding because of the data matching exercises (to other Commonwealth datasets) necessary to satisfy clauses A12 and A17a of the Addendum. Responsibility for the cost recovery of positively matched activities falls under the remit of Commonwealth compliance officers. However, subject to the results of Commonwealth compliance, matched records may be excluded from the calculation of NWAU (section A221 of the addendum).

The difference between the NWAU figures calculated in Stage 1 and in Stage 2 for each dataset equates to the activity assessed from Commonwealth compliance as true matches and therefore potentially ineligible for Commonwealth NHR funding. Any data matching activities will take place following consultation with jurisdictions. There may also be a requirement for the resubmission of public hospital activity data in relation to potentially miscoded private patients.

CALCULATION PROCESS

SUBMISSION

Hospital activity datasets submitted by the States and the MBS and PBS services datasets submitted by the Commonwealth are to be provided within the specified timeline for each period via the provision mechanisms outlined in the Administrator's Three-Year Data Plan.

The Administrator prompts jurisdictions for the provision of relevant data via correspondence with officials, discussions with jurisdictions and through the Administrator's Jurisdictional Advisory Committee (JAC).

The submission of hospital activity datasets and the MBS and PBS services datasets to the Administrator are required to be accompanied by a Statement of Assurance from a senior health department official. Statements of Assurance are to be provided at the Q2 and Q4 hospital activity data submissions in line with the NHFB 3-Year Data Plan. Ideally, this Statement of Assurance should align with the minimum requirements outlined in the guidance document (Attachment of the compliance policy), certifying the completeness and accuracy of the approved data submissions (clause I93 of the Addendum).

VALIDATION

Upon provision the datasets are validated by existing validation processes and specified validation rules. The validation processes include:

1. Data submission receipt and validation by the IHACPA's Secure Data Management System [confidential_data_management_policy_v5.0_-_review_2023.pdf (ihacpa.gov.au)] as per dataset specifications (i.e. format, field sequence and specification etc.).
2. Regrouping of data by IHACPA.
3. IHACPA providing the NHFB the validation report and corresponding Statement of Assurance for each dataset submitted by the State.

IDENTIFY HOSPITALS/PROVIDERS

The data provided by States may cover a wide range of hospitals/providers who receive Commonwealth NHR funding through ABF or Block Funding. To ensure that the Administrator uses data relating only to those hospitals and providers that are subject to Reconciliation, a list of ABF providers is used as per State advice, including within which LHN each hospital and provider sits.

Any alterations to the ABF hospital list are required to be advised to the Administrator as soon as possible for the change to be reflected in the relevant Reconciliation process. This list of ABF hospitals is compared to the list of hospitals in the NEC for the relevant financial year as determined and advised by IHACPA and used in the calculation of Block funding. This comparison is made to ensure that hospitals are not funded under both Block and ABF.

The identification of Block funded providers is also required for the purpose of block funding reconciliation and applying the Safety and Quality adjustment.

IN-SCOPE HOSPITAL SERVICES (DETERMINED BY THE IHACPA)

Clauses A100 to A110 of the Addendum state that IHACPA is responsible for determining the scope of services eligible for Commonwealth NHR funding, which are:

- all admitted services, including hospital in the home programs, forensic mental health inpatient services, and virtually provided care
- all emergency care services provided by a recognised emergency department service, including virtually provided care, or other emergency care service (excluding ambulance services)
- specialist outpatient clinic services
- other non-admitted patient services, including new models of care or service delivery, outpatient care, mental health, subacute services or other services that directly substitute or directly reduce demand for hospital services, regardless of setting, provider, or mode of delivery

In-scope hospital services are specific types of the General List of in-scope public hospital services. For example, all admitted services are eligible for Commonwealth NHR funding, while some non-admitted services such as general practice and primary care, family planning and Commonwealth funded aged care assessment services are ineligible.

This determination is conveyed annually in IHACPA's NEP Determination.

ASSESSMENT OF THE GENERAL LIST OF ELIGIBLE SERVICES (ADVISED BY THE IHACPA)

As per clause A102 of the Addendum, IHACPA defines the 'General List' of hospital services in scope for Commonwealth NHR funding. IHACPA then assesses proposals from States for individual services to be included under that General List. The final General List is forwarded to the Administrator for use in Commonwealth NHR funding purposes.

As directed and advised by IHACPA, the in-scope services identified as belonging to in-scope hospitals are then subject to an assessment of the applicability of services contained in the General List.

The evaluation of each individual service is conducted by IHACPA, with the Administrator and the NHFB advised of a matrix of in-scope services by LHN and Tier 2 clinics (the latter being for non-admitted services) and whether they are considered eligible for Commonwealth NHR funding.

NWAU CALCULATION

In-scope and eligible services data is used to calculate NWAU by running the relevant data elements for these services through the IHACPA NWAU calculators, price weights and reference files. Unique NWAU calculators are used for each activity stream and classification. The NWAU calculators and *National Pricing Model Technical Specification* for each financial year are published on the IHACPA website for transparency of the calculation process.

It is important that the calculation of NWAU for the Administrator's Reconciliation processes is based precisely on the formula developed by the IHACPA to ensure accuracy and transparency of calculations.

States can access the NWAU calculators published on the IHACPA's website to calculate consistent NWAU figures.

Given the volume and characteristics of the data, SAS software is necessary as the mechanism for conducting calculations. Access to the IHACPA SAS NWAU calculator codes for each financial year and ABF service category has been granted by the IHACPA to the NHFB to assist in the operation of the Administrator's functions.

The Administrator and the NHFB liaise with the IHACPA to ensure the NWAU calculation approach and basis is consistent between both parties in each Reconciliation period. Several analyses are undertaken to ensure data is processed correctly. A summary of these checks is outlined below.

- Reasonableness checks on the distribution of the data (by age, Indigenous status, location, classification, service category, etc.).
- Reasonableness of the NWAU outcomes (by State, LHN, Hospital, Service Category).
- Comparing the outcomes to previous years to detect any variations.
- Ensuring the IHACPA NWAU calculator and Technical Specifications, and States' provided information is correctly applied (e.g. hospital ABF listing).

The Safety and Quality Adjustments are applied at this step for ABF data.

ADVICE TO JURISDICTIONS

States are advised of the outcomes and associated documentation relating to their jurisdiction each Reconciliation period, including:

- Structured Reconciliation document. This document outlines a high-level summary of the data submission, data preparation and NWAU calculation. Further detail regarding each hospital and LHN is provided via a separate mechanism (detailed below).
- State summary of the NWAU calculation by each ABF hospital and LHN, including the total number of services, number of in-scope services and number of NWAU for each service category.
- Each State's data by each record item including the NWAU (inclusive of loadings), ABF flag, in-scope flag and cross-border flag, where applicable.
- Safety and Quality adjustments.
- Data matching report setting out all identified data matches and the potential private admitted matches which States are required to investigate and report on.

DATA RESUBMISSION (IF REQUIRED)

The acceptance of resubmissions initiated by jurisdictions is subject to the discretion of the Administrator for the purposes of calculating funding entitlements. Resubmissions may be requested to correct errors, anomalies or omissions in the previous data provided as outlined in the Statement of Assurance.

Statements of Assurance should include commentary on:

- Steps taken to promote **completeness** and **accuracy** of activity data (for example audit tools or programs, third-party reviews, stakeholder engagement strategies)
- Efforts applied to ensure the **classification** of activity was in accordance with the current year's standards, data plans and determinations
- **Variations** in activity volumes and movements between activity-based funding and block funding
- Explanations on any **significant changes in activity** and national weighted activity unit (NWAU) values from the prior financial year (as part of annual data submission)
- Other information that may be relevant to users of the data, as determined by the signing officer.

A guidance document with suggested key content and structure is provided in the *Guidance for the drafting of Statements of Assurance* published on www.publichospitalfunding.gov.au.

Outlined below is a high-level protocol for data resubmissions.

1. Flag intention to request resubmission of data with NHFB

Each approved submission or resubmission of data must be accompanied by a Statement of Assurance. Statements of Assurance accompanying initial submissions should flag the potential need for any resubmissions, including commentary on the reasons why this should be necessary. The Administrator will make a note of such requests and respond in writing to the relevant jurisdiction.

The following dates for quarterly data submissions are:

- First-quarter period ending 30 September each year by 15 December that year
- Six-month period ending 31 December each year, by 15 March the following year
- Third-quarter year-to-date period ending 31 March each year, by 15 June that year
- Annual period ending 30 June each year, by 15 September that year (pending any resubmissions requested by the Administrator).

As of 2025-26, States will have a two-week resubmission window following the final quarterly submission deadline and are able to resubmit data as required during this window (i.e. Administrator approval to resubmit is not required). Any resubmissions made during this period will be considered compliant. Every effort should be made to ensure the correctness of the data submitted by 15 September, to minimise the possibility of errors and data resubmissions, noting the requirement for the Administrator, under the Addendum, to provide preliminary Annual Reconciliation numbers to jurisdictions by 30 November (A135 of the Addendum).

TABLE 13 Submission timeframes and resubmission window

Period	Submission timeframe	Two-week resubmission window
Q1	**15 December**	29 December
Q2	**15 March**	29 March
Q3	**15 June**	29 June
Q4	**15 September**	29 September

2. NHFB continues to work with the jurisdiction

The NHFB continues to liaise with the State to track the progress and suitability of the data.

3. Formal data resubmission request sent to the Administrator

If data resubmission is desired by a State outside the two-week resubmission window, a formal request from an appropriate jurisdictional official is to be provided to the Administrator. This request must include which dataset(s) is requested to be resubmitted and the rationale for the resubmission.

4. Administrator considers the resubmission request

Under the Agreement, the Administrator (or the NHFB on behalf of the Administrator) is not obliged to accept data resubmissions. In assessing whether resubmission is appropriate, the Administrator will assess whether accepting the resubmission compromises the timeliness and quality of the Reconciliation process and consequential Commonwealth NHR funding calculations. The Administrator discusses with IHACPA the ability and timelines for data validation. Data cannot be incorporated into Reconciliation activities without this validation process; therefore, the ability of IHACPA to validate data resubmissions is essential.

5. Administrator responds to the resubmission request

Based on the assessment in Step 4, the Administrator responds to the relevant jurisdiction. This response could be either:

a) Resubmission is supported

Along with the response, the Administrator provides a timeline for data resubmission. This timeline allows sufficient time for the associated processing, validation and Reconciliation calculations and for these to be included in the Commonwealth NHR funding calculation. This timeline must be met.

b) Resubmission is not supported

The Administrator's response includes the rationale for the resubmission not being supported, and any follow up or remedial action that can be taken.

6. Data are collated and resubmitted (if Step 5a occurs)

The jurisdiction addresses and corrects the issue that instigated the resubmission request and resubmits the relevant data to the Administrator. The jurisdiction develops strategies to mitigate the need for resubmission occurring in future data submissions.

An updated Statement of Assurance must be provided at the time of the resubmission. Ideally, this Statement of Assurance should align with the minimum requirements outlined in the guidance document, an attachment to the Administrator's Compliance Policy.

7. Advise other jurisdictions (if required)

If the resubmission impacts other jurisdictions, for example the Reconciliation adjustment timelines are deferred, the Administrator advises the other jurisdictions accordingly.

Depending on the ability and timelines of the Reconciliation process, the Administrator may elect to offer all jurisdictions the opportunity to resubmit relevant datasets, where it is viewed as necessary. This opportunity is not guaranteed and is at the discretion of the Administrator.

The Administrator may request data re-submission from States to correct for inaccuracies or errors within 12 months of the end of the financial year (clause A143). In this instance, steps 6 and 7 would be followed.

ADVICE TO THE COMMONWEALTH TREASURER

The Administrator provides advice to the Commonwealth Treasurer upon completion of the Annual Reconciliation, outlining the basis of the calculated Commonwealth NHR funding. This includes analysis of growth in Commonwealth NHR funding, hospital activity and NWAU across State, LHNs and service categories.

The adjustment of Commonwealth Funding Entitlement of States with reported Safety and Quality adjustments is advised to the Commonwealth Treasurer.

Reconciliation between estimates and actual NWAU

Any adjustments to Commonwealth NHR funding arising from the Reconciliation process are spread equally across payments for a subsequent quarter (clause A142 of the Addendum).

The intended Reconciliation and adjustment timeline under the Agreement is:

- For the annual period July to June, adjustments to Commonwealth payments are scheduled to be spread equally over the three months April to June of the following year or earlier pending finalisation of the Annual Reconciliation (typically January to March).

The Administrator reserves the right to alter the adjustment timeline where circumstances make it difficult to achieve reconciliation without compromising the quality of the calculations. These timeframes may vary depending on:

- timeliness of data submitted to the IHACPA and the Administrator;
- complexity of Reconciliation;
- timing of the Commonwealth Treasurer's issuance of the Federal Financial Relations (National Health Reform Payments) Determination; or
- other factors.

Jurisdictions are advised accordingly whenever there is a change in the timelines.

Annual Adjustment

The annual actual NWAU is reconciled to the annual estimated NWAU for each LHN in every State with the CCR of a State then recalculated using the annual actual NWAU. The following steps enable the calculation of the Annual Reconciliation adjustment.

RECONCILED NWAU

For each LHN in a State, the amount that should have been paid for each service category based on the annual actual NWAU is calculated.

The Funding Cap is applied to Commonwealth NHR funding based on actual activity. The Administrator determines the final Commonwealth Funding Entitlement for the relevant financial year at this time, inclusive of the Funding Cap, Minimum Funding Guarantee, non self governing territory and the Sentinel Event Safety and Quality adjustment.

BLOCK FUNDING RECONCILIATION

An adjustment to Block funding will be incorporated following the reconciliation of Block funding. The Annual Reconciliation adjustment is calculated as the difference between the Commonwealth Block Funding based on the estimated NEC allocation and the actual cost incurred for the relevant financial year as per payments from the State Managed Fund.

Historically, Block funding reconciliation was undertaken by incorporating updated Block funding costs advised by the IHACPA during the annual reconciliation. The difference between estimated costs paid under the NEC determination and updated advice, would be the basis for the Block funding reconciliation adjustments. Highly Specialised Therapies being a separate case where States submit cost data directly to the Administrator for reconciliation.

As now required by clause A130, the estimated Commonwealth NHR funding provided for Block funding will be reconciled with the actual payments from State Managed Funds for delivering these activities. As part of the annual reconciliation process and required by A132 and A178, States will provide to the Administrator an annual State Managed Fund acquittal and a Statement of Assurance from a senior health department official on the completeness and accuracy of the acquittal.

These must be in a format specified by the Administrator and be provided within annual reconciliation timeframes and include the following

- all State-reported in-scope expenditure at the LHN level,
- establishment or agency level,
- output program or grant description
- identification of any payments to State Governments for shared services arrangements or statewide services contributing to delivery and overall in-scope funding for block-funded services.

The required data specifications and submission timeframes will be finalised pending consultation with IHACPA and the States prior to the 2026-27 Annual Reconciliation.

ADJUSTMENT PERIOD

The Treasurer's Determination of final entitlement amounts will be actioned by the Administrator through the annual adjustment to Commonwealth payments into the National Health Funding Pool. This annual adjustment will commence in the next practicable monthly payment run following the Determination (A141).

The Annual Reconciliation adjustment, being the difference between the amounts calculated for each State under the Commonwealth Funding Entitlement and what was already paid to the State is determined.

If the amount identified is a negative amount that would reduce a States Commonwealth NHR funding for the relevant three-month period to below zero, the Reconciliation adjustment cannot be fully affected in the identified (three month) period. In these circumstances, the Administrator has determined that the Reconciliation adjustment period for that State is extended until the Reconciliation adjustment can be recovered from future months' payments to the State.

The amount for each State identified is spread evenly over the relevant adjustment period with any rounding differences made up in the final month of the adjustment period. If an outstanding amount exists at the end of the period, this amount is recovered is consultation with the State. The Administrator seeks advice from the State on the preferred recovery mechanism if this circumstance arises.

Cross Border Data and Reconciliation

RECONCILIATION

The cross-border reconciliation process will be incorporated into the annual reconciliation process with the Administrator responsible for calculating and advising States (and the Commonwealth in relation to Australian Government administered Territories or Islands) of cross-border contributions from the Commonwealth and resident State (A196).

The Administrator will provide cross-border reconciliation outcomes to State Health Ministers (and the Commonwealth Minister in relation to Australian Government administered Territories or Islands).

DATA

The Administrator will release actual cross-border activity data and Commonwealth contribution advice to the States within one month of the Treasurer's Determination to support bilateral cross-border reconciliations (Clause A199). Administrator cross-border data made available to States will include:

- Commonwealth percentage funding rates for relevant States
- Commonwealth funding contributions and modelled State contributions
- Activity flows for ABF and block-funded hospitals.

Each State receives a cross-border dataset with information on patients reported to be residents of that State who received a public hospital service in another State. This data includes the patient level data, by record item, for ABF and Block funded hospital services. It is provided in the format described in the Submission step. The process for determining a patient's State is outlined in **Appendix F.**

CALCULATION OF FUNDING AMOUNTS

The Administrator will calculate cross border prices at the NEP, as determined by the IHACPA, including adjustments for any loadings for the provider LHN (Clause A204). Commonwealth and State proportions for cross border patients in ABF and block funded hospitals will be calculated as per **Table 14**:

TABLE 14 Cross-border funding calculation for ABF and Block funded hospitals

Funding Component	Calculation Methodology
ABF Hospital Commonwealth Contribution	Cross Border NWAU26 * NEP26 * Provider ABF CCR
ABF Hospital State Contribution	Cross Border NWAU26 * NEP26 * (1 – Provider ABF CCR)
Block Hospital Commonwealth Contribution	Block establishment NEC26 * Provider Block CCR
Block Hospital State Contribution	Cross Border NWAU26 * NEP26 * (1 – Provider Block CCR)

For activity in block-funded hospitals, including small rural hospital services, the Commonwealth's contribution will be set at the National Efficient Cost (NEC). Prices used to calculate resident State contributions will be set at the NEP where activity data is available, as determined by the IHACPA, including any pricing adjustments (A205). If activity data is not available, the resident State's contribution will not be payable.

For block-funded services (i.e. services listed in the NEC26 determination such as Teaching, Training and Research), the resident State will contribute the provider State's National Efficient Cost for each of these services. The amount less the Commonwealth contribution will be determined by the IHACPA (A206).

SERVICES NOT APPROPRIATELY COVERED BY DIAGNOSIS RELATED GROUPS

Clause A207 references Services Not Appropriately Covered by Diagnosis Related Groups (SNACDRGs). As separate cross border reconciliation arrangements for SNACDRGs have not been specified these will fall under the Administrator's cross border reconciliation responsibilities.

To develop a nationally consistent approach to cross border reconciliation, the Administrator is seeking submissions from States of hospital services considered to be SNACDRGs. States are encouraged to submit the below to the NHFB Dropbox.

- The data relating to the hospital activity unable to be appropriately covered by DRGs
- supporting evidence of the cost of delivery of care

The information provided will be assessed against existing classification mechanisms and used to develop a nationally consistent approach to cross border reconciliation. Development will be made in consultation with the States.

TIMING AND PAYMENT ARRANGEMENTS

Gross cross-border funding contributions by the resident State will be made to the provider State through the National Health Funding Pool, either:

- monthly, as a pro-rata payment agreed between the jurisdictions and informed by the most recent activity plus agreed growth, with the final reconciliation payment to be made within three months of receiving the advice from the Administrator, or
- within three months of receiving the advice from the Administrator (i.e. four months post NHFB's annual reconciliation).

NON SELF GOVERNING TERRITORY (NSGT) RECONCILIATION

Clause A195 states that from 1 July 2026 onwards, where a resident of a Territory of Island administered by the Australian Government receives a treatment in a provider State the Commonwealth will pay 100 per cent of the National Efficient Price for that service to the provider State, this funding will be exempt from the provider State's Funding Cap.

Australian Government Administered Regions (AGARs) include:

- Jervis Bay
- Christmas Island
- Norfolk Island
- Cocos Island

CALCULATION AND TIMING

Calculation methodology of the Commonwealth funding for these services will be as the ABF calculation listed in Clause A22 (NEP * NWAU * Contribution Rate) where the Commonwealth contribution rate will be set at 100% (A195). Amounts are to be advised and subject to the finalisation timeframes of the Administrator's Annual Reconciliation.

PAYMENT MECHANISM

The results of these calculations with be advised by the Administrator to the Commonwealth Treasurer as part of the annual reconciliation. This will inform payments to be made to the States and Territories. The calculation is subject to accurate data in relation to the actual public hospital services delivered to NSGT patients.

Certainty of Reconciliation

Issues may be identified with actual hospital activity data submitted in prior years for Reconciliation purposes that affect the accuracy of the Commonwealth NHR funding to a State. Such issues may require the Administrator to implement an adjustment to funding in prior years and recalculate related items such as forward year Funding Caps.

In making the decision on whether to adjust prior year funding, the Administrator takes into consideration the materiality of the adjustment, the requirement for national consistency in the calculation of the Commonwealth NHR funding, and any other relevant information.

Prior year adjustments are provided and considered in the next year's Commonwealth Treasurer's Determination as a further adjustment to the prior year amounts to be paid to States.

The final Commonwealth Funding Entitlement of a State, once decided by the Commonwealth Treasurer's Determination will not be adjusted under the National Funding Model except in the following circumstances

- where an Auditor General or other relevant body finds fraud or other illegal or dishonest activity, the Administrator may make these adjustments at any time
- where the Administrator has identified matched payments through the process described at clause A218, the Administrator may make these adjustments to take effect in a future year's reconciliation.

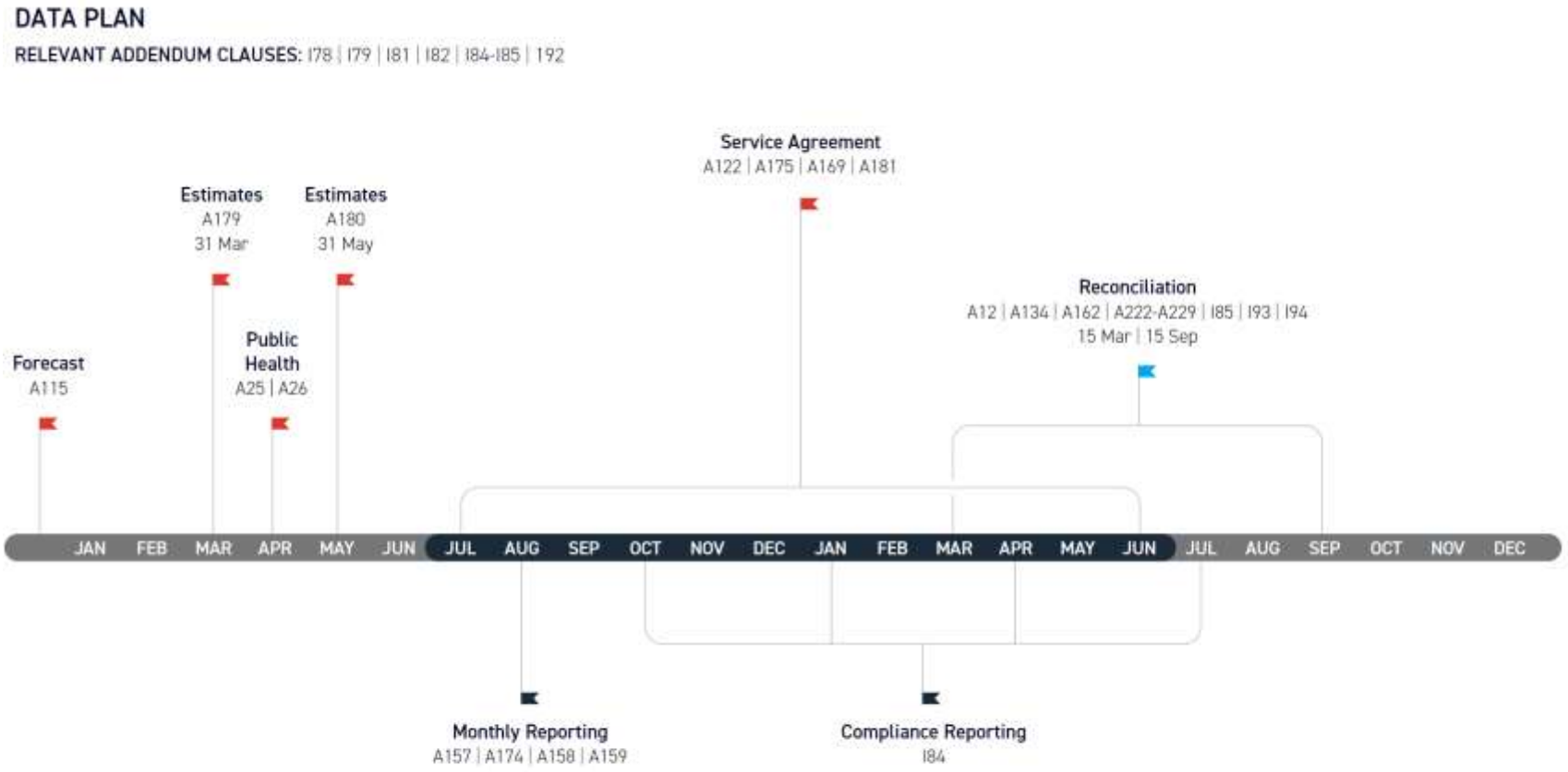
Clause A114 denotes the processes under which adjustments will be made.

12 TIMELINE

The timeline (see **Figure 5**) shows each stage of the Administrator's processes, and key data submission points by jurisdictions.

It highlights the iterative nature of the Administrator's calculations and the stages of funding calculation (i.e. estimated and actuals).

FIGURE 5 Data cycle timeline



Note: All clauses are from the *Addendum to the National Health Reform Agreement 2026-2031*.

13 REPORTING

The Administrator undertakes several reporting mechanisms to enable transparency of the funding for public hospital services, including an annual report and monthly reports.

Section 240 of the Act requires the Administrator to provide monthly reports to the Commonwealth and each State or Territory, and to make these publicly available. The monthly reports contain detail for the month and year-to-date funding and payments into and out of the State Pool Accounts and State Managed Funds paid to LHNs, including the NWAU funded. These are described by Commonwealth and States contributions and by service category.

The Administrator also provides payment advice to the Commonwealth Treasurer as needed to facilitate cash payments from the Commonwealth into the NHFP. The purposes for the Administrator's advice to the Commonwealth Treasurer are described in further detail below.

Advice to the Commonwealth Treasurer

The Administrator's advice to the Commonwealth Treasurer is provided for specific purposes, including:

- the Commonwealth Budget, based on initial estimates of hospital activity from States and Territories, in April each year;
- Payment Advice for the relevant financial year, based on confirmed estimates of hospital activity from States and Territories. The Payment Advice can be updated monthly;
- Input to the Commonwealth's Mid-Year Economic and Fiscal Outlook (MYEFO); and
- the annual Treasurer's Determination of public hospital funding based on Reconciliation of actual hospital activity for the prior year. This advice is issued in the second half of the following financial year.

As part of the Administrator's Payment Advice to the Commonwealth Treasurer, information on Funding Cap entitlements and adjustment is provided. This outlines the States' uncapped Commonwealth Funding Entitlement and how these are impacted by the Funding Cap. In addition, advice is provided on the application of the Commonwealth's Minimum Funding Guarantee for the relevant year with the decision on its application a matter for the Commonwealth.

14 EXTERNAL DEPENDENCIES FOR CALCULATIONS

For the successful calculation of Commonwealth Funding Entitlement in a timely manner there are external dependencies; these are outlined throughout the document and summarised below in **Table 15**.

TABLE 15 External dependencies on Commonwealth NHR calculations

Entity	Component	Required for	Required by	Document section
Commonwealth Department of Health, Disability and Ageing	Public Health funding growth factor for each State	Public Health funding	Prior to commencement of the year and when the Public Health funding growth factor alters	8
IHACPA	NEC Determination	Block funding	Prior to commencement of the year and if the NEC Determination alters.	7
IHACPA	NEP Determination	ABF	Prior to commencement of the year, and if the NEP Determination alters.	6
States	LHN and aggregate NWAU estimates by service category	ABF and Funding Cap	Prior to commencement of the year, and if the NWAU alters.	5, 6
States	LHN annual actual hospital activity data by service category	ABF	15 September of the following financial year	6, 10, 11
States	Safety and Quality events	Safety and Quality Adjustment	15 September of the following financial year	10
Commonwealth Treasurer	Treasurer's Determination	ABF	15 May to enable payment within the following financial year	11

APPENDIX A – METHODOLOGY FOR CALCULATING ABF

TABLE 16 ABF calculation at the State, service category and LHN level

Step 1 – Determine the Input CCR to be applied in 2026-27 calculations						
The higher of a State's 2025-26 ABF CCR or Glide path CCR for 2026-27 (40.5%)						
Step 2 – Calculate total uncapped Commonwealth ABF for a State						
2026-27 ABF CCR	x	Relevant financial year NWAU	x	Relevant financial year NEP	=	Total State Uncapped ABF amount
Step 3 – Calculate uncapped Commonwealth ABF for each service category: [State level]						
2026-27 ABF CCR	x	State aggregate NWAU for service category	x	Relevant financial year NEP	=	Total ABF for service category
Step 4 – Calculate the uncapped funding amount for each LHN by service category: [LHN level]						
2026-27 ABF CCR	x	LHN service category NWAU	x	Relevant financial year NEP	=	Commonwealth uncapped funding for LHN service category
Step 5 – Aggregate each ABF funded service category for each LHN [LHN level]						
Emergency Department	Acute admitted	Admitted mental health	Sub-acute	Non-admitted	Community Mental Health	Total Cwlth ABF at the LHN level

APPENDIX B – METHODOLOGY FOR CALCULATING BLOCK FUNDING

TABLE 17 Block funding calculation

Step 1 – Determine Input CCR to be applied in 2026-27 calculations							
The higher of a State's 2025-26 Block CCR or Glide path CCR for 2026-27 (40.5%)							
Step 2 – Calculate total funding each block service category for a State							
2026-27 Block CCR	x	Relevant service category NEC ($)	=	Commonwealth Block Funding for service category			
Step 2a – For Highly Specialised Therapies							
50% Contribution rate	x	Highly Specialised Therapy NEC ($)	=	Commonwealth Block Funding for Highly Specialised Therapies			
Step 3 – Aggregate Block funded service category: State or Territory level							
Small Rural Hospitals	+	Teaching, Training & Research	+	Other Mental Health	+	Other Block funded service categories	=	Aggregate Commonwealth Block funding

APPENDIX C – FUNDING CAP CALCULATION

The Funding Cap calculation steps are summarised below in **Table 18**. Each step is then described in terms of the relevant inputs and outputs. **Table 19** then describes the calculation steps required in the event the Funding Cap is exceeded.

TABLE 18 Funding Cap calculation

Step 1 – Calculate the Funding Cap funding amount using the 2025-26 Baseline: State or Territory level						
2025-26 Commonwealth Funding Amount	+	2025-26 Schedule K One off funding top up	x	110.25 per cent	=	2026-27 Funding Cap
2025-26 Commonwealth Funding Entitlement is the sum of ABF, Block and Public Health funding. If the uncapped Commonwealth Funding Entitlement is less than the Funding Cap, Step 2 is not required. The uncapped Commonwealth Funding Entitlement is the sum of ABF, Block and Public Health funding for the relevant financial year.						
Step 2 – Calculate the individual State funding excess, when Uncapped Commonwealth Funding Entitlement exceeds the Funding Cap: State or Territory						
Uncapped Commonwealth Funding Entitlement	-	Relevant Financial Year Funding Cap			=	Individual State Funding Excess

Note: If the Funding Cap is exceeded, the Individual State Funding Excess is applied to the ABF funding only.

TABLE 19 Calculation if the Funding Cap is exceeded

Step 1 – Calculate Funding Cap impact on ABF Entitlement: State or Territory level						
Uncapped ABF entitlement	-	Individual State Funding Excess			=	Funding Cap ABF entitlement
Step 2 – Calculate revised Funding Cap CCR for the State						
Funding Cap ABF Entitlement	/	(Relevant FY NWAU x Relevant FY Price)			=	Revised Funding Cap CCR
Step 3 – Apply Funding Cap CCR to calculate State service category ABF subject to Funding Cap						
Revised Funding Cap CCR	x	State Service Category NWAU	x	Relevant financial year NEP	=	Service category ABF funding subject to Commonwealth Funding Cap
Step 4 – Apply Funding Cap CCR to calculate LHN service category ABF subject to Funding Cap						
Revised Funding Cap CCR	x	LHN service category NWAU	x	Relevant financial year NEP	=	LHN service category ABF funding subject to Commonwealth Funding Cap

Step 5 – Aggregate service category ABF for a LHN to determine total LHN funding subject to Funding Cap					
Funding Cap Emergency	Funding Cap Acute admitted	Funding Cap Admitted mental health	Funding Cap Sub-acute	Funding Cap non-admitted	Total Funding Cap Cwlth ABF at the LHN level

APPENDIX D – RELEVANT NHR AGREEMENT AND ADDENDUM CLAUSES

TABLE 20 Summary of the Addendum to the National Health Reform Agreement (2026-3031)

Addendum to the National Health Reform Agreement (2026-2031)	
Implementation of the Agreement	
A18	This Addendum is to be used for calculating the Commonwealth's funding contribution to the States for the five financial years of 2026-27 to 2030-31. The calculation of the Commonwealth's funding contribution for 2025-26 will be undertaken according to arrangements and processes in Schedule K – Addendum to the National Health Reform Agreement: Revised public hospital funding and health reform arrangements for 2025-26.
Commonwealth Activity Based Funding Calculation	
A20	The Commonwealth will fund ABF service delivery at an increasing rate, as determined by the glide path (clause A36).
A22	The Commonwealth's funding contribution for each ABF service category will be calculated individually for each State by multiplying: ▪ activity – the volume of weighted ABF services provided in the current year for that ABF service category as measured in National Weighted Activity Units (NWAUs) ▪ price – the National Efficient Price for that year as determined by the IHACPA ▪ input contribution rate – the rate for that financial year as determined by clauses A34 to A36.
Block Funding Calculation	
A24	The Commonwealth's funding contribution for each block service category will be calculated for each State by multiplying: ▪ cost – the National Efficient Cost for each State in the current year for that block service category as determined by the IHACPA ▪ input contribution rate – the rate for that financial year as determined by clauses A34 to A36.

Public Health Funding Calculation	
A25	The Commonwealth's funding contribution to public health will continue to grow by the former National Healthcare Specific Purpose Payment (SPP) growth factor until the process for incorporating Public Health Funding in the Block Funding stream is resolved and adopted by unanimous agreement of the Parties through HMM (see clause A80).
Commonwealth Contribution Rate	
A32	The new funding model requires a separately defined Commonwealth Contribution Rate for each of ABF and Block Funding. Each State's Commonwealth Contribution Rates for these funding streams will be calculated in each year as follows: ▪ ABF Commonwealth Contribution Rate (ABF CCR): $$State\ Y's\ ABF\ CCR = \frac{\text{ABF entitlement for Year X in State Y}}{\text{Total volume of weighted services for Year X in State Y} \times NEP \text{ for Year X}}$$ Tasmania's 2025-26 ABF CCR, accounting for the Transfer of the Mersey Community Hospital, will be calculated instead as follows: $$TAS\ 2025\text{-}26\ ABF\ CCR = \frac{\text{ABF entitlement for TAS in 2025/26} + \$32{,}858{,}722}{\text{Total volume of weighted services for TAS in 2025/26} \times NEP \text{ for 2025/26}}$$ where $32,858,722 is the 2025-26 funding adjustment as set out in Table 1 of the National Partnership on Transfer of the Mersey Community Hospital. ▪ Block Commonwealth Contribution Rate (Block CCR): $$State\ Y's\ Block\ CCR = \frac{\text{Block Funding entitlement for Year X in State Y}}{\text{National Efficient Cost for Year X in State Y}}$$
A35	The Input Contribution Rate for the ABF and Block Funding streams for each year of this Addendum is the greater of: a) the rate specified in clause A36, or b) the State's 2025-26 ABF or Block CCR respectively, as calculated as per clause A32, or c) if a service category is moved from one funding stream to another, the input contribution rate to be paid for that service category will be that of the higher funding stream (up to a maximum of 45.0 per cent) – that is, there will be no inherent funding disadvantage due to a change of input contribution rate caused by a change in funding stream, or d) any otherwise specified rate for particular service types described in this Addendum for example, High-Cost, Highly Specialised Therapies (refer clause A235(a)).
A36	The minimum value for the Commonwealth Input Contribution Rate for both ABF and Block Funding streams is specified below: Commonwealth Contribution Glide Path

2026-27	2027-28	2028-29	2029-30	2030-31
40.5%	41.0%	41.5%	42.0%	42.5%

A37	As the 2025-26 annual reconciliation will not be completed until after the commencement of this Addendum, each State's ABF and Block CCR for 2025-26 will be provisionally calculated based on the most recent payment advice provided by the Administrator to the Commonwealth Treasurer. The ABF and Block CCRs will be recalculated once the 2025-26 annual reconciliation is completed.

Funding Cap	
A38	The Commonwealth's combined annual funding contribution to each State for all funding streams under this Addendum (as described in clause A8) will be subject to a funding cap.
A40	The funding cap amount for each State for each year of the Addendum will be calculated as a percentage of the State's funding entitlement for 2025-26, with the 2025-26 funding entitlement, or funding base, being determined as: 2025-26 NHRA entitlement + 2025-26 additional amount Where 2025-26 additional amount refers to the additional funding of States under Schedule K – Addendum to the National Health Reform Agreement: Revised public hospital funding and health reform arrangements for 2025-26, FFA payment amount (as per clause K7(c)), and the 2025-26 NHRA entitlement is determined as follows:
A41	The funding cap amount will be calculated individually for each State by multiplying the funding cap from the prior year (to the nearest dollar) by the relevant formula as specified in the table below:

Year	Cap value calculation
2026-27	(2025-26 $total\ NHRA\ entitlement$ + 2025-26 $additional\ amount$) × 110.25%
2027-28	(2026-27 cap) × 108.00%
2028-29	(2027-28 cap) × 108.00%
2029-30	(2028-29 cap) × 108.00%
2030-31	(2029-30 cap) × 108.00%

Minimum Funding Guarantee	
A53	The Commonwealth will provide a minimum additional $15.0 billion in NHR funding over the period 2026-27 to 2030-31 when compared to the maximum amount that States would have received if the 2020-2025 Addendum funding arrangements applied. a) The intent is that a minimum amount of NHR funding across all States over this Addendum period is guaranteed on an annual, state-specific basis.
A55	As part of the annual reconciliation process, if the final NHR funding entitlement for a State is less than that State's MFG entitlement for that same year, the Commonwealth will pay the difference between these amounts in the next feasible financial year (clause A114 refers).
Small Rural Hospitals	

A73	In determining the Block Funding Criteria as part of the National Efficient Cost Determination, the IHACPA will have further regard to the need to set criteria for block-funded hospitals so that activity or expenditure thresholds are aligned to the current list of block-funded hospitals. a) These criteria will apply to block-funded, non-fixed-plus-variable hospitals categories as listed in the National Efficient Cost Determination, including: i. standalone hospitals providing specialist mental health services ii. standalone major city hospitals providing specialist services, and iii. other standalone hospitals that are not appropriately funded by the fixed-plus-variable small rural hospital National Efficient Cost model. b) The IHACPA will continue to set the expenditure and activity threshold for small rural hospitals and apply the National Efficient Cost model for calculating Commonwealth block-funding contributions for small rural services. c) If hospitals are listed as block-funded hospitals but funded by States through activity-based funding, these hospitals will be removed from the list.
Sentinel events, Hospital Acquired Complications and Avoidable Hospital Readmissions	
A87	The Parties agree to retain existing pricing adjustments for Sentinel Events, Hospital Acquired Complications (HACs) and Avoidable Hospital Readmissions (AHRs) noting: a) a review will be completed by the ACSQHC by 30 June 2027 (described in clauses D51 to D55), and the adjustments will be retained for the full term of the Addendum if they are found to be fit-for-purpose and effective b) following the review, Parties may consider introducing appropriate mechanisms for reinvesting pricing adjustments in safety and quality improvement activities c) modifications to pricing adjustments may be implemented by IHACPA following recommendations of the review.
A90	The Parties agree that while the ACSQHC is undertaking the review of clause A87(a), absolute pricing penalties for HACs and AHRs will not be applied to states. These will be shadow priced only during this time. However, Parties agree that pricing penalties will be considered as part of a long-term solution to drive higher quality, safer care in public hospitals, and pricing adjustments will be reintroduced if the review finds they are effective. This short-term pause will allow the ACSQHC to review the existing pricing adjustments, and the IHACPA to complete the work outlined below.
A91	The Parties agree that any episode of care that gives rise to a Sentinel Event will not be funded by the Commonwealth. For each state, total NWAU associated with Sentinel Events will be calculated each year. a) Where states are below the funding cap in any given year, the episode will be assigned a NWAU of zero. b) Where states are over the funding cap in any given year, the total Commonwealth contribution for this number of NWAU will be applied as an absolute funding penalty, after the funding cap. c) For the avoidance of doubt, any penalties associated with Sentinel Events will not affect future funding caps outlined at clause 41
Process to Pay the Commonwealth's funding contribution	

A114	The process to pay the Commonwealth's contribution to funding public hospital and health services set out in this section is summarised as follows: a) for all relevant funding streams, States and relevant entities provide estimates to the Administrator of expected service delivery (and other relevant factors) before the start of each financial year. Other relevant entities are those that provide input to inform the formal forecast at subclause (b) b) the Administrator calculates and provides a formal forecast to the Commonwealth and States of each State's preliminary Commonwealth funding entitlement, including future amounts owing and prior amounts owed from reconciliations and other adjustments c) the Parties make monthly payments into the National Health Funding Pool based on the Administrator's calculation d) As set out in clause A226, the Commonwealth's monthly payment may be subject to the Data Conditional Payment (refer clauses A222 to A229) e) the Administrator makes payments from the National Health Funding Pool based on State estimates, at the discretion and direction of the relevant State f) adjustments may be made throughout the year if necessary, for example to reflect updated activity estimates, finalised reconciliation processes for prior years, or final activity data g) following the end of financial year, a reconciliation process is undertaken by the Administrator based on States' actual activities delivered and other adjustments applied at this time h) the Administrator provides advice to the Commonwealth Treasurer regarding States' post-reconciliation entitlement amounts i) the Treasurer determines each State's final entitlement amounts j) the Administrator makes the relevant adjustments to future payment advice arising from the Treasurer's Determination.
Calculation Preliminary Commonwealth Funding	
A115	The Administrator will provide the Commonwealth and States with a formal forecast of the Commonwealth's funding contribution for each funding stream, including, where relevant, each service category, before the start of each financial year. The formal forecast will be provided within 14 calendar days of receipt of both: a) service volume information for all Local Hospital Networks (LHNs) within a State, which will be aligned to Service Agreements provided in accordance with the timing set out in clause A169 i. If Service Agreements are not finalised within these timeframes, a service volume statement signed by the State's relevant authorising agent will be provided to the Administrator that contains the minimum detail specified in clause E7 for each LHN b) the published National Efficient Price and National Efficient Cost from the IHACPA.
A116	If States do not provide Service Agreements or service volume statements by the agreed timeframes set out in clause A169, or do not meet the requirements as set out in this Schedule and Schedule E, the Administrator may use the previous financial year's Service Agreement to calculate the formal forecast, increased by the growth in the published National Efficient Price for the relevant year.

A118	The Administrator will calculate a State's preliminary entitlement in accordance with the application of the funding cap as per clauses A38 to A47.
A122	For the Administrator to make in-year funding adjustments to the ABF stream, States must provide the Administrator updated Service Agreements or amended service volume statements (as per clause A115). a) States and LHNs can agree updates or amendments to adjust service volumes or pricing to take account of such matters as changing health needs, variations in actual service delivery, and hospital and health service performance. b) States, as the system managers of public hospitals and health services, can determine the frequency of alterations to Service Agreements or signed service volume statements. States will notify the Administrator within 14 calendar days of any agreed variations.
Annual Reconciliation	
A125	The Administrator will undertake annual reconciliation for each State following receipt of Required Data from that State.
A129	The Administrator should consider issues that may affect the annual reconciliation including, but not limited to, general transcription errors such as incorrect coding of services provided and duplicate entries, the exclusion of services paid for by the Commonwealth via other funding programs, and the exclusion of services for which data has not been provided or is incomplete (in either the year being reconciled or the prior year) or services that have not been accurately classified as a public hospital service eligible to receive a Commonwealth funding contribution.
A130	The Parties agree the annual adjustment should also include an adjustment for the Block Funding component where the estimated Commonwealth funding provided for eligible Block activities in the National Efficient Cost Determination is reconciled with the actual payments from State Managed Funds for delivering these activities.
A132	To support the reconciliation of Commonwealth contributions occurring through State Managed Funds, States will provide the Administrator an annual State Managed Fund acquittal and a Statement of Assurance from a senior health department official on the completeness and accuracy of the acquittal. These must be in a format specified by the Administrator and be provided within annual reconciliation timeframes. The following will also apply: a) For the Block Funding steam, States will also provide their acquittal to the IHACPA. The acquittal will include detail on: i. block-funded service category ii. establishment or agency iii. output, program or grant description iv. identification of any payments to State Governments for shared services arrangements or statewide services contributing to delivery and overall in-scope funding for block-funded services.
National Health Funding Pool	
A148	A single National Health Funding Pool will be maintained, comprising a Reserve Bank of Australia account for each State, for the purposes of receiving all Commonwealth and State public hospital and health services funding under this Addendum.

A151	There will be complete transparency and line-of-sight of respective contributions into and out of Pool accounts to LHNs, discrete State Managed Funds, or to State health departments in relation to Public Health Funding, and of the basis on which the contributions are calculated. There will also be complete transparency and line-of-sight of respective contributions out of State Managed Funds to LHNs.
A153	Commonwealth payments into the Pool will be made monthly, calculated as 1/12th of the estimated annual payment and then adjusted as required to account for reconciliation and other payments. Commonwealth payments will be made into the Pool in accordance with Schedule D of the Intergovernmental Agreement on Federal Financial Relations.
A155	Payments will be made from the Pool accounts to LHNs and State Managed Funds in accordance with Service Agreements (or signed service volume statements as set out in clause A122).
A157	The payment arrangements for Commonwealth funding are as follows: a) ABF will flow directly to LHNs through Pool accounts b) Block Funding will flow through Pool accounts to State Managed Funds and from there to LHNs c) Service Model Reform Funding will flow through Pool accounts to State Managed Funds and from there to LHNs or relevant entities depending upon the specific funding arrangements for each project d) funding for teaching, training and research will flow through Pool accounts to State Managed Funds and from there to LHNs or other organisations (such as universities and training providers) depending upon the specific funding arrangements established in each State for the provision of those services e) Public Health Funding will flow through Pool accounts to State health departments.
Cross Border Reconciliation	
A194	All cross-border arrangements established under the relevant section of the 2020-2025 Addendum expire on 30 June 2026, unless all Parties to such an arrangement have agreed otherwise in writing.
A196	The cross-border reconciliation process will be incorporated into the annual reconciliation process with the Administrator responsible for calculating and advising States (and the Commonwealth in relation to Australian Government administered Territories or Islands) of cross-border contributions from the Commonwealth and resident State. a) The Administrator will provide cross-border reconciliation outcomes to State Health Ministers (and the Commonwealth Minister in relation to Australian Government administered Territories or Islands).
A199	The Administrator will release actual cross-border activity data and Commonwealth contribution advice to the States within one month of the Treasurer's Determination to support bilateral cross-border reconciliations. Administrator cross-border data made available to States will include: a) Commonwealth percentage funding rates b) Commonwealth funding contributions c) activity flows for ABF and block-funded hospitals.

A200	Gross cross-border funding contributions by the resident State will be made to the provider State through the National Health Funding Pool, either: a) monthly, as a pro-rata payment agreed between the jurisdictions and informed by the most recent activity plus agreed growth, with the final reconciliation payment to be made within three months of receiving the advice from the Administrator, or b) within three months of receiving the advice from the Administrator.
A204	Prices will be set at the NEP, as determined by the IHACPA, including adjustments for any loadings for the provider LHN, unless otherwise agreed by the Parties to the specific cross-border agreement.
A205	For activity in block-funded hospitals, including small rural hospital services, the Commonwealth's contribution will be set at the National Efficient Cost (NEC). Prices used to calculate resident State contributions will be set at the NEP where activity data is available, as determined by the IHACPA, including any pricing adjustments. a) If activity data is not available, the resident State's contribution will not be payable.
A206	For block-funded services, the resident State will contribute the provider State's National Efficient Cost for each of these services, as determined by the IHACPA, less the Commonwealth contribution.
A208	High Cost, Highly Specialised Therapies (HST) will be excluded from cross-border reconciliations and subject to separate reimbursement by agreement between States based on the actual cost, less any Commonwealth contribution, as outlined in clause A235(a), for in-scope and ancillary services.

APPENDIX E – CALCULATION EXAMPLES

The Administrator calculates the Commonwealth NHR ABF and Block entitlement for each State for all service categories based on the latest estimate of in-scope NHRA activity supported by service agreements and cost information provided by IHACPA

1. ABF and Block – Calculation based on estimates

If NWAU estimates are revised the ABF amount is recalculated, leading to a change in the overall calculated Commonwealth NHR funding amount. Similarly, if the cost amounts determined by IHACPA are updated the Block amount is recalculated. The last opportunity to advise the Administrator of an alteration to take effect in the relevant financial year is 15 May.

Example 1 (referred to in Section 6 - Calculating ABF) outlines the calculation of the ABF and Block based on estimates for the relevant financial year.

TABLE 21 Example 1: ABF and Block – Based on estimated activity for relevant financial year for State A.

Information at the commencement of the relevant financial year (estimates):

2025-26 Base Year Estimated ABF CCR	37.5%
2067-27 Glide Path CCR	40.5%
2026-27 ABF NWAU:	2,750,500 estimate
2026-27 NEP:	$7,418
2025-26 Base Year Estimated Block CCR	35.5%
2026-27 Glide Path CCR	40.5%
2026-27 Determined Block Cost	$820 million

The estimated ABF entitlement at the State level would be calculated as:
Higher of (37.5% or 40.5%) x $7,418 x 2,750,500 = $8.263 billion

This calculation would then be applied to the aggregate State NWAU for each service category to determine the funding allocation for each service category.

Similarly, the calculation is then applied to each LHN's NWAU for each service category to determine the funding for each LHN. The sum of the service category amounts is the total Commonwealth NHR funding for ABF based on estimated activity.

The estimated Block Funding entitlement at the State level would be calculated as:
Higher of (35.5% or 40.5%) $820 million = $332.1 million

An aggregated block funding calculation is provided in this example; however, this calculation would be applied to each Block service category to determine the funding allocation for each service category.

Note: totals may not equal the sum of components due to rounding

2. ABF and Block – Calculation based on actuals

Stage 2 of the NHR funding calculation occurs upon receipt of actual annual hospital activity for the relevant financial year, and Reconciliation of this data (Chapter 10 Reconciliation of actual activity to estimated service volumes).

The calculation of ABF, based on actual annual hospital activity relating to the relevant financial year is shown in **Table 22**, with the Acute admitted service category used in the example. The components that differ from the **Table 21** (estimated activity for the relevant financial year) are highlighted in red and italics. The impact of 'back-casting' and base year funding base is not included as they no longer form part of the Commonwealth funding calculation.

In this example, 2025-26 annual reconciliation has occurred and the 2025-26 base year CCR has been revised to account for actual outcomes.

TABLE 22 Example 2: ABF – based on relevant financial year actual annual activity

Continuing from **Table 21**, relevant financial year annual actuals are now finalised, necessitating ABF allocation for the relevant financial year to be recalculated.

Updated information based on annual actuals:

2025-26 Base Year Actual CCR	38.0%
2026-27 Glide Path CCR	40.5%
2026-27 ABF NWAU:	2,865,342 actual
2026-27 NEP:	$7,418
2025-26 Base Year Actual Block CCR	36.5%
2026-27 Glide Path CCR	40.5%
2026-27 Determined Block Cost	$800 million

The ABF funding allocation, determined using relevant financial year annual actuals, would now be calculated as:
Higher of (38.0% or 40.5%) x 2,865,342 x $7,418 = $8.608 billion

This calculation would then be applied to the aggregate State NWAU for each service category to determine the funding allocation for each service category.

As before, the calculation is applied to each LHN's NWAU for each service category to determine the funding for each LHN. The sum of the service category amounts is the total Commonwealth NHR funding for ABF based on annual actual hospital activity for the relevant financial year.

The Block funding allocation, determined using relevant financial year annual actuals, would now be calculated as:
Higher of (36.5% or 40.5%) $800 million = $324 million

The table below shows the final 2026-27 funding allocations by ABF service category. These amounts are relevant for determining the Funding Cap which is demonstrated in Section 9 *Funding Cap*.

Service category	**2026-27 Glide Path CCR**	**2026-27 NWAU/Cost**	**2026-27 Funding**
Emergency Department	40.5%	382,549	$1,149.3m
Acute Admitted	40.5%	1,717,170	$5,158.9m
Admitted Mental Health	40.5%	125,962	$378.4m
Sub-acute	40.5%	178,492	$536.2m
Non-admitted	40.5%	293,006	$880.3m
Community Mental Health	40.5%	168,163	$505.2m
Total ABF	40.5%	$6,656.3m	$8,608.3m
Block Funding	40.5%	$800.0m	$324.0m
Public Health	100%	$70.0m	$70.0m
Total Commonwealth NHR funding			**$9,002.3m**

Note: Amounts used are for example purposes. Totals may not equal the sum of components due to rounding.

APPENDIX F – DETERMINING A PATIENT'S STATE

Table 23 below outlines the 15 postcodes that span more than one state. The process for determining a patient's state, for the purpose of cross-border patient flow calculation, is as follows:

- SA2 code will be used to determine patient state.
- Where the patient's SA2 code is not available or not valid, the patient postcode will be used to determine state.
- Where the patient's postcode and SA2 are not available or not valid, the patient state will be determined by the hospital state except for postcodes that span over more than one state where the patient state will be determined by the state with the largest proportion of that postcode's population.

TABLE 23 Postcodes that span over more than one state with no valid SLA

Postcode	State postcode spans	Determined state	Population proportion of relevant state
0872	NT, SA and WA	NT	80%
2406	NSW and QLD	NSW	84%
2540	ACT and NSW	NSW	99%
2611	ACT and NSW	ACT	100%
2618	ACT and NSW	NSW	76%
2620	ACT and NSW	NSW	98%
3644	NSW and VIC	VIC	80%
3691	NSW and VIC	VIC	100%
3707	NSW and VIC	VIC	96%
4375	NSW and QLD	QLD	100%
4377	NSW and QLD	QLD	100%
4380	NSW and QLD	QLD	100%
4383	NSW and QLD	QLD	71%
4385	NSW and QLD	QLD	93%
4825	NT and QLD	QLD	98%

CCR References

Term	Meaning
ABF CCR	Activity Based Funding Commonwealth Contribution Rate
Base Year ABF CCR	The 2025-26 ABF CCR post application of the Soft or National Cap for a State. Based on 2025-26 estimates until the 2025-26 annual reconciliation is finalised.
Base Year Block CCR	The 2025-26 Block CCR post application of the Soft or National Cap for a State. Based on 2025-26 estimates until the 2025-26 annual reconciliation is finalised.
Block CCR	Block Funding Commonwealth Contribution Rate
CCR	Commonwealth Contribution Rate
Funding Cap CCR	The ABF CCR of a State subject to the Funding Cap, as ABF gets reduced when a State is over their Funding Cap. Also referred to as the 'Revised Funding Cap CCR' or 'Capped CCR'.
Glide Path CCR	The Commonwealth contribution rate as per the path described in clause A36. Subject to the relevant financial year (40.5% for 2026-27).
Input Contribution Rate or Input CCR	The CCR used to calculate uncapped ABF funding or block funding. This is the greater of the Glide Path CCR or of the Base Year ABF/Block CCR as per Clause A35.
Provider ABF CCR	The ABF CCR of the State providing hospital services. Used for cross border calculations
Provider Block CCR	The Block CCR of the State providing hospital services. Used for cross border calculations

Acronyms, abbreviations and terms

Term	Meaning
ABF	Activity Based Funding
ACSQHC	Australian Commission on Safety and Quality in Health Care
Administrator	Administrator of the National Health Funding Pool
AIHW	Australian Institute of Health and Welfare
CAMHS	Child and Adolescent Mental Health Services
CCM	Commonwealth Contribution Model
CCR	Commonwealth Contribution Rate
MFG	Minimum Funding Guarantee
CHC	COAG Health Council
COAG	Council of Australian Governments
Data Plan	Three Year Data Plan
DHDA	Commonwealth Department of Health, Disability and Ageing
DRG	Diagnosis Related Groups
EDW	Enterprise Data Warehouse
Funding cap	Commonwealth funding cap
GST	Goods and Services Tax
HAC	Hospital Acquired Complication
HST	Highly Specialised Therapies
ICU	Intensive Care Unit

Term	Meaning
IHACPA	Independent Health and Aged Care Pricing Authority
JAC	Jurisdictional Advisory Committee
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
NEC	National Efficient Cost
NEP	National Efficient Price
NHFP or Pool	National Health Funding Pool
NHFB	National Health Funding Body
NHR	National Health Reform
NHR Act	National Health Reform Act 2011
NHR Agreement	National Health Reform Agreement
NMDS	National Minimum Data Sets
NPCR	National Partnership on COVID-19 Response
NWAU	National Weighted Activity Unit
PBS	Pharmaceutical Benefits Scheme
Parties	Signatories to the National Health Reform Agreement, being the Commonwealth, States and Territories
PIN	Personal Identification Number
RBA	Reserve Bank of Australia
SMF	State Managed Fund
States	Refers to both States and Territories
The Addendum	Addendum to the National Health Reform Agreement 2026-2031
The Payments System	National Health Funding Pool Payments System
The Pool	National Health Funding Pool