

Victoria – Public hospitals and mental health services

Policy and funding guidelines 2004–05

General conditions of funding

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1 Australian Health Care Agreement (AHCA)

The Australian Health Care Agreement (AHCA) is an agreement between the Commonwealth of Australia and the State of Victoria, to provide and jointly fund health care for eligible persons who choose to use State funded health services for the five years from 1 July 2003 to 30 June 2008. It outlines the principles that are to guide the delivery of public hospital services.

Public hospitals in Victoria must ensure that public hospital services are provided in accordance with the terms of the AHCA, and that eligible persons are able to access public hospital services as public patients.

An electronic version of the AHCA between Victoria and the Commonwealth is available at:

<http://www.health.gov.au/ahca/index.htm>

Acute Health Circular 3/99 (as amended from time to time) provides further State Government advice on the AHCA.

1.1 Hospitals to work within the framework of the AHCA

The AHCA provides that where an eligible person receives public hospital services as a public admitted patient, no charges will be raised for medical or hospital services. Under the AHCA, a nursing home type patient is excluded from being an eligible person in relation to public hospital services. State Government policy for charging non-admitted patients is set out in the State's Fees Manual, Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals. This information is available at the Department Internet website: The AHCA commits the Commonwealth and Victoria to comply with the following Medicare principles as well as other related sections of the 2003-08 AHCA:

1. Eligible persons must be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals
2. Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period
3. Arrangements are to be in place to ensure equitable access to such services, for all eligible persons, regardless of their geographical location.

The requirement to meet these principles is absolute.

There are additional obligations on Victoria that are linked to the Medicare Principles. These obligations, together with possible interpretations are contained in the *Department of Human Services' Hospital Circular 33/2003*.

The following is a summary of some of the additional obligations:

The range of services available to public patients should be no less than was available on 1 July 1998.

All public hospital services available to private patients should be accessible on a public patient basis, where there is demonstrated clinical need.

Eligible veterans retain the right to be treated as public patients when accessing public hospitals, notwithstanding the agreement between Victoria and the Department of Veterans Affairs (DVA).

All eligible patients must elect to receive admitted public hospital services as a public or private patients. This is to be exercised in writing in accordance with the National Standards for Public Hospital Admitted Patient Election Process.

Eligible patients presenting to public hospital emergency departments will be treated as public patients unless a third party has entered into an arrangement with the hospital or Victoria to pay for such services, such as the TAC, Workcover or DVA.

Pre-admission and post discharge care should be provided 'free of charge' as a public hospital service for those patients who have elected to be public patients.

Public hospitals must ensure that all relevant staff understand and comply with the obligations agreed to under the new AHCA. Failure to do so, could result in Victoria incurring significant penalties for not meeting one or more of the compliance requirements over consecutive years.

1.2 Admission of patients

None of the following factors are to be a determinant of an eligible person's priority for receiving hospital services:

- a) whether or not an eligible person has health insurance
- b) an eligible person's financial status or place of residence, or
- c) whether or not an eligible person intends to elect or elects to be treated as a public or private patient.

1.2.1 The hospital will ensure that:

- a) an eligible person, at the time of admission, or as soon as practicable thereafter, elects or confirms whether he or she wishes to be treated as a public patient or a private patient and this election process conforms to the 'National Standards for Public Hospitals Admitted Patient Election Processes'
- b) any ineligible person is appropriately identified as such in the Victorian Admitted Episodes Dataset (VAED).

1.2.2 The hospital will only admit patients in accordance with the Minimum Criteria for Admission as specified in the PRS/2 Manual Version 12.0 and shall provide documented justification for the admission of all Type C Professional Attention Procedures (exclusion list) patients or those admitted overnight for designated Band 1 procedures of the Health Insurance Basic Table as defined by subsection 4(1) of the National Health Act 1953 (Commonwealth), see *Hospital Circular 15/1998*.

1.2.3 The hospital will make every effort to verify the place of residence of interstate patients.

1.2.4 The hospital will ensure that all patients admitted to hospital are asked whether they are of Aboriginal or Torres Strait Islander descent. The identification of Aboriginality is a mandatory data item to be reported by hospitals to the VAED. Aboriginal and Torres Strait Islander patients identified on the VAED will be funded at 30 percent higher than the nominated payment for WIES12.

1.3 Claims for Medicare benefits

The hospital will ensure that aftercare services for public patients and funded outpatients and accident and emergency services do not attract claims for Medicare benefits or claims for benefits under Veterans' Affairs Legislation.

1.4 Commonwealth-State programs

Hospitals may receive specific purpose payments arising from Commonwealth-State Agreements. Funding received under such arrangements is subject to each program's specific conditions.

2 Components of funding

2.1 Components of funding

Public targets will comprise:

- target A volumes, paid at the relevant rate
- sub-acute services paid at the relevant rate
- non-admitted patient grants
- T&D grants
- other specified grants
- payments for eligible veterans.

These grants and admitted patient and outpatient target volumes are shown in *Victoria – public hospitals and mental health services Policy and funding guidelines 2004–05* and shown in the Hospital's HSA.

Funding is provided to hospitals on the basis that the current range of services provided is continued. Before hospitals undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed and agreed with the department. In rural areas, the appropriate discussion should be held with the Regional Director or their delegate, in the case of small rural hospitals participating in the Small Rural Health Services (SRHS) funding and accountability approach, reference should be made to the SRHS Guide (August 2003). In the metropolitan area discussions should be held with the relevant officer in the Metropolitan Health and Aged Care Division. In all cases except for SRHSs, the Executive Director of Metropolitan Health and Aged Care Services Division or Rural and Regional Health and Aged Care Services Division must provide the final approval.

2.2 Calculation of the payment for admitted patient services

2.2.1 The term “weighted inlier equivalent separation” means the measure of the activity calculated by multiplying the DRG weight by the number of Inlier Equivalent Separations in the DRG and summing over all DRGs. For 2004–05 this statistic will be abbreviated as WIES12. The method and calculation of WIES12 is shown in *Calculation of WIES*.

2.2.2 For Hospital patient throughput for public patients up to the level included in targets, the case payment is:

Major Providers (Metropolitan Health Service & Barwon Health)	\$2,919
Rural Group B > 13,000 WIES	\$3,055
Rural Group B 7,500–13,000 WIES	\$3,144
Rural Group B 5,000–7,500 WIES	\$3,216
Rural Group B < 5,000 WIES	\$3,235
Rural Group C	\$3,040

Throughput above target

- 2.2.3 In ongoing recognition of the difficulty of precise demand management, throughput in excess of target of up to 2 percent will be paid at \$1,100 per WIES.
- 2.2.4 Same day “medical” targets are specified in each Hospital’s HSA as a percentage of total actual throughput. Same day medical throughput in excess of the specified target will not be funded by the department. The targets have been set at 6.5 percent (excluding “exempt” hospitals). Throughput in same day units within emergency departments will be considered as part of the mid-year review.

Quarterly reports

- 2.2.5 Quarterly targets will be nominated by the agency. Actual throughput against target will be reviewed at the end of the second, third and fourth quarters. Funding adjustments may be made where actual performance varies significantly (more than 2 percent) from the nominated quarterly targets.

- 2.2.6 Nursing home type patient payment

The Hospital will receive \$170 for each nursing home type bed day as reported in the VAED. This component of funding will be subject to increased scrutiny to ensure that WIES outlier payments are not used inappropriately to fund nursing home equivalent care.

- 2.2.7 Rural/isolated payment

This payment provides a contribution for rural hospitals, rural health services, isolated hospitals and isolated health services, for additional costs incurred in transferring some patients in non-metropolitan areas. This payment is supplementary to the higher WIES payment received by non-metropolitan hospitals and does not purport to represent a payment for total ambulance transfer costs in any individual patient case. The payment, which applies to all WIES, not just those with an ambulance component, is as follows:

- For isolated hospitals the additional ambulance transfer payment is \$47 for each weighted inlier equivalent separation up to the agreed contract volume.
- For other rural hospitals the additional payment is \$18 for each weighted inlier equivalent separation up to the agreed contract volume.

- 2.2.8 Interim payments for long, high-cost patients

The department will consider interim payments for long stay patients accumulating significant amounts of WIES, who remain unseparated at 30 June.

Hospital can apply in writing for special consideration for individual admitted patient episodes, indicating the amount of WIES accumulated, based on an interim DRG and a notional separation date of 30 June. Under no circumstances should such patients be statistically separated.

If the department agrees to the interim payment, the hospital will be asked to designate the episode as a contracted patient, using a specific Contract/Spoke ID code. When the patient is finally separated, the payment will be adjusted accordingly, for example, full WIES payment less interim amount. It is noted that the final DRG may differ from the interim DRG due to the addition of [further] complications, co-morbidities and procedures.

- 2.2.9 There will be no strict Length of Stay or WIES criteria for patients to be covered by this arrangement, but the following may provide some guidance:
- still in at 30 June, LOS already exceeds a year
 - still in at 30 June, LOS already exceeds six months, might reasonably be expected to still be in the hospital at 31 December
 - still in at 30 June, LOS already exceeds six months, in receipt of significant mechanical ventilation.

During the course of the financial year, the department will hold discussions with external payers and provide further specific information to hospitals in regard to applicability of this approach for certain Care Types and Account Classes.

2.3 Payments for specified purposes

- 2.3.1 Additional payments will be provided to the Hospital for specific agreed services.
- 2.3.2 Where the grant is based on a particular level of service, and there is a significant reduction in such services, the grant may be reduced during the course of the financial year. (A significant change for the purpose of this clause is defined as one which involves a reduction in the service levels of more than 10 per cent.) Where an increase in the particular level of service is agreed with the Acute Health Division, an increase in funding may also be agreed.

2.4 Compensable patients

- 2.4.1 Department of Veteran Affairs (DVA) Patients
- a) Current funding arrangements for eligible DVA patients/clients have operated since 1 July 1998. The current contract will expire in June 2004 and DVA and a new six-year Agreement to commence from 1 July 2004 is being negotiated. The new Agreement will be implemented retrospectively after the date of signature. Preliminary discussions indicate that the major features of the current Agreement will be retained and that payment for DVA services will continue to attract a premium and be paid on a reconcilable basis as detailed below. The premium price is paid for treating veterans to ensure the ability of public providers to compete on a level approaching an equitable basis with the private sector in terms of quality of service to Veterans.
 - b) Under the current arrangements, separate capped public targets and uncapped veterans' estimates are incorporated into hospital and mental health service provider budgets as applicable. This aspect of the arrangement will continue.
 - c) Under the current Agreement DVA funds a majority of public hospital services and mental health service providers for veterans on the basis of outputs at prices that allow the department to pay providers to cover costs of training, research and other items. The State Government is reimbursed for actual work done after confirmation of eligibility by DVA. This means veteran throughput is uncapped. DVA funding cannot be substituted for other services for non-veterans, for example DVA WIES under performance cannot be substituted or converted into public WIES.
 - d) Payment requires an exact match of hospital and mental health service provider veteran data with DVA records. The rate of rejection of records submitted by hospitals is

generally between 1 to 2 percent, however, for mental health service providers the rejection rate has been much higher. Many of these rejections are due to agencies not collecting sufficient information from the eligible veteran to allow for an exact matching of veteran data by DVA. It is imperative that agencies ensure that they collect and provide to the department the eligible veteran's name, unique identifier, date of birth and sex. The department will not accept any risk for the 'assumed' revenue lost by not meeting the DVA eligibility requirements.

- e) Hospitals will continue to receive payment at a premium for the following services to eligible veterans.

For each hospital, the department will estimate DVA patient/client/attendee throughput for the following services:

Admitted patient services

- WIES
- sub-acute services. (GEM, CRCs, continence clinics, interim and palliative care)
- PAC
- Victorian Maintenance Dialysis Program
- Nursing Home Type
- Mental Health Services.

Non admitted patient services

- VACS encounters
- allied health occasions of service
- non admitted radiotherapy weighted activity units
- continence clinics
- Community Rehabilitation Clinic services.

- f) Under the current arrangement the premium is payable for all eligible DVA patients matched with DVA records (as reported in the VAED, RAPID or where appropriate AIMS) including numbers in excess of the estimate. If hospitals do not achieve the DVA target, any funding which has been cash flowed will be recalled at the full DVA rate. It is imperative that hospitals ensure that their own records and reporting to the department are complete, comprehensive and timely.
- g) If the hospitalisation of an eligible veteran is likely to exceed a continuous period of thirty-five days, hospitals shall ensure that the veteran's status is reviewed and that either:
- (i) certificate under Section 3B of the Health Insurance Act 1973 is completed by a medical practitioner and forwarded to the department's DVA Contract Manager forthwith, or
 - (ii) the Beneficiary is reclassified to a Nursing Home Type patient and the payment adjusted accordingly.

- h) Where an admitted veteran's length of stay is greater than thirty-five days and no acute care certificate in accordance with the above has been forwarded to DVA by the department, hospitals will only be reimbursed at the Nursing Home Type patient payment rate.
- i) For all the services included in this Section, final payment for treatment of veterans will only be authorised after:
 - the veteran's eligibility has been confirmed by DVA; and
 - the veteran's unique number and veteran details reported to the department exactly match those held by the DVA for each eligible patient/resident/attendee.
- j) If hospitals do not pay sufficient attention to these requirements and make assumptions about eligibility for patients who are rejected or amended by DVA those hospitals will need to retrospectively reclassify these patients to reflect any changes in care type and the preferences indicated by the patient on the form of election for admission. It should be noted that to date, as a result of the timing of the reconciliation process, the department has borne the risk for ineligible veteran records. This will be strictly enforced in 2004-05 and hospital funding adjusted. The department will not accept any risk for "assumed" revenue.
- k) Eligible veterans will not be covered under the DVA arrangement if they:
 - elect to be public patients under the Australian Health Care Agreement
 - are compensable patients, such as TAC and workcover
 - elect to use their private health insurance.
- l) The current DVA Agreement prohibits agencies from raising any charges directly on an eligible veteran except where provided for under Commonwealth legislation. This prohibition does not, however, prevent agencies from charging a cost for the provision of personal services such as for access to television and/or telephone services at the facility.
- m) Veterans who are reclassified to nursing home type patients may be charged a patient contribution, in line with the provisions of the Health Insurance Act 1973.
- n) Experience has shown that those hospitals that actively develop service quality and marketing plans and employ Veteran Liaison Officers, are more likely to in fact retain such patients. Hospitals are therefore strongly advised to develop and market such plans and consider employment of a VLO.
- o) Eligible Veterans and War Widow(er)s have access to a wide range of benefits and services through the DVA. These include (but are not limited to) hospital, medical and allied health services, respite and convalescent care, rehabilitation aids and appliances, assistance with transport and accommodation allowance. Further details can be obtained under DVA Facts or Health from the Internet at:
http://www.dva.gov.au/health/vets_info.htm.

2.4.2 Transport Accident Commission (TAC) patients

- a) A new contract for Public Hospital services to TAC patients is currently under negotiation and will apply from the date of signature which is anticipated to be early in 2004-05. The contract will cover pricing of services and details of services included for TAC patients.

Until the time the new contract commences the current funding arrangements for TAC admitted patients which commenced from 1 July 2002 will continue in 2004-05. It is not anticipated that there will be any changes to the payment processes detailed below.

The department will receive funding directly from the Transport Accident Commission for the admitted patient treatment of TAC patients eligible for WIES funding and will cash flow hospitals accordingly. That is, separate uncapped TAC WIES targets have been incorporated into hospital budgets for 2004-05 based on throughput previously reported in the VAED.

- b) Hospitals will continue to receive WIES payments for TAC patients directly from the department. Hospitals, however, will need to continue to charge TAC directly for the medical costs associated with these admitted patient episodes.
- c) Spinal patients: The whole of episode payment will be applied in 2004-05 for all spinal patients, including TAC, only at Austin Health. This payment will comprise the initial continuous acute and rehabilitation episodes of the patient's stay in hospital.
- d) For the department to receive payment from TAC, patient information reported by the hospitals to DHS via PRS/2 must match those held by the Transport Accident Commission for each admitted patient separation. Details of the new data elements required to assist in this process are published in the Specifications for Revision to PRS/2 and to the VAED for 1 July 2003 at <http://www.health.vic.gov.au/hdss/>
- e) Notwithstanding the provisions of Clause 2.2, the department will pay a rate applicable for all TAC patients matched with TAC records (as reported in the VAED) including numbers in excess of the target. If hospitals do not achieve the TAC target, any funding which has been cash flowed will be recalled at the full TAC rate. It is imperative that hospitals ensure that their own records are complete, comprehensive and timely.
- f) The department will be actively monitoring the status of TAC patient records and liaising with the hospitals to ensure that for records where claims not accepted by TAC, either (i) additional information is transmitted to allow the claim to be accepted or (ii) hospitals retrospectively reclassify these patients to reflect any changes in care type and the preferences indicated by the patient on the form of election for admission.

2.5 Victorian Workcover Authority (VWA)

- a) Victorian Workcover Authority patients treated in Victorian public hospitals are directly funded by VWA insurers. This process will continue in 2004-05 at the standard rates and indexation processes agreed with the VWA. A new contract for services is anticipated to commence early in 2004-05. This contract will detail funding and service arrangements between the department and VWA and it is expected that there will be no change to existing payment processes.

2.6 Redirection of funds

2.6.1 Where total earnings for the Metropolitan Health and Aged Care Services Division program exceed the expenses incurred in delivery of the full quantity of services specified in the HSA, the surplus may be used by the Hospital for any purpose connected with its agreed function.

2.6.2 This clause does not apply if contrary arrangements regarding unexpended funding provided for a specially identified purpose are agreed.

2.7 Privacy

2.7.1 The Hospital, its employees, agents and subcontractors must comply with the requirements of the Information Privacy Act 2000 (Vic) and Health Records Act 2001 (Vic) (both as amended and in force from time to time), with respect to any act done, or practice engaged in, for the purposes of this Agreement.

2.7.2 The Hospital must take reasonable steps to ensure that its employees, agents and subcontractors comply with this requirement. In this clause:
"subcontractor" includes any person employed or engaged by a subcontractor.

2.8 Decentralised programs

Continuous Positive Airways Pressure (CPAP)

2.8.1 Since July 2001, the Continuous Positive Airways Pressure (CPAP) program ceased as a separate program funded by a specified grant. Funding for this service has been incorporated into the VACS outpatient base grant for Metropolitan Health Services/Major Rural Regional Hospitals, or the general outpatient grant for non-VACS funded hospitals. Funding for CPAP will continue to form part of these outpatient grants and the amount a particular agency allocates for these services is a matter for the agency. Routine reporting of these services to the department is not required.

Home Enteral Nutrition

2.8.2 Since July 2001, the Home Enteral Nutrition program ceased as a separate program funded by a specified grant. Funding for this service has been incorporated into the VACS outpatient base grant for Metropolitan Health Services/Major Rural Regional Hospitals, or the general outpatient grant for non-VACS funded hospitals and the amount a particular agency allocates for these services is a matter for the agency. Routine reporting of these services to the department is not required.

Victorian Artificial Limb Program (VALP)

2.8.3 Since July 2002, funding for the artificial limbs services has been converted to general WIES equivalents and rolled into and added to the individual agency's (or health service's) budgets. Therefore, the amount a particular agency allocates for these services is a matter for the agency and its assessment of clinical priorities.

Hospitals that continue to be funded for these services are:

- Austin and Repatriation Medical Centre (Royal Talbot Rehabilitation Centre)
- Ballarat Health Services (Queen Elizabeth Centre)

- Barwon Health (Grace McKellar Centre)
- Bayside Health Service (Caulfield General Medical Centre)
- Bendigo Health Care Group (Anne Caudle Centre)
- Melbourne Health Service (Melbourne Extended Care & Rehabilitation Service)
- Latrobe Regional Hospital
- Peninsula Health Service (Mt Eliza Aged Care & Rehabilitation)
- South West Healthcare (Warrnambool & District Base Hospital)
- St Vincent's Hospital
- Women's and Children's Health Service (Royal Children's Hospital)

2.8.4 It is expected that within two years, this data will be routinely collected as part of standard reporting and the general Cost Weight Study.

For 2001-02, agencies were asked to provide the department with six monthly activity statements of provision of limbs and repairs. From 2002-2003 these statements have been required yearly. Agencies have been notified of the format for reporting statements.

2.9 Cystic fibrosis

2.9.1 An additional specified grant for outpatient allied health services is provided to three specialist services for Cystic Fibrosis: the Royal Children's Hospital, The Alfred Hospital and Monash Medical Centre. Funding is provided for outpatient physiotherapy, dietetic and counselling occasions of service (psychology and social work).

The original grant was based on estimated activity. For 2004-05, hospitals that have not reached expected limits will continue to receive the current grant. Hospitals that have reported higher than expected activity have had their grant increased accordingly.

2.10 Accountability for visiting medical officer payments

The department supports sessional arrangements, rather than VMO arrangements within public hospitals. However, the department acknowledges that in some areas, sessional arrangements are impracticable.

Consistent with departmental policy and findings of the Victorian Auditor-General in relation to Visiting Medical Officer arrangements, hospitals that have engaged medical practitioners on a fee-for-service basis are required to establish and maintain appropriate accountability procedures in place over these payments. These financial controls are in addition to standard employment conditions for providers, such as regular review of credentials and clinical privileges. The type of accountability measures to be established will vary according to the size of the agency and the extent to which fee-for service arrangements are used, but may include:

- installation and use of purpose-specific software to monitor and audit claims
- conducting a regular manual audit of fee-for-service claims – comprehensive or random
- establishment and/or review of guidelines and procedures governing the administration and payment of fee-for-service costs.
- ensuring that contractual agreements are current for all providers who are remunerated on a fee-for-service basis, and that all such contracts clearly specify applicable rates and conditions of payment

- reviewing trends in service delivery and outputs for patient care provided on a fee-for-service basis. The department may, from time to time, require agencies to report on the nature and extent of fee-for-service claims and the accountability measures that have been put in place to monitor claims. For 2004-05, all agencies are required to provide a report to the relevant departmental offices by 30 September 2004.

3 Fire risk management

3.1 Health and safety

- 3.1.1 The hospital is responsible for ensuring that it complies with all laws relating to fire protection, health, and general safety which apply to any premises from which the hospital operates irrespective of whether the relevant regulatory requirements place the obligation upon the owner or occupier of those premises.
- 3.1.2 The hospital is also responsible for ensuring that it complies with the department's Capital Development Guidelines: Series 7 (Fire Risk Management) insofar as they are relevant to the Hospital.

3.2 Operational readiness

- 3.2.1 The hospital must ensure that appropriate operational readiness measures are developed, implemented and reviewed. This includes (but is not limited to) fire emergency management and evacuation procedures, and training of staff to implement the procedures developed. The Hospital must also ensure that essential services are maintained.

3.3 Client placement

- 3.3.1 At the time of patient placement in any premises, the hospital must ensure the premises complies with all laws relating to fire protection, health, and general safety which apply to any premises from which the Hospital operates. The hospital must also ensure that the premises are suitable for the client to be evacuated reasonably, taking into account the fire systems installed, and the evacuation capacities of the client. Where any relevant change occurs which may affect the client's ongoing ability to evacuate safely, the suitability of the placement must be reassessed, and appropriate action taken.

3.4 Certificate of fire safety compliance

- 3.4.1 The Hospital shall complete and return Certificate No. 6 of Fire Safety Compliance for 2004-05 to the department by the due date specified in "Agency Fire Safety Return Table for 2004-05", available on the department's web site.

4 Revenue

4.1 Hospital fees and charges

- 4.1.1 Hospitals will raise fees and charges in accordance with the department's manual Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals. It is located at: <http://www.health.vic.gov.au/feesman/>

The department's Fees Manual stipulates that public hospitals are permitted to raise fees for the following non-admitted patient services:

- (a) dental services
 - (b) spectacles and hearing aids
 - (c) pharmaceutical at a level consistent with Pharmaceutical Benefits Scheme statutory co-payments
 - (d) surgical supplies
 - (e) prostheses (this does not include artificial limbs or surgical implanted prostheses), aids and appliances and home modifications
 - (f) services provided to compensable and ineligible patients.
- 4.1.2 Hospitals cannot raise fees for these services where they are services provided to admitted patients on discharge. The one exception is for pharmaceuticals provided by hospitals participating in the Australian Health Care Agreement – Pharmaceutical Reforms.
- 4.1.3 Admitted patient fees revenue includes fees raised for prostheses.
- 4.1.4 Any shortfall in outpatient revenue will be absorbed by the hospital. Any revenue generated in excess of the target will be retained by the hospital.

4.2 Payments and revenue from treating private patients

- 4.2.1 Arrangements for private patients

Under current arrangements for acute inpatients, each hospital has a specified private revenue target. Since June 1999 and the introduction of Lifetime Health Cover and a 30 per cent rebate scheme by the Commonwealth Government, the number of people with private health insurance has increased from 29 percent in December 1998 to 43 percent in March 2004.

Whilst public hospitals are requested to follow Medicare principles, and give priority to patients based on clinical needs, in 2002–03 and 2003–04 the department provided incentives for hospitals that treat a mix of patients based on the proportion of people holding private health insurance in the community. This incentive has been retained for 2004–05.

5 Other financial administrative conditions

5.1 Goods and Services Tax

The Commonwealth Government's introduction of the Goods and Services Tax (GST) from 1 July 2000 requires that at a minimum, hospitals to be registered with the ATO, have an ABN, and are able to submit as required a Business Activity Statement to the ATO.

Hospital management is responsible for ensuring that their hospital is compliant with the GST, and meets the reporting obligations. The Government will not be responsible for the inability of hospitals to identify and claim all input credits owing to them.

5.2 Long Service Leave

Commencing with the 2000-01 financial year the department assumed the liability arising from the net increase in the Long Service Leave (LSL) provision of public hospitals. Hospitals will therefore record a net increase in the LSL liability as revenue with the department a debtor. This was advised to hospitals in circular 13/2001. That circular provides details of the appropriate accounting treatment. Discussions are being held with Department of Treasury and Finance and the Auditor General to enable a similar treatment with respect to Annual Leave, however no agreement has been reached on that issue to date, and separate advice on this will be provided.

5.3 Accounting for Long Service Leave (LSL)

As advised in hospital circular 3/2001, at the introduction of casemix the department included a loading of 1.8 percent of salaries for LSL purposes and this loading has continued to be applied in funding for award increases ever since. Analysis of data over the past four years indicates that generally hospitals manage cash outgoings within the 1.8 percent payment. However, where hospitals are paying out cash in excess of funding, the department has agreed to provide additional funding to meet the excess cash outgoing. This will be based on the annual reports provided after year end.

The debtor established by the non-cash revenue recognition can be run down in future years by a negative non-cash liability movement or by the claiming of cash revenue to match a cash expense greater than the amount recognised in Health Service Agreement cash budgets.

5.4 Cash flow to hospitals

Subject to meeting the requirements of the Hospital Conditions of Funding, payments for WIES and other activity will be made available to the hospital in twenty four (24) payments based on the quarterly targets specified by hospitals and recorded in the HSA, or negotiated cash flow requirements.

Cash so advanced will be adjusted annually to match hospital earnings.

5.5 Force majeure

Circumstances (including industrial action), beyond the reasonable control of hospital management, may sometimes prevent the attainment of targeted throughput. The department will continue its policy whereby, on a case by case basis it will fund hospitals according to their cash flow projections irrespective of throughput, but only for so long as force majeure continues. Hospitals are expected to

actively mitigate their financial exposure and throughput decline during and following such events, and will not be additionally funded for extra “catch-up” throughput in specific service areas undertaken around a period of force majeure. The relevant quarter’s performance together with other available data and indicators will be used to determine the net impact of any period of force majeure.

5.6 Risk management

Risk management is recognised as an integral part of good business management practice. Hospital management can directly influence the control of risks through the development of a risk management strategy supported by a risk management process. This regime should reduce the likelihood and consequences of adverse outcomes occurring from hospital activities.

The department’s insurer and risk adviser, Victorian Managed Insurance Authority (VMIA) recommends the use of the Standard AS/NZS 4360:1999 Risk Management for the risk management process which incorporates:

- risk identification
- risk analysis
- risk evaluation
- risk treatment
- communication & consultation
- on-going monitoring and review.

The “shadow apportionment” of premium cost introduced for hospitals during 2001-02 was maintained for the 2003-04 financial year. The proposal to allocate premiums based on a combination of past claims performance and risk exposure will continue to be developed during 2004-05.

The containment of future premium costs is a significant financial incentive to hospitals. It is therefore in the interests of hospitals to develop a risk management culture not only to help minimise claims losses but also achieve best practice quality care within an overall sound corporate governance framework.

5.7 Health Service Agreement

Annual Statement of Priorities will replace Health Service Agreements for metropolitan and rural hospitals during 2004-05. The HSA is the vehicle used by the department to ‘purchase’ health services from providers on behalf of the community. A HSA is effectively the contract between the department and another legal entity under which the department provides public funds to ‘purchase’ direct services for individuals or groups in the community. These services may be varied over the life of the agreement.

A Health Service Agreement which lists the conditions applicable to relevant hospitals for 2004-05 is available at the department website <http://www.dhs.vic.gov.au/ahs>. The Annual Statement of Priorities, to be signed by Board Chairs and the Minister, will outline the key performance expectations and targets for the year for metropolitan and major regional health services. Rural hospitals will be required to sign the Department Health Service Agreement including schedules specific to each individual hospital.

6 Reporting

6.1 Supply of statistics and information¹

- 6.1.1 The hospital or Multi-Purpose Service (MPS) will comply with standard definitions for reporting financial and statistical data as set out in the Notes and Definitions for Use in Completing the 2004-05 Annual Return, the VAED Manual Version 14.0, AIMS Public Hospital User Manual Version 12.0, VEMD Manual Version 9.0, ESIS Manual Version 6.0, and any other amending documentation prepared by the department.
- 6.1.2 The hospital or MPS will code patient episodes in accordance with the current Australian Coding Standards effective 1 July 2004, Victorian Additions to the Australian Coding Standards and ICD Coding Newsletters issued by the department.
- 6.1.3 The hospital or MPS will provide data to the department as specified in the HSA and in these Conditions of Funding.
- 6.1.4 The hospital will provide AIMS data to the department electronically via the Victorian Hospital Information Services website and by the dates prescribed in the AIMS Public Hospital User Manual Version 12.0.
- 6.1.5 To assist with the calculation of the Prior Year Adjustment all AIMS forms should be completed by 17 September 2005.

6.2 Financial information

- 6.2.1 F1 financial returns for major providers (metropolitan health services, Barwon Health, Ballarat Health Services and Bendigo Health Care Group) are required twelve days after the end of the month for which the financial data is provided (for example, the F1 for July is required by 12 August). F1 financial returns for all other hospitals are required fourteen days after the end of the month for which the financial data is provided.
- 6.2.2 Metropolitan Health Service/s will provide Finance (Form F1) returns at the Metropolitan Health Service level. All other hospital returns will be provided at the hospital or campus level.

¹ Hospitals within the scope of the Small Rural Health Services (SRHS) funding and accountability approach must continue to report statistical, financial and other data according to the requirements set out in this section. For further information on SRHS funding and accountability approach see <http://www.dhs.vic.gov.au/rrhacs>.

6.3 Specific data requirements

- 6.3.1 Commonwealth/State
- a) Hospitals and MPS receiving funding under Commonwealth/State programs are required to submit regular statistical and financial reports for the monitoring of activity, payment of grants and acquittance to the Commonwealth.
 - b) The information required, format and timelines for individual programs are detailed in the guidelines applicable to the appropriate Commonwealth or State Programs.
- 6.3.2 Metropolitan Health Services and major rural hospitals are required to operate and maintain, to a minimum standard, patient costing systems that monitor service provision to patients and allow recalibration of the DRG funding formulae. Such hospitals are required to provide, sufficient accurate and timely information from the system, as specified by the department to allow recalibration of the DRG relative weights. Penalties for non-provision of costing data will be based on, and may exceed, the average cost of operating an appropriate clinical costing system according to the operating size of the agency.
- 6.3.3 Metropolitan Health Services and major rural hospitals are required to maintain systems that enable monitoring of clinical effectiveness and provide to the department coded clinical data that are of appropriate reliability and quality for the monitoring and development of the Clinical Indicator Program
- 6.3.4 In addition to the monthly reports specified in section 6.1.2, Metropolitan Health Services, hospitals and MPSs are required to complete an Annual Return by 30 September 2005 in accordance with the detailed requirements specified by the department.
- 6.3.5 Failure of a Metropolitan Health Service, hospital or MPS to supply accurate and timely statistical and financial data in accordance with the Conditions of Funding: Metropolitan Health and Aged Care Services may result in penalties or suspension of payments by the department.

6.4 Transmission of minimum employment dataset

- 6.4.1 Metropolitan Health Services, hospitals and MPSs are required to transmit information detailed in the Minimum Employment Data Set. The Minimum Employment Data Set requires that data be transmitted to the department by the tenth day following the end of the relevant month.
- 6.4.2 Metropolitan Health Services, hospitals and MPSs who have their payroll/budget processing undertaken by Allegiance systems will continue to have their data forwarded direct to the department. Agencies whose payroll/budget processing is being undertaken by other operators are required to transmit the information detailed in the Minimum Employment Data Set directly to the department. Where payroll/budget processing operators are changed, Metropolitan Health Services, hospitals and MPSs will be required to satisfactorily complete the Accreditation process detailed in the Minimum Employment Data Set.

6.5 Transmission of admitted patient data

- 6.5.1 The hospital will transmit data to the VAED via PRS/2 according to the timelines detailed in clauses 6.5.1. (a) and 6.5.1(b).
- a) Admission and separation details for any month are to be transmitted in time for the VAED file consolidation on the 17th day of the following month (see (d) below for processing schedule).
 - b) Diagnosis and procedure and sub-acute details in any month are to be transmitted in time for the VAED file consolidation on the 17th day of the second month following (see (d) below for processing schedule).
 - c) Data for the financial year should be completed in time for the VAED file consolidation on 17 August 2005. Any corrections must be transmitted before finalisation of the VAED database on 17 September 2005.
 - d) It is the hospital's responsibility to ensure that data are transmitted to the VAED to meet the processing schedule for inclusion in the Allegiance Systems file consolidation on the 17th of each month. VAED data (sent by modem) must be received by 5pm on the 17th of each month, regardless of the actual day of the week. VAED (sent by disc) must be received by 12pm (noon) on the last working day on or before the 17th of the month.
 - e) WIES12, multi-purpose service and sub-acute payments will be:
 - fully paid for data originally submitted in accordance with the deadlines specified in clauses 6.5.1.(a) and 6.5.1(b) above, even if data is subsequently amended; or
 - paid at a reduced rate (50 per cent), or not recognised for payment, according to Schedules 1 and 2 located at the end of this section if the data has not been submitted in accordance with either deadline specified in clauses 6.5.1(a) and 6.5.1(b) above; or
 - not recognised for payment, if data has not been submitted in accordance with both deadlines specified in clauses 6.5.1(a) and 6.5.1(b) above.

This clause applies to all account classes including DVA.

- f) If difficulties are anticipated in meeting the relevant data transmission timeframes for either admission and separation data, or diagnosis and procedure details, the Metropolitan Health Service, hospital or MPS must write to the department, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for one-off late submission of data will generally only be considered for computer system problems that are beyond the control of the Metropolitan Health Service, hospital or MPS. (Metropolitan Health Services, hospitals or MPSs undertaking the PRS/2 data submission testing process are automatically exempted). Exemptions for late submission of admission and separation data will also be considered for staffing problems that are beyond the control of small rural hospitals and MPSs. Exemptions for late submission of admission and separation data will be automatically granted to hospitals or MPSs maintaining a consistently high level of timely data submission.

6.6 Transmission of emergency department data

6.6.1 Hospitals receiving the non-admitted emergency services grant will transmit data to the VEMD according to the following timelines:

VEMD, 2004–05	Timeline
First 14 days of the month	At least one submission must be received by the 21 st of the reporting month (for example, 1-14 July data by 21 July).
Full month	Remainder of the month must be supplied by the 10 th of the following month. Must be complete, i.e. zero rejection and notifiable edits, by the 21 st of the following month (for example, July data by 21 August).

Note: the department will endeavour to return rejection and notifiable edit reports within three working days of submission.

6.6.2 Where hospitals are non compliant with these timelines, the department will apply a penalty no greater than:

- a) \$2,000 if a file containing data from the first 14 days of the month and/or the full month is not submitted by the timeline specified in 6.6.1;
- b) \$1,000 for each record from the full month that is not completed by the timeline specified in 6.6.1; and
- c) \$2,000 for each record from the full month that is not completed within one month of the timeline specified in 6.6.1

6.6.3 If difficulties are anticipated in meeting the monthly timeline, the hospital must write to the department indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for late submission of data will generally only be considered for computer system problems that are beyond the control of the hospital. For the period that the hospital is unable to supply unit record data, the hospital may be asked to submit aggregate data.

6.7 Transmission of elective surgery data

6.7.1 Hospitals with at least 3,000 WIES in elective surgery separations will transmit data to ESIS according to the following timeline:

ESIS, 2004–05	Timeline
Full month	Initial file must be supplied by the 10 th of the following month. Must be complete, i.e. zero rejection and notifiable edits, by the Full month 21 st of the following month (for example, July data by 21 August).

Note: The department will endeavour to return rejection and notifiable edit reports within three working days of submission.

6.7.2 Where hospitals are non compliant with these timelines, the department will apply a penalty no greater than:

- a) \$2,000 if a file containing data from the full month is not submitted by the timeline specified in 6.7.1
- b) \$1,000 for each record which is not completed by the timeline specified in 6.7.1
- c) \$2,000 for each record which is not completed within one month of the timeline

specified in 6.7.1.

- 6.7.3 If difficulties are anticipated in meeting the monthly timelines, the hospital must write to the department indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for late submission of data will generally only be considered for computer system problems that are beyond the control of the hospital. For the period that the hospital is unable to supply unit record data, the hospital may be asked to submit aggregate data.

6.8 Transmission of AIMS data

- 6.8.1 Metropolitan health services, hospitals or MPSs will transmit data to AIMS according to timelines specified in the AIMS Manual, Version 12.0.
- 6.8.2 Where hospitals are non-compliant with these timelines the department will apply a penalty of no greater than \$2,000 for each return not submitted within one month of the due date specified in the AIMS Manual.
- 6.8.3 If the annual redevelopment of the AIMS software causes any delay in the release of on-line forms, hospitals will be advised of revisions to timelines.
- 6.8.4 If difficulties are anticipated in meeting the specified timeline, the hospital must write to the department indicating the nature of the difficulties, remedial action being taken and the expected schedule for data submission. Exemptions for late submission of data will generally only be considered for computer problems beyond the control of the hospital.

6.9 Patient data

- 6.9.1 The Metropolitan Health Service, hospital or MPS will provide sufficient access to data and records to allow an audit of patient records, patient coding and data transmitted to the VAED.
- 6.9.2 If the audit shows a difference in assignment of DRGs and/or other data items that alter the allocation of WIES, or that patients fail to meet admission criteria, then the number of weighted inlier equivalent separations and/or throughput payments to the Metropolitan Health Service, hospital or MPS may be adjusted to take account of those differences.
- 6.9.3 Where the audit indicates that a Metropolitan Health Service, hospital or MPS has been consistently erroneous in the application of admission criteria and/or coding standards, the department will adjust or suspend the relevant throughput payments until such time as the issue is resolved to the satisfaction of the department.
- 6.9.4 The department also reserves the right to undertake supplementary audits to confirm an issue and/or monitor improvement; the cost of which is to be borne by the Metropolitan Health Service, hospital or MPS.
- 6.9.5 Access to data and records for interstate patients transmitted to the VAED will also be required should State or Territory Health Authorities request an independent audit to verify information on DRG weighted separations.

- 6.9.6 The Metropolitan Health Service, hospital or MPS will also provide sufficient access to data and records to allow an audit of patient records and data transmitted via AIMS as part of VACS.
- 6.9.7 Access to data and records for emergency department patients and persons on waiting lists will also be required should this department or the Commonwealth require an audit to verify information used for funding calculations either at the hospital or State level.

6.10 Access to hospital patient level data

- 6.10.1 The department will have access to patient level cost data and to patient level data transmitted to the VAED, VEMD, and ESIS.

Schedule 1

Timelines for the receipt of admission and separations details (E2)

VAED consolidation date

Month of separation 2004-05	17 Aug	17 Sept	17 Oct	17 Nov	17 Dec	17 Jan	17 Feb
July	Full rate	Half rate	Nil	Nil	Nil	Nil	Nil
August		Full rate	Half rate	Nil	Nil	Nil	Nil
September			Full rate	Half rate	Nil	Nil	Nil
October				Full rate	Half rate	Nil	Nil
November					Full rate	Half rate	Nil
December						Full rate	Half rate
January							Full rate

VAED consolidation date

Month of separation 2004-05	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Nil	Nil	Nil	Nil	Nil	Nil	Nil
January	Half rate	Nil	Nil	Nil	Nil	Nil	Nil
February	Full rate	Half rate	Nil	Nil	Nil	Nil	Nil
March		Full rate	Half rate	Nil	Nil	Nil	Nil
April			Full rate	Half rate	Nil	Nil	Nil
May				Full rate	Half rate	Nil	Nil
June					Full rate	Half rate	Nil

Schedule 2

Timelines for the receipt of diagnoses and procedure (X2, Y2) and sub-acute details (S2)

VAED Consolidation date

Month of Separation 2004-05	17 Sept	17 Oct	17 Nov	17 Dec	17 Jan	17 Feb	17 Mar
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate

VAED Consolidation date

Month of Separation 2004-05	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Half Rate	Nil	Nil	Nil	Nil		
January	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
February		Full Rate	Half Rate	Nil	Nil	Nil	Nil
March			Full Rate	Half Rate	Nil	Nil	Nil
April				Full Rate	Half Rate	Nil	Nil
May					Full Rate	Half Rate	Nil
June						Full Rate	Half Rate