

Victoria–public hospitals and mental health services  
Policy and funding guidelines  
2008–09

General conditions of funding

A Victorian  
Government  
initiative



# **Victoria—public hospitals and mental health services**

## **Policy and funding guidelines 2008–09**

### **General conditions of funding**

The 2008-09 *General conditions of funding* are to be read in conjunction with the following two documents:

- The Victoria-Public hospitals and mental health services: Policy and funding guidelines 2008-09
- Victoria-Public hospitals and mental health services: Policy and funding guidelines 2008-09 - **Technical information**

These documents are available online at: [www.health.vic.gov.au/pfg](http://www.health.vic.gov.au/pfg)

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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.

**The currency of the 2003-08 AHCA between the Commonwealth of Australia and the State of Victoria has, by the agreement of the Council of Australian Governments on 26 March 2008, been extended to 30 June 2009.**

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: [www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm) *Hospital Circular 33/2003* (as amended and updated 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's website: [www.health.vic.gov.au/feesman](http://www.health.vic.gov.au/feesman)

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 Circulars.

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 Repatriation Commission..

- All eligible patients must elect to receive admitted public hospital services as a public or private patient. 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 Transport Accident Commission (TAC), WorkSafe Victoria, or the Department of Veterans' Affairs (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 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.
- The Agreement provides that in those hospitals that rely on general practitioners for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own general practitioner, either as part of continuing care or by prior arrangement with the doctor.

## 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.

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).

The hospital will only admit patients in accordance with the Minimum criteria for admission as specified in the VAED Manual 18th Edition, and shall provide documented justification for the admission of all Type C professional attention procedures (exclusion list) patients, Extended medical treatment 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 the current Department of Human Services Hospital Admission Policy.

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

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 Indigenous status 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 per cent higher than the nominated WIES payment for 2008-09.

### **1.3 Claims for Medicare benefits**

The hospital will ensure that aftercare services for patients funded through the Department of Human Services, or a third party arrangement (for example, TAC, DVA, or WorkSafe Victoria), including outpatients and patients receiving accident and emergency services, do not attract claims for Medicare benefits.

### **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

Targets will comprise:

- target A volumes, paid at the relevant rate
- elective, renal DVA and TAC volumes, paid at the relevant rates
- sub-acute volumes paid at the relevant rate
- non-admitted patient grants
- training and development grants
- other specified grants.

These grants and admitted patient and outpatient target volumes are shown in the Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2008–09 and shown in the hospital’s Health Service Agreement (HSA), or Annual Statement of Priorities (SOP).

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 (SRHSs) 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 Services 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

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 2008–09 this statistic will be abbreviated as WIES15. The method and calculation of WIES15 are outlined on the Department of Human Services’ Casemix website: [www.health.vic.gov.au/casemix/index.htm](http://www.health.vic.gov.au/casemix/index.htm).

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

- Major providers (Metropolitan Health Service and Barwon Health) \$3,468
- Rural Group B > 14,000 WIES \$3,635
- Rural Group B 7,500-14,000 WIES \$3,743
- Rural Group B 5,000-7,500 WIES \$3,834
- Rural Group B < 5,000 WIES \$3,864
- Rural Group C \$3,948

### 2.2.1 Throughput above target

In ongoing recognition of the difficulty of precise demand management, throughput in excess of target up to two per cent will be paid at \$1,200 per WIES.

During 2008–09 WIES generated in designated same day medical DRGs (excluding deaths and transfers) will be funded in full. The previous limit of 6.5 per cent of a health service or hospital throughput (excluding exempt hospitals) no longer applies.

### 2.2.2 Monthly reports

Monthly targets will be nominated by the agency. Actual throughput against target will be monitored on a monthly basis by the Department of Human Services Access and Metropolitan Performance Branch.

Subject to a mid-year review, monthly target adjustments may be made where actual performance varies significantly (more than two per cent) from the nominated monthly targets.

#### **Nursing Home Type patient payment**

The hospital will receive \$200 for each Nursing Home Type (NHT) bed day, as reported on 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.

It is expected that Metropolitan Health Services will have limited use of non-DVA NHT in 2008–09. Therefore there will be no targets or funding cash-flowed for this service type for Metropolitan Health Services in 2008–09.

#### **Interim payments for long-stay, high-cost patients**

The department will consider interim payments for long-stay patients accumulating significant amounts of WIES, who remain unseparated at 30 June 2009.

Hospitals 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 2009. 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, comorbidities and procedures.

There will be no strict Length of Stay (LOS) or WIES criteria for patients to be covered by this arrangement, but the following may provide some guidance:

- still in at 30 June 2009, LOS already exceeds a year
- still in at 30 June 2009, LOS already exceeds six months, might reasonably be expected to still be in the hospital at 31 December 2009
- still in at 30 June 2009, 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

Additional payments will be provided to the hospital for specific agreed services.

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).

## 2.4 Compensable patients

### 2.4.1 Department of Veterans' Affairs (DVA) patients

- a) The major features of ongoing payment arrangements for eligible DVA veterans have been retained for 2008-09. Hospitals should note that payment for DVA services will continue to attract a premium for throughput based services and be paid for patients who elect to be treated as a veteran and on a reconcilable basis as detailed below. The premium price for treating veterans is paid to ensure the ability of public providers to compete on an equitable basis with the private sector in terms of quality of services to veterans.

Hospitals should note that the 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.
  - Subcontracting of DVA patient services to a private hospital or facility. Where a bed is not available for a DVA patient the patient is to be formally discharged and transferred to the private hospital. Subcontracting for transition care is exempt from this requirement.
- b) For 2008-09, as in previous years, separate capped public targets and uncapped veterans' estimates will be incorporated into hospital and mental health service provider budgets as applicable.
  - c) DVA will continue to fund a majority of public hospital acute, post-acute and mental health services 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 submitted veteran data with DVA records. The rate of rejection of records submitted by hospitals is generally between one and two per cent, however, for mental health service providers the rejection rate has historically been much higher. Many of these eligible veteran rejections are due to agencies not collecting sufficient information from the veteran to allow for an exact matching of veteran data by DVA.

It is imperative that agencies ensure that patients elect to be treated as a veteran and that they collect and provide to the department the eligible veteran's name, DVA 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. As reconciliations become more timely, hospitals will be requested to reclassify rejected records as public and transmit the revised records to the Department of Human Services, as is the case with other rejected compensable records

- e) For each hospital, the department will estimate eligible DVA patient/client/attendee throughput for the following services and a premium will continue to apply:

**Admitted patient services**

- WIES
- Sub-acute services (rehabilitation, GEM and palliative care)
- Post Acute Care (PAC)
- Victorian Maintenance Dialysis Program
- Nursing Home Type (Maintenance Care)
- Mental Health Services.

**Non-admitted patient services**

- Victorian Ambulatory Classification System (VACS) encounters
  - Allied health occasions of service (in VACS funded hospitals)
  - Non-admitted radiotherapy Weighted Activity Units (WAUs).
- f) Transition care will be block funded for DVA patients in 2008-09 with the aim of moving to throughput based service provision in 2009-10.
- g) In 2008-09 Sub-acute Ambulatory Care Services (SACS) funded services will be block funded for DVA patients with the aim of moving to throughput based service provision in 2009-10.
- h) The premium to both the private patient WIES price and public price for other services is payable for all eligible DVA patients matched with DVA records (as reported in the VAED or appropriate outpatient data system) including numbers in excess of the estimate. If hospitals do not achieve the DVA target, any funding that 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.
- i) Section 3B of the Health Insurance Act 1973 was repealed by the Commonwealth Government. However under the current DVA Hospital Services Arrangement with Victoria if the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days, DVA still requires that hospitals ensure that the veteran's status is reviewed and that either:
- 1) A certificate similar to that previously required under Section 3B is completed by a medical practitioner and forwarded to:  
Public Hospital Contract Manager  
c/o Department of Veteran Affairs  
300 La Trobe Street  
Melbourne VIC 3000

Or

  - 2) The Beneficiary is reclassified to a Nursing Home Type patient and the changed status and payment adjusted accordingly.

- j) Where an admitted veteran's length of stay is greater than 35 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.
- k) For all the throughput based 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
  - the veteran's DVA unique identifier and veteran details reported to the department exactly match those held by the DVA for each eligible patient/resident/attendee.
- l) 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 eligible status. 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. As the timing of reconciliation improves, this requirement will be strictly enforced in 2008-09 and hospital funding adjusted. The department will not accept any risk for *assumed* revenue.
- m) Eligible veterans will not be covered under the DVA arrangement if they:
- do not elect to be treated as a DVA patient
  - elect to be public patients under the Australian Health Care Agreement
  - are compensable patients, such as TAC and WorkSafe Victoria; or
  - elect to use their private health insurance.
- n) 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*.
- o) Experience has shown that those hospitals that actively develop service quality and marketing plans and employ Veteran or Patient 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 Veteran or Patient Liaison Officer.
- p) 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:  
[www.dva.gov.au/health/vets\\_info.htm](http://www.dva.gov.au/health/vets_info.htm).

#### **2.4.2 Transport Accident Commission patients**

The funding agreement between the department and Transport Accident Commission (TAC) for hospital prices for services is effective from 1 July 2007 to 30 June 2010. WIES funding of TAC admitted patients in public hospitals and separate trauma related specified payments will continue to apply in 2008-09. TAC WIES throughput is uncapped (refer to *Hospital Circular 4/2008*).

The Rehabilitation 1 and 2 rates will be paid at the TAC specific rate shown in the *Department of Human Services Fees and Charges* website. All other services will be paid at the public rate.

- a) The funding agreement covers pricing of services and details of services included for TAC patients. The department will receive funding directly from the TAC 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 2008-09 based on throughput previously reported in the VAED.

- b) Hospitals will continue to receive WIES throughput and trauma specific payments for TAC patients from the department. Hospitals, however, will need to continue to charge TAC directly for the specialist medical and imaging costs associated with these admitted patient episodes, rehabilitation and non-admitted patient services.
- c) For the department to receive payment from TAC, TAC must accept the claim and issue a claim number. The patient information reported by the hospitals to the department via PRS/2 must match those held by TAC 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 as updated at: [www.health.vic.gov.au/hdss/](http://www.health.vic.gov.au/hdss/).
- d) The department will pay a rate applicable for all accepted 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.**
- e) Hospitals should only accrue revenue for accepted TAC records. Any rejected records will be automatically funded as public in the Prior Year Adjustment process, provided that the hospital does not exceed its WIES target.
- f) Hospitals should ensure that TAC records are updated in the PRS/2 with monthly information fed back by the department. This will ensure that updated records will be accepted by TAC and therefore minimise delays in reconciling activity and payment for records with TAC.
- g) Errors that are not corrected by health services, such as a patient's date of birth, continuously cycle through both the department and TAC databases, and remain unmatched and unfunded. This causes additional review, reconciliation and problem solving by the TAC and department. **Hospitals are required to ensure that information is keyed in with a high level of accuracy to prevent future errors and to be proactive in identifying and remedying anomalies prior to sending data to the department.**
- h) Patients are required to complete a TAC claim form. Hospitals should make themselves aware of the form's specific requirements. Where hospital data does not exactly match the details a patient has entered on a TAC claim form there will be significant delays in payment from the TAC as both TAC and the department will be impacted by the reconciliation processes.
- i) For records where claims are not accepted by TAC, either:
  - additional information is required to be transmitted by hospitals to allow the claim to be accepted, or
  - 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.
- j) As TAC claimants have 12 months to lodge a claim with the TAC, following the end of each financial year, any resulting hospital funding adjustments will be undertaken through the Prior Year Adjustment process.
- k) Ultimately, care in data entry will significantly improve and streamline the reconciliation process.

### 2.4.3 WorkSafe Victoria

WorkSafe Victoria (formerly Victorian Workcover Authority) patients treated in Victorian public hospitals are directly funded by WorkSafe insurers. This process will continue in 2008-09 at the rates and indexation processes of prices for all services agreed with WorkSafe Victoria on behalf of hospitals by the Department of Human Services. It is expected that there will be no change to existing payment processes. Any amendments to the current services and prices will be documented on the *Department of Human Services Fees and Charges* website and an advisory circular issued.

## 2.5 Hospital Medical Officers on rotation (secondment) to external (receiving) hospitals

Many training programs for HMOs involve a rotation to a site other than their parent hospital. The parent hospital is responsible for managing the annual leave of Hospital Medical Officers (HMOs) on rotation, and where annual (or other) leave is planned within the rotation period, both hospitals should approve this leave. The receiving hospital is not to pay out annual leave, as this is included in the overheads paid to the parent hospital (for more information see *Hospital Circular 2/2005*).

The parent hospital will make every endeavour to organise suitable relief when a seconded HMO also takes other leave (either planned or unexpected) for greater than one week. The parent hospital will make every endeavour to ensure that the relieving HMO has commensurate experience and skills to ensure that the expected level of service in the rotating hospital can continue to be provided.

## 2.6 Redirection of funds

Where total earnings for the funded program exceed the expenses incurred in delivery of the full quantity of services specified in the Statement of Priorities or Health Service Agreement, the surplus may be used by the Hospital for any purpose connected with its agreed function.

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

## 2.7 Privacy

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 the Statement of Priorities or Health Service Agreement which applies to the hospital.

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

### 2.8.1 Continuous Positive Airways Pressure

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.

### **2.8.2 Home Enteral Nutrition**

Since July 2001, the Home Enteral Nutrition (HEN) 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.

### **2.8.3 Victorian Artificial Limb Program (VALP)**

Since July 2002, funding for the artificial limbs services has been converted to general WIES equivalents and rolled into and added to the relevant 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 (The McKellar Centre)
- Bayside Health (Caulfield General Medical Centre)
- Bendigo Health Care Group (Anne Caudle Centre)
- Melbourne Health (Royal Melbourne Hospital – Royal Park Campus)
- Latrobe Regional Hospital
- Peninsula Health Service (Mt Eliza Aged Care and Rehabilitation)
- South West Healthcare (Warrnambool and District Base Hospital)
- St Vincent's Hospital
- The Royal Children's Hospital

It is expected that over time, 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. Since 2002-03 these statements have been required yearly. Agencies have been notified of the format for reporting statements.

## **2.9 Cystic fibrosis**

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).

Agencies are required to report occasions of service activity to AIMS six-monthly on the S7 111 form.

## **2.10 Accountability for Visiting Medical Officer payments**

The department supports sessional arrangements, rather than Visiting Medical Officer (VMO) arrangements within public hospitals. However, the department acknowledges that in some areas, sessional arrangements are impractical.

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.

## **3 Fire risk management**

### **3.1 Health and safety**

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.

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**

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**

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**

The hospital shall complete and return *Certificate No. 6 of Fire safety compliance for 2008-09* to the department by the due date specified in *Agency fire safety return table for 2008-09*, available on the department's web site at: <http://www.health.vic.gov.au/firesafe/index.htm>.

## 4 Revenue

### 4.1 Hospital fees and charges

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*. The manual is located at: [www.health.vic.gov.au/feesman/](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) surgical supplies
- (d) prostheses (this does not include artificial limbs or prostheses which are surgically implanted, either permanently or temporarily or are directly related to a clinically necessary surgical procedure, including breast prostheses)
- (e) pharmaceuticals at a level consistent with Pharmaceutical Benefits Scheme statutory co-payments (this applies only to admitted patients upon separation)
- (f) aids, appliances and home modifications
- (g) other services as agreed between the Commonwealth and Victoria.

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.

Admitted patient fees revenue includes fees raised for prostheses.

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.

As at December 2007, the number of people with private health insurance was 43 per cent.

Whilst public hospitals are requested to follow Medicare principles, and give priority to patients based on clinical needs, the department provides incentives for hospitals that treat a mix of patients based on the proportion of people holding private health insurance in the community.

## 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 be registered with the Australian Taxation Office (ATO), have an ABN, and be able to submit as required a Business Activity Statement to the Australian Taxation Office (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.

The ATO has ruled (*GSTR 2006/11 Appropriations*) that funding from the Department of Human Services to public hospitals and other VPS owned entities such as Ambulance Services is outside the scope of GST pursuant to section 9-15(3)(c) of the *Goods and Services Tax Act 1999*. This has been confirmed in the ATO private binding ruling number 70297 dated 24 January 2007 provided to the department.

From 1 July 2007, funding from the Department of Human Services to public hospitals (other than denominational) no longer attracts GST.

Hospitals should be aware that transactions between hospitals are not covered by *Ruling GSTR 2006-11* and remain as normal taxable supplies, although some items may receive differing treatment such as GST free medical services. Commercial type sales of goods or services to the Department of Human Services should continue to be treated as taxable supplies that include the imposition of GST.

### 5.2 Long Service Leave

Prior to 1 July 2008 the department assumed the liability arising from the net increase in the Long Service Leave (LSL) provision of public hospitals. Commencing 1 July 2008, the department provides full funding of LSL through the WIES price.

### 5.3 Full funding of Long Service Leave

In past years funding for the cash component of long service leave has been incorporated into the WIES price. The basis for this has been that the department provides 1.8 per cent of salaries and wages as a contribution to an agency's long service leave liability. The difference between this contribution and the hospital's provision has been met through the creation of a non-cash Department of Human Services debtor; these arrangements are contained in departmental circular 13/2008. From 1 July 2008 circular 13/2008 is rescinded and the WIES price increased to provide for full funding of LSL. The additional funding included in the WIES price fully allocates the remaining LSL funding allocated to the department. The residual Department of Human Services LSL debtor will be fixed at 30 June 2008 levels and paid out over the next four to five years. One impact of this change will be that where a staff member moves between hospitals, if the LSL is not paid out the cash will need to be transferred to the new employer.

### 5.4 Cash flow to hospitals

Subject to meeting the requirements of these Conditions of Funding, payments for WIES and other activity will be made available to the hospital in 24 payments based on the monthly targets specified by hospitals and agreed with the department or other negotiated cash flow requirements.

Any cash so advanced will be adjusted annually to match hospital earnings.

## 5.5 Capital works

Despite any provision of a Service Agreement/Statement of Priorities, the hospital agrees to obtain the approval of the department prior to seeking to borrow funds, or enter into third party finance arrangements for capital works expenditure.

The hospital further agrees not to enter into any expenditure (including finance leases) related to capital works, where the estimated total end costs of the works exceeds 10 per cent of the annual revenue of the hospital or \$2,000,000, whichever is the lesser amount, unless:

- (a) the hospital has provided the Secretary with a detailed business plan relating to the proposed expenditure, and
- (b) the expenditure has been approved by the Secretary.

The approval of the Secretary in relation to any expenditure referred to the above clause does not imply the provision of any financial support for the works by the Secretary.

## 5.6 Intellectual Property

The Intellectual Property of each party, which exists at the date of a Service Agreement/Statement of Priorities, remains the property of that party.

All Intellectual Property developed by either party under a Service Agreement/Statement of Priorities and relating to the Services and Funding, vests in the State of Victoria.

The hospital may in writing seek a licence from the State of Victoria through the appropriate Minister to use the Intellectual Property which vests in the State of Victoria under a Service Agreement/Statement of Priorities, and the hospital acknowledges that the granting of such a licence is solely at the discretion of the Minister.

The hospital warrants that it will not use any Intellectual Property under a Service Agreement/Statement of Priorities if that use would breach the rights of any other person.

On, or prior to, the completion date, the hospital will deliver to the Department of Human Services immediately following a written request by the department, all materials in which intellectual property vests in the State of Victoria under this clause. The hospital may keep a copy of all such material.

## 5.7 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.

## 5.8 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 and consultation
- in-going monitoring and review.

The proposal to allocate premiums based on a combination of past claims performance and risk exposure will continue to be developed during 2008-09.

The containment of future premium costs should be seen as a significant financial incentive to hospitals. It is therefore in the interests of hospitals to develop a risk management culture encompassing clinical and all other operational activities not only to help minimise claims losses but also achieve best practice quality care within an overall sound corporate governance framework.

## 5.9 Openness and probity in purchasing, tendering and contract activities

In line with the Victorian Governments policy statement *Ensuring openness and probity in Victorian Government contracts*, all public hospitals are required to have regard to the government's overall disclosure policy and to document their own procurement and disclosure policies accordingly. All public hospitals must at a minimum adopt and deliver standards of probity at least as high as those required under Victorian Government Purchasing Board (VGPB) guidelines.

## 5.10 Annual Statements of Priorities/Health Service Agreements

Annual Statements of Priorities (SOP) replaced Health Service Agreements (HSA) for Public Health Services<sup>1</sup> and three denominational hospitals<sup>2</sup> during 2004-05. The annual SOP, to be signed by Board Chairs and the Minister before 1 October 2008, will outline the key performance expectations and targets for the year for each Public Health Service and the three denominational hospitals. All other hospitals will be required to sign a Health Service Agreement, as specified in the *Health Services Act 1988*, that includes schedules specific to each individual hospital.

The SOP and HSAs (as applicable) require hospitals to comply with these General Conditions of Funding.

A HSA, which lists the conditions applicable to rural hospitals for 2008-09 is available at the department website: [www.dhs.vic.gov.au/srvc\\_agmnt/](http://www.dhs.vic.gov.au/srvc_agmnt/).

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<sup>1</sup> 'Public Health Services' as defined under schedule 5 of the *Health Services Act 1988* are: Austin Health, Bayside Health, Eastern Health, Melbourne Health, Northern Health, Peninsula Health, Peter MacCallum Cancer Institute, The Royal Children's Hospital, The Royal Victorian Eye & Ear Hospital, The Royal Women's Hospital, Southern Health, Western Health, Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Goulburn Valley Health and Latrobe Regional Hospital.

<sup>2</sup> 'Denominational hospitals' as defined under schedule 2 of the *Health Services Act 1988* are Bethlehem Hospital Incorporated, Mercy Public Hospitals Incorporated, a single SOP for St Vincent's Hospital (Melbourne) Limited, St Georges Hospital and Caritas Christi Hospice.

## 6 Reporting

### 6.1 Supply of statistics and information<sup>3</sup>

The hospital or Small Rural Health Service (SRHS) will comply with standard definitions for reporting financial and statistical data as set out in the Instructions for completing the Annual Return and 2008-09 versions of the VAED Manual, AIMS Public Hospital User Manual, VEMD Manual, ESIS Manual, VINAH Manual and any other amending documentation prepared by the department.

The hospital or SRHS will code patient episodes reported to the VAED in accordance with the current Australian Coding Standards, current Victorian Additions to the Australian Coding Standards and any amending documentation issued from time to time by the department.

Amending documentation is usually issued via the Health Data Standards and Systems (HDSS) Bulletin. Hospitals and SRHSs should ensure that appropriate staff subscribe to the HDSS Bulletin in order to remain current with any changes. The HDSS Bulletin is issued electronically via both web and e-mail and is free of charge. Subscriptions may be arranged through the HDSS Help Desk.

The hospital or SRHS will provide data to the department as specified in the HSA and in these Conditions of Funding.

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.

To assist with the calculation of the Prior Year Adjustment, all AIMS forms must be completed by 17 September 2009.

### 6.2 Financial information

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 14 days after the end of the month for which the financial data is provided.

Metropolitan Health Services 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.

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<sup>3</sup> 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 [www.dhs.vic.gov.au/rrhacs](http://www.dhs.vic.gov.au/rrhacs).

## 6.3 Integrated Cancer Services

### Accountability requirements of Integrated Cancer Services (ICS)

ICS will be required to:

- participate in site visits (minimum two per annum)
- submit an annual report
- submit financial statements at the end of the second, third and fourth quarters
- submit to the *ICS initiatives register* by 1 September 2008 and 1 March 2009
- conduct an annual forum
- participate in clinical audit processes
- submit requested information to evaluate cancer reforms activities
- have a current strategic plan that integrates service planning activities for cancer across all health services in the ICS.

### Accountability requirements of ICS host agencies

- As collaborations of health services the ICS are not formal legal entities, host agencies are required to hold funds on behalf of the ICS, and act as the employing authorities for ICS staff as required.
- The ICS executive/governance groups are responsible for decision making regarding the use of funds, in accordance with the priority areas outlined above.
- Host agencies are required to ensure that appropriate processes and procedures are in place to enable access to ICS funds by ICS program staff, in accordance with the directions of the ICS executive/governance groups.
- Charges levied by Host agencies for infrastructure support need to be agreed between the Host agencies and the ICS Executive/Governance Groups, and reflected in the ICS budgets
- Host agencies are required to ensure that appropriate accounting procedures are in place to identify and quarantine ICS funding, and that regular reports are available to ICS Program staff and executive/governance groups. Financial statements should be submitted to the department by ICS at the end of the second, third and fourth quarters.
- Unexpended ICS funds may be subject to recall by the Department of Human Services. Recall will depend on ICS performance reviews.

## 6.4 Specific data requirements

### 6.4.1 Commonwealth/State

- a) Hospitals and Small Rural Health Services (SRHS) 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.

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 and VACS 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.

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.

In addition to the monthly reports specified in Section 6.2 above, Metropolitan Health Services, hospitals and SRHSs are required to complete an Annual Return by 30 September 2009 in accordance with the detailed requirements specified by the department.

Failure of a Metropolitan Health Service, hospital or SRHS 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.

## 6.5 Transmission of minimum employment dataset

Metropolitan Health Services, hospitals and Small Rural Health Services (SRHS) 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 (for example, the July data is required by 10 August).

Metropolitan Health Services, hospitals and SRHSs who have their payroll/budget processing undertaken by The Pay Office Australia will continue to have their data forwarded direct to the department. Agencies, where the 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 SRHSs will be required to satisfactorily complete the Accreditation process detailed in the Minimum Employment Data Set.

## 6.6 Transmission of admitted patient data

The hospital will transmit admitted patient data to the Victorian Admitted Episodes Dataset (VAED) via PRS/2 according to the timelines detailed in clauses (a) and (b) below.

- 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 the processing schedule].
- b) Diagnosis and procedure and sub-acute details in any month must 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 must be completed in time for the VAED file consolidation on 17 August 2009. Any corrections must be transmitted before consolidation of the VAED database on 17 September 2009.
- 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 PRS/2 file consolidation on the 17th of each month. VAED data (sent electronically) must be received by 5pm on the 17th of each month, regardless of the actual day of the week. VAED (sent by disk) must be received by 12pm (noon) on the last working day on or before the 17th of the month.
- e) WIES15, Small Rural Health Service (SRHS) and sub-acute payments will be:
  - fully paid for data originally submitted in accordance with the deadlines specified in clauses (a) and (b)

above, even if data is subsequently amended

- 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 (a) and (b) above, or
- not recognised for payment, if data has not been submitted in accordance with both deadlines specified in clauses (a) and (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 data, the Metropolitan Health Service, hospital or SRHS must write to the Manager, Health Data Standards and Systems, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. A proforma to assist this process is provided on the HDSS website at: [www.health.vic.gov.au/hdss/vaed/index.htm](http://www.health.vic.gov.au/hdss/vaed/index.htm).

Occasional exemptions for late submission of admission and separation (E-record) data may be granted to Metropolitan Health Services, hospitals or SRHSs maintaining a consistently high level of timely data submission.

Exemptions for late submission of admission and separation (E-record) data will also be considered for staffing problems that are beyond the control of Small Rural hospitals and SRHSs.

Exemptions for late submission of diagnosis and procedure (X-record) data will only be considered for circumstances beyond the control of the hospital.

Software problems are, of themselves, insufficient justification for late submission of data. Hospitals are expected to have arrangements in place with their software vendor to ensure that statutory reporting requirements are met.

Metropolitan Health Services, hospitals and SRHSs undertaking the PRS/2 data submission testing process are automatically exempted for the applicable months of data.

Submissions for exemption should be received by the appropriate consolidation deadline outlined in clause (a) or (b) above. Under no circumstances will consideration of exemption from late penalties be given to submissions received after 5pm on 17 September 2009.

## 6.7 Transmission of mental health data to the VAED

Metropolitan Health Services, hospitals and Small Rural Health Services (SRHSs) must transmit data for admitted mental health patients to the VAED via PRS/2 according to the timelines and specifications outlined in this document, the VAED Manual and any amending documentation.

Where hospitals are non-compliant with the timelines and specifications, the department may apply a penalty for each non-compliant record no greater than the amount of the applicable notional bed-day rate published in the *Victoria-Public hospitals and mental health services Policy and funding guidelines*.

## 6.8 Transmission of emergency department data

Hospitals receiving the non-admitted emergency services grant or otherwise designated by the department will transmit data to the Victorian Emergency Minimum Dataset (VEMD) according to the following timelines:

VEMD, 2008-09	Timeline
First 14 days of the month	At least one submission must be received by the 21st of the reporting month (for example, 1-14 July data by 21 July).
Full month	Remainder of the month must be supplied by the 10th of the following month. Must be complete, i.e. zero rejection and notifiable edits, by the 21st of the following month (for example, July data by 21 August).

Any corrections must be transmitted before consolidation of the VEMD database on 21 August 2009.

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 above
- b) \$1,000 for each record from the full month that is not completed by the timeline specified above
- c) \$2,000 for each record from the full month that is not completed within one month of the timeline specified in above or database consolidation, whichever comes first.

If difficulties are anticipated in meeting the monthly timelines, the hospital must write to the Manager, Health Data Standards and Systems indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule.

Exemptions for late data will only be considered for circumstances beyond the control of the hospital.

Software problems are, of themselves, insufficient justification for late submission of data. Hospitals are expected to have arrangements in place with their software vendor that to ensure that statutory reporting requirements are met.

Submissions for exemption should be received by the appropriate consolidation deadline. Under no circumstances will consideration of exemption from late penalties be given to submissions received after 5pm on 21 August 2009.

For any period that the hospital is unable to supply unit record data, the hospital may be asked to submit aggregate data.

## 6.9 Transmission of elective surgery data

Effective from 01 August 2008 until further advised, all hospitals reporting to ESIS will be required to adhere to the following minimum submission timelines. Hospitals may submit more frequently than the minimum standards specified below.

The broad intent of these changes is to increase the frequency of submission from monthly reporting periods to twice-monthly reporting periods. The aim is to have Health Services send a submission for each half-month within three working days of the end of that period and to have edits from that submission resolved no later than the next half-month's submission date.

**Minimum frequency of data submission**

<b>Must include all activity (registrations, removals, readiness, urgency and scheduling events) covering the period:</b>	<b>Due:</b>
First fifteen days of the month (1st to 15th).	Received at the Department of Human Services no later than 5:00pm on the 18th of the month where this is a working day, or by 5:00pm on the next working day if the 18th is not a working day.
The remaining days of the month (16th and subsequent).	Received at the Department of Human Services no later than 5:00pm on the 3rd day of the following month, where this is a working day, or by 5:00pm on the next working day if the 3rd is not a working day.

All edits must be resolved within 21 days of the Extract End Date of the submission in which they were first triggered, or the due date of the next reporting period's minimum frequency submission, whichever occurs first.

The Department of Human Services will endeavour to process submissions within three working days of receipt.

**Examples**

- An error triggered in a submission with an extract end date of Thu 07 August 2008 must be corrected by Thu 28 August 2008. (21 days)
- An error triggered in a submission with an extract end date of Fri 15 August 2008 must be corrected by Wed 03 September 2008. (19 days)
- An error triggered in a submission with an extract end date of Sun 31 August 2008 must be corrected by Thu 18 September 2008. (18 days)
- An error triggered in a submission with an extract end date of Wed 15 April 2009 must be corrected by Mon 04 May 2009. (19 days)

Timelines may be further varied by the Department of Human Services to make reasonable allowances for public holiday periods such as Christmas, Easter and Melbourne Cup.

Any corrections must be transmitted before consolidation of the ESIS database on 21 August 2009.

Where hospitals do not comply with these timelines, the department may apply a penalty of up to:

- a) \$2,000 if a reporting period's activity (1st to 15th being a period and 16th and subsequent being a period) is not submitted by the timeline specified above
- b) \$1,000 for each Rejection and Notifiable edit that is not resolved by the timeline specified above
- c) \$2,000 for each Rejection and Notifiable edit that is not resolved within thirty days of the timeline specified above or database consolidation, whichever comes first.

Please note that it is not expected that penalties would be applied to Health Services during the transition period to the new reporting times.

If difficulties are anticipated in meeting the monthly timelines, the hospital must write to the Manager, Health Data Standards and Systems indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule.

Exemptions for late data will only be considered for circumstances beyond the control of the hospital.

Software problems are, of themselves, insufficient justification for late submission of data. Hospitals are expected to have arrangements in place with their software vendor to ensure that statutory reporting requirements are met.

Submissions for exemption should be received by the appropriate consolidation deadline. Under no circumstances will consideration of exemption from late penalties be given to exemption requests received after 5pm on 21 August 2009.

For any period that the hospital is unable to supply unit record data, the hospital may be required to submit aggregate data. Additional penalties may apply for failure to submit aggregate data when required.

### Specific variations to new ESIS reporting time lines

As noted in the previous section, the Department of Human Services may vary the general rule to make reasonable allowances for public holiday periods such as Christmas, Easter and Melbourne Cup. The following specific dates apply:

#### Minimum frequency of data submission

Month	Reporting Period	Date Due
July 2008	Whole month	08 August 2008
August 2008	1st to 15th	20 August 2008
	16th and subsequent	03 September 2008
September 2008	1st to 15th	18 September 2008
	16th and subsequent	03 October 2008
October 2008	1st to 15th	20 October 2008
	16th and subsequent	06 November 2008
November 2008	1st to 15th	19 November 2008
	16th and subsequent	03 December 2008
December 2008	1st to 15th	18 December 2008

## 6.10 Transmission of AIMS data

Metropolitan Health Services, hospitals or Small Rural Health Services (SRHSs) will transmit data to AIMS according to timelines specified in the AIMS Manual.

Where hospitals are non-compliant with these timelines, the department may apply a penalty of no greater than \$2,000 for each return not submitted by the due date specified in the AIMS Manual.

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 problems beyond the control of the hospital.

Software problems are, of themselves, insufficient justification for late submission of data. Hospitals are expected to have arrangements in place with their software vendor that to ensure that statutory reporting requirements are met.

## 6.11 Transmission of SACS, HARP-CDM, PAC and Community Palliative care data

Metropolitan Health Services, hospitals or Small Rural Health Services (SRHSs) in receipt of funding under the Sub-acute Ambulatory Care Services (SACS), Health Admission Risk Program-Chronic Disease Management (HARP-CDM), Post Acute Care (PAC) or Community Palliative Care programs must transmit data to the Victorian Integrated Non Admitted Health (VINAH) minimum dataset according to the following timelines:

VINAH, 2008–09	Timeline
Full month	<p>All data for a reporting month must be received and all edits resolved by the 17th of the following month.</p> <p>It is strongly advised that initial data transmissions be made with sufficient time to allow for correction of any errors in the data by the 17th.</p>

Any corrections must be transmitted before consolidation of the VINAH database on 17 September 2009.

Metropolitan Health Services, hospitals or SRHSs still transitioning to VINAH reporting must continue to report data via AIMS until advised in writing to cease AIMS reporting.

A penalty system for late or incomplete VINAH reporting will be introduced in 2008–09. Details will be advised.

**Note:** Community Palliative Care may continue to report data to VINAH via the VicPCRS system for 2008–09 as advised, however the above reporting timelines still apply. Community Palliative Care agencies will be advised of transition arrangements from VicPCRS as this information becomes available.

## 6.12 Transmission of specialist outpatient clinic and allied health data

The department is currently conducting a trial of patient-level outpatient data via the VINAH data collection system. The department may transition health services to VINAH-based reporting for some or all of these services.

## 6.13 Patient data

The Metropolitan Health Service, hospital or SRHS will provide sufficient access to data and records to allow audits of patient records, patient coding and data transmitted to the VAED, VEMD, ESIS, VINAH, AIMS and other data collection systems [including Victorian Ambulatory Classification System (VACS) data].

If these audits show a difference in assignment of DRGs and/or other data items that alter the allocation of WIES or other funding, or that patients fail to meet admission or other eligibility criteria, then the number of WIES and/or throughput payments and/or other funding payments to the Metropolitan Health Service, hospital or SRHS, may be adjusted to take account of those differences.

Where these audits indicate that a Metropolitan Health Service, hospital or SRHS has been consistently erroneous in the application of admission criteria and/or coding standards and/or other eligibility criteria, the department may adjust or suspend the relevant throughput or funding payments until such time as the issue is resolved to the satisfaction of the department.

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 SRHS.

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.

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

## Schedule 1

Timelines for the receipt of admission and separations details (E4)

### VAED consolidation date

Month of separation 2008-09	17 Aug	17 Sep	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 2008-09	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 (X4, Y4) and sub-acute details (S4)

### VAED consolidation date

Month of Separation 2008-09	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 2008-09	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Half rate	Nil	Nil	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