Compensable patients

Principles for public health services

Introduction

This document sets out the principles that apply to compensable patients, and to those who fund their public hospital care. Where a funder is legally required to pay for a patient's care, the patient is considered to be a 'compensable patient' and the funder a 'third party payer'.[1]

Compensable patients form an important source of revenue for public hospitals, even though they account for only a small proportion of overall activity. It is important to ensure that decisions about compensable patients – whether made centrally by the Department of Health and Human Services, or by individual health services – are based on a consistent set of principles.

The purpose of this policy is to:

- communicate the department's expectations for health services' dealings with compensable payers and patients
- ensure that the approach to pricing public hospital services for compensable patients is transparent
- assist health services to understand the department's role in negotiating with third party payers, and what they can expect when the department negotiates on their behalf.

Principles

Three sets of core principles underpin dealings with compensable patients and third party payers: access principles, funding principles, and relationship management principles.

Dealings with third party payers should be consistent with these principles where possible. Some of these principles, such as the access principles, will apply to all compensable patients. However, different groups of compensable patients have different needs, and legal or other requirements may limit the matters to which a third party funder can agree. It may therefore be neither possible nor appropriate to apply all principles to all compensable patient groups.

The principles should nevertheless be a starting point for all dealings and negotiations with third party payers. It is expected that all principles will initially be considered, and that a decision will then be made about which to prioritise in the specific circumstances.

[1] Private health insurers are not considered to be 'third party payers' for the purposes of this policy. Although private patients and Medicare ineligible patients who hold private health insurance may elect to use their insurance, the patient themselves is responsible for costs and the insurer's obligation to pay arises only from a private commercial arrangement, rather than from a legal obligation to pay compensation.

Access principles

- Patients who are eligible to have their public hospital treatment funded by a third party payer may elect to be treated either as a public patient or a compensable patient.
- All patients in need of urgent treatment are able to access care in public health services, regardless of their funding status.
- Compensable patients are entitled to access all services provided to public patients.
- A patient's election to be treated as a compensable patient will be based on their understanding of the implications of being treated as a compensable patient, including the requirement to lodge a claim, informed financial consent (including payment of an excess where applicable), services for which prior approval is required, and the provision of patient information to the funder.

Guidelines

Patient election

All patients who meet a funder's eligibility criteria may elect to be treated as a compensable patient.

A patient's election should be in writing, and should be made before, at the time of, or as soon as possible after the public hospital episode. Where a patient does not make a valid election, and they are otherwise eligible for Medicare, they will be treated as a public patient until a valid election is made. Once a valid election has been made, that election will be considered to apply to the whole of the episode of care, unless the third party does not cover all or part of the care required by the patient for any reason.

Health services should seek instructions as to whether the patient wishes to be treated as a public or private patient in the event that the funder does not cover their claim. This election must be in accordance with all patient election requirements. However, health services should note that private health insurance policies generally do not allow for benefits to be paid where there is an entitlement to compensation or damages, and require the patient to pursue their claim with the third party funder. Some policies may allow the insurer to make a provisional payment while the outcome of the claim is pending, on the condition that the patient repays the insurer if or when their claim is successful.

Patients should be made fully aware of the implications of choosing to be treated as a compensable patient. Patients will also need to comply with the funder's processes for lodging a claim. If the funder requires the patient to pay an excess, the patient should be made aware of this so that they can give informed financial consent. Patients should also be aware that, if they elect to be treated as a compensable patient, the health service may be required to provide specific health and personal information to the funder.

Access and care

All patients are to receive the same level of care, regardless of whether they are treated as a compensable patient or a public patient.

A patient must not receive priority access based on whether they are a public or a compensable patient. All decisions are to be based on clinical need, and not on the funding status of the patient.

Requirements of funders

Compensable patients may access all services provided to public patients, providing that the service is covered by the funder. Different funders may cover treatment for specific conditions only, may exclude certain services or procedures, or may require health services to obtain approval before treatment is provided to a patient. Health services are expected to confirm what services the relevant funder will cover, and to obtain prior approval for a patient's treatment if necessary. If the health service has not confirmed these matters and the funder rejects payment, then the patient will be treated as either a public or private patient in accordance with their election form.

Common law compensation and public liability claims

Some patients may be entitled to make a public liability or common law damages claim. Health services may wish to pursue payment from the insurer or relevant third party in cases where liability has been accepted and there is a

clear responsibility for medical costs. However, in deciding whether to pursue payment, health services should consider the administrative costs in doing so.

Funding principles

- simplicity and transparency: the funding model should be as simple as possible, and the fee-setting process should be transparent
- methodological consistency: funding should be consistent across all patient cohorts, and arrangements should reflect the Victorian public hospital funding model where possible and appropriate
- 'user pays' approach: funding should be based on activity where this is possible and appropriate, although other payments may sometimes be appropriate (for example, payments relating to availability or trauma)
- equitable approach: fees should be based on the same price for the same service across public hospital services of the same type
- full cost recovery: the prices that are set should be sufficient to fully recover costs, including capital and depreciation
- efficient and effective service delivery: the model should promote efficient delivery and provide users with incentives to utilise the services efficiently and appropriately

Guidelines

Fees for some compensable patients are set by health services, whereas others are negotiated by the department with third party payers. In both cases, the funding principles are intended to be a starting point for pricing approaches and negotiations.

Flexible application of principles

It will not be possible to apply all principles in every case. In some circumstances, it may be appropriate to prioritise certain principles or to adopt a more tailored approach. For example, the department may agree to fund some services on an activity basis in accordance with the 'user pays' principle, even if the Victorian funding model block funds the same service.

However, all of the principles should be considered, and a conscious decision then made as to which should be prioritised in the circumstances.

Fee setting

Where possible, the department uses cost data to ensure that prices are adequate. However, as prices are a matter for negotiation with third party payers, there may be some compromise before final prices are agreed.

Where the department does not have an arrangement with the third party funder, prices are set by individual health services. In these instances, health services are responsible for ensuring that there is an acceptable level of cost recovery, and for considering the same funding principles.

Full cost recovery

The following factors are to be considered when negotiating prices with third party payers, and when assessing whether an acceptable level of cost recovery is achieved:

- the cost of delivering efficient services
- the costs associated with the additional complexity of a specific patient cohort
- costs associated with capital utilisation
- the additional administrative costs associated with a specific patient cohort
- whether a contribution to specified grants is required.

Complexity

Parties should consider whether data shows that patients in the cohort are more complex than average, and whether existing funding arrangements capture the extent to which the cohort deviates from the average cost.

If data confirms that the cohort is more complex than average, and the cohort is too small to have an impact on standard prices – which are generally based on average costs – then an adjustment for complexity should be made to ensure that health services are fairly compensated for treating that group of patients.

Where the most complex patients of the cohort are concentrated in only a small number of locations (for example, at major trauma services) then the additional costs to these services should also be considered, as the high cost of these patients cannot be spread over a broader revenue base.

Capital

All users of the public hospital system – whether public, private, compensable or other patients – benefit from the State's investment in capital. Prices for public and other State-funded patients do not need to incorporate a capital utilisation fee, as it is considered that the State has already borne capital costs for these patients. However, Commonwealth and private funders have not contributed to the cost of capital, and so these payers should be required to pay a utilisation fee for their patients' use of the public hospital system.

Administrative costs

An allowance for administrative costs should be made if there are additional costs associated with the patient cohort – for example, costs associated with lodging claims or additional reporting requirements.

The location of patients should also be considered, as this may also have an impact on administrative costs. There may be administrative and efficiency gains if patients are concentrated in a small number of locations; on the other hand, this means that any additional cost associated with these patients cannot be spread over a broader revenue base.

Specified grants

It may be appropriate to seek a contribution to specified grants, given that public prices are not intended to cover the full cost of a patient's treatment. Grants should be considered for relevance on a case-by-case basis. It is appropriate for third party funders to pay a contribution towards teaching, training and research and other grants from which they benefit. However, other grants may not be relevant to the patient cohort (for example, a specified grant for the provision of HIV and sexual health services is unlikely to be relevant for a patient injured in a motor vehicle accident), in which case a contribution should not be sought.

Relationship management principles

- The department should negotiate prices on behalf of health services where there is evidence to show that the patient cohort is more complex than average, and the patient cohort is large enough to justify this.
- The department should consider entering into a written agreement with the third party payer in situations where the patient cohort is large enough to justify this and a formal arrangement would deliver mutual benefits, such as information sharing, service planning or advance cash flows.

Guidelines

For some groups of compensable patients, patient numbers are too small for the department to set either a specific fee for each group or a generic 'compensable' fee based on average costs. For these patients, health services are expected to set their own fees at rates that achieve full cost recovery.

Where the department negotiates on behalf of health services, the arrangements and prices should be reviewed every three years, with fees to be indexed at an agreed rate in the years between reviews.

From time to time, third party payers may approach health services directly to seek their involvement in specific projects relating to patients in that cohort. The department expects that, where there is a written agreement between the funder and the department, health services will keep the department informed of any such approaches.