

Section B — Conditions of Funding: Acute Health

Conditions of Funding: Acute Health

The standard conditions of funding, which are not program specific, are detailed in Schedule 1 of the Health Service Agreement 1999–2000. The conditions below apply specifically to the Acute Health Program.

1. Australian Health Care Agreement (AHCA) Framework

The Australian Health Care Agreement (AHCA) is the successor to the Medicare Agreement which expired on 30 June 1998. The 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 1998 to 30 June 2003. 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 on the Internet at <http://www.dhs.vic.gov.au/ahs/index.html>

Acute Health Circular 3/99 (as may be 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 commits the Commonwealth and Victoria to the following Principles:

1. Eligible persons must be given the choice to receive public hospital services free of charge as public patients;
2. Access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period; and
3. Eligible persons should have equitable access to public hospital services, regardless of their geographical location.

The Commonwealth and Victoria agree that principles 2 and 3 are met if Victoria is using its best endeavors to achieve the outcomes sought in those principles to the greatest extent practicable.

Under Principle (2), it is Victorian Government policy that both public and private patients should receive access to public hospital services on the basis of clinical need. The Victorian Government will allow preferential access for eligible veterans to public hospitals, but only so long as care of public patients is not impaired, consistent with Principle 2. Greater detail is given in the Department of Human Services Victoria Hospital Circular 17/1998.

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.

Based on the AHCA, 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* (as may be amended from time to time) To access this advice, please refer the Department Internet website:

<http://www.dhs.vic.gov.au/ahs/feesman/index.htm>

1.2 Admission of Patients.

None of the following factors is 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 is recorded on the approved Patient Election form;
- (b) in making the election referred to above, the eligible person is informed of the consequences of electing to be treated as a public patient and not as a private patient or vice versa;
- (c) an eligible person's health insurance status or financial status or intention in respect of an election will not be a determinant in the priority for receiving hospital services; and
- (d) any ineligible person is appropriately identified as such in the Victorian Admitted Episodes Dataset (VAED) formerly called the Victorian Inpatient Minimum Database (VIMD).

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 9.0 dated July 1999 and shall set in place administrative procedures for the certification of all patients admitted for Type C Professional Attention Procedures (exclusion list) or 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).

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 10% higher than the nominated payment for WIES7.

1.3 Claims for Medicare Benefits.

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

1.4 Pharmaceutical Benefits.

The hospital will ensure that except in an emergency, it does not issue a prescription to an admitted patient on discharge, an outpatient or an accident and emergency patient, that would attract pharmaceutical benefits as defined in the National Health Act 1953 or Veterans' Affairs Legislation. (Note, this is shortly expected to change).

1.5 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. Basis For Determining Government Funding

2.1 Components of Funding.

A hospital's funding will be based on:

- *Target A* volumes, paid at the relevant rate;
- *Target A Margin* volumes at the relevant rate;
- *Option WIES* accepted by the hospital or Network, paid at the relevant rate;
- *Tender WIES* sought by the hospital or Network and allocated by the Department, and paid at the tendered rate;
- Non-Admitted Patient Grants;
- Training and Development grant; and
- Other specified grants.

These grants and admitted patient and outpatient target volumes are shown in *Section A* and shown in the agency's Health Service Agreement.

Funding is provided to hospitals and Networks on the basis that the current range of services provided are continued. Before hospitals or Networks 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 Provider Manager or Acute Health Manager. In the metropolitan area discussions should be held with the Acute Health Program and the Region. In all cases, the Director of Acute Health Division must provide the final approval.

Hospitals will also receive revenue from private patients. Government Grant payments to hospitals will consist of the hospital's entitlements as specified in the HSA and Conditions of Funding, net of relevant patient revenues (see clause 4).

2.2 Calculation of the Payment For Admitted patient Services

2.2.1 The term "weighted inlier equivalent separation" means the measure of activity calculated by multiplying the DRG weight by the number of Inlier Equivalent Separations in the DRG and summing over all DRGs. For 1999–2000 this statistic will be abbreviated as WIES7. The method and calculation of WIES7 is shown in *Section C*.

Notional Fixed Grant

2.2.2 The following rates have been applied to Target A (fixed) when calculating the notional fixed grant for 1999–2000:

Major Providers (Network and Barwon Health):	\$833
Rural Group B (greater than 10,000 WIES)	\$847
Rural Group B (less than 10,000 WIES) & Group C	\$868
Rural Group D	\$891
Rural Group E	\$891

Under the formula separate weights have been provided for certain DRGs (e.g. renal dialysis and high theatre/prosthetics DRGs) for the purpose of calculating fixed and variable WIES7. Under WIES7 the notional fixed Target A is lower or equal to the variable Target A.

Variable Grant

2.2.3 The Variable admitted patient payments are calculated as follows:

- (a) For hospital throughput up to the level prescribed by Target A, the variable case payment is \$1,371 per WIES7 for a public patient and \$970 per WIES7 for a private patient (refer *Section A*).
- (b) Hospitals have been given a 2 percent margin Target A which will be paid for at a rate of \$960 for a public patient, \$679 for a private patient.
- (c) Throughput above the agreed levels will not be paid for.
- (d) Same day "medical" targets are specified in each agency's Health Service Agreement 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 per cent (excluding “exempt” hospitals).

2.2.4 Option & Tender Pool.

Conditions for these payments are outlined in *Section A*.

2.2.5 Quarterly targets will be determined 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%) from the nominated quarterly targets.

2.2.6 Nursing Home Type Patient Payment.

The hospital will receive \$126 for each nursing home type bed day as reported in the VAED.

2.2.7 Rural/Isolated Payment.

This payment provides a contribution for isolated and rural hospitals for additional costs incurred in transferring patients in non-metropolitan areas. This payment is supplementary to the higher fixed WIES payment received by non-metropolitan hospitals and does not purport to represent a payment for total ambulance transfer costs. The payment is as follows:

For isolated hospitals the additional ambulance transfer payment is \$35 for each weighted inlier equivalent separation up to the agreed contract volume.

For other rural hospitals the additional payment is \$14 for each weighted inlier equivalent separation up to the agreed contract volume.

2.3 Department of Veteran Affairs (DVA) Patients.

New funding arrangements for eligible DVA patients came into place from 1 July 1998. In accordance with these arrangements, separate capped public targets and uncapped veterans estimates were incorporated into hospital budgets during 1998–99 for WIES, rehabilitation and nursing home type beddays. Hospitals received payment at a premium to casemix for these services to eligible veterans. Payment required an exact match of hospital veteran data with DVA records. In addition, a premium was paid for VACS encounters and allied health occasions of service based on a three month survey.

For each hospital, the Department will specify an estimate of DVA patient throughput for the following services:

- WIES

- Rehabilitation
- VACS encounters
- Allied health occasions of service
- Outpatient radiotherapy services
- Dialysis
- Nursing Home Type

Notwithstanding the provisions of Clause 2.2 the Department will pay a premium to the casemix rate applicable for all eligible DVA patients matched with DVA records (as reported in the VAED 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.

The Department will work with hospitals to collect electronically, veteran data for VACS, allied health and outpatient radiotherapy which will allow DVA to confirm eligibility.

- 2.3.1 If the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days, hospitals shall ensure that the veteran's status is reviewed and that either:
- a) a certificate under Section 3B of the *Health Insurance Act 1973* is given by a medical practitioner and forwarded to the DVA's Contract Manager forthwith, or
 - b) the Beneficiary is reclassified to a Nursing Home Type patient.

Where an admitted veteran's length of stay is greater than 35 days and no acute care certificate in accordance with (a) above has been forwarded to DVA, hospitals will only be reimbursed at the Nursing Home Type patient payment rate.

2.4 Non-Admitted Patients Grant.

- 2.4.1 The Victorian Ambulatory Classification System (VACS) operates in selected hospitals. For details of the VACS system and funding allocations including emergency department allocations for 1999–2000 refer to *Section A*.
- 2.4.2 For non-VACS funded hospitals, the non-admitted patients grant is for the provision of services specified in the Health Service Agreement.
- 2.4.3 If there is a significant reduction in services to non-admitted patients in non-VACS funded hospitals 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 ten percent.)

- 2.4.4 Hospitals are responsible for providing such ambulance transport as is necessary, on clinical grounds, to ensure access for outpatients without charge to these patients.
- 2.4.5 Where hospitals failed to reach target levels set for 1998–99, adjustments have been made for the 1999–2000 targets.
- 2.4.6 The Victorian Ambulatory Classification System patient payments are calculated as follows:

VACs rate per weighted encounter	\$109
Allied health per occasion of service	\$40

2.5 Training and Development Grants.

- 2.5.1 The Training and Development Grant is allocated to fund the specific programs and positions specified in the Health Service Agreement. **The grant will be paid to the employer of the funded position.** Where training positions include a period of rotating placements, participating agencies are required to ensure that the host agency receive a proportion of the grant equal to the length of the rotation.
- 2.5.2 Where positions remain unfilled by staff with credentials approved by the Department or programs offered by the hospital are not operated at budget levels, the Training and Development Grant will be adjusted to reflect actual performance.
- 2.5.3 Funding for all nursing programs is based on the academic year and is dependant on adequate financial acquittals being provided to the Department of Human Services regarding expenditure of the Grant.
- 2.5.4 Graduate Nurse Programs must meet the following criteria:
 - (a) hospitals must participate in the Nursing Computer Match Service in order to attract funding for Graduate Nurse positions;
 - (b) no fees are to be charged to nurses applying for, undertaking, or exiting from Graduate Nurse positions; and
 - (c) the positions offered must be full time. Under exceptional circumstances exceptions may be made following consultation with the Department of Human Services.

In addition, the programs should conform to the *Graduate Nurse Program Guidelines* Department of Human Services (September 1997).

- 2.5.5 For the Graduate Nurse, Student Midwife and Postgraduate Programs, approval must be sought from the Department of Human Services for any increase in numbers over and above projected numbers submitted at the start of the academic year.

2.5.6 Student Midwives

- (a) Funding is at the level of \$3000 per student midwife undertaking clinical experience for a minimum total of 50 days during the academic year.
- (b) Adjustment may be made to the amount of funding to those hospitals which accommodate a large number of students undertaking clinical placement for periods of less than 50 days. Pro rata funding for these students may be provided after discussion with the Department.

2.5.7 Rural Supplement

- (a) A supplement of \$250 per nurse will be allocated to rural hospitals that offer specialist nursing courses in collaboration with a university to support costs incurred by nurses who must undertake a clinical placement a significant distance from the hospital where they are employed.
- (b) The 'significant distance' criteria are to be agreed upon by the Regional and Central Office.

2.5.8 The research and development component of the Training and Development Grant is designed to fund research infrastructure for the hospital (including support for institutional ethics committees) together with support for academic units based at the hospital, including units funded by universities and independent research institutes. Hospitals in receipt of this grant will need to demonstrate that at least the amounts allocated have been expended for these purposes.

2.5.9 The Training and Development Grant also includes a component (10%) designed to fund the cost associated with clinical placements of undergraduate students including medical, nursing and allied health students. The allied health undergraduate component is allocated on the basis of clinical placement days.

2.6 Payments for Specified Purposes.

- 2.6.1 Additional payments will be provided to the hospital for the purposes specified in the Health Service Agreement.
- 2.6.2 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 ten percent.)

2.7 Victorian Maintenance Dialysis Program.

- 2.7.1 Hospitals participating in the Victorian Maintenance Dialysis Program will receive funding in two components: a program grant; and (for admitted patients) a case payment.
- 2.7.2 The program grant will be received by parent hospitals. Parent hospitals are required to negotiate with satellite centres arrangements for the provision of satellite dialysis services to be funded by the program grant.
- 2.7.3 A grant will be provided for each patient receiving dialysis supervised by the hospital. The rates are:
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|---|-------------|
| In-Centre : | \$24,660 pa |
| Satellite Haemodialysis | \$19,624 pa |
| Home Haemodialysis: | \$27,961 pa |
| Intermittent Peritoneal Dialysis | \$25,318 pa |
| Continuous Ambulatory Peritoneal Dialysis | \$35,183 pa |
- This grant is provided for patients receiving care supervised by a public hospital and will not be paid for patients dialysed in private hospitals.
- 2.7.4 The grant will be based on monthly statistical returns from the hospital (AIMS Form 111/S6).
- 2.7.5 Funds will be advanced on the basis of current patient numbers as recorded in the Health Service Agreement and payments adjusted for actual service provision on a quarterly basis.
- 2.7.6 Total numbers of patients being dialysed in Victoria will be monitored, and if the increase in numbers exceeds the number provided for in *Section A*, the payments may be capped by the Department.
- 2.7.7 For dialysis services provided within the hospital, variable payments will also result from the VAED coding of the admitted patients as set out in Section C.

2.8 Rehabilitation

- 2.8.1 Only those agencies specifically **designated** by the Department as providers of rehabilitation services are eligible for payment of rehabilitation grants.
- 2.8.2 The new system VicRehab will apply for all designated units with 20 beds or more. In 1999–2000, this includes:
- Austin and Repatriation Medical Centre
 - Ballarat Health Services-Queen Elizabeth Centre
 - Barwon Health-Grace McKellar
 - Bendigo Health Care Group-Anne Caudle Campus

- Bundoora Extended Care Centre
- Caulfield General Medical Centre
- Goulburn Valley Health
- Hampton Rehabilitation Hospital
- Kingston Centre
- Latrobe Regional Hospital
- Mount Eliza Aged Care & R.S
- North West Hospital
- Peter James Centre
- Royal Talbot Rehabilitation Centre
- St George's Health Service
- St Vincent's Hospital
- Sunshine Hospital.

- 2.8.3 Funding for these units will be based on weighted units for Level 2 patients using the CRAFT classification. It will also include specified grants for Level 1 and Level 2 categories: amputees, spinal, head injury and burns cases. DVA patients (refer Chapter 2) will continue to be paid at a bedday rate.
- 2.8.4 A budget/activity cap will be allocated to VicRehab agencies. Rehabilitation weighted units and bed days will be calculated from data reported in the VAED. No payment will be made for services in excess of the target.
- 2.8.5 For two years payment is guaranteed to the current Network and rural regional levels. Compensation grants will be paid for two years.
- 2.8.6 Level 1 rehabilitation is for use by designated specialty programs providing rehabilitation following spinal cord injury, head injury or amputation and where the rehabilitation episode directly follows the acute care episode in which the injury was the principal diagnosis. Subsequent episodes of care following the initial rehabilitation episode are not classified as Level 1.

The Level 1 bedday rate is \$350 per bedday.

- 2.8.7 Funding for designated units of less than 20 beds will continue to be block funded based on the following bedday rates:

Level 1: \$350 per bed day

Level 2: \$291 per bed day

Agencies designated at Level 3 (interim designation) will be paid at Level 2 rates.

- 2.8.7.1 A target bedday cap will apply to these agencies. Where the actual number of bed days provided is less than the allocation payments will be adjusted to reflect the actual service provision. No payment will be made for services in excess of the target.

2.9 Radiation Oncology.

A standard payment per weighted activity unit, introduced in 1998–99 will be continued in 1999–2000. Payments will be based on monthly statistical returns from the hospital (AIMS 111/S8). Funding will be provided at the rate of \$103.10 per weighted activity unit.

Growth of up to 2.5% on public patients will be funded at the full variable rate.

2.10 Hospital Accreditation

Guidelines for funding through the Accreditation Outcomes Program are outlined in *Section A —Appendix 3*.

2.11 Specific Purpose Grants for Admitted patient Services to Persons from Non-English Speaking Backgrounds (NESB Grants)

2.11.1 Networks and hospitals will be notified of NESB grants for 1999–2000. They will be calculated on the same basis as in 1998–99.

2.11.2 The broad intent of the NESB grant is to encourage hospitals to improve service delivery to admitted patients of non-English speaking background. Hospitals receiving grants are required to be able to spend the amounts allocated on strategies which are consistent with those outlined in the publication *Working with Patients from non-English speaking backgrounds: Guidelines for Health Agencies*.

2.12 Hospital Access Program.

Hospital Access Program performance bonuses will be determined in accordance with the provisions of *Section A — Appendix 4*.

2.13 Hospital in the Home.

Hospital in the Home incentive payments will be determined in accordance with the 1999–2000 HITH Policy. Hospitals are required to operate within Guidelines as outlined in *Section A —Appendix 7*.

2.14 Hospital Complaints Indicator Program

In 1999–2000, the Quality Branch proposes piloting two indicators relating to complaints management: a state wide indicator to monitor the number of hospitals regularly reporting data to the Office of the Health Services Commissioner (OHSC); and an indicator to monitor the effectiveness of hospital complaints management processes.

- Hospitals will be required to report complaints information to the Department on a quarterly basis. A format for the provision of this information, via the AIMS, is being developed in consultation with hospitals and other relevant stakeholders. The first report will be due in October 1999 (for complaints information from the July-September 1999 quarter);

- Reports for AIMS are required within 10 working days from the beginning of the month in which they are due; and
- The Quality Branch, Acute Health will be responsible for monitoring the complaints indicator reporting by hospitals.

2.15 Neonatal Services

As a result of the Review of Neonatal Services, hospitals with Neonatal Intensive Care Units and Special Care Nurseries will be expected to undertake some specific activities. These are:

- a) to provide a report on implementation of the recommendations of the Neonatal Services review by 30 June 2000.
- b) to nominate to the Department a Level 3 hospital for the purposes of establishing professional linkages by 30 October 1999 (for non-networked hospitals with Level 2 nurseries).

Targeted hospitals are receiving growth funding in 1999–2000. In order to retain these growth funds, these hospitals are required to show evidence of the following:

For Special Care Nurseries:

- a) A reduction in the number of refusals of transfer from Level 3 facilities.
- b) A higher average number of beds open than in 1998-99.

Neonatal Intensive Care Units:

- a) A reduction in the number of transfers to other Level 3 facilities.
- b) A higher average number of beds open than in 1998-99.

2.16 Redirection of Funds.

Where total earnings for the Acute Health program exceed the expenses incurred in delivery of the full quantity of services specified in the Health Services Agreement, the surplus may be used by the hospital for any purpose connected with its agreed function.

2.17 Privacy

2.16.1 The Hospital, its employees, agents or subcontractors must comply with the Department's Information Privacy Principles and any relevant legislative provisions that bind the Department in relation to privacy as amended from time to time including in relation to the collection, retention, management, use, quality, disclosure or transfer of information regardless of whether the Hospital, its employees, agents or subcontractors are bound by those legislative provisions.

2.16.2 The Hospital must ensure that its employees, agents and subcontractors comply with this requirement.

2.16.3 In this clause:

- (a) "subcontractor" includes any person employed or engaged by a subcontractor; and

- (b) "information" means:
- (i) in relation to an employee - information acquired whilst acting in the course of employment;
 - (ii) in relation to an agent - information acquired whilst acting on behalf of the Hospital; or
 - (iii) in relation to a subcontractor-information acquired whilst providing services to, or on behalf of, the Hospital.

3. Fire Risk Management

3.1 Health and Safety

The Agency 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 Agency operates irrespective of whether the relevant regulatory requirements place the obligation upon the owner or occupier of those premises.

The Agency is also responsible for ensuring that it complies with the DHS Capital Development Guidelines: Series 7 (Fire Risk Management) insofar as they are relevant to the Agency.

3.2 Operational Readiness

The Agency 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 Agency must also ensure that essential services are maintained.

3.3 Client Placement

At the time of patient placement in any premises, the Agency must ensure the premises complies with all laws relating to fire protection, health, and general safety which apply to any premises from which the Agency operates. The Agency 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 Agency shall complete and return Certificate No. 6 of Fire Safety Compliance 1999–2000 to the Department of Human Services by the due date set out in the "Agency Fire Safety Return Table for 1999–2000", which will be available on the DHS web site.

4. Revenue

Since the signing of the Australian Health Care Agreement the Commonwealth will compensate the States for reductions in the levels of private health insurance, but not for reductions in private patient revenue beyond that. Due to a 30% rebate on private health insurance commencing on 1 January 1999, the level of privately insured persons has not declined and no adjustment is expected to be made to hospital revenue budgets over 1999–2000. Therefore hospitals are expected to take actions to retain their levels of private patient revenue over 1999–2000. Any short falls will need to be made up by the hospital.

- 4.1 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.dhs.vic.gov.au/ahs/feesman/index.htm>

- 4.2 Admitted patient fees revenue includes fees raised for prostheses.
- 4.3 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.
- 4.4 The States Fees Manual *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals* (as may be amended from time to time) stipulates that public hospitals are permitted to raise fees for the following non admitted patient services; but are not permitted to raise fees for the following services provided to admitted patients on discharge:
- (a) dental services;
 - (b) spectacles and hearing aids;
 - (c) pharmaceutical at a level consistent with Pharmaceutical Benefits Scheme statutory copayments;
 - (d) surgical supplies;
 - (e) prostheses (this does not include artificial limbs or surgical implanted prostheses), aids and appliances and home modifications; and
 - (f) compensable and ineligible patients.

5. Cash Flow to Hospitals

- 5.1 Subject to meeting the requirements of the Hospital Conditions of Funding, notional fixed grant payments will be made available to the hospital in twenty four (24) payments based on negotiated cash flow requirements.
- 5.2 Cash flow to the hospital for variable payments will be based on the targets specified in the Health Service Agreement.

- 5.3 Cash advanced for variable payments will be adjusted quarterly to match hospital earnings.

6. Reporting

6.1 Definitions.

- 6.1.1 The hospital will comply with standard definitions for reporting financial and statistical data as set out in the Notes and Definitions for Use in Completing the 1999–2000 Annual Return, the PRS/2 Manual Version 9.0, the Agency Information Management System Public Hospital User Manual Version 7.0, and any other amending documentation prepared by the Department.
- 6.1.2 The hospital will code patient episodes in accordance with the current Australian Coding Standards effective 1 July 1998, Victorian Additions to the Australian Coding Standards and ICD Coding Newsletters issued by the Department.
- 6.1.3 During 1999–2000, hospitals will be advised of details of the operation of the Victorian Hospital Patient Register which will be developed for the linking of multiple admissions.

6.2 Supply of Statistics and Information.

- 6.2.1 The hospital will provide data to the Department as specified in the Health Service Agreement.

The following categories of reporting are specified:

- (a) Agency Level/Aggregated Hospital. The hospital will report on each of the Agency Level forms by the due dates.
- (b) Program Specific. The hospital will report on the forms relevant to the hospital's program sources of funding, in accordance with the Agency Information Management System Public Hospital User Manual 1999–2000.

The data specified in this section will be supplied in hard copy paper returns or computer readable form in accordance with Departmental specifications.

F1 financial returns are required 14 days after the end of the month for which the financial data is provided (e.g. November F1 is required by 14 December).

- 6.2.2 (a) Hospitals 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 time lines for individual programs are detailed in the guidelines applicable to the appropriate Commonwealth or State Programs.

6.2.3 Networks and major hospitals are required to operate and maintain, to a minimum standard, patient costing systems to allow recalibration of the DRG funding formulae. Such hospitals are required to provide, to a designated independent party, 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 the average cost of operating an appropriate clinical costing system according to the operating size of the agency.

6.2.4 In addition to the monthly reports specified in section 6.2.1, hospitals and aggregated hospitals are required to complete an Annual Return by 30 September 2000 in accordance with the detailed requirements specified by the Department.

6.2.5 Failure of a hospital to supply accurate and timely statistical and financial data in accordance with the Hospital Conditions of Funding may result in fines or suspension of payments by the Department.

6.3 Transmission of Minimum Employment Data Set.

Hospitals are required to transmit information detailed in the Minimum Employment data set. Hospitals who have their payroll/budget processing undertaken by Allegiance systems will continue to have their data forwarded direct to the Department. Agencies opting to cease payroll/budget processing at Allegiance Systems should provide to Allegiance Systems extracts from their new payroll system and satisfactorily complete an accreditation process outlined in the Minimum Employment Data Set.

The Employment Minimum Data Set and Collection procedures are under review. A Departmental and hospital steering committee has been created to refine future information requirements. Agencies will be advised of the revised arrangements as soon as possible.

6.4 Transmission of Admitted Patient Data.

6.4.1 The hospital will transmit data to the Victorian Admitted Episodes Dataset (VAED) formerly called the Victorian Inpatient Minimum Database (VIMD) via PRS/2 according to the timelines detailed in clauses 6.4.1.(a) and 6.4.1(b).

- (a) Admission and separation details for any month are to be transmitted in time for the VAED file consolidation on the **21st day** of the following month (see Section (d) 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 **21st day** of the second month following (see Section (d) for processing schedule).
- (c) Data for the financial year should be completed in time for the VAED file consolidation on **21 August**. Any corrections must be transmitted before finalisation of the VAED database on **21 September**.
- (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 **21st** of each month. Because of the various methods of transmission used by hospitals, and Allegiance Systems processing schedules, data must be transmitted by the PRS/2 feeder systems to the VAED by, at the latest, the **17th day** of each month; however, weekends or public holidays may bring the deadline forward to the **14th day**.
- (e) Amendments and/or additions to previously reported details may result in an increase in the WIES7 for a particular month. Such a WIES7 increase will be:
 - 1. fully paid if the increase results from changes to data previously submitted in accordance with the deadlines specified in clauses 6.4.1.(a) and 6.4.1(b); or
 - 2. paid at a reduced rate (50%), or not recognised for payment, according to Schedules 2.1 and 2.2 located at the end of this section if the data has not been submitted in accordance with *either* deadline specified in clauses 6.4.1(a) and 6.4.1(b); or
 - 3. not recognised for payment, if data has not been submitted in accordance with *both* deadlines specified in clauses 6.4.1(a) and 6.4.1(b).

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 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. (Hospitals 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 the small rural hospitals. Exemptions for late submission of admission and separation data will be automatically granted to hospitals maintaining a consistently high level of timely data submission.

- (g) Data should be reconciled after each transmission against the hospital's in-house computer or manual systems and against the Monthly Return-Admitted Patients and any required corrections transmitted with data for the subsequent period.

6.5 Coding Audits.

- 6.5.1 The hospital will provide sufficient access to data and records to allow an audit of patient records, patient coding and data transmitted to the Victorian Admitted Episodes Dataset (VAED).
- 6.5.2 If the audit shows a significant difference in assignment of DRGs or that patients fail to meet admission criteria, then the number of weighted inlier equivalent separations and variable throughput payments to the hospital may be adjusted to take account of those differences.
- 6.5.3 Where the audit indicates that a hospital has been consistently erroneous in the application of admission criteria and/or coding standards, the Department may adjust or suspend the relevant variable throughput payments until such time as the issue is resolved to the satisfaction of the Department.
- 6.5.4 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 hospital.
- 6.5.5 Access to data and records for interstate patients transmitted to the Victorian Admitted Episodes Dataset (VAED) will also be required should State or Territory Health Authorities request an independent audit to verify information on DRG weighted separations.
- 6.5.6 The hospital will also provide sufficient access to data and records to allow an audit of patient records and data transmitted via the Agency Information Management System as part of the Victorian Ambulatory Classification System.
- 6.5.7 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.

6.6 Access to Hospital Data.

The Department will have direct access to all data transmitted to the VAED, VEMD, ESIS and PRISM and to non-confidential aggregate data drawn from systems at Allegiance Systems including the transmission of cost data.

Timelines for the Receipt of Separations Details

VAED Consolidation Date

Month of Separation 1999	21 September	21 October	21 November	21 December	21 January	21 February	21 March	21 April
July	Full Rate	Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
August	Full Rate	Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
September		Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
October			Full Rate	Half Rate	Nil	Nil	Nil	Nil
November				Full Rate	Half Rate	Nil	Nil	Nil
December					Full Rate	Half Rate	Nil	Nil
January						Full Rate	Half Rate	Nil

VAED Consolidation Date

Month of Separation 2000	21 March	21 April	21 May	21 June	21 July	21 August	21 September
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

Timelines for the Receipt of Diagnoses and Procedure and Sub-Acute Details

VAED Consolidation Date

Month of Separation 1999	21 September	21 October	21 November	21 December	21 January	21 February	21 March	21 April
July	Full Rate	Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
August		Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil	Nil
November					Full Rate	Half Rate	Nil	Nil
December						Full Rate	Half Rate	Nil

VAED Consolidation Date

Month of Separation 2000	21 March	21 April	21 May	21 June	21 July	21 August	21 September
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