

Circular



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Contact: Regional Office
Distribution: Public Hospitals

Purpose

1. The purpose of this circular is to advise hospitals of the overall approach to be used by the Department for 1993/94 hospital funding arrangements. It thus provides detailed advice on implementation of the Conditions of Funding.

Total Acute Health Budget

2. The total Acute Care budget base for public hospitals in 1993/94 was \$2160.8M (gross operating costs). The effect of the Government's Financial Management Strategy released on 6 April 1993 and subsequent Ministerial decisions regarding the distribution of the savings requirements means that this is to be reduced by \$120M in 1993/94, and a further \$105m in 1994/95. Variations in the relative performance of the States in the terms of the Medicare Agreement, and subsequent State Government decisions may, however, vary these figures.

Hospital Savings Strategies and Use of VDP

3. In general, the Government's savings strategy is that all service restructuring and other management actions necessary to achieve the required savings should be completed by the end of June 1994, with the 1994/95 savings being achieved as the full year effect of actions already taken in 1993/94.
4. Consistent with this approach, the Government will make available substantial funding for voluntary departure packages (VDPs) in 1993/94, but does not currently propose to offer VDPs in 1994/95. Hospitals should therefore plan to reduce expenditures to a level which can be sustained by likely revenues under the casemix arrangements. In this regard hospitals should assume that there will be no compensation grants in 1994/95.
5. The Government is committed to longer term budget planning including two or three year Health Service Agreements. However, given the magnitude of the changes being introduced with casemix funding, it is not appropriate to introduce two year Health Service Agreements for 1993/94.

Approach to Hospital Funding in 1993/94

6. The overall policy on hospital funding was announced on 16 June 1993. The key funding parameters were outlined in *Casemix Funding; Victoria's Policy* released on that date and include:
 - hospitals will receive a fixed grant and variable payments.
 - the fixed grant will be specified in each hospital's health service agreement which is to be finalised by 20 August 1993.

the variable payment is \$800 per weighted inlier equivalent separation up to a base amount. Adjustments will, however be made for outlier days in excess of the norm for the group in accordance with clause 2.8.2d of the conditions of funding.

additional funding will be available for additional throughput above the base amount at the rate of \$600 to \$800 per weighted inlier equivalent separation for the 1993 September and December quarters. The rate for the March and June quarters will depend on available funds in the "throughput pool".

an additional \$300 per weighted inlier equivalent separation is paid for all public patients.

all rural and isolated hospitals will receive payments of \$14 and \$35 respectively per weighted inlier equivalent separation.

hospitals will receive an additional \$110 per nursing home type day.

7. Variable payments will be made to hospitals for actual weighted inlier equivalent separations as specified in the Health Service Agreement and the Conditions of Funding.
8. The 1993-94 Conditions of Funding require each hospital to pay directly for a number of services previously paid by the Department on the hospital's behalf. These services are Health Computing Services charges (\$3.8M statewide total); audit fees (\$1.6M statewide total) and industrial relations services (\$0.7M statewide total in a full year, current Departmental service to be discontinued from 1 January 1994, so only half year effect in 1993/94). Ambulance Services will also commence billing hospitals for clinic transport as from 1 September 1993, based on usage cost. The current statewide cost is \$2.6M in a full year. All of these costs are thus now regarded as being incorporated in the casemix funding formula.
9. An allocation of \$37M has been set aside in an additional throughput pool in 1993/94, allocated equally over the four quarters. This will allow for full marginal payment (\$800 per weighted inlier equivalent separation) for a 7 per cent increase in throughput over 1992/93 activity levels. A further \$10M has been set aside to cover the medical costs for an increase in the number of public weighted inlier equivalent separations.
10. The additional throughput pool funding (and the additional public patient funding) is derived from additional Commonwealth funding from the Medicare Agreement (\$20M), \$8M reallocated from previous special grants (described in Point 8 above) and from a further general budget reduction (\$19M).
11. The introduction of Workcover has resulted in reductions in the industry premium rates from those applicable under Workcare from 3.26% to 1.84% of salaries for acute hospitals, and from 5.78% to 3.26% of salaries for Nursing Homes. Although some of this reduction is due to improved performance in dealing with workers' compensation issues, much is due to changes in Government policy.
12. All budgets have been adjusted to reflect the reduction in staffing costs from the implementation of new State Government legislation. At this stage savings from this change are to be regarded as a bringing forward of the proposed 1994/95 budget reduction. The total savings for the Workcover changes is estimated at \$25M p.a for the acute hospitals.

13. The \$120M budget reduction, represents an average 5.5% reduction on gross operating costs. This gross reduction is partially offset by the increased Commonwealth funding which flows into the additional throughput pool. Workcover reduction represents a further 1.15% reduction on total costs.

Basis for prospective payments

14. Prospective payments to hospitals have been formulated on the following basis:
- benchmark overhead of \$850 per weighted inlier equivalent separation in 1992 (\$900 for Group E hospitals) except where the 1992 hospital activity level is a demonstrably inappropriate base for fixed costs in 1993/94; 1992/93 estimates or other appropriate periods were then used as a base for overhead costs. The 1992 fixed grant differs from that previously published because of the use of corrected information, particularly for DRGs 565 & 931. The benchmark overhead grant has also been adjusted for Workcover changes (see below).
 - Where hospitals have a markedly higher proportion of outlier days than other hospitals in their group, outlier days above the median proportion for the group have been counted as 0.5 of an outlier day.
 - training and development grants as outlined in the policy paper with some minor increases to adjust for changed circumstances from 1991/92 and for new information provided by hospitals.
 - outpatient allocations have generally been reduced by 6.25%. Where hospitals have allocations to outpatients greater than 20% of gross operating costs, outpatient budgets have been cut by 50% of the amount in excess of 20% of GOC, and 6.25% on the remainder.
 - formula based specified payments have been allocated according to the conditions of funding.
 - non-formula based specified payments, certain Aged Care and Psychiatric Services program payments and community health expenditure have been reduced by an average of 6.25% across the State.
 - the compensation grants across the state have been reduced by 62.5% to yield the balance of the gross expenditure reductions required.
 - Workcover savings are the result of reduced staffing costs and have therefore been deducted from all components of a hospital's services. For Acute inpatients, the total saving has been deducted from the fixed overheads grant.
15. Where application of the formula produces a negative compensation grant, the following approach has been taken.
- Where the agency concerned also provides nursing home services, and these services are budgeted to cost more than CAM/SAM rates after the application of the savings required by the Aged Care Division, the fixed overhead grant has been reduced by the difference between the Aged Care Division budget level, and the CAM/SAM level of funding. This counteracts any possible misallocation of costs from Acute Care to Aged Care during the establishment of the base position.

The remaining negative compensation grant is then offset against the savings requirements in Acute Care Outpatients and/or Specified Grants.

Where a portion of negative compensation grant remains, the Acute Care fixed grant has been reduced by one half of this amount (ie. the hospital will ultimately receive one half of the amount of the negative compensation grant, provided throughput is maintained at 92/93 levels, through the normal operation of the variable payment arrangements).

16. The casemix funding approach results in hospitals being paid on the basis of throughput generated over 365 days of the year. The Department will therefore not provide payments to match variations in the hospitals input costs structures, such as the incidence of paydays. Hospitals will need to make provision for the 27th pay and other extraordinary costs from their normal earnings under the casemix formula.
17. Whilst the fixed grants, maximum base level payments, and additional throughput rates to be paid by the Department will be specified in each hospital's Health Service Agreement, individual hospital expenditure budgets are for hospitals to determine themselves. The final outcome of the overall level of Government funding to a particular hospital will only be known at year end - when the outcome in terms of the number of weighted inlier equivalent separations for the hospital, and for all other hospitals, is known.

Cashflow

18. The new system of funding distinguishes between hospital earnings and cash flow to hospitals. Hospitals' cash flow requirements for the fixed component of the grant should be negotiated as part of the Health Service Agreement. Cashflow for variable components (including, where applicable, projections of calls on the additional throughput pool) will be based on estimates of performance, and adjusted for actual performance once codings are finalised. Cashflow will be adjusted to take into account projections of inpatient and outpatient revenue.

Operation of the additional throughput pool

19. As provided in the Conditions of Funding, hospital activity over the base amount is funded from the Additional Throughput Pool. Final allocations from the pool will be made quarterly, approximately eight weeks after the end of the quarter.
20. There are essentially five stages in allocating funds for activity up to the base amount and activity funded from the additional throughput pool:
 - Hospital actual activity (measured in terms of weighted inlier equivalent separations) for the quarter is identified.
 - Activity up to the base amount is paid for at \$800 per weighted inlier equivalent separation.
 - Activity up to the base amount is deducted from total activity, the remainder being transferred to the pool.
 - The amount of money in the pool is divided by the total weighted inlier equivalent separations transferred to the pool, yielding the pool payment per weighted inlier equivalent separation.

Each hospital will be paid this amount for each weighted inlier equivalent separation in excess of the base amount for the quarter.

21. In allocating the additional throughput pool, separations which have not been coded according to the timelines included in the Conditions of Funding will be allocated a DRG weight of zero. However, where these cases are subsequently coded, they will be funded in subsequent periods at half the rate prevailing for the quarter in which the separation occurred. This provides a continuing incentive for hospitals to complete their coding.
22. The base amount for access to the additional throughput pool is specified in the Health Services Agreement. This amount is to be no larger than the hospital's expectations (as recorded in the Health Services Agreement) or the 1992/93 activity levels, except where specifically approved by Acute Health Services Division.

Service reviews

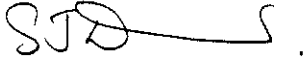
23. Many of the services being funded under "payments for specified purposes" have not been the subject of detailed Departmental review.
24. Each of these services will be reviewed in 1993/94 to ensure a more appropriate base for 1994/95. The reviews will be a mixture of programatic reviews (e.g. all reference laboratory services funded by the Department to ensure they are functioning at efficient levels) and case-by-case reviews of efficiency and effectiveness.
25. Palliative care programs funded under the Medicare Incentive Package have been transferred to the Aged Care Program. Most other services funded under the Medicare Incentives Program were designed to reduce length of hospital stay (or encourage day surgery) and so are essentially payments for inpatient activity. These services are assured funding under the application of the formula and hence this funding has been added to the compensation grant. A small number of projects, for which the objectives are unclear, have been funded as a specified grant for the September quarter 1993, during which time they will be reviewed.
26. Similarly, domiciliary midwifery services are also often substitutes for inpatient care. These services will also be reviewed during the September quarter 1993 and have been funded as a specified grant for the September and December quarters, 1993. The balance of the money for these programs has been set aside pending the outcome of that review.

Outpatients

27. Following decisions of the March 1993 Health Ministers' Conference, the Department is working on the assumption that responsibility for hospital outpatient services provided by medical practitioners will be transferred to the Commonwealth from 1 July 1994. Hospital budgets will be reduced by the amount of funds transferred to the Commonwealth.
28. Hospital annual returns for the 1992/93 year are being structured to require hospitals to provide details of their outpatient expenditure classified by type of service provided.
29. Additional comparative costing information will be provided to hospitals after receipt of the annual returns to facilitate hospital review of the efficiency of their outpatient services. Relative efficiency of outpatient services, based on the information in the 1992/93 annual return, will be used as a basis for setting the 1994/95 outpatient budget.

Review of casemix funding

30. The terms of reference of the Department's Clinical Sub-Committee and the Casemix Committee have been changed to include a responsibility to monitor the impact of casemix funding. Accordingly, hospitals with any comments on the new arrangements are invited to submit these to the Department, via Regional Offices, for consideration by those Committees.
31. Casemix funding represents a major challenge for hospitals and the Department. It provides a better framework for the relationship between hospitals and the Department for service based reimbursement and will lead to more efficient hospital services. The operation of the throughput pool should also lead to improvements in access for Victorians to public hospital services.



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