IAA Health Section

Casemix Funding In Australia

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1 Introduction and Conclusions

1.1 Introduction

1.1.1 In Australia in both the private sector and the public sector third parties use Casemix funding arrangements to pay hospitals. However Casemix funding arrangements have developed quite differently in these sectors and also in the public sector there are quite different versions of Casemix funding across states of Australia. Differences are encouraged in the public sector so that eventually best practice options will emerge.

1.1.2 The private sector has developed a quite different model to those in the public sector and this paper will firstly describe how the private sector model evolved, detail the elements of a hospital contract between an insurer and a large private hospital that provides a very comprehensive service. The paper also examines the various public sector models that are used and provides technical details of one of the more advanced models.

1.1.3 It is worth noting that all patients discharged from a hospital in Australia have detailed information coded on a computerised discharge record. This record includes the information which occasioned the admission the procedures performed the admission and discharge dates the destination of the discharged patient etc. Of course the record also details the name, sex, date of birth and normal address of the patient etc. This information is collated by states and also an abstract is sent to the Australian Institute of Health and Welfare. States and the AIHW are able to collate the records for all residents of a state not only for the services received in that state but services received in any state of Australia. Also this can be done for Australia as a whole. This system has been in place for many years and thus there is a very valuable database of hospital utilisation information available to researchers.

1.2 Conclusions

1.2.1 Casemix funding of hospitals is an evolving funding system. The pure form of Casemix funding where hospitals are funded entirely from discharge diagnostic related grouping arrangements can lead to many anomalies and therefore gaming opportunities. The private sector developments, in particular, are designed to overcome these deficiencies. The public sector has also developed techniques to reduce gaming opportunities but in doing so may have opened up opportunities for other forms of gaming of perhaps a political nature.

1.2.2 Although the private sector does use Casemix payments for some DRGs many more single episodic payments are provided using Commonwealth Medical Benefit Schedule (CMBS) coding as the episode identifier. The private sector also uses a complex cost centre based benefit structure as the principle benefit structure for the vast majority of items of service that can be provided in private hospitals. Usually high volume well defined services will attract an episodic payment from an insurer but most often it will be defined by CMBS rather than AN-DRG.

2 Historical Perspective

2.1 Funding of Hospitals prior to 1975

2.1.1 The Medibank national health insurance system came into operation on July 1, 1975. Prior to the introduction of Medibank nearly the whole population of Australia was covered either by private health insurance, the pensioner or war veterans' arrangements or, in the case of the population of Queensland, the allegedly free treatment provided by the public hospitals of Queensland, which are funded by the Queensland State Government. Around 2% to 3% of the population of Australia were not covered by any of these arrangements and these persons generally were aboriginal people living in tribal communities, jackaroos and jillaroos (outback farm hands) and some recent migrants who were not recruited into a health insurer the moment they stepped ashore in Australia.

2.1.2 Of course some people slipped through the cracks in the system but generally those who were unemployed or on low incomes had their health insurance coverage either fully or partially subsidised by the Commonwealth Government.

2.1.3 Health insurers only provided per diem payments for hospital treatment under these pre-Medibank arrangements. Generally health insurers had three tables of benefit. The first table provided benefits for public (nightingale) ward treatment in hospital (a nightingale ward might have 20 or 30 beds in it). The second more expensive table covered shared or intermediate ward treatment (an intermediate ward might have as many as 4 or 6 beds in it). The third table provided cover for single room accommodation.

2.1.4 There were no benefits based on the types of services rendered in hospital (eg surgery, intensive care, etc) prior to 1975 and, as can be expected, the public hospitals required additional funding from state governments and the private hospital system was very undeveloped except for a few religious and charitable hospitals that relied heavily on additional funding from their religious or charitable orders.

2.2 How Private Hospital Funding Changed after 1975

2.2.1 The Medicare arrangements provided full medical insurance to every Australian resident and entitlement to free public hospital treatment. The latter is secured by an agreement between the Commonwealth Government and each State Government. Currently these agreements last for 5 years.

2.2.2 From July 1, 1975 private health insurers were left with the supplemental role of providing cover for treatment in private hospitals and treatment in public hospitals if the insured asked to be treated by their particular medical practitioner. So private insurance effectively conferred freedom of choice of doctor, improved access to hospital treatment and a wider choice of hospital – so in effect a better range of options than was available to the non-insured (unless they were reasonably wealthy and could afford to take the risk in not being insured).

2.2.3 The insurers reacted slowly to Medicare but one insurer led the way with the introduction of what was then called cost-centre based benefit arrangements for private hospitals. Cost centre benefits were designed to directly fund the major cost centres of hospitals and to drive desirable reductions in lengths of hospital stays and improvements in facilities. Initial cost-centre benefits included benefits for operating theatre usage (2 benefits the first year, 4 the next), benefits for the use of labour wards and intensive care units and benefits for special nursing and other special costs such as therapies provided in the hospital costs of prosthetic appliances etc.

2.2.4 Within 2 or 3 years the simple cost-centre benefit structures started to become more complex as it became necessary to recognise the level of complexity of the services a hospital provided, whether it undertook teaching, etc. So by about 1978 the first hospital classification systems were introduced. These systems classified private hospitals into advanced surgical, surgical, medical and psychiatric/other hospitals, with advanced surgical hospitals (or category 1) getting the highest per diem benefits and the psychiatric/other hospitals (category 4) got the least per diem benefits. Classification was done using recent utilisation information or in the case of new hospitals a provisional classification was provided from information provided by the hospital and/or from the inspection of the facilities of the hospital. Also hospital that were accredited with the Australian Council of Health Care Standards got an extra per diem benefit.

2.2.5 During the period from 1975 to 1984 the national health insurance arrangements were changed on quite a few occasions. The Commonwealth Government became interested in the hospital categorisation arrangements and developed its own scheme for use nationally among insurers. It wasn't a success because private hospitals quickly learnt to exploit the dispute mechanism that was built into the arrangements and by the time of its demise around half the private hospitals in the country had lodged an objection to their classification. The Commonwealth Government hardly ever won a dispute if it got to court and so many private hospitals became inappropriately categorised.

2.2.6 In 1986 the hospital categorisation arrangements changed to patient categorisation. Under this arrangement private hospital patients are classified into advanced surgical, surgical, medical, psychiatric, rehabilitation, palliative care and nursing-home-type patients and per diem benefits are prescribed as appropriate. Usually, the per diem benefits are further split into two or three levels within a patient category so insurers will provide one level for the first x days in hospital, a second lower level for the next y days and so on.

2.2.7 While the hospital and then patient categorisation system was developing insurers were refining the other components of the cost centre benefit structures. The operating theatre benefits changed from 4 levels to about 14 levels and there was increasingly sophisticated arrangements being introduced for labour ward benefits, intensive care units, coronary care units and the like.

2.2.8 Some insurers also started to make rudimentary contractual arrangements with some private hospitals in the period from 1986 to 1995. Benefits for some well

defined procedures (often performed on a day only basis) were drawn together into one payment amount although often the theatre fee benefit component was provided separately.

2.2.9 The first public sector Casemix arrangements were introduced in Victoria's state funded public hospital system in 1993. The Commonwealth Government then mounted pressure on the private insurers by to adopt Casemix funding arrangements in their own benefit arrangements but the insurers rejected this pressure pointing out that the arrangements that had already been developed were a form of Casemix but were much more flexible and more suitable for the insured system. Nevertheless the insurers and private hospitals formed a Private Sector Casemix Unit, which studied various alternatives for about 3 years before eventually concluding that the benefit structures developed by the insurers were more appropriate than a straight Diagnostic Related Group system. Also the unit found that both the private sector arrangements and the various public sector arrangements were in a state of evolution and this evolution would benefit from the diversity that currently existed.

2.2.10 The Private Sector Casemix unit found many discrepancies in a DRG based payment system. For example one DRG was found to cover a number of operative services that under the then private hospital benefit arrangements provided benefits from 8 different levels of the theatre fee benefit schedule. These benefits ranged from about $200 to well over $2000. Clearly the introduction of just one benefit payment for this DRG would have encouraged a lot of gaming with hospitals concentrating on the services whose operations were classified in the first few levels and eschewing the patients that required more costly operations. Eventually anomalies like this would have impaired the reputation of the whole private sector.

2.2.11 Although the private insurance system's benefit structures for private hospitals were becoming increasingly sophisticated the insurers did not change the benefit structures for public hospitals. These remained purely on a per diem basis although in Victoria and Tasmania the patient classification structure of per diem payments was introduced. The main reason for the lack of development of appropriate public hospital benefit structures appears to have been the various agreements between the Commonwealth and the States over the provision of public hospital services to Australian residents irrespective of insurance status. From the insurers point of view there was no logic to setting up a preferred provider contract with a public hospital when the agreement signed by the State and Commonwealth Ministers of Health did not permit the hospital to enter into any arrangement that gave preference to patients of a particular insurer. It was also in the insurers long term best interest to have the private hospital system differentiated from the public hospital system, particularly as the private system was generally appearing to provide a "better" and more efficient service.

2.2.12 There is no doubt that the pro-active stance taken by certain private health insurers in the mid 1970's provided a major incentive for the transformation of the private hospital industry in Australia from its cottage industry beginnings.

2.3 Modern Private Sector Casemix Arrangements.

2.3.1 An outline of the rules of a typical benefit arrangement between an Australian health insurer and a private hospital that provides fairly comprehensive hospital services is detailed in Section 4.1.

2.3.2 Section 4.2 shows the Casemix Episodic Payments (CEPs) payable by that insurer for the particular hospital. These have been made relative to 1000 and so are not the actual payments in the current contract. For some of these CEPs there is a modified payment if the hospital discharges the patient within a set number of days. These CEPs are not shown but provide incentive to the hospital to discharge healthy patients early.

2.3.3 Section 4.3 shows the other Casemix payments payable by that insurer for services not specifically covered by a CEP mentioned in Attachment 2. These amounts are also relative using the same relativity factor used in section 4.2. At the end of this list there are a large number of payment amounts for various procedures using the Commonwealth Medical Benefits Scheme (CMBS) code. Only the first few items are shown. Generally insurers have found that the CMBS coding system is far more appropriate for allocating episodic payments than DRGs.

2.3.4 The AN DRG 4.1 system is currently used in agreements. Transition between versions of AN DRG can be a fairly long process as agreements have to be effectively renegotiated. As indicated above CMBS coding is used for episodic payments much more than DRGs.

2.3.5 It should be understood that generally insurers have an agreement with each private hospital that their patients are likely to have contact with. Occasionally insurers or hospitals can't agree and then payments may be based on some minimum schedule or often on the lowest amount agreed between the insurer and a similar hospital in that state. This latter basis is often used by insurers for hospitals that can rarely admit a patient who is covered by the insurer. (For example a hospital in a country town in Western Australia and an insurer based in a country town in Victoria).

3 Public Sector Casemix Arrangements

3.1 The Early Fixed and Variable Model

3.1.1 In the late 1980's and early 1990's the state of Victoria was (arguably) politically mismanaged to the point where the newly elected State Government decided to take some rather drastic steps to improve the State's financial viability. One step that the new State Government took was to introduce DRG (now known as Casemix) funding arrangements for its public hospitals. The new funding arrangement that was introduced on July 1, 1993 provided through Casemix payments approximately 25% of public hospitals' funding with the remaining 75% being provided on area/population funded basis. The model is known as the fixed and variable model.

3.1.2 More specifically, the concept behind the funding model was that the Casemix payments would cover the variable costs of hospitals and the fixed population based area funding would cover the fixed costs. The theory behind this approach is that efficiency is maximized if the incentives are such that hospitals can treat additional patients up to the point at which marginal treatment cost equals marginal revenue. The marginal revenue is the Casemix payment made by State health authorities. This fixed and variable model mitigates the incentive for hospitals to maximize admissions. After current capacity limits are reached, additional fixed costs are required (e.g., for the commissioning of new wards), but these are not fully reimbursed by the Casemix funding system. In theory then, under this model, the State Government retains control over any growth in overall system capacity while providing strong incentives to hospital to utilize existing capacity to the limit.

3.1.3 Of course it soon became apparent that hospitals recognised that the payments provided under the Australian DRG system were inadequate for certain patients and they either made strong representations for adjustments or they found reasons to be unable to treat those patients (or perhaps classify them differently). So the original Casemix arrangements have evolved considerably from this beginning.

3.1.4 Unfortunately it was never possible to measure efficiency gains in Victoria as a result of the introduction of the fixed and variable Casemix model. This was because it was introduced at the same time as significant hospital funding cuts were made so it became impossible to determine what component of the funding package was responsible for what overall outcome.

3.1.5 South Australia followed Victoria in 1994-95, with a similar Casemix funding approach that also accompanied by significant budget cuts.

3.1.6 Victoria eventually changed to the Integrated Casemix Model from July 1, 2000.

3.2 The Integrated Casemix Model

3.2.1 The integrated model provides an integrated payment to hospitals for each patient treated, covering both the fixed and variable costs. This model in various guises was initially introduced in 3 other states of Australia and then Victoria changed to this model in the year 2000. Although this model provides an integrated payment there are a number of additional features State Governments have introduced to reduce the incentives to maximize admissions particularly for those services which appeared to be rather well funded through the Casemix model.

3.2.2 As each state introduced this model they also coincidentally reduced hospital funding so again it was not possible to determine the impact of the introduction of the Casemix funding in isolation to the other funding changes.

3.2.3 In theory the Integrated Casemix model reduces the likelihood of politics playing a significant role in the determination of hospital budgets as the budget of any hospital will be primarily determined by the patient mix and

throughput. But, of course in practice, the systems adopted by the states have just moved the political factor to a different level of complexity. For example, the Casemix payment for any DRG will not necessarily be the same for each hospital in the State. It was recognized fairly early in the development of these arrangements that some hospitals needed higher benefits because of the extra facilities they provided, or because their geographic location created additional costs, or because of their unique teaching facilities, or because of the ethnic mix of their patients or, no doubt, because of a number of other reasons.

3.2.4 In small states, such as the Northern Territory each public hospital was so different that the Casemix payments for any given DRG are different for every single hospital. Of particular concern is the vastly greater resource utilization of hospitalized Australian Aboriginal people compared to Caucasian and Asian people. Therefore States have usually had to either adjust Casemix payments for the historical ethnic mix of the hospital or have a different set of Casemix payments for persons of Aboriginal descent. Of course this creates further complications as the determination of Aboriginality is not necessarily very straight forward. Many persons might claim to be Aboriginal when they are not and many persons might be presumed to be Caucasian from their appearance when in fact they are living with Aboriginal people as an Aboriginal.

3.3 Some Technical Details on the Victorian Integrated Casemix Model[1]

3.3.1 Hospital separations are coded using the International Classification of Diseases, Tenth revision (ICD-10). Inpatient separations are allocated into Diagnosis Related Groups (DRGs) for the purpose of funding using a modified form of AR-DRG Version 4.1, the VIC-DRG4. The main modifications to AR-DRG Version 4.1 are:

- discrimination between peritoneal and Haemodialysis;
- regrouping of the principal diagnoses in non-same day cases involving radiotherapy for malignancy to attract the increased costs associated with radiotherapy;
- the separation of Allogenic and other, mainly autologous, bone marrow transplants.

3.3.2 The payment unit is the Weighted Inlier Equivalent Separation (WIES). The WIES value for a separation is derived by converting each separation into an "inlier equivalent" and multiplying that by a cost weight. Most separations are classed as inliers (i.e. their length of stay falls between lower and upper trim points). Separations that are outliers (i.e. their length of stay falls outside the lower and upper trim points) are converted into inlier equivalents (see outlier section). The cost weights and length of stay trim points are updated annually which, in turn, alters the WIES value for a given length of stay in a particular DRG. The WIES version used for payments in 2000/01 is WIES8.

[1] The information in this section is taken directly from a paper by Peter McNair and Stephan Duckett in Australian Health Review Volume 25 No 1 (2002) and relates to 2000/01 financial year.

3.3.3 Generally, Victoria adopts a "L3H3" policy for determining abnormal lengths of stay: inlier cases are those with a length of stay within "trim points" set as one third (low trim point) and three times (high trim point) the average length of stay for the DRG. Cases with lengths of stay below or above the trim points are termed low or high stay outliers respectively.

3.3.4 The additional payment per diem for high outliers in any particular DRG is based on the WIES8 cost weight, excluding the costs associated with operating theatres and prostheses. An outlier is converted to an 'inlier equivalent' by adding a per diem payment for high outlier days (i.e. days of stay above the high boundary point) to the inlier payment. The per diem payment is generally set as a discounted payment on the average per diem payment for an outlier. For most patients (patients with mechanical ventilation and certain other high cost patients are exceptions), the additional payment to convert to an inlier equivalent is equal to the number of days above the high boundary point divided by the inlier average length of stay all multiplied by the discount factor.

3.3.5 The discount is 0.8 for medical cases and 0.7 for surgical cases. These corrections compensate for the less intensive treatment anticipated in the latter stages of an admission, particularly for surgical separations. Specialist separations where the intensity of treatment is constant do not attract this adjustment. A final adjustment for high outlier weight payments may be made to distinguish rural and urban hospitals. The adjustment currently limits the range of additional per diem payments to between $213 and $810 per day (2000/01). The payment for low stay outliers varies by DRG. For some DRGs designated 'same day DRGs', same day low outliers are paid according to a "same day weight" (based on estimated costs for same day cases, not a formula related to the inlier weight), and other low outlier cases are paid according to the low outlier per diem weight described above. For other DRGs, if the low boundary point is one day, a same day low stay outlier is paid half of the multi-day inlier weight. If the low boundary point is more than one day, the low stay per diem payment is half of the multi-day inlier weight divided by the low boundary point.

3.3.6 Cost weights are set on an annual basis using a range of up to twenty hospitals that are able to provide patient level cost data from clinical costing systems. Data for a financial year (year 0) are compiled and analyzed over the subsequent six-nine month period (year 1) and used for relative weights for funding policy applying in the following year (year 2) This process results in an inherent lag of around two years between the cost patterns of treated patients being used for payment purposes. This may lead to anomalies where there is rapid technological change. The contract to conduct the cost weight study is tendered annually. Cost relativities arising from the data analysis may be adjusted by Casemix panels from relevant clinical services areas.

3.3.7 Hospital inpatient funding is capped by setting WIES targets. Each hospital is allocated a quantum of WIES known as Target A. The hospital receives full funding for inpatient activity up to the level of Target A and funding at the marginal rate up to WIES Target B. Target B has been introduced in

recognition of the difficulty experienced by hospitals in precisely predicting the number and type of separations that will be provided in any given period. Target B is set at five per cent of the total WIES allocation for metropolitan hospitals and three per cent for rural hospitals. Department of Veterans Affairs (DVA) patients are not included in the WIES8 targets for hospitals and health services. Hence, payments for these patients are effectively uncapped. DVA funded separations attract a premium of approximately $50 more than the payment for Target A WIES8 separations. The premium price paid by DVA for public hospital services and the uncapped nature of the number of services provided has made DVA patients an attractive option for raising health service revenue.

3.3.8 Target A payments vary for different hospitals with smaller hospitals attracting a higher base rate implicitly recognizing economies of scale, albeit at a very low level. The payment rate for smaller rural hospitals only exceeds the payment to equivalent larger rural hospitals by about 1.5 per cent. WIES8 payments for private patients in public hospitals are between $408 and $411 below that for public patients (Table 14). The adjustment accounts for private patient payments made by individuals and Medicare for medical, pathology and radiology services that would otherwise be funded by the state through WIES8 payments.

4 Private Sector Casemix Arrangements

4.1 Casemix Rules

4.1.1 Casemix Episodic Casemix episodic payments (CEPs) will be based on DRG version x. The rules state the circumstances when the version will change and how this will be accomplished.

4.1.2 The payment will be structured around the DRGs median length of stay. The rules state how the benchmark median lengths of stay are obtained.

4.1.3 The Schedule of DRGs attached to the contract will be used. The rules state how circumstances under which this schedule will be changed.

4.1.4 Changes due to changes in technology and how these changes are implemented.

4.1.5 Recognition that the inlier separation is eligible for an unadjusted payment and definition of an inlier.

4.1.6 Definition of a short stay patient (duration is in the short stay outlier range).

4.1.7 Definition of a long stay patient (duration is in the long stay outlier range).

4.1.8 **Example of Short and Long Outliers.** A DRG has a Short Outlier Range of 1- 4 days and Long Outlier Range of 14 + days.

- The Casemix Episodic Payment is paid for Inlier lengths of stay from 5 to 13 days.
- For short stay lengths of 1 to 4 days, no Casemix Episodic Payment is made and per diem rates apply.
- Outlier payments are paid from day 14 onwards.
- Inlier separations do not receive per diem payments from day 1 to 4 in addition to the Casemix Episodic Payment.

4.1.9 Example of no Short Outlier Range. A DRG has no Short Outlier Range and Long Outlier Range of 14 + days

- The Casemix Episodic Payment is paid for Inlier lengths of stay up to and including 13 days.
- Outlier payments are paid from day 14 onwards.
- There are no Inlier payments for this DRG even same day services receive the Casemix Episodic Payment.

4.1.10 Rules relating to any conflicts between the Commonwealth Medical Benefit Schedule and the definition of the DRG.

4.1.11 Critical and Intensive Care Unit days attract an 'add-on' payment in addition to the Casemix Episodic Payment (CEP) but that these payments only apply to episodes of care subject to the CEP. This means that if DRG X has a payment of $2500 and inlier patient spends 1 day in ICU (add-on benefit $800) then total benefit is $3,300. However if the patient is an outlier and spends 3 days in ICU then the add-on benefit does not apply but the benefit payable is in accordance with the per diem, theatre and ICU ordinary benefits.

4.1.12 Treatment of single room additional payments to CEP.

4.1.13 Resolution of issues not covered by rules.

4.1.14 Resolution of disputes.

4.1.15 Outline of benefit bundling philosophy.

4.1.16 Treatment of transfers and readmissions.

4.1.17 Provision for interim payments other than CEP.

4.1.18 Claiming procedures including details that must be included on the claim form.

4.1.19 Auditing Processes.

4.1.20 Special patient provisions.

4.1.21 Definitions

- Admission Code
- Discharge Code
- DRG (and version)
- Error DRG
- DRG Creep (manipulation of coding by hospitals)
- DRG Grouper.
- Acute Length Of Stay (ALOS) and Non-Acute LOS
- Episode of Care
- Leave days
- Non-Acute Days

- Inlier
- Outlier
- Diagnostic Codes (Principal and Secondary).
- Procedure Codes (Principal and Secondary)
- Separation
- Separation Mode (status and place to which the patient is discharged)

4.2 Casemix Episodic Payments

4.2.1 The Casemix Episodic Payments (CEPs) for this example hospital are detailed in the table below. Please note that the relativity between these payments is factual but the payments themselves are not. Also Long Outlier payments per day and the private room payments per day are not the actual amounts in the contract and are shown for illustrative purposes only.

Description	Pat Cat	Payment	Days Payment Based on	Short Outlier Range	Long Outlier range	Short Outlier Per Diem Payment	Long Outlier Per Diem Payment	Add on per day Private Room
Sinus, mastd&cmplx mddl ear pr	S	**$ 166**	1.10		4 +	Pat Cat	$ 100	$ 35
Tonsillectomy, adenoidectomy	S	**$ 151**	1.00		3 +	Pat Cat	$ 100	$ 35
Corony bypass+inva inve pr+ccc	AS	**$ 2,222**	14.00	1 - 3	20 +	Pat Cat	$ 100	$ 35
Corony bypass+inva inve pr-ccc	AS	**$ 1,650**	10.40	1 - 5	16 +	Pat Cat	$ 100	$ 35
Corony bypas-inva inve pr+cscc	AS	**$ 1,349**	8.50	1 - 4	15 +	Pat Cat	$ 100	$ 35
Corony bypas-inva inve pr-cscc	AS	**$ 1,190**	7.50	1 - 3	14 +	Pat Cat	$ 100	$ 35
Percutan corny angioplasty+ami	S	**$ 679**	4.50		11 +	Pat Cat	$ 100	$ 35
Cardiac pacemaker implantation	S	**$ 679**	4.50		11 +	Pat Cat	$ 100	$ 35
Perc crny angioplsty-ami+stent	S	**$ 452**	3.00		9 +	Pat Cat	$ 100	$ 35
Perc crny angioplsty-ami-stent	S	**$ 362**	2.40		8 +	Pat Cat	$ 100	$ 35
Vein ligation & stripping	S	**$ 226**	1.50		5 +	Pat Cat	$ 100	$ 35
Crc dsrd+ami+inva inve pr+cscc	S	**$ 830**	5.50	1 - 1	12 +	Pat Cat	$ 100	$ 35
Crc dsrd+ami+inva inve pr-cscc	S	**$ 528**	3.50		10 +	Pat Cat	$ 100	$ 35
Crc dsrd-ami+ic in pr+cmpdx/pr	S	**$ 377**	2.50		7 +	Pat Cat	$ 100	$ 35
Crc dsrd-ami+ic in pr-cmpdx/pr	S	**$ 151**	1.00		4 +	Pat Cat	$ 100	$ 35
Rectal resection + ccc	S	**$ 2,334**	16.00	1 - 7	22 +	Pat Cat	$ 100	$ 35
Rectal resection - ccc	S	**$ 1,433**	9.50	1 - 5	16 +	Pat Cat	$ 100	$ 35
Mjr small & large bowel pr+ccc	AS	**$ 2,113**	14.00	1 - 6	20 +	Pat Cat	$ 100	$ 35
Mjr small & large bowel pr-ccc	AS	**$ 1,585**	10.50	1 - 2	17 +	Pat Cat	$ 100	$ 35
Appendicectomy + cscc	S	**$ 981**	6.50	1 - 2	13 +	Pat Cat	$ 100	$ 35
Appendicectomy - cscc	S	**$ 603**	4.00		7 +	Pat Cat	$ 100	$ 35
Abdom, umb & oth hernia pr a>0	S	**$ 362**	2.40		8 +	Pat Cat	$ 100	$ 35
Inguinal&femoral hernia pr a>0	S	**$ 301**	2.00		6 +	Pat Cat	$ 100	$ 35
Anal & stomal procedures +cscc	S	**$ 226**	1.50		8 +	Pat Cat	$ 100	$ 35
Anal & stomal procedures -cscc	S	**$ 226**	1.50		7 +	Pat Cat	$ 100	$ 35

Hip revision + cscc	AS	**$ 2,332**	15.00	1 - 5	21 +	Pat Cat	$ 100	$ 35
Hip replac+cscc/hip revsn-cscc	AS	**$ 1,904**	12.00	1 - 6	18 +	Pat Cat	$ 100	$ 35
Hip replacement - cscc	AS	**$ 1,428**	9.00	1 - 4	15 +	Pat Cat	$ 100	$ 35
Knee replacemt & reattach+ccc	AS	**$ 1,904**	12.00	1 - 7	18 +	Pat Cat	$ 100	$ 35
Knee replacemt & reattach-ccc	AS	**$ 1,349**	8.50	1 - 1	15 +	Pat Cat	$ 100	$ 35
Other hip & femur proc + cscc	AS	**$ 1,904**	12.00	1 - 4	16 +	Pat Cat	$ 100	$ 35
Other hip & femur pr a>54-cscc	AS	**$ 1,428**	9.00	1 - 1	15 +	Pat Cat	$ 100	$ 35
Other hip & femur pr a<55-cscc	AS	**$ 555**	3.50		10 +	Pat Cat	$ 100	$ 35
Other back & neck procs + cscc	AS	**$ 952**	6.00	1 - 1	12 +	Pat Cat	$ 100	$ 35
Other back & neck procs - cscc	AS	**$ 1,428**	9.00	1 - 2	15 +	Pat Cat	$ 100	$ 35
Other Shoulder Procedures	S	**$ 301**	2.00		5 +	Pat Cat	$ 100	$ 35
Knee procedures	S	**$ 181**	1.20		3 +	Pat Cat	$ 100	$ 35
Other Elbow or Forearm Procedures	S	**$ 181**	1.20		7 +	Pat Cat	$ 100	$ 35
Foot Procedures	S	**$ 377**	2.50		8 +	Pat Cat	$ 100	$ 35
Minor procs for malignant breast conditions	S	**$ 377**	2.50		9 +	Pat Cat	$ 100	$ 35
Minor procs for non-malignant breast cond	S	**$ 151**	1.00		5 +	Pat Cat	$ 100	$ 35
Skin subcultaneous tissue & breast plast	S	**$ 151**	1.00		5 +	Pat Cat	$ 100	$ 35
Other skin subcultaneous tissue & breast procs	S	**$ 151**	1.00		5 +	Pat Cat	$ 100	$ 35
Transurethral prostectomy+cscc	AS	**$ 754**	5.00		11 +	Pat Cat	$ 100	$ 35
Transurethral prostectomy-cscc	AS	**$ 362**	2.40		8 +	Pat Cat	$ 100	$ 35
Testes procs w cc	S	**$ 301**	2.00		8 +	Pat Cat	$ 100	$ 35
Testes procs w/o cc	S	**$ 151**	1.00		4 +	Pat Cat	$ 100	$ 35
Hysterectomy for Non-Malignancy	S	**$ 875**	5.80	1 - 1	10 +	Pat Cat	$ 100	$ 35
Female Repro System Reconstructive Procs	S	**$ 679**	4.50		11 +	Pat Cat	$ 100	$ 35
Caesarean delivery w multi	S	**$ 1,779**	10.00	1 - 5	16 +	Pat Cat	$ 100	$ 35
Caesarean delivery w severe	S	**$ 1,326**	7.00	1 - 3	13 +	Pat Cat	$ 100	$ 35
Caesarean delivery w moderate	S	**$ 1,326**	7.00	1 - 2	13 +	Pat Cat	$ 100	$ 35
Caesarean delivery w/o comp	S	**$ 1,175**	6.00	1 - 1	11 +	Pat Cat	$ 100	$ 35
Vaginal delivery w comp OR proc	S	**$ 1,301**	7.00	1 - 2	13 +	Pat Cat	$ 100	$ 35
Vaginal delivery w multi	S	**$ 1,377**	7.50	1 - 4	14 +	Pat Cat	$ 100	$ 35
Vaginal delivery w severe	S	**$ 1,151**	6.00	1 - 3	11 +	Pat Cat	$ 100	$ 35
Vaginal delivery w moderate	S	**$ 1,045**	5.30	1 - 2	9 +	Pat Cat	$ 100	$ 35
Vaginal delivery w/o comp	S	**$ 1,000**	5.00	1 - 2	9 +	Pat Cat	$ 100	$ 35

4.2.2 For all CEPs in this contract the theatre fee or labour ward charge benefits are not bundled with the CEP. All in-hospital pharmacy benefit payments are bundled with the CEP. All prosthetic appliances benefits are not bundled with the CEP. All therapy services (physiotherapy, occupational therapy, etc) are bundled with the CEP. All laboratory charges are bundled with the CEP. Any benefits for charges for pre-admission and post discharge services are not bundled with the CEP. Any benefits for rehabilitation services are not bundled with the CEP and if there are benefits for any special units of the hospital then these are not bundled with the CEP.

4.2.3 Note that some hospital contracts may include or exclude from the CEPs different items than those outlined in 4.2.1 and also may include some items in some CEPs but not in other CEPs.

4.2.4 There is also a further limited schedule of CEPs that provide different benefits for patients that are discharged earlier than allowed for in the above schedule. The second schedule benefits are lower but not by the amount of the imputed

per diem payment for the reduced days and therefore provide an incentive to the hospital to discharge healthy patients early.

4.3 Other Casemix Payments

4.3.1 The table below details the non-episodic Casemix payments for the same hospital for which the CEP amounts are shown in 4.2. Again the amounts are relative but with the same relativities to the CEP payments. There are 100 items on the schedule of payments for individual procedures (CMBS code) but only the first 5 items are detailed.

ACCOMMODATION

		Rates		
		Private	Shared	Days
Advanced Surgery	Step 1	$48	$44	1 to 10
Advanced Surgery	Step 2	$34	$30	11+
General Surgery	Step 1	$46	$42	1 to 7
General Surgery	Step 2	$34	$30	8+
Medical	Step 1	$41	$37	1 to 10
Medical	Step 2	$34	$30	11+
Vaginal Delivery	Step 1	$43	$39	1 to 5
Vaginal Delivery	Step 2	$31	$28	6+
Caesarean Delivery	Step 1	$43	$39	1 to 7
Caesarean Delivery	Step 2	$31	$28	8+

SAME DAY ACCOMMODATION

	Benefit
Sameday Band 1	$72
Sameday Band 2	$83
Sameday Band 3	$93
Sameday Band 4	$104

Other Same Day

Outpatient Lymphoedema Program

			Benefit
W132	Outpatient Lymphoedema	Per Session	$37

The hospital agrees to explain to the patient that this is an outpatient program and not all funds may wish to cover the sessions, in which case the hospital agrees to refer the patient to the relevant fund for benefit advice. Generally the duration of the program is 10-15 days. The hospital will contact the fund and provide further information if a patient requires more than 15 sessions to determine whether further benefits apply and provide informed financial consent to the patient.

Sameday Type C and Outpatient Fees

	Benefit
Exceptions (Band 1 Accommodation Rate)	$72

Band 1 accommodation rate may be charged providing the attending medical practitioner has completed the relevant section of the Day Only certificate, indicating a valid medical reason or special circumstances requiring the patient to be admitted to the hospital for the procedure.

Rehabilitation - Day Programs

			Benefit
R302	Day Cardiac Rehabilitation	Program	$11
	Item Limit:	Max $756 per Calendar Year	

SPECIAL UNIT ACCOMMODATION

	Days	Benefit
Category A		$622
Category B		$476
Category CC (CCU)		$253

Note: certification of diagnosis, treatment & category must accompany claim.

Neonatal Special Care Nursery Category 1	1 to 4	$229
Neonatal Special Care Nursery Category 1	5 to 14	$103
Neonatal Special Care Nursery Category 1	15+	$83
Neonatal Special Care Nursery Category 2	1 to 4	$133
Neonatal Special Care Nursery Category 2	5 to 14	$97
Neonatal Special Care Nursery Category 2	15+	$71
Neonatal Special Care Nursery Category 3	1 to 4	$98
Neonatal Special Care Nursery Category 3	5+	$72

THEATRE FEES

	Benefit
Band 1A	$40
Band 1	$74
Band 2	$125
Band 3	$152
Band 4	$209
Band 5	$301
Band 6	$369
Band 7	$495
Band 8	$687
Band 9A	$642
Band 9	$868
Band 10	$1,025
Band 11	$1,217
Band 12	$1,358
Band 13	$1,644
Labour Ward	$245
Caesarean Section	$269

A charge for either labour ward or caesarean theatre can only be raised when case payment is not applicable, i.e. obstetric transfers (see note).

Multiple Procedures

First Procedure	100%
Second Procedure	33%
Subsequent Procedures	20%

OTHER PROCEDURE FEES

EPISODIC PACKAGES

All Inclusive Endoscopy Procedures

CMBS

30473 Oesophagoscopy/Panendoscopy

Case Payment	$136
Procedure Only Charge	$59

		Bundled Items:	Ancillary, Disposables, Exceptional Drugs, Theatre, Pharmacy
30475	Endoscopy Dil. Gastric Stric.		Fee
		Case Payment	$136
		Procedure Only Charge	$59
		Bundled Items:	Ancillary, Disposables, Exceptional Drugs, Theatre, Pharmacy
30476	Panendoscopy/Gastroscopy		
		Case Payment	$142
		Procedure Only Charge	$64
		Bundled Items:	Ancillary, Disposables, Exceptional Drugs, Theatre, Pharmacy
30478	Oesophagoscopy		
		Case Payment	$136
		Procedure Only Charge	$59
		Bundled Items:	Ancillary, Disposables, Exceptional Drugs, Theatre, Pharmacy
32075	Sigmoidoscopy Exam GA		
		Case Payment	$166
		Procedure Only Charge	$86
		Bundled Items:	Ancillary, Disposables, Exceptional Drugs, Theatre, Pharmacy

4.3.2 There are a large number of rules relating to the payments of the various amounts and some of these relate back to sections of the National Health Act. These rules are voluminous and not really relevant to the scope of this paper.

5 References

1) Stephen Duckett - Australian Hospital Services: an Overview

2) Abby L. Bloom – The funding of Private Hospitals in Australia

3) Peter McNair & Stephen Duckett – Funding Victoria's Public Hospitals: the Casemix Policy of 2000-2001

4) John Moss – Funding of South Australian Public Hospitals.

5) Dale Fisher and Alan Rubin – Funding of Northern Territory Public Hospitals.

6) Medical Journal of Australia Casemix Supplement – Casemix Moving Forward.