Topics

• Overview of Funding in Victoria
• National Health Reforms – Impact on Victoria
• WIES/Casemix
• Other Funding Models
Victorian Comprehensive Cancer Centre
Overview
Department of Health and Human Services

The Department of Health & Human Services (the department) is a public sector organisation that develops and delivers policies, programs and services that support and enhance the wellbeing of all Victorians on behalf of the state government.

For the 2016-17 financial year the department budget total was $21 billion, an increase of 5.5 per cent in overall funding from the previous financial year. This boost in funding is intended to enable hospitals to increase capacity, treat more patients sooner, and reduce elective surgery waits and waiting times in emergency departments.
Overview
Funding flow from the Commonwealth

1. Commonwealth budget
2. State Budget
3. DHHS funding allocations
4. Acute health services (public hospitals)
5. Acute health service (public hospitals) funding streams
National Health Reforms – Understanding the Drivers

Under the 2016–17 Victorian approach:

• Activity targets were set according to the existing Victorian funding models, which are supported by current information and financial systems

• In-scope activity targets will be converted into the equivalent National Weighted Activity Units (NWAU); funding will be flowed to health services through the National Funding Pool according to those targets

• Health services will report activity and monitor revenue using the existing Victorian funding models
“...Victoria’s obligations under the *National health reform agreement* to pay hospitals according to the national model will continue to be met by converting Victoria’s activity targets into NWAUs and flowing funding through the National Funding Pool according to these targets...”
Figure 2.1: Payment flows under national activity based funding

Commonwealth
- ABF and block funds

National Funding Pool comprising individual state accounts
- Commonwealth and state ABF funds

Department of Health
- Commonwealth block funds
  - Non-admitted mental health,
  - SRHS
  - Teaching training and research
- Funding for small rural health services and teaching, training and research

State (Victoria)
- ABF funds only
  - State block funds
    - Small rural health services
    - Teaching training and research
    - Non-admitted mental health

Local hospital networks (health services)

HACC, aged care and public health
Casemix Funding

• Victoria has had Casemix funding since 1993 – national leader in ABF
• The Victorian model acknowledges that not all activities are suitable for ABF approach, where some activities have relatively high fixed costs, new technology or not readily classifiable – specified grant top up e.g. Therakos kits
• Since the National Health Reform Victoria has kept the WIES system but uses the national pricing model to determine the Commonwealth’s contribution to Victoria rather than the mechanism for which all funding flows to the health services – to maintain consistency and stability
Principles behind Activity Based Funding

Equitable Access
- Allocate services in accordance with need for services
- Provides patient choice
- Promote the delivery of appropriate care at the appropriate time and setting to maximise quantity and quality of health care
- Patient health needs are treated alike (horizontal access equity)
- Patients with greatest needs are treated preferentially (vertical access equity)

Patient not Provider focussed
Effectiveness
- Increase health care outputs and/or improve health outcomes

Evidence Based, Multidisciplinary, Integrated
Technical Efficiency
- Deliver highest quality care for the resources used

Transparency, Accountability
- Auditable

Sustainability
- Reduces long-term health expenditures
Casemix Funding in Victoria

(WIES = Weighted Inlier Equivalent Separation)

• Important as it is the key funding mechanism for 40-50% of a typical acute hospital’s income

• Casemix is used to pay hospitals a fair price for the work actually done (in theory - but it’s a partially an illusion – 75% on average).

• The payment is based on a per weighted inpatient episode.

• It is calculated after separation.

• Casemix payment covers all costs – wards, operating theatre, pharmacy, food, etc.

• Under casemix, all health services are funded equally
Casemix

• Calculation is based on standardised coding undertaken by HIS staff
• Every inpatient stay is assigned a code for a particular group of diagnosis (diagnosis related groups = DRGs)
• If a person has more than one relevant diagnosis, the more complex DRG will be allocated (Heart attack which caused a broken leg – the heart related DRG will take precedence)
• Each DRG has a weight for the relative cost of providing that treatment, and an average length of stay
• Hospitals are paid the DRG weight multiplied by a standard price, for average patient stays.
• Complex procedures have a higher weighting (e.g. liver transplant versus carpal tunnel)
Various Funding Models
ABF in a state of Transition

Inpatient Funding
Moving from WIES to NWAU

Outpatients
Acute Non Inpatient Services, moved from VACS to Block Funding then to Tier 2
Emergency Services, moved from ED Grants to Block Funding then to URG’s
Sub Acute
  CRAFT, Rehab, GEM, Palliative Care, moved to iSNAC and then to AN-SNAP
Mental Health Inpatient
  Beds, moved to Wot (Waited Occupancy target) to NWAU

Other Specified Grants
  Training & Development
  Medical / Research / Nursing

Statement of Priorities

• All health services agree to a SoP, which is the key service delivery and accountability agreement between the government and health services

• SoPs are agreed annually between the Minister for Health and board chairs of major public health, and

• Publically available documents
Casemix Funding Under the Hood

Victorian Department of Health’s current acute funding model is called WIES which stands for Weighted Inlier Equivalent Separation.

Step 1 = Diagnostic Related Group (DRG)
Step 2 = WIES weight plus adjustment
Step 3 = Determine Inlier Equivalent
Step 4 = Price
Step 1 - At the coal face data is collected when each patient is discharged

Principal diagnosis = reason for admission, after study
Other diagnoses
Procedures performed
Birth weight
Age
Under the Hood – Step 1 DRG

Patient

Coding
ICD-AM xth Edition
Complications and/or co-morbidities
Patient age or sex
Length of stay
Same Day Status
Admission weight for infants aged < 365 days
Hours of continues mechanical ventilation
Mental health legal status
Mode of Separation

DRG Grouper

Patient coded to an AR-DRG

Surgical
Medical
Other

MDC (23) or a Pre MDC (8)
Under the Hood – Step 1 DRG

Discharge patients are classified into a DRG

• Major Diagnostic Category, based on body system and principal diagnosis
• If procedural, classified on procedure(s)
• If not procedural, classified on principal diagnosis
• Further sub-classification on the presence of complications or co-morbidities and age
• There are more than 600 DRGs
Under the Hood – Step 1 DRG

Example DRG – I03A

• Major diagnostic category I = Hip Replacement W Catastrophic CC

• 03 = Hip replacement

• A = With catastrophic or severe complicating diagnoses or co-morbidities
Under the Hood – Step 1 DRG

Example DRG – P67D

- Major diagnostic category P = Newborns and other neonates
- 67 = Admission weight > 2,499g
- D = No significant operating room procedure or problem
Under the Hood – Step 2 Weight

Patient coded to a DRG

Same Day weight

LOS

One Day weight

Determine Multiday Weight
Convert LOS into WIES
Mechanical Ventilation
Hospital in the Home

Multiday weight

Other Adjustments
Aboriginal or Torres Strait Island decent

Weighted Inlier Equivalent Separation (WIES)
Each DRG has an “acceptable” range of LOS

- I03A - from 2 days to 25 days
- P67D - from 1 day to 17 days

- Patients whose LOS falls in these ranges are called “inliers” for that DRG
Under the Hood – Step 2 Weight

Calculating WIES

• Each DRG has an inlier WIES

• I03A is 4.4413

• P67D is 1.2415

• A WIES is worth $4,640 for a public patient (Major Provider).

• These WIES payments are fixed, regardless of the patient’s LOS within the inlier range
Under the Hood – Step 3 Inlier Equivalent

Outliers

• Their LOS is outside the inlier range

• WIES payments for low outliers are discounted

• High outliers receive additional WIES for each day that their LOS exceeds the high boundary point for inliers
Convert Multiday LOS into WIES

Examples: DRG G02A Major Small & Large Bowl Procedure W Cat CC  (inlier Weight = 9.6296)

If LOS = 8 then IES = 1 therefore 1 IES X 9.6296 weight = 9.6296 WIES

IF LOS = 2 then IES = NA Days X per low outlier per diem weight
2 days x 0.9086 = 1.8172 WIES

IF LOS = 80 then IES = NA Days X per high outlier per diem weight + Inlier Weight
(7 days x 0.2496 = 1.7472) (1.7472 + 9.6296 = 11.3768 WIES)
What does it all mean

• Health Services bear the commercial risk for the care of acute inliers, regardless of their LOS

• DHHS sets the inlier WIES to reflect the cost of care for a patient with an average LOS

• Cost of high outliers significantly exceeds revenue
**DRG: A01Z – Liver Transplant**

- WIES 22 Payment = $4,640
- Same day weight = 5.2613
- One day weight = 6.4661
- Low outlier per diem = 2.1686
- Inlier weight = 28.1519
- High outlier per diem = 0.3621
- Boundary High = 93 days
- Average Length of stay = 22.7 days
<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>Mech. co-payment</th>
<th>Other co-payment</th>
<th>Boundary - Low</th>
<th>Boundary - High</th>
<th>Avg Inlier stay</th>
<th>Same/one-day DRG</th>
<th>Same-day weight</th>
<th>One-day weight</th>
<th>Multi-day low outlier per diem</th>
<th>Inlier weight</th>
<th>High outlier per diem</th>
<th>HITH outlier per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>F79A</td>
<td>Arrhythmia, Cardiac Arrest and Conduction Disorders, Major Complexity</td>
<td>D</td>
<td></td>
<td>1</td>
<td>13</td>
<td>4.0</td>
<td>Same day</td>
<td>0.3326</td>
<td>1.1783</td>
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<td>1.1783</td>
<td>0.2367</td>
<td>0.1894</td>
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<tr>
<td>F76B</td>
<td>Arrhythmia, Cardiac Arrest and Conduction Disorders, Minor Complexity</td>
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<td></td>
<td>0</td>
<td>5</td>
<td>1.6</td>
<td>Same day</td>
<td>0.2023</td>
<td>0.5634</td>
<td>0.0000</td>
<td>0.5634</td>
<td>0.2752</td>
<td>0.2202</td>
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<tr>
<td>G01A</td>
<td>Rectal Resection, Major Complexity</td>
<td>D</td>
<td></td>
<td>8</td>
<td>78</td>
<td>27.3</td>
<td>Same day</td>
<td>2.3446</td>
<td>2.8928</td>
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<td>10.5676</td>
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<tr>
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<td>Rectal Resection, Intermediate Complexity</td>
<td>D</td>
<td></td>
<td>4</td>
<td>30</td>
<td>13.4</td>
<td>Same day</td>
<td>2.0788</td>
<td>2.6404</td>
<td>0.8426</td>
<td>6.0103</td>
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<tr>
<td>G01C</td>
<td>Rectal Resection, Minor Complexity</td>
<td>D</td>
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<td>2</td>
<td>23</td>
<td>7.5</td>
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<td>1.8777</td>
<td>2.5245</td>
<td>0.6468</td>
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<td>0.1937</td>
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<tr>
<td>G02A</td>
<td>Major Small and Large Bowel Procedures, Major Complexity</td>
<td>D</td>
<td></td>
<td>8</td>
<td>73</td>
<td>23.3</td>
<td>Same day</td>
<td>1.8414</td>
<td>2.3606</td>
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<td>G02B</td>
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<td>3</td>
<td>29</td>
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<tr>
<td>G02C</td>
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<td>D</td>
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<td>1</td>
<td>15</td>
<td>5.0</td>
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<td>1.5495</td>
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<td>G03A</td>
<td>Stomach, Oesophageal and Duodenal Procedures, Major Complexity</td>
<td>D</td>
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<td>6</td>
<td>54</td>
<td>17.5</td>
<td>Same day</td>
<td>2.4761</td>
<td>3.0510</td>
<td>0.9748</td>
<td>8.9100</td>
<td>0.2813</td>
<td>0.2251</td>
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<tr>
<td>G03B</td>
<td>Stomach, Oesophageal and Duodenal Procedures, Intermediate Complexity</td>
<td>D</td>
<td></td>
<td>2</td>
<td>22</td>
<td>7.3</td>
<td>Same day</td>
<td>1.8079</td>
<td>2.4990</td>
<td>0.6911</td>
<td>3.8812</td>
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<td>0.2120</td>
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<tr>
<td>G03C</td>
<td>Stomach, Oesophageal and Duodenal Procedures, Minor Complexity</td>
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<td></td>
<td>0</td>
<td>8</td>
<td>2.6</td>
<td>Same day</td>
<td>1.8260</td>
<td>1.8260</td>
<td>0.0000</td>
<td>1.8260</td>
<td>0.2930</td>
<td>0.2344</td>
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<tr>
<td>G04A</td>
<td>Peritoneal Adhesiolysis, Major Complexity</td>
<td>D</td>
<td></td>
<td>4</td>
<td>40</td>
<td>13.3</td>
<td>Same day</td>
<td>1.5032</td>
<td>2.0570</td>
<td>0.8306</td>
<td>5.3794</td>
<td>0.2323</td>
<td>0.1858</td>
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</tbody>
</table>
Under the Hood – Step 4 Price

<table>
<thead>
<tr>
<th>Payment</th>
<th>All health services $</th>
<th>Metropolitan and regional $</th>
<th>Subregional and local $</th>
<th>Small rural $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public WIES23</td>
<td>–</td>
<td>4,640</td>
<td>4,857</td>
<td>4,724</td>
</tr>
<tr>
<td>Private WIES23</td>
<td>–</td>
<td>3,527</td>
<td>3,690</td>
<td>3,590</td>
</tr>
<tr>
<td>Transport Accident Commission WIES23</td>
<td>4,136</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Department of Veterans’ Affairs WIES23</td>
<td>4,927</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
Case Mix

• Casemix is an average price, which does not always meet the treatment cost: “Swings and roundabouts”.

• This is because the cost weights are determined by an annual survey of all Victorian Hospitals. 2016/17 cost weights are based on 2014/15 clinical costing data.

• E.g. “Implantation or replacement of Pacemaker, Total System, minor complexity” (F12B = 1.9393) Revenue of $8,998. However, the cost of some types of defibrillators can be as much as $30k.

• The logical response is to ration and cap the high-cost procedures
Casemix Cost Income

DRG G02A Major Small & Large Bowl Procedure, major complexity (inlier Weight = 9.6296 Inlier)

<table>
<thead>
<tr>
<th>Length of Stay (days)</th>
<th>Low Boundary</th>
<th>Average</th>
<th>High boundary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>23.3</td>
<td>73</td>
</tr>
</tbody>
</table>

WIES $\times$ Price $=$ Income

<table>
<thead>
<tr>
<th>REVENUE (Public Patient)</th>
<th>WIES</th>
<th>Price</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Private Patient)</td>
<td>9.6296</td>
<td>$4,640</td>
<td>$44,681</td>
</tr>
<tr>
<td></td>
<td>9.6296</td>
<td>$3,527</td>
<td>$33,964</td>
</tr>
</tbody>
</table>
Good News Story
The Private Patient

Public WIES
$4,640

Private WIES
$3,527
Case Mix WIES

• Examples
  • Lung Transplant
    • DRG A03Z
    • Weight = 21.1109
    • WIES price = $4,640
    • So total revenue for a public patient with an average length of stay 26.5 days would be
      21.1109 x $4,640 = $97,955

• Carpel Tunnel Release
  • DRG B05Z
  • Weight = 0.3802
  • WIES price = $4,640
  • Average inlier 1 day 
    0.3802 x $4,640 = $1,764
Example of different lengths of stay = B04A (inlier between 3 – 30 days)
• 2 Days (Low outlier) = 2 x 0.8108 x $4,640 = $3,762
• 3 Days (inlier) = 4.5083 x $4,640 = $20,919
• 40 Days (High outlier)
  = (30 days = 4.5083 x $4,640) + (10 days = 10 x 0.2327 x $4,640)
  = $20,919 + $10,797 = $31,716
## WIES example – Different Lengths of Stay

**A08B Inlier (days between 6-15) Autologous Bone Marrow Transplant, Minor Complexity**

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Day Weight</td>
<td>0.336</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Day Weight</td>
<td>0.6539</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiday Low Outlier Weight</td>
<td>0.5299</td>
<td>0.5299</td>
<td>0.5299</td>
<td>0.5299</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Total</td>
<td>1,559</td>
<td>3,034</td>
<td>4,917</td>
<td>7,376</td>
<td>9,835</td>
<td>12,294</td>
<td>17,786</td>
<td>17,786</td>
<td>17,786</td>
<td>17,786</td>
<td>17,786</td>
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<td>17,786</td>
<td>17,786</td>
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<tr>
<td>Outlier Weight</td>
<td>0.2397</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outlier Days</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Outlier Revenue</td>
<td>1,112</td>
<td>2,224</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total Revenue</td>
<td>1,559</td>
<td>3,034</td>
<td>4,917</td>
<td>7,376</td>
<td>9,835</td>
<td>12,294</td>
<td>17,786</td>
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<td>17,786</td>
<td>17,786</td>
<td>17,786</td>
<td>17,786</td>
</tr>
</tbody>
</table>
**WIES Boundaries**
Each Diagnosis Related Group is based upon an average length of stay (ALOS)
For Maximum WIES, the patient episode needs to be close to the boundary
## Table 2.3: Victorian funding recall rates, 2016–17

<table>
<thead>
<tr>
<th>Service</th>
<th>Funding recall policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute admitted services</td>
<td>• 0–3 per cent below target: 50 per cent of the weighted relevant rate or wrap value.</td>
</tr>
<tr>
<td>Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)</td>
<td>• &gt; 3 per cent below target: 100 per cent of the relevant rate.</td>
</tr>
<tr>
<td>Non-acute admitted services (maintenance care)</td>
<td></td>
</tr>
</tbody>
</table>

## Table 2.4: Funding for throughput above target, 2016–17

<table>
<thead>
<tr>
<th>Service</th>
<th>Funding recall policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute admitted services</td>
<td>Fifty per cent of relevant public rate or wrap value for activity up to four per cent above target.</td>
</tr>
<tr>
<td>Subacute services (GEM, rehabilitation and palliative care combined)</td>
<td>Any activity above four per cent will not attract additional funds.</td>
</tr>
<tr>
<td>Non-acute admitted services (maintenance care)</td>
<td></td>
</tr>
</tbody>
</table>
Department of Health and Human Services policy and funding guidelines 2016

Volume 1: Departmental overview
Volume 2: Health operations 2016–17
Other Program & Funding Streams

- HITH
- Renal Services (Facility and Home Dialysis)
- Radiotherapy (WAUs)
- Organ & Tissue Donation
- Blood Supply Funding
- Genetics Program
- Pharmaceuticals
- VALP (Victorian Artificial Limb Program)
- Palliative Care
Subacute inpatient services (Subacute WIES)

• Subacute admitted rehabilitation and geriatric evaluation and management activity is under an episodic funding model in 2016–17. The funding model will classify activity according to the Australian National Subacute and Non-Acute Patient version 4 (AN-SNAP).

• AN-SNAP is a casemix classification that includes four subacute care types (rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care). Subacute WIES1

• Patients are classified on the basis of setting, care type, phase of care, assessment of functional impairments, age and other measures. The admitted branch of the classification contains 83 classes for subacute overnight episodes/phases, six for subacute same-day admissions1 and six for non-acute episodes
## Subacute WIES1 - Rates

<table>
<thead>
<tr>
<th>Payment</th>
<th>All health services $</th>
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<tbody>
<tr>
<td>Admitted public</td>
<td>10,247</td>
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<tr>
<td>Admitted private</td>
<td>9,530</td>
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<tr>
<td>Department of Veterans’ Affairs</td>
<td>12,399</td>
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<tr>
<td>TCP bed places (per diem rate)</td>
<td>150</td>
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<tr>
<td>TCP home places (per diem rate)</td>
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*State component only*
<table>
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<tr>
<th>Code</th>
<th>Class</th>
<th>Description</th>
<th>Inlier low</th>
<th>Boundary high</th>
<th>Avg length of stay</th>
<th>Bed-day weight</th>
<th>Low outlier weight</th>
<th>Inlier weight</th>
<th>High outlier weight</th>
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<tbody>
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<td>4A21</td>
<td>AN-SNAP</td>
<td>(Rehab) Orthopaedic conditions, all other (including replacements),</td>
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<td>13</td>
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Mental health inpatients

• 2013-14 ABF model introduced a shadow Weighted Occupancy approach. 2016-17 DHHS has decided not to pursue WOTs.

• From 2016–17, funding for admitted mental health activity will be distributed to health services based on the bed capacity that is available at each health service. A supplementary transition grant will be provided to support the transition towards the new model.

• Acute – child and adolescent, adult and aged care provided by health services that deliver admitted inpatient mental health care will be reimbursed based on a single unit price, irrespective of the bed setting or patient characteristics in 2016–17.
Home and Community Care

• On 7 March 2016 the Aged Care Assessment Service (ACAS) transitioned into My Aged Care, the electronic system for capturing client, assessment and service provision information. Services for older Victorians (people aged 65 and over and aged 50 and over for Aboriginal and Torres Strait Islander people) are now directly funded and managed through the Commonwealth Home Support Programme by the Commonwealth Department of Health.

• Home and Community Care - Targeted to people aged under 65 (and Aboriginal people aged under 50) with disabilities and their carers, the Home and Community Care (HACC) program is funded by the Victorian government to provide a range of services in the home or in healthcare or community-based agencies. The goal of the program is to allow participants to continue living in their homes and their communities.
Teaching, training and research

Training and development grants were introduced into the original casemix formula to recognise the additional costs inherent in the teaching, training and research activities of public health services. It comprises four streams of funding:

- research
- professional-entry student placements
- graduate funding
- postgraduate medical, nursing and midwifery funding.
Medicare ineligible patients

- Medicare ineligible patients – can be charged by the hospital and should be at a full cost recovery rate
- Duty of care to treat emergency patients (regardless of status)
- Planned services should only occur if capacity not affected, patient’s assurance of payment for the services
- Not refugees or asylum seekers – they are funded by different mechanisms