Introduction to Revenue
Acknowledgements
Overview

On completion of this module the participant will have an understanding of:

- The main revenue streams that can be found in most public hospitals
- The importance of correct allocation of a patient’s financial class and how this relates to revenue
- Revenue opportunities that exist as part of Additional Revenue Groups
- How the patient journey can affect revenue.
What is Revenue?
Revenue can be defined as “The income generated from sale of goods or services, or any other use of capital or assets, associated with the main operations of an organization before any costs or expenses are deducted.”

Revenue is usually displayed in an income (profit and loss) statement. Charges, costs and expenses are subtracted from revenue to produce net income.

(BusinessDictionary.com, 2016)
Revenue is the life blood of any business - it is no different in the healthcare sector. Both the delivery of patient care and the overall health of the hospital can be affected by the flow of revenue.

Health service administrators working in this area play a vital role in the overall financial security and welfare of their health service.

(Feigenbaum, 2016)
Factors Affecting Revenue

There are a number of factors that affect hospital revenues (and expenses). Some of these are listed below to help begin forming a picture:

• Number of patients
• Patients’ insurance sources
• Types of services a health service offers
• Frequency of use of different services
• The ability to capture all billable revenue

(Feigenbaum, 2016)
Like any business, one of the purposes of revenue is to cover expenditure, which ultimately enables the healthcare organisation to remain viable and sustainable.

This image shows the major Australian public hospital recurrent expenditure categories for 2013-14. In 2013-14, public hospital recurrent expenditure (including salary expenditure) was $44 billion (excluding depreciation), 62 per cent of which was apportioned to salary payments.

(Australian Institute of Health and Welfare, 2015)
Importance of Maximising Revenue

Maximising revenue opportunities is essential for a health service to be efficient and ultimately continue to provide high-quality patient services that meet patient needs and expectations.

(Australian Institute of Health and Welfare, 2015)
What are the different revenue streams?
Funding Complexities

Australia’s healthcare is jointly funded by a number of parties, including the Commonwealth Government, State/Territory and Local Governments, and the private sector.

This system of funding flows is highly complex, with varying levels of public and private expenditure across a range of health services including hospitals, medical and allied health services, and pharmaceuticals. Healthcare funding is also subject to changes, such as with various political influences.

All governments provided 68.3 per cent of total health expenditure ($100.8 billion for health care) in 2012-13.

(Australian Government, 2016)
Three Main Categories

Revenue for health services can come from many and varied sources – not all health services have the same sources of revenue.

For the purpose of this module, we have broadly defined health service revenue sources by three categories:

1. Government Funding (Commonwealth and State/Territory)
2. Patient Fees
3. Other Revenue
Government funding - Commonwealth
With respect to public hospitals, the state/territory governments and the Australian Government provide the majority of the funds.

In contrast to this, private hospitals are mainly funded by private health insurance funds.

This image shows major funding sources for public and private hospitals between 2012-13.

(Australian Institute of Health and Welfare, 2015)
Commonwealth Funding Streams

Under the National Health Reform Agreement, the Commonwealth, States, and Territories are jointly responsible for funding public hospital services, using the following two major streams:

- Activity Based Funding (ABF)
- Block grant funding
Although you are not required to know how to calculate ABF, it may be helpful to gain a basic understanding. To read more, follow the link:

Public Hospital Eligibility for Commonwealth ABF or Block Grant Funding

Under the National Health Reform Agreement, the scope of public hospital services that are funded on an activity or block grant basis and are eligible for a Commonwealth funding contribution currently includes:

• All admitted and non-admitted services
• All emergency department services provided by a recognised emergency department
• Other outpatient, mental health, sub-acute services and other services that could reasonably be considered a public hospital service.
To read further about specific areas of Australia’s health care system that receive Commonwealth Funding, follow the links below:

https://www.pmc.gov.au/who-we-are/grants-and-funding

Medicare and Pharmaceuticals

The Commonwealth also has a distinct role in funding medical and pharmaceutical benefits through the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) respectively, which patients access through bulk billing and rebates on payments that they make to service providers.
Public Hospital Revenue Direct from Commonwealth

Public hospital revenue that comes from the Commonwealth is first fed to the States/Territories via the National Health Funding Pool (i.e. ABF) or via the State Managed Fund (i.e. block grant funding).

However, some public hospital revenue comes directly from the Commonwealth – the following will be briefly explored later in the module:

- Outpatients – Private (MBS) Clinics
- Inpatients – Private (MBS) Practice
- Commonwealth grants
Outpatient vs. Inpatient

- An outpatient is a patient who is receiving ambulatory care as an outpatient in a clinic (i.e. not admitted)

- An inpatient is a patient who is receiving acute care and is admitted to hospital
Government Funding - State
The state/territory governments (state governments) are the major funders of hospital services and provide the bulk of revenue. State governments are also the majority funders of emergency care, including ambulance and retrieval services, and follow-up community care services.

The state governments allocate funding through their respective Health Care Agreements. They also provide different types of grants for a range of areas, such as:

- highly specialised drug programs
- indigenous programs
- rural access to health services
- equipment and infrastructure
- capital works
- other special purposes

(Department of the Prime Minister and Cabinet, 2014)
It is worth noting that although the State Government is the major funder of hospital services, the Commonwealth is the dominant contributor for funding of healthcare in its entirety. As an extension of this, it is important to have an understanding of how Government funding flows to health services, including the main types of funding. The view this in a simplified way, follow the link below:

Patient Fees
Patient Fees

Patient Fees, which account for approximately 10% - 15% of hospital revenue, are payments made by:

- Patients
  - This refers to patients who pay a contribution, that being individuals (non-insured) and patients from overseas.
- Health insurance funds
  - The private sector contributes significantly to funding health care in Australia. This includes patient contributions, primarily through out-of-pocket costs and private health insurance premiums. Revenue raised from the private health insurers of private patients helps to support hospital budgets. Without them, hospitals would rely solely on government funding and would not have the opportunity to increase revenue.
- Other authorities
  - Some examples of 'other authorities' include:
    - Medicare Benefits Schedule (MBS)
    - Pharmaceutical Benefits Scheme (PBS)
    - Transport Accident Commission (TAC) / Motor Accident Commission (MAC)
    - SafeWork / WorkSafe
    - Department of Veteran Affairs (DVA)
Other Revenue

Areas of revenue generation that fall under ‘other revenue’ can be quite extensive and form a pivotal contribution to revenue across a healthcare organisation.

A small proportion of hospital revenue falls under ‘other revenue’, which incorporates a range of areas such as:

- Private practice fees
- Car-parking
- Donations and bequests
- Research
- Training and development
- Consultancy fees
- Catering
- Retail sales
- Rents
- Business unit
- Other commercial activities
What do we mean by the patient’s Financial Class?
Broad Financial Class

We class patients financially – that’s called a patient’s financial class or patient election status and it determines what revenue can be raised and where the revenue comes from, such as from Additional Revenue Groups.

A patient’s financial class falls under one of the following broad financial class categories:

• Public
• Private/Compensable Inpatient, or
• Private/Compensable Outpatient.

The term ‘compensable’ refers to patient revenue generated through the various Additional Revenue Groups (excluding private revenue) mentioned earlier. TAC / MAC and WorkSafe / SafeWork patients are examples of compensable patients.
Trend – Private Patients in Public Hospitals

It should be noted that with respect to public health services, the majority of patients will be classed as public.

There has been a growing trend however, of private patients electing to be treated in public hospitals. Between 2005-06 to 2010-11, private patients in public hospitals increased by 50%, whilst public patients in private hospitals increased by only 16% over the same period.

This highlights the growing opportunity to capture additional revenue related to private patients.

(King, 2013)
Financial Class

Below identifies the various financial classes that fall under the broader classes of Private/Compensable Inpatient and Private/Compensable Outpatient:

- **Private/Compensable Inpatient**
  - Private inpatient insured
  - Private inpatient self-funded
  - Private psychiatric
  - Private rehabilitation
  - TAC / MAC
  - WorkSafe / SafeWork
  - DVA
  - Overseas

- **Private/Compensable Outpatient**
  - Private/MBS
  - Private psychiatric
  - Private subacute
  - TAC / MAC
  - WorkSafe / Safework
  - DVA
  - Overseas
Once the patient’s financial class has been established, the services received by the patient can then be determined, which further informs the source and amount of hospital revenue entitlements. Some examples of services that attract additional revenue opportunities include:

- **Private/Compensable Inpatients:**
  - Bed fees/accommodation
  - Prostheses
  - Diagnostics
  - Procedures
  - Consultations

- **Private/Compensable Outpatients**
  - Diagnostics
  - Procedures
  - Consultations
To gain a slightly deeper understanding of revenue that can be attributed to particular patient financial classes, click here for a Victorian example.

**PDF:** Inpatient and Outpatient Revenue Categories

To view the fees and charges for acute health services in Victoria, follow this link:

Healthcare Funding – The Buckets

Often a simplified way of looking at health service funding is according to its two main ‘buckets.’

The larger bucket is the State Funding (predominately Activity Based Funding) or in smaller health services this would be the block grant funding.

This smaller bucket refers to Commonwealth Funding.
Healthcare Funding – Additional Buckets

There are also multiple buckets that fall under ‘additional buckets’. These are often referred to as Additional Revenue Groups. These additional buckets are often referred to and accounted for under patient fees.
Additional Revenue Groups
Private Patients

A private patient is essentially a patient covered by private health insurance who elects to be treated as a private patient. Private patients can choose their own doctor and decide whether to go to a public or private hospital that their particular doctor attends.

People who are covered by private health insurance can also choose to be treated in a public hospital as a public patient, at no charge. Under these circumstances, the hospital appoints a doctor for the patient.
Benefits to the Health Service

In most cases private patients allow health services to generate additional revenue. Revenue raised from private patients helps to support health service budgets. Without private patients, health services would receive funding only from the government, without the opportunity to increase additional revenue.

Additional private patient revenue assists health services to do things like:

• Purchase new equipment
• Recruit more staff
• Improve patient services, and
• Fund research
Benefits to the Patient

Most health services adopt some form of benefits for privately insured patients in order to encourage the uptake of private health insurance usage by eligible patients. Some benefits may include:

- No excess fees
- No co payments
- Hassle free billing – no accounts to the patient
- Choice of doctor
- Free paper, TV or pay TV
- Choice of meal
- Coffee vouchers
What is Billable?

With private patients, the following is billable:

- Prostheses
- Diagnostics (pathology and radiology)
- Medical procedures and consultations
The private Weighted Inlier Equivalent Separations (WIES) rate is always lower than the public, however there is an opportunity to bill.

- Private revenue = bed fees, prosthesis, specialist fees, pathology, radiology and anaesthesia.
- There are many variables to the amount of private revenue that can be raised, such as the type of accommodation (e.g. shared room vs single room accommodation charges) and whether a specialist was involved.
To learn more about fees and charges for acute health services from a Victorian perspective, follow the link:

Outpatients – Private (MBS) Clinics

Public outpatient funding is capped, therefore establishing a private (MBS) clinic enables hospitals to provide specialist services that would otherwise not be available to patients. It serves community demand for access to specialist services and attracts specialist and teaching opportunities.

Private (MBS) Clinics receive no public funding – all costs in offering the service rely on billing Medicare under the specialist’s provider number.

There are Medicare requirements that need to be met – the private (MBS) clinics function in accordance with these requirements.
Opportunity for Additional Revenue – The Outpatient Private (MBS) Picture

1) Patient referred to a specialist via a GP, hospital doctor or another specialist. The referral must meet Medicare requirements
2) Patient elects to be treated as a private patient
3) Referral is triaged and allocated to the private specialist clinic
4) Patient presents as scheduled
5) Specialist treats the patient and after the consultation, the patient reports to the clinic reception to sign the bulk bill assignment form
6) Hospital bills Medicare under the specialist’s provider number on behalf of the specialist
7) The service is charged at 85% of the MBS fee – the bulk bill rate
8) Medicare pays for the service electronically and the revenue is then allocated according to the specialist’s Private Practice Agreement.

9) The portion of revenue that is allocated to the hospital is called a facility fee. This fee covers the cost of running the private (MBS) clinic.

10) Diagnostics related to the private specialist consultation are also billed to Medicare, pending the patient signs the bulk bill assignment form.
Further Revenue Opportunities for Private (MBS) Clinics

It is not uncommon for a patient to require consultations from multiple specialists associated with their condition. All of these activities are billable at the same rates (see diagram below).

<table>
<thead>
<tr>
<th>MBS Item Number</th>
<th>MBS Item Description</th>
<th>85% MBS (2016-17 rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>Initial consultation</td>
<td>$128.30</td>
</tr>
<tr>
<td>116</td>
<td>Review consultation</td>
<td>$64.20</td>
</tr>
</tbody>
</table>
The following links provide further reading around private (MBS) clinics in Victoria:

Specialist Clinics in Victorian Public Hospitals: A resource kit for MBS-billed services

Specialist Clinics in Victorian Public Hospitals: Access Policy
https://www2.health.vic.gov.au/getfile/?sc_itemid=%7BE6447CD4-2AD8-48B3-8760-08A028FC788E%7D&title=Specialist%20clinics%20in%20Victorian%20public%20hospitals%20%3A%20Access%20policy
Inpatients – Private (MBS) Practice

Patients have a choice to be treated as public or private, and most hospitals waive excess fees and co-payments to encourage patients to elect to be treated as private.
Opportunity for Additional Revenue – The Inpatient Private (MBS) Picture

1. Patient elects to be treated as a private patient
2. Hospital bills the private health insurer under the hospital’s provider number for bed fee accommodation and prostheses
3. Private health insurer pays 100% of the accommodation and prostheses services billed
4. Medicare pays 75% of the MBS fee for diagnostics, consultations and procedures and the private health insurer pays the remaining 25% of the MBS fee. These services are billed and paid under the specialist’s provider number
Although public ABF attracts more revenue when compared to private ABF, this picture depicts how utilising and maximising inpatient private (MBS) practice can result in substantial additional revenue for the health service.
The Transport Accident Commission (TAC) is the statutory insurer of third party personal liability for road accidents in the state of Victoria. It was established under the Transport Accident Act 1986.

Patients (including pedestrians and cyclists) who are injured in an accident caused by the driving of a car, motorcycle, bus, train or tram, are covered under TAC.

Under such circumstances, the patient lodges a claim and the TAC assesses the claim based on certain criteria.
TAC – Patient Benefits

Once the patient’s claim is accepted, TAC will pay for the cost of hospital, medical and rehabilitation treatment in public and private hospitals.

Patients can claim loss of earning and other benefits such as therapy services, household and community services, medication, equipment and travel. Patients also have entitlements to pursue personal injury claims.
TAC – Hospital Benefits

TAC Weighted Inlier Equivalent Separations, or WIES (Victoria’s form of Activity Based Funding) and TAC sub-acute funding is not capped, therefore hospitals can treat as many TAC patients as capacity allows and be expected to be funded for services and care provided.

Hospitals that receive TAC WIES funding, do so in addition to the revenue that is billed for diagnostics, medical consults and procedures in the emergency, inpatient and outpatient setting.
TAC – What is Billable?

A number of items are billable through the TAC, these include:

• Diagnostics
• Medical procedures and consultations
• Outpatient prosthetics
• Discharge and Outpatient medication
• Patient equipment
Patients covered by WorkCover are those who have sustained a work-related injury (any physical or mental disease) that occurs in the course of employment or where employment is a significant contributing factor - this includes reoccurrences, aggravations, accelerations, exacerbations or any pre-existing injury or disease.

Patients need to lodge a claim to Worksafe and Worksafe will assess the claim and advise of whether the claim is accepted. Benefits are only paid if the claim is approved.
WorkSafe – Patient Benefits

Worksafe covers the cost of hospital, medical and rehabilitation treatment in public and private hospitals.

Patients can claim loss of earning and other benefits such as therapy services, household and community services, medication, equipment and travel.

Patients also have entitlements to pursue personal injury claims.
WorkSafe – Hospital Benefits

There is no funding or capped targets to treat WorkCover patients, therefore hospitals can treat as many WorkCover patients as they can and be expected to be paid by the insurer.

Hospitals raise Diagnostic Reporting Group (DRG) funding which pays for bed accommodation and prostheses plus all the revenue that is billed for diagnostics, medical consults and procedures in the emergency, inpatient and outpatient settings.

Of course funding and payments are only made by Worksafe on accepted claims.
WorkSafe – What is Billable?

A number of items are billable through WorkSafe, including:
• Bed accommodation fees and prostheses
  – built in a DRG fee to cover treatment.
• Diagnostics
• Medical procedures and consultations
• Outpatient prosthetics
• Discharge and Outpatient medication
• Patient equipment
Overseas Patients

There are two types of overseas patients that require correct identification in order for health services to capture the correct revenue and funding.

1) Reciprocal overseas patient
2) Medicare ineligible/overseas patients

There is no Government funding available for hospitals in treating Medicare ineligible/overseas patients.
To read further about reciprocal overseas patients, follow the link below:

Overseas Patients – Hospital Benefits

Hospitals receive no funding to treat overseas patients – this is why health services must attempt to recover 100% of costs involved associated with these patients (e.g. through their health insurance or patient paying).

The way that many public hospitals recover these costs is by billing at 125% of the MBS rate for bed accommodation, prostheses diagnostics, medical consults and procedures in the emergency, inpatient and outpatient settings.

Medicare ineligible/overseas patients can present an ethical dilemma for hospitals who may be faced with a sick patient from overseas who is not adequately insured.
Department of Veteran Affairs (DVA) patients are those whose healthcare treatment and services are funded and covered by the Department of Veterans’ Affairs.

- Gold card holders are fully covered and no restrictions apply.
- White card holders are only covered for certain medical conditions and treatment.
- Orange card holders are only covered for subsidised pharmaceuticals.
DVA – Hospital Benefits

DVA covers cost of hospital, medical and rehabilitation treatment in public and private hospitals. Patients also have benefits such as therapy services, household and community services, medication, equipment and travel.

DVA funding is not capped, therefore health services can treat as many DVA patients that capacity allows and be expected to be funded for services and care provided.

Hospitals that receive DVA funding, do so in addition to the revenue that is billed for diagnostics, medical consults and procedures, in the inpatient and outpatient setting.
DVA – What is Billable?

A number of items are billable through DVA, including:

• Diagnostics
• Medical procedures and consultations
• Outpatient prosthetics
• Discharge and Outpatient medication
• Patient equipment
How can the patient journey affect revenue?
The Patient Journey

The process by which a patient passes through a hospital is known as the patient journey. When a patient is admitted to hospital, they should be allocated to a funding class based on whether they choose to be treated privately - where revenue is generated through individual patient fees or private insurance payments, publicly, or as compensable patient where revenue will be generated through these other authorities – we spoke about that earlier.
Patient Choice

If the patient chooses to be treated as a public patient, the revenue will come through the government bodies and there is therefore no opportunity to raise additional revenue.

If the patient chooses to be treated as a private patient, that opens up the opportunity to raise additional revenue through bed accommodation fees, and separately recover costs for prosthesis, diagnostics, medical consultations and procedures.
Patient Entry Points

There are two ways a patient will enter a hospital for treatment:
1. Through the Emergency Department (ED), or
2. Referred by their Doctor or Specialist.

EDs are block funded, whereas the patient hospital journey beyond the ED is activity funded. We will now look at a scenario to follow the patient journey and the impact on revenue.
Emergency Department Presentation

1) Patient financial class is identified, e.g.:
   - Public
   - TAC / MAC
   - WorkSafe / SafeWork
   - DVA
   - Ineligible/Overseas

   A patient is not considered to be a private financial class at the point of registration. If a patient chooses to be treated as a private patient, this occurs when they need to be admitted and not at the point of presentation to the emergency department.

2) Patient treated in ED - Tests incur costs, for example:
   - Pathology (Blood tests)
   - Imaging (Xray/CT/MRI)

3) Diagnosis is determined and a transfer or discharge plan is created
   - Diagnosis determines payment/funding
   - Discharge plan articulates:
     - Where the patient is being released to (e.g. home, admitted or another facility)

   If the patient is transferred internally (i.e. is admitted), their Diagnostic Reporting Group (DRG) determines the Activity Based Funding for an episode of care, that the hospital provides.
Patient admitted to ward
Further tests
Diagnosis confirmed
Documented in history throughout patient journey
 Treatment documented
Treatment
Patient discharged home
Patient transferred
Admission

1) The clerical staff member for every admission determines the patient financial class or bucket for this admission through the initial administrative process. The importance of allocating the patient to the correct financial class from the beginning, cannot be understated.

2) Tests then occur which have associated costs. These costs over time, can attract different amounts of Activity Based Funding.

3) The clinical diagnosis of the patient’s condition is determined. This information is then documented and based on this, the patient receives the appropriate treatment. This treatment is also then documented.

4) If a patient is admitted to hospital, costs will continue to be incurred until such time as the patient is discharged.

As can be seen, the patient occupies a bed, undergoes tests and is treated by various professionals and with various drugs; they are then discharged – either returning to their home or are transferred to another healthcare facility such as aged care facility.

5) The Diagnosis Reporting Group (DRG) is then determined when the patient’s episode is clinically coded. Hospital revenue is then determined by whether the patient is public, private or compensable.

6) Documentation of complications determine additional ABF funding described at DRG +/- complications.
Importance of Administrative Processes

In terms of the patient journey, at all aspects of treatment encompass opportunities for the raising of revenue. But whether it is from individuals and health insurance funds or from other authorities is dependent on identifying the correct funding class of the individual patient, and being aware of the rules of each funding authority.