Australian Government
Department of Health

Request for Information

Modernising Health and Aged Care Payments Services Program

Commonwealth of Australia as represented by the Department of Health

Any questions regarding this RFI should be addressed to the RFI Contact Officer at the following address:
MACPenquiries@health.gov.au

Lodgement of Submission

Closing Time: 2.00 pm, 4 April 2017 (Canberra, Australian Capital Territory local time)

Submissions must be lodged in accordance with Part C of the RFI.

Request for Information

Modernising Health and Aged Care Payments Services Program

Part A – Introduction

1. Background

(a) Each year, through health and aged care programs, the Government makes in excess of 600 million payments to individuals and health and aged care providers, worth approximately $50bn.

(b) The current IT systems supporting health and aged care payments are a complex web, which have evolved over 30 years. The Medicare systems alone comprise over 200 applications and 90 databases, many of which are aging and based on obsolete technology.

(c) The systems are no longer fit for purpose. They are unable to support the level of flexibility and service innovation that users – individuals and providers – and the Government expect.

(d) To address this challenge, the Government has decided to replace the IT systems supporting health and aged care payments.

(e) Consistent with its digital transformation agenda, the Government is seeking to harness existing commercial technology to develop a new digital health and aged care payments platform (the Digital Payments Platform). The new Digital Payments Platform, underpinned by modern, reliable and flexible technology will support the Government continuing to own, operate and deliver health and aged care payments into the future.

2. Modernising Health and Aged Care Payments Services Program

(a) There are multiple departments involved in delivering the Commonwealth's health and aged care payments services. The Commonwealth Entities involved and their individual roles in delivering the health and aged care claims and payments are described in 'Supporting Attachment 2 – Department Roles'.

(b) The Government has established the Modernising Health and Aged Care Payments Services Program (the Program) to deliver the transformation of the health and aged care payments services and the implementation of a new Digital Payments Platform.

(c) The Program is expected to be completed over the coming several years and comprise multiple phases.

(d) The vision for the Program is to deliver a new Digital Payments Platform that supports a digital-first (or digitally enabled) service delivery business model and simpler, faster, easier services for users.

(e) The Program is seeking to deliver core infrastructure that can support an increased scale and scope of services over time, as detailed in this RFI.

(f) A cross-government team has been established to manage the Program, led by the Department of Health and supported by the Department of Human Services, the Department of Veterans' Affairs and the Digital Transformation Agency.

3. Government Objectives

The new Digital Payments Platform should meet the following objectives:

(a) supports contemporary, best practice health, aged care and related veterans' payments services now and into the future;

(b) supports a seamless experience for users of government services;

(c) supports the rapid implementation of new programs and policies, including any new, efficient, citizen-centric health and aged care models;

(d) uses innovation to support continuous improvement in claiming and payments services, in line with the Commonwealth's Digital Service Standard;

(e) supports streamlined, high integrity, secure service delivery, minimising manual touch points;

(f) delivers leading practice data capture and analytics capability; and

(g) meets all relevant legislative, regulatory and policy requirements, including privacy, cybersecurity and data law, including that it ensures security capabilities are best practice and all security requirements are met, both within and between each service layer.

4. The Request for Proposals process

(a) The Commonwealth intends to conduct a two stage Request for Proposals (RFP) process to support the design, development and procurement of the new Digital Payments Platform.

(b) It is currently anticipated that the RFP process will include the following stages leading up to implementation:

(i) Stage One: Request for Information (RFI) stage, which is designed to obtain information on how the new Digital Payments Platform should be designed and delivered; the capabilities that exist in the market to deliver it; and potential procurement approaches. The information received in this stage is expected to inform the development of the Commonwealth's requirements for Stage Two; and

(ii) Stage Two: the procurement phase, which will be designed to procure and deliver the preferred Digital Payments Platform approach. The preferred approach will be informed by the review of Submissions, information from other consultative processes and any other relevant information. It may include any one or a combination of procurement methods in order to facilitate the selection of one or more service providers and delivery of a fit-for-purpose Digital Payments Platform.

5. Purpose of this Request for Information

(a) This RFI is part of broader consultation with users, providers, key health and aged care sector stakeholders, and other interested parties.

(b) Through this RFI we are seeking to:

(i) identify innovative ideas and approaches to designing and delivering the Digital Payments Platform;

(ii) gain insight into how innovation and contributions from players of varying sizes and areas of focus can be integrated into the new Digital Payments Platform;

(iii) understand how to maximise participation in any future procurement process to ensure government makes use of information technology in as an effective way as possible, to deliver the best possible user services at the best possible cost;

(iv) validate market capability, capacity and interest;

(v) understand potential industry partnering opportunities;

(vi) understand indicative costs associated with different approaches;

(vii) understand risks to the Commonwealth arising from different approaches, including in relation to Commonwealth capability;

(viii) understand possible implementation timing and milestones, including how demonstrated progress could be achieved by early 2019; and

(ix) understand how transition might be managed.

(c) For the avoidance of doubt, we are only seeking Submissions that are consistent with the Government's commitment to own, operate and deliver health and aged care payment services into the future.

(d) The Commonwealth intends to use Submissions to help inform the development of its requirements for the new Digital Payments Platform and future procurement strategies. As such, lodging a Submission will assist in maximising any opportunities that could be available to the Respondent in any Stage Two Procurement.

(e) Submissions will not be competitively evaluated and the Commonwealth will not use this RFI or any Submission to shortlist suppliers for any Stage Two Procurement.

(f) Requirements for Submissions are included in Part C and Part D of this RFI. Submissions should be provided in the form set out in the Returnable Attachment 2 – Form of Response.

6. Timetable

The table below sets out the indicative timetable for the RFI. The Commonwealth may vary the timeframes.

Activity	Timeframe
Release of this RFI on AusTender	6 March 2017
Closing date for the receipt of questions / clarifications	2pm, 28 March 2017 (Canberra, Australian Capital Territory local time)
Closing Time for lodgement of Submissions	2pm, 4 April 2017 (Canberra, Australian Capital Territory local time)

At this stage, the commencement of Stage Two is indicatively scheduled for the middle of 2017.

7. RFI Contact Officer

(a) Prior to lodging a Submission, the Respondent may request clarification from the Commonwealth about any part of this RFI or any other information provided by the Commonwealth in relation to this RFI. All enquiries or requests for clarification are required to be:

(i) made in writing;

(ii) directed to the Contact Officer using the email address shown on the cover page of this RFI; and

(iii) received by the Commonwealth no less than five Business Days before the Closing Time.

(b) Further information regarding communications in relation to this RFI can be found in clause 12 of Part C.

8. Interpretation

(a) In this RFI, all capitalised terms have the meaning given in clauses 1 and 2 of Supporting Attachment 1 – Glossary, interpretation and precedence.

(b) In this RFI, except where the contrary intention is expressed, the interpretation rules in clause 3 of Supporting Attachment 1 – Glossary, interpretation and precedence apply.

(c) If any part of this RFI conflicts, the order of precedence set out in clause 4 of Supporting Attachment 1 – Glossary, interpretation and precedence applies.

Part B – Objectives and Scope

9. Overview

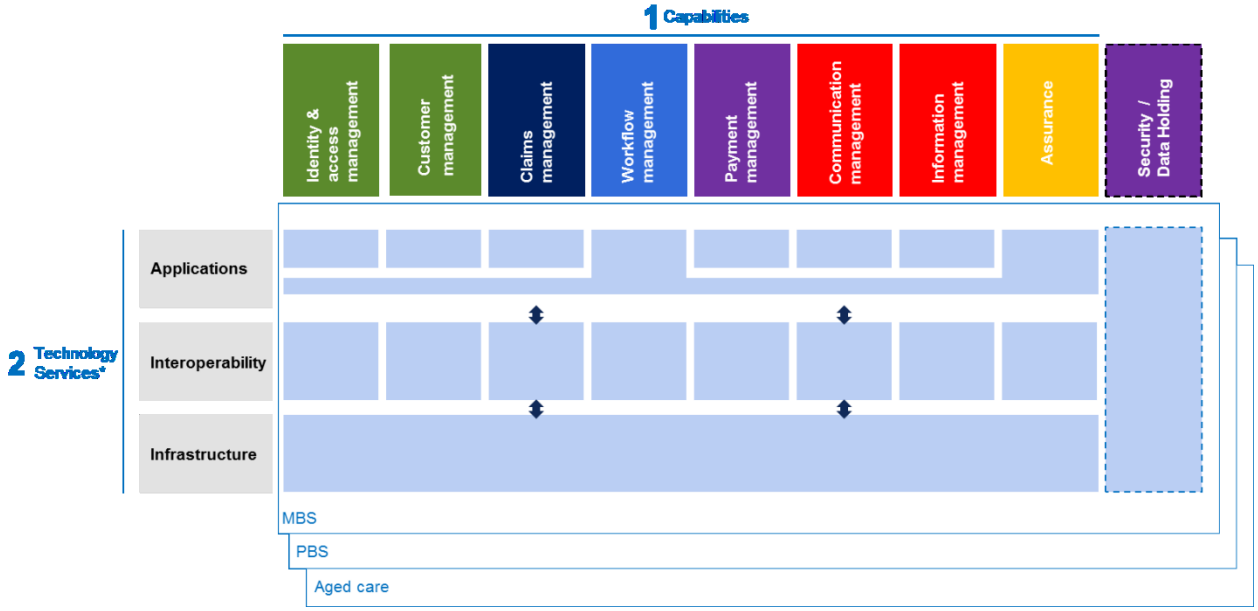
9.1 Overview

(a) The Commonwealth is seeking to implement a payments approach that delivers flexibility and service innovation.

(b) The new Digital Payments Platform should support the delivery of in-scope Programs and Payments through a range of payment types by providing applications, interoperability, and infrastructure technology services across each of the capabilities needed to execute the end-to-end claims and payment service.

(c) Figure 1 represents the Commonwealth's current thinking about the full range of components that would be required to achieve the Government Objectives and commitments.

Figure 1. Capabilities, Technology Services and Programs



(d) Through this RFI the Commonwealth is seeking information on approaches and technical service bundles that address all or some of the components (Component Solution) to inform the final design of the Digital Payments Platform and Stage Two Procurement.

(e) The Commonwealth has a strong focus on identifying innovative approaches.

9.2 Submissions

(a) This RFI is seeking information to inform the design and procurement of a new Digital Payments Platform, based on existing commercial technology. It provides Respondents with an opportunity to provide views on how the new Digital Payments Platform should be designed and delivered, based on existing commercial technology.

(b) Submissions should provide information on the approach the Commonwealth should take on implementing the new Digital Payments Platform, including in relation to technical approach, delivery approach, commercial and risk issues.

(c) Respondents are invited to provide information about any capabilities and solutions they could offer. Respondents are also invited to highlight their capabilities and relevant experience to inform future procurement strategies.

(d) A Respondent's Submission should relate to all Programs and Payments or provide rationale for why certain Programs and Payments are excluded and how these would otherwise be supported.

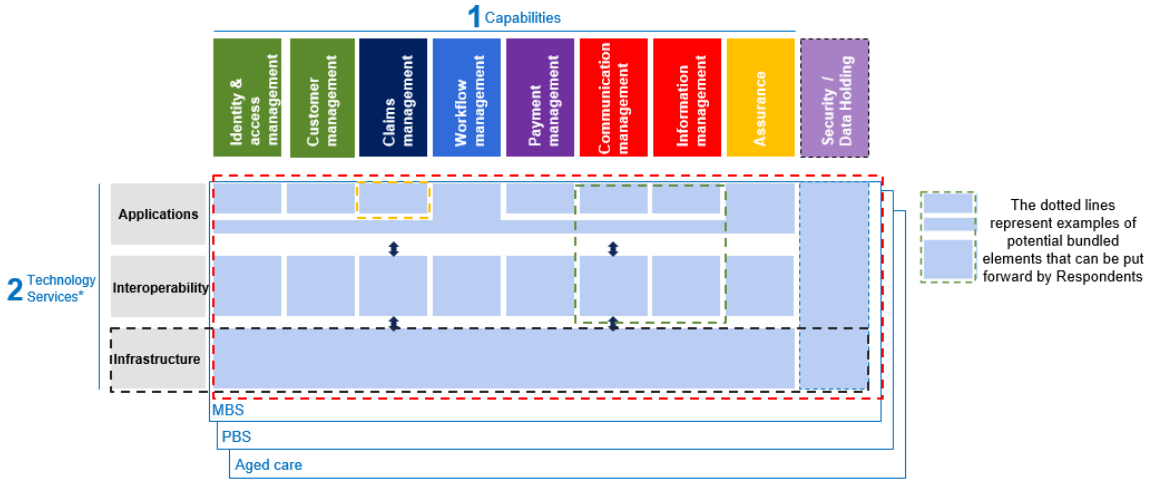
(e) Respondents should also describe the Component Solution addressed through their Submission.

(f) As illustrated in Figure 2, a Respondent's Submission:

(i) may relate to the provision of all or selected component(s) of the Capabilities; and/or

(ii) may relate to the provision of all or selected component(s) of the Technology Services.

Figure 2. Capabilities and Technology Services potential bundling



(g) As such, Respondents can propose different Component Solutions such as:

(i) applications and interoperability for certain Capabilities;

(ii) delivery of the overall Solution across all eight Capabilities and three Technology Services; or

(iii) infrastructure only across all Capabilities.

(h) The Government is seeking innovative ideas to inform the design of the Digital Payments Platform. Respondents may propose options that include characteristics of some or all of the following, provided they are consistent with the Government's commitment that the Government will continue to own, operate and deliver health and aged care payment services:

(i) Software as a Service (SaaS);

(ii) Platform as a Service (PaaS);

(iii) Infrastructure as a Service (IaaS);

(iv) Service Integration (SI); and

(v) Hybrid (SI + IaaS, SaaS + PaaS etc).

(i) Respondents are permitted to provide Submissions with a completely different approach, including different Capability and Sub-capability break-downs, if they consider that would better achieve the Government Objectives and commitments. This RFI is seeking to understand the different approaches that may be taken, and encourages all ideas and concepts to be put forward by Respondents. For the avoidance of doubt, the Government is not seeking proposals for outsourcing.

(j) Further, Respondents should provide Submissions as per Returnable Attachment 2 – Form of Response (including Annexure A – indicative costing template).

9.3 Current Solution Overview

The current solution architecture supporting existing claims and payments has been summarised at a high level in Supporting Attachment 3 – Current State Technology Overview. More detail will be provided in Stage Two to help inform a more detailed understanding of the complex system architecture.

10. Scope

10.1 Payment processing out of scope

Payment processing operations do not fall within the scope of the Program. The Commonwealth will continue to conduct the business processing of payments using the Solution, including providing any face-to-face or call centre support that may be required, discretionary decision-making, and shaping of the business rules to implement the Programs and Payments. The Solution should enable or contribute to the streamlining and simplification of these business processes where appropriate.

10.2 In Scope Programs and Payments

(a) There are currently over 60 programs that need to be supported by the new Digital Payments Platform, including Medical, Pharmaceutical, and Ageing and Aged Care Programs and specialised programs for veterans. A detailed list of in scope Programs and Payments can be found in Supporting Attachment 4 – Scope of Programs and Payments.

(b) The programs affect up to 99 per cent of Australians and require interactions with a broad range of medical and allied health providers, pharmacists, aged care providers as well as patients and care recipients.

(c) Australia's health and aged care systems are subject to ongoing review and reform as user needs change and new, citizen centric policies are developed. Accordingly the new Digital Payments Platform should be flexible enough to deliver the rapid implementation of any changes the Government may wish to make to deliver better health and well-being outcomes, including the introduction of any new programs or payment types. For example, the aged care system is undergoing reform to ensure it remains sustainable and continues to meet the needs of the aging population. It is expected this reform will require future adjustments to the Digital Payments Platform to support consumer choice and control of aged care services. Examples of previous system changes required to deliver new policies are included in 'Supporting Attachment 5 – Typical program changes and example of business needs that impact technology'.

(d) The current programs together support in excess of 600 million payments to individuals and providers each year. In 2015 - 2016:

(i) approximately 407 million services were claimed through MBS systems, of which 18 million were for veterans' MBS services and 96 percent of which were claimed electronically;

(ii) approximately 221 million services were claimed through PBS systems, of which 11 million were DVA's Repatriation Pharmaceutical Benefits Scheme (RPBS) services and 99 percent of which were claimed electronically on behalf of patients by pharmacists; and

(iii) approximately 55,000 aged care claims were processed through the main aged care systems for an average of 300,000 clients per month. The calculation of the monthly totals is based on daily eligibility and the means of income tested subsidy and supplement amounts for each care recipient at their level of care. Over 90 percent of these claims were made electronically by providers.

(e) Some relevant trends and volumetrics are included in 'Supporting Attachment 6 - Demographic trends and indicative volumes'.

(f) The Commonwealth currently has many different ways of paying providers or reimbursing patients and other 'customers' of Commonwealth-funded or Commonwealth-subsidised services. It is expected that the Solution will need to support existing payment types, which include:

(i) fee-for-service;

(ii) fee-for-service, with conditions attached to that service. For example: different fees for different 'concessional status' of the patient/customer; fees payable for one service only if another service is also provided; fees payable for one service only if other services are not provided; and fees paid up to an absolute dollar cap;

(iii) forms of payment linked to the treatment overall of a specified condition for a group of patients/customers, e.g., conditional payments based on age group; and

(iv) incentive payments to providers, linked to the carrying out of a volume of activity, or use of only certain item numbers in a schedule.

10.3 Capabilities and Sub-capabilities

(a) The Commonwealth expects that the Digital Payments Platform will need to provide certain Capabilities and Sub-capabilities in order to execute health and aged care payments services accurately and efficiently.

(b) The Commonwealth has identified eight (8) core Capabilities, common across all programs and payment types, that it expects would need to be supported by the new Digital Payments Platform. These eight (8) Capabilities are illustrated in Figure 3. Table 1 provides further description and examples.

Figure 3. Capabilities and Sub-capabilities

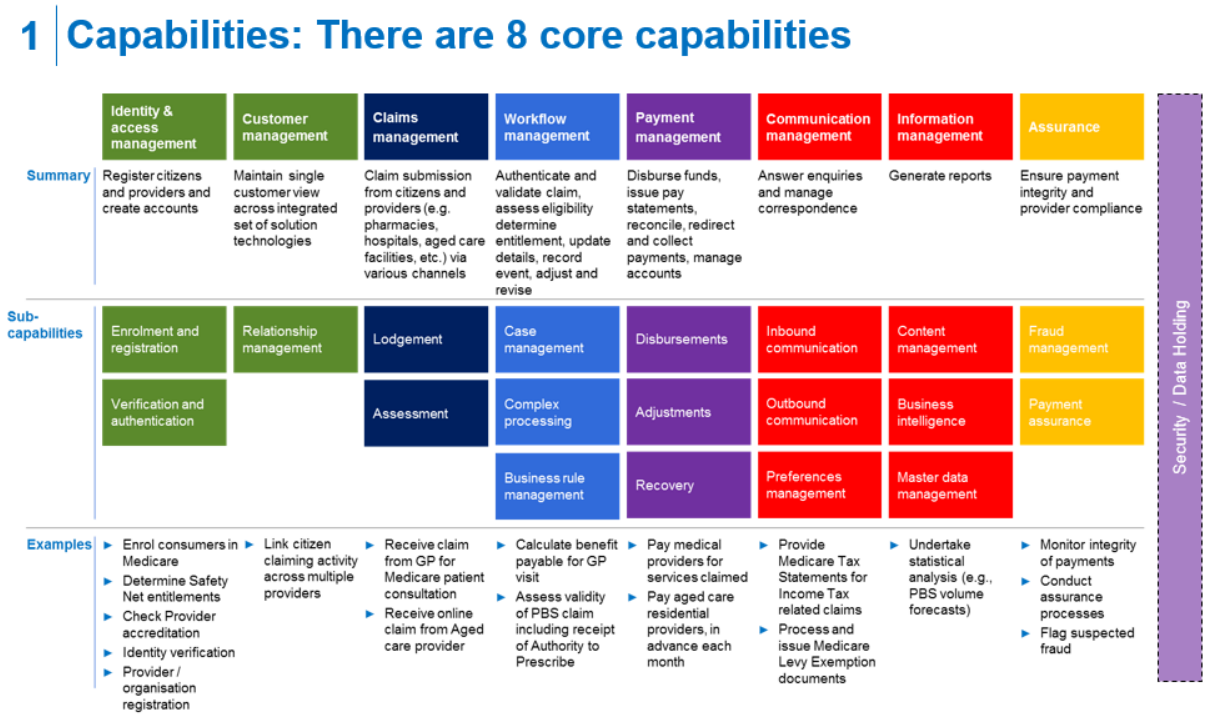


Table 1, below provides descriptions of each of the Capabilities and Sub-capabilities along with example Commonwealth activities.

Table 1. Capability and Sub-capability descriptions and examples

Capability	Sub-capability	Purpose	Example Commonwealth activities
1. Identity & Access Management	*Allows citizens and provider organisations to register and create user access to the Programs and Payments, including integration with current government capabilities that support Identity and Access Management through Digital Health (e.g. My Health Record).*		
	A. Enrolment and registration	Ability for a user or an organisation to register with the payment platform and manage enrolments for all Programs and Payments	Enrol consumers in Medicare Register, update and determine entitlements for Safety Net
	B. Verification and authentication	Ability for a user or an organisation to formulate a set of credentials to recognise themselves on the Solution	MyGov authentication and authorisation to Medicare online
2. Customer Management	*Maintain a single customer view across an integrated set of solution technologies, including integration with current government capabilities that support Customer Management through Digital Health (e.g. My Health Record).*		
	C. Relationship Management	Ability to record and manage user and organisation interactions	
3. Claims Management	*Claim submission from citizens and providers (e.g pharmacies, hospitals, aged care facilities, etc) via various channels*		
	D. Lodgement	Provides the functionality for patients, clients and providers to lodge claims, and ensure claims are authenticated, authorised and validated.	Receive claim submitted by General Practitioner for Medicare for patient consultations Receive claim submitted by Aged care provider online each month with details of care receivers
	E. Assessment	Provides the functionality to assess claim eligibility against business rules and ensure accuracy of assessment and payment	Assess the validity of a PBS claim – including ensuring Authority to Prescribe has been received, if required
4. Workflow Management	*Authenticate and validate claim, assess eligibility, determine entitlement, update details, record an event, adjust and revise*		
	F. Case Management	Ability to manage and track user or organisation requests from creation through to reaching an outcome	Claims for patients requiring multiple and/or ongoing treatments on separate occasions (e.g. assisted reproductive (fertility) treatments, chronic disease management) or multiple simultaneous services (heart lung transplants, cancer treatments (surgery, pathology, radiation) can be assessed with minimal administrator interaction

Capability	Sub-capability	Purpose	Example Commonwealth activities
	G. Complex Processing	Ability to handle exceptions that require additional processing which may require out of platform or manual intervention	Claims related to a patients' treatment across multiple sources, eg medical practitioners, health insurers, hospitals can be handled electronically
	H. Business Rule Management	Ability to define, configure and maintain the business rules derived from policies	Claim assessment rules for patient one-off and ongoing treatments and the respective eligible subsidies are validated in context of the patient
5. Payment Management	*Disburse funds, issue pay statements, reconcile, redirect and collect payments, manage accounts*		
	I. Disbursements	Ability to distribute funds	Pay medical providers for services claimed Reimburse patients Conduct monthly reconciliation of payments to pharmacists Pay aged care residential providers, in advance each month
	J. Adjustments	Ability to alter a payment based on the eligibility	
	K. Recovery	Ability to recover over payments	
6.Communication Management	*Answer enquiries and manage correspondence*		
	L. Inbound Communication	Ability to receive user or an organisations notifications	Patients/providers/pharmacists/aged care providers can communicate electronically/enquire about payment progress via phone (designated provider/patient enquiry lines), email or, in real time, via webchat Aged care providers can communicate electronically/enquire about payment progress via My Aged Care service provider portal
	M. Outbound Communication	Ability to send user or an organisation notifications	Providers can securely communicate with program areas, receive statements and notifications about programs, manage notifications (cf HPOS messages) Providers can register to receive electronic updates about changes to the MBS, PBS, etc
	N. Preferences Management	Ability to create and manage notification preferences	Securely create and manage MyGov user notifications preferences
7.Information Management	*Generate reports and provide business intelligence and analytics capability*		

Capability	Sub-capability	Purpose	Example Commonwealth activities
	O. Content Management	*Ability to create, manage, publish and support the lifecycle of information in any form*	Providers electronic update for MBS, PBS etc template management
	P. Business Intelligence	*Ability to collate and analyse data and report on insights according to business needs*	Provide trending information against claim and payment types for medical specialists
	Q. Master data management	*Ability to consistently define and manage organisational information*	Medicare, PBS, Aged Care data dictionary definitions
8. Assurance	*The Payment Assurance Capability provides data required for payment auditing, detection of fraudulent events, confirming the integrity of payments against relevant payments schedules and ensuring data quality standards are upheld. It also includes Security functions and requirements associated with securing payment transactions during processing, securing the data in the Solution (including physical security) and access control. This data may be required by all Capabilities*		
	R. Fraud Management	Ability to prevent and manage incidents of fraud	Monitor integrity of payments Conduct assurance processes to ensure checks and balances across process Flag suspected payment fraud and halt or recover payment.
	S. Payment Assurance	Ability to review compliance with policy and identify breaches	

Table 2. Security

Security requirements are embedded within each of the Technical Services and across the eight Capabilities.

Requirement	Technical Services Layer	Purpose	Example Commonwealth activities
1.Security	*Security consists of set of techniques, policies, and activities intended to enhance trust and mitigate vulnerabilities inherent in a complex service delivery ecosystem underpinned by a complex technology landscape.* *Security of the end to end technology ecosystem allows the citizens and the provider services to build trust across all participating parties and will enable the Commonwealth to meet relevant Government policies and the ICT security policies. This includes provision of audit and monitoring for intervention and response to security incidents to support the confidentiality, integrity and availability of information.* *Government policies include:* • *Australian Government Protective Security Policy Framework (PSPF)* • *Information Security Manual (ISM)* • *National Identity Security Strategy (NISS)* • *Australian Signals Directorate (ASD) Top 4 Strategies* • *Australian Security Intelligence Organisation (ASIO) T4 Protective Security Standards* • *Information Security Registered Assessors Program (IRAP)* *Legal and Legislative Policies include:* • *Privacy Act 1988* (Cth); • *Electronic Transactions Act 2011* (Cth); • *Archives Act 1983* (Cth); • *Cybercrimes Act 2001* (Cth).		

Requirement	Technical Services Layer	Purpose	Example Commonwealth activities
	A. Application Security	Ability to protect critical data from external or internal threats by ensuring there are no unintended flaws that allow access to the software used to run the business that compromise the customer/provider/government information The application environments will also have audit and logging enabled to monitor and manage privileged access to the system by operators and system admins etc. The management of privileged access is important to protect critical data from external or internal threats	Preserving privacy and confidentiality by logging the viewing of information by any participant in the system to limit browsing Ensure all user interactions are authenticated and authorised by appropriate level of information driven by user profile Support federated single sign-on for access Ensure all data inputs are validated for expected format prior to processing
	B. Interoperability Security	Secure the business services that provide the data exchange across the business functions with relevant authentication, authorisation and user/transaction context information to ensure data integrity and authenticity The services will also have audit and logging enabled to monitor and manage privileged access to the system by operators and system admins etc. The management of privileged access is important to protect critical data from external or internal threats	Information will be encrypted while in transit Authenticate or validate all authenticated users access Use the same identity credential when accessing all services in a process Support for coarse and fine grained access controls
	C. Infrastructure Security	Secure the core infrastructure services that provide the compute and serve the business service experience with high degree of transaction integrity, data storage, audit, archive, availability, backup and restore	Physical storage destruction at device end of useful life Backup all data including the software applications

Technology Services

10.4 Application layer

(a) The set of applications included in the Digital Payments Platform will need to deliver the business specification and rules of the Programs and Payments, in accordance with relevant legislative requirements. For further information refer to 'Supporting Attachment 7 – Key Legislation'. Commonwealth legislation is subject to change.

(b) The set of applications should also interoperate with claiming channels. 'Supporting Attachment 8 – Channels' sets out current manual and electronic claiming channels used in the lodgement of claims by users and the delivery of Programs and Payments. These channels are subject to change.

(c) The applications should be:

(i) **end-user centric** – Incorporate human-centred design; cater for a wide range of users; integrate with existing Government capabilities; utilise innovative user engagement principles; adhere to the Commonwealth's Digital Service Standard;

(ii) **digitally-enabled** - Support traditional digital user engagement through engaging web and mobile device experiences and extend the digital channels to innovative new channel experiences;

(iii) **device and channel agnostic** - Create a consistent look and feel and experience across devices, channels, interaction approaches and end-user segments; and

(iv) **readily extensible** – Meet future operational and system needs and enable innovation, flexibility and evolution at the same time by minimising the operational overhead and reducing delivery cycle times.

10.5 Interoperability layer / IT Service Catalogue

(a) The Commonwealth expects the Solution will need to interoperate with internal and external systems and other technology stacks to enable the exchange of information necessary to execute claims and payments services and act as a fully-functioning Solution.

(b) The Capabilities from the underlying technology and data environment and the platform will be pulled through the stack leveraging Application Programming Interface (API) technology and exposed as consumable, reusable services to:

(i) serve any User on any channel (e.g. customer management, identity management);

(ii) manage existing interactions and services in a digital way (e.g. customer management, workflow management);

(iii) innovate for new experiences by leveraging the native platform capabilities (e.g. enhance user/service experience);

(iv) work with digital tools to collaborate and manage business (e.g. case management, data and insights); and

(v) provide a consistent user experience.

(c) The Solution should include a model to support the management of data and workflows to enable interoperability between applications and rapid creation, continuous deployment, core stability, and tight data governance.

10.6 Infrastructure layer

The infrastructure component of the Solution should:

(a) include a collection of technical services, technology management applications, information, and infrastructure comprised of pools of compute, network, information, and storage resources;

(b) enable the components to be rapidly orchestrated, provisioned, implemented and decommissioned, and scaled up or down as required to meet the business needs;

(c) provide enhanced collaboration, agility, scaling, and availability, and provides the potential for cost reduction through optimized and efficient computing;

(d) provide for an on-demand utility-like model of allocation and consumption to best utilise the investment;

(e) ensure a high degree of information security and reliability;

(f) if it includes cloud services or data centres, comply with the following Commonwealth policies (in addition to ISM and PSPF):

  (i) gateway certification by the Australian Signals Directorate (ASD);

  (ii) IT security audit by a certified Information Security Registered Assessors Program (IRAP) assessor;

  (iii) security vetting of staff in accordance with the PSPF and undertaken by the Australian Government Security Vetting Agency (AGSVA);

  (iv) ASIO-T4 protective security audit of data centre by the Australian Security Intelligence Organisation (ASIO); and

  (v) 'Strategies to Mitigate Targeted Cyber Intrusions' by ASD.

(g) maintain data integrity and confidentiality, supporting additional controls and data classifications, and meeting all relevant security and data management standards and certifications;

(h) ensure all health internal and external user, management and operational information remains in Australia; and

(i) ensure business continuity.

Additional information on the current state is provided in Supporting Attachment 3 – Current State Technology Overview.

Part C – Submission lodgement

11. Closing Time

(a) Respondents must lodge their Submissions before the Closing Time set out on the cover page of this RFI.

(b) The Commonwealth may extend the Closing Time and if so, will issue an addendum accordingly.

12. Communications

12.1 AusTender, the Government Procurement System

(a) AusTender is the Government's procurement information system (**AusTender**). Access to and use of AusTender is subject to terms and conditions. In participating in the RFI process, Respondents should comply with those terms and conditions and any applicable instructions, processes, procedures and recommendations as advised on the AusTender website at https://www.tenders.gov.au/?event=public.termsOfUse.

(b) All queries and requests for technical or operational support should be directed to:

AusTender Help Desk
Telephone: 1300 651 698
International: +61 2 6215 1558
Email: tenders@finance.gov.au

The AusTender Help Desk is available between 9am and 5pm ACT local time, Monday to Friday (excluding ACT and national public holidays).

12.2 Communication between the Commonwealth and Respondents

(a) Respondents should direct all communications through the RFI Contact Officer by email in writing to the email address on the cover page of this RFI, unless advised otherwise by the RFI Contact Officer. Any notice by a Respondent to the Commonwealth will be effective upon receipt only if in writing and delivered to the RFI Contact Officer at the email address specified on the cover page of this RFI.

(b) Respondents should nominate a person for the purpose of answering enquiries which may arise during the RFI process. The name, address and contact details of that person should be included in the Submission.

(c) If a Respondent finds any discrepancy, error or omission in this RFI, that Respondent should notify the Commonwealth in writing as soon as possible.

12.3 Addenda, clarifications and other notices

(a) Subject to clause 12.3(b) of Part C, the Commonwealth will:

(i) respond to requests for clarification; or

(ii) vary or supplement this RFI,

by written notification issued on AusTender or in accordance with clause 12.4 of Part C and may do so on a non-attributable basis and without disclosing any confidential information of a Respondent.

(b) The Commonwealth may refuse to answer any question received less than five Business Days before the Closing Time or received otherwise than in accordance with this clause 12.3 of Part C.

(c) Respondents who have registered and downloaded the RFI documentation will be notified by AusTender via email of the issue of any addenda, clarifications or other notices in respect of the RFI documentation. It is in the interests of Respondents to ensure they have correctly recorded their contact details prior to downloading RFI documentation. If Respondents have not recorded their details correctly, they should amend their details and download the RFI documentation again.

(d) Respondents are required to log in to AusTender and collect addenda, clarifications and other notices as notified.

(e) The Commonwealth will accept no responsibility if a Respondent fails to become aware of any addendum notice which would have been apparent from a visit to the AusTender page for this RFI.

(f) If a Respondent has obtained RFI documentation other than from AusTender, they will need to visit AusTender, register as a user and download the RFI documentation for this RFI.

12.4 Other written notifications

The Commonwealth may deliver any written notification to a Respondent after the Closing Time by:

(a) leaving it or causing it to be left at the address; or

(b) sending it to the email address,

of the Respondent's Contact, as specified in the Submission, or as otherwise nominated in writing by the Respondent to the RFI Contact Officer.

12.5 Information provided to Respondents

(a) No representation made by, or on behalf of, the Commonwealth in relation to this RFI will be binding on the Commonwealth unless that representation is in writing and is incorporated into a formal agreement with the Commonwealth.

(b) No representation or warranty, express or implied, is made by the Commonwealth or any of its officers, employees, advisers or agents that the documents and information provided to Respondents are complete, accurate or up-to-date.

13. Information to be provided in Submissions

Respondents should provide as part of their Submission a completed:

(a) Submission Checklist; and

(b) Form of Response.

14. Other specific requirements for Submissions

14.1 Language

The Submission should be written in English.

15. Lodging a Submission

(a) Submissions must be lodged electronically via AusTender before the Closing Time and in accordance with the Submission lodgement procedures set out in clause 16 of Part C and on AusTender.

(b) Submissions lodged by any other means (including physically, facsimile or email), or after the Closing Time may not be accepted or considered.

16. Electronic lodgement

16.1 Preparing to lodge an electronic Submission

(a) *Submission File Formats, Naming Conventions and Sizes* – Respondents are to lodge their Submissions in accordance with the requirements set out in this clause 16.1(a) for file formats, naming conventions and file sizes. Failure to comply with any or all of these requirements may result in the Submission not uploading successfully.

(i) **Submission File Format** – Submissions should be lodged in Microsoft Word 2010 and Microsoft Excel 2010 or any subsequent versions or upgrades to those software products. While Submissions should be lodged in the specified formats, the Commonwealth may require Respondents to provide the relevant document or part of the Submission in its original format (ie, the file format prior to the file being converted into the accepted specified format) at any stage of the RFI process.

(ii) **Submission Naming Convention** – The Submission file name(s):

(A) should incorporate the Respondent's company name; and

(B) should reflect the various parts of the Submission they represent, where the Submission comprises multiple files.

(iii) **Submission File Size** – The Submission file size cannot exceed a combined file size of five (5) megabytes per upload.

(b) AusTender will accept up to a maximum of five files in any one upload of a Submission. Each upload should not exceed the combined file size limit of five (5) megabytes. If an upload would otherwise exceed five (5) megabytes, the Respondent should either:

(i) transmit the Submission files as a compressed (zip) file not exceeding five (5) megabytes; and/or

(ii) lodge the Submission in multiple uploads ensuring that each upload does not exceed five (5) megabytes and clearly identify each upload as part of the Submission.

(c) Submissions should comply with any recommended word limits specified in the Form of Response.

16.2 Late Submissions

Any attempt to lodge a Submission after the Closing Time will not be permitted by AusTender.

17. Alterations, erasures, additional information or illegibility

Should a Respondent become aware of any discrepancy, error or omission in its submitted Submission prior to the Closing Time, and wish to lodge a correction or additional information, that material should be in writing and lodged in the same manner as the Submission.

18. Clarification of Submission

(a) After the Closing Time, the Commonwealth may seek additional information or clarification on any matter from any Respondent.

(b) Respondents should:

(i) respond to any request for clarification or additional information within the time period and in the format specified by the Commonwealth; and

(ii) ensure that clarifying information provided answers the Commonwealth's enquiry.

Part D – Conditions of Submission

19. No contract or undertaking

(a) This RFI is an invitation for Respondents to provide information in connection with the Modernising Health and Aged Care Payments Services Program.

(b) No binding contract (including a process contract) or other understanding (including any form of contractual, quasi-contractual, restitutionary rights, or rights based upon similar legal or equitable grounds) will exist between the Commonwealth and a Respondent in relation to the information provided during the RFI process other than in respect of the licence granted in accordance with clause 24(c) of Part D.

20. Rights and liabilities of the Commonwealth

20.1 Rights

In addition to the other rights detailed in this RFI and without limiting its rights at law or otherwise, the Commonwealth may at any stage of the RFI process:

(a) amend this RFI;

(b) seek amended, or call for new, Submissions;

(c) allow any Respondent to change its Submission at any time;

(d) require additional information or clarification from any Respondent or anyone else at any stage of the RFI process and may review and consider such additional information provided by a Respondent or anyone else;

(e) make independent inquiries about any matters that may be relevant to the RFI and any Submission;

(f) provide additional information or clarification to Respondents;

(g) change the structure and timing of the RFI process;

(h) vary or extend any time or date in this RFI at any time and for such period as the Commonwealth may consider appropriate;

(i) reassess its needs in relation to the Modernising Health and Aged Care Payments Services Program;

(j) conduct other industry engagement activities in the relation to the Modernising Health and Aged Care Payments Services Program, including issuing any Stage Two Procurement documentation;

(k) decide not to proceed with any Stage Two Procurement;

(l) use information obtained through this RFI process to inform and conduct a Stage Two Procurement;

(m) obtain information and use information obtained outside of this RFI process to inform the Commonwealth in relation to the Modernising Health and Aged Care Payments Services Program including to inform and conduct Stage Two Procurement; and

(n) suspend or terminate the RFI process.

20.2 Commonwealth not liable

To the extent permitted by law, neither the Commonwealth nor its officers, employees or advisers will be liable to any Respondent on the basis of any promissory estoppel, quantum meruit or on any other contractual or restitutionary ground or any rights with a similar legal or equitable basis whatsoever or in negligence as a consequence of any matter or thing relating or incidental to a Respondent's participation in the RFI process, including instances where:

(a) the Commonwealth decides not to proceed with any or all parts of the Modernising Health and Aged Care Payments Services Program;

(b) the Commonwealth suspends or terminates the RFI process;

(c) the Commonwealth does not proceed with a Stage Two Procurement in relation to any component or all of the Modernising Health and Aged Care Payments Services Program;

(d) the Commonwealth decides to proceed with a procurement that is not an open tender for the Modernising Health and Aged Care Payments Services Program or any component of the Modernising Health and Aged Care Payments Services Program;

(e) the Commonwealth exercises or fails to exercise any of its other rights under or in relation to this RFI (whether or not the Commonwealth has informed a Respondent of its exercise of the rights);

(f) a Submission or any other material or communication relevant to this RFI is not received in time, is corrupted or altered or otherwise is not received as sent, cannot be read or decrypted, or has its security or integrity compromised; or

(g) the Commonwealth makes, or fails to make, information available to a Respondent relating to projected future, current or historical requirements.

20.3 Decision making

The Commonwealth has sole and absolute discretion in connection with any and all decisions or actions made or taken, refused to be made or taken or required to be made or taken, by it in connection with the RFI process. The Commonwealth has no liability to any Respondent for any such decision, action or refusal.

21. Respondents to meet costs and expenses

The Respondent's participation in any stage of the RFI process, or in relation to any matter concerning the RFI, is at the Respondent's sole risk, cost and expense. The Commonwealth will not be responsible for any costs or expenses incurred by any Respondent in preparation or lodgement of a Submission or taking part in the RFI process.

22. Acknowledgement

This RFI is issued, and Submissions will be lodged and reviewed and considered, on the basis that:

(a) lodgement of a Submission does not of itself entitle, qualify or disqualify a Respondent from being invited to participate in a Stage Two Procurement;

(b) the Commonwealth may approach other suppliers to provide information relevant to the Modernising Health and Aged Care Payments Services Program, including information the same as or similar to that requested by this RFI;

(c) Respondents will not, in deciding whether or not to lodge a Submission, or in preparing a Submission or in lodging a Submission, rely on:

(i) any representation (whether oral or in writing) other than as expressly set out in this RFI; or

(ii) any other conduct of the Commonwealth, or any of its officers, employees, advisers or agents;

(d) this RFI (and other documents and information provided by the Commonwealth) is designed to summarise information concerning the Commonwealth's requirement only and is not necessarily a comprehensive description of it; and

(e) to the maximum extent permitted by law, neither the Commonwealth, nor its officers, employees, advisers or agents will in any way be liable to any person or body for any cost, expense, loss, claim or damage of any nature arising in any way out of or in connection with any statement or other representations, actual or implied, contained in or omitted from this RFI or by reason of any reliance on them by any person or body.

23. Use of former Commonwealth personnel

(a) A Respondent should not, in the absence of written approval from the Commonwealth, permit a person to contribute to, or participate in, the preparation of the Respondent's Submission or the RFI process, if the person was at any time an employee of, service provider to, or otherwise engaged by, the Commonwealth and:

(i) was involved in an activity related to the Program during the 12 months immediately preceding the date of issue of this RFI or during the period from the date of issue of this RFI to the Closing Time; or

(ii) was involved in the preparation of this RFI or management of the RFI process.

(b) The Commonwealth may impose any conditions on its approval, including requiring statutory declarations from the Respondent or the relevant person.

24. Ownership of Submission files

(a) Intellectual property rights that exist in a Submission remain the property of the Respondent or other relevant third party.

(b) The Commonwealth will retain all files and documents lodged in response to this RFI to enable the review and consideration of Submissions for requirement development and procurement planning purposes, including to assist the Commonwealth identify, refine and cost the Solution or develop any part of the Modernising Health and Aged Care Payments Services Program, develop any aspect of the implementation strategy and to inform the preparation of any future capability development and solicitation documentation, and to comply with obligations relating to accountability and record keeping. Accordingly, Respondents lodge files and documents in response to this RFI on the basis that those files and documents will become the property of the Commonwealth.

(c) In lodging a Submission, and subject to clause 25 of Part D, Respondents grant to the Commonwealth a licence to use, reproduce, adapt, modify and disclose (including to the responsible Minister and any advisers) on a royalty-free, perpetual and irrevocable basis any material contained in a Submission, or provided by a Respondent in response to this RFI, for the purposes of:

(i) the RFI process, reviewing and considering or clarifying Submissions;

(ii) informing and developing any Stage Two Procurement undertaken by the Commonwealth in relation to the Modernising Health and Aged Care Payments Services Program or one or more components of the Modernising Health and Aged Care Payments Services Program, including for requirement development and procurement planning purposes and including to:

(A) assist the Commonwealth identify, refine and cost its requirement;

(B) develop any part of the Modernising Health and Aged Care Payments Services Program;

(C) develop any aspect of the implementation strategy; and

(D) inform the preparation of any future capability development and solicitation documentation;

(iii) audit requirements;

(iv) complying with governmental and parliamentary reporting requirements, including requests for information by Parliament or Parliamentary Committees;

(v) providing information to another person in the situations specified in clause 25(c) of Part D;

(vi) addressing any dispute concerning this RFI process;

(vii) any other purpose related to the RFI process; and

(viii) the development of any other procurement process conducted by the Commonwealth or verifying the currency, consistency and adequacy of information provided under any other procurement process conducted by the Commonwealth.

25. Use of Submissions

(a) The Respondents should note that the Commonwealth may need to use and disclose information from Submissions for the purpose of informing and conducting any Stage Two Procurement.

(b) Subject to clause 25(c) of Part D and to the use and disclosure of any such information for the purpose of informing and conducting any procurement processes after the RFI process, the Commonwealth undertakes to keep confidential all Submissions provided to the Commonwealth by Respondents prior to the completion of the RFI process.

(c) The obligation of confidentiality in clause 25(b) of Part D does not apply if the confidential information:

(i) is disclosed by the Commonwealth to its advisers or employees, or to other Commonwealth Entities and their advisers or employees, solely in order to consider Submissions, clarify a Submission or for a purpose specified in clause 24 of Part D;

(ii) is disclosed by the Commonwealth or other Commonwealth Entities to Ministers or the Parliamentary Secretary (and their advisers) or Cabinet, including for the purposes described in clause 25(c)(i) of Part D;

(iii) is disclosed to the Commonwealth's internal management and senior personnel, to enable effective management or auditing;

(iv) is disclosed by the Commonwealth, in response to a request by a House or a Committee of the Parliament of the Commonwealth of Australia;

(v) is shared by the Commonwealth within the Commonwealth, or with another State or Territory agency or department or a Commonwealth Entity, where this serves the Commonwealth's legitimate interests;

(vi) is disclosed by the Commonwealth in response to a request made by the Auditor-General, or by a person authorised by the Auditor-General;

(vii) is disclosed as agreed with the Respondent;

(viii) is authorised or required by law to be disclosed; or

(ix) is in the public domain otherwise than due to a breach of clause 25(b) of Part D.

26. Application of laws and Commonwealth policy

(a) The law applying in the Australian Capital Territory applies to this RFI and to the RFI process.

(b) Respondents should obtain, and will be deemed to have obtained, their own advice on the impact of legislation and related guidelines on their participation in this RFI process.

(c) Respondents should not make false or misleading statements in their Submissions. Respondents should be aware that giving false or misleading information to the Commonwealth is a serious offence under section 137.1 of the schedule to the *Criminal Code Act 1995* (Cth).

27. Security

(a) Respondents' attention is drawn to the:

(i) Protective Security Policy Framework, which sets out controls for the Government to protect its people, information and assets, at home and overseas (further information can be found at https://www.protectivesecurity.gov.au/Pages/default.aspx); and

(ii) the Information Security Manual, which is the standard that governs the security of government ICT systems (further information can be found at https://www.asd.gov.au/infosec/ism/). The ISM complements the PSPF,

and Respondents should familiarise themselves with those documents.

(b) More information in relation to security requirements that will apply to the new Digital Payments Platform (or any component of it), including any security classification, will be provided during the Stage Two Procurement.

28. Cloud computing policy

(a) Respondents' attention is drawn to the Government's position on cloud computing (further information can be found at https://www.finance.gov.au/cloud/).

(b) Respondents should note that non-corporate Commonwealth entities are required to use cloud services for new ICT services and when replacing any existing ICT services, whenever the cloud services are fit for purpose, offer the best value for money and provide adequate management of risk to information and ICT assets as defined by the Protective Security Policy Framework.

29. Disclosure of information

The *Freedom of Information Act 1982* (Cth) gives members of the public rights of access to official documents of the Commonwealth and its agencies. The *Freedom of Information Act 1982* (Cth) extends, as far as possible, the right of the Australian community to access information (generally documents) in the possession of the Commonwealth, limited only by considerations of the protection of essential public interest and of the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities.

30. Privacy

(a) The *Privacy Act 1988* (Cth), including privacy principles, provides a national scheme for the collection, use, storage and disclosure of personal information by the Commonwealth and certain entities.

(b) Any contract following a Stage Two Procurement will provide that the contractor is a 'contracted service provider', as defined in the *Privacy Act 1988* (Cth). Under the *Privacy Act 1988* (Cth), contracted service providers are required to comply with the *Australian Privacy Principles* as if they were an agency for the purposes of the *Privacy Act 1988* (Cth).

Request for Information

Supporting Attachment 1 – Glossary, interpretation and precedence

Modernising Health and Aged Care Payments Services Program

SUPPORTING ATTACHMENTS

Supporting Attachment 1 – Glossary, interpretation and precedence

1. Acronyms and abbreviations

In this RFI, the following abbreviations and acronyms are used:

Abbreviation	Description
DHS	Department of Human Services
DVA	Department of Veterans' Affairs
ECLIPSE	Electronic Claim Lodgement and Information Processing Service Environment
MBS	Medicare Benefits Schedule
PBS	Pharmaceutical Benefits Scheme
RPBS	Repatriation Pharmaceutical Benefits Scheme

2. Definitions

In this RFI, capitalised terms have the following meaning:

Term	Definition
Ageing and Aged Care Programs	the ageing and aged care programs specified in clause 4 of Supporting Attachment 4 – Scope of Programs and Payments.
AusTender	the Government online tendering system, described in clause 12.1 of Part C of the RFI.
Business Day	any day that is not a Saturday, Sunday or public holiday in Canberra, Australian Capital Territory.
Capabilities	the capabilities described in clause 10.3 of the Objectives and Scope.
Closing Time	the date and time by which Submissions must be lodged, as set out on the cover page of the RFI, as amended by any addendum issued in accordance with clause 12.3 of Part C of the RFI.
Commonwealth	the Commonwealth of Australia as represented by the Department of Health, ABN 83 605 426 759.
Commonwealth Entity	(a) a body corporate or an unincorporated body established or constituted for a public purpose by Commonwealth legislation, or an instrument made under that legislation; (b) a body established by the Governor-General or by a Minister of State of the Commonwealth including departments; or (c) an incorporated company over which the Commonwealth exercises control.

Term	Definition
Component Solution	an approach or a solution proposed by a Respondent in a Submission which addresses all or some components of the required Solution.
Department	the Commonwealth of Australia as represented by the Department of Health, ABN 83 605 426 759.
Digital Payments Platform	has the meaning given in clause 1(e) of Part A of this RFI.
Form of Response	the Returnable Attachment set out at Returnable Attachment 2 – Form of Response.
Glossary	the glossary for the RFI set out at Supporting Attachment 1 – Glossary, interpretation and precedence.
Government Objectives	has the meaning given in clause 3 of Part A of this RFI.
Information Security Manual or ISM	the document suite published by the Australian Signals Directorate that details controls, principles and rationale for information security on ICT systems, which can be accessed at http://www.asd.gov.au/infosec/ism/index.htm.
Medical Programs	the medical programs specified in clause 2 of Supporting Attachment 4 – Scope of Programs and Payments.
Medicare Benefits Program	has the meaning given in the *Guidelines for Medicare Benefits and Pharmaceutical Benefits Program* (Cth) issued under section 135AA of the *National Health Act 1953* (Cth).
Modernising Health and Aged Care Payments Services Program or Program	the program to modernise payment services for the Commonwealth's medical, pharmaceutical, and ageing and aged care programs, as well as related veterans' entitlement programs.
Objectives and Scope	Part B of this RFI and its attachments.
Pharmaceutical Benefits Program	has the meaning given in the *Guidelines for Medicare Benefits and Pharmaceutical Benefits Program* (Cth) issued under section 135AA of the *National Health Act 1953* (Cth).
Programs and Payments	the programs and payments described in clause 10.2 of the Objectives and Scope.
Protective Security Policy Framework or PSPF	the Government's protective security requirements for the protection of its people, information and assets (which replaced the *Commonwealth Protective Security Manual 2005*), as amended or replaced from time to time.
Request for Information or RFI	the Request for Information in relation to the Modernising Health and Aged Care Payments Services Program, including the RFI terms and conditions, Objectives and Scope, attachments, schedules, annexures and any related addenda issued by the Commonwealth.
Respondent	a respondent or potential respondent to this RFI.
Returnable Attachment	a document titled returnable attachment attached to this RFI.
RFI Contact Officer	the person to whom enquiries regarding the RFI should be directed. The RFI Contact Officer contact details are set out on the cover page of the RFI.
Solution	the overall solution for the provision of a digital payments platform described in the Objectives and Scope.

Term	Definition
Stage Two Procurement	any procurement process subsequent to this RFI, in relation to the Program.
Sub-capabilities	the sub-capabilities as described in clause 10.3 of the Objectives and Scope.
Submission	all documents and materials lodged, submitted or provided by a Respondent in response to the RFI.
Submission Checklist	the checklist set out at Returnable Attachment 1.
Supporting Attachment	a document titled supporting attachment attached to this RFI.
Technology Services	the technology services described in clauses 10.4 - 10.6 of the Objectives and Scope.

3. Interpretation

In this RFI, except where the contrary intention is expressed:

(a) a reference to time, unless specified otherwise, is to the time in the Australian Capital Territory;

(b) words importing a gender include each other gender;

(c) words in the singular include the plural and vice versa;

(d) a reference to A$, $A, dollar or $ is to Australian currency;

(e) if any word or phrase is given a defined meaning, any other part of speech or other grammatical form of that word or phrase has a corresponding meaning;

(f) a reference to a clause, paragraph, schedule or annexure is to a clause, paragraph, schedule or annexure to this RFI;

(g) a reference to a person includes a natural person, partnership, body corporate, association, governmental or local authority, agency or other entity;

(h) a reference to a statute, ordinance, code or other law includes regulations and other instruments under it and consolidations, amendments, re-enactments or replacements of any of them; and

(i) the meaning of general words is not limited by specific examples introduced by including, ‘for example’ or similar expressions and the word ‘include’ is not a word of limitation.

4. Precedence

If any part of this RFI conflicts with another part, the part higher in the following list will take precedence:

(a) Parts A, C and D – respectively Introduction, Submission lodgement and Conditions of Submission;

(b) Supporting Attachment 1 – Glossary, interpretation and precedence;

(c) Part B – Objectives and Scope;

(d) Supporting Attachments 2-8 – Department roles, Current State Technology Overview, Scope of programs and payments, Typical program changes and examples business needs that impact technology, Demographic trends and indicative volumes, Key legislation and Channels; and

(e) Returnable Attachments 1-2 – Submission Checklist and Form of Response.

Australian Government
Department of Health

Request for Information

Supporting Attachment 2 – Department roles

Modernising Health and Aged Care Payments Services Program

Supporting Attachment 2 – Department roles

1. This Supporting Attachment

This Supporting Attachment provides an overview of the Commonwealth Entities involved in health and aged care claims and payments. It provides additional information to Part A – Introduction.

2. Overview of Departments

2.1 Relevant agencies

The Commonwealth Entities involved in health and aged care claims and payments comprise the Department of Health (the Department), Department of Veterans' Affairs (DVA), and Department of Human Services (DHS). The Department of Social Services (DSS) offers additional support to DHS for aged care.

2.2 Department of Health

(a) The Department promotes, develops, and funds health and aged care services for the Australian public.

(b) The Department has a diverse set of responsibilities, but throughout there is a common purpose, which is reflected in the Vision statement: 'Better health and wellbeing for all Australians, now and for future generations.' The Department aims to achieve the Vision through strengthening evidence-based policy advice, improving program management, research, regulation and partnerships with other Government agencies, consumers and stakeholders.

2.3 Department of Veterans' Affairs

(a) DVA delivers government programs for war veterans, current and former members of the Australian Defence Force, the Australian Federal Police and their dependants.

(b) DVA and DHS are currently conducting a business case for the transformation of DVA – from a focus on claims processing, to a client focused, responsive and connected service. This business case forms part of the strategic plan, *DVA Towards 2020*, which sets a high-level strategic direction for departmental planning. Key components of this strategy are to upgrade and integrate IT systems, reduce claims processing times, and develop policies for delivering improved compensation and support to clients. *DVA Towards 2020* will drive business planning and improvements of DVA's future service delivery.

2.4 Department of Human Services

DHS supports individuals, families and communities to achieve greater self-sufficiency; through the delivery of policy advice and high quality accessible social, health and child support services and other payments; and support providers and businesses through convenient and effective service delivery. DHS provides these services through the following programs:

(a) Medicare and associated health support programs;

(b) Pharmaceutical Benefits Scheme

(c) Health payments on behalf of Veterans affairs;

(d) Aged care including home care and residential programs;

(e) Centrelink (not in scope for this RFI); and

(f) Child support (not in scope for this RFI).

2.5 Department of Social Services

(a) DSS works in partnership with other government and non-government organisations to ensure the effective development, management and delivery of policies, programs, and services focused on improving the lifetime wellbeing of people and families in Australia.

(b) DSS is part of the Social Services Portfolio with DHS, which is administered separately.

(c) Aged care moved from the DSS portfolio to the Department's portfolio in 2015.

Australian Government

Department of Health

Request for Information

Supporting Attachment 3 – Current State Technology Overview

Modernising Health and Aged Care Payments Services Program

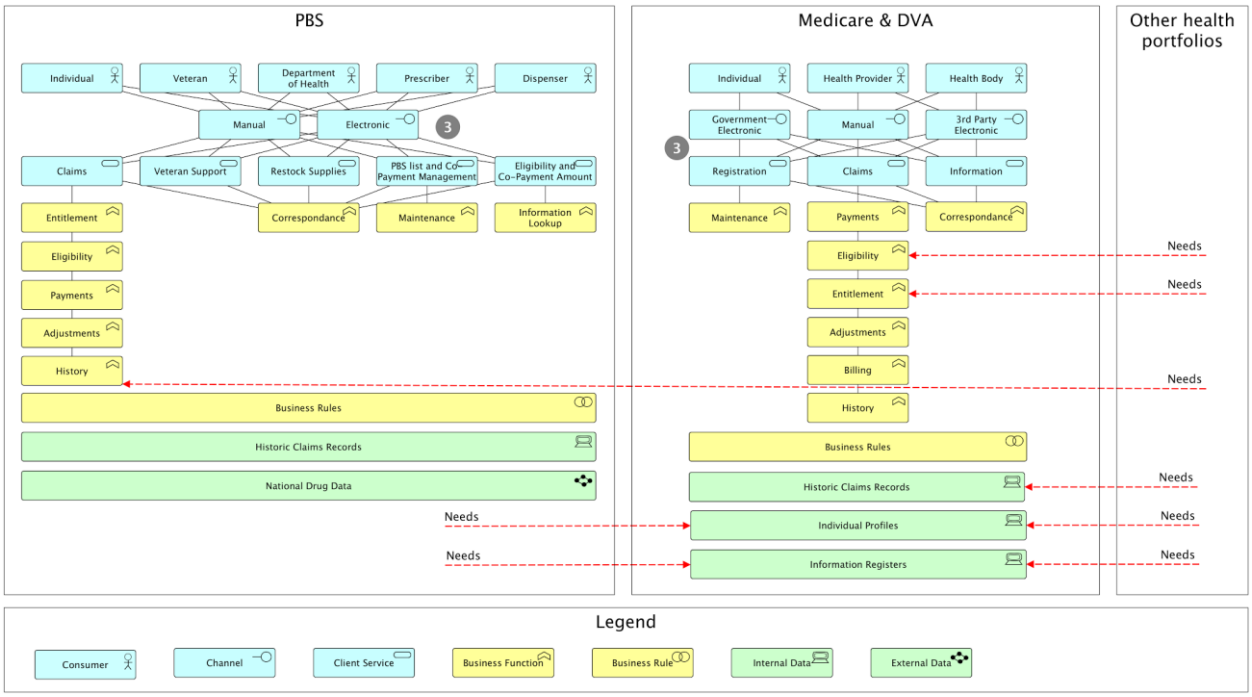
Supporting Attachment 3 – Current State Technology Overview

1. Technology Overview

The existing IT landscape supporting the end to end claims and payments journeys for health care consumers, providers and health fund providers is ageing with a significant portion of the underlying technologies delivering the services today past or near end of life. The existing applications enable user engagement, business process orchestration, business rules execution and customer service management through to payment management.

There are complex integrations for data exchange within the business programs and across the health and aged care sector to facilitate easier interactions at the point of service, for example: the doctor's surgery, or aged care facility.

To support the policy goals as they have evolved over successive governments the current systems have become increasingly complex with a tightly coupled and inflexible architecture.



The current system architecture consists of three key areas of technology enablement that complete the health payments ecosystem, they are:

(a) consumer and provider interaction channels that enable engagement with consumers;

(b) core business functional logic and rules that orchestrate the health service entitlement; and

(c) payment disbursement and reconciliation for payment assurance.

2. Consumer and provider interaction channels

There are currently several consumer channels available for the user to access health and aged care services in various methods, including at the point of service, online, through a call centre or at a government shopfront.

Providers make use of digital and call centre channels to interact with the systems and receive payment for services and products delivered.

Across the variety of health and aged care services there are several bespoke entry points and processes to support the entry of different claim types under different business rules. Both the consumer and provider web experiences are bespoke applications, built, hosted and managed by DHS with different authentication processes for consumers and providers.

External software systems connect to the current system using custom adapters that are implemented and supported by DHS. There are around 400 adapters currently in use by third party software companies. Changes to these adapters would require health providers to update their software.

The systems are currently required to support greater than or equal to 98% availability, 24 hours a day every day of the year.

3. Customer Management and Workflow Management

The Department of Health governs the health and aged care related policy, these policies are managed as rules within the current systems, such as in the 'Medicare Common Assessing' application. This core system is integral to every Medicare claim that is requested by the user/provider and performs the eligibility and endorsement of the claim based on the consumer and provider eligibility criteria as per the government's policy and set fee for the service.

While the vast majority of claims are electronically lodged, a significant portion of these claims currently require manual processing before payment can be processed, resulting in an incomplete end to end digital process for some consumer and provider payments.

Consumer and provider data is managed through several main 'System of Record' (SOR) applications that register each user and provider and their respective claim history (with support from other components in the architecture). These applications are:

(a) Provider Directory System (PDS)

(b) Consumer Directory Maintenance System (CDMS)

(c) Pharmaceutical Benefits Scheme (PBS)

(d) System for Payment of Aged Residential Care (SPARC)

(e) Aged Care Management Payment System (ACMPS).

These directories for consumer and provider business are critical applications for the vast majority of the current DHS health and aged care program transactions. These applications are hosted on mainframe and midrange technologies. The applications were built and are supported by DHS.

There are a significant number of other business critical services that support the end to end processes of, registration, connect to claim, consumer and provider claim eligibility services that support the 'SOR' applications.

There are also systems to monitor and re-examine both consumer and provider eligibility and policy compliance.

4. Payment Management and Reconciliation

(a) There are four key payment systems shared across the programs in the architecture. Fin-net, CPS and EPS provide the payment gateway capabilities. Both Fin-net and CPS are used to make payments for consumers and providers. DHS uses the SAP FI/CO module for payments through the Reserve Bank of Australia.

(b) Reconciliatory services are provided by BRUCE and Medicare BREFTE for Cheque and EFT payments respectively.

Request for Information

Supporting Attachment 4 – Scope of programs and payments

Modernising Health and Aged Care Payments Services Program

Supporting Attachment 4 – Scope of programs and payments

1. This Supporting Attachment

This Supporting Attachment provides an overview of the key program payment types within the Medical (including Repatriation Medical Fee Schedule (DVA) programs), Pharmaceutical (including RPBS programs) and Aged Care (including veterans' programs) entitlement programs which are in-scope for this RFI. This Supporting Attachment provides additional information to Part B – Objectives and Scope. Note: The information presented in this attachment may continue to be modified.

2. Medical Programs

The major medical program, Medicare, is a Government program that provides access to medical and hospital services. All Australian residents, as well as certain categories of visitors to Australia, can enrol in Medicare and access these services.

The Medicare Benefits Schedule (MBS) lists services that are subsidised by the Government under Medicare. Medicare covers:

- free or subsidised treatment by health professionals such as doctors, specialists, optometrists, and in specific circumstances, dentists, and other allied health practitioners
- free treatment and accommodation for public Medicare patients in a public hospital
- 75% of the Medicare Schedule fee for services and procedures for a private patient in a public or private hospital – this does not include hospital accommodation and items such as theatre fees and medicines.

The Department of Health is responsible for developing Medicare policy and the Department of Human Services administers Medicare and the payment of Medicare benefits. DHS' key responsibilities are:

- implement key health-related initiatives
- improve the effectiveness and efficiency in the delivery of health and pharmaceutical payments and services
- administer Veterans' Affairs processing on behalf of the Department of Veterans' Affairs.

The following medical program payment types are in scope for this RFI.

Table 1. Scope of medical programs

A: Major program payment type	B: Specific program within major program payment type
Core MBS claims (excluding DVA Repatriation Medical Fee Schedule)	MBS items (excluding ancillary items such as Cleft Lip and Cleft Palate Scheme below) Medicare Safety Net
Repatriation Medical Fee Schedule (RMFS) and other DVA specific claims	RMFS and other DVA specific items, including: • Local Medical Officer (LMO) consultations • Specialist consultations • Medical services (including DVA-specific claims) • Dental services • Public hospitals and private hospitals • Allied Health services • Allied Health care products • Access to DVA funded Health Services for

A: Major program payment type	B: Specific program within major program payment type
	British and Commonwealth Allied Veterans (BCAL) • Vietnam Veterans' Sons and Daughters Support Program • Coordinated Veterans' Care
Ancillary medical payments programs delivered through MBS	Cleft Lip and Cleft Palate Scheme
Other medical payments programs with linkages to MBS	Practice Incentive Payments: 11 incentives paid to medical practices and individual providers to encourage improvements in general practice. These apply to: • Aged care access • After hours • Asthma • Cervical Screening • Diabetes • eHealth • Indigenous health • Procedural GP Payment • Quality prescribing • Rural loading • Teaching
	Health Care Homes Practice Nurse Incentive Program Radiation Oncology Health Programs Grant Scheme Child Dental Benefits Schedule External Breast Prostheses Reimbursement Program GP Rural Incentives Rural Procedural Grants Program
Other medical programs	Medical Treatment Overseas Hearing Services Program Compensation Recovery Program Disaster Health Care Assistance Scheme Australian Immunisation Register National Bowel Cancer Screening Register
Insurance Support Payments	Medical Indemnity Support Scheme Private Health Insurance Rebate Midwife Professional Indemnity Scheme
Other DVA medical payments	Travel for Treatment, including Ambulance Services Rehabilitation Appliances Hearing Services Program (DVA) Household services Community Nursing Attendant care

3. Pharmaceutical Programs

The Pharmaceutical Benefits Scheme (PBS) is a Government program that benefits all Australians by subsidising medicines to make them more affordable. The Scheme is available to all Australian residents who hold a current Medicare card. Overseas visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA) are also eligible to access the Scheme.

The PBS Schedule lists all of the medicines available to be dispensed to patients at a Government-subsidised price.

The Scheme is managed by the Department of Health and administered by the Department of Human Services.

The following pharmaceutical program payment types are in scope for this RFI.

Table 2. Scope of pharmaceutical programs

A: Major program payment type	B: Specific program within major program payment type
Core PBS claims (excluding RPBS)	PBS items including the following special arrangement programs • Growth Hormone • Efficient Funding of Chemotherapy • Highly Specialised Drug Program • Botulinum toxin Program PBS Safety Net (and Processing Fee)
Core DVA PBS (paid against the Repatriation Pharmaceutical Benefits Scheme) (RBPS)	Including Veterans' RPBS specific items, that is, items not available under the general PBS, but only to eligible veterans.
Programs under 6th Community Pharmacy Agreement	Dispensing Fee AHI Fee Dangerous Drug Fee Premium Fee Dispensing Incentive Fund Chemotherapy Compounding Fee Medication Adherence Programs • Dose Administration Aids • Staged Supply • Clinical Interventions Medication Management Programs • Home Medicines Review • Residential Medication Management Reviews • MedsCheck Aboriginal and Torres Strait Islander (ATSI) Specific Programs • Quality Use of Medicines Maximised for ATSI People (QUMAX) • S100 Support Allowance • ATSI Workforce Programme Rural Support Programmes • Rural Pharmacy Workforce Program • Rural Pharmacy Maintenance Allowance

A: Major program payment type	B: Specific program within major program payment type
Ancillary pharmaceutical payments delivered through PBS / RPBS	Paraplegic and Quadriplegic Program Closing the Gap PBS co-payment Remote Area Aboriginal Health Services
Other pharmaceutical payments with linkages to PBS	Continuing Medication Opiate Dependence Treatment Program
Payments for provision of services and/or medical aids or appliances	Stoma Appliances National Epidermolysis Bullosa Dressing Scheme National Diabetes Services Scheme
Other pharmaceutical programs	Life Saving Drugs Program (LSDP)

4. Ageing and Aged Care Programs

The Government Aged Care programs provide subsidised care services to over 1.2 million older Australians. This includes the provision of a range of services and programs to help older people to live independently in their own homes; to transition from hospital care; to access restorative care and, where older people are unable to continue living independently in their own home, through access to subsidised residential care.

The Government supports the provision of services through a variety of aged care payments and subsidies to aged care providers to assist eligible care recipients in meeting the costs of those services. Each program or package has eligibility criteria and an assessment process to ensure older Australians receive the care and support they need.

The Aged Care programs are managed by the Department of Health, and means testing and payments are processed by the DHS. DHS' key responsibilities are:

- delivery of accurate information and payments through ongoing program integrity and compliance initiatives;
- maintaining strong external stakeholder relationships to enhance the delivery of aged care programs; and
- contribute to delivering significant changes to the aged care sector in support of the government's Aged Care Reform package

The following ageing and aged care program payment types are in scope for this RFI.

Table 3. Scope of ageing and aged care programs

A: Major program payment type	B: Specific program within major program payment type
Residential	Residential Care Residential Respite Transition Care Short-term restorative care Veterans' Residential Aged Care (DVA) POWs in Residential Care (DVA) Residential Respite in Commonwealth Aged Care facilities(DVA) Residential Respite in Institutions (Supported Residential Service) (DVA) Convalescent Care in non-hospital (DVA)

A: Major program payment type	B: Specific program within major program payment type
Home Care	Home Care Package Veterans' Home Care (DVA) In Home Respite and Emergency Short-Term Home Relief (ESTHR) (DVA)
Other non-grant programs	Continence Aids Payment Scheme Support Services for Remote and Indigenous Aged Care (*emergency payments only)* Aged Care Education Training Incentive (ACETI) *note: no new claims being accepted. Payments for remaining clients until 2020.*

Note: Grant payments such as the Commonwealth Home Support Program are not in scope.

Disclaimer: The list above is current at the date of this document and may change depending on policy direction in the future.

Request for Information

Supporting Attachment 5 – Typical program changes and example business needs that impact technology

Modernising Health and Aged Care Payments Services Program

Supporting Attachment 5 – Typical program changes and example of business needs that impact technology

1. This Supporting Attachment

This Supporting Attachment provides an indicative overview of typical level of program changes as well as a number of example business needs which will have an impact on the Solution. This Supporting Attachment provides additional information to Part B – Objectives and Scope.

2. Typical program changes

2.1 Overview

This section of this Supporting Attachment provides an indicative overview of typical level of change supported by the existing claims and payments systems for MBS, PBS, Veterans' and Aged Care payments.

This Supporting Attachment provides additional information to Part B – Objectives and Scope.

2.2 Overview

Ongoing system changes occur over two broad categories:

(a) *Policy changes:* implementing MBS, PBS, Veterans' and Aged Care service and policy measures which require claims assessment and payment changes; and

(b) *Regular variance to schedules:* implementing ongoing changes to relevant schedules that occur frequently.

In addition to these two broad categories, there are regular maintenance updates. These involve monthly minor updates (including fixes) across all aspects of the services.

The sections below provide more information about the indicative level of change associated each of MBS, PBS, Veterans' and Aged Care.

2.3 Medicare Benefits Scheme

MBS can typically involve the following number of changes each year:

(a) *Policy changes*: Over the period of many governments there have historically been anywhere from monthly to once a year and can vary considerably.

(b) *Regular variance to schedules:* over the period of many governments there have historically been a varied number of amendments to MBS schedule items made each month for processing a month ahead of the effective date. The major releases generally occur in January, May, July and November. Typically, changes in January are relatively minor; changes in May build on Mid-year Economic and Fiscal Outlook changes; modifications in July cover fee indexation (three tables are required to be updated annually based on fee increases); and Budget changes occur in November. However, there are no set rules on these releases and the extent of the changes can vary in complexity and timing. MBS changes can also be made outside these periods.

Over the period of many governments, these have historically been, on average, four "standard" changes to MBS schedule items which fall within this category:

(a) each batch can amend, delete or add between 20 to 300 items, application clauses or descriptors.

(b) Indexation changes in July. This typically requires indexation of the MBS fee for approximately 5,800 items.

In addition, over the period of many governments, there have historically been, on average, 2 to 4 minor changes which are outside the normal, "standard" changes. These are typically a handful of amendments, deletions or additions to items.

2.4 Pharmaceutical Benefits Scheme

PBS can typically involve the following number of changes each year:

(a) *Policy changes:* Over the period of many governments, there have historically been approximately one to four policy changes each year requiring a system change. A baseline indication from past policy requirements includes one major policy or program change, a moderate policy or program change and two or more smaller changes per annum. When a Community Pharmacy Agreement is negotiated, a large number of changes are usually required within a relatively short period of time.

In addition, there are ad hoc complex changes to PBS/RPBS schedule listings which require system changes to ensure accurate claims processing. This includes changes to eligibility conditions and other criteria. These changes may be linked to an MBS schedule listing, but are in many cases specific to PBS/RPBS and involve additional processing complexity; and

(b) *Regular variance to schedules:* The major releases for changes to the PBS occur in March, June, September and December. Over the period of many governments there have historically been approximately 1,200 to 1,500 changes to the PBS schedule each year, reflecting additions and deletions of items. This typically includes around 300 to 400 new listings per year.

2.5 Department of Veterans' Affairs

DVA participates in the implementation requirements of the broader MBS and PBS policy changes by governments where relevant to DVA operations.

There are also Veterans' specific medical, allied and pharmaceutical policy changes to related schedules and business rules. This can typically involve the following number of changes each year:

(a) *Policy changes:* Major Veterans' specific policy changes tend to occur from time to time and do not typically require claims assessment and payment system changes outside 'business-as-usual' variances; and

(b) *Regular variance to schedules:* There are approximately 1,400 regular changes / variances to items which are separate to core MBS and PBS and are DVA specific schedules, such as RPBS. This comprises approximately 200 additions, 200 amendments and 1,000 deletions.

2.6 Aged Care

Aged Care services can typically involve the following number of changes per year:

(a) *Policy changes:* over the period of many governments there have historically been approximately two smaller reforms per year requiring major system changes; and

(b) *Regular variance to schedules:* while there is no relevant "schedule" for Aged Care as there is for MBS and PBS, over the period of many governments there have historically been approximately 20-40 standard changes a year (based on 2 to 3 standard changes per month).

3. Example Business Needs

3.1 Overview

This section of this Supporting Attachment provides examples of instances where business or legislative needs mean that there are certain conditions, data sets or additional checks that apply to the payments and claims process. These are provided to illustrate a variety of complex program considerations and are non-exhaustive. This Supporting Attachment provides additional information to Part B – Objectives and Scope.

3.2 Aged Care

Program Description	On 1 October 1997, *the Aged Care Act 1997* (Cth) came into force. This legislation is the basis upon which Residential and Home Care programs are delivered. Subsequent to this date, a number of legislative changes have been made to support aged care reforms. Many of the changes have been implemented through primary legislation, however some changes have also been implemented through subordinate legislation – namely the Aged Care Principles and the Aged Care Determinations.
Payment Type	Aggregated subsidy payment – monthly in advance and reconciled monthly in arrears.
Business Need	A key principle has been followed over time to ensure that existing care recipients are not disadvantaged by changes to aged care legislation subsequent to their entry into aged care. In line with this, the arrangements for care recipients who were already in care at the time have been maintained regardless of future changes, and this is referred to as grandfathering (or grandparenting) provisions. The System for Payment of Aged Residential Care (SPARC) system is used to support the management of care recipient classification and subsequent subsidy/supplement payments for residential aged care and has been in place since the introduction of the *Aged Care Act 1997* (Cth). Since 1997 there have been numerous changes made to SPARC to accommodate amendments to the legislation, while at the same time continuing to accommodate grandfathering provisions over time. In addition, further changes have been made to SPARC to address operational issues which may have a similar impact on a grandfathered person.
Data/System links	• SPARC (payments to providers of residential and transition care services) • CASPER (data warehouse and reporting) • NAPS (aged care provider approvals and places management) • ACMPS (payments to providers of home care services) • My Aged Care (eligibility, assessment, assignment of funding and referrals to services)

3.3 Medicare Safety Net

Program Description	**Medicare Safety Net** The Original Medicare Safety Net works in conjunction with the Extended Medicare Safety Net. **Original Medicare Safety Net** (OMSN) Under the OMSN, once the annual threshold is reached, Medicare benefits increase to 100 per cent of the Medicare Benefits Schedule (MBS) Fee for all out of hospital services for the rest of the calendar year. The maximum amount of out-of-pocket cost per service that can count towards the OMSN threshold is the 'gap amount', i.e. the difference between the Medicare rebate and the MBS Fee. The OMSN is calculated prior to the EMSN. The OMSN threshold from 1 January 2017 is $453.20. This threshold is indexed by the Consumer Price Index (CPI) on 1 January each year. **Extended Medicare Safety Net** (EMSN) The EMSN provides an additional rebate for Australian families and singles who incur out-of-pocket costs for Medicare eligible out-of-hospital services. Once the relevant annual threshold of out-of-pocket costs has been met, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services

	for the remainder of the calendar year. However, there is an upper limit (benefit cap) on the amount of benefit that can be paid under the EMSN for a small number of Medicare services. There are two thresholds for the EMSN. These thresholds are indexed by the Consumer Price Index (CPI) on 1 January each year. From 1 January 2017 the annual EMSN thresholds are: • $656.30 for Commonwealth concession cardholders, including those with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card, and people who receive Family Tax Benefit (Part A); and • $2,056.30 for all other singles and families.
Payment Type	Medicare - Safety Net reduction
Business Need	**Allocation of out-of-pocket expenses to family groups** Individuals don't need to register for the Medicare Safety Net as DHS will automatically keep a total of out-of-pocket medical expenses. Couples and families must register for the Medicare Safety Net, even if all family members are listed on the same Medicare card. Registering as a family allows eligible out-of-pocket costs for each individual family member to count toward the family's safety net threshold. Users only need to register once, but need to let DHS know if family members change. For example, if a student dependent is no longer studying or you have a newborn baby. One of the complexities of the safety net is managing family registrations to ensure all out-of-pocket expenses are captured / allocated appropriately. This is particularly difficult with blended families, where parents have separated and the children belong to more than one family group.

Data/System links	• Medicare system
	  • patient registration data
	  • patient claims data, including out-of-pocket expenses
	• Medicare Safety Net system
	  • family group registration data
	  • threshold data, accrual of out-of-pocket services

3.4 Pathology Services

Program Description	**Pathology Services** The Pathology Services Table (PST) is a Schedule to the Health Insurance (Pathology Services Table) Regulation 2016. It lists the pathology tests for which Medicare benefits are available, their Schedule fees and conditions for use. In the PST, each professional service listed has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable). For pathology services under the MBS, a patient episode comprises a pathology service or services which are requested for a single patient, on the same day by one or more practitioners.
Payment Type	Medicare – Pathology Services (Fee for service)
Business Need	**Multiple Services Rule** The Multiple Services Rule (Rule 3 of the Pathology Services Table) restricts the payment of Medicare benefits so that when one or more requests are made on the same day for pathology services covered by the same item in the PST, only one benefit will be payable for the item, regardless of the number of times the test is performed either on the same day or on different days. Rule 4 provides for a number of exemptions to this restriction allowing multiple

	services to attract benefits whenever they are performed for seriously ill or chronically ill patients with certain specified conditions. In these circumstances the account is endorsed "Rule 3 Exemption" by the pathology provider so that the Department of Human Services pays the rebate. **Episode Coning** Episode coning is an arrangement, described in Rule 18, which places an upper limit on the number of services in an episode for which Medicare benefits are payable and was introduced to prevent over servicing by doctors. Generally, when more than three items are requested in an episode by a general practitioner for an out-of-hospital service, Medicare only pays for the three most expensive items. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.
Data/System links	Medicare system

3.5 Authority to Prescribe

Program Description	**Pharmaceutical Benefits Scheme** The aim of the Pharmaceutical Benefits Scheme (PBS) is to provide all Australian Residents and eligible overseas visitors' access to prescription medicine in an affordable, reliable and timely manner. Through the PBS, the Government subsidises the cost of prescription medicines, making them affordable for Australians and eligible overseas visitors. The medicines available to be dispensed to patients at a Government-subsidised price are listed in the PBS Schedule.
Payment Type	Pharmaceutical Benefits Scheme (PBS)
Business Need	**Authority required benefits** Pharmaceutical benefits listed in the PBS Schedule fall into four broad categories: 1. Unrestricted benefits – these have no restrictions on their therapeutic uses; 2. Restricted benefits – these can only be prescribed for specific therapeutic uses (noted as Restricted benefit); and 3. Authority required benefits – these fall into two categories: a) Authority required benefits are restricted benefits that require prior approval from DHS or DVA (noted *as Authority required*). b) *Authority required (STREAMLINED)* benefits are restricted benefits that do not require prior approval from DHS or DVA but require the recording of a streamlined authority code (noted as *Authority required (STREAMLINED)*). 4. Medicines supplied under special arrangements as specified in S100 of the NHA **Authority required PBS Prescriptions** Approval of authority PBS prescriptions may be sought by posting a relevant form to DHS, calling DHS or using the DHS PBS authorities website. Approval of DVA authority prescriptions may be obtained by posting a relevant form to DVA or by calling DVA. An authority PBS/RPBS prescription is not valid until it has been approved by DHS or where appropriate DVA. Without this approval, a pharmacist must not supply the item as a PBS/RPBS benefit. Each authority required PBS/RPBS item must be written on an Authority PBS/RPBS prescription form, which includes:

	• the patient/pharmacist copy, which records prescriber, patient, and pharmaceutical benefit item details and is retained by the pharmacist; • the prescriber's copy or DHS /DVA copy is kept by DHS/DVA for record purposes when approval is sought in writing. When approval is by telephone or by the authorities website, the prescriber must keep this copy for 12 months. This copy must record the daily dose, details of the disease, clinical justification for using the item, the patient's age (if the patient is a child) and whether the patient has previously received an authority for this pharmaceutical benefit. **Authority required (STREAMLINED) PBS Prescriptions** Prior approval is not required from DHS or DVA to prescribe an authority required (STREAMLINED) item (except where increased quantities and/or repeats are required). Instead the authority prescription form must include a four digit streamlined authority code. Authority required (STREAMLINED) PBS prescriptions must be written on an authority PBS/RPBS prescription form, which includes: • the pharmacist/patient copy, which records prescriber, patient, and pharmaceutical benefit item details. The prescription is given directly to the patient to be dispensed at their pharmacy; • the prescriber's copy is kept by the prescriber for 12 months. This copy must record the daily dose, details of the disease, clinical justification for using the item, the patient's age (if the patient is a child) and whether the patient has previously received an authority for this pharmaceutical benefit. **Implications for Payments and Claims system** Issuing approval for authority PBS prescriptions will remain with the Government. However, any claims and payments system must be able to check that a claim for an authority required prescription is eligible for payment based on: • whether the relevant authority to prescribe has been issued by Government; • whether the additional information required for an authority required prescription has been provided. The system should only make the payment if the relevant eligibility conditions have been met.
Data/System links	Prescription Dispensing Software

3.6 PBS Claiming

Program Description	**Pharmaceutical Benefits Scheme** The aim of the Pharmaceutical Benefits Scheme (PBS) is to provide all Australian residents and eligible overseas visitors' access to prescription medicine in an affordable, reliable and timely manner. Through the PBS, the Government subsidises the cost of prescription medicines. The medicines available to be dispensed to patients at a Government-subsidised price are listed in the PBS Schedule.
Payment Type	Pharmaceutical Benefits Scheme (PBS)
Business Need	**Claiming under the PBS** The *National Health Act 1953* (Cth) provides the basis for supply of pharmaceutical benefits to Australians. Pharmaceutical benefits are supplied by

	approved pharmacists or authorised medical practitioners, who are then reimbursed by the Commonwealth. To claim their payment, approved suppliers lodge claims with the Department of Human Services (DHS) detailing PBS prescriptions supplied. For prescriptions issued under the RPBS, claims are forwarded to the Department of Veterans' Affairs (DVA). DHS' primary service delivery channel for PBS and RPBS has been the PBS Online channel. Manual claiming has been retained as an option for providers that have not transitioned, approximately 0.1% of providers use this channel. Currently the legislation provides for payments to approved pharmacies to be made in advance, on the basis of real-time dispensing information through the PBS Online claiming channel. Payment by DHS and DVA is estimated and made automatically at the time of dispensing. Potential claiming errors are captured in real-time and approved suppliers are provided with rejections or warnings, which facilitate immediate adjustment if necessary. Pharmacies are then required to submit a claim for payment that reconciles the dispense information with medicines supplied. A reconciliation process is conducted by the pharmacy and a claim for payment submitted to DHS. From 1 April 2015, a new transaction known as 'Close a Claim' has been introduced as part of the PBS Online channel. This enables approved suppliers to close claims electronically via the PBS Online channel using their dispensing software. Pharmacies are no longer required to send paper prescriptions with a claim for payment form to DHS, and are instead required to retain prescriptions (in paper or electronic form) for quality and audit purposes for a period of 2 years under the *National Health Act 1953* (Cth). Benefits of the transition to the PBS Online channel include: • More frequent/ timely payments to approved suppliers • Certainty about the amount to be covered by Medicare • Detection and correction of errors before customers leave the pharmacy • Automatic reconciliation of electronic statements
Data/System links	Prescription Dispensing Software

3.7 Medicare – ART / IVF

Program Description	**Medicare – Assisted Reproductive Technology (ART) services** Medicare benefits are available for ART services to assist patients with diagnosed medical infertility in achieving conception. These services are listed under Subgroup 3 of Group T1 in the *Health Insurance (General Medical Services Table) Regulation 2016*.
Payment Type	Medicare – ART Services
Business Need	While most Medicare Benefits Schedule (MBS) items refer to a specific service (e.g. a pathology test or x-ray), ART 'global' items are a package of care that include all consultations, pathology and diagnostic imaging services performed for a patient as part of their ART treatment within a treatment cycle (generally 31 days). Legislation (the *Health Insurance Act 1973* (Cth)) dictates that an item cannot be billed to Medicare until the descriptor has been satisfied and the service rendered in full. As such, an ART 'global' item can only be billed to Medicare once the treatment cycle is complete (generally 31 days after treatment commenced). This creates a

	significant lag between the effective start date of the item and the billing of that item. In some cases, different practitioners separately bill Medicare for consultations, pathology and diagnostic imaging services related to ART treatment, which should only be billed to Medicare under a 'global' item by the ART specialist. At the time of assessment, it is not possible to identify that the separately billed services relate to ART treatment. This can only be identified once an ART 'global' item is billed to Medicare. Medicare benefits are not payable for separately billed consultations, pathology and diagnostic imaging services when these are performed as part of ART treatment. Any Medicare benefits paid for separately billed services are to be recovered from the practitioner who rendered the service. The length of an ART treatment cycle can differ, dependent on the length of the patient's menstrual cycle. Patients may have short cycles, i.e. less than 26 days or long cycles, i.e. greater than 31 days.
Data/System links	Medicare system • Patient history • Claims assessment

3.8 Practice Incentives Program

Program Description	**Practice Incentives Program** There are 11 individual incentives under the Practice Incentives Program (PIP). The PIP provides incentive payments to general practices and Service Incentive Payments (SIPs) to general practitioners (GPs) and other medical practitioners that work in PIP practices. These payments support activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients. In order to participate, practices must be accredited, or registered for accreditation against the Royal Australian College of General Practitioners (Standards for general practices). Incentive payments are made to both practices and providers based on the practice eligibility to the different PIP incentives.
Payment Type	Incentive payments are made quarterly in February, May, August and November each year.
Business Need	In order to be eligible for the PIP, the practice must: • be accredited (by an authorised accrediting body) in meeting the Royal Australian College of General Practice (RACGP) standard for General Practice, • have current public liability insurance for the practice, and • have at least one practitioner (with current professional indemnity insurance) providing services at the practice. Once the practice has met the PIP program eligibility requirements, that practice must then meet the individual incentive requirements in order to receive the respective incentive payments. The Asthma, Cervical Screening and Diabetes incentives are triggered from a practice sign-on payment. On-going incentive payments are made to the practice based on whether the practice has met the target rates for that incentive. Practice targets for these incentives are drawn from the practice patient cohort and the associated MBS services provided at the practice.

	The Asthma, Cervical Screening and Diabetes MBS items also trigger a provider payment (as part of the Service Incentive Payments (SIP) also known as the PIP SIP). Some MBS services for the Cervical Screening Incentive are provided by Victorian Cytology Services on behalf of a practice and this data is provided separately on a weekly data stream (via the EDI Gateway). The Aged Care Access incentive (ACAI) is a provider based payment that is paid to providers within an eligible PIP practice for the services provided at an Aged Care facility (this payment is also known as the SIP ACAI payment). The Teaching incentive is paid based on claims from practices identifying the teaching sessions that have taken place at the practice. The After Hours and eHealth incentive payments are declaration based incentives and are paid for practices that have successfully applied (i.e. meet the criteria and agree to the terms and conditions) for the incentive. As part of the practice incentive application the practice must agree to the incentive eligibility requirements. The Indigenous Health incentive has two main components of payments. The first is a once-off practice registration payment for successfully applying for the incentive. The second payment is a payment made for registering patients (that meet the incentive eligibility requirements) during a calendar year. **Note**: Additional tiered payments are provided for the Indigenous Health incentive based on the completion of care plan items and the majority of services provided for the patient. The Procedural GP incentive is paid for practices that have successfully applied for the incentive and have practitioners that are rendering Procedural GP items at the practice. The Quality Prescribing incentive is paid based on the data provided from the National Prescribing Services. A Rural loading is applied to all PIP payments once they have been calculated. The loading is paid based on the Rural, Remote and Metropolitan Area (RRMA) classification system. The Rural loading is paid if they practice in a RRMA 3-7 location. PIP payments are made quarterly via Electronic Funds Transfer (EFT) to the bank account nominated by the practice on the application form. PIP practice payments for the eHealth, Quality Prescribing and After Hours incentives and for Asthma, Cervical Screening and Diabetes sign-on payments are based on a measure of the practice size known as the Standardised Whole Patient Equivalent (SWPE) value. The SWPE value is calculated using MBS claims by patients attending the practice during the rolling 12 month period, that commences 16 months prior to the payment quarter. Once registered, every payment quarter, a batch system job is automatically run which obtains provider specific data for the SWPE from the Medicare history files, provider details from PDS, patient details from CDMS (for Indigenous Health incentives only) and PIP specific information from the PIP database to calculate the payment amounts. The payment is made directly into the practice's bank account (for PIP payments) or provider's account for SIP payments, through the Electronic Payment System (EPS) and Common Payment System (CPS) via the Reserve Bank of Australia. Payment advices are mailed via FUJI or made available through Health Professional Online Services (HPOS) if the practice has access to HPOS.
Data/System links	PIP online (via HPOS for external users)

	Internal • Medicare History Files • Provider Directory Services • Consumer Directory Maintenance System • Geospatial Services **External** • National Prescribing Services • Victorian Cytology Services • Accreditation Bodies (currently Australian General Practice Accreditation Limited (AGPAL) and GPA Accreditation (GPA)

3.9 Medicare – Medicare Compensation Recovery Programme

Program Description	The Compensation Recovery Programme operates to process recoveries under the provisions of the *Health and Others Services (Compensation) Act 1995* (Cth) (the Act). Compensation payers are legally obligated to notify DHS of compensation judgements and settlements which are greater than $5,000. DHS must be reimbursed for medical expenses incurred in relation to the compensatory illness or injury as well as nursing benefits and residential care subsidies before the claimant is paid the remainder of the settlement. Solicitors are able to notify DHS on judgements and settlements when authorised by the injured person.
Programme Type	Medicare Compensation Recovery Programme
Business Need	Medicare Compensation Recovery programme requires DHS to access Medicare data and nursing home data in order to assess a consumer's compensatory debt. To assess the amount of debt owing to the Commonwealth, further information is sourced from the injured person (such as relevant medical services), and insurers and solicitors (such as settlement details). The Medicare Compensation Recovery programme has strict legislative parameters that need to be met which are very complex in their nature. Penalties are applied if certain legislation time frames are not met. A case can be registered when either, a notice of settlement is received, or a request for a Medicare history statement is received from either the insurer or solicitor. From registration of the case, where a compensation claim has reached judgement or settlement, the Compensation Payer (usually the insurer) must within 28 days notify the department of the date the judgment or settlement was made. This notification is usually accompanied with an Advance Payment. The Advanced Payment must be 10% of the judgement or settlement and be provided to DHS within 28 days of the judgement to be a valid payment. When an injured person or their solicitor requests a Medicare History statement DHS has 28 days to issue this. The injured person has 28 days to return the completed Medicare history statement to DHS. After receipt of the completed history statement (or notification that the injured person has no relevant medical services) the department must give a Notice of Past Benefits (Statement of Account) to the injured person (or their solicitor).

	Failure to give the Notice of Past Benefits within 3 months of the date the department was notified of the judgement or settlement; or the date the Advanced Payment is made (whichever is the later), results in the whole of the Advance Payment returned to the injured person. This payment operates as a discharge of the compensable person's liability to pay amounts payable. The Commonwealth is also liable to pay interest on the advance payment. The Medicare Compensation Recovery programme has authority to access old Medicare information. This is different from the authority for other Medicare programmes, which only has authority for up to 5 years. The Medicare Compensation Recovery programme holds data back to 1984, and this data will need to be retained and transitioned to any new ICT solution. Note: As the injured person is able to authorise another party to act on their behalf, third party interactions will need to be managed. In most cases this is a solicitor but can at times be a nominee.
Data/System links	• Compensation Case Management System (CCMS) (programme case management) • IBM Websphere / MQ, (connects CCMS to Mainframe DB2, handles staff access) • Mainframe DB2 (Compensation Recovery data storage) • Mainframe COBOL (facilitates the provision of DB2 data within CCMS)

Australian Government
Department of Health

Request for Information

Supporting Attachment 6 – Demographic trends and indicative volumes

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Supporting Attachment 6 – Demographic trends and indicative volumes

1. This Supporting Attachment

This Supporting Attachment provides an overview of key demographic trends and indicative volumetrics and provides additional information to the Objectives and Scope. Further statistical information can be obtained from the Department of Human Services' and the Department of Health's websites and annual reports.

2. Demographic trends and indicative volumetrics

Table 1. Demographic trends and indicative volumetrics[1]

	Metric	FY 13-14	FY 14-15	FY 15-16
Demographics	Australian Resident Population	23.5 million	23.8 million	24.1 million
MBS	People enrolled for Medicare[2]	23.8 million	24.2 million	24.6 million
	Active Medicare cards	13.5 million	13.7 million	13.9 million
	New enrolments to Medicare	603,070	581,922	588,574
	Number of MBS services claims	358.3 million	373.5 million	389.0 million
	Total value of MBS benefits	$19.3 billion	$20.5 billion	$21.4 billion
	Percentage of claims lodged electronically	93.1%	94.9%	96.1%
	Number of services Bulk Billed	270.0 million	285.6 million	299.8 million
	Number of claims submitted through Patient Claiming	36.1 million	40.3 million	43.6 million
	Number of claims submitted through Simplified Billing	27.4 million	29.4 million	30.3 million
	Number of MBS debt items raised for recovery	970	1,760	1,924
PBS	Approved PBS pharmacies	5,457	5,511	5,588
	PBS approved dispensing medical practitioners	23	21	19
	Approved hospital authorities – private hospitals	104	116	122
	Approved hospital authorities – public hospitals participating in pharmaceutical reforms	159	161	161
	Approved hospital authorities – highly specialised drugs only	78	77	79

[1] 2015-2016 DHS Annual Report, DVA Annual Reports, Medicare Group Reports, PBS Group Reports, MBS Books, PBS Books, AIHW.
[2] Greater than Australian Resident Population likely due to residents of Reciprocal Health Care Agreement (RHCA) countries visiting Australia (and other factors).

	Metric	FY 13-14	FY 14-15	FY 15-16
	Number of PBS service claims	211.8 million	213.9 million	210.1 million
	Percentage of claims lodged electronically	99.9%	99.9%	99.9%
	Total value of PBS benefits	$9.3 billion	$9.2 billion	$10.9 billion
	Number of PBS debt items raised for recovery	146	211	222
Aged Care	Number of Aged Care services	4,962	4,898	4,862
	Number of Aged Care services transmitting online	3,403	2,947	3,805
	Number of Aged Care claims processed	60,315	59,183	54,944
	Total value of Aged Care benefits paid (both under and outside Aged Care Act 1997)[3]	$11.3 billion	$12.1 billion	$13.2 billion
DVA (MBS and RPBS)	Treatment population	217,562	208,181	200,245
	Number of new DVA (MBS) services processed	19.9 million	19.0 million	18.4 million
	Total value of DVA (MBS) benefits paid	$2.2 billion	$2.1 billion	$2.0 billion
	Number of RPBS services processed	12.3 million	11.6 million	10.5 million
	Total value of RPBS benefits paid	$0.4 billion	$0.4 billion	$0.3 billion

[3] Including $1.2 million paid on behalf of DVA for FY 15-16.

Request for Information

Supporting Attachment 7 – Key legislation

Modernising Health and Aged Care Payments Services Program

Supporting Attachment 7 – Key legislation

Key legislation & legislative instruments relating to payment programs

1. Aged Care Program

1.1 Acts

- *Aged Care Act 1997* (Cth)
- *Aged Care (Transitional Provisions) Act 1997* (Cth)
- *Aged Care (Accommodation Payment Security) Act 2006* (Cth)
- *Aged Care (Accommodation Payment Security) Levy Act 2006* (Cth)
- *Australian Aged Care Quality Agency Act 2013* (Cth)
- *Human Services (Medicare) Act 1973* (Cth)
- *Home and Community Care Act 1985* (Cth)

1.2 Aged Care Principles (made under s 96-1 of the *Aged Care Act 1997*)

- *Accountability Principles 2014* (Cth)
- *Allocation Principles 2014* (Cth)
- *Aged Care (Transitional Provisions) Principles 2014* (Cth)
- *Approval of Care Recipients Principles 2014* (Cth)
- *Approved Provider Principles 2014* (Cth)
- *Classification Principles 2014* (Cth)
- *Committee Principles 2014* (Cth)
- *Complaints Principles 2014* (Cth)
- *Extra Service Principles 2014* (Cth)
- *Fees and Payments Principles 2014 (No 2)* (Cth)
- *Grant Principles 2014* (Cth)
- *Information Principles 2014* (Cth)
- *Quality of Care Principles 2014* (Cth)
- *Records Principles 2014* (Cth)
- *Sanctions Principles 2014* (Cth)
- *Subsidy Principles 2014* (Cth)
- *User Rights Principles 2014* (Cth)

1.3 Other legislative instruments

- *Aged Care (Conditions of Allocation) Determination 2016* (Cth)
- *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Cth)
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* (Cth)

2. Medicare Benefits Program

2.1 Acts

- *Health Insurance Act 1973* (Cth)
- *Dental Benefits Act 2008* (Cth)
- *Human Services (Medicare) Act 1973* (Cth)
- *Health and Other Services (Compensation) Act 1995* (Cth)
- *Health and Other Services (Compensation) Care Charges Act 1995* (Cth)

2.2 Regulations

- *Health Insurance Regulations 1975* (Cth)
- *Health Insurance (Diagnostic Imaging Services Table) Regulations 2016* (Cth)
- *Health Insurance (General Medical Services Table) Regulation 2016* (Cth)
- *Health Insurance (Pathology Services) Regulations 2016* (Cth)
- *Health Insurance (Pathology Services Table) Regulations 2016* (Cth)
- *Health Insurance (Vocational Registration of General Practitioners) Regulations 1989* (Cth)
- *Health and Other Services (Compensation) Regulations1995* (Cth)

2.3 Other legislative instruments

- *Dental Benefits Rules 2014* (Cth)
- *Declaration of Relevant Professional Bodies under subsection 129AAD(13) (RPB 1 of 2011)* (made under the *Health Insurance Act 1973*)
- *Health Insurance (Accredited Pathology Laboratories – Approval) Principles 2002* (Cth)
- *Health Insurance Act 1973 – Declaration of Quality Assurance Activity under section 124X* (Cth)[4]
- *Health Insurance Act 1973 – Determination of patient contribution under subsection 3(1)* (Cth)[5]
- *Health Insurance (ALK Gene Testing) Determination 2015* (Cth)
- *Health Insurance (Allied Health Services) Determination 2014* (Cth)
- *Health Insurance (Anaesthesia service) Determination 2016* (Cth)
- *Health Insurance (Application for Acceptance of Approved Pathology Authority Undertaking) Determination 2002* (Cth)
- *Health Insurance (Approval of Billing Agents) Guidelines (No. 1) 2004* (Cth)
- *Health Insurance (Approved Pathology Undertakings) Approval 2002 (HS/12/2002)* (Cth)
- *Health Insurance (Billing Agents – Conditions of Approval) Determination (No. 1) 2004* (Cth)
- *Health Insurance (Bone Densitometry) Determination 2012* (Cth)
- *Health Insurance (Cleft Lip and Cleft Palate Services) Determination 2012* (Cth)
- *Health Insurance (Diabetes Testing in Aboriginal and Torres Strait Islander Primary Health Care Sites) Determination 2015* (Cth)
- *Health Insurance (Diagnostic Imaging Accreditation) Instrument 2010* (Cth)
- *Health Insurance (Diagnostic Imaging Accreditation – Approved Accreditors) Instrument 2010* (Cth)
- *Health Insurance (Diagnostic Imaging Accreditation – Designated Persons) Instrument 2010* (Cth)
- *Health Insurance (Duplex Scanning for Erectile Dysfunction) Determination 2010 (No. 1)* (Cth)
- *Health Insurance (Eligible Collection Centres) Approval Principles 2010* (Cth)
- *Health Insurance (Eligible Pathology Laboratories) Determination 2015* (Cth)
- *Health Insurance (Extended Medicare Safety Net) Determination 2009* (Cth)
- *Health Insurance (Follow up service – Indigenous persons) Determination 2009* (Cth)
- *Health Insurance (FTB(A) Family) Determination 2004* (Cth)
- *Health Insurance (Gippsland and South Eastern New South Wales Mobile MRI Service and Rockhampton, Bundaberg and Gladstone Mobile MRI Service) Determination 2012* (Cth)
- *Health Insurance (IncobotulinumtoxinA) Determination 2015* (Cth)
- *Health Insurance (Indium-labelled Octreoticide Study) Determination 2010* (Cth)
- *Health Insurance (Intracytoplasmic Sperm Injection) Determination 2008* (Cth)
- *Health Insurance (Leukoscan) Determination 2010* (Cth)
- *Health Insurance (Optical Coherence Tomography) Determination 2016* (Cth)
- *Health Insurance (Optometric services) Determination 2016* (Cth)
- *Health Insurance (Midwife and Nurse Practitioner) Determination 2015* (Cth)
- *Health Insurance (Pathologist-determinable Services) Determination 2015* (Cth)
- *Health Insurance (Pathology – Licensed Collection Centres) Principles 1999* (Cth)
- *Health Insurance (Permitted benefits – diagnostic imaging services) Determination 2008* (Cth)
- *Health Insurance (Permitted benefits – pathology services) Determination 2008* (Cth)
- *Health Insurance (Pharmacogenetic Testing – Human Epidermal Growth Factor Receptor 2) Determination 2015* (Cth)
- *Health Insurance (Poly Implant Prosthese MRI) Determination 2012* (Cth)
- *Health Insurance (Prescribed Pathology Services) Determination 2011* (Cth)

[4] Multiple declarations under s 124X of the *Health Insurance Act 1973* have been made. These are publicly available on the Federal Register of Legislation at https://www.legislation.gov.au/.
[5] Multiple determinations relating to the definition of 'patient contribution' have been made under s 3(1) of the *Health Insurance Act 1973*. These are publicly available on the Federal Register of Legislation at https://www.legislation.gov.au/.

- *Health Insurance (Radiation Oncology) Determination 2010* (Cth)
- *Health Insurance (Sacral Nerve Stimulation) Determination 2008* (Cth)
- *Health Insurance (Section 19AB Exemptions) Guidelines 2016* (Cth)

3. Pharmaceutical Benefits Program

3.1 Acts

- *National Health Act 1953* (Cth)
- *Human Services (Medicare) Act 1973* (Cth)

3.2 Regulations

- *National Health (Pharmaceutical Benefits) Regulations 1960* (Cth)
- *National Health (Pharmaceuticals and Vaccines – Cost Recovery) Regulations 2009* (Cth)
- *National Health Regulation 2016* (Cth)

3.3 Other legislative instruments

- *Continence Aids Payment Scheme 2010* (Cth)
- *Determination – Exempt items (PB 58 of 2007)* (Cth)
- *Determination under subsection 84AE(3B) of the National Health Act 1953 (PB 27 of 2010)* (Cth)
- *Determination under subsection 84BA(2) of the National Health Act 1953* (Cth)
- *Determination under subsection 99(4)) of the National Health Act 1953* (Cth)
- *Determination under subsection 99ACA(3) of the National Health Act 1953 (PB 59 of 2007)* (Cth)
- *National Health (Australian Community Pharmacy Authority Rules) Determination 2011 (PB 65 of 2011)* (Cth)
- *National Health (Botulinum Toxin Program) Special Arrangement 2015 (PB 87 of 2015)* (Cth)
- *National Health (Claims and under co-payment data) Rules 2012 (PB 19 of 2012)* (Cth)
- *National Health (Claims Transmission System Exemption) Guidelines 2015 (PB 38 of 2015)* (Cth)
- *National Health (Ceasing of Co-marketed Brands) Determination 2013 (No. 1)* (Cth)
- *National Health (Circumstances for Payment of Supplier of Pharmaceutical Benefits) Determination 2002* (Cth)
- *National Health (Collaborative arrangements for midwives) Determination 2010* (Cth)
- *National Health (Collaborative arrangements for nurse practitioners) Determination 2010* (Cth)
- *National Health (Concession or entitlement card fee) Determination 2012 (PB 102 of 2011)* (Cth)
- *National Health (Continued Dispensing) Determination 2012* (Cth)
- *National Health (Efficient Funding of Chemotherapy) Special Arrangement 2011 (PH 79 of 2011)* (Cth)
- *National Health (Eligible midwives) Determination 2010* (Cth)
- *National Health (Entitlement to Pharmaceutical Benefits – Special Evidentiary Categories) Determination 2001* (Cth)
- *National Health (Epsworth and Cabrini Private Hospitals Paperless Prescribing and Claiming Trial) Special Arrangement 2016 (PB 28 of 2016)* (Cth)
- *National Health (Growth Hormone Program) Special Arrangement 2015 (PB 85 of 2015)* (Cth)
- *National Health (Highly specialised drugs program) Special Arrangement 2010 (PB 116 of 2010)* (Cth)
- *National Health (Indigenous Chronic Disease – PBS Co-payment Measure) Special Arrangement 2016* (Cth)
- *National Health (Immunisation Program – Designated Vaccines) Determination 2014 (No. 1)* (Cth)
- *National Health (IVF Program) Special Arrangement 2015 (PB 60 of 2015* (Cth)
- *National Health (Listed drugs on F1 or F2) Determination 2010 (PB 93 of 2010)* (Cth)
- *National Health (Listing of Pharmaceutical Benefits) Instrument 2012 (PB 71 of 2012)* (Cth)
- *National Health (Medication chart prescription trial hospital) Declaration 2015 (PB 22 of 2015)* (Cth)
- *National Health (Multiple Hospitals Paperless Claiming Trial) Special Arrangement (PB 59 of 2016)* (Cth)
- *National Health (Originator Brand) Determination 2015 (PB 100 of 2015)* (Cth)
- *National Health (Paperless Prescribing, Dispensing and Claiming Trial) Special Arrangement 2013 (PB 71 of 2014)* (Cth)

- *National Health (Paraplegic and Quadriplegic Program) Special Arrangement 2010 (PB 118 of 2010)* (Cth)
- *National Health (Pharmaceutical Benefits) (Application to supply pharmaceutical benefits following the death of approved pharmacist – documentary evidence) Determination 2015 (PB 5 of 2015)* (Cth)
- *National Health (Pharmaceutical Benefits) (Conditions of approval for approved pharmacists) Determination 2007 (PB 42 of 2007)* (Cth)
- *National Health (Pharmaceutical Benefits – early supply) Instrument 2015 (PB 120 of 2015)* (Cth)
- *National Health (Pharmaceutical benefits supplied by private hospitals) Determination 2010* (Cth)
- *National Health (Pharmaceutical benefits supplied under section 93A(4)) (Repeal) Determination 2015* (Cth)
- *National Health (Pharmaceutical Benefits – Therapeutic Groups) Determination 2010 (PB 1 of 2010)* (Cth)
- *National Health (Prescriber bag supplies) Determination 2012 (PB 73 of 2012)* (Cth)
- *National Health (Price and Special Patient Contribution) Determination 2010 (PB 109 of 2010)* (Cth)
- *National Health (Remote Aboriginal Health Services Program) Special Arrangements Instrument 2010 (PB 65 of 2010)* (Cth)
- *National Health (Residential Medication Chart) (Repeal) Determination 2015 (PB 20 of 2015)* (Cth)
- *National Health (Subsection 84C(7)) Determination 2010* (Cth)
- *National Health (Supplies of out-patient medication) Determination 2010 (PB 125 of 2015)* (Cth)
- *National Health (Weighted average disclosed price – October 2016 reduction day) Determination 2016 (PB 39 of 2016)* (Cth)
- *Privacy Guidelines for the Medicare Benefits and Pharmaceutical Benefits Program* (Cth) (made under s 135AA of the *National Health Act 1953* (Cth))

4. Veterans' Payments (including RPBS)

4.1 Acts

- *Veterans' Entitlements Act 1986* (Cth)
- *Repatriation Pharmaceutical Benefits Scheme 2013* (Cth)
- *Safety, Rehabilitation and Compensation Act 1988* (Cth)
- *Military Rehabilitation and Compensation Act 2004* (Cth)
- *Australian Participants in British Nuclear Tests (Treatment) Act 2006* (Cth)

4.2 Other legislative instruments

- *Repatriation Pharmaceutical Benefits Scheme 2013* (Cth) (made under s 91 of the *Veterans' Entitlements Act 1986*)
- *Treatment Principles (Instrument 2013 No. R52)* (Cth) (made under s 90(4) of the *Veterans' Entitlements Act 1986*)
- *Military Rehabilitation and Compensation Act - Treatment Principles* (Instrument 2013 No. MRCC53) (Cth) (made under subsection 286(2) of the *Military Rehabilitation and Compensation Act 2004*)
- *Veterans' Affairs (Extended Eligibility for Treatment) Instrument 2015* (Cth)

5. Other health payments (including private health insurance)

5.1 Acts

- *Medical Indemnity Act 2002* (Cth)
- *Premium Support Scheme 2004* (Cth)
- *Private Health Insurance Act 2007* (Cth)
- *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* (Cth)

5.2 Regulations

- *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth)
- *Private Health Insurance (Complying Product) Rules 2015* (Cth)
- *Private Health Insurance (Data Provision) Rules 2016* (Cth)

- *Private Health Insurance (Health Benefits Fund Enforcement) Rules 2015* (Cth)
- *Private Health Insurance (Health Benefits Fund Policy) Rules 2015* (Cth)
- *Private Health Insurance (Incentives) Rules 2012 (No. 2)* (Cth)
- *Private Health Insurance (Levy Administration) Rules 2015* (Cth)
- *Private Health Insurance (Lifetime Health Cover) Rules 2007* (Cth)
- *Private Health Insurance (Prostheses) Rules 2016 (No. 2)* (Cth)
- *Private Health Insurance (Prostheses) Rules 2016 (No. 4)* (Cth)
- *Private Health Insurance (Registration) Rules 2015* (Cth)
- *Private Health Insurance (Risk Equalisation Administration) Rules 2015* (Cth)

Key legislation & legislative instruments relating to data requirements (including privacy, secrecy & security)

6. Privacy & secrecy/confidentiality

- *Aged Care Act 1997* (Cth) – see in particular Chapter 6, Part 6.2
- *Dental Benefits Act 2008* (Cth) - see in particular Part 5
- *Health Insurance Act 1973* (Cth) - see in particular s 130
- *Healthcare Identifiers Act 2010* (Cth) - see in particular provisions relating to the collection, use and disclosure of healthcare identifiers)
- *Information Principles 2014* (Cth) (made under s 96-1 of the *Aged Care Act 1997*)
- *My Health Records Act 2012* (Cth) and *My Health Records Regulation 2012* (Cth) - see in particular provisions relating to the collection use and disclosure of health information included in a My Health Record
- *National Health Act 1953* (Cth) - see in particular s 135A
- *Privacy Act 1988* (Cth) and *Privacy Regulation 2013* (Cth)[6]

7. Data security, storage & other data/records management requirements

- *Archives Act 1983* (Cth) and *Archives Regulations* (Cth)[7]
- *Crimes Act 1914* (Cth)
- *Data-matching Program (Assistance and Tax) Act 1990* (Cth)
- *Electronic Transactions Act 1999* (Cth)
- *Electronic Transactions Regulations 2000* (Cth)
- *Evidence Act 1995* (Cth)
- *Freedom of Information Act 1982* (Cth)[8] – see in particular s 6C (provision of documents by contracted service providers)
- *Guidelines for the Conduct of the Data-Matching Program* (Cth) (made under s 12(2) of the *Data-matching Program (Assistance and Tax) Act 1990*
- *Health Insurance Regulations 1975* (Cth) – see in particular regs 13AA, 13AB and 13AC
- *National Health (Claims and under co-payment data) Rules 2012 (PB 19 of 2012)* (Cth)
- *(NHMRC) Guidelines approved under section 95A of the Privacy Act (12 March 2014)*
- *Privacy Guidelines for the Medicare Benefits and Pharmaceutical Benefits Program* (Cth) (made under s 135AA of the *National Health Act 1953*)
- *Privacy (Tax File Number) Rule 2015* (Cth) (made under s 17 of the *Privacy Act 1988* (Cth))
- *Public Governance, Performance and Accountability Act 2013* (Cth)

[6] Additional privacy resources such as guidelines issued by the Office of the Australian Information Commissioner, such as the *Australian Privacy Principles Guidelines*, are available at https://www.oaic.gov.au/.

[7] For additional non-legislative resources such as record keeping standards, policies and guidance material, please see the National Archives of Australia's website: http://www.naa.gov.au/information-management. Relevant resources include General Records Authorities, Digital Continuity 2020 Policy, Guidelines on Records Issues for Outsourcing, and ISO 16175 (Principles and Functional Requirements for Records in Electronic Office Environments).

[8] Additional FOI resources such as guidelines and fact sheets issued by the Office of the Australian Information Commissioner, such as the *Guidelines issued by the Australian Information Commissioner under s 93A of the Freedom of Information Act 1982*, are available at https://www.oaic.gov.au/.

Request for Information

Supporting Attachment 8 – Channels

Modernising Health and Aged Care Payments Services Program

Supporting Attachment 8 – Channels

1. This Supporting Attachment

This Supporting Attachment provides an overview of claiming channels currently available to providers and individuals. This Supporting Attachment provides additional information to Part B – Objectives and Scope.

2. Manual and electronic channels

The following manual and electronic channels are currently in operation.

Table 1. Channels

Program	Channel type	Channel
MBS	Manual *(approximately 4 per cent of total claims in 2015-16)*	Provider / Billing Agent by mail Patient by mail Patient by phone Patient at service centre with staff assistance Patient at service centre to dropbox Patient Medicare two-way
	Electronic *(approximately 96 per cent of total claims in 2015-16)*	Provider/Patient Medicare Online Provider/Patient Medicare Easyclaim Billing Agent SMTP Provider Health Professionals Online Service (HPOS) Provider / Billing Agent Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE) Patient myGov Patient Express Plus Medicare mobile app
PBS	Manual *(approximately 0.1 per cent of total claims in 2015-16)*	Pharmacist by mail Pharmacist CTS diskette (only claims for prescriptions prior to March 2015) Patient by mail Patient in person at service centre
	Electronic *(approximately 99.9 per cent of total claims in 2015-16)*	Pharmacist PBS Online
Aged Care	Manual *(approximately 10 per cent of total claims in 2015-16)*	Provider mail, fax, courier, or email
	Electronic *(Approximately 90 per cent of total claims in 2015-16)*	Provider Homecare Online Portal – Aged Care Online Services (ACOS) Provider Residential Care Online Portal – Aged Care Online Claiming (ACOC) Provider Veterans' Home Care Provider Portal

Request for Information

Returnable Attachment 1 – Submission Checklist

Modernising Health and Aged Care Payments Services Program

RETURNABLE ATTACHMENTS

Returnable Attachment 1 – Submission Checklist

The following checklist is provided to assist Respondents in preparing and lodging their Submissions. The checklist is a guide only. It is the responsibility of Respondents to satisfy themselves that they have met all conditions of this RFI.

Respondents should complete this checklist and submit it with their Submissions.

Action	Reference	Completed (Yes/No)	File name
Before lodging Submission			
Read the RFI including Supporting Attachments, Returnable Attachments and any annexures and attachments.			
Note the Closing Time and the last day for submitting questions.	clause 6 of Part A and clauses 11 and 12.3(c) of Part C		
Ensure all requests for clarification are submitted at least five Business Days before the Closing Time	clauses 12.3(b) of Part C		
Check that any and all addenda have been received.	clause 12.3 of Part C		
Lodging Submission			
Complete Submission Checklist and Form of Response to submit with Submission including the related pricing response.	clause 13(a) of Part C		
Ensure that all lodgement requirements are met.	clauses 14 and 16 of Part C		
Lodge the Submission as required and by the Closing Time.	clauses 11(a), 15 and 16 of Part C		
Retain a copy of the Submission for your records.			

Request for Information

Returnable Attachment 2 – Form of Response

Modernising Health and Aged Care Payments Services Program

Returnable Attachment 2 – Form of Response

1. Request for Information Details

A	Organisational Details
Organisation Name	
Location	
Service provider classification:	Managed service provider / System integrator / Infrastructure provider / Software provider / Other (please specify)
Summary of the organisation's operations	

B	Contact Person
Name	
Title	
Email	
Phone	

C	Lodgement Details
Method of Lodgement	Electronic copy lodged Files to be provided in Microsoft Word 2010 and Microsoft Excel 2010 format File title: **XX** – Organisation's Name
Closing Time and Date	2:00 pm Canberra, ACT local time **4 April 2017**

2. Request for Information – content

Technical

D	General

The Respondent should describe how its Component Solution would deliver all or part of the Capabilities and Technology Services (including security requirements) for the in-scope Programs and Payments. The Respondent should also describe the extent to which its Component Solution would allow the Commonwealth to meet the Government Objectives described in Clause 3 of Part A of this RFI.

In the event that the Component Solution does not relate to all Programs and Payments the Respondent should provide rationale for why certain Programs and Payments are excluded and how it suggests these would otherwise be supported.

If a Respondent wishes to use an alternative method of describing the Capabilities and/or Technology Services (including security requirements) it should describe how these relate to the Capabilities and Technology Services in Figure 1, Part B.

A full list of in-scope Programs and Payments is provided in Supporting Attachment 4 – Scope of programs and payments.

Response Guide: 4,000 words

E	Capability

The Respondent should describe the Capabilities its Component Solution can provide and relevant examples of solutions delivered in similar environments.

Response Guide: 1,000 words

F	Innovation

The Respondent should describe what innovative approaches exist in its Component Solution and for how long they have been available.

Response Guide: 2,000 words

G	Methodology

The Respondent should describe the methodology that it considers should apply to incorporate ongoing innovation during the life of its Component Solution.

Response Guide: 1,000 words

H	Risks

The Respondent should identify any specific risks attached to the implementation of its Component Solution and how those risks would be mitigated.

Response Guide: 1,000 words

Delivery

I Teaming and engagement

If the Respondent is proposing a Component Solution that it would deliver, it should provide an overview of which other entities (if any) it would team with to deliver the Component Solution. The Respondent should provide an overview of the roles and responsibilities of each identified entity and how risk would be shared between each identified entity.

If applicable, the Respondent should provide an overview of where this teaming arrangement has been used before.

If the Component Solution does not deliver all Capabilities and Technology Services, the Respondent should identify the extent to which it has identified that there are other entities that might be able to provide the missing components and how it considers the Commonwealth would bring all the components together.

Response Guide: 1,000 words

J Demonstrated early progress

The Respondent should describe how its Component Solution would assist in implementing elements of the new digital payments platform by January 2019.

The Respondent should provide an overview of the specific milestones to implement its Component Solution, noting the Commonwealth is seeking evidence of demonstrated progress in implementing the Digital Payments Platform by 2019.

Response Guide: 500 words

K Delivery flexibility and agility

The Respondent should describe the preconditions that would need to be met for its Component Solution to deliver the rapid implementation of changes to Payments and Programs and the introduction of new payment types.

The Respondent should describe their proposed methodology that they would use to implement and transition to the Component Solution.

Response Guide: 1,000 words

L Long-term delivery

The Respondent should describe how it recommends that vendors should work with the Commonwealth long-term as the Commonwealth delivers the business processes that would be enabled by the Component Solution. The Respondent should also describe the capabilities and skills that would be required within the Government to support the implementation and ongoing delivery of the Component Solution.

Response Guide: 1,000 words

Commercial & Risk

M Indicative Cost

The Respondent should outline the indicative cost of providing its Component Solution.

The indicative cost should include: design and build costs; implementation costs; transition costs and run/operation costs and other costs for its Component Solution only. The indicative cost should not include costs to enhance its Component Solution.

The Respondents should complete and include with their Submission the separate Excel spreadsheet attached to this RFI.

The Respondent should separately identify the cost to build, deliver and implement its Component Solution, across Sub-capabilities.

The Respondent should also identify the methodology it would adopt to pricing changes or enhancements.

Response Guide: Complete Annexure A – Indicative costing template (Excel document)

N Procurement Packaging

The Respondent should describe how the Commonwealth should package the Capabilities and Technology Services and how it should conduct the procurement(s) in Stage Two of the process to deliver a value for money outcome and achieve the Government Objectives.

Response Guide: 500 words

O Contracting

The Respondent should describe the form of contracting, including term and payment arrangements it considers would deliver the best value for money outcome to meet the Government Objectives.

Response Guide: 1,000 words

P Other

The Respondent should provide any further information which they consider relevant and has not been covered in any of the topics above.

Response Guide: 1,000 words

Annexure A - Returnable Attachment 2
Indicative Costing information for the Request for Information for the Modernising Health and Aged Care Payments Services Program

Respondent:

This proforma collects indicative costing information requested as part of the Request for Information for the Program.

Costing information presented in this proforma should relate to the aspects of the required Solution the Respondent addresses through its Submission. Indicative costing for the entire Solution is not required unless it is the Respondent's Component Solution.

Instructions

Instructions for completing this proforma:

a) provide the entity name in cell 'C3' of 'Coverpage'

b) indicative cost information should:

i) be stated in AUD;

ii) be exclusive of GST; and

iii) be stated in real costs as at February 2017.

c) the completed proforma should be returned as part of the Respondent's Submission in Microsoft Excel 2010 or later format ensuring that the file, workbook, worksheets and any fields contained within it are fully accessible and not password protected.

d) Complete 'proforma - costing by Subcapability':

i) complete the indicative cost tables as provided in proforma.

ii) Respondents are only required to enter costing information in sections of proforma that are relevant to the aspects of the required Solution the Respondent addresses through its Submission, i.e. its Component Solution. If the Respondent's Submission addresses components of the required Solution (rather than the entire Solution), costing information presented in this proforma should not reflect the indicative cost of providing the entire Solution.

iii) where Respondents are proposing the delivery of the entire Solution across all eight Capabilities and three Technology Services or infrastructure across all Capabilities, costing information may be presented in the 'Total Solution Cost' row only.

iv) complete the costing assumptions and further information section

v) if 'Other costs' are identified in column 'M' of the proforma, identify the costing period to which the costs relate

Indicative Cost Information - Modernising Health and Aged Care Payments Services Program

Respondent: -

This proforma collects indicative costing information for the Program by Sub-capability.

Costing information presented in this proforma should relate to the aspects of the required Solution the Respondent addresses through its Submission (i.e. its Component Solution).

Respondents are therefore only required to enter costing information in the relevant sections of the proforma that relate to the aspects of the required Solution the Respondent addresses through its Submission.

Where Respondents are proposing the delivery of the entire Solution across all eight Capabilities and three Technology Services or infrastructure across all Capabilities, costing information may be presented in the 'Total Solution Cost' row only.

Indicative cost tables by sub-capability

Sub-Capabilities	(A) Design & Build Costs (GST exclusive) $'000 Real	(B) Implementation Costs (GST exclusive) $'000 Real	(C) Transition costs (GST exclusive) $'000 Real	(D) Run / operation costs (GST exclusive) $'000 Real	(E) Other costs (GST exclusive) $'000 Real
Costing period	5 years	5 years	5 years	Annual	[please specify]
Identity & access management					
Enrolment and registration					
Verification and authentication					
Customer management					
Relationship management					
Claims management					
Lodgement					
Assessment					
Workflow management					
Case management					
Complex processing					
Business rule management					
Payment management					
Disbursements					
Adjustments					
Recovery					
Communication management					
Inbound communication					
Outbound communication					
Preferences management					
Information management					
Content management					
Business intelligence					
Master data management					
Assurance					
Fraud management					
Payment assurance					
Other*					
other costs (please specify)					
other costs (please specify)					
other costs (please specify)					
other costs (please specify)					
Total Solution Cost					

* a) Please specify where costs will occur due to an additional security overlay outside of standard security within the Component Solution across columns A - E.

b) If an additional security overlay cost is included, please ensure that your Submission clearly outlines the security overlay that will be provided outside of what is embedded in your proposed Component Solution.

Costing assumptions and further information

The indicative costing above relates to:

- ○ infrastructure across all Capabilities;
- ○ delivery of the entire solution across all eight Capabilities and three Technology Services;
- ◉ certain applications and interoperability across a subsection of the eight Capabilities and three Technology Service; or
- ○ other (please provide further information below).

If 'other' is selected, please provide further information below:

Please provide any further key assumptions used to develop indicative costing: