MEMORANDUM OF UNDERSTANDING

between

the Secretary
DEPARTMENT OF HEALTH AND AGEING

and

the Chief Executive Officer
MEDICARE AUSTRALIA

An agreement under section 7A of the Medicare Australia Act 1973
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PART 1

1. BACKGROUND

1.1 Under the Administrative Arrangements Order made by the Governor-General of the Commonwealth on 25 January 2008, as amended on 1 May 2008 and updated on 1 July 2008 (as consolidated):

1.1.1 the Minister for Health and Ageing and the Department of Health and Ageing (DoHA) administer health and ageing policy and legislation including the Health Insurance Act 1973, the National Health Act 1953, the Aged Care Act 1997, the Health and Other Services (Compensation) Act 1995, the Private Health Insurance Act 2007, the Private Health Insurance ( Transitional Provisions and Consequential Amendments) Act 2007, the Private Health Insurance Incentives Act 1998 and the Medical Indemnity Act 2002;

1.1.2 the Minister for Human Services and the Department of Human Services are responsible for the development, delivery and co-ordination of government services, and development of policy on service delivery and administration of the Medicare Australia Act 1973.

1.2 In accordance with section 5(1) of the Medicare Australia Act 1973, the functions of the Chief Executive Officer of Medicare Australia (the CEO) are:

(a) the Medicare Australia functions conferred by or under the Health Insurance Act 1973;

(b) service delivery functions in accordance with arrangements made under section 7(2) of the Medicare Australia Act 1973 between the CEO and the principal officer of a Commonwealth authority;

(c) functions conferred on the CEO under other Acts;

(d) functions that the Minister for Human Services directs the CEO to perform;

(e) functions prescribed in the Medicare Australia Regulations 1975; and

(f) anything incidental to or conducive to the performance of any of the above functions.

1.3 Under section 7A of the Medicare Australia Act 1973, the CEO may enter into agreements about the exercise or performance of the CEO’s powers or functions. This Memorandum of Understanding (MoU) is an agreement under section 7A and is made in order to:

(a) clarify roles and the relationship between DoHA and Medicare Australia in implementing the health and ageing functions conferred on, or powers exercised by, the CEO;

(b) articulate and commit to principles which will guide the relationship between DoHA and Medicare Australia;
specify the services to be provided by Medicare Australia in relation to relevant health and ageing functions and provide a framework for dealing with specific functions or programs as outlined in Business Practice Agreements (BPAs) to this MoU;

(d) outline performance monitoring procedures to be used to ensure that the services provided meet the policy requirements of the Government and outline measures to improve performance; and

(e) establish procedures and mechanisms which will form the basis for improving the collaborative relationship between DoHA and Medicare Australia, particularly in relation to consultation and information sharing.

1.4 The CEO performs functions and exercises powers in accordance with the Minister for Human Services' annual Statement of Expectations. This MoU operates against requirements on the CEO in the Statement of Expectations in areas such as timely consultation with, and information provision and performance reporting to, the Minister for Human Services; and working collaboratively with the Department of Human Services.

2. **PARTIES TO THE MOU**

2.1 This is an agreement between the CEO and the Secretary of DoHA (the Secretary).

3. **STRUCTURE AND OPERATION OF THE MOU**

3.1 This MoU is intended to cover all relevant health and ageing functions performed and powers exercised by the CEO, irrespective of how the functions or powers have been conferred on the CEO.

3.2 The MoU comprises:

(a) Part 1 - being the "core" MoU;

(b) Part 2 - dealing with protocols covering matters of a cross-program nature;

(c) Part 3 - dealing with the business practices for specific programs; and

(d) Schedules.

3.3 The MoU will operate for 3 years from the date of signature of this document but may be extended or varied with the written consent of the Secretary and the CEO.

3.4 Any extension of the term of this MoU will similarly extend the term of all BPAs in force at the time of that extension to the MoU, unless the BPA has an expiry date that is expressly not tied to the expiry of the MoU.

3.5 Any proposed extension or variation to the MoU will be handled by the CEO in accordance with the CEO's responsibilities under the Statement of Expectations to involve the Minister
for Human Services (through the Department of Human Services). DoHA may assume the
CEO has fulfilled this obligation before agreeing to the extension or variation.

4. INTERPRETATION

4.1 Unless otherwise indicated, terms used in this MoU should be interpreted as follows:

“Business Practice Agreement” (BPA) means an agreement established in accordance with
section 7 and Part 3 of this MoU;

“CEO” means the Chief Executive Officer of Medicare Australia;

“DoHA” means the Department of Health and Ageing;

“FMA Act” means the Financial Management and Accountability Act 1997;

“Management Committee” means the committee referred to in section 9.1;

“MoU” means this Memorandum of Understanding including Protocols established under
Part 2;

“MoU Managers” mean the officers of DoHA and of Medicare Australia appointed under
section 9.2 as primary points of contact in relation to MoU matters;

“new business” means the supply of new, and/or changes to existing, outputs, services or
products delivered by Medicare Australia (this covers both new policies as well as changes to
existing policies);

“Program Manager” means a manager, at or above Senior Executive Band 1 level, identified
in a BPA;

“Protocol” means a document established in accordance with Part 2 of this MoU;

“Protocol Manager” means a manager identified in a Protocol;

“relevant health and ageing functions” means health and ageing functions which are conferred
on the CEO in accordance with section 5(1) of the Medicare Australia Act 1973, which
Medicare Australia assists the CEO in the performance of;

“Secretary” means the Secretary of the Department of Health and Ageing; and

“Statement of Expectations” means the document issued annually by the Minister for Human
Services to the CEO, that sets out the Minister’s expectations concerning the operation and
performance of Medicare Australia.

4.2 In this MoU unless the contrary intention appears, words in one gender include every other
gender.
4.3 Every effort should be made to maintain consistency in the use of terminology between this MoU and any BPAs made in accordance with Part 3.

4.4 If there is any inconsistency between this MoU and a BPA, where that BPA is not included in a service arrangement made under section 7(2) of the Medicare Australia Act 1973, the terms of the MoU will prevail unless the Management Committee has explicitly agreed otherwise.

5. ROLES AND RESPONSIBILITIES

5.1 The role of DoHA is to support the Government in the development and implementation of national health policy. It takes a lead role in developing a system which:

(a) meets people's needs throughout their life;
(b) is responsive, affordable and sustainable;
(c) provides accessible, high quality services including preventive, curative, rehabilitative, maintenance and palliative care; and
(d) seeks to prevent disease and promote health.

5.2 DoHA is responsible for policy development in relation to relevant DoHA programs. It also advises the Government, through the Minister for Health and Ageing, and the community on the objectives and impact of health and ageing policies.

5.3 Medicare Australia is accountable to the Minister for Human Services, reporting through the Department of Human Services (in accordance with the Statement of Expectations), for administering Government health policy through general service delivery and the development, delivery and co-ordination of payments for relevant health and ageing programs. Medicare Australia also provides necessary infrastructure, information and support to DoHA in the administration of specific health programs and uses technology to continually improve the customer service experience.

6. ABIDING PRINCIPLES

6.1 The parties recognise the importance of maintaining a positive and cooperative working relationship, and agree that the relationship will be based on the following principles.

6.2 Delivering Quality Outcomes

6.2.1 DoHA and Medicare Australia will work collaboratively to deliver the best possible quality outcomes for Government initiatives. In order to do so, DoHA and Medicare Australia will use this MoU as the basis for a productive relationship. This framework will be the foundation that will be used by the Management Committee in examining progress. It will also form the basis of mutual day-to-day activities within each organisation.

6.3 Program Integrity
6.3.1 DoHA and Medicare Australia will jointly pursue the achievement of relevant Government objectives, and in so doing recognise the importance of a “no surprises” approach, early engagement, and the value of taking a cooperative and holistic approach to the development of new programs and significant changes to existing programs. In this context, the parties recognise that:

(a) each party makes a different and essential contribution to achieving Government objectives and furthering the health and wellbeing of the Australian public;

(b) the ability to understand issues from the other party’s perspective is important to the enhancement of program integrity; and

(c) the effective combination of DoHA policy development and Medicare Australia service delivery expertise will facilitate the achievement of the Government’s objectives.

6.3.2 DoHA and Medicare Australia recognise that they have mutual interests in a number of areas impacting on compliance activities and agree to support each other’s outcomes and will consult as necessary on:

(a) complex cases requiring policy or legal interpretation; and

(b) program integrity costs and savings of new policy proposals.

6.4 Relationship

6.4.1 In managing their relationship, DoHA and Medicare Australia will:

(a) help each other to achieve corporate goals and contribute to each other’s corporate planning processes as appropriate;

(b) collaborate and encourage openness;

(c) be accountable to each other;

(d) be responsive to each other’s needs for ad hoc advice, information and assistance;

(e) be dynamic and responsive to change;

(f) trust the other to be an expert in and manage its own business;

(g) manage and review performance;

(h) resolve disputes via agreed procedures; and

(i) monitor the relationship to ensure it is effective and contributing to the achievement of Government objectives.
6.5 Communication and Information Sharing

6.5.1 The Medicare Australia/DoHA relationship will be more productive where there is a high degree of transparency, regular consultation and sharing of information between the organisations. Medicare Australia and DoHA will, in relation to relevant health and ageing programs:

(a) consult each other about specific operational issues (including new policy and new business proposals) which require a cooperative or coordinated approach. Consultations should be early enough to enable business requirements and funding issues to be considered before Medicare Australia commits to implementation timeframes; and

(b) encourage openness and share relevant information and data, subject to compliance with legislative requirements.

6.5.2 DoHA recognises that Medicare Australia also has responsibilities to engage early with the Minister for Human Services (through the Department of Human Services), on the development and costing of new policies and proposals.

7. BUSINESS PRACTICE AGREEMENTS

7.1 BPAs will be entered into as required in accordance with Part 3.

7.2 These will be:

(a) agreements under section 7A of the Medicare Australia Act 1973 in relation to existing functions or powers of the CEO; and

(b) agreements under section 7A of the Medicare Australia Act 1973 in relation to functions and powers conferred on the CEO in the future.

7.3 Service arrangements entered into in the future under section 7(2) of the Medicare Australia Act 1973 may include BPAs for the purposes of this MoU, or separate BPAs may be entered into in relation to the services.

7.4 BPAs should be read as though they are part of this MoU.

7.5 A list of BPAs will be jointly maintained by the MoU Managers.

7.6 DoHA recognises that Medicare Australia has responsibilities to engage with the Minister for Human Services (through the Department of Human Services) on the development of BPAs and service arrangements, and any variations to these agreements.

7A. OTHER “IN PRINCIPLE” AGREEMENTS, ARRANGEMENTS OR UNDERSTANDINGS

7A.1 Where, prior to the date of operation of this MoU, Medicare Australia and DoHA have made an in-principle agreement, arrangement or understanding in writing, relating to a relevant health and ageing function that does not constitute a BPA, but which is intended to be
superseded by a BPA, that in-principle agreement, arrangement or understanding will be read subject to the terms of this MoU and Protocols.

8. FUNDING AND FINANCIAL MANAGEMENT ARRANGEMENTS

8.1 Overview

8.1.1 Government funds Medicare Australia to perform either functions or programs of DoHA. The CEO performs service delivery functions in relation to DoHA programs or functions.

8.1.2 Departmental funds are provided to Medicare Australia to fund the performance of their functions through either of the following mechanisms:

(a) direct appropriation through the annual appropriation Acts; and

(b) receipt of the transfer of funding under section 31 of the Financial Management and Accountability Act 1997 (FMA Act) for functions or programs that Medicare Australia has undertaken for or on behalf of DoHA and DoHA have agreed to fund from their appropriations.

8.1.3 Administered funds are directly appropriated to DoHA through both special and annual appropriations. For those administered programs for which Medicare Australia provides the payment function, these funds are made available to Medicare Australia through the delegation of drawing rights from DoHA. Medicare Australia requires timely and appropriate access to such funds to allow Medicare Australia to meet program delivery obligations.

8.1.4 Any change to Medicare Australia’s funding requirements will be managed in accordance with the Budget Consultation Protocol at Schedule 1.

8.2 Medicare Australia Direct Appropriation – Departmental Funds

8.2.1 Funds for specified operations of Medicare Australia are directly appropriated to Medicare Australia as departmental funds in annual appropriation Acts.

8.2.2 In agreeing to a new or additional function, or a variation to an existing program to be performed by Medicare Australia, DoHA and Medicare Australia will jointly consider how the potential financial impact should be managed. It may be agreed that DoHA will support a proposal from Medicare Australia to increase their appropriation, or provide a proposal to increase Medicare Australia’s appropriation. It may be agreed that DoHA will provide funding as a section 31 relevant agency receipt (section 8.3 refers).

8.3 Medicare Australia – Section 31 Relevant Agency Receipts

8.3.1 DoHA can provide funding from its appropriations to Medicare Australia to pay for agreed functions which Medicare Australia has not received funding for in its direct departmental appropriation. In these instances funding is transferred from

8.3.2 In agreeing to a new or additional function, or a variation to an existing program to be performed by Medicare Australia, which is not specifically covered by Medicare Australia’s direct appropriation, DoHA and Medicare Australia (in consultation with the Department of Human Services) will jointly consider how the potential financial impact should be managed. In this context:

(a) the estimated cost impact must be supported by signed and agreed business requirements in accordance with the External Costing Guidelines and Request Form agreed between Medicare Australia and DoHA;

(b) in the absence of an agreed scope and funding arrangement, Medicare Australia will only commence work if there is an appropriately authorised interim funding arrangement, or written acceptance between both agencies to proceed without funding;

(c) the possibility to offset savings in other relevant DoHA functions will be considered; and

(d) DoHA may assume that Medicare Australia has fulfilled its obligation to consult with the Department of Human Services in relation to the new or additional functions or variations to an existing program.

8.3.3 All cost estimates and related agreements associated with the above arrangements and DoHA’s departmental appropriation are to be agreed by the Chief Financial Officers (CFOs) of Medicare Australia and DoHA respectively.

8.3.4 Where agreed functions are funded through a DoHA administered appropriation, the relevant DoHA First Assistant Secretary should formally agree to the above arrangements.

8.3.5 Medicare Australia must not commence work without written DoHA agreement.

8.4 Management of Administered Funds paid by Medicare Australia Pursuant to Drawing Rights

8.4.1 Administered funds relating to relevant health and ageing functions are appropriated to DoHA. For those administered programs for which Medicare Australia provides the payment function, funds management arrangements are required. This is to ensure each agency meets its obligations under the Finance Ministers Orders. Specifically:

(a) The Secretary:

(i) has delegated to the CEO the power to issue drawing rights in relation to administered payments to be made by Medicare Australia;

(ii) may request a report on the use of the drawing right delegation;
(iii) will authorise the CEO to draw funds from the sweeping account for both special appropriations, and annual appropriations which are subject to prescribed limits on amounts which may be drawn for specified purposes, and will update these annual appropriation limits after each Budget and may update the limits at other times as appropriate;

(iv) will maintain systems to advise Medicare Australia of the limits on administered annual appropriation funding available for each specified purpose; and

(v) will ensure drawing rights on special and annual appropriations are kept up to date and valid.

(b) The CEO:

(i) will ensure drawing rights on special and annual appropriations are kept up to date and valid;

(ii) will issue drawing rights to appropriate officers within Medicare Australia and ensure that:

   a funds are used only for the specific purpose for which they are made available;

   b the limits on available funding for each specific purpose on annual appropriations, as advised by DoHA, are not exceeded;

   c a report will be provided on the use of the drawing right delegation upon request by DoHA; and

   d officers will work cooperatively with DoHA to address any concerns related to the management of drawing rights relevant to a DoHA appropriation; and

(iii) will ensure that:

   a material accrual financial information is reported to DoHA by the third working day after the end of each month and any additional requirements specified in BPAs; and

   b appropriate additional financial information is available to enable DoHA to prepare financial statements at hard close and year end;

(c) The CEO is to provide the information listed below to the Secretary at a date agreed between the two CFOs. This date will need to be determined and communicated prior to 31 March of the financial year that the
information relates to. The information will be in the form of a written certificate that:

(i) confirms that powers and functions exercised under any delegation under section 53 of the FMA Act have been exercised in accordance with the requirements set out in those delegations in respect of:

a  the FMA Act and Financial Management and Accountability Regulations 1997 and Financial Management and Accountability Orders 2008 made under the FMA Act; and

b  directions given by the Minister of Finance and Administration; or

(ii) if the terms of such delegations were not met, or the drawing rights issued under such delegations were exceeded details:

a  the circumstances in which the terms were not met or the drawing rights were exceeded; and

b  the corrective action taken or proposed to be taken including the timelines for completion of such action.

(d) If the Secretary requires further relevant information in addition to that provided in the written certificate referred to above, the CEO will, wherever possible, provide such information within 30 days of a request made in writing by the Secretary.

8.5 Reconciliation

8.5.1 Medicare Australia and DoHA will ensure that:

(a) there is a reconciliation at the end of every month between the two agencies’ respective records in relation to cash and accrual transactions;

(b) the CFOs of both agencies meet quarterly to review that financial reconciliations are being completed within mutually agreed timeframes; and

(c) in consultation with the Australian National Audit Office, there is a joint sign off as part of the hard close and annual financial statement preparation specifically in relation to cash payments, expenses and material balance sheet accruals between DoHA and Medicare Australia.

8.6 Other Financial and Operational Information

8.6.1 Specific arrangements relating to each relevant health and ageing function or CEO function or both will be included in BPAs.
9. GOVERNANCE ARRANGEMENTS

9.1 MoU Management Committee

9.1.1 The parties agree to participate on a MoU Management Committee which will have the following functions:

(a) oversee the operation of the MoU;

(b) promote an effective working relationship between the parties;

(c) seek opportunities to improve the effectiveness and efficiency of the working relationship;

(d) resolve disagreements referred by the managers of Protocols and BPAs; and

(e) advise the Secretary and the CEO on any matters relevant to the operation of the MoU, including variations to the MoU, the Protocols and BPAs.

9.1.2 The Management Committee:

(a) will have equal representation from both agencies with a minimum of three members each, nominated by the Secretary and the CEO;

(b) will be chaired by the member designated by the CEO until 30 June 2009, after which the chair will be nominated by the Secretary or the CEO, as appropriate, on an annual rotation basis;

(c) will meet as required, but not less than twice in any 12 month period; and

(d) may address urgent or difficult matters out of session or through the appointment of sub-committees. Sub-committees must include at least one member of DoHA and one member of Medicare Australia and will operate for a limited period of time. This time limit does not apply to committees referred to in section 9.3.

9.2 MoU Managers

9.2.1 DoHA and Medicare Australia will each appoint a MoU Manager who will be the primary point of contact in relation to MoU matters. The role of the MoU Managers will be to:

(a) support the Management Committee;

(b) encourage and support the application of the principles set out in section 6; and

(c) perform other functions necessary for the administration of the MoU.
9.2.2 The MoU Managers will not be a conduit for all activity and communication between DoHA and Medicare Australia, but they will be integral to ensuring that the relationship between DoHA and Medicare Australia is operating optimally.

9.2.3 DoHA and Medicare Australia agree to notify the other of any permanent change in the identity of the MoU Manager within one week of the change.

9.3 **Protocols and Business Practice Agreements**

9.3.1 Appropriate arrangements for consultation, performance monitoring and reporting should be included in each Protocol and BPA. This may include the establishment of a program specific Governance Committee which will be accountable to the MoU Management Committee.

9.4 **Medicare Australia Governance**

9.4.1 DoHA will continue to be represented on, and provide input to, higher level governance committees and working groups that provide steerage for Medicare Australia’s annual compliance plan.

10. **VARIATION**

10.1 This MoU and BPAs established in accordance with Part 3 may be varied by the written agreement of the Secretary and the CEO.

10.2 The MoU Management Committee will provide advice to the Secretary and the CEO in relation to proposed variations.

11. **STAKEHOLDER MANAGEMENT**

11.1 In carrying out the business of Government and servicing the Australian health sector, Medicare Australia and DoHA will be required to interact with stakeholders external to the MoU such as other government agencies and industry bodies. This interaction is expected to take various forms including:

(a) consultation and briefing;
(b) formal engagement and collaboration;
(c) reporting; and
(d) data/information collection and analysis.

11.2 It is agreed that Program Managers are the most appropriate points for initial exchange of advice in relation to interaction with external stakeholders.

11.3 Medicare Australia and DoHA agree that liaison and consultation with external stakeholders will be done in a manner that recognises the policy and service delivery roles of DoHA and Medicare Australia respectively, as described in section 5. Detailed agreements in relation to interaction with stakeholders may be included in BPAs.
12. INTELLECTUAL PROPERTY

12.1 DoHA and Medicare Australia recognise and agree that all intellectual property (IP) created in association with the administration of relevant health and ageing functions is owned by the Commonwealth. DoHA and Medicare Australia further agree to work cooperatively in dealing with the management of IP rights and in accordance with the *Intellectual Property Principles for Australian Government Agencies (the Statement of IP Principles)* (released on 11 May 2007).

12.2 Arrangements for the custodianship and management of data, information systems and other IP relating to relevant health and ageing functions shall, as required, be set out in the Protocols and BPAs made in accordance with Part 2 and Part 3.

13. POLICY AND LEGISLATIVE INTERPRETATION

13.1 The parties agree that the following principles should be applied when interpreting legislation and policy relating to relevant health and ageing functions. Subject to any decision of a court of competent jurisdiction:

(a) the views of the relevant Health and Ageing Portfolio Minister are conclusive in relation to which interpretation of legislation administered by the Minister for Health and Ageing best gives effect to policy intent;

(b) the views of the relevant Health and Ageing Portfolio Minister are conclusive on the interpretation or intent of a policy position in relation to a program (for example, who is eligible for what level of payment under a grant program and in what circumstances);

(c) the views of the Minister for Human Services are conclusive in relation to the delivery of a program (for example, how payments are made; shop front accessibility).

13.2 The parties agree that the following principles should be applied in developing policy relating to relevant health and ageing functions:

(a) the Minister for Health and Ageing and his department will consult with the Minister for Human Services, his department and Medicare Australia in regard to service delivery considerations; and

(b) the Minister for Human Services, his department and Medicare Australia will consult with the Minister for Health and Ageing and his department on health and ageing policy considerations.

13.3 In cases where officials perceive tension between the Government’s health and ageing policy and service delivery policy, the processes set out in the Policy and Legislative Interpretation Protocol at Schedule 5 will apply. This Protocol provides guidelines on the application of these principles.
14. **LEGAL PROCEEDINGS**

14.1 Medicare Australia will inform DoHA promptly of legal proceedings to which it is a party or becomes joined to as a party or becomes involved in, in any other capacity, for instance as *amicus curiae*, concerning relevant health and ageing functions.

14.2 DoHA will inform Medicare Australia promptly of any legal proceedings to which it is a party or becomes joined to as a party or becomes involved in, in any other capacity, for instance as *amicus curiae*, concerning service delivery matters.

14.3 Medicare Australia is responsible for legal action related to service delivery matters, including costs, but agrees to consult with DoHA before initiation of legal proceedings on the approach taken, consistent with section 13. The level of consultation may reflect the urgency of the matter.

14.4 DoHA is responsible for any legal action related to policy matters concerning relevant health and ageing functions, including costs, but where the action relates to service delivery, DoHA agrees to consult with Medicare Australia on the approach taken, consistent with section 13. The level of consultation may reflect the urgency of the matter.

14.5 Medicare Australia and DoHA acknowledge it may not be possible to distinguish between service delivery and policy matters and that they may be jointly responsible for legal action in these circumstances (with cost sharing to be agreed between Medicare Australia and DoHA).

15. **MEDIA LIAISON**

15.1 DoHA and Medicare Australia agree to cross-refer media enquiries relating to relevant health and ageing functions in accordance with the following principles:

(a) only Medicare Australia (in consultation with the Department of Human Services, which consultation DoHA may assume has occurred) will provide information about its performance as a service delivery agency;

(b) only DoHA will provide information about the policy intent and performance of programs;

(c) DoHA and Medicare Australia will consult in relation to enquiries which have both service delivery and program performance aspects; and

(d) either party may refer enquirers to sources of publicly available information.

15.2 BPAs may include guideline material or program specific examples to clarify the boundary between service delivery and program performance issues.

16. **NEW BUSINESS**

16.1 It is recognised that proposals to develop new outputs, services or products within existing programs are sometimes formulated outside of the Budget process. DoHA recognises the need for Medicare Australia to provide input to these policy development processes so that the operational integrity of programs can be maximised. Similarly, DoHA input to the
development or revision of risk management and program integrity controls may be appropriate.

16.2 Where DoHA develops new business which relates to relevant health and ageing functions which may impact on Medicare Australia, the relevant DoHA Program Manager will, at an early stage in the policy formulation, consult with the relevant Medicare Australia Program Manager to enable both business requirements and funding arrangements to be agreed to a point that enables Medicare Australia to commit to an implementation timeframe.

16.3 The CEO will keep the Minister for Human Services fully informed of such new business proposals in accordance with the CEO’s responsibilities under the Statement of Expectations. DoHA may assume the CEO has fulfilled this obligation when consulting with Medicare Australia in relation to new business proposals.

16.4 The funding requirements for new business proposals should be jointly considered in accordance with section 8 and the Budget Consultation Protocol at Schedule 1.

17. AUDIT AND FRAUD CONTROL

17.1 DoHA and Medicare Australia recognise that audit and fraud control activities are essential elements of an agency’s governance framework. Consistent with the provisions of the FMA Act, a fundamental tenet of audit and fraud control activities is the ability to provide independent assurances and advice to agency Chief Executives. It is acknowledged that there may be instances where liaison and collaboration between DoHA and Medicare Australia will be required or desirable on audit and fraud control activities and both parties are committed to ensuring program integrity from policy development through to on going operation.

17.2 To ensure that the requirements of section 45 of the FMA Act and the Commonwealth Fraud Control Guidelines are met without duplication, both DoHA and Medicare Australia agree that:

(a) each agency will be responsible for developing fraud control plans in relation to the program activities over which they have operational control;

(b) each agency will be responsible for investigating possible offences in relation to the program activities over which they have operational control;

(c) each agency will be responsible for preparing and submitting the statistics and other information prescribed in the Commonwealth Fraud Control Guidelines on allegations of fraud in relation to the program activities over which they have operational control; and

(d) DoHA has the right to request reports on audit and fraud control plans in relation to all program activities that fall within the policy responsibilities of DoHA.

17.3 DoHA and Medicare Australia agree to consult and involve each other, as appropriate, where audit, investigation and fraud control activities require consideration by both parties.
18. DISPUTE RESOLUTION

18.1 The parties agree to work co-operatively at all levels to advance the Government’s relevant health and ageing policies and service delivery objectives.

18.2 If any dispute or disagreement arises, DoHA and Medicare Australia officers will make every effort to resolve the matter amicably and expeditiously.

18.3 Disagreements relating to policy and legislative interpretation will be handled in accordance with the procedures described in the Policy and Legislative Interpretation Protocol at Schedule 5.

18.4 Disagreements relating to an individual Protocol or a BPA will, in the first instance, be addressed by the Protocol Manager or Program Managers, as appropriate. If they are unable to resolve the matter, the Protocol Manager or Program Manager may notify a disagreement to their MoU Manager. The MoU Manager will, in consultation with the other MoU Manager, arrange for the matter to be considered by the Management Committee which must consider the matter within 30 days of the first MoU Manager’s advice to the second MoU Manager. If the Management Committee is unable to resolve the matter, it will be referred to the Secretary and the CEO for resolution.

18.5 The CEO will report to the Minister for Human Services (through the Department of Human Services) on any disputes that have been referred for Secretary/CEO resolution. DoHA may assume the CEO has fulfilled this obligation.

19. PERFORMANCE REPORTING

19.1 The Management Committee will bring significant issues to the attention of the Secretary and the CEO as necessary, and will submit an annual report. The annual report will:

(a) assess the quality and effectiveness of the working relationship between DoHA and Medicare Australia;

(b) identify any areas where, to a significant degree:

(i) DoHA or Medicare Australia did not meet its obligations under this MoU; or

(ii) DoHA or Medicare Australia’s performance inhibited the other party’s capacity to meet its obligations under the MoU;

(iii) program performance or service delivery suffered due to factors within the joint control of DoHA and Medicare Australia; and

(iv) recommend any actions which it considers appropriate to improve the working relationship.

19.2 The Management Committee may develop performance indicators and introduce reporting requirements for Program Managers as necessary for the production of its annual reports and/or performance reports for the Management Committee.
19.3 Performance reporting requirements in relation to specific programs will be set out in BPAs.

19.4 In accordance with the requirements of the Statement of Expectations, the CEO will also provide the Minister for Human Services (through the Department of Human Services) with regular performance reports on the operation of the MoU and BPAs. DoHA may assume the CEO has fulfilled this obligation.

PART 2 – CROSS PROGRAM PROTOCOLS

20. PROTOCOLS

20.1 The parties agree to adhere to the attached Protocols dealing with the following issues:

(a) Budget Consultation (Schedule 1);
(b) Parliamentary and Ministerial Coordination (Schedule 2);
(c) Legislation Consultation (Schedule 3);
(d) Information Management and Release (Schedule 4);
(e) Policy and Legislative Interpretation (Schedule 5); and
(f) Program Integrity and Risk Management (Schedule 6).

20.2 The Protocols are intended to articulate how DoHA and Medicare Australia will interact, and manage their relationship in matters which are not specific to a single program.

20.3 The Protocols must be consistent with Part 1 of this MoU unless the Management Committee has explicitly agreed otherwise.

21. ADDITION OF NEW PROTOCOLS

21.1 The Management Committee may recommend that the Secretary and the CEO establish additional Protocols as required from time to time.

22. VARIATION TO PROTOCOLS

22.1 The parties intend that the Protocols should be “living documents” which are always in tune with the current environment and operational requirements. DoHA and Medicare Australia Protocol Managers will jointly keep them under review and recommend variations, as required, to the Secretary and the CEO via the Management Committee.

23. TERMINATION OF PROTOCOLS

23.1 If the Management Committee considers that a Protocol is no longer necessary or helpful, it can recommend to the Secretary and the CEO that the Protocol be terminated. The written agreement of both parties is required for the Protocol to be terminated, in accordance with section 10.1.
PART 3 – BUSINESS PRACTICE AGREEMENTS

24. BUSINESS PRACTICE AGREEMENTS

24.1 The parties agree that all relevant health and ageing functions performed and powers exercised by Medicare Australia in assisting the CEO will be covered by a Business Practice Agreement (BPA) made under section 7A of the Medicare Australia Act 1973 except when similar information has been agreed as a part of a service arrangement under section 7(2) of the Medicare Australia Act 1973.

24.2 The parties acknowledge that they only enter into a BPA in relation to functions conferred on the CEO in accordance with section 5 of the Medicare Australia Act 1973 or powers otherwise exercised by the CEO. These agreements are made subject to the MoU unless otherwise negotiated between the parties.

24.3 The BPAs must be consistent with Part 1 of this MoU unless the Management Committee has explicitly agreed otherwise.

25. NEW BPAS

25.1 The Secretary and the CEO will establish new BPAs as soon as practicable after the conferral of a new relevant health and ageing function on the CEO.

26. VARIATION TO BPAS

26.1 The parties intend that the BPAs should be “living documents” which are always in tune with the current environment and operational requirements. The Program Managers will jointly keep them under review and recommend variations, as required, to the Secretary and the CEO via the Management Committee. Schedules or attachments to BPAs may only contain matters of procedure relating to the delivery of the service covered by the BPA and these schedules or attachments may be amended from time to time at Program Manager level.

27. TERMINATION OF BPAS

27.1 Where a BPA is no longer required, the Program Managers may jointly recommend termination to the Secretary and the CEO via the Management Committee. Where there is an ongoing need for data supply or other services in relation to a defunct program, the Program Managers may recommend that the BPA be varied to reflect only the ongoing needs.
Signed by Ms Jane Halton PSM
Secretary, Department of Health and Ageing:

Date: 2 May 2009

In the presence of:

Name: [Signature]

Signed by Ms Philippa Godwin
Acting Chief Executive Officer, Medicare Australia:

Date: 8 May 2009

In the presence of:

Name: [Signature]
BUDGET CONSULTATION PROTOCOL

1. CONTEXT

1.1 The purpose of this Protocol is to document the arrangements for consultation between the Department of Health and Ageing (DoHA) and Medicare Australia on Budget proposals, other new policy proposals and program changes relating to relevant health and ageing functions. The Protocol takes account of APS-wide procedures outlined in Estimates Memoranda from the Department of Finance and Deregulation (DoFD).

1.2 It is made pursuant to Part 2 of the Memorandum of Understanding (MoU).

2. DEFINITIONS

2.1 In this Protocol, unless the context otherwise requires, terms are as defined in the MoU. In addition:

“DoFD” means the Department of Finance and Deregulation;

“DHS” means the Department of Human Services.

3. GENERAL PRINCIPLES APPLYING TO BUDGET MATTERS

3.1 Medicare Australia and DoHA agree that the success of some government initiatives in the health and ageing portfolio is conditional on both agencies actively contributing to the development of the proposal, particularly relating to Budget proposals, other new policy proposals and program changes.

3.2 In that context, while recognising that there may be occasions when it is not possible to do so, both parties will use their best endeavours to adhere to the funding and financial management arrangements set out in section 8 of the MoU and this Protocol.

3.3 The parties agree that each party will provide the other with sufficient time to prepare a financial analysis of the impact of any proposal being considered which has funding implications, and on the basis of that analysis, contribute to that proposal.

3.4 In addition to the general Budget procedures (including guidelines, timeframes and pro formas) specified by DoFD in Estimates Memoranda, during the Budget process, DoHA and Medicare Australia will adhere to all other timeframes agreed between the Assistant Secretary Budget Branch (DoHA), and the Branch Head, Budgeting and Management Accounting Branch (Medicare Australia). Such timeframes will be agreed within 2 weeks of Budget timelines being released by DoFD.

3.5 Any costings are to be developed in accordance with the External Costing Guidelines and Request Form agreed between DoHA and Medicare Australia.

3.6 DoHA will lead the development of Budget proposals, other new policy proposals and program change proposals affecting health and ageing policy and Medicare Australia will lead the development of Budget proposals, other new policy proposals and program change proposals with the principal aim of changing service delivery.
3.7 Where Budget proposals, other new policy proposals and program change proposals impact upon both agencies, the responsible agency will consult with the other agency to allow for their consideration and input into the proposal before it is submitted to Government for consideration.

3.8 Once a new proposal has been approved by Government, the agencies will meet as soon as possible, but no later than one month after the approval, to agree to timeframes around the major deliverables for the proposal.

3.9 Each agency will provide the other agency with sufficient information and time to prepare an analysis of the impact of any Budget proposals, other new policy proposals, and program change proposals and on the basis of that analysis contribute to the development of the proposal. Technical and time constraints may impact on the provision of information between agencies, but both agencies will advise the other of such issues wherever possible.

4. CONSULTATION

4.1 The Chief Financial Officer (Medicare Australia) and the First Assistant Secretary, Portfolio Strategies Division (DoHA) will meet on a quarterly basis to monitor Budget and other new policy and program change issues. The DoHA Chief Financial Officer may also attend these quarterly meetings, where applicable.

4.2 New policy proposals brought forward in the Budget process

4.2.1 All proposals that have a cost or policy impact on the other agency and are being submitted for consideration by Government in the Strategic Budget Committee (SBC) process, will be provided to the affected agency, as soon as possible, but no later than one month prior to the date costings are due with DoFD.

4.2.2 Each agency will advise the other of the proposals impacting upon them which the SBC process agrees to take forward into the next Budget as soon as possible, but no later than one (1) week after the SBC meeting.

4.2.3 All other proposals being brought forward in the Budget process will be provided subject to clearance from the relevant Minister.

4.2.4 To adhere to the requirements set by DoFD, the lead agency will ensure that the other agency has sufficient information, in an appropriate timeframe, to assess the impact on its business activity and to allow it to develop a plan and associated costings, in accordance with the External Costing Guidelines and Request Form, and in enough detail to agree with DoFD.

4.2.5 In the event of the Contact Officers and Protocol Managers having difficulty reaching agreement, the issue of reasonable costing requirements will be put to the Chief Financial Officer (Medicare Australia) and the First Assistant Secretary, Portfolio Strategies Division (DoHA) for resolution. The DoHA Chief Financial Officer may also attend these meetings, where applicable.

4.3 New policy proposals and other activities brought forward outside the Budget process

4.3.1 Medicare Australia may agree to undertake work for DoHA where that work is generated outside of the Government’s Budget cycle.
4.3.2 Where such work has an impact on Medicare Australia’s costs, DoHA and Medicare Australia will agree how the financial impact should be managed. In this context, section 8 of the MoU covers cost impact, agreement on cost and commencement of work. For any functions not covered by direct appropriation, the arrangements through which funds are provided to Medicare Australia will be specified in the relevant BPA, In-Principle Agreement or other interim agreement, or service arrangement.

4.4 Act of Grace Claims

4.4.1 Act of Grace claims and payments will be made in accordance with directions from DoFD. Consultation will also occur with regard to the handling of any actual or potential Act of Grace claims.

4.5 Compensation for Detriment Caused by Defective Administration

4.5.1 Medicare Australia and DoHA are each responsible for claims made against them under the Compensation for Detriment caused by Defective Administration (CDDA) Scheme. Where a CDDA claim involves both Medicare Australia and DoHA, the parties agree to consult in relation to managing the claim and the resolution of any apportionment of payment(s) to the affected parties as between Medicare Australia and DoHA.

4.6 Setting new commencement dates

4.6.1 Agencies will consult with each other to consider the impact of proposed starting dates (having regard to software release processes and the priorities of initiatives) to ensure that implementation of proposals is achievable.

5. CONTACT OFFICERS

5.1 The officers responsible for the overall management of this Protocol (the “Protocol Managers”) will be:

<table>
<thead>
<tr>
<th>DoHA</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Secretary</td>
<td>Branch Head</td>
</tr>
<tr>
<td>Budget Branch</td>
<td>Budgeting and Management Accounting Branch</td>
</tr>
</tbody>
</table>

5.2 The officers responsible for the day-to-day administration of the Budget matters (the “Contact Officers”) will be:

<table>
<thead>
<tr>
<th>DoHA</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>Manager</td>
</tr>
<tr>
<td>Budget Management Section</td>
<td>Business Pricing</td>
</tr>
</tbody>
</table>

5.3 Any changes to these contact details will be promptly notified to the other party and to the MoU Managers in DoHA and Medicare Australia.
6. REVIEW AND VARIATION

6.1 The Protocol Managers will jointly monitor the operation of this Protocol and recommend any necessary or desirable variation to Secretary and the CEO via the MoU Management Committee.
PARLIAMENTARY AND MINISTERIAL COORDINATION PROTOCOL

1. CONTEXT

1.1 This document sets out the protocol for inter-organisational communication between the Department of Health and Ageing (DoHA) and Medicare Australia on Parliamentary and Ministerial matters of mutual significance.

1.2 The Protocol supplements the APS-wide procedures outlined in the "Cabinet Handbook" (produced by the Department of the Prime Minister and Cabinet) and documents giving effect to these guidelines, eg the "Essentials" in DoHA, and the Ministerial and Parliamentary handbook of DHS.

1.3 It is made pursuant to Part 2 of the Memorandum of Understanding (MoU).

2. DEFINITIONS

2.1 In this Protocol, unless the context otherwise requires, terms are as defined in the MoU. In addition:

"DHS" means the Department of Human Services.

3. GENERAL PRINCIPLES

3.1 DoHA and Medicare Australia are responsible for managing their own Parliamentary and Ministerial liaison, but both organisations agree to:

(a) consult on Parliamentary and Ministerial matters of mutual concern;

(b) refer matters across, in a timely manner, that are more appropriately addressed by the other organisation in accordance with their roles and responsibilities as set out in section 5 of the MoU, or as agreed in BPAs; and

(c) collaborate in preparing joint documentation as appropriate.

3.2 It is recognised that Parliamentary and Ministerial liaison in Medicare Australia occurs through DHS.

4. SENATE ESTIMATES AND PARLIAMENTARY COMMITTEES

4.1 DoHA and Medicare Australia agree that Program Managers will consult each other as necessary prior to Senate Estimates or parliamentary committee hearings.

4.2 Such consultation will include, at minimum, agreement on which issues each party will provide responses to, in line with the agreed roles and responsibilities as described in section 5 of the MoU.

4.3 In addition, DoHA and Medicare Australia undertake to advise each other in a timely manner of any question they have referred to the other agency at Senate Estimates or parliamentary committee hearings.
5. CONSULTATION ON MINISTERIAL AND PARLIAMENTARY DOCUMENTS

5.1 DoHA and Medicare Australia undertake to inform and appropriately consult each other on Ministerial and Parliamentary documents of mutual significance, including:

(a) Question Time briefs;
(b) Current Issues briefs;
(c) Briefing notes and speeches;
(d) Parliamentary questions (without notice/on notice/in writing);
(e) Ministerial correspondence; and
(f) Minutes to ministers.

5.2 It is recognised that many Ministerial and Parliamentary documents are extremely time critical. For example, Question Time briefs are often requested within hours of being required. DoHA and Medicare Australia will endeavour to provide an appropriate response to requests for input to Ministerial and Parliamentary documents from the other agency in a timely manner.

5.3 Upon request and in consultation with the relevant minister’s office, DoHA and Medicare Australia will provide the other agency with copies of relevant Question Time briefs and/or Current Issues briefs.

6. CONSULTATION ON CABINET DOCUMENTS

6.1 In the spirit of collaboration and cooperation as described in the MoU, and in accordance with the standards and procedures set out in the Cabinet Handbook and the Drafter’s Guide, DoHA and Medicare Australia undertake to consult each other and share information as appropriate on relevant health and ageing matters.

6.2 In particular:

(a) where DoHA initiates a Cabinet document which may impact on Medicare Australia or the delivery of programs administered by Medicare Australia, DoHA agrees that the program area with primary responsibility for the document will consult with Medicare Australia;

(b) where Medicare Australia initiates a proposal which may impact on relevant health and ageing functions, Medicare Australia agrees to:

(c) inform DoHA prior to developing the proposal; and

(d) work closely with DoHA in the development of the Cabinet document.
7. CONTACT OFFICERS

7.1 The officers responsible for the overall management of this Protocol will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Secretary</td>
<td>Manager</td>
</tr>
<tr>
<td>Ministerial and Parliamentary Support Branch</td>
<td>Communication and Government Relations Branch</td>
</tr>
</tbody>
</table>

7.2 The primary contact officers for issues relating to this Protocol will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>Manager</td>
</tr>
<tr>
<td>Cabinet, Parliamentary Support and Community Sector Support Section</td>
<td>Parliamentary Section</td>
</tr>
<tr>
<td>Ministerial and Parliamentary Support Branch</td>
<td></td>
</tr>
</tbody>
</table>

7.3 Any changes to these contact details will be promptly notified to the other party and to the MoU Managers in DoHA and Medicare Australia.

8. REVIEW AND VARIATION

8.1 The Protocol Managers will jointly monitor the operation of this Protocol and recommend any necessary or desirable variation to the MoU Management Committee (as defined in section 9(1) of the MoU).
LEGISLATION CONSULTATION PROTOCOL

1. CONTEXT

1.1 The purpose of this Protocol is to document the arrangements for consultation between the Department of Health and Ageing (DoHA) and Medicare Australia on Legislation matters relating to relevant health and ageing functions.

1.2 The Protocol should be read in conjunction with the APS-wide procedures outlined in the "Legislation Handbook" (produced by the Department of Prime Minister and Cabinet).

1.3 It is made pursuant to Part 2 of the Memorandum of Understanding (MoU).

2. DEFINITIONS

2.1 In this Protocol, unless the context otherwise requires, terms are as defined in the MoU. In addition:

"DHS" means the Department of Human Services; and

"Legislation" has its ordinary meaning and includes (where the context permits) regulations and legislative instruments.

3. GENERAL PRINCIPLES

3.1 DoHA undertakes to appropriately consult with Medicare Australia at an early stage on all Legislation matters that:

(a) relate to relevant health and ageing functions and impact on Medicare Australia or Medicare Australia’s general service delivery, or the delivery of the programs it administers; or

(b) relate to proposals for new programs which may involve Medicare Australia.

3.2 Medicare Australia undertakes to consult with DoHA, at an early stage, in relation to all Legislation matters impacting on the health and ageing portfolio and to work closely with DoHA in developing Legislation bids. It is recognised that Legislation initiatives are progressed in Medicare Australia through DHS.

3.3 DoHA and Medicare Australia each undertake to keep the other informed of the progress of, and to continue to consult in relation to, Legislation matters referred to in this section.

4. CONSULTATION DURING LEGISLATION BIDDING PERIODS

4.1 DoHA and Medicare Australia agree, wherever possible, to adopt the following practices in relation to the preparation and co-ordination of Legislation bids.
4.2 Proposals initiated by DHS on behalf of Medicare Australia

4.2.1 Medicare Australia agrees to discuss all ideas for potential DHS Legislation bids that it is cognizant of with implications for health policy or DoHA programs with DoHA at an early stage in the Legislation process. Initial discussions should be held with the relevant program area within DoHA.

4.2.2 Where a proposal is to be progressed further, the Medicare Australia contact officer will contact the DoHA contact officer for further discussion.

4.2.3 Medicare Australia agrees to work closely with DoHA in developing and refining the proposal prior to formally progressing it through DHS.

4.3 Proposals initiated by DoHA

4.3.1 Where DoHA proposes to initiate a Legislation bid that:

(a) relates to relevant health and ageing functions and impacts on Medicare Australia or the delivery of the programs it delivers; or

(b) relates to proposals for new programs which may involve Medicare Australia,

the DoHA contact officer will consult with the Medicare Australia contact officer at an early stage in the Legislation process prior (wherever possible) to seeking formal comments from other agencies.

4.3.2 Medicare Australia will be responsible for ensuring that DHS is kept appraised of relevant health and ageing Legislation proposals.

4.4 Legislation proposals originating in other agencies

4.4.1 While co-ordination comment will be provided separately by Medicare Australia/DHHS and DoHA, both agencies agree to consult with each other on any matter which potentially involves the other agency.

5. CONTACT OFFICERS

5.1 The officers responsible for the overall management of this Protocol (the “Protocol Managers”) will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Secretary</td>
<td>General Counsel</td>
</tr>
<tr>
<td>Legal Services Branch</td>
<td></td>
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</tbody>
</table>
5.2 The officers responsible for the day-to-day administration of the legislation matters (the "Contact Officers") will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislative Liaison Officer</td>
<td>General Counsel</td>
</tr>
<tr>
<td></td>
<td>DHS contact officer:</td>
</tr>
<tr>
<td></td>
<td>General Counsel</td>
</tr>
</tbody>
</table>

5.3 Any changes to these contact details will be promptly notified to the other party and to the MoU Managers in DoHA and Medicare Australia.

6. REVIEW AND VARIATION

6.1 The Protocol Managers will jointly monitor the operation of this Protocol and recommend any necessary or desirable variation to the MoU Management Committee (as defined in section 9.1 of the MoU).
INFORMATION MANAGEMENT AND RELEASE PROTOCOL

1. PURPOSE

1.1 The purpose of this Protocol is to:

   a) document how the Department of Health and Ageing (DoHA) and Medicare Australia will work together, in general terms, to manage information relating to relevant health and ageing functions;

   b) establish the principles that will govern the provision of information relating to relevant health and ageing functions by Medicare Australia;

   c) provide guidance on the interpretation and implementation of the Overarching Principles; and

   d) establish a framework to promptly resolve disputes concerning the implementation and interpretation of this Protocol.

1.2 The Protocol is made pursuant to Part 2 of the Memorandum of Understanding (MoU) and should be interpreted having regard to the Overarching Principles (see Attachment A) and the provisions set out in the MoU.

1.3 Specific agreements in relation to information management will be set out in Business Practice Agreements (BPAs) made pursuant to Part 3 of the MoU.

2. JOINT OBLIGATIONS

2.1 The Parties agree to work co-operatively and abide by their obligations under relevant legislation, regulations made there under and government best practice dealing with information management and release. This includes but is not limited to: (i) Secrecy provisions; (ii) Privacy Act; and (iii) FOI Act.

3. DEFINITIONS

3.1 In this Protocol, unless the context otherwise requires, terms are as defined in the MoU. In addition:

   “Agency” means, depending on the context, either the Department of Health and Ageing (DoHA) or Medicare Australia and “Agencies” means both of them;

   “Archives Act” means the Archives Act 1983;

   “Business Practice Agreement” means agreements made in accordance with Part 3 of the MoU;

   “Health Program Information” means any information required by DoHA which is in Medicare Australia’s possession or control by virtue of it being collected as part of the administration of relevant health and ageing functions;

   “FOI Act” means the Freedom of Information Act 1982;
“IMSC” means the Information Management Sub-Committee established under section 8 of this Protocol;

“Information” means data of any kind and includes, but is not necessarily limited to:

(a) “personal information” as defined in the Privacy Act 1988;

(b) information to which section 135A of the National Health Act 1953 applies;

(c) information to which section 130 of the Health Insurance Act 1973 applies; and

(d) Health Program Information (HPI).

“MoU Management Committee” means the committee established under section 9.1 of the MoU;

“Overarching Principles” means the document agreed to by the Minister for Health and Ageing and the Minister for Human Services which is Attachment A to this Protocol; and

“Privacy Act” means the Privacy Act 1988.

4. GENERAL PRINCIPLES

4.1 The parties agree that information management in relation to relevant health and ageing functions will be governed by the following principles:

(a) Medicare Australia will provide DoHA with HPI as required by DoHA for policy development and program management purposes. DoHA may hold such HPI in its own information systems, subject to any applicable legislative restrictions; and

(b) Medicare Australia will provide advice to DoHA at an early stage if any errors about accuracy, completeness and reliability of HPI are identified and will consult with DoHA on appropriate action.

5. INFORMATION QUALITY

5.1 The principles in section 6 of the MoU describe principles to apply to all aspects of the relationship between Medicare Australia and DoHA, including recognition of the importance of a “no surprises” approach and early engagement on issues by both parties. In addition, the following principles are agreed as a basis for cooperation:

(a) Medicare Australia is responsible for ensuring the integrity of information;

(b) DoHA will consult with Medicare Australia on the form and content it needs for the provision of information; and

(c) the definition of information items must be consistent with the underlying policy and intended policy outcomes.
6. INFORMATION RELEASE

6.1 Any public disclosure of information will be done in accordance with the Overarching Principles.

7. COST OF INFORMATION PROVISION

7.1 DoHA’s information requirements shall be set out in the relevant BPA. The information described in the BPA will be provided at no additional cost unless otherwise indicated in the BPA.

7.2 New policy proposals will be costed and agreed to by DoHA and Medicare Australia in accordance with section 8 of the MoU and the Budget Consultation Protocol to ensure that Medicare Australia is appropriately resourced to manage related information activities including the provision of relevant information to DoHA.

7.3 Where DoHA seeks information from Medicare Australia which is:

(a) not identified in existing BPAs; and/or

(b) does not constitute a new policy proposal; and

(c) requires Medicare Australia to incur additional costs to extract the information from its systems

the terms on which such information will be provided to DoHA will need to be negotiated between DoHA and Medicare Australia. If necessary, a costing request will be made by DoHA in accordance with section 8 of the MOU.

7.4 Where the parties are unable to agree on which agency should bear the cost for the provision of information, the matter will be referred to the relevant BPA Program Managers who will make every effort to resolve the matter amicably and expeditiously. If the dispute or disagreement cannot be resolved then the dispute resolution process outlined in Section 18 of the MoU will apply.

8. GOVERNANCE

8.1 The parties will agree to establish an Information Management Sub-Committee (IMSC) of the MoU Management Committee. The IMSC will replace all existing joint committees relating to information management issues. The IMSC will:

(a) include up to four representatives nominated by DoHA and up to four representatives nominated by Medicare Australia;

(b) be chaired by a member nominated by Medicare Australia until 30 June 2009, after which the chair will be nominated by DoHA or Medicare Australia, as appropriate, on an annual rotation basis;

(c) meet at least quarterly, but may conduct business out-of-session as required;
have the following functions:

(i) assist with resolving information-related problems arising between DoHA and Medicare Australia;

(ii) establish relative priorities and feasible time-tables for information changes;

(iii) monitor the implementation of these changes and escalate unresolved issues to the MoU Management Committee;

(iv) oversee the development and implementation of information standards in relation to relevant health and ageing programs;

(v) manage the shared need for meta-data and, where required, approve definitions of information items;

(vi) coordinate the approach taken by DoHA and Medicare Australia to the development and implementation of national information standards in the health and aged care sectors;

(vii) provide advice to the MoU Management Committee on the effectiveness of the operation of the MoU in relation to information issues;

(viii) encourage and support joint initiatives by DoHA and Medicare Australia to improve information management; and

(ix) any other function required by the operation of this Protocol or determined by the MoU Management Committee.

(e) will create working groups as required:

(i) working groups established by the IMSC would be invited to resolve issues and report outcomes within agreed and nominated timeframes;

(ii) agreed outcomes of working groups must be referred to the IMSC for consideration; and

(iii) issues which cannot be agreed by the IMSC can be referred to the MoU Management Committee, eg. for resolution, or for recommendation of further resourcing towards resolution.

8.2 Members of DoHA or Medicare Australia may refer issues to the IMSC with the endorsement of their Program Manager (refer to section 9).
9. CONTACT OFFICERS

9.1 The officers responsible for the overall management of this Protocol (the "Protocol Managers") will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Secretary Economic and Statistical Analysis Branch</td>
<td>Manager</td>
</tr>
<tr>
<td></td>
<td>Legal, Privacy and Information Services Branch</td>
</tr>
</tbody>
</table>

9.2 The primary contact officers for issues relating to this Protocol will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Secretary Economic and Statistical Analysis Branch</td>
<td>Manager</td>
</tr>
<tr>
<td></td>
<td>Legal, Privacy and Information Services Branch</td>
</tr>
</tbody>
</table>

9.3 Any changes to these contact details will be promptly notified to the other party and to the MoU Managers in DoHA and Medicare Australia.

10. REVIEW AND VARIATION

10.1 The Protocol Managers will jointly monitor the operation of this Protocol and recommend any necessary or desirable variation to the MoU Management Committee.
OVERARCHING PRINCIPLES

1. The views of the relevant Health and Ageing Portfolio Minister are conclusive in relation to the policy intent of legislation administered by the Minister for Health and Ageing.

2. The views of the relevant Health and Ageing Portfolio Minister are conclusive in relation to the interpretation or intent of a policy position in relation to a health and ageing program.

3. The views of the Minister for Human Services are conclusive in relation to matters concerning the delivery of services under a health and ageing program.

4. In developing policy, the Minister for Health and Ageing and her department will consult with the Minister for Human Services, his department and Medicare Australia on service delivery considerations.

5. In determining the means of service delivery, the Minister for Human Services, his department and Medicare Australia will consult with the Minister for Health and Ageing and her department on health and ageing policy considerations.

6. In the public release of information and data, as detailed in the attached schedule:

   • the Minister for Health and Ageing and her department will be responsible for the release where the information and data relates to the policy intent of, or the impact of, health and ageing policy initiatives;

   • the Minister for Human Services, his department and Medicare Australia will be responsible for the release where the information and data relates to service delivery issues; and

   • the agreement of both Ministers and their departments will be sought where the release has implications for both health and ageing policy and service delivery.
**SCHEDULE TO OVERARCHING PRINCIPLES**

| Minister for Health and Ageing Data Release | • Policy about Health and Ageing programs.  
• Information and data which would indicate program changes over time and variations by geographic classifications. For example:  
  - Medicare Benefits paid by Location Specific Practice Number [LSPN];  
  - Australian Childhood Immunisation Register data; and  
  - GP Immunisation Incentives payments data.  
• All private health insurance data except national summary data on service delivery activities performed by Medicare Australia.  
• Magnetic Resonance Imaging (MRI) unit and usage information, including data obtained from sources other than Medicare Australia.  
• Bulk billing rates, safety net benefits, patient co-payments and schedule fee observance.  
• Number of Medicare providers. |
| Minister for Human Services Data Release | • Issues around service delivery.  
• Mechanics of public and provider access to programs.  
• Volume of transactions by time, locations, etc.  
• Speed of transactions.  
• Nature of transactions (eg on-line, over the counter, by mail).  
• Information of how to claim.  
• Medicare offices – number, location, opening hours etc.  
• Information about eligible MRIs for Medicare claiming purposes  
• On-line billing arrangements.  
• Number of Medicare cards.  
• Numbers of registrations.  
• How payments are made. |
| Joint Data Release | • Routine reporting in accordance with BPAs (or legacy arrangements until BPAs are raised). For example, PBS expenditure and/or script volumes by drug category (by ATC) and MBS Benefits paid by type of service.  
• Variations to routine reporting in accordance with BPAs (or legacy arrangements until BPAs are raised).  
• Whole of program expenditure figures (e.g. total MBS expenditure) based on agreed definitions (e.g. cash or accrual adjusted in an agreed manner).  
• Instances where Medicare Australia and DOHA agree through exchange of correspondence on particular data release arrangements.  
• MBS item utilisation. |

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1 The Schedule is not intended to be a comprehensive list of Ministerial capacity for data and information release. It will be amended in accordance with amendments made to Information Release and Management Protocol, as agreed from time to time.

2 Data released by the Minister for Health and Ageing will be data released by any geographic area and electorate.

3 “Joint Data Release” means that agencies may release data independently or jointly once both agencies have checked and agreed to the release of the data.
POLICY AND LEGISLATIVE INTERPRETATION PROTOCOL

1. CONTEXT

1.1 The purpose of this Protocol is to document the guidelines and procedures applying to consultation on matters of policy and legislative interpretation between the Department of Health and Ageing (DoHA) and Medicare Australia.

1.2 It is made pursuant to Part 2 of the Memorandum of Understanding (MoU).

1.3 It is acknowledged that both DoHA and Medicare Australia will act in accordance with their respective obligations under the Legal Service Directions 2005 (the Legal Services Directions) in relation to the provision of legal services.

2. DEFINITIONS

2.1 In this Protocol, unless the context otherwise requires, terms are as defined in the MoU. In addition:

"DHS" means the Department of Human Services.

3. GENERAL PRINCIPLES

3.1 Officers of DoHA and Medicare Australia will operate in a manner consistent with the Overarching Principles which sets out the role of:

(a) the Minister for Health and Ageing, supported by DoHA, to determine and articulate the intent of Government health and ageing policy; and

(b) the Minister for Human Services, supported by DHS and Medicare Australia, to determine and deliver appropriate service delivery arrangements.

4. POLICY INTERPRETATION

4.1 It is noted that new policy and policy variations can have a material impact on processes, systems, outputs and outcomes, even where there is no change to legislation. Similarly, policy may at times be subject to refinement during an implementation phase, or may be adjusted in light of emerging priorities.

4.2 It is accepted that new policy, changes to, and the refinement or clarification of health and ageing policy intent, may impact on systems administered by Medicare Australia. In the event of an impact, Medicare Australia may provide a policy impact statement to DoHA detailing that impact. DoHA and Medicare Australia agree to consult regarding these matters, including funding and resource implications and implications for agreed outputs.

4.3 It is acknowledged that there may be exceptional cases where there is actual or perceived tension between the Government's health and ageing policy and its service delivery objectives. In these cases, officers will make every effort to agree a policy position which balances the Government's health and ageing policy and service delivery objectives.
5. LEGISLATIVE INTERPRETATION

5.1 It is noted that legislation can be interpreted in a number of different ways, some of which may produce outcomes which are more or less consistent with the intent of Government health and ageing policy. It is agreed that, in accordance with legal principle, legislation administered by the Minister for Health and Ageing (‘health and ageing legislation’) is to be interpreted:

(a) in a manner which best reflects the intent of Government health and ageing policy;
(b) as determined by the Minister for Health and Ageing;
(c) taking into account the merits of the individual case; and
(d) subject to any decision of a court of competent jurisdiction that deals with the relevant provision(s) of the legislation that is being administered.

5.2 In the case of 5.1 (d), the effect of the court’s decision must be complied with, taking into account the merits of the particular case.

5.3 It is noted that specific powers and functions are conferred on the CEO both under the health and ageing legislation itself and through Ministerial Directions made under the Medicare Australia Act 1973. It is agreed that where Medicare Australia officers exercise such powers or perform such functions, the relevant legislative provisions will be interpreted in a manner which best reflects the intention of the Government’s health and ageing policy as determined by the Minister for Health and Ageing taking into account the merits of the individual case, subject to any decision of a court of competent jurisdiction that deals with the relevant provision(s) of the legislation that is being administered. In the latter case the effect of the court’s decision must be complied with.

5.4 It is acknowledged that both DoHA and Medicare Australia will, as a matter of routine, seek, obtain and provide legal advice in relation to the interpretation of the other party’s legislation to assist in performing their respective functions in the conduct of their day to day activities.

5.5 DoHA and Medicare Australia agree to promptly consult with the other party in cases where any legal advice being sought, obtained or provided has, or is likely to have, significant health and ageing policy or service delivery implications. Examples of where consultation may be required include where:

(a) the advice could be contrary to existing policy or could raise new policy issues in respect of the legislation; or
(b) a potential weakness in the legislation has been identified.

5.6 In matters where there is conflicting legal advice about the interpretation of health and ageing legislation, Medicare Australia will, if requested by DoHA, act in accordance with DoHA’s preferred legal advice, subject to:

(a) the advice adequately addressing any legal and practical issues of concern identified by Medicare Australia in relation to the matter; and
(b) Medicare Australia being satisfied that the conclusions in the advice are reasonably arguable and that acting on the advice would be consistent with Medicare Australia’s obligation to act as a model litigant under paragraph 4.2 of the Legal Services Directions 2005.

5.7 Should Medicare Australia consider it is unable to act in accordance with DoHA’s preferred legal advice, officers from DoHA and Medicare Australia will make every effort to resolve the matter expeditiously and in a manner which enables Medicare Australia to deliver services in a manner which is consistent with Government health and ageing policy, as determined by the Minister for Health and Ageing, and the service delivery policy determined by the Minister for Human Services.

6. **DISPUTE RESOLUTION**

6.1 The parties agree to work co-operatively to resolve any disputes which may arise in regard to legislative and policy interpretation.

6.1.1 **Disputes involving policy interpretation**

(a) Disagreements involving policy interpretation will in the first instance be addressed by the Managers identified in the relevant Business Practice Agreement or Protocol, or if in relation to a program or policy not addressed by a Business Practice Agreement, by the Managers responsible for the issue. It is expected that both Managers will draw on internal legal advice where matters of legislative interpretation are involved.

(b) If they are unable to resolve the matter, either Manager may notify a disagreement to their MoU Manager. The Manager(s) notifying the disagreement must provide a written description of the issue which details the nature of the dispute, specific areas of disagreement, and the potential policy, service delivery, or legislative impact of the matter. The MoU Manager will, in consultation with the other MoU Manager, arrange for the matter to be considered by the Management Committee which must consider the matter within 15 working days of the first MoU Manager’s advice to the second MoU Manager. In considering the matter, the Management Committee may refer the issue to the Assistant Secretary of Legal Services Branch in DoHA and the General Counsel in Medicare Australia for advice.

(c) Where the Management Committee is then unable to reach resolution, the Management Committee will refer the matter to the Secretaries of DoHA and Medicare Australia for resolution and, at the same time, the CEO will advise the Secretary, DHS. DoHA may assume the CEO has fulfilled this obligation.

(d) If both the Secretary and the CEO agree that the matter cannot be resolved, or if after 15 working days either the Secretary or the CEO believes that the matter cannot be resolved, it will be referred to both the Minister for Health and Ageing and the Minister for Human Services for agreement on the position to be adopted.
6.1.2 Disputes involving legislative interpretation

(a) Disputes involving legislative interpretation are subject to paragraph 10.6 of the Legal Services Directions.

(b) In the first instance, it is expected the parties will attempt to resolve any disagreements by negotiation between the respective legal branches and, if necessary, the Assistant Secretary of Legal Services Branch in DoHA and the General Counsel in Medicare Australia. Such negotiations should occur within 15 working days of the receiving party being notified of the dispute by either the Assistant Secretary of Legal Services Branch in DoHA or the General Counsel in Medicare Australia.

(c) If the legal branches and the Assistant Secretary of Legal Services Branch in DoHA and the General Counsel in Medicare Australia are unable to resolve the dispute, the issue should be referred to the Office of Legal Services Coordination in the Attorney-General’s Department for advice from the Solicitor-General.

(d) The parties agree to be bound by the Solicitor-General’s interpretation of the legislation in dispute. The parties will share the costs of the Solicitor-General’s fees on a 50/50 basis.

7 CONTACT OFFICERS

7.1 The officers responsible for the overall management of this Protocol (the “Protocol Manager”) will be:

<table>
<thead>
<tr>
<th>Department of Health and Ageing</th>
<th>Medicare Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Secretary</td>
<td>General Counsel</td>
</tr>
<tr>
<td>Legal Services Branch</td>
<td></td>
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<tr>
<td>Business Group</td>
<td></td>
</tr>
</tbody>
</table>

7.2 The primary contact officers for issues relating to this Protocol will be:

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<th>Department of Health and Ageing</th>
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<td>Manager</td>
</tr>
<tr>
<td>Governance, Safety and Quality Branch</td>
<td>Communication and Government Relations</td>
</tr>
<tr>
<td>Regulatory Policy and Governance Division</td>
<td>Branch</td>
</tr>
</tbody>
</table>

7.3 Any changes to these contact details will be promptly notified to the other party and to the MoU Managers in DoHA and Medicare Australia.

8. REVIEW AND VARIATION

8.1 The Protocol Managers will jointly monitor the operation of this Protocol and recommend any necessary or desirable variation to the MoU Management Committee (as referred to in section 9.1 of the MoU).
PROGRAM INTEGRITY AND RISK MANAGEMENT PROTOCOL

1. CONTEXT

1.1 The purpose of this Protocol is to set out responsibilities and obligations of the parties in relation to program integrity, risk management and compliance.

1.2 It is made pursuant to Part 2 of the Memorandum of Understanding (MoU).

2. DEFINITIONS

2.1 In this Protocol, unless the context otherwise requires, terms are as defined in the MoU. In addition:

“compliance” means the act of conforming, acquiescing, and obeying a specified body of rules;

“fraud control plan” means a plan of the type referred to in Clause 17 of the MoU;

“National Compliance Program” means a program described in Clause 4 of this Protocol;

“program integrity” means programs are initiated, governed, and performed in such a manner so as to comply with applicable laws and rules and regulations; and

“risk management” means the process for identification, analysis and mitigation of uncertainty, threat and harm based on the relative risk consequence and likelihood commensurate with adequate resource allocation strategies.

3. GENERAL PRINCIPLES

3.1 Medicare Australia manages a number of Government health and payment programs including Medicare, the Pharmaceutical Benefits Scheme (PBS), the Private Health Insurance Rebate Scheme, the Commonwealth Medical Indemnity Schemes, the Organ Donor Register, the Practice Incentives Program and a range of other Associated Government Programs.

3.2 Medicare Australia’s role as the administrator of these programs is not just to deliver the programs, but to protect them so that Australians can continue to access affordable health care. In administering these programs Medicare Australia has a responsibility to the Australian taxpayer to ensure the right person receives the right payment at the right time.

3.3 This responsibility includes ensuring people who access the programs are compliant with the relevant rules and laws, and that the programs have appropriate risk management and systems in place to protect their overall integrity.

4. NATIONAL COMPLIANCE PROGRAM

4.1 As part of its Fraud Control Program and responsibilities under section 7 of the Medicare Australia Act 1973, Medicare Australia will produce, annually, a National Compliance Program.

4.2 The National Compliance Program will detail Medicare Australia’s planned activities in relation to:

a) risk identification and assessment activities;
b) compliance; and

c) ensuring program integrity.

4.3 DoHA will be consulted during the formulation of the National Compliance Program each year.

5. FRAUD CONTROL

5.1 To ensure that the requirements of Section 45 of the Financial Management and Accountability Act 1997 and the Commonwealth Fraud Control Guidelines are met, DoHA and Medicare Australia agree that:

a) each agency is responsible for meeting its statutory obligations in relation to financial management and governance, including compliance with the Financial Management and Accountability Act 1997, the Public Service Act 1999, the Medicare Australia Act 1973, and other Commonwealth laws;

b) each agency will be responsible for developing fraud control plans in relation to the program activities over which they have operational control;

c) each agency will be responsible for investigating possible offences in relation to the program activities over which they have operational control;

d) each agency will be responsible for including in its annual report to the Attorney-General’s Department information concerning all allegations of fraud in relation to the program activities over which they have operational control; and

e) DoHA may request reports on fraud control plans and investigations in relation to all program activities funded by DoHA.

6. ROLE AND RESPONSIBILITY OF MEDICARE AUSTRALIA

6.1 Medicare Australia’s role is to:

a) ensure program integrity and manage risks associated with the programs it manages;

b) develop and coordinate its compliance activities;

c) produce a National Compliance Program on an annual basis;

d) allocate appropriate resources and deliver the activities identified in the National Compliance Program;

e) perform its service delivery functions under the Medicare Australia Act 1973, including “undertaking education, compliance, investigation and enforcement activities relating to the provision of services”; and

f) enforce the legislation developed by DoHA using an appropriate risk management approach and proportionate enforcement response.

6.2 Medicare Australia has an obligation to:

a) advise DoHA on its performance against the National Compliance Program including significant emerging risks, their treatment and outcomes.

b) provide input into DoHA’s policy development and new business proposals in relation to compliance and risk management; and

c) provide advice and input into DoHA’s reviews of legislation, programs or systems.
7. ROLE AND RESPONSIBILITY OF THE DEPARTMENT OF HEALTH AND AGEING

7.1 DoHA’s role is to:
   a) address policy issues that affect program integrity, risk management and compliance;
   b) develop clear and unambiguous legislation and rules which enable Medicare Australia to achieve positive compliance outcomes; and
   c) identify any new or increasing risks to the integrity of its programs.

7.2 DoHA has an obligation to:
   a) consult on compliance and risk management impacts where proposals to develop new outputs, services or products are formulated;
   b) consider and provide a timely response to Medicare Australia’s requests for legislation or policy reviews, or policy advice;
   c) seek Medicare Australia’s input into policy development;
   d) communicate to Medicare Australia any new or increasing risks to the integrity of its programs; and
   e) where relevant communicate with Medicare Australia on its compliance and risk management expectations, as well as its assessment of Medicare Australia’s actions against the National Compliance Program.

8. ADDITIONAL PROGRAM INTEGRITY CHECKS AND COMPLIANCE RESEARCH

8.1 DoHA may engage Medicare Australia to undertake specific or additional compliance checks, research or tasks (“additional tasks”) which fall outside of the National Compliance Program.

8.2 DoHA will negotiate the timing, conduct and brief of these additional tasks on a case by case basis with the appropriate Medicare Australia compliance manager.

8.3 Where DoHA engages Medicare Australia to undertake an additional task, DoHA and Medicare Australia will enter into a written agreement which sets out the scope of the task, how it is to be performed, the funding to be provided, and expected outcomes.

9. NEW BUSINESS

9.1 The general principles, responsibilities and obligations in relation to new business are discussed in the MoU as well as the Legislation Consultation Protocol.

9.2 Where DoHA develops new business proposals which may impact on Medicare Australia, the relevant DoHA program manager will, at an early stage in the policy formulation, consult with the relevant Medicare Australia program manager. This is to enable both business requirements and funding arrangements to be agreed to a point that enables Medicare Australia to commit to an implementation timeframe.

9.3 In developing new policy or business proposals which may impact on Medicare Australia, DoHA will have specific regard to the compliance measures that may be required to protect the integrity of the new policy or business, as well as the activities that may be necessary to ensure program integrity.
9.4 Where Medicare Australia is required by Government to develop new compliance measures in relation to a DoHA program, the relevant Medicare Australia program manager will consult with the relevant DoHA program manager to enable both business requirements and funding arrangements to be agreed to a point that enables both agencies to commit to an implementation timeframe.

9.5 Where new compliance measures are developed by Medicare Australia to provide quantifiable savings on administered expenditure, Medicare Australia will consult with DoHA to enable agreement upon measurement and reporting of such savings.

9.6 The funding requirements for risk management and compliance activities relating to new business proposals should be jointly considered in accordance with Section 8 of the MoU and the Budget Consultation Protocol.

10. FUNDING

10.1 Any change to Medicare Australia’s departmental funding requirements resulting from new policy proposals will be managed in accordance with the MoU and the Budget Consultation Protocol. The MoU stipulates that where DoHA introduces new business requirements which impact on Medicare Australia’s costs, DoHA and Medicare Australia will jointly consider how the financial impact should be managed. Both parties agree to include funding for appropriate risk management, program integrity and compliance activities.

11. COMMUNICATION AND INFORMATION SHARING

11.1 The MoU acknowledges that the Medicare Australia/DoHA relationship will be more productive where there is a high degree of transparency, regular consultation and timely sharing of information. The MoU also recognises the need for Medicare Australia to provide input into DoHA’s policy development processes so that the operational integrity of programs can be maximised. Similarly the MoU acknowledges that DoHA input into the development or revision of risk management and compliance controls may be appropriate.

12. POLICY INTERPRETATION

12.1 Where the interpretation of policy impacts on compliance or risk management activity the parties agree to the process set out in the MoU as well as the Policy and Legislative Interpretation Protocol set out at Schedule 5.

13. CONTACT OFFICERS

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