Queensland Government
Queensland Health

Australian Government
Department of Health and Ageing

Health Workforce Queensland

qdgp

RDAQ
RURAL DOCTORS ASSOCIATION OF QUEENSLAND

ROYAL FLYING DOCTOR SERVICE OF AUSTRALIA (QUEENSLAND SECTION)

QUEENSLAND ABORIGINAL & ISLANDER HEALTH COUNCIL

Medicare Billing for Primary Care in Small Rural Hospitals

COAG Section 19 (2)
Exemption for Non-admitted Services

April 2007

Queensland statewide guidelines for implementation

The guidelines are to assist local level negotiations and implementation of the Section 19 (2) exemption. The guidelines are consistent with the *Memorandum of Understanding* which has been signed between the Commonwealth and the State and provides the framework for the cooperative implementation of the initiative. Review date for guidelines by steering committee will be one year from implementation.

Purpose

Definition of the COAG Section 19 (2) exemption initiative:

This initiative will provide exemptions under Section 19 (2) of the Health Insurance Act 1973 to enable Medicare rebate to be claimed for state-remunerated primary health care services (for non-admitted and non-referred patients) in some rural and remote communities of less than 7,000 people.

Intent of initiative

To increase small communities' access to primary health care and enhance service delivery to these communities and assist in staff retention.

To improve health services and service delivery in identified rural and remote communities, whilst not threatening the sustainability and viability of existing private practices in those communities.

To improve the interface between public and private primary health care service delivery.

To support the existing medical workforce, specifically medical sustainability.

The intention of the Section 19 (2) exemption is not to pursue revenue generation for its own sake for any party, but any revenue arising should be used to enhance primary health care services in these communities.

Terms of agreement

The Section 19 (2) exemptions will be granted until end of financial year 2009/10. The *Memorandum of Understanding* expires on 1 July 2010.

Service arrangements

Initial implementation of the Section 19 (2) exemption will be in agreed trial sites identified using the following criteria:

1. rural or remote community of less than 7,000 people
2. the community must have a workforce shortage, specifically a General Practitioner (GP) shortage which is defined as less than one GP per 1,400 people
3. the community must be agreed to by the State and Commonwealth as in scope to apply for Section 19 (2) exemption
4. the initiative can not proceed without written agreement by the parties to the local agreement
5. once a Section 19 (2) exemption has been granted it continues regardless of changes in service arrangements criterion 1, 2, 3 or 4 until the end of the term of agreement, however reviews will be held at a locally agreed time
6. funds generated must be used to enhance primary health care in the community in which the funds were generated
7. implementation of the initiative should not threaten the sustainability and viability of existing private practices in the community.

Revenue

Collection and use of revenue

- Patients are not to be charged a co-payment.

Options:
See Matrix A and B working papers attached.

Application of funds

Principles

1. Funds generated by the exemption must be used to enhance primary health care in the community.
   – Examples of enhancements to primary health care may include support for locum cover, employing additional salaried doctors or nurses, allied health practitioners and other supporting staff, professional development and chronic disease initiatives.
2. The revenue raised is not to be considered the most significant benefit of the initiative. The local community has an opportunity to construct incentives which assists in the attraction and retention of primary health care practitioners.
3. Some financial recognition should be given to the person and/or organisation doing the Medicare Benefits Schedule (MBS) billing.
4. Governance mechanisms need to be in place to oversee the use of funds.
   – An implementation committee would oversee the use of the funds generated by the exemption so that primary health care was enhanced in the community. The implementation committee membership would consist of local representations from any agency or person party to the agreement, and it may have consumer representation and/or interested party representation depending upon local circumstances.

Management of risks

The intention is not to set up a duplicate bulk billing service or to threaten the viability or sustainability of private practice.

Issues to consider in local implementation:

- to ensure all negotiations and monitoring of the initiative include the local private practitioners and if appropriate, division of general practice
- in some communities where there are concerns about the exemption threatening the viability of the private GP practice, the community may consider arrangements such as limiting the billing of non-admitted patients to out of hours at public facilities. These arrangements should not limit patients' access to primary health care services.

Negotiations and monitoring must follow these principles:

- The clinical need of the patient/s must be the paramount concern.
- The main objective is to enhance primary health care services in the community.
- The sustainability and viability of a private practice should not be threatened.
- Local flexibility with arrangements are necessary to be responsive to the community, however consideration should be given to equity between communities and parties involved.
- If conflict arises the parties involved should make every effort to resolve this locally.
- If the conflict escalates the issues need to be more formally raised with the Health Service District and in turn the Area Health Service.
- If the conflict is not resolved and requires further escalation it can be raised with the Section 19 (2) steering committee which has key stakeholder representation.
- Should the conflict raise Commonwealth-State issues, or breach the *Memorandum of Understanding*, or there are inconsistencies with the MBS billing, the Commonwealth Funding Unit, Queensland Health will need to be advised in writing and where necessary, will raise this with the Commonwealth to resolve.
- Any party at any point of the agreement can ask for the agreement to be reviewed by the local parties to the agreement.
- The sites will be reviewed one year after implementation.
- Once an exemption is granted to the community the exemption will remain, however local arrangements may change when circumstances change, such as the arrival of new primary health care practitioners. All parties would need to agree in writing to the new arrangements.

Monitoring and Evaluation

- Each initiative should be reviewed one year after commencement or earlier if any party to the agreement believes there is a need.
- The following issues should be monitored locally as these will feed into an eventual national evaluation as referred to in the MOU Part 10.

- impact on retention of small rural hospitals and health services
- impact on primary care services/non-medical services
- impact on those materially affected by initiative
- assessment of additional services that assisted in recruitment and retention.

Parties to the local agreement

The signatories of the agreement include:

- The Queensland State Government
- The Australian Government
- All primary health care medical practitioners who provide services to the community and/or are materially affected by the initiative. These may include:
  - any General Practitioners
  - full salaried Queensland Health doctors
  - Medical Superintendents/Medical Officers with rights to private practice
  - any Aboriginal Medical Service in the area
  - the Royal Flying Doctors Services if they provide services in the community
- Relevant Division of General Practice.

Other stakeholders to the agreement who may need to be consulted include:

- Rural and Isolated Practice Registered Nurses (RIPRNs)
- Queensland Health Service District
- Local council representative
- Consumer health council
- Primary Health Care Partnership Councils
- Health Community Councils
- Other private primary health care providers including allied health.

Implementation process

As agreed to in the *Memorandum of Understanding* between the State and the Commonwealth, the implementation process coordinated by Queensland Health (a delegate of the District Manager) is as follows:

- Identify the locality.
- Provide information package to all parties.
- Local negotiations to take place with all relevant stakeholders. The Commonwealth Funding Unit, Queensland Health will provide advice as necessary. Process may need to be documented to satisfy Commonwealth requirements. This could take the form of minutes of meetings with local stakeholders.
- Ensure support in writing by all local primary care providers operating in areas where section 19 (2) exemptions are sought.
- Identify the intended increased support for primary health care services where an exemption is applied for.
- Agree to the timeframe of the exemption. The 19 (2) exemptions will be granted until end of financial year 2009/10. The *Memorandum of Understanding* expires on 1 July 2010.
- Commonwealth issues an exemption where both the Commonwealth and State agree that the locality meets the guidelines on eligibility.
- Agree to report on level of services provided, level of support provided and be involved in evaluation of the initiative.
- Diagnostics and ancillary services are subject to normal MBS billing.
- Although RIPRNS can not currently bill MBS, this initiative aims to include RIPRNS working under the direction and supervision of a primary care doctor which is consistent with current arrangements with practice nurses in general practice.
- Agree to local communication plan:
  - educate patients to ensure they have a Medicare card and to bring to service
  - any media coverage needs to make reference to the Commonwealth's role and quantum of financial contribution.

Steps to seek the Section 19 (2) exemption from the Commonwealth

- Preliminary list of potential Section 19 (2) sites submitted to the Commonwealth so that eligibility can be agreed upon for in-scope sites.
- Queensland Health to gauge interest in the initiative at the sites. Interest can be driven by the local community, however Queensland Health will ensure Health Service Districts have the appropriate information to understand the initiative.
- Agree on bilateral *Memorandum of Understanding* at an officer level between the State and the Commonwealth.
- The *Memorandum of Understanding* will be signed between the Commonwealth and the State.
- Draft Implementation Plan lodged with the Commonwealth and the process of agreeing to the details begins.
- Comprehensive consultation process with all stakeholders in eligible and interested sites occurs and written consent is gained.
- The sites will forward the signed letter of support by the local parties and the Local Area Implementation Plan to the Commonwealth Funding Unit.
- Commonwealth Funding Unit, Queensland Health will write to the Director Acute and Aged Interface Section, Australian Government Department of Health and Ageing to seek a Section 19 (2) exemption attaching the site's final Implementation Plan (schedule B of *Memorandum of Understanding*) (sites can do this at any time).
- The Commonwealth will provide the Section 19 (2) exemption via a Determination under the *Health Insurance Act 1973* in writing.
- Queensland Health must ensure that medical practitioners who plan to claim Medicare benefits for the provision of eligible services have provider numbers specific to the locations where the eligible services will be provided.
- Medical practitioners must apply for a provider number for an additional location on their own behalf (Queensland Health can make practitioners aware of their responsibility, but cannot apply on behalf of the practitioners).
- Each new doctor entering the agreement must apply for a provider number or an upgrade on their existing provider number.

Risks to be explored

- Consider whether the cost of managing and acquitting a quarantined funding stream can outweigh the benefit of the revenue.
- Gauge the flow-on effects of the potential increase in more primary health care work in public facilities, especially during out of hours, as there could be more costs than gains due to additional workload on a variety of staff in public health facility and additional costs of supplies.

Matrix A

Working paper on Funding/Revenue Options
(these scenarios are not exhaustive and are to be used as examples)

Medical arrangements where private GP practice exists in the community				
Funding options				
	Billing arrangements/ revenue retention	**Who bills**	**Risks**	**Consider limits on arrangements**
QH full salaried medical officer	Provide primary health care service from public facility QH keeps all revenue to enhance primary health care (Subject to Industrial Agreement)	QH staff via paygroup link and money goes into trust account	MO must be eligible to apply for provider number Time to seek provider number may be longer than MO term of employment at site Where QH keeps all revenue MO provides additional services for no reimbursement, as opposed to doctors employed under other arrangements Where no bulking billing practice exists, may drive patient behaviour to seek bulk billed services from public facility	Where private GP practice viability is threatened, limit services, eg. to after hours or certain scope of services
MS/MORPP	Provides primary health care from public facility MS/MORPP keeps all revenue but a percentage of revenue raised is used to enhance primary health care via a fund, with the remaining percentage retaining with the MS/ MORPP; or MS/MORPP keeps all revenue and the primary care enhancement is retention of the doctor and medical service	MS/MORPP bills directly	Difficult to differentiate patients as public or private for same service May threaten viability of GP service Different percentage of payment to doctors at each site may create some inequities/tensions	Where GP practice viability is threatened, limit services to particular scope, eg. after hours or certain type of primary health care services

Medical arrangements where private GP practice exists in the community				
Funding options				
	Billing arrangements/ revenue retention	**Who bills**	**Risks**	**Consider limits on arrangements**
Private GP (part of Section 19 (2) arrangement)	GP contracts to QH to provide VMO sessions or is employed by QH; or GP reimburses QH a percentage of revenue raised and a percentage is kept in fund to enhance primary health care; or GP keeps all revenue and the primary health care enhancement is retention of the doctor and medical service	QH via paygroup; or Doctor bills direct (whoever bills is reimbursed for administration costs)	If doctor in community charges patient a co-payment, patient may prefer to see same doctor in public health facility where no co-payment arrangement exists Different rates of payment to doctors at each site may create some statewide inequities/tensions Dispute may arise over the amount of revenue raised through the initiative and the proportional remuneration to the GP	Limit primary health care service provided by the GP in public facility may be specific service, eg. Chronic disease clinic Subject to Industrial Agreement, agree statewide on rates for payment to doctors An open disclosure process may need to be negotiated/ at agreed intervals to ensure remuneration is proportional to workload/ revenue raised
QH full salaried medical officer + GP contract services; or MS/MORPP + GP contracted services	Any of the above arrangements	QH via paygroup; or Doctor bills direct (whoever bills is reimbursed)	Different revenue retention and billing arrangements for different types of employment arrangements at same facility would create confusion and inequities for similar primary health care work Different rates of payment to doctors at each site may create some statewide inequities/tensions	Operate same revenue retention option and same billing procedures for both types of employees, eg. QH bills or doctor bills for both type of employees Subject to Industrial Agreement

Legend

QH Queensland Health
MSRPP Medical Superintendent with Rights to Private Practice
MORPP Medical Officer with Rights to Private Practice
MO Medical Officer
VMO Visiting Medical Officer

Matrix B

Working Paper on Funding/Revenue Options
(these scenarios are not exhaustive and are to be used as examples)

Medical arrangements where no private GP practice exists in the community				
Funding options				
	Billing arrangements/ revenue retention	**Who bills**	**Risks**	**Consider limits on arrangements**
QH full salaried medical officer	Provide primary health care service from public facility QH keeps all revenue to enhance primary health care (Subject to Industrial Agreement)	QH staff via paygroup link and money goes into trust account	MO must be eligible to apply for provider number Time to seek provider number may be longer than MO term of employment at site MO on an award and any additional financial entitlements may breach the award	Subject to Industrial Agreement
MS/MORPP	Provides primary health care from public facility MS/MORPP keeps all revenue but a percentage of revenue raised is used to enhance primary health care via a fund with the remaining percentage staying with the MS/ MORPP; or MS/MORPP keeps all revenue and the primary health care enhancement is retention of the doctor and medical service	MS/MORPP bills directly	Difficult to differentiate patients as public or private for same service Different rates of payment to doctors at each site may create some inequities/ tensions	Local agreements regarding the arrangements of revenue billing and retention can have different timeframes