Memorandum summarising outcomes of the MBS Review Stakeholder Forums – October and November 2015

As part of the stakeholder consultation process for the Medicare Benefits Schedule (MBS) Review, the Taskforce established a series of plenary forums to solicit additional input from stakeholders and foster broader discussion about the Review.

This note summarises stakeholder input from the second round of forums, which were held in Melbourne (27 October 2015) and Sydney (3 November 2015). The 150 participants of these forums represented a wide array of craft groups and medical disciplines, as well as consumers, the health care industry and other stakeholders.

Context and Purpose of the MBS Review

Professor Bruce Robinson, Chair of the MBS Review Taskforce, opened the discussion with an overview of the Review, its broader context and an update on the approach and progress to date. Professor Robinson highlighted that the primary purpose of the MBS Review is to achieve better value for the Australian healthcare system through improved patient health outcomes. Australians enjoy a high-performing health system, achieving the second-highest life expectancy at birth, and the fourth-highest self-reported health score among OECD countries. To sustain and improve upon these achievements, updates to the MBS are needed. There are more than 5,700 services listed on the MBS, over 70 percent of which have not been amended since they were created. Healthcare consumers could benefit from more evidence-based care, increased access to valuable yet underutilised treatments, prevention of unnecessary treatments and tests, more appropriate referrals and appointments, and adoption of new, best-practice health care technologies and services.

Update on approach and progress to date

Additional detail was shared on the functioning of the Clinical Committees: approximately 35 of these peer-nominated clinically-led groups will be launched against each major discipline, establishing subsidiary Working Groups as needed to distribute work. The Committees will initially triage item numbers based on usage patterns, evidence base and item descriptors, to determine which services require detailed review. They will then conduct rapid evidence reviews (where needed) before appraising evidence and making recommendations to the Taskforce. Consultation with colleges, peak bodies and other stakeholders will occur before finalisation of the Taskforce's recommendations to the Minster about changes to an MBS item.

An initial wave of six pilot Clinical Committees has been launched, designed to include a diverse range of topics and levels of complexity. Professor Michael Permezel, Chair of the Obstetrics Clinical Committee, shared his experiences at the Melbourne forum. He presented several of the issues the committee has taken on, including potentially grouping antenatal pathology tests, updating point-of-care ultrasound, updating antenatal visits, and addressing regional variation in items such as pregnancy planning and management, complex labour and birth, mid-trimester miscarriage and postnatal care.

Two other important themes of the Review were also highlighted. Firstly, there is no savings target – the Review is focused more on how we get more value from our healthcare spend. Secondly, there is a need to look to the full breadth of the $19.1 billion MBS spend, not just General Practitioner services.

In terms of the timing of the MBS Review, several stakeholder forums were conducted in July 2015 and a Consultation Paper was released in September 2015. This will inform a 1st Interim Report to Government in December 2015, which will also lay the foundation for the bulk of the Review to be conducted during 2016. It is anticipated that a 2nd Report to Government will be submitted in December 2016.

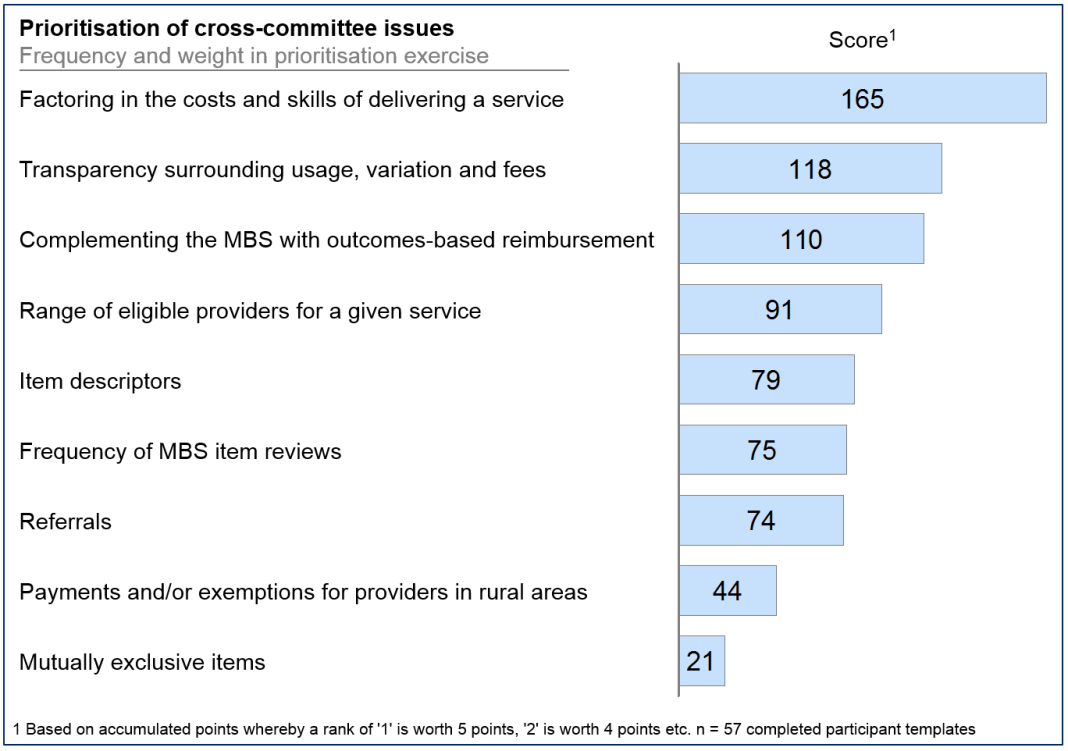
Overview of topics discussed by participating stakeholders

The forums covered three major areas: high level issues affecting many or all of the services under review; feedback on specific items for consideration by the relevant Clinical Committee; and plenary discussion on the MBS Review and its implementation. Several common themes emerged, as described below.

Discussion of 'macro' issues affecting the MBS as a whole

In addition to the item-level reviews which Clinical Committees are taking on, the scope of the MBS Review includes the over-arching Rules which govern the MBS' administration. Furthermore, several cross-Committee issues have implications for numerous disciplines and a common view is essential to ensure consistency.

Participants were asked to prioritise and discuss the 'macro' issues for the Taskforce's consideration. From a list of potential key issues, there was general consensus around the most significant topics:



Several of these themes recurred in comments throughout the Forums. Key points from plenary discussions are:

1) **Factoring in the costs and skills of delivering a service** was the highest-scoring theme, sparking several discussions. For instance, participants suggested setting a single payment level for some assistance services, regardless of which professional type provided the service, in order to create an incentive for innovation in skill mix. Another example raised is after-care: out-of-date item numbers can reimburse one provider for after-care which is provided by another provider. For instance, some orthopaedic surgery item numbers could be unbundled to move after-care from the surgeon to the after-care provider (e.g. a geriatrician). The high variation in 'normal' after-care intensity was raised as an issue, with length-of-stay seen as a relatively weak proxy for treatment intensity. Finally, participants raised the issue of updating items to reflect shifts towards community-based care (e.g. palliative care) to support adequate access in the appropriate setting.

2) **Data transparency** was another frequently raised cross-committee issue. Participants indicated widespread interest in accessing comparative metrics on variance in volumes and outcomes versus peers, to inform clinical practice decisions. This could build on the refined metrics that were developed during the previous round of releases.

It was also suggested that the public could benefit from increased transparency, e.g., the volume of each procedure performed per surgeon or per hospital, as well as clinical efficacy by item number. In the words of one participant, "procedures that do and don't work should be publicly known." To enable robust, unbiased data sets, it was suggested that payment could be conditional upon data sharing in some cases.

3) **The gatekeeper role** of GPs was seen by some participants as limiting the effectiveness of team-based care. For instance, psychologists and speech pathologists must both re-direct patients to their GP as a referral conduit. Dentist and ENT referrals were among the other examples raised. Suggested measures included enabling direct referral for select cases (e.g. physiotherapists requesting a knee x-ray), and/or creating in-perpetuity referrals for target patient populations of certain services. Other participants reaffirmed the importance of GPs being the gatekeepers to specialist care.

The timeliness of referrals was a frequently-raised related issue. Dermatologists and psychologists were two common instances where patients can be sent back to their GP solely for renewal or referral based on financial consideration not clinical need.

4) **Outcomes-based care** was the focus of animated discussion. While many participants felt the MBS could improve quality of care by paying for performance, concerns were voiced that clinicians may be averse to taking on high-risk patients who are unlikely to achieve target outcomes. Furthermore, some rebates may need to reflect the additional risk that providers would be taking on – potentially a complex analysis.

5) **Item descriptor design** was seen as a promising means to reduce inappropriate use by more fully specifying items as needed (e.g. specifying patient conditions, identifying items which are mutually exclusive/inclusive, etc.). At the same time, several participants opined that the MBS should not actively guide clinical decision-making (in lieu of

protocols by the relevant professional bodies) but rather reimburse consistently with guidelines, rewarding good practice.

There was general consensus that, to remain complementary, the MBS must have a clear scope in how it influences decision-making. For instance, colonoscopy frequency may be relatively straightforward to regulate, whereas determining when to perform a neurosurgical procedure may be too complex to address within an item descriptor.

Specific items

Stakeholders also provided feedback on specific item numbers that required review; these suggestions are being integrated into each Clinical Committee's evidence base for consideration during the triage and evaluation processes. The rationale for review fell into six main categories: obsolete items, misused items, items used on inappropriate patients, under-utilised high-value items, undue restrictions on providers, and items which do not reflect the way services are most frequently performed. Illustrative examples are provided below for each:

1) **Items which appear to have obsolete elements**

Examples provided by participants:

- Item 59503: Pelvimetry
- Item 41855: Microlaryngoscopy

2) **Items which may be misused**

Examples provided by participants:

- Podiatry items under chronic management plans being used for basic foot care
- Item 104: "initial consultations with surgeons are underfunded and therefore may drive the decision to operate"

3) **Items which may be used inappropriately given particular patient circumstances**

Examples provided by participants:

- Spinal surgery for pain only (i.e. not for threatening disease or damage situations): "lack of evidence (and, in most cases, rationale), significant long-term morbidity and instability, and inconsistent with holistic approaches to patients with chronic non-cancer pain"
- Items 597-598: "In urban areas, after hours GP care that is driven by a commercial imperative to see all patients with 597-598 MBS items is probably not (a) a cost effective way to deliver after hours care, or (b) a good way to drive patient access to medical care"
- Breast reduction surgery where less than 250g of tissue is removed

4) **High-value services that may be underused, e.g., due to inappropriate fee levels**

Examples provided by participants:

- Item 35503: "Family Planning Australia have stated that the fee for IUD insertion does not give GPs an appropriate incentive to promote the uptake of long-lasting reversible contraception"
- GPs in nursing homes: "How do we get GPs to visit nursing homes? Can we reward them for avoidable hospital admissions for nursing home residents?"

5) **Restrictions on providers which may be inappropriate**

Examples provided by participants:

- Cleft items: "Need to extend approved providers to speech pathologists. Speech pathologists are critical team members of in-patient cleft services but [there is] no rebated access once child leaves hospital-based care"
- Chronic disease management items: "For people who are mainly managed by specialists chronic disease management plans should be able to be prepared by the specialist, who is more likely to be aware of practitioners with specialised skills (e.g. physios with paediatric expertise), rather than having to go back to a GP for a care plan"

6) **Items which may not reflect the way services are most frequently performed.**

Examples provided by participants:

- Bilateral procedures with unilateral numbers, e.g. 11300 for cochlear implantation / CI programming. There is a "financial and time incentive to perform a single procedure when it's best for the patient to do both on the same day, but can only claim once. E.g. 11300 for right ear, 11300 for left ear."
- Item 66605: The MBS item for "vitamin assays specifies 1 or more; commonly several are requested. Therefore, add '2 or more' and increase fee to $40."

Plenary feedback on the MBS Review

The forums yielded valuable input into how the MBS Review should be conducted to deliver the best results. The two principal areas of discussion were how the review process could be improved, and how stakeholders would like to be engaged.

1) **Review process**

For diverse areas such as psychiatry, participants questioned whether a single Committee could reasonably evaluate all areas. Professor Robinson explained that each Committee may set up Working Groups with the competencies and remit to intensively focus on a sub-discipline.

There were differing views on whether a process to educate/explain the MBS to clinicians is needed. While some argued that descriptors should provide clear information without a need for further interpretation, others voiced concerns that, currently, new clinicians are told which codes to use by colleagues or business managers without further education.

Participants suggested increasing the cross-pollination amongst Clinical Committees (e.g., Pathology Committee members should attend Endocrinology, Mental Health, Obstetrics, etc. and vice versa). The conclusion was reached that craft groups should proactively suggest important intersections where cross-Committee collaboration is needed, to complement the Taskforce's guidance on this topic.

2) **Stakeholder engagement**

Participants supported the Taskforce's commitment to ongoing consultation with key stakeholders during the review process. In particular, some participants stressed the importance of the Taskforce's plan to share the evidence base supporting recommendations, in order to afford the opportunity to include additional research into the evidence base.

It was suggested that some Clinical Committees may require additional support to yield optimal recommendations, such as targeted HTA assessments as needed.

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We thank you again for taking the time to provide input into our process. Your feedback has been forwarded to the Taskforce and specific issues are being communicated to the relevant Clinical Committees. While this memorandum does not provide an exhaustive list of all your input, as noted above we hope it provides a platform for our future conversations. We would also welcome any further thoughts you may have via the official email address (MBSReviews@health.gov.au).

Many thanks again, and we look forward to our future discussions.

Professor Bruce Robinson

Chair, MBS Review Taskforce

November 2015