PAXTON PARTNERS

DEPARTMENT OF HEALTH AND AGEING

MBS USE BY PUBLIC HOSPITALS

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Table of Contents

Appendices:

Disclaimer:

The information provided in this report is based on Paxton Partners' discussions with State and Territory Health Departments and Health Services and on information provided directly by Health Departments and Services current as at the date of the report. Paxton Partners has relied on the information and data as sourced and has not sought to independently verify information provided.

Glossary

AMA	Australian Medical Association
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
FFS	Fee For Service
MBS	Medicare Benefits Schedule
NHA	National Healthcare Agreement
PST	Pathology Services Table
REI	Rural Enhancement Initiatives
SMO	Salaried Medical Officer
VMO	Visiting Medical Officer

1. Background

As part of the 2009-10 Budget, the Commonwealth Government committed to implementing a Quality Framework for the review and listing of MBS items.

The MBS is widely used in public hospitals not only to claim rebates on services provided to certain patients, but also as a pricing mechanism when purchasing some services from external parties and as a fee setting mechanism when providing some services to external parties.

DoHA is seeking to understand in which areas and to what extent the MBS is used in public hospitals and in other public health settings to assist in ensuring changes made under the Quality Framework and in other policies do not have unintended consequences.

The objective of this review was to gain an understanding of arrangements and processes currently in place which utilise the MBS.

2. Terms of Reference

The specific terms of reference are to make a detailed examination of the use of the MBS as a medical services fee schedule by states and territories. Specific items examined will provide clarity to the relationship between the MBS and state and territory health operations, including hospitals, business units within hospitals, physicians and other matters which are relevant. This includes:

- The purposes for which the MBS is used – such as internal reference for fee setting (or other) processes, managing agreements, as reference for public services external to hospitals and any other arrangements;
- The arrangements used by clinics within hospitals – such as Government Business Enterprises within a hospital acting as an independent business;
- The arrangements used for clinicians providing eligible services in public hospitals;
- Where relevant, differences between each state and territory health operation and/or between metropolitan and regional hospitals should be identified;
- Any other purpose for which the MBS is used; and
- Where relevant, changes which may occur due to wider health reform.

3. Methodology

The findings in this report are a combination of:

- Consultation with all state and territory Health Departments (refer Appendix 2 for list of consultations);
- Limited survey of state and territory Health Services (questionnaire included at Appendix 3). Questionnaires were provided to a metropolitan and a rural health service in each state, excepting those states where the questionnaire was collated by the relevant Health Department on behalf of the state; and
- Search of publicly available data / information sources.

A schematic of the methodology applied is included at Appendix 1.

4. Structure of Public Health

4.1. Government roles

Public hospitals are jointly funded by the Commonwealth and state and territory governments, with the state and territory governments having primary responsibility for the delivery of health services through the public hospital system.

The respective roles of each level of government are set out in the National Healthcare Agreement ("the Agreement"), which is an adjunct to the Intergovernmental Agreement on Federal Financial Relations.

The Commonwealth subsidises public hospitals through the Agreement, together with the MBS, the PBS and other programs.[1]

4.2. Medicare Benefits

Medicare benefits are payable to eligible medical practitioners for services provided in Australia. The benefits payable and the rules for billing benefits are set out in the MBS, which includes details of benefits for consultations, procedures and tests, set out in eight schedules:

1. Professional attendances;
2. Diagnostics procedures and investigations;
3. Therapeutic procedures;
4. Oral and maxillofacial services;
5. Diagnostic Imaging services;
6. Pathology services;
7. Cleft lip and cleft palate services;
8. Miscellaneous;

The key components of the MBS are:

- MBS Item numbers – a unique identifier of up to five digits for each individual item listed in the MBS;
- Descriptors – description of the item;
- Fee applicable – the fee from which the benefit payable is calculated; and
- Billing rules that set out the circumstances in which a benefit can be billed and sometimes apply limits to the amount or frequency of the amount that can be billed. Billing rules are specific to the relevant schedule (e.g. the pathology services table sets out the rules specific to billing pathology services).

4.3. Public hospital patients

There are three broad categories of public hospital patients:

- Inpatients, where the patient is admitted to hospital

[1] National Healthcare Agreement, clause 20.

- Non-admitted patients, which in turn can be categorised as:
    - Accident and emergency patients treated in emergency departments; and
    - Outpatients treated at public hospital clinics.

The application of the MBS differs in relation to each of these patient categories.

- Public hospitals are able to bill Medicare Australia using the MBS for some financial classes of public hospital inpatient (refer 4.4 below).
- The National Healthcare Agreement specifically requires public hospitals to provide accident and emergency services to eligible patients as public patients, i.e. free of charge, and thus services cannot generate charges against the MBS (except in some limited circumstances described below).
- Commonwealth funding of outpatient services is more complex. The National Healthcare Agreement allows patients that have been referred to a named medical specialist who is exercising a right of private practice to be treated as a private patient if they so choose and thus a charge can be levied against the MBS. This option has allowed public hospitals to structure some outpatient type clinics as MBS billable clinics. The Agreement also contains a number of requirements in relation to public hospitals not restricting access to publicly funded outpatient clinics.
- The Agreement also allows hospitals that rely on general practitioners in small rural and remote hospitals to provide bulk-billed non-admitted and non-referred primary care type services provided in emergency departments and outpatient clinics (refer section 5.8.1)

4.4. Financial class of hospital inpatients

The number and proportion of public hospital inpatient separations for each financial class of patients are shown in the table below.

Figure 1 Public Hospital Inpatient Separations by Patient Financial Class 2009-10

Patient Financial Class	Inpatient Separations (000's)	% Total
Public	4,319,437	85.1%
Private health insurance	501,819	9.9%
Self-funded	58,715	1.2%
Workers compensation	21,584	0.4%
Motor Accident	24,987	0.5%
DVA	118,539	2.3%
Other	28,350	0.6%
Total	***5,073,431***	**100.0%**

Source: Australian Institute of Health and Welfare, Australian Hospital Statistics 2009-10

4.4.1. Public patients

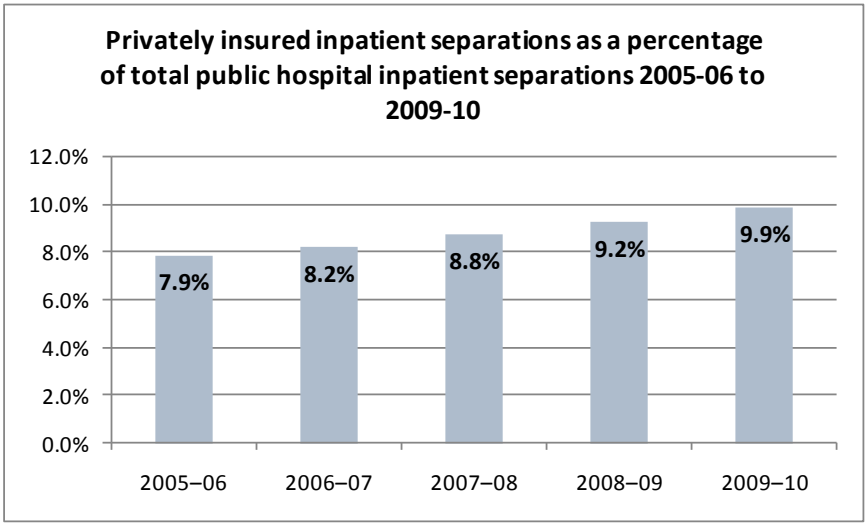
The National Healthcare Agreement requires that eligible persons are required to be given the choice to receive health and emergency services as public patients free of charge. The Agreement specifically precludes services provided to public patients from generating charges against the MBS. Accordingly, public hospitals are funded by government to provide these services and cannot charge public patients for services provided as part of public hospital care.

Public patients comprise the vast majority of services provided by public hospitals, being over 85% of public hospital separations in 2009-10.

4.4.2. Privately insured patients

Privately insured inpatients, being patients who elect to use their private health insurance, comprise 9.9% of all public hospital inpatient separations. The proportion of public hospital inpatients electing to use their private health insurance has grown from 7.9% to 9.9% of public hospital inpatients during the past five years.

Figure 2 Growth in privately insured public hospital inpatients



Source: Australian Institute of Health and Welfare, Australian Hospital Statistics 2009-10

Medical practitioners charge fees in accordance with the MBS to Medicare Australia (at the rate of 75% of the MBS). The fees are then topped up by Private Health Funds to the rate agreed between PHIs and medical practitioners.

4.4.3. Workers Compensation and Motor Vehicle Accident patients

Public hospitals are funded by third parties (state and territory workers compensation and motor vehicle accident compensation authorities) for health services provided to patients injured at work or in motor vehicle accidents.

The third party authorities generally pay medical practitioners separately from public hospitals. The rates used to pay medical practitioners vary by state using the authorities own fee schedules.

4.4.4. Department of Veterans' Affairs patients

Department of Veterans' Affairs ("DVA") patients are those veterans who hold either gold cards, entitling the veteran to free health care for all conditions, or white cards which cover specific conditions.

Arrangements for these services are the subject of a separate Commonwealth-State agreement that takes priority over the National Healthcare Agreement.

DVA funds medical practitioners at public hospitals separately from the public hospitals charges using their own Repatriation Medical Fee Schedule ("RMFS").

4.4.5. Self-funded inpatients

Self-funded inpatients are those patients who were not Medicare eligible at the time of receiving treatment in a public hospital. This category of patients comprises overseas patients and Australian non-residents.

4.4.6. Other inpatients

Other inpatients comprise public hospital inpatients who are funded by third parties, generally being the Department of Defence and state and territory Correctional Authority patients. The number of patients in this class is relatively immaterial.

4.5. Relationship between Public Hospitals and Medical Practitioners

4.5.1. Private practice arrangements

Medical practitioners can apply for rights of private practice under their terms of employment with public hospitals. Rights of private practice allow medical practitioners to bill Medicare for services provided to privately insured, compensable and DVA patients.

These arrangements vary by state (refer section 5.3.3.4), and in some states by hospital, particularly in relation to whether facility fees are payable to the hospital and if so, the applicable percentage. In many instances medical practitioners donate 100% of all Medicare billings generated to the public hospital in return for a higher base salary.

Thus public hospitals have a financial interest in medical practitioners MBS billings either through the proceeds of the billings being donated to the hospital or via the facility fees paid by the medical practitioner.

The nature of private practice arrangements will thus determine the extent to which public hospitals benefit from the billing of medical specialist fees using the MBS.

4.6. Medical Workforce

4.6.1. Medical specialists

Workforce arrangements for the medical specialists working in public hospitals vary by state and territory, however the manner in which public hospitals access medical specialist services is generally as follows:

1. As a Salaried Medical Officer ("SMO"), whereby the public hospital employs the medical specialist who is paid a salary, for either full time or sessional employment.
2. As a Visiting Medical Officer ("VMO"), whereby the specialist is contracted by the hospital to provide services. Arrangements for contracting VMO services vary by state.

4.6.2. General practitioners

Rural hospitals are often dependent on general practitioners to provide medical services.

4.6.3. Other workforce

Recent changes to the MBS have allowed midwives and nurse practitioners to charge for services using the MBS in certain circumstances. Our consultations with state and territory Health Departments and survey of health services indicated limited use of the MBS by these staff types, with only one Health Service indicating some limited use of the MBS. (We note one Health

Department indicated use of the MBS by midwives and nurse practitioners would be likely to increase).

5. Specific public hospital uses of the MBS

5.1. Overview

Generally, public hospitals use the MBS in two ways:

1. As the basis of billing medical services provided to privately insured patients; and
2. As a schedule to determine fees payable for medical services between the hospital and a third party (non-Medicare):
    a. Where fees are determined by direct reference to the MBS (e.g. some public hospitals pay fee-for-service Visiting Medical Officers using the MBS)
    b. Where fees are derived by reference to elements of the MBS (e.g. use MBS item number or use MBS rates with a loading).

The following sets out our findings in relation to specific public hospital use of the MBS.

5.2. Summary of specific public hospital uses of the MBS

SUMMARY OF PUBLIC HOSPITAL USE OF MBS BY STATE AND TYPE OF USE											Relationship to MBS		
	Financial Impact to Public Hospitals		State / Territory								Medicare	Non-Medicare	
Area of Use	Revenue	Expense	Vic	NSW	Qld	SA	WA	NT	ACT	TAS		MBS descriptors and rates	Item descriptors from MBS
1. Public hospital inpatients - medical specialists													
(a) Privately insured	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		
(b) DVA	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓
(c) Workers compensation	✓		✓	×	✓	✓	×	×	×	×			✓
(d) Motor vehicle accident	✓		✓	×	✓	✓	×	×	×	×			✓
(e) Other (e.g. non-Medicare eligible)	✓		Varies	×	×	✓	✓	✓	✓	×			✓
2. Public hospital inpatients - other practitioners	✓		×	×		×	×	×	×	×	✓		
3. Payments to medical specialists													
(a) VMOs - fee for service		✓	Rural	×	×	Rural	Non-teaching	Metro: Radiation oncology Rural: MSOAP clinics	✓	×		✓	
(b) SMOs - after hours / on-call		✓	✓	×	×	Metro support to Country AHS	×	×	×	×		✓	
4. Non-admitted patients													
(a) MBS billable specialist clinics	✓		Varies	✓	✓	✓	✓	Limited	✓	✓	✓		
(b) Diagnostic tests	✓		Varies	✓	✓	✓	✓	Minor	✓	✓	✓		
5. Purchased services													
(a) Diagnostic tests (pathology /diagnostic imaging / radiotherapy)		✓	✓	Limited	Diagnostic imaging	Diagnostic imaging	Rarely	Mostly diagnostic imaging	×	Rural only		✓	
(b) Other		✓	×	×	×	×	×	Radiation Oncology	×	×		✓	

Legend: ✓ Applies × Does not apply

SUMMARY OF PUBLIC HOSPITAL USE OF MBS BY STATE AND TYPE OF USE											Relationship to MBS		
	Financial Impact to Public Hospitals		State / Territory								Medicare	Non-Medicare	
Area of Use	Revenue	Expense	Vic	NSW	Qld	SA	WA	NT	ACT	TAS		MBS descriptors and rates	Item descriptors from MBS
6. Hospital service provision													
(a) Diagnostic tests	✓		✓	✓	✓	✓	✓	×	✓	✓	✓		
(b) Other	✓		×	×	×	✓	×	×	×	×		✓	
7. Primary care activities													
(a) GP staff A&Es (Section 19 exemption)	✓		×	×	✓	✓	✓	✓	×	×	✓		
(b) Other	✓		×	×	×	✓	×	×	×	×		✓	
(c) GP super clinics operated by Public Hospital			✓			✓							
8. Other													
(a) Internal cross charging (transfer pricing)	✓			✓	✓	✓	✓	×	n/a	✓			✓
(b) Other	✓			×	×	✓	×	✓	×	×			

Legend: ✓ Applies × Does not apply

5.3. Public hospital Inpatients

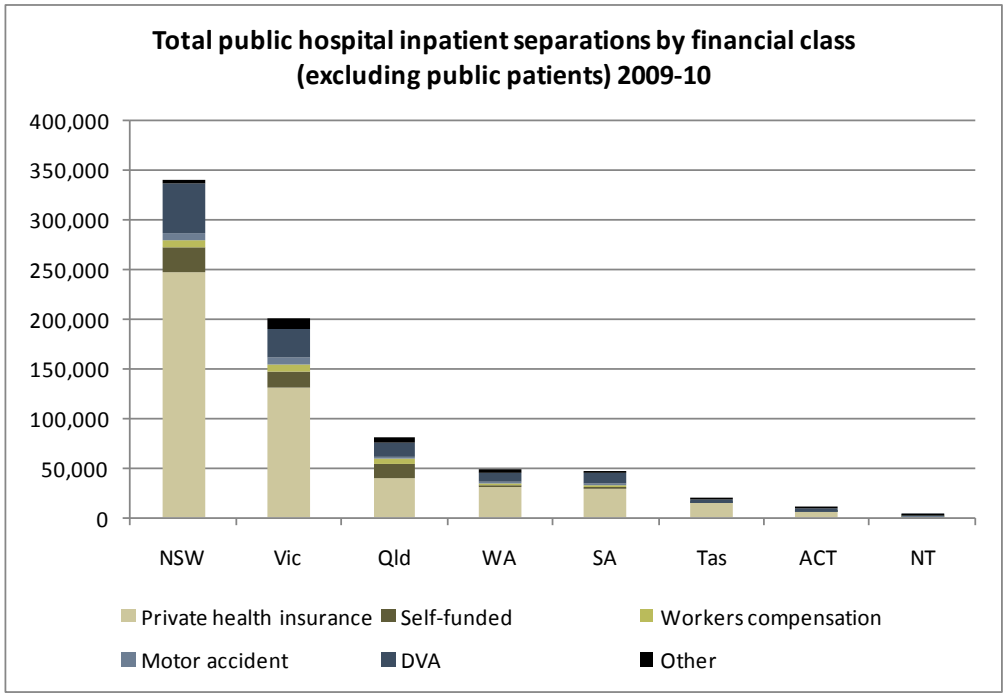
There are three determinants to the extent of public hospitals' use of the MBS in relation to public hospital inpatients:

1. The volume of each financial class of hospital inpatient;
2. The extent to which the MBS is used as the basis of billing each financial class of public hospital inpatients; and
3. Private practice arrangements, which set out the manner in which MBS billable fees are allocated between medical practitioners and the public hospital.

5.3.1. Volume of privately insured, compensable, DVA and other financial classes of public hospital inpatients

New South Wales and Victoria treat the largest volumes of non-public inpatients in public hospitals, with these two states treating approximately 72% of all non-public inpatients.

Figure 3 Public Hospital Inpatient Separations by State / Territory by Financial Class



Source: AIHW Hospital Statistics 2009-10

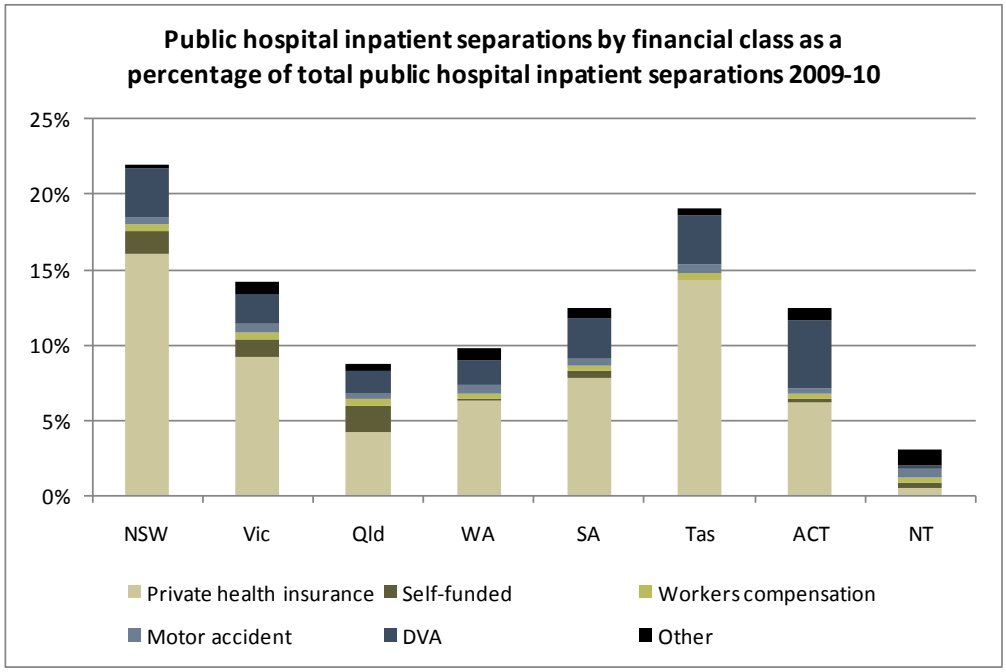
The variation in the volume of non-public inpatients treated is a function of both:

- the overall volume of inpatient activity; and
- the proportion of public hospital inpatients in each financial class, particularly privately insured inpatients using their private health insurance.

There is substantial variation by state and territory in the proportion of privately insured patients being treated in public hospitals, with New South Wales recording the highest percentage (over

16% of all public hospital inpatient separations relate to privately insured patients) and the Northern Territory reporting the lowest proportion (approximately 1%).

Figure 4: Variation in percentage of public hospital inpatients by financial class (excluding public inpatients) by state and territory



There are a number of reasons for the variation in the volume and proportion of privately insured inpatients by state. The key factors influencing the variation include:

- Level of PHI coverage in each state, however the correlation between PHI coverage and the percentage of public inpatients electing to be treated as privately insured patients is not clear in New South Wales and Victoria, where similar levels of private health insurance are held, however New South Wales public hospitals treat a higher proportion of privately insured inpatients (NSW 16% compared to Victoria 9%);
- Access to private hospitals compared to public hospitals for elective surgery (i.e. long waits in public hospitals drives some patients to attend private hospitals);
- Location of private hospitals relative to public hospitals;
- Clinical profiles of public hospitals compared to private hospitals (particularly the provision of high end clinical services in tertiary public hospitals which are often not available in private hospitals) ; and
- The focus of state Health Departments to ensure patients are offered the choice to use their private health insurance in public hospitals.

The proportion of public hospital inpatients in financial classes other than private health insurance patients (DVA, Workers Compensation, Motor Accident, Self-Insured and other) does not vary materially by state and territory.

5.3.2. Extent to which the MBS is used in relation to each financial class of public hospital inpatient

5.3.2.1. Privately insured public hospital inpatients

All public hospitals treat privately insured inpatients, with the volume and proportion of total patients varying for the reasons stated at 5.3.1 above. Doctors' fees for all privately insured inpatients are billed to Medicare Australia using the MBS with the MBS billing rules being applied. Doctors' fees will include fees for surgical procedures, consultations, anesthetist fees and diagnostic fees (pathology and diagnostic imaging).

We note that generally, privately insured inpatients are not usually required to make copayments for services received in public hospitals, with health services having varying arrangements in place to ensure this including:

- State-wide policy that doctors are not to charge gap fees (i.e. medical fees are charged at 75% of the MBS);
- Private practice arrangements in place at individual public hospitals that prohibit medical practitioners from charging public hospital inpatients gap fees (i.e. medical fees charged as above); and
- Health services bearing the cost of any gap fee charged by a medical practitioner (i.e. medical specialists bill at a rate above 75% of the MBS).

5.3.2.2. Department of Veterans' Affairs

The DVA sets their own schedule of medical specialist fees for public hospital inpatients and agrees these fees with each state and territory Health Department. These fees are set out in the Repatriation Medical Fee Schedule ("RMFS").

Fees for admitted patient consultations and services, including pathology and diagnostic and imaging services are paid to medical specialists at either:

- The MBS rate for non-DVA registered medical practitioners; or
- THE DVA rate set out in the RMFS for medical practitioners registered with the DVA local medical officer scheme.

RMFS rates vary depending on whether the medical service was provided in hospital or out of hospital:

- Out of hospital medical service fees are paid using the MBS at a rate of either 135% of the MBS (consultations) or 140% of the MBS (procedures) or 100% of the MBS for diagnostic tests.
- In-hospital medical service fees are paid using DVA's own schedule of fees which is based on "private health industry fees" not on the MBS. The following table indicates the RMFS fee in relation to five item numbers that could be billed in relation to a hospital attendance:

Item No.	Description	MBS $	DVA $	DVA %MBS
13870	ICU Consultation	348.40	418.15	120%
48921	Shoulder replacement	1,494.55	2,277.30	152%
45000	Local muscle repair	520.85	717.25	138%
44367	Knee amputation	502.15	662.35	132%
45021	Scar Abrasive Therapy	170.65	243.10	142%

DVA augments MBS derived fees (i.e. out of hospital) with additional payments in certain circumstances, for example a Rural Enhancement Initiatives (REI) loading.

5.3.2.3. Workers Compensation and Motor Accident inpatients

Medical specialist fee schedules for public hospital inpatients are set out in fee schedules determined by the relevant state / territory Workers Compensation Authority. The arrangements vary by state and are derived from either MBS or AMA rates:

- Fee schedules in Victoria, South Australia and Queensland are derived from the MBS (e.g. relate fees to specific MBS item numbers and set the fees as being a percentage of the relevant MBS item). Fee schedules may also include additional billing rules (e.g. Worksafe Victoria and Transport Accident Commission apply various rules that preclude multiple procedures / operations being billed and restrict supervision of multiple concurrent operations).

  MBS rates differ by state, and usually by item, within each authority's fee schedule. An example of the variation in fees for five different MBS items is set out below:

Item No.	Description	MBS $	VIC Motor Accident $	VIC Workcover $	SA Workcover $	Qld Workcover $
13870	ICU Consultation	348.40	459.65	442.70	400.90	509.00
48921	Shoulder replacement	1,494.55	3,027.10	3,194.15	2,663.00	2,909.00
45000	Local muscle repair	520.85	1,055.15	1,033.10	907.40	1,014.00
44367	Knee amputation	502.15	1,017.10	895.80	779.10	978.00
45021	Scar Abrasive Therapy	170.65	346.05	293.95	259.30	342.00

Item No.	Description		VIC Motor Accident %MBS	VIC Worksafe %MBS	SA Workcover %MBS	Qld Workcover %MBS
13870	ICU Consultation		132%	127%	115%	146%
48921	Shoulder replacement		203%	214%	178%	195%
45000	Local muscle repair		203%	198%	174%	195%
44367	Knee amputation		203%	178%	155%	195%
45021	Scar Abrasive Therapy		203%	172%	152%	200%

- Fee schedules in other states (excepting New South Wales, refer below) are derived from the AMA fee schedule, which sets rates that are higher than the MBS (generally in a magnitude of 2 – 3 times the equivalent MBS rate).
- Medical services provided to motor vehicle accident inpatients in New South Wales hospitals are only separately billable in certain circumstances:
    - Fees for medical services provided by employed doctors (without rights of private practice) are not separately billable as these are included in lump sum payments under a Bulk Billing Agreement between Insurers and the NSW Department of Health
    - Fees for medical services provided by VMOs or staff specialists exercising their right of private practice are calculated using AMA rates.

5.3.2.4. Self insured and other inpatients

States and territories (and sometimes individual public hospitals within states and territories) have different fee schedules for overseas patients, sometimes using the MBS (generally at 100% of the MBS) and sometimes using alternative fee schedules such as AMA rates.

5.3.3. Private Practice Arrangements

Private practice arrangements are agreed between public hospitals and medical specialists and are usually the basis of an important revenue stream for both the hospitals and the doctors.

Private practice arrangements are agreed on a statewide basis in most states and territories (the exception being Victoria) and are usually a function of the state's Medical Specialist Enterprise Award together with supplemental agreements made between the Health Department and medical specialists.

Private practice arrangements usually provide medical specialists with multiple options in relation to how the receipts from their MBS billings are to be allocated between themselves and the public hospital.

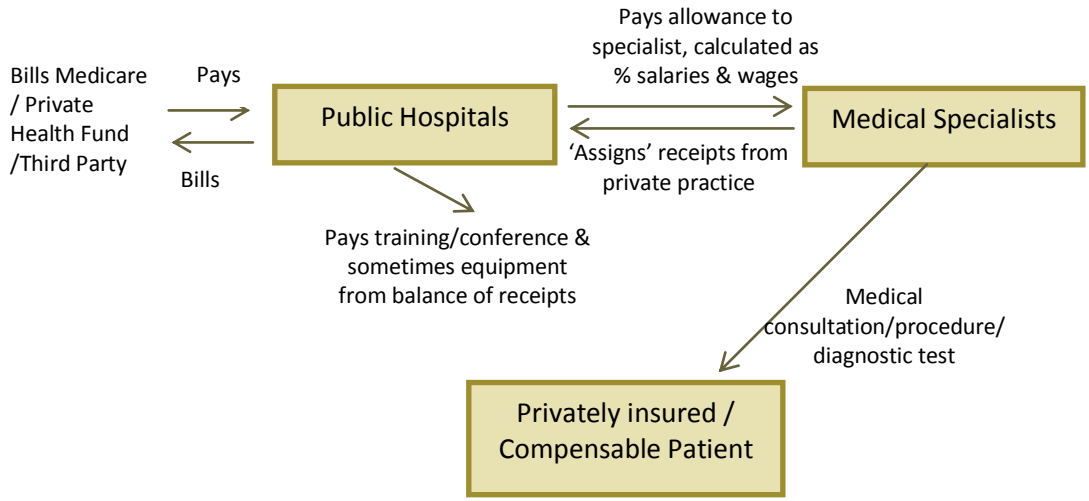
These options can be summarised in three models as follows:

5.3.3.1. Model 1: 100% Donation Model

In this type of model, the medical specialist donates 100% of all receipts from privately insured and other compensable categories of patients to the public hospital, in return for an allowance being paid in addition to their base salary. The medical specialists medical indemnity insurance is also paid by the state under this type of private practice arrangement.

This model is the most common model in Victoria and it also represents the base option in private practice schemes in Western and South Australia.

Figure 5 Schematic of 100% donation private practice model



The public hospitals receive the gross benefit from the receipts raised from private billings, however the benefit to the public hospital will be offset by the cost of the additional wages and salaries paid to medical specialists.

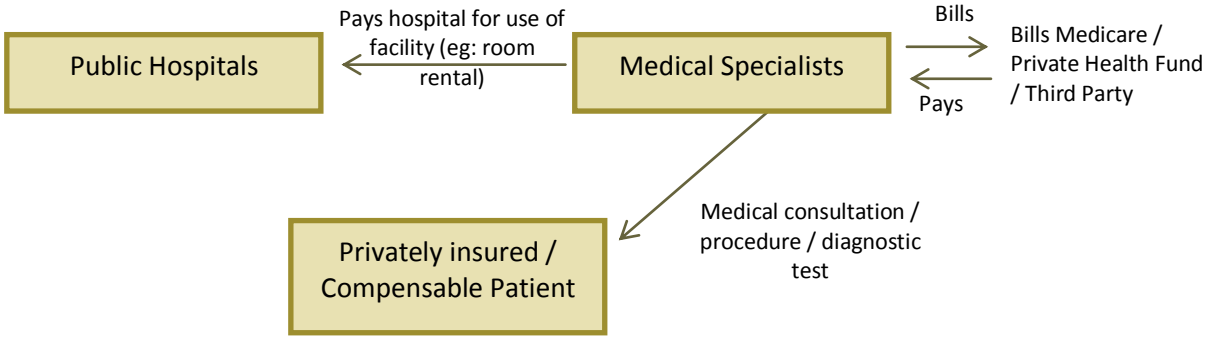
The public hospital usually bills on behalf of the medical specialist. Some arrangements require public hospitals to allocate a percentage of the receipts to fund specialists' conference attendance and travel and sometimes equipment.

5.3.3.2. Model 2: 100% Retention Model

This type of model is common with VMOs, who are not employed by public hospitals, whereby the VMO bills the patient directly for the medical service provided.

In these circumstances the public hospital's interest in revenue from MBS billings would be limited to any facility fee received from the medical specialist for the use of hospital facilities. This facility fee is often not directly derived from the value of MBS billings, for example, the facility fee could be arranged as a fixed rent for the lease of hospital space. The details of the VMO billing arrangement with the private patient may not be shared with the public hospital as VMOs sometimes bill the patients directly for the medical service provided. (Note that several states require all VMO billings to be made via hospital billing systems).

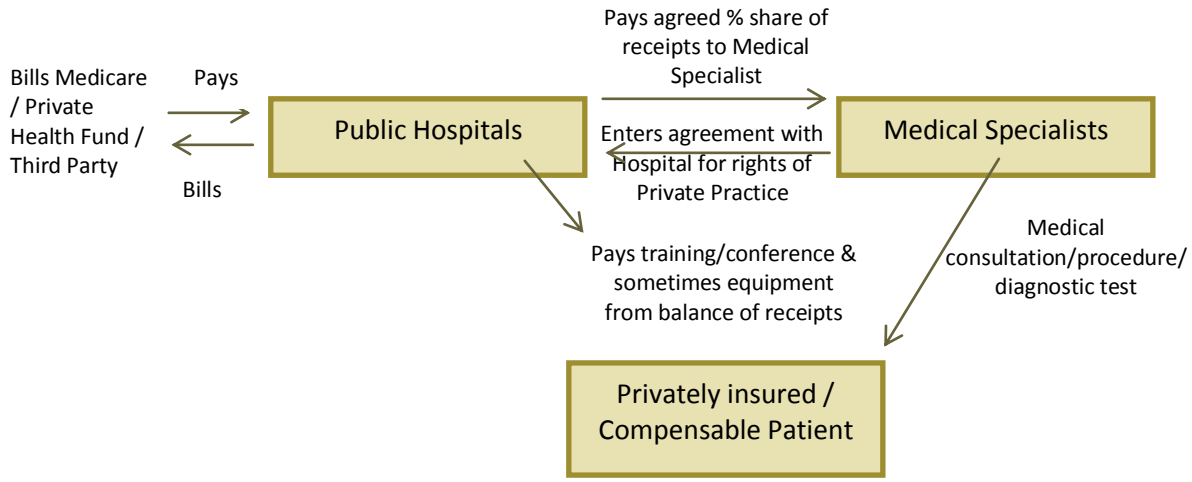
Figure 6 Schematic of 100% retention private practice model



5.3.3.3. Model 3: Receipts shared between public hospital and medical specialist

There are a number of models in which receipts from privately insured public hospital inpatients are shared between the public hospital and the medical specialist, sometimes calculated in reference to base salary and wages, with the public hospital retaining receipts in excess of the proportion agreed. Some of these models also involve the medical specialist placing some proportion of their base salary at risk in return for an interest in receipts generated from MBS billings, for example the New South Wales medical specialists private practice scheme (refer below), with each "level" of private practice increasing the medical specialists' interest in MBS billings. Private practice arrangements in Western Australia and South Australia also provide arrangements for medical specialists.

Figure 7 Schematic of shared receipt private practice model



These schemes usually require medical specialists to allow the public hospital to bill on their behalf and sometimes also require the public hospital to allocate a proportion of receipts raised to medical specialists' conference, travel and sometimes equipment replacement. We also note some instances of private practice income being required to be made available by the public hospital to other categories of staff, e.g. medical scientists in pathology laboratories, for training and conference leave.

These types of private practice arrangements usually allow for the hospital to charge a facility fee, calculated as a percentage of the total amount billed. The amount of the hospital facility fee (usually expressed as a percentage of fees billed) sometimes varies within medical specialist groups, particularly within pathology, whereby hospitals generally receive a higher facility fee for pathology tests that are conducted on automated equipment (e.g. hematology and biochemistry) and a lower facility fee for those tests that are more dependent on manual intervention (e.g. anatomical pathology). Hospital facility fees can be charged at up to 60% of the billed amount. (The magnitude of facility fees varies substantially by state, refer specific comments in table below).

5.3.3.4. Detail of private practice arrangements by state and territory

Private practice arrangements in relation to each state are described in the following table:

State	Basis of private practice arrangement
Victoria	No prescribed statewide arrangement, although Department of Health strongly prefers a 100% donation model, which is the prevailing model in Victoria. Health Services agree private practice

State	Basis of private practice arrangement
	arrangements with individual medical specialists.
New South Wales	Five tiered structure, with each increasing tier producing a higher salary to the staff specialist: • Level 1: 100% of salary + 20% allowance • Level 2: 100% of salary + 14% allowance + 24% drawing rights (guaranteed supplementation if insufficient billing – up to 11%) • Level 3: 100% of salary + 8 % allowance + 36% drawing rights (guaranteed supplementation if insufficient billing – up to 17%) • Level 4: 100% of salary + 50% drawing rights (guaranteed supplementation if insufficient billing – up to 25%) • Level 5: 75% of salary + 100% drawing rights Allowance - paid as salary and not specifically set aside from income raised from private practice Drawing rights – specifically set aside for medical specialist from income raised from private practice
South Australia	There are three choices for employed medical specialists under SA Health's Health Private Practice Arrangement 2008 together with the SA Health Salaried Medical Officer Enterprise Agreement. In addition to base salary: • Scheme 1: Capped private practice ceiling of 65% of base salary after paying 9% admin/indemnity fee, together with a 30% attraction and retention allowance • Scheme 2, Option A - minimum 30% allowance in lieu of private practice. • Scheme 2, Option B - 100% of all billings up to 65% of base salary, one third of billings from 65-100% of salary and 15% of billings thereafter after paying a 9% admin/indemnity fee. VMOs bill patients and pay hospitals a 5% fee to manage billings and a 4% fee for medical indemnity insurance. Pathologists are entitled to a private practice allowance of 65% of base salary in lieu of the 65% capped private practice amount.
Queensland	Private practice arrangements are based on a statewide policy with staff specialists having two broad options with specific variations for pathologists and radiologists: • Option A (most common type) SMO receives a supplementary allowance equivalent to a percentage of base salary and Queensland Health retains all billings generated from private patients. (Note that pathologists have access to a variation on

State	Basis of private practice arrangement
	this arrangement: Option P, which is the same as Option A, except that a small percentage of billings is set aside in a pool to be shared by SMOs). • Option B - SMO earns income in addition to base salary, up to a ceiling and then receives one third of additional net billings with the remainder lodged into a private practice study, education and research trust account. (Note that radiologists have access to a variation of this arrangement (Option R), which has reduced administration and facility fees). Queensland Health is the billing agent.
Western Australia	There are two options available for employed medical specialists under the statewide awards (there are separate awards for metropolitan and country employed medical specialists). In addition to base salary: • Rights assigned to health service to bill and specialist receives an allowance (increasing from 3.25% to 4.5% of base salary over three years). Hospitals bill on behalf of the medical practitioner. • Specialist bills private patients and pays facility fee to hospitals. Medical practitioners are responsible for their own billings. Specialists are able to retain earnings up to a nominated percentage, which varies by type of medical practitioner Facility fees are charged at 50% of net earnings from private practice for: • EMG • Radiation oncology • Pathology • Nuclear medicine • Ultrasound (outside of a radiology department) • Pulmonary physiology • Audiology • EEG.
Northern Territory	Limited application of private practice in the Northern Territory with there being no statewide arrangement.
Australian Capital Territory	Whole of territory agreement for staff specialists to have rights of private practice which sets out three schemes: • Scheme A: Specialist receives an allowance of 20% of base salary in lieu of private practice • Scheme B: Specialist receives a bonus on earnings from

State	Basis of private practice arrangement
	private practice billings of up to 50% of base salary • Scheme C: Specialist receives 75% of base salary, plus a bonus of up to 133.33% of base salary from private practice billings. Pathologists and radiologists have handed over their rights of private practice to ACT Health in return for increased remuneration. Private patients seen by VMOs are billed by the VMO in a separate business capacity, with no billing being performed by ACT Health and no facility fee being received.
Tasmania	Statewide arrangements for salaried doctors with two options: • Option A. Pays participating specialists an allowance of up to 35% of projected base salary and then pays amounts to staff development and equipment accounts • Option B. Pays as per option A with differing amounts being paid to staff development and equipment accounts. Statewide arrangements also provide for hospitals to charge facility fees to VMOs where VMOs see patients in their own rooms at public hospitals.

5.4. Payments to medical specialists for fee for service arrangements

5.4.1. Visiting Medical Officers

VMOs are sometimes contracted by hospitals to provide medical services to public patients and are paid either on a fee for service basis using the MBS as the basis of charging their fees or sessional arrangements. Medical specialists often prefer fee for service arrangements as they usually result in higher payments than sessional rates. Fee for service arrangements are also more consistent with their private sector arrangements in which the doctors bill Medicare Australia, health funds and patients on a fee for service basis.

Hospitals generally prefer to pay VMOs on a sessional basis as this results in a lower cost.

Fee for service arrangements are generally more prevalent in rural and remote hospitals where VMOs have more bargaining power with public hospitals due to the scarcity of medical specialists. In several states, VMO fee for service arrangements differ between metropolitan and rural regions, with VMOs in metropolitan hospitals being paid on a sessional basis and VMOs in regional and rural hospitals being paid fee-for service, specifically:

- Victoria;
- South Australia; and
- Western Australia.

VMO fee for service arrangements are usually based on the MBS, with the VMO being paid a fee calculated as a percentage of the MBS. Arrangements for determining the percentage of the MBS to be paid varies by state:

- Some states prescribe a VMO rate (as a percentage of the MBS) that is part of an award (e.g. New South Wales, where the prescribed percentage is 100% of the MBS);

- VMOs negotiate directly with public hospitals in Victoria with the MBS rate varying substantially by hospital and sometimes by VMO within a hospital. In our experience, the percentage of the MBS billed is usually in excess of 100% MBS;
- Western Australia has developed its own fee schedule, the WA Government Medical Services Schedule ("WAGMSS") for VMO fee service payments. The WAGMSS comprises a subset of the MBS and then applies some additional billing rules and also includes some additional items that are not included in the MBS. VMOs are restricted to billing public hospitals for only those services that are listed in the WAGMSS. An indication of the relationship between the WAGMSS and the MBS is shown in the following table:

Item No.	Description	WA WAGMSS $	WA WAGMSS % MBS
13870	ICU Consultation	415.60	119%
48921	Shoulder replacement	1,827.40	122%
45000	Local muscle repair	636.85	122%
44367	Knee amputation	602.75	120%
45021	Scar Abrasive Therapy	208.65	122%

VMOs contract individually with public hospitals and agree the percentage of the MBS to be charged. The contracted percentage is applied to the WAGMSS fee.

There are some states where there are almost no VMOs paid on a fee for service basis:

- Northern Territory employs the vast majority of medical specialists There are some minor exceptions where fee for service applies (e.g. radiation oncologists who fly in from interstate)
- Tasmania where all VMOs are paid on a sessional basis.
- New South Wales where according to NSW Health most medical specialists are paid on a sessional basis (however we note that the NSW VMO award does provide for VMOs to be paid on a fee for service basis using the MBS as a basis of determining their fee and we are also aware of specific instances of VMOs being paid a fee for service payment .)

5.4.2. Salaried Medical Officers

There are some isolated instances in which elements of a salaried medical officer's remuneration are tied to the MBS. The specific instances noted are:

- Some hospitals in Victoria pay SMOs after-hours call back fees with the fee being calculated as a percentage of the MBS. The percentage of the MBS payable is determined as part of Health Service specific employment agreements.
- Metropolitan medical specialists providing VMO services to rural South Australian public hospitals sometimes charge the public hospital for their services using the MBS as the basis for billing.

Other states pay SMOs for after-hours / call-back via allowances and fees that are not derived from the MBS. These arrangements include fixed allowances or payments based on their own schedule of fees which are not derived from the MBS.

5.5. Revenue from non-admitted patient activities

5.5.1. Outpatients

Most states have set up outpatient clinics as MBS billable specialist clinics in at least some public hospitals, the exception being Northern Territory where the low level of private insurance and the relatively high proportion of the population not having Medicare cards does not make MBS billable clinics worthwhile.

The extent of MBS billable specialist clinics varies by state and also by individual public hospital (e.g. in Victoria some public hospitals use MBS specialist clinics extensively whereas others do not use MBS specialist clinics at all).

Given the sensitivity about compliance with the National Healthcare Agreement and use of MBS specialist clinics, some states have developed frameworks and guidelines to assist public hospitals in determining whether an outpatient service can be provided as an MBS specialist clinic. Examples include:

- Victoria: "Specialist clinics in Victorian public hospitals: a resource kit for MBS-billed services";
- Western Australia: "Protocol applying to Medical Practitioners participating in the ambulatory surgery initiative and the privately referred non-inpatients model";
- New South Wales has a number of policy documents relating to specific circumstances (e.g. circumstances in which a visiting radiologist can charge a privately referred non-admitted patient).

Medical specialists are usually required to bulk bill patients attending MBS billable specialist clinics, resulting in Medicare Australia being billed at 85% of the MBS.

5.5.2. Diagnostic tests

Diagnostic tests for hospital outpatients are billed to the MBS in certain circumstances, particularly in instances where patients attend MBS billable specialist clinics. These arrangements vary significantly between health services. Diagnostic tests are bulk billed in these instances (i.e. at 85% of the relevant MBS fee plus bulk billing incentive fees / supplements).

5.6. Payments for services provided by external organisations

5.6.1. Diagnostic testing

The level of outsourced services varies between the states and territories:

- More radiology is outsourced than pathology, due to the difficulty of attracting radiologists into the public sector, particularly in regional and rural areas. Outsourced arrangements vary from fully outsourced to outsourcing of key specialist services (e.g. reading and reporting of radiology images).
- Public hospital radiology contracts generally use the MBS as the basis of determining fees payable to private providers, however some contracts are based on a fixed rate per exam per modality, which is unrelated to the MBS.

  Most states and territories provide their own pathology service, with several states having single statewide services that provide all public pathology services (Queensland, Western Australia and South Australia). The MBS is commonly used as the basis of determining

charges between the state provider and public hospitals. In our experience, not all MBS billing rules are applied in determining the fee to be charged (e.g. coning, use of episode fees).

- Victoria is the only state with significant outsourcing of pathology to the private sector, particularly in regional and rural public hospitals. Public hospital pathology contracts with private providers are universally based on the MBS, with full application of relevant billing rules. Private providers supplement the MBS with their own fee schedules for items that are not listed on the MBS.

The rate of the MBS to be applied is nearly always determined as a result of a contestable procurement process, with diagnostic service providers usually being required to price their tenders as a percentage of the MBS. Diagnostic service providers will determine the rate to be charged based on their assessment of the cost of providing the service, the arrangements to be priced as a percentage of the MBS (e.g. sometimes after-hours on-call arrangements are charged separately at a fixed rate per call out, rather than being included in the MBS billable price) market issues and their desired profit margin.

One health service noted that diagnostic tests provided as part of clinical trials or other research activities were billed to the commercial sponsor using the MBS, where applicable, to determine the fee.

5.6.2. Other

No other services provided by external organisations and charged for using the MBS were identified other than radiology and pathology.

5.7. Revenue from services provided to external organisations

5.7.1. Diagnostic testing

Many public hospitals have community based private pathology services , for example:

- SA Pathology (formerly IMVS) is the largest provider of private pathology services in South Australia. SA Pathology has a “no gap” policy for patients and bills at the bulk bill rate for those items with an MBS item number
- ACT Pathology (part of ACT Health) is the largest provider of private pathology services in the ACT. ACT Pathology also has a “no gap” policy and bulk bills patients; and
- Many other public hospitals are the sole provider of diagnostic tests in a geographic area (e.g. pathology or high end diagnostic imaging modalities such as CT or MRI) and mostly bulk-bill services provided.

The magnitude of revenues raised from pathology and diagnostic imaging businesses has influenced private practice arrangements in some states with pathologists and / or radiologists sometimes having different private practice arrangements to other groups of medical specialists (refer section 5.1 for specific examples).

5.8. Primary care type activities

5.8.1. S19 exemptions

Exemptions are available to states and territories under the section 19 (2) of the National Healthcare Agreement to allow GP staffed rural and/or remote public hospitals to bulk-bill their services using the MBS.

The Commonwealth has set criteria under which the S19 exemption can be applied. The criteria considers population size (must be a community of less than 7,000 people), the ratio of GPs to the population, use of the income raised from GP billings (which should be directed to enhancement of local primary health care service delivery) and also the impact on any existing GP practices.

This exemption is use by public hospitals in the following states:

- Western Australia;
- Northern Territory;
- Queensland; and
- South Australia (limited use).

Queensland has the highest use of S19 exemptions (14 sites). Queensland Health actively encourages remote hospitals to apply to the Commonwealth for S19 exemptions (provided that the sites comply with the criteria listed above).

5.8.2. GP Super Clinics

The new GP super clinics are to be operated by public hospitals or state / territory health departments, and sometimes as part of a consortium with other parties such as GPs:

- State health departments expect that GP super clinics would break even (i.e. the GP super clinic should not be cross-subsidised from core public hospital operations).
- GP super clinics are dependent on MBS billings to generate revenue. This would include MBS billings by GPs and nurse practitioners.

5.8.3. Other

Northern Territory Health noted that the Commonwealth funds a Medical Specialist Outreach Assistance Program (e.g. at Tennant Creek Hospital). Under this program primary care services are provided at the hospital as outpatient type clinics where doctors can elect to charge a sessional rate or to forgo the sessional rate and bill to Medicare.

5.9. Other activities

5.9.1. Internal cross –charging

A number of states noted that the MBS is used as the basis of cross charging pathology and / or diagnostic imaging from one public hospital to another, or internally within the hospital. New South Wales, some health services in Victoria, South Australia, Queensland, Western Australia and the ACT all use the MBS as the basis of cross-charging pathology and diagnostic imaging services.

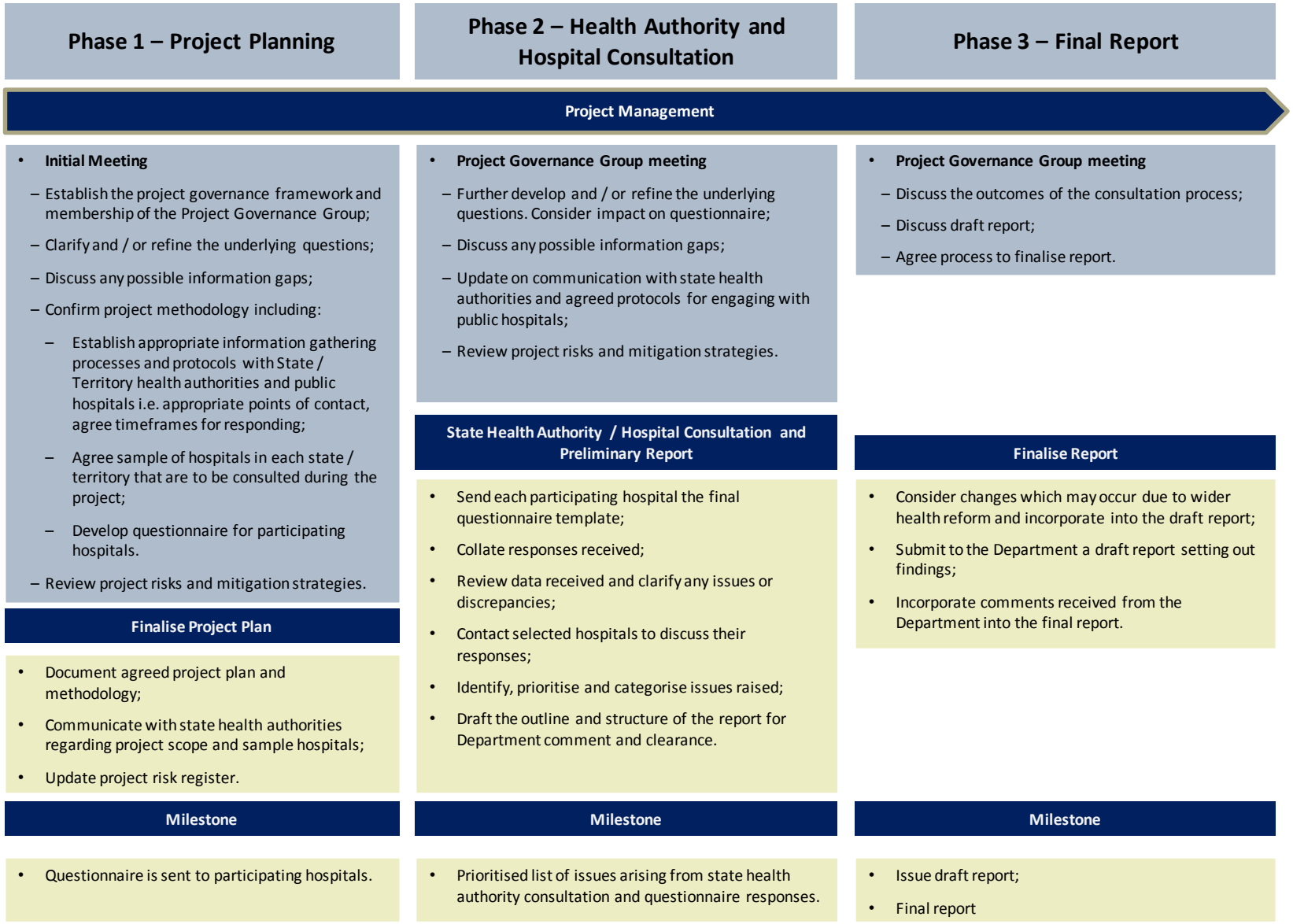
There are various arrangements in place to determine the percentage of the MBS to be charged by state and within state:

- NSW has a policy of hospital pathology services charging services to the hospital in order to achieve cost recovery. The percentage of the MBS is determined as a mathematic outcome (cost divided by activity). We note that there are substantial variations in how the percentage is determined (e.g. different application of MBS billing rules (such as inclusion of episode fees), differing accounting rules determining which costs are included, and different approaches to the inclusion of capital replacement in the cost to be allocated).
- The use of the MBS to internally cross charge pathology varies by Health Service in Victoria with each Health Service, where used, having its own approach to determining the percentage of the MBS to be charged. The states with statewide pathology services (South Australia, Western Australia and Queensland) tend to set a standard price (expressed as a percentage of the MBS):
    - South Australia Pathology bills metropolitan health services at a rate of 100% of the MBS and country health services at a rate of 75% of the MBS.
    - We do not have specific information in relation to Queensland and Western Australian billing policies.

5.9.2. Benchmarking cost

Northern Territory notes that that the MBS is used to benchmark the cost of internal versus external radiology provision.

Appendix 1 Methodology



Appendix 2 List of Consultations

Organisation	Individuals Consulted
NSW Health	• Richard Matthews, DDG Intergovernmental Policy • Janet Anderson, Director Inter-Governmental and Funding Strategies • John Roche, Chief Financial Officer
Department of Health Victoria	• Bruce Prosser, Director Funding Policy and Budget Unit • Maree Roberts, Assistant Director, Service Performance and Government Unit • Melissa Arduca, Manager Funding Policy and Budget Unit
WA Health	• Audrey Koay, Senior Clinical Advisor
Northern Territory Department of Health	• Robyn Cahill, Director Systems Performance - Acute
Department of Health and Human Services Tasmania	• Paul Greeves, Principal Consultant, Government Relations Policy and Intergovernmental Relations
Queensland Health	• Sandra Daniels, Acting Director Intergovernmental and Funding Unit
SA Health	• Chris Tan, Director, Hospital Revenue Services

Appendix 3 Questionnaire

Department of Health and Ageing (DoHA)
Use of the Medicare Benefits Schedule (MBS) in Public Hospitals

Prepared by

PAXTON PARTNERS

Summary

Selected Health Services are requested to complete this questionnaire regarding their use of the MBS . Responses will be de-identified and used to inform DoHA about the potential impacts on Health Services arising from changes to the MBS as a result of DoHA's Quality Framework review.

Background

As part of the 2009-10 Budget, the Commonwealth Government committed to implementing a Quality Framework for the review and listing of MBS items. The nature of the Quality Framework and the issues being examined are set out in a discussion paper that is available to view by clicking here.

The MBS is widely used in public hospitals not only to claim rebates on services provided to certain patients, but also as a pricing mechanism when purchasing some services from external parties and as a fee setting mechanism when providing some services to external parties.

DoHA is seeking to understand in which areas and to what extent the MBS is used in public hospitals and in other public health settings to assist in ensuring changes made under the Quality Framework do not have unintended consequences.

It should be noted this process is NOT about cost shifting rather it is to gain an understanding of arrangements and processes currently in place which utilise the MBS.

Nature of the survey

DoHA has engaged Paxton Partners to undertake research and consultations across all health jurisdictions and to provide a written report in relation to the utilisation of the MBS in public hospitals and other public health settings. Paxton Partners methodology includes:

- Consultation with State and Territory Health Departments
- Survey a limited number of metropolitan and regional Health Services in each State and Territory
- Limited consultation with Health Service's completing the questionnaire.

Paxton Partners, in consultation with your State/Territory Health Authority has determined that your Health Service participate in this review by completing the attached qualitative survey.

All survey responses will be treated as confidential. Survey responses will be de-identified by Paxton Partners. Identified results will not be made available to State or Territory Health Authorities or DoHA.

Instructions for completing the survey

- In answering the questions, please enter X in the appropriate box or, where required, type free-hand text in the spaces provided or, if necessary, attach additional pages
- In response to several questions you are required to answer using the following scale:

Not at all	Minimal	Moderate	Extensive	Exclusive

Where:

- Minimal means >0% but <30% of the time
- Moderate means >31% but <70% of the time
- Extensive means >71% but <100% of the time
- Exclusive means 100% of the time

Application of the questionnaire to a "Health Service"

We note that many Health Services have multiple hospitals. We do not expect Health Services to exhaustively document every MBS arrangement in every public hospital, however, it is expected questionnaire responses will provide information about the variety of arrangements in place in the Health Service and indicate how these arrangements may vary (e.g. differences between craft groups, differences between metropolitan, regional, rural and remote hospitals).

Returning the completed questionnaire

- We expect that completion of the questionnaire will require input from multiple personnel. Please submit a single response from the Health Service.
- Where relevant, we would appreciate you either forward electronic copies of any relevant policy documents or provide details of where these documents can be found on the internet.

Table of Contents

The survey requests information about to the areas in which the MBS is utilised and the extent to which it is utilised.

This questionnaire is set out under headings in the table below. Please indicate which sections of the questionnaire would apply to your Health Service where indicated.

1. Health Service Details

1.1 Overview

Name of Health Service			
Respondent Name			
Respondent Title			
Date		**Contact Telephone**	
Email Address			

Please confirm that the completed questionnaire is reviewed and authorised by either the Chief Executive or Chief Financial Officer (type "X" in box to confirm):

1.2 Revenue

As an indication of the size of the Health Service, please indicate the total revenue of the Health Service in 2009/10?

$	m

2. Privately Insured Hospital Inpatients – MBS Billings and Facility Fees

The patient cohort of public hospitals includes privately insured inpatients to varying extents. Doctor fees are typically billed to Medicare / Private Health Funds using the MBS, with Health Services / Hospitals often having some financial interest in the fees billed by doctors through private practice arrangements.

(We note that doctor fees will also be charged for compensable patients, i.e. Department of Veterans' Affairs, Workers Compensation and Motor Accident patients. This questionnaire is not seeking information relating to these arrangements. These will be documented on a statewide basis).

2.1 (a) Does the Health Service / Hospital have a financial interest (e.g. revenue received as a facility fee) in doctors' fees billed to **privately insured hospital inpatients**.

Yes	No

(b) If so, please describe how private practice arrangements work (e.g. hospital specific arrangement, covered by statewide arrangement) in relation to:

(i) Staff specialists (i.e. doctors who are employed by the Hospital/Health Service/State)

(ii) Visiting Medical Officers (i.e. doctors who provide services to patients at public hospitals, but are not employed by the Hospital/Health Service/State)

(c) Please either attach a copy of the relevant policy to your questionnaire response, or indicate where private practice policies can be found (if available on the internet)

2.2 Are there any differences in the manner in which private practice arrangements are provided by speciality group (e.g. variation in facility fee percentage received by the Hospital/ Health Service for privately insured patients attended by orthopaedics, cardiology, ophthalmology etc.). If so, please describe the basis on which these arrangements vary (eg. Hospital / Health Service receive a higher proportion of facility fee for capital intensive specialties, covered by statewide arrangement etc).

2.3 Are there any other classes of public hospital inpatient that are billed by doctors, using the MBS as the basis of billing (e.g. overseas patients)? If so, please describe the basis of these arrangements.

2.4 Are there any categories of Health Service / Hospital staff other than doctors who bill **privately insured hospital inpatients** using the MBS? (e.g. midwives, nurse practitioners)?

Yes	No

If so, please describe the basis of arrangement:

2.5 As an indication of the materiality of revenues derived from MBS billable inpatient services, please detail the proportion of the Health Services' inpatients in each of the following categories:

	%
Public inpatients	
Privately insured inpatients	
Compensable inpatients (DVA, Workers Compensation, Motor Accident)	
Other	
Total (must add to 100%)	

3 Payments to Doctors for Fee-for-Service Arrangements

Doctors are engaged by Health Services / Hospitals under various arrangements including employment, engagement on a sessional basis and engagement on a fee-for-service basis. This section of the questionnaire seeks to understand the extent to which the MBS is used as the basis of making payments to doctors.

3.1 Visiting Medical Officers

(a) To what extent is the Health Service reliant on Visiting Medical Officers who bill the Hospital for their public inpatient services on a Fee for Service basis using the MBS as the basis of the billing?

Not at all	Minimal	Moderate	Extensive	Exclusive

(b) What is the basis of the arrangement between the Health Service / Hospital and VMOs?

	Click to mark where arrangement applies	Comments
Individual contracts /agreements between Health Service and VMO		
Health Service agreement with specific specialist groups (e.g. anaesthetists)		
Standard agreement for all VMOs with Health Service		
Statewide agreement or other agreement determined outside the control of the Health Service		
Other arrangement (describe):		

(c) If the MBS is used as the basis of billing, which aspects apply?

	Not at all	Minimal	Moderate	Extensive	Exclusive
MBS Rates					
MBS Descriptors					
MBS Billing Rules					
Other: (please specify)					

Explanatory Comments:

3.2 Staff Specialists (i.e. employed doctors)

(a) Are there circumstances in which the Health Service remunerates Staff Specialists for their public inpatient services on a Fee for Service basis using the MBS as the basis of payment? (e.g. after hours, on call)

Not at all	Minimal	Moderate	Extensive	Exclusive

(b) What is the basis of the arrangement between the Health Service / Hospital and Staff Specialists?

	Click to mark where arrangement applies	Comments
Individual employment contracts /agreements between Health Service and staff specialist		
Health Service agreement with specific specialist groups (e.g. anaesthetists)		
Standard agreement for all staff specialists with Health Service		
Statewide agreement or other agreement determined outside the control of the Health Service		
Other arrangement (describe):		

(c) Where the MBS is used as the basis of billing, which aspects apply?

	Not at all	Minimal	Moderate	Extensive	Exclusive
MBS Rates					
MBS Descriptors					
MBS Billing Rules					
Other: (please specify)					

Explanatory Comments:

3.3 Other Medical Services

(a) Is the MBS used as the basis of payment for any other aspects of medical services provided to public hospital inpatients?

Yes	No

(b) If "Yes", please describe what the service is and how the MBS is used:

4. Non-Admitted Patient Services

Most public Health Services / Hospitals provide specialist clinics that are:

- Outpatient clinics; and / or
- MBS billable clinics.

This section of the survey seeks to understand the extent to which Health Services / Hospitals receive revenue from non-admitted patient services, billed using the MBS and what categories of MBS items are billed.

4.1 MBS billable specialist clinics

(a) To what extent do specialist clinics operate as MBS billable clinics?

Not at all	Minimal	Moderate	Extensive	Exclusive

(b) Where these specialist clinics exist, please list the types of specialist clinics operating as MBS billable clinics.

(c) What are the relevant State/ Health Service policies for establishing such clinics? Please attach copy of policy, or provide information on where policy can be found on the internet.

4.2 Diagnostic tests

To what extent does the Health Service bill diagnostic services using the MBS as the basis of billing for:

(a) Patients attending outpatient clinics:

	Not at all	Minimal	Moderate	Extensive	Exclusive
Pathology					
Medical Imaging					

Describe the basis of arrangements:

(b) Patients attending MBS billable specialist clinics

	Not at all	Minimal	Moderate	Extensive	Exclusive
Pathology					
Medical Imaging					

Describe the basis of arrangements:

(c) Non-admitted patients other than those attending outpatient clinics and MBS billable clinics (e.g. patients attending licensed pathology collection centres)

	Not at all	Minimal	Moderate	Extensive	Exclusive
Pathology					
Medical Imaging					

Describe the basis of arrangements:

5. Services purchased by the Health Service from External Parties where the MBS is used as the basis of billing

Many Health Services / Hospitals purchase diagnostic or other services from external providers (either public or private providers) using a variety of arrangements. Sections 5 of the questionnaire seeks to understand the extent to which the MBS is used as a purchasing currency and which aspects of the MBS are applied.

5.1 Diagnostic Services

(a) Where diagnostic services are purchased from an external party, to what extent is the MBS used as the basis of billing?

	Not at all	Minimal	Moderate	Extensive	Exclusive
Pathology					
Medical Imaging					

(b) Where the MBS is used, provide details about the basis of service provision (e.g. is the service fully outsourced, partly outsourced or ad hoc purchasing only from an external party)

(c) If the MBS is used as the basis of billing, which aspects apply?

	Not at all	Minimal	Moderate	Extensive	Exclusive
MBS Rates					
MBS Descriptors					
MBS Billing Rules					
Other: (please specify)					

Explanatory Comments:

(d) Where the MBS is not used as the basis of billing, what mechanism is used? (for example, fixed rate per test / exam)

Explanatory Comments:

5.2 Other Services

(a) Other than pathology / medical imaging services, are there other services purchased from an external party where the MBS is used as the basis of billing?

Yes	No

If "Yes", please describe the service and how the MBS is used:

6. Services provided by the Health Service to External Parties where the MBS is used as the basis of billing

Many Health Services / Hospitals provide diagnostic or other services to external providers (other public Health Services or privately operated services) using a variety of arrangements. Sections 6 of the questionnaire seeks to understand the extent to which the MBS is used as a purchasing currency and which aspects of the MBS are applied.

6.1 Diagnostic Services

(a) Where diagnostic services are provided by the Health Service to an external party, to what extent is the MBS used as the basis of billing?

	Not at all	Minimal	Moderate	Extensive	Exclusive
Pathology					
Medical Imaging					

(b) Where the MBS is used, please provide details about the basis of service provision (e.g. is the service fully outsourced, partly outsourced or ad hoc provision only to an external party)

(c) If the MBS is used as the basis of billing, which aspects apply?

	Not at all	Minimal	Moderate	Extensive	Exclusive
MBS Rates					
MBS Descriptors					
MBS Billing Rules					
Other: (please specify)					

Explanatory Comments:

(d) Where the MBS is not used as the basis of billing, what mechanism is used? (for example, fixed rate per test / exam)

Explanatory Comments:

6.2 Other Services

(a) Other than Diagnostic Services, are there other services provided to an external party where the MBS is used as the basis of billing?

Yes	No

If "Yes", please describe the service and how the MBS is used:

7. Primary Care Services

This section of the questionnaire seeks to understand the extent to which the MBS is used in relation to non-acute services by public Health Services / Hospitals.

7.1 To what extent does the Health Service use the MBS as the basis of billing for "primary care" type services?

(a) After-hours GP clinics operated by the Health Service

Not at all	Minimal	Moderate	Extensive	Exclusive

(b) GP type services provided by Accident & Emergency in rural and remote areas (section 19(2) COAG exemption)

Not at all	Minimal	Moderate	Extensive	Exclusive

(c) Community Health GP services

Not at all	Minimal	Moderate	Extensive	Exclusive

(d) Other Primary Care services

List Service	Not at all	Minimal	Moderate	Extensive	Exclusive

Please describe basis of arrangements:

8. Other uses

8.1 Transfer pricing diagnostic services within a Health Service

8.1 Does the Health Service transfer price pathology / diagnostic imaging / other services, using the MBS as the basis of pricing between hospitals / business units / departments within the Health Service?

	Not at all	Minimal	Moderate	Extensive	Exclusive
Pathology					
Medical Imaging					
Other: (describe)					

8.2 Other uses

(a) To what extent does the Health Service use the MBS for other purposes (e.g. benchmarking cost of service provision)?

Not at all	Minimal	Moderate	Extensive	Exclusive

(b) If the MBS is used for other purposes, please describe the other purposes for which it is used and how it is applied:

(c) Are there any other matters that you believe would be relevant to the DoHA in implementing a Quality Framework for the review and listing of MBS items?

Comments