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# Medicare Benefits Schedule Review Taskforce

## Taskforce Findings

### Specialist and Consultant Physician Consultation Clinical Committee Report

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This document outlines the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) recommendations in response to the final report from the Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC).

The Taskforce considered the recommendations from the SCPCCC and feedback from stakeholders received during a targeted consultation period.

<b>Number of items reviewed</b>	143
<b>Number of recommendations made</b>	21

The Taskforce endorsed 18 recommendations from the SCPCCC Report and submitted them to the Minister for Health for Government consideration.

The recommendations are intended to encourage best practice, improve patient care and safety, and ensure that MBS services provide value for the patient and the healthcare system through deleting obsolete or low clinical value items; consolidating or splitting items to address potential misuse; modernising item descriptors to reflect best practice; and providing clinical guidance for appropriate item use through explanatory notes.

### List of Taskforce Recommendations

#### **Recommendation 1 - Introduce attendance items based on attendance duration and patient complexity factors**

The Taskforce recommends introducing time-tiered attendances items to replace most of the current standard attendance items. Ten new time-tiered attendance items would be introduced that set out activities to be performed at each time tier. All specialists and consultant physicians would have access to the same standard attendance items (ie this model would equalise the rebate for attendances for specialists and consultant physicians). This model also involves a move away from initial and subsequent consultations.

The Taskforce notes that significant additional work will need to be undertaken before time-tiering could be implemented, including extensive data collection and modelling and consultation with peak organisations, clinicians and consumers.

### **Recommendation 2 – Introduce new attendance items for acute, urgent and unplanned attendances**

The Taskforce recommends creating four new time-tiered attendance items for acute, urgent and unplanned attendances that take place outside consultant specialists<sup>1</sup> consulting rooms and public hospital emergency departments. It is recommended that the duration of these time-tiers should be the same as Levels B, C, D and E under Recommendation 1 and schedule fees would be higher than for standard time-tiered attendances.

### **Recommendation 3 - Further considerations when implementing time-tiering**

The Taskforce recommends the Government works closely with peak organisations, clinicians and consumers to refine the detail of implementation, and ensure an effective and sustainable transition. This includes collecting data on the duration of attendances across specialities and the activities performed during these attendances and using that data to accurately model the impact of time-tiering on service volumes and benefits.

### **Recommendation 4 – Approach to fee setting**

The Taskforce recommends building support among peak bodies, clinicians and consumers for the principles of time-tiering before introducing schedule fees; ensuring a linear relationship between attendance time tiers and schedule fees from the outset; ensuring non-patient facing time is factored into the new fee structure and ensuring that this fact is well communicated; and recognising that there is a lack of data on the current duration of consultant specialist attendance times and the activities performed in these attendances.

### **Recommendation 5 – Impact on time-tiering on distant outreach services**

The Taskforce recommends monitoring the impact of time-tiering on distant outreach services and, if a problem exists, developing a non MBS process to address the issue.

### **Recommendation 6 - Removing consultant physician, addiction medicine, and sexual health medicine complex plan items**

The Taskforce recommends removing consultant physician, addiction medicine, and sexual health medicine complex plan items from the MBS (items 132, 133, 6023, 6024, 6057, and 6058) and incorporating these items into standard time-tiered attendances.

### **Recommendation 7 – Retain access to paediatric complex plan items with strengthened descriptor**

The Taskforce recommends retaining paediatric complex plans (item 135) and amending the descriptor and explanatory note to allow access for children with fetal alcohol spectrum disorder (FASD) and other

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<sup>1</sup> Consultant specialists is an umbrella term the Taskforce has proposed to capture both specialists and consultant physicians.

complex neurodevelopmental disorders. The Taskforce recommends replacing the outdated term pervasive developmental disorder with complex neurodevelopmental disorder.

**Recommendation 8 – Retain the geriatrician specific consultation items**

The Taskforce recommends retaining items 141, 143, 145 and 147 and not including under time-tiering. The Taskforce noted feedback received on the draft report, which originally proposed folding all of the geriatric MBS items into time-tiering. In particular, the Taskforce noted there are a number of unique, specific requirements for a comprehensive geriatric assessment and management plan. The Taskforce agreed to retain these items in the MBS to ensure that older Australians can continue to access this high-value care.

**Recommendations 9 & 10 (Referred) – New framework for and reinvestment in telehealth**

The SCPCCC telehealth recommendations involve phasing out the current 50 percent loading items for specialist and consultant physician telehealth attendances, reinvesting the savings into other incentives support the uptake of telehealth, and introducing a new time-tiered framework for specialist and consultant physician telehealth services.

The Taskforce referred consideration of the SCPCCC's telehealth recommendations to its Telehealth Working Group, which considered these and other telehealth-related recommendations from across the MBS Review and developed guiding principles and recommendations to underpin the future use and reform of telehealth. These are set out in the Taskforce's Telehealth Report.

**Recommendation 11 - Introduce a new framework of case conference items and allow access to all consultant specialists**

The Taskforce recommends introducing a new simplified framework of case conference items, featuring three types:

- a. discharge planning case conferences - a case conference to facilitate better post-discharge care and communication;
- b. community case conferences - a case conference to facilitate the provision of better multidisciplinary care; and
- c. treatment planning case conferences (new) - a case conference that explores and analyses potential treatment options and their respective benefits.

The Taskforce also recommends introducing requirements for greater GP and patient participation in case conferences.

**Recommendation 12 - Introduce case conference items for allied health professionals (AHPs) and nurse practitioners**

The Taskforce recommends that AHPs who access these items should be limited to those who are eligible to access AHP items under Group M3 of the MBS.

**Recommendation 13 – Referral for examination of informed financial consent**

The Taskforce recommends that the Principles and Rules Committee examine the issue of informed financial consent for out-of-pocket fees charged with case conference items.

**Recommendation 14 - Establish a minimum data set to inform evidence-based clinical practice and inform patient choice**

The Taskforce recommends a step-wise approach to establishing a national minimum data set to record outcome and process data on topics such as mortality, morbidity, readmissions, quality measures of consultations and patient-reported outcomes.

**Recommendation 15 – Provide transparency on the cost and quality of consultant specialist services**

The Taskforce recommends that:

- a. MBS cost data, including data on out-of-pocket fees, is shared at an institutional and individual provider level;
- b. consultant specialist risk-weighted outcome data discussed in Recommendation 14 is shared at an institutional, disease-specific unit level;
- c. cost and outcome data are publicly available to enable discussion with the GP at the time of referral; &
- d. the presentation of cost and outcome data should be co-designed with consumers and include a clear explanation of the data and its limitations.

**Recommendation 16 - Improve informed comprehensive patient consent and shared decision-making practices**

The Taskforce recommends:

- a. Including the following in standard attendance item descriptors (refer to Recommendation 1) when multiple treatment options are available:
  - i. discussion of patient treatment options to assess the risks and benefits of each option, given the patient’s characteristics and medical history;
  - ii. consideration and discussion of referrals to other health professionals; and
  - iii. a requirement for written documentation, made available to the patient and/or carer, which outlines treatment options and information on associated risks and benefits.
- b. That provider education on the patient consent process be promoted through colleges and the Australian Commission on Safety and Quality in Health Care’s standards, achieved via media campaigns and by informing general practice.
- c. Improving the consent process by enhancing provider education materials and other relevant materials.

### **Recommendation 17 – Incentivise adoption of My Health Record**

The Taskforce recommends:

- a. introducing a single incentive payment to consultant specialists upon their adoption of My Health Record, triggered by achieving a volume of uploads that is proportional to the number of attendances that the provider performs; and
- b. reviewing the effectiveness of the incentive payment after a defined period such as two years.

### **Recommendation 18 – Use of My Health Record for case conferences and complex plans**

The Taskforce recommends that case conference outcomes, geriatric complex plans and paediatric complex plans are uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.

### **Recommendation 19 – Encourage adoption of My Health Record**

The Taskforce recommends:

- a. improving the functionality of My Health Record and educating consultant specialists on the benefits of its use;
- b. continuing to develop and enhance the functionality and ability to search the data of My Health Record, so that it becomes a value-add tool for consumers and clinicians in day-to-day quality patient care;
- c. broadening training for health care providers to include education about using the My Health Record system clinically, and about its benefits for patients and the health system;
- d. including the development of appropriate scenarios relevant to the full range of health care providers across disciplines and clinical settings; and
- e. working with academic institutions to embed digital health competencies into undergraduate and postgraduate training and continuing professional development programmes.

### **Recommendation 20 (Not agreed) – Extend the current specialist to specialist referral validity period**

The Taskforce did not agree to the SCPPCC's recommendation to extend the specialist to specialist referral validity period from three months to six months. The Taskforce noted that this issue had been examined by a number of their clinical committees and that the key role of the GP is as 'gatekeeper' to the broader health system and primary point of patient contact. They noted that the three-month limit facilitated regular ongoing contact between patient and GP.

The Taskforce recommends retaining the specialist-to-specialist referral validity of three months.

### **Recommendation 21 – Introducing a new AHP pathway**

The Taskforce recommends introducing an AHP pathway for consultant specialists under certain circumstances, but only after a full review of the evidence and the associated costs and benefits of any suggested pathway.