
Medicare Benefits Schedule Review Taskforce

Taskforce Findings: Participating Midwives Reference Group Report

This document outlines the Taskforce’s recommendations in response to the report from the Participating Midwives Reference Group (PMRG).

The Taskforce endorsed eight recommendations from the Final Report from the PMRG and made one independent recommendation, these were submitted them to the Minister for Health for Government consideration.

Number of items reviewed	12
Number of recommendations endorsed	8
Number of independent Taskforce recommendations	1

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 independent Taskforce Recommendations

Note: The Taskforce deliberations questioned whether the MBS is the best model of care for midwifery services. In the long-term, the Taskforce agrees alternative models and pathways and funding mechanisms, outside the MBS, should be explored and considered.

The Taskforce further notes the following should be considered in the long-term:

- a. establishment of an intergovernmental group,
- b. a holistic review of the existing model,
- c. review into whether MBS is the most appropriate pathway for the midwife model of care,
- d. workforce planning,
- e. discussions involving state and territory governments, workforce, peak bodies, colleges etc., and
- f. a full investigation of international care models and how they might be incorporated into the Australian system.

The Taskforce has also created an additional recommendation relating to PMRG Recommendation 8:

Taskforce Recommendation 4 - Investigate an alternative funding model for home birthing for patients with low-risk pregnancies

The Taskforce acknowledges the importance of safe, high quality care for all obstetric patients. Low risk deliveries may include birth in the home, under the care of an appropriately trained midwife working collaboratively with multidisciplinary support.

The Taskforce considers that the MBS is not the appropriate funding model or pathway to support collaborative quality patient care for low-risk home births and agrees the PMRG did not offer a suitable alternative solution.

Alternative funding models could be developed to support for low-risk home birthing services. If the Government was to explore this, the Taskforce recommends the following be considered:

- a. define appropriate collaborative arrangements to ensure patient safety,
 - (a) undertake a thorough review into current access barriers, including:
 - (i) definition of low risk
 - accepted mechanisms to support patient safety and best practice, and
 - medical/professional indemnity insurance arrangements for participating midwives
- (b) Develop a definitive care framework supporting collaborative care arrangements between the patient, participating midwife, general practitioner obstetrician and/or specialist obstetrician for the duration of the pregnancy and at least two weeks post-partum.
- (c) Evaluate maternal and neonatal outcomes in the Australian health system.

List of Taskforce endorsed Participating Midwives Recommendations

Recommendation 1 – Include a minimum duration for initial antenatal attendances

This recommendation proposes, in the short-term, amending the item 82100 (initial antenatal professional attendance) descriptor to increase the minimum time of consultation to 60 minutes.

Recommendation 2 – Amend the antenatal attendance items to appropriately reflect the time they take

This recommendation proposes amending the descriptor for item 82105 (short antenatal attendance) to specify a minimum duration of 10 minutes and remove the maximum duration of 40 minutes, and amending the item 82110 (long antenatal attendance) descriptor to describe the attendance as “routine” rather than “long”.

Recommendation 3 – Introduce a new item for complex antenatal attendance leading to a hospital admission

This recommendation proposes creating a new item for a complex antenatal attendance leading to a hospital admission, with a minimum time duration of three hours and a maximum of three services per pregnancy. This item would be restricted from co-claiming with all other antenatal attendances.

Recommendation 4 – Restrict claiming of maternity care plans to prevent low value care

This recommendation proposes, in the short-term, restricting claims of item 82115 (assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks) to instances where the woman has had at least two prior antenatal attendances with the claiming midwife during the pregnancy. Additionally, co-claiming with corresponding GP/obstetric items for maternity care plans should be restricted, so that only one care plan (independent of provider) can be claimed per pregnancy with the items for co-claim restrictions.

Note: The Taskforce supports this recommendation in the short-term but agrees alternative funding models and pathways should be explored for a longer-term solution. The Taskforce notes bundled/package care could be considered in this case.

Recommendation 5 – Amend time tiering of intrapartum items

This recommendation proposes:

- a. creating two new intrapartum items, time tiered at up to six hours:
 - i. (Example of new item number: 821AA) – Management of labour for up to 6 hours, including birth where performed OR attendance and immediate post-birth care at an elective caesarean section
 - ii. (Example of new item number: 821BB) – Management of labour for up to 6 hours, including birth where performed, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)
- b. amending existing intrapartum items 82120 and 82125 to create a time-tier of between 6 and 12 hours and allow for birth where performed,
- c. measuring the intrapartum item time-tiers by midwife attendance duration, not labour duration,
- d. allowing the intrapartum items 82120, 82125, 821AA and 821BB to be claimed up to a total of 30 hours attendance by up to two participating midwives and subsequently allowing co-claiming to account for two or more midwives attending a labour,

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- e. allowing new item 821AA to be claimed for a participating midwife’s attendance at an elective caesarean section to ensure skin-to-skin contact of mother and baby immediately following birth and initiation of infant feeding in theatre and the recovery unit, until transfer of care to postnatal staff, and
- f. reflecting modern language by replacing “delivery” with “birth” and “confinement” with “labour” across the intrapartum items.

NOTE: The Taskforce supports the need to address barriers in improving quality and continuity of care, however, the following implications must be considered and mitigated with safeguards, should the Government endorse this recommendation:

- schedule fees should be carefully considered to reflect appropriate clinical input,
- the likelihood of significant shifts of public midwives to private,
- the subsequent cost-shifting effects of this swing between public and private, and
- whether post C-section should be included in the time brackets.

Recommendation 7 – Enable intrapartum items to be claimed from the time the midwife attends the patient for labour care

This recommendation proposes amending intrapartum item descriptors to include the word “attendance” (i.e. “up to 6 hours attendance” or “between 6 and 12 hours attendance”) to ensure that the billing periods start whenever the midwife is in attendance for the labour and birth (including out of hospital).

Recommendation 9 – Amend the postnatal attendance items

This recommendation proposes amending the descriptor for item 82130 (short postnatal attendance) to specify a minimum duration of 20 minutes and remove the maximum duration of 40 minutes, and amending the item 82135 (long postnatal attendance) descriptor to describe the attendance as “routine”, rather than “long.

Recommendation 10 – Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance

This recommendation proposes amending the item 82140 (postnatal attendance on a patient not less than six weeks but not more than seven weeks after delivery of a baby) descriptor to introduce a minimum duration of 60 minutes and to include a birth debrief and mental health screening.