



AACP

AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS

DEVELOPMENT OF A QUALITY FRAMEWORK FOR THE MEDICARE BENEFITS SCHEDULE

Submission from the Australian Association of Consultant Physicians

June 2010

EXECUTIVE SUMMARY

The Australian Association of Consultant Physicians (AACP) welcomes the opportunity to comment on the draft proposals concerning the operation of the quality framework.

The AACP has concerns about the complexity of the proposed evaluation and assessment processes and the lack of clarity about the timeframe within which assessment decisions are made. The AACP is particularly concerned that the proposed process whereby fees for Medicare benefit for new or amended items are related to existing items, rather than being separately costed to ensure they reflect actual costs. Under the proposed process, increasingly patient rebates would not reflect costs and therefore patients are likely to face increasing out of pocket costs.

The AACP believes the Quality Framework process should ensure that patient rebates should seek to reflect the real cost of delivering high quality medical services.

BACKGROUND AND GENERAL COMMENTS

The Discussion Paper sets out proposed arrangements for evaluating applications for new Medicare items, for review of existing items and for setting fees for Medicare benefit. For new items, a seven stage “MBS time-limited listing process” is proposed; for review of existing items, a six stage “Review System” is envisaged. These variously include inputs from external applicants, external evaluators, a range of stakeholders, appointed experts, three committees and the Department, as well as the Minister for Health and Ageing who receives advice from the Department.

The Background to the Discussion Paper states that “the Medicare Benefits Schedule (MBS) lists rebates payable to patients for private medical services provided on a fee-

for-service basis ... (and) is a cornerstone of the Australian health care system". The proposition that the MBS is one of the cornerstones of Australia's health system is fully supported as is the view that a contemporary, properly funded MBS is fundamental to the provision of quality medical care to Australian patients.

It is also noted that the paper defines "Schedule fee" as "the amount the Government considers appropriate as a recommended fee for an MBS item" (even though the paper also notes that "a Schedule fee does not determine the amount a health professional can charge for providing the service"). Under the Medicare arrangements, the Government cannot determine what a doctor can charge a patient. The Medicare Benefits Schedule sets out a list of fees on which Medicare patient rebates are based, namely, the amount that the Government has determined it will pay to a patient as a rebate for a particular medical service. The Medicare fee thus represents a price on which a Medicare rebate is based; it is neither a recommended fee, nor a required fee that must be charged.

DEMONSTRATING "IMPROVED HEALTH OUTCOMES"

The Discussion Paper states that the MBS Quality Framework will ensure that services listed on the MBS "improve health outcomes for patients". The MBS Quality Framework's processes need to recognise that an improved health outcome cannot always be directly linked to a particular medical service, for example, where a diagnostic procedure is involved or where an attendance item may result in the diagnosis of a medical condition but the treatment (and thus health outcome) may be dependent on a different medical service (such as a surgical procedure). In the case of attendance items, the paper identifies this as an issue, but it is not clear how the process will differentiate between the different types of services.

THE NEW MBS TIME-LIMITED LISTING PROCESS

The process, as set out in the Discussion Paper, raises concern about the complexity and number of steps in the process, the likelihood of the process becoming protracted and the lack of a clear timeframe within which the application and review process will be completed.

Stage 1: Item Submission

The Discussion Paper notes that MSAC will "maintain the capacity to recommend interim funding for new items to facilitate the collection of evidence for later review". In establishing any MBS Quality Framework evaluation process, there needs to be certainty that the data generated under the agreed approaches is what ultimately is evaluated. One of the problems of undertaking such assessments is that medicine is not static; by its nature it is a constantly evolving discipline. The processes of the MBS Quality Framework will need to balance a three to four year assessment program with a changing medical environment to ensure there is fair evaluation of the results of the assessment.

While it is appreciated that the intent is to develop evaluation methodologies that reflect the type of medical service and the likely outlays and that such an evaluation should be designed to be completed within the designated timeframe, the example of

the PET Data Collection Project (undertaken from 2002 to 2009) is worth noting in terms of ensuring that review of the data generated is completed in a timely manner.

In this regard it is noted that the “criteria to determine the appropriate assessment pathway and the assessment process that will be used are continuing to be developed”; while there is value in assuring assessment processes are effective, there is also concern that ongoing development of the process will mean engender uncertainty about the process itself.

The Department will determine whether an application is processed through MSAC or the MBS Quality Framework; however it is not clear what criteria will be used to determine the most appropriate pathway, or who will actually make these decisions.

“Endorsement” and “joint endorsement” of a proposed service is required by the relevant medical organisation/s and “certification” that it is “clinically relevant and accepted as part of modern medical practice”. In the case of proposed consultation items, in relation to which the Discussion Paper acknowledges that clinical trial evidence of the type expected by PBAC or MSAC is unlikely to be available, it is not clear whether the “certification” process will be regarded as a surrogate for clinical trial evidence.

Initial assessment criteria

Criteria for use by the Department to determine whether a proposed service is listed on the MBS, evaluated or rejected are not yet developed. It is unfortunate that these are not available for comment.

However, it is noted that assessment of proposed new items will “also include consideration of potential offsets or savings”. It is of concern that there appears to be an assumption that any new item potentially requires a reduction in fees for Medicare benefit in existing items or the deletion of an existing item in order that funds “within the group” can be re-allocated. There can be no assumption that a new service necessarily replaces an existing service. The expectations of the Australian community are that it will have access to appropriate new medical services; the expectation is not that this access comes at the cost of access to Medicare benefits for existing services.

The Discussion Paper notes that where an applicant has identified an impact on a different specialty or area, including potential savings in Medicare outlays, the affected specialties must be involved in the application process. It is not clear whether the expectation is that the other specialty area/s should be involved at the time of the application, or that they will be brought into the assessment and consultation process.

However, the process should ensure that where the same medical service is provided, patients of different specialties or sub-specialties should be eligible to receive the same Medicare benefits.

Stage 2: Quality Framework assessment of applications

Eligibility

The Discussion Paper states that applications will be checked for eligibility for assessment. Eligibility will include “whether the proposed service meets the Government’s current policy parameters for funding professional services under Medicare”. This eligibility assessment criterion potentially introduces a high degree of uncertainty into the process.

First, an appropriate medical service may be blocked from entering the assessment process; and secondly, a change of Government policy in the intervening years may result in the results of an assessment over a period of three or four years being disregarded and the time-limited item listing removed from the MBS, irrespective of the value of the service demonstrated by the evaluation.

Review

It is noted that there is provision to request a review concerning eligibility for application or of a decision concerning the appropriate assessment pathway by the First Assistant Secretary of the Medical Benefits Division. The criteria for this review are not stated.

Stage 3: Development of an evaluation plan and Schedule fee prior to listing

The Department will develop the evaluation plans for time-limited listings and it is noted that the Department is tendering for a panel of providers of health services evaluations. It is not clear whether the Department will accept a recommendation from the applicant for an evaluation plan. Given the applicant is likely to have the most detailed knowledge of the medical service, it may be appropriate to encourage applicants to make recommendations.

It is noted that, from the information provided by the applicant, the Department will set a fee for Medicare benefit based on “the time and practice costs identified as included in the service, relative to fees for other services provided by the specialty”. This statement is of considerable concern since it implies that the current level of Medicare fees represents appropriate costs both for the professional and the technical component of the various services. Given that increases in fees for Medicare benefit have not kept pace with inflation for many years, this is not the case and basing new fees for Medicare benefit on existing fees for Medicare benefit, rather than on the actual cost of providing the service will result in further erosion of the level of Medicare rebates available to patients for many medical services.

It is also noted that while there are some funds available “to finance evaluations” up to 30 June 2011, evaluation costs after that date will be factored into to the cost of assessing the new item. There is concern that the cost of evaluations may become unnecessarily high, and that the applicant/s have neither control nor knowledge of the costs incurred within the Department and the cost of consultants engaged by the Department. There needs to be further information provided as to the likely cost to an evaluation of Departmental input, consultant advice and other costs to be added to an application in order that the applicants may make an informed decision about how to proceed. Further, the Department needs to provide guidance in terms of what it will

regard as an appropriate level of cost for an evaluation compared with the estimated outlays for a particular medical service if it is time-listed.

Review

There is provision for “applicants or other stakeholders” to request a review of the decision of the MBS Quality Framework Expert Advisory Committee’s recommendations concerning time-limited listing. It is not stated who will conduct such a review, or the timeframe for a review.

Stage 7: Evaluation following Time-Limited Listing

There appears to be an assumption in the paper that the evaluation of a time-limited listing will occur at the end of the listing period, but at the same time it is noted that the “default position” for a time-limited listing at the end of the listing period is non-continuation of Government funding unless the formal evaluation of the evidence gathered during the listing period merits otherwise.

At this stage it is unknown how many evaluations may be underway and therefore what time commitment is required of the Department to complete the evaluations. However, it is clear that the evaluations must be framed such that the evaluation period ends well in advance of the time-listing period in order that the assessment of the evaluation is completed in advance of the final date of the time-listing. Otherwise items may cease to be funded under the “default position” or will have to be extended under some other arrangement.

In the absence of detail about how the assessment of the evaluations will be undertaken and by whom, there is genuine concern about the conduct of the assessment of the evaluation and the completion of other required processes in advance of the end date for time-limited listings. (It is noted that there is provision for extension of time-limited listings to collect more evidence, however this is also subject to a further evaluation plan being agreed.) In both cases, the potential workload associated with both the development of and agreement to evaluation plans and the assessment of the evaluation outcomes may be significant.

Further, it is noted that: “the final decision on the evaluation plan rests with the Minister for Health and Ageing”. It is difficult to see how the Minister would have the expertise to determine whether an evaluation plan is appropriate, or more importantly, the time to consider every plan, and potentially any requests for extension of evaluation plans as envisaged under item 43 of the Discussion Paper.

It is suggested that the whole process of the development and approval of evaluation plans, and the assessment of the outcomes of evaluations, needs to be reconsidered. One of the major criticisms of the MSAC process has been the time taken for the process of reviewing applications, submitting recommendations to the Minister, consideration of those recommendations by the Minister and consideration of financial information by the Department of Finance and Administration and Treasury, drafting of the item descriptor, and subsequent listing, should the application be successfully steered through this time-consuming process. Unless the Department has significant resources to allocate to the Quality Framework evaluation process it has the potential to become just as delayed as the MSAC process has been, given all the steps that are involved.

It is pleasing to note there is expected to be significant variation in the evaluation requirements for different MBS items, based on the type of service and the complexity and cost of the item, with the majority “most likely requiring only minor evaluations”. Nevertheless, with even a minimum requirement for evaluation and the associated process the lack of resources allocated to the scheme beyond mid 2011 is of concern.

While it is noted that evaluations will be designed to protect patients’ rights to privacy, it is not clear whether there will be an expectation that ethics approvals will be required. Given that public hospitals now routinely use Medicare items consideration needs to be given to whether any data collection undertaken with respect to hospital patients will need ethics approval and, if so, the potential impact on evaluation design.

It is also noted that reference is made to “further questions raised or modifications identified during post implementation reviews”. This suggests additional reviews during the implementation phase.

FRAMEWORK FOR REVIEWING EXISTING MBS ITEMS

Principles to guide MBS Reviews

The Discussion Paper notes a number of principles (p 26), including:

- reviews are independent of Government financing decisions
- reviews are conducted in consultation with key stakeholders including, but not limited to the medical profession and consumers

In relation to the above, it is noted that eligibility for assessment for new items is dependent on compliance with current Government policy; however the above seems to suggest that reviews of existing items are not necessarily treated in the same way.

In relation to consultation, the Department’s advice as to the range of “stakeholders” it envisages may be involved in such reviews would be appreciated.

MBS Reviews Process – Stage 1: Environmental Planning

The Discussion Paper lists a number of means of identifying items for review. It is noted that Medicare Australia would now appear to be referring items to the Department based on its surveillance and compliance processes and that there is provision for public nomination of items. In the latter case, it is not clear why public nomination is being considered. If public nomination is to be pursued, there would need to be very clear criteria under which a nomination were accepted from a member of the public. The Discussion Paper states a number of principles underpinning the MBS reviews as particularly relevant (patient safety risk, limited health benefit, inappropriate use and/or intentional mis-use of MBS services); it would seem more likely that Medicare Australia, the medical practitioner and/or his/her peers or the Medical Board is far more likely to be in a position to identify concerns about a particular medical service than the patient. It is unclear whether this mechanism may simply generate complaints that should more appropriately have been referred to other more organisations.

Stage 2: Prioritising and Scoping Review Activity

A set of draft criteria has been proposed in the discussion paper. These appear appropriate, in terms of considering overall clinical impact, quality and safety in the selection of items. However it is noted there is reference to alteration of use from the original item intent. In these instances it would be more appropriate for consultation between the Department and the relevant medical provider group about such use and, where appropriate, to reword the item descriptor, rather than embarking on a lengthy formal review under the Quality Framework.

The proposed review process is multi-layered. There would have to be concern about the cost and resource intensive nature of the proposed reviews.

According to the Discussion Paper, in most cases it is expected that an external, independent organisation with demonstrated expertise in health services evaluation will be engaged to conduct the evaluation. A clinical expert/s will be engaged by the MQFEAC to provide appropriate input to the review process, although the criteria for such engagement are not provided (for example, whether he/she will be in current clinical practice, whether they are from the public or private sector or whether they are paid).

For existing MBS items, the Discussion Paper acknowledges there are challenges and complexities involved in the review of items, particularly with respect to the “generally poor evidence-base for some items”. Examples are not provided of the items or categories of items to which this comment refers except that it is noted earlier in the paper that the Department is aware of the likely lack of “clinical trial evidence of the kind expected by PBAC or MSAC” for consultation items.

The Discussion Paper suggests that the lack of an evidence base for some items may “necessitate a broader, more pragmatic approach to consideration of ‘evidence’, including alternate data sources (such as clinical registers) and analysis methods, and where this does not unduly affect the rigour of the reviews”. One of the concerns will be that, as has occurred previously with MSAC evaluations, while different levels of “evidence” initially may be deemed acceptable, when it has come to the actually assessing the “evidence” provided on this basis, the evaluation has been heavily in favour of only higher levels of evidence.

It will be important to ensure there is clear agreement at the outset about what levels of evidence will be provided and subsequently evaluated as part of this review process.

As presently set out, there is a range of possible approaches to the evaluation process and for the potential applicant, it may not necessarily be clear which approach is going to be taken.

In relation to “individual service reviews” it is suggested that a “rapid review of the scientific literature” will be conducted. It is not clear who will be undertaking the reviews and the advice of the Department is sought on this point.

Primary Review Outcomes

It is noted that where there are potential amendments to the MBS arising from reviews there will be consultation with the “relevant stakeholder groups”. The Department’s

advice is sought about who will be considered “relevant stakeholder groups”. In recent times, such consultations have extended well beyond the organisation that would normally have been considered the relevant group; these added groups potentially expanded the time required for consultation without necessarily adding anything new to the discussions.

Supplementary Review Outcomes

It is noted that a number of strategies may be implemented in response to a review outcome; however it is also noted that stakeholder consultation is not indicated in relation to these strategies. It is assumed this is an oversight since the involvement of the relevant medical professional organisation in the promotion of quality health care initiatives such as the development of guidelines, education and training, development of research opportunities and exploration of incentive-based initiatives to promote improved practices is critical.

Review of decisions mechanism

It is noted that there will be provision for lodging a request for a review but the process for receiving and managing these requests has yet to be developed. It is not clear whether it is proposed that the First Assistant Secretary, Medical Benefits Division, will undertake the reviews, as with the initial decisions concerning eligibility to lodge an application, and what timeframe will apply.

INPUT BASED SCHEDULE FEE SETTING – MEASURES AND METHODOLOGY

The Discussion Paper describes the process of setting fees for Medicare benefit for new and existing services that will be undertaken relative to the fees for Medicare benefit for other services provided by the particular specialty. However, that pre-supposes existing fees for Medicare benefit reflect actual costs for professional, technical and capital inputs to the service – in other words, that the existing fees for Medicare benefit are appropriate, both in terms of providing a rebate to the patient for the particular medical service, and therefore that they are appropriate for benchmarking new or amended fees for Medicare benefit. The AACP does not believe this to be the case.

For example, in the case of consultation items, there has been little recognition of the time taken by the consultant physician/paediatrician in essential non-face to face activities, or quality assurance and CME activities. The increasing complexity in presenting conditions in patients of all ages – from paediatric to geriatric patients – is not adequately recognised within the current item structure and therefore is not adequately addressed by the fees for Medicare benefit.

The Quality Framework process is stated as having two broad purposes. The first is “to undertake cost-neutral reviews of existing services ... which may reduce some of the inequities of payments between services, including cross-subsidisation”; the second relates to “providing a recommendation for a schedule fee which is related to the fees of existing services, so that (the new) service is remunerated according to its time and cost components consistently with the broad range of MBS fees for services offered within the specialty”.

In neither case is the process concerned with ensuring that both the existing and new fees for Medicare benefit actually reflect the real cost of delivering the service. The intent, as stated above, is to assure internal consistency across a set of fees for Medicare benefit.

Having said that, the paper does recognise the potential impact on the Medicare Safety Net of the fees for Medicare benefit for different services and that clearly is a concern if the fee for Medicare benefit does not reflect cost and thus there is likely to be a patient co-payment. Further, the only way to assess the impact on the Medicare Safety Net is if an applicant indicates, as part of the application, the price that will be charged to the patient. However, until a fee for Medicare benefit is determined, the actual co-payment, if any, cannot be specified.

The overall concern about the proposed process is not with the intent to properly quantify inputs, but rather that it has the potential to be an artificial process that simply reflects internal relativities.

The proposed approach does not have the potential to ensure that fees for Medicare benefit are realistic and do not mean patients will face increasing out-of-pocket payments.

The Discussion Paper notes that existing sources of information such as the Relative Value Study, international experience, AIHW and ABS data may be of assistance. It is noted that various documents relating to the Relative Value Study (RVS) are now available on the Department's website. The Department's advice is sought as to whether the RVS reports will be used as a source of advice to the Department and if so, to what extent will they be used as a source of advice, given they are now 10 years old and based on information up to 15 years old.

The other concern is that there needs to be a clearer indication as to what role a detailed and transparent costing will have as the basis for setting fees for Medicare benefit. The Discussion Paper indicates that its new process for setting fees for Medicare benefit should provide results which meet the ongoing needs of clinicians and facilitate the provision of safe, high quality, services for the public. However, at the same time it appears that only practice costs will be used as input costs; the cost of the professional is a time input only, to be related back to existing fees for Medicare benefit to determine the "professional component" of the fee for Medicare benefit. This proposal would ensure that patient rebates are essentially "frozen" at 2010 levels – and reflect costs that existed well before that time since most fees for Medicare benefit have increased at rates lower than inflation.

Therefore, relating the fees for Medicare benefit for any new items to the existing items in the group will further consolidate the problem of the increasing gap between the patient rebate and the cost of the service.

The further statement that "there could be other factors, such as policy issues, which are beyond the definable inputs discussed in this paper and that might be taken into account in a final decision on the Schedule fee for an MBS item" does not inspire confidence that new or revised fees for Medicare benefit will reflect real costs or that any submission no matter how detailed or transparent, will necessarily result in realistic fees for Medicare benefit do not potentially leave patients increasingly out of pocket.