NCOPP
National Coalition of Public Pathology

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Att: Prof Bruce Robinson
MBS Reviews Team
Australian Department of Health
MBSReviews@health.gov.au

CC Ms Fifine Cahill, Fifine.Cahill@health.gov.au
CC Ms Joanne Tester, Joanne.Tester@health.gov.au

Dear Prof Robinson

MBS Review

The National Coalition of Public Pathology (NCOPP) welcomes the Federal Government's review of the Medicare Benefits Schedule (MBS) and appreciates the opportunity to comment on the MBS Review. NCOPP would like to make the following submission in relation to the Review.

Background

NCOPP represents public pathology services throughout Australia. Our members are the major government owned and operated pathology services in each State and Territory in Australia. They provide the vast majority of pathology services in Australia's public hospitals, service a number of private hospitals, and operate community based collection services for patients upon request from GPs and Specialists.

In addition to diagnostic services, NCOPP members conduct research and teaching in the areas of new and existing diseases, tests and treatments, and collaborate closely with colleagues in all areas of patient care, with many pathologists also performing clinical roles. Their laboratory testing and medical consultation services play a crucial role in timely clinical diagnosis, in monitoring therapy and in prevention of disease in individuals and the community.

NCOPP has been a co-signatory to previous Pathology Funding Agreements between the Australian Government and the pathology profession. These Agreements managed pathology use and expenditure under the MBS to ensure that pathology services are of high quality, accessible and affordable. Many public pathology services are also funded from State Government/Local Hospital Networks on a fee for service basis with reference to the MBS. As such, NCOPP is well placed to contribute to the MBS Review.

Submission

NCOPP welcomes a review of the MBS and its governing rules in the interests of improving the quality and cost effectiveness of health care. We support an inclusive and evidence-based approach to the Review, centred on patient health outcomes. Of vital importance is the need to ensure patients have continued access to quality, affordable pathology services and that the pathology sector is sustainable and viable. Pathology influences clinical pathways across a broad array of other medical specialities, and therefore recommendations relating to pathology testing made in non-Pathology clinical groups must be referred to the Pathology Clinical Committee for appropriate consideration by specialist pathologists. Similarly testing by newer or more sensitive and specific technologies might have the ability to alter the way other medical interventions or investigations are done and those pathology specific investigations should be discussed by a wider group to judge the impact of the introduction or uptake of these.

Ph +61 2 9431 8672 | Fax +61 2 9431 8677 | www.ncopp.org.au
PO Box 576 Crows Nest NSW 1585 Australia | ncopp@ncopp.org.au | ABN 93 439 259 975

Pathology is unique to other medical specialities, as pathology MBS items have been subject to years of review and adjustments through Pathology Funding Agreements and the Pathology Services Advisory Committee (PSAC) and its predecessor committees. Despite this, many tests are inappropriately remunerated or not remunerated at all. There are also inappropriate, inequitable and/or anti-competitive practices propagated by the MBS which need to be addressed, such as differential episodic fees for public compared to private pathology providers. This paper highlights those areas for consideration as part of the MBS Review.

Why the Review is warranted

A review of the MBS is required as the schedule does not encourage patient-centred, outcomes based medical care including pathology testing. This was highlighted in NCOPP's Management of Pathology MBS Outlays paper: 'The current system does not encourage best requesting practice. There is no emphasis on maintaining the currency of the MBS in line with best clinical practice. The current system rewards providers with high volumes, rather than focussing on high value tests and ordering practices that contribute to better patient outcomes.'[1]

The MBS does not represent the costs of pathology tests and does not facilitate the adoption of new technology which could improve health outcomes and/or reduce MBS expenditure. Federal health priorities such as improving health outcomes of the Aboriginal and Torres Strait Islander and rural and remote populations, and screening (e.g. for cervical cancer), are also not reflected in appropriate MBS fees under the Pathology Services Table (PST).

NCOPP acknowledges the work of the Pathology Services Advisory Committee (PSAC) taken to align items in the PST with clinical evidence. NCOPP recommends that PSAC reconvenes at some point following conclusion of the review, as the PST needs to change as clinical evidence and technology evolves. However, a more transparent appointment process, feedback from industry groups and participation of requestors (e.g. GP endorsed by Royal Australian College of General Practitioners, Physician endorsed by the Royal Australasian College of Physicians) is essential to ensure that recommendations are appropriate for both patients, the pathology sector and requestors.

The MBS Review process

NCOPP commends the Department in conducting the Review and agrees with its vision for the MBS to 'provide affordable universal access to best practice health services that represent value for the individual patient and the health system.'[2]

The use of open consultation forums and a formal submission process has provided an excellent opportunity to contribute towards the Review. NCOPP would like to acknowledge the open communication style of the Department's Pathology Management Section during the process. Regular communication is particularly important as the Review process to date has been particularly fluid.

NCOPP agrees that the Pathology Clinical Committee, Pathology Business Group and discipline specific Working Group structure are an appropriate way to facilitate a review of the PST. However, NCOPP recommends further consideration be given to the composition of those groups. For instance, appointment of only one representative nominated from the public sector and nine representatives from the private sector on the Pathology Business Group is disproportionate relative to the broad reaching nature and different market focus of public pathology providers. Furthermore to eliminate a perception of bias, it would have been more appropriate to have a formal, open

[1] NCOPP, January 2014. Delivered to the Australian Department of Health in January 2014.
[2] Australian Department of Health, MBS Consultation Paper, p.2, September 2015

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nominations process, rather than nominate people on committees upon recommendation from medical colleges alone in the first instance.

The MBS as a Tool

The MBS does not currently guide quality medical practice, and it could be used more effectively to drive health policy objectives. There are a number of changes that would be required before this could be achieved.

While the MBS is a good source of information on billable activity, this does not represent the total pathology workload due to multiple coning rules including the grand cone (which limits claiming to the three most expensive pathology items in the episode of care, P15.5 MBS) and the multiple test rules. If the MBS is to be used more than just an administrative claiming tool, consideration needs to be given to the impact of coning and its appropriateness.

Over the years, MBS data has been used to identify the top 20 pathology items by benefits and growth. Consideration of items for fee or descriptor adjustments has generally occurred if they are viewed as high cost and high volume. However, it would be much better for patients and funders if tests were reviewed on the basis of clinical efficacy.

The previous high volume/high cost item approach to pathology item review is also concerning as MBS fees do not reflect the true cost of tests. In pathology, it would be appropriate for MBS fees to reflect actual test costs as competition has resulted in high rates of bulk billing.[3] The MBS Review should be accompanied by establishment of a formal fee setting mechanism. An extension of the work commissioned by the Department of Health in 2012 in relation to a fee setting model would be an appropriate starting point in this regard. Funding models that target improved clinical outcomes rather than activity alone should be explored.

Unexpected variation

While MBS is data rich, it is information poor. For example it is not possible to drill down within a state to explore variation in tests within population groups or between pathology providers. NCOPP has recently commissioned a pilot benchmarking program to explore variation in the public pathology sector.

To reduce unexpected variation in test ordering, bundled episodic payments should be considered for certain conditions. For example, there could be a diabetes test bundle which would include tests in line with the recommended clinical pathway (e.g. HbA1c, lipids, urine protein, renal function test with a designated retest frequency). Limitations around retesting must take into consideration that knowledge of testing conducted by other providers is unavailable and that it is difficult to compare results between providers due to differences in testing and reporting methodologies.

Other tests may be ordered even though they don't fall within designated clinical pathways and/or have little impact on the management of conditions. One way of dealing with this is to limit referrals to particular speciality groups (e.g. the Factor V Leiden gene mutation test Item 73308 could be restricted to request by clinicians with a special interest in deep vein thrombosis and coagulation abnormalities (typically clinical haematologists)). Rather than impeding access, this approach could encourage appropriate access.

[3] Australian Department of Health, http://health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics

To reduce inappropriate pathology ordering without imposing an additional burden or penalty on pathology providers, NCOPP proposes a consultation item for the provision of pathologist advice to requesting clinicians to ensure clinically appropriate tests are ordered. To ensure this item is billed appropriately, it could be available for advice given for specific items and evidenced by a change in the request documented in clinical notes (for instance, clinical investigation of macrocytic anaemia where iron studies are not done but vitamin B12 is added after consultation, with folate in the case of a patient with coeliac disease; in many patients, where there is no evidence of anaemia iron studies would be stopped and B12 and folate would not be tested). The overall aim would be to reward and pay appropriate consultations that result in improved requesting of pathology through the clinician. Currently there is negative incentive to stop inappropriate testing as it reduces remuneration while requiring significant effort by the pathologist and is therefore not done outside the public sector.

Implementation issues

There is considerable cross-subsidisation of under-funded items in the PST. As such, any change in MBS items must be supported by appropriate modelling and this includes changes due to coning. There should also be staged timing of adjustments so that it does not jeopardise the financial viability of pathology providers. Before recommendations are implemented, there needs to be adequate time to educate requesters, modify laboratory information systems/billing modules and upskill administrative personnel.

Guiding principles

The MBS should maintain and improve the quality, access and affordability of health services.

Pathology has been treated differently to medical specialities on the MBS. Recent fee cuts and other policy decisions such as collection centre deregulation, have materially negatively impacted the pathology sector. There is recent evidence of market failure, further industry consolidation, and loss of diversity as a result. Australia is already one of the most consolidated pathology markets in the western world. It is therefore important that the Review must:

1. Ensure there is a diversity of pathology providers (public and private, large and small, for-profit and not-for-profit) as this is essential for maintaining high quality, competition, and patient choice;

2. Ensure a stable, appropriate, equitable and sustainable funding environment;

3. Support innovation to maintain Australia's world-leading pathology industry;

4. Recognise that pathology is a medical service, delivered by highly trained and experienced medical doctors;

5. Consider multi-disciplinary approaches to developing care sets, and newer models of professional service delivery such as electronic decision support to improve quality and the rational use of testing;

6. Reduce the complexity of the many rules and item descriptors in the PST;

7. Ensure that appropriate modelling and trials (where appropriate) are conducted before any changes are adopted; and

8. Ensure any discussion of issues relating to pathology tests during the current MBS review in non-pathology Review committees must allow for pathology input and also be referred to the Pathology Clinical Committee.

Impact of the Review

The impact of the Review can be measured in purely simplistic terms, such as number of alterations made to the MBS to reflect contemporary, evidence based practice, and the number of particular services and benefits claimed. However, it would be more informative to evaluate effectiveness on the basis of improvements to health outcomes for patients. The Review also provides an opportunity to understand the value of pathology in terms of significant downstream savings to government due to early diagnosis and treatment. Examples include better recognition of patients with undiagnosed diabetes, better control of treatment targets that can be measured (for example well controlled hypertension, lipid levels, diabetic control), and the number of hospital admissions with certain diagnosis before and after changes are made in the Review.

MBS Item Adjustments

There should be accepted grounds for Item review during the current MBS Review and thereafter. It is important to acknowledge that the volume of pathology testing may be driven by both need, and also a change in attitude. Furthermore, it can be very difficult for pathology providers to influence requesting behaviour in the current schedule; not only is there no incentive to do so, it is counter-intuitive to do so for large corporate providers who operate on a volume of scale business model. To overcome this, NCOPP proposes the following grounds and items for review.

Low value patient care items

In relation to low value patient care items, NCOPP continues to support the following grounds for Item review:

- The test has low clinical efficacy;
- There is inappropriate/redundant use (e.g. frequency more than a certain number / repeat requests within a certain time frame contrary to acceptable clinical guidelines); and/or
- Analytical performance of the test is poor or variable.[4]

While there may be exceptions and a need for pathologist determinable component to certain tests, examples of low value tests include:

- Erythrocyte sedimentation rate (ESR, Item 65060) - while ESR features in many clinical guidelines, there is a poor evidence from controlled trials in favour of utilising the test. While the test has been recently discussed by PSAC, it needs to be reviewed by the clinical groups if we aim to remove it from clinical guidelines;
- Iron studies (Item 66596) - instead of a full suite of iron studies, a case can be made for limiting investigation to ferritin only (Item 66593) in the large majority of cases. The only benefit of the addition of iron and transferrin is in the question of haemochromatosis, which is typically associated with high ferritin levels;
- Blood group - there may be little need for another blood group test (in the absence of bone marrow transplant.) The only time a blood group should be repeated is before a surgical intervention, or a planned transfusion.

In order to reduce duplicate testing within designated timeframes, it is important that providers have visibility of whether the test has already been performed by another provider. It is also important to ensure that pathologists are recognised for providing consultation advice to improve appropriate ordering as mentioned above.

[4] NCOPP, Management of Pathology MBS Outlays, January 2014.

High value patient care items

There are a number of high value patient care items which are either not reimbursed, inadequately reimbursed or underutilised. Examples include complex testing, such as infectious organism identification and monitoring (especially for multi-resistant organisms), high complexity anatomical pathology services, genetic testing where knowledge of the genetic type will influence treatment decisions (such as inclusion of IP19q-co deletion detection by FISH), bone marrow transplant testing, transfusion in patients with antibodies, typing of tuberculosis / Hepatitis B & C, multidisciplinary team meetings and second opinions. Increasing the fee for these services to reflect their cost and value will enable better investment in developing new testing areas that seek to improve health outcomes in complex settings.

NCOPP supports the appropriate use of new service models such as point of care testing and testing near to the patient. If the introduction is well planned and supervised, this will assist in addressing equity of access to healthcare in regional and remote communities. It is important to identify specific tests that are of benefit and situations where the availability will improve patient care. There may need to be consideration of structure of such an item to reduce duplicate confirmatory testing where appropriate. It is also crucial that appropriate quality assurance, training of the operator and a good clinical understanding of performance and limitations of the testing are ensured.

In some instances, MBS Items do not reflect the way tests are conducted. For instance, consideration should be given to support separation of testing and interpretative components in specific genomic testing. The disaggregation of service elements will support the development of specialist skills, lead to adoption of new innovative technology and will support better outcomes for patients.

In other instances it may be more appropriate to consider bundles of tests to facilitate best practice requesting and patient management, particularly in the area of chronic disease. For example, there could be a set chronic renal failure test suite (including full blood count, urea & electrolytes, liver function test, calcium phosphate, parathyroid hormone) that could be conducted at three monthly intervals. For patients with multiple chronic diseases, there could be an episode cone to eliminate duplicate testing. However, this predicates knowledge of the test being conducted previously by another provider and this is unavailable. There are clear benefits in leveraging serial data obtained by identical technology, particularly in the management of chronic disease. However, testing methodology and terminology is not consistent across different laboratories. Well considered regulation in these instances could identify a period of time where patients are required to stay with one provider to optimise use of the testing information. However, this needs to be balanced against the value and importance of patient choice of pathology provider and principles of open competition.

In terms of high value tests that are underutilised, there is cause for concern that diabetes related item numbers are underutilised. There are 1.2 million known and registered diabetics in Australia.[5] An additional 16% of Australian adults have lesser abnormalities of glucose tolerance. Clinical guidelines state that HbA1c should be tested quarterly in patients with diabetes. However, there were only 1,149,690 HbA1c tests conducted for the management of diabetes (Items 66551 and 66554) in 2014/15, clearly demonstrating underutilisation of the test. In addition, the recently introduced HbA1c test for diagnosis (Item 66551) was only used on 122,097 occasions in 2014/2015, despite 50% type 2 diabetics being undiagnosed.[6]

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[5]. This includes all types of diagnosed diabetes https://www.diabetesaustralia.com.au/diabetes-in-australia.

[6] Med J Aust. 2003 Oct 6;179(7):379-83.

Certain Commonwealth health priorities are not adequately supported by the MBS, because technology has advanced or fees are well below the cost of Items. Screening for cervical cancer is one such example. NCOPP supports the change in the cervical cancer screening Item to reflect changing technology (from pap smears to Human Papillomavirus (HPV) testing with reflex liquid base cytology). However, NCOPP is concerned that the fee for the changed Item won't reflect the cost of the test, as is the case with the current Pap smear item. This Item 73053 is $19.45, but the cost of the test is in excess of $60.00. As a result, private providers charge a significant out of pocket expense which can deter patients from screening or leave the provider chasing unpaid debts. Alternatively if the service is bulk billed, the provider has significant unfunded costs to bear.

Rules and regulations

Whole of MBS Rules

There are cross-cutting issues with rules which affect the whole of MBS, such as the inappropriateness of freezing indexation as inflation clearly increases the costs of providing services. Despite a significant increase in automation in pathology, 70% of the cost of pathology services lies in salaries and wages which are adjusted for CPI in public sector Award negotiations. Consideration may also need to be given to fees given the status of technology (e.g. high costs at initial investment compared to lower cost as the technology matures). Other cross-cutting issues include lack of recognition of the higher cost of providing medical services to rural and remote populations, and how to manage the hospital: community interface.

Pathology Services Table Rules - Coning

There are also rules pertaining specifically to the Pathology Services Table (PST) which are unduly burdensome, restrict access and competition. Coning is an artificial means of controlling demand, where pathology providers are penalised for performing all the tests requested. This skews activity data sets, leading to difficulties in assessing the impact of demand management and policy decisions. While the idea initially might have been to incentivise the providers to improve requesting patterns, this has not happened as the providers were afraid of losing business to competing practices that would provide all testing without questions asked.

Some coning rules disadvantage public pathology providers over the private sector. For example, Rule 25 on time limited tests and the multiple test rules, disadvantage the public sector where private patients are routinely sent to have frequent tests in accordance with their care plans. This directly disadvantages patients with complex and chronic diseases. This issue may be addressed by improved structuring and application of coning rules depending on the treatment locations of the patient.

In addition there has been an increasing range of referrals redirected from private pathology to public service on the basis that these tests will be coned out when billed. The default position is that the State is funding tests which would normally be undertaken by the Commonwealth. A potential solution would be to restrict coning rules to Approved Pathology Authorities (APAs) rather than the patient/occasion of service.

Pathology Services Table Rules – Patient Episode Initiation Fee

Another area of concern within the PST Rules is the inequity of funding between public and private providers per pathology episode. Patient Episode Initiation (PEI) fees (Group P10) were introduced in 1992 to cover transaction costs such as collection and transport which were not a direct function of pathology tests. Initially this was restricted to private pathology providers. As both public and private pathology services are subject to the same type of transaction costs, PEI fees were introduced for the public sector in 2007. These fees were introduced at a lower

rate than the private sector, with the intention to explore removing the distinction between public and private laboratory access to PEI items.[7]

Despite support for fee parity, there has been no progression of the issue. Currently, the PEI fee for an approved collection centre (ACC) specimen collection for a private provider is $5.95 (Item 73928), but only $2.40 for public pathology providers (Item 73929). The transactional costs of pathology in the public sector are not cheaper than that in the private sector. In addition, the public sector also has to fulfil community service obligations and provide services in non-profitable areas. For example, pathology specimens collected in remote communities in Western Australia or APY Lands in the Northern Territory entail considerable costs to air freight specimens to public laboratories for testing.

There are also a range of PEI fees payable to private pathology providers depending on the nature of the collection, for example $10.25 for a home collection (Item 73932) and $8.20 for a biopsy taken from a non-inpatient (Item 73926). However if these episodes are serviced by a public pathology provider the PEI fee is $2.40 regardless of the type of collection. This needs to be addressed as the cost of collections varies depending on the nature of the specimen and the location of the patient, not whether the pathology provider is private or public. Fee disparities such as those in P10 of the PST disadvantage public pathology providers, restrict competition and are contrary to the National Competition Principles.

The reimbursement of costs for pre and post analytical services needs review given changing requirements. The historical disparity between private and public sector recognised the additional fixed costs for collection centres established predominantly by private pathology providers. As hospital services are pushed more into the primary and community care space, public pathology providers are required to have an increasing presence in the community. This may be through commercial collection centres and home collection services. It is therefore no longer appropriate to have a disparity in the fee based on commercial structure.

There needs to be a change to MBS Rules (e.g. P.6.2), adjustment to P10 fees and other fees associated with items referenced to the PEI (such as the P13 Bulk Billing Incentives (BBI), cervical screening PEI). One way of addressing this is to roll up the episodic fee into the Item test fee and have only the one fee for a particular test regardless of the type of pathology provider. Other options which should be considered to ensure rural and remote populations are appropriately serviced include a loading on the PEI or modification to the Bulk Billing Incentive (BBI). Incentives for laboratories to improve turn-around times for tests for rural and remote patients would assist in delivering timely diagnosis and treatment and overcome the tyranny of distance many patients living in rural and remote communities face.

Consumer perspective

Consumers need to be appropriately informed about their pathology tests, and this includes the nature of the test, the reason for the test and whether they have already had the test previously. There is therefore cause for the government to extend funding to promote Lab Tests Online,[8] to develop consumer education programs which may be linked to the Know Pathology Know Healthcare awareness initiative,[9] and to continue to work with the pathology sector on the upload of pathology reports into the myHealth Record.

[7] Australian Government, Pathology Funding Agreement 2004-2009, Clause 8.6.

[8] http://www.labtestsonline.org.au/

[9] http://www.knowpathology.com.au/ An initiative of Pathology Awareness Australia Ltd.

NCOPP trusts that these comments are of assistance to the MBS Review team and the Department of Health in relation to the MBS Review. NCOPP consents to this submission being made publically available. For any points of clarification or further information, please contact NCOPP CEO Jenny Sikorski at ceo@ncopp.org.au.

Yours sincerely

Prof Hans Schneider, President Ms Jenny Sikorski, CEO