



Feedback – Medicare Benefits Schedule (MBS) Review: Report from the Mental Health Reference Group

May 2019



The Victorian and Tasmanian PHN Alliance is pleased to provide feedback on the *Medicare Benefits Schedule (MBS) Review: Report from the Mental Health Reference Group (2018)*.

Context and roles

The Alliance provides a platform for the Tasmanian and six Victorian Primary Health Networks (PHNs) to work together. The Alliance enables the PHNs to collectively achieve the best possible outcomes for local communities and organisations through leadership, collaboration, coordination and synergy across the jurisdictions. More information about the role of PHNs are provided as Attachment 1.

Review of Mental Health MBS items

The Alliance acknowledge that the recommendations of the Mental Health Reference Group (Reference Group) were guided by two overarching themes:

- the value of applying a stepped care approach to MBS mental health services, an approach embraced by PHNs in the provision of commissioned services, and;
- the importance of increasing the flexibility of MBS mental health services, in recognition of the diversity in needs and circumstances of people with mental ill-health.

The Alliance supports the following key recommendations of the Reference Group provided in the Report of the Mental Health Reference Group (2018):

1. Mental Health Treatment Plans (MHTP)

- expansion of the Better Access program to at-risk patients thereby supporting early intervention
- increase in the maximum number of sessions per MHTP-initiated referral to 10 sessions per calendar year instead of the current policy of six sessions followed by a requisite general practitioner (GP) review of the MHTP to obtain the four remaining sessions.

2. Introduction of a 3-tiered system in Better Access sessions for patients with a diagnosed mental illness. The proposed 3-tiered system will allow the provision of a greater number of sessions (instead of the maximum 10 sessions per calendar year), according to the severity of the patient's mental health condition, under the stewardship of the GP.





The Alliance recommends the following:

1. Increasing the fees for professional attendance of a GP in relation to a mental disorder

Current rebates do not adequately cover the cost of services, particularly considering the level of non-face-to-face activity required.

Increasing the rebate for the MBS Mental Health items:

- acknowledges the time required to identify and address mental health concerns and conditions (including the impact on GPs own mental health);
- incentivises GPs to obtain mental health skills training;
- incentivises GPs to work in other primary health service settings such as headspace centres, and secondary schools.

The Alliance recommends increasing the rebates in relation to the preparation of a MHTP, provision of mental health treatment consultation, and review of a MHTP.

1.1 Preparation of a MHTP (2700)

The preparation of a MHTP not only involves assessing the patient, but also includes the following:

- a) discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- b) identifying and discussing referral and treatment options with the patient, including appropriate support services;
- c) agreeing goals with the patient, what should be achieved by the treatment and any actions the patient will take;
- d) provision of psycho-education;
- e) preparing a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- f) making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- g) documenting the results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date in the patient's MHTP.

These activities often require a consultation time of more than 20 minutes but less than 40 minutes (Item 2700), allowing the GP to claim \$71.70, a rebate lower than a standard 20 minute consult (Level C, Item 36 \$72.80).





Similarly, if the consultation is at least 40 minutes (Item 2701), a GP can claim \$105.55, lower than the claim for Item 44 or Level D consult (equal to or greater than 40 minutes) of \$107.15.

1.2 Provision of mental health treatment consultation (2713)

The GP Mental Health Treatment consultation item of at least 20 minutes duration, involves taking relevant history and identifying the patient's presenting problem(s), providing treatment, advice and/or referral for other services or treatment, and documenting the outcomes of the consultation in the patient's medical records.

Similar to Item 2700, GPs can only claim \$71.70; despite patients with more complex needs often require more than 20 minutes of consultation time.

Anecdotal reports suggest that some GPs, may be more inclined to see patients with physical conditions rather than explore, identify and manage mental health concerns. It is also reported that GPs who see patients with mental health concerns use Items 36 or 44 to access higher rebates, uphold patient privacy and not disadvantage them in cases where a recorded mental illness can potentially affect people's access to employment and insurance.

1.3 Review of a MHTP (2712)

GPs play an important role in the preparation of the MHTP, which contextualises the mental health diagnosis and treatment goals as part of the patient's overall health. Regular review by the referring GP is part of best practice to ensure that the referred psychological services delivered by psychologists, social workers and occupational therapists, remain person-centred and goal directed.

Increasing the fee for this item acknowledges the time GPs dedicate in reviewing MHTPs, and more importantly promotes continuity of care.

Tiering this item according to the GP's level of mental health training (e.g. higher rebate for GPs who have undertaken mental health skills training), may increase uptake for further mental health training by GPs.

The Reference Group's proposed 3-tiered system for patients with a diagnosed mental illness increases the likelihood for GPs needing to review and revise a patient's MHTP, earlier than three months after the first review, and more frequent than the anticipated two reviews per 12-month period.

2. Using a tiered system for Better Access sessions for patients with a diagnosed mental illness

The Alliance agrees with the findings of the Reference Group that 10 mental health sessions a calendar year are often insufficient for people with moderate to severe mental illness.





The Alliance welcomes the new MBS support for eating disorders commencing on 1 November 2019 that provides a dedicated single MBS item number for eating disorder treatment for those with severe and complex illness. This item can deliver up to 60 Medicare funded sessions of treatment (40 psychotherapeutic and 20 dietetic) across the range of eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical presentations).

Apart from eating disorders, GPs often see a number of mental health disorders in the moderate to severe spectrum considered not 'severe enough' to be able to access specialist state funded mental health services, or able to qualify for hospital admission, or eligible for an National Disability Insurance Scheme (NDIS) package of care.

Limited by the quantum of funding provided, the PHN stepped care model is often restricted to disadvantaged groups such as those unable to afford or access psychological services.

The Alliance is supportive of the Reference Group's recommendation to apply a stepped care approach to the suite of MBS mental health services allowing GPs the option to offer a set of interventions according to the patient's identified mental health needs (based on diagnosis, severity and complexity).

In addition, the Reference Group's recommendation to provide MBS mental health services to patients 'at risk' of developing a mental health disorder means that services will be provided early in the treatment pathway, with focus on prevention and psychoeducation, including the provision of information on available evidence-based online services.

In the 3-tiered approach:

10 sessions per calendar year may be suitable for patients with high prevalence disorders such as uncomplicated depression and anxiety;

20 sessions per calendar year may be suitable for patients with low prevalence disorders such as schizophrenia, bipolar disorders, and complicated depression and anxiety disorders with a required review after every 10 sessions; and

30 or 40 sessions per calendar for patients with severe and complex mental disorders, with a required review after every 10 sessions.

Good clinical governance needs to underpin this tiered model to include clinical risk management, clinical review and monitoring, and credentialing of practitioners.

Using a stepped care approach will also require the following elements:

- easy to use assessment tools to assist with triaging to the appropriate level of care;
- requirement of a periodic review by the GP (using MBS Item 2712), every 10 sessions to ensure patients receive appropriate care based on their needs;
- support for GPs in using case conferencing for patients with moderate to severe mental disorders and complex needs;





- mental health training and professional development activities to support the use of the 3-tiered model; and
- an efficient system to monitor the outcomes of psychological therapies accessed through MBS.

Many patients accessing this tiered model will likely have co-morbidities such as alcohol and other drug use and chronic diseases such as diabetes; hence, it is important to monitor the effectiveness of the mental health interventions delivered in this model.

There is likewise value in linking these sessions as part of patients' Chronic Disease GP Management Plans (GMGP) Items 229 or 721 and Team Care Arrangements (TCA) Items 230 or 723.

The PHN stepped care model for mental health aims to provide the best possible care for people experiencing mental illness and to make care available in a way that best suits individuals.

The stepped care model not only provides a platform for delivering a range of services to address local mental health needs, but also a reference framework for GPs to understand the range of available primary care services in the region for different levels of intensity of mental illness and across different age groups.

The PHN stepped model of care (Figure 1) is expected to align with and complement the Reference Group's proposed Tiered Better Access model (Figure 2) as illustrated below.

Figure 1. PHN stepped model of care

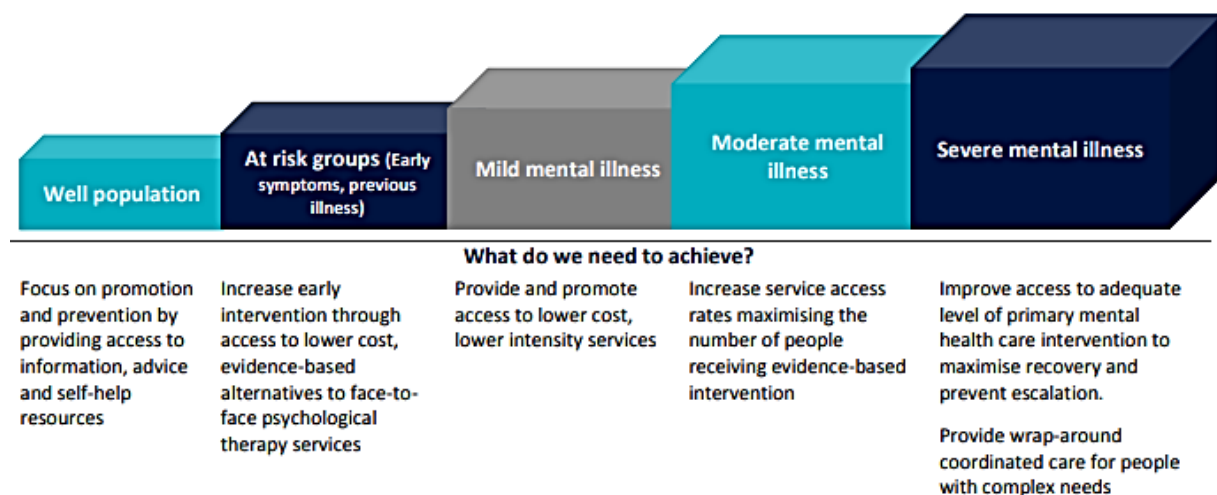
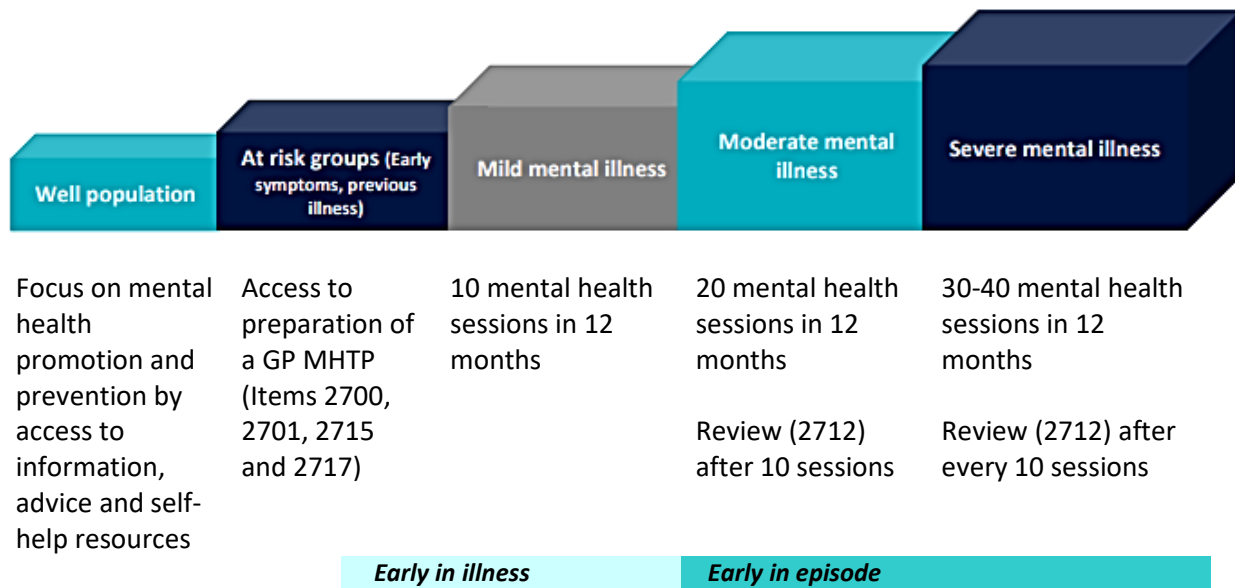


Figure 2. Proposed tiered Better Access model





3. Case Conference

Although the benefits arising from case conferences are widely known and researched, uptake by GPs remains low due to numerous challenges.¹

Benefits that may arise from case conferences	Challenges in coordinating and participating in case conferences
• availability of time and structure to deal with complex cases • facilitation of a holistic approach to patient care • improved contact and communication with other health care providers • empowers patient and improves patient-doctor relationship • financial compensation for GPs to manage chronic illness • potential reduction in rates of hospital admissions, morbidity and mortality • improvements in continuity of care	• difficult to justify the effort involved in organising and participating in case conferences compared with the informal telephone liaison already done regularly • work demands on GPs leave very little time to organise or take part in case conferences • onerous bureaucratic requirements

A significant number of mental disorders are likely to be present for at least six months, associated with co-morbidities such as diabetes, hypertension and heart disease, and often involve multiple health providers. As such, GPs can utilise The MBS case conference Items (735-758) to achieve the benefits listed in the above table.

¹ Mitchell GK et al (2002). General practitioner attitudes to case conferences: how can we increase participation and effectiveness? *Medical Journal of Australia*; 177(2): 95-7.





Addressing the challenges and barriers to the uptake of these items is important particularly to support the implementation of the 3-tiered MBS for Better Access sessions for patients with a diagnosed mental illness.

Reducing the required number of health professionals in attendance to a minimum of two will definitely make case conferences easier to organise. Examples include a GP and a psychologist, or a GP and a social worker.

4. Telehealth

The Alliance supports the recent changes to the Better Access Telehealth initiative improving access to psychological services for rural and remote patients:

From 1 September 2018, 10 consultations per calendar year can be delivered via videoconference without the requirement for a face-to-face consultation.

From 1 November 2018, GPs and medical practitioners that have met the mental health skills training and Medicare accreditation requirements are eligible to deliver services under the Better Access Telehealth initiative (Items 283 to 287, 371 and 372).

A new set of MBS items allows a GP to provide mental health services to a patient with mental health issues by video conference (2121, 2150 and 2196) where the patient and the GP are located within a drought affected eligible area. These three items expire on the 30th of June 2020 and are only available to 23 drought affected eligible areas in Australia, three of which are in Victoria (see below).

Drought affected eligible areas in Victoria	PHN catchment
Buloke	Murray PHN
West Wimmera	Western Victoria PHN
Yarriambiack	Western Victoria PHN

The Alliance recommends that Items 2121, 2150 and 2196 continue beyond 30th of June 2020 and are expanded to enable access that will more broadly support patients in remote and rural areas experiencing significant workforce shortages and other barriers to accessing services (e.g. transport difficulties, health conditions and social and economic worries).

According to the 2018 Australian Institute of Health and Welfare on mental health services² report, Victoria had the highest percentage of patients (10.7% of its population) and highest rate of services (527.6 per 1,000 population) in receipt of Medicare-subsidised mental health-specific services provided by GPs, psychiatrists, psychologists, and other allied health

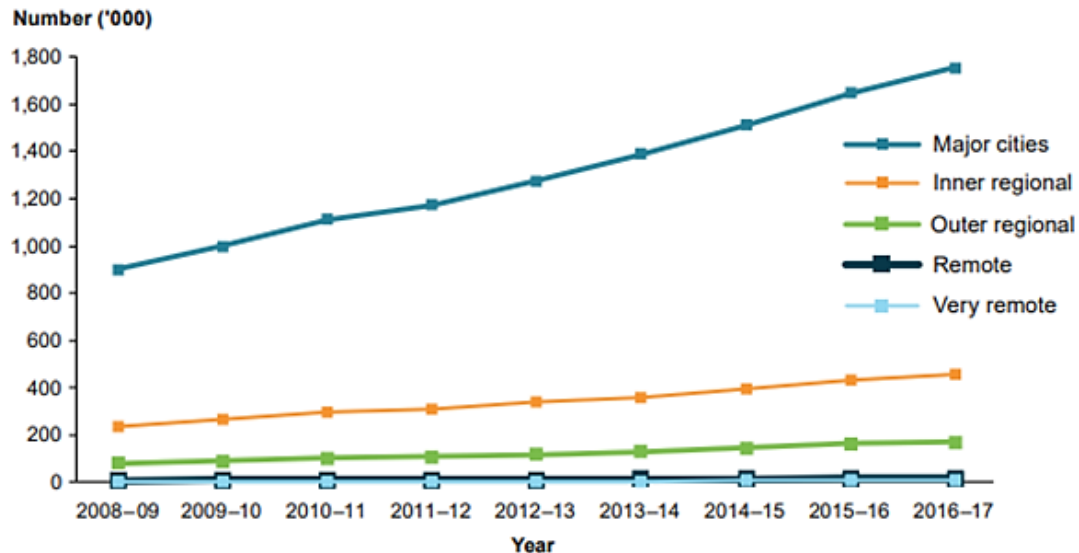
² Australian Institute of Health and Welfare 2018. Mental health services—in brief 2018. Cat. no. HSE 211. Canberra: AIHW





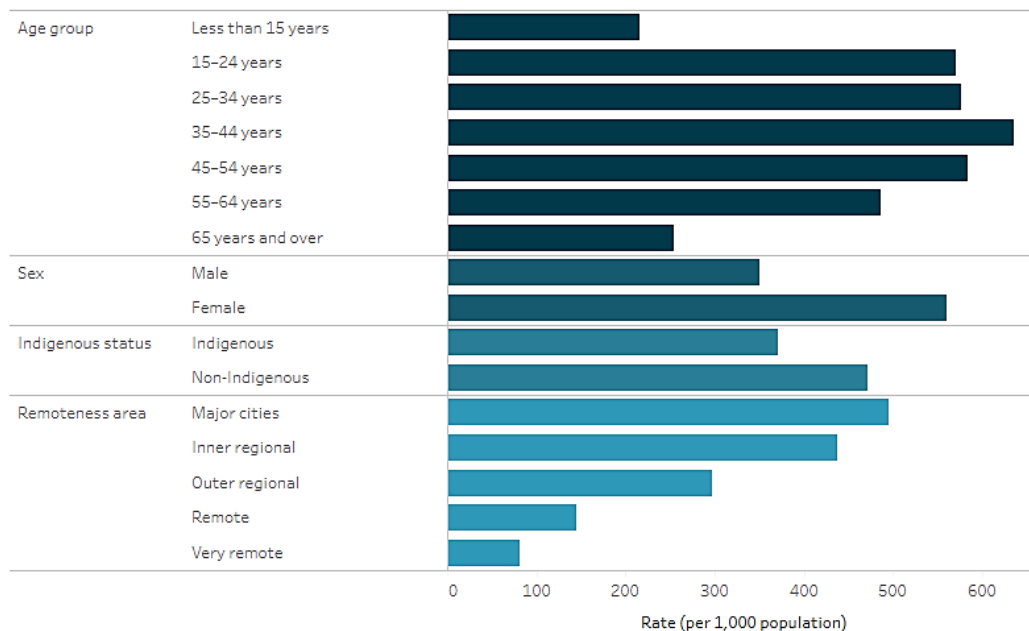
professionals. Across Australia, the rate of people receiving services decreased as remoteness increased as seen in Figure 3.

Figure 3. Number ('000) of people receiving Medicare-subsidised mental health-specific services, by remoteness, 2008–09 to 2016–17



The breakdown of Medicare-subsidised mental health specific services according to patient demographics such as age, sex, indigenous status and remoteness is illustrated in Figure 4.

Figure 4. Rate (per 1,000) of Medicare-subsidised mental health specific services by patient demographics, 2016–2017



Source: MBS data; Table MBS 10





The lower utilisation of mental health specific MBS items in the outer regional and remote areas are not reflective of population need but rather an indication of limited access to workforce such as GPs and qualified mental health professionals. The 2014-15 MBS data on mental health specific services in Gippsland Victoria illustrate this issue.

MBS data for mental health service provision in Gippsland:

- East Gippsland has the lowest proportion of its population claiming a mental health item (7.3%), while Baw Baw has the highest proportion claiming (11.1%).
- Gippsland service provision was provided primarily by allied health professionals (38% compared to 28% for Australia) and GPs (34% compared to 30%), with less services provided by psychiatrists (14% compared to 24%) and clinical psychologists (14% compared to 18%).
- East Gippsland and Wellington residents have an especially low usage of psychiatrists and clinical psychologists compared to other Local Government Areas.

Source: Department of Health, MBS mental health items by patient for PHN and SA3,
http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Health_Data

In contrast to the lower utilisation of mental health specific MBS items, regional and remote areas have a higher rate of prescribing of mental health medications, including anti-depressants, likely attributed to the lack of referral options particularly in the area of psychological therapies.

In summary, although improving access to telehealth and use of digital mental health options have the potential to improve access to suitable services in regional and remote areas, broader ad systemic issues such as workforce shortages need to be addressed.

5. Implementation considerations

The Alliance advocates the following implementation considerations in line with a previous submission ([Feedback: MBS Schedule Review Taskforce consultation, March 2019](#)):

5.1 Comprehensive implementation planning that is both consumer and sector responsive

The approach to implementation planning must not be limited to workforce-oriented strategies (e.g., via professional bodies, peak bodies, and registered training organisations) in isolation, it requires broadening to include organisational strategies. The unit of analysis must be the general practice and PHNs are well placed to apply this approach. The benefits of matrixed approaches which involve a breadth of parties to extend reach and coverage should occur within the context of a regional plan for implementation (e.g. aligned to PHN catchment boundaries) to foster a coordinated approach.





5.2 Value for the health system must be achieved through a coordinated national approach to recommendation implementation

A cost-effective approach may be facilitated through a formalised, collaborative and regional approach whereby the vision for care is incorporated into broadly nationally consistent pathways. Outputs of this type may mitigate issues of unwarranted clinical variation and potentially conflicting messages. This is considered essential to ensuring both a user-oriented approach for both GPs and consumers who may traverse PHN catchment boundaries and the Reference Group's focus on realising value. There may be implications for PHN schedules and resourcing commitment that may be required to support the efforts described in the recommendations.

5.3 The interface between primary and acute care must be strengthened

The proposed tiered system for Better Access sessions for patients with a diagnosed mental illness is of particular relevance to Local Hospital Networks (LHNs). The Victorian public hospital system comprises over 200 public and private hospitals (including day procedure centres), which form 85 health services. The Victorian LHN model is comparable with that of other jurisdictions; however, the alignment between the six Victorian PHNs are not equivalent 'like for like' particularly in the area of mental health. For example, North Western Melbourne PHN and Eastern Melbourne PHN have seven and five Area Mental Health Services respectively within their local catchments.

6. Additional considerations

6.1 Increasing the benefit claim

The Alliance recommends increasing the benefit claim of five Mental Health MBS Items from 75% to 100% to improve patient access. The MBS Items are:

- preparation of a GP MHTP (Items 2700, 2701, 2715 and 2717);
- review of a GP MHTP (Item 2712).

General practices have reported to PHNs that patients with limited financial resources are more likely to consult GPs for mental health concerns if they do not have to pay the out of pocket costs that can range from \$17.90 to \$33.50.

To ensure that socioeconomically disadvantaged patients receive appropriate mental health services, a significant number of GPs are often compelled to bulk bill rather than claim the Medicare scheduled fee. This affects the practice business model and can become a disincentive for practices to promote their mental health trained GPs.

6.2 Explore bundled care models in mental health

Models for bundled care for chronic conditions are currently being tested with Health Care Homes and should be considered for mental health care. A bundled care model in the primary setting (through a bundled payment mechanism) has the potential to facilitate the





alignment of incentives for health service providers to work together across the care continuum resulting in the collaboration of partners across all specialties and settings, maximising quality and efficiency, and improving patient outcomes. However, the Alliance recognises that there are other policy levers to promote best practices in mental health, aside from payment mechanisms for providers.

Future recommendations

The Alliance support the Reference Group's longer-term recommendations of:

- enabling family and carers to access therapy sessions where the identified patient is not present and where the primary focus is the identified patient's treatment or assessment needs
- measurement of outcomes to inform effectiveness of interventions and initiatives; and
- using a 12-month period commencing from the date of the initial referral, instead of a calendar year.

The Victorian and Tasmanian PHN Alliance look forward to supporting the implementation of reform toward a patient-centred primary care model supporting GP stewardship.

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Supplemental detail: Context for response

Attachment 1 - Primary Health Networks

The objectives of [Primary Health Networks \(PHNs\)](#) are to increase the efficiency and effectiveness of medical services and improve coordination of care to ensure patients receive the right care, in the right place, at the right time. PHNs apply a regional perspective, informed by the needs of consumers, carers, and communities examining and supporting:

- the health workforce
- organisational processes
- networked systems of care.

PHNs are change agents for health improvement at the ‘meso’ or middle layer of the Australian primary care system, acting as a conduit between individual providers/services and State, Territory and Commonwealth Governments. PHNs provide a nationally consistent infrastructure for solutions design and implementation support at the local level. Central to this are inclusive and participatory methods involving consumers and providers to design and achieve change. PHNs achieve objectives by:

- Understanding the health care needs of their PHN communities through analysis, planning in collaboration with clinical and community/consumer advisory groups (and other consumer engagement and co-design mechanisms), while maximising value and efficiency.
- Providing practice support services so that GPs are better placed to provide care to patients subsidised through the MBS and Pharmaceutical Benefits Scheme and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.
- Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating evidence of best practice. This includes aggregating and reporting data to support continuous improvement.
- Assisting general practices in understanding and making meaningful use of digital health systems, to streamline the flow of relevant patient information across the local health provider community.
- Working with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need.

The Victorian and Tasmanian PHNs support the primary care services using system levers in a range of ways.

- **As an improvement partner** – PHN provider and whole-of-organisational support for quality improvement efforts. PHNs are one of several primary care service improvement partners, which is reflective of inter-organisational or networked approaches to patient safety and quality. Victorian and Tasmanian PHN contributions include:





- o Facilitating all general practice staff to have access to meaningful data analytical capability using their own data, and supporting data integrity
 - o Collaborative approaches to change implementation, involving clinical support and networking
 - o Delivery of continuous professional development training for the primary care workforce including GPs, nurse/nurse practitioners, allied health and pharmacy.
- **As a commissioner** – PHNs commission primary care services in areas of community need and operate consistent with the relevant clinical governance policies and protocols. This includes commissioning of the following:
 - o General practice and community pharmacies for the provision of afterhours support
 - o Providers to assist Aboriginal and Torres Strait Islander people access primary care services and better manage their complex and chronic health needs through care coordination and outreach support
 - o Alcohol and other drug services
 - o Mental health stepped care models, utilising a diverse mental health workforce, including allied health professionals, mental health nurses, and other workforce structures.

This **dual role** creates a unique contribution to system capacity to advance safety and quality within primary care.

- **As an improvement partner**, PHNs have an active role in supporting the clinical and non-clinical workforce to build individual skills and expertise and to implement systems of care.
- **As a commissioner**, PHNs have a role in developing and shaping primary care services to deliver evidence-based models of care across a geographical area. These services are understood as ‘the market’ in economic terms, and the task of procuring primary care services cannot occur in isolation of market development to mitigate the risk of market failure. PHNs have a lead role in working alongside primary care services and fostering a market which can meet expectations in relation to a suite of measures of effectiveness, including safety and quality expectations (e.g. scope of practice, clinical supervision and workforce credentialing).

