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ANAO Audit

AMA submission to ANAO Audit – Managing Health Provider Compliance

The AMA has always supported the appropriate use of public health funds and therefore supports appropriate compliance activities. However, in pursuing increased provider compliance, the AMA strongly believes the approach can be improved via proactive education, communication and consistency in advice and interpretation from Government, to the medical profession. It is important that in compliance action there is balance.

The AMA has had many members experience a lack of consistency of advice on MBS items from Government. It has not been uncommon to receive conflicting advice between the Department of Health (the Department) and the Department of Human Services / Medicare, and often, in differing responses and lack of clarity from the askMBS helpline. This places practitioners in an impossible situation, without a clear direction from Government on how to use a particular item, before doing so. It should be pointed out this experience has been on the basis of the MBS not radically changing year from year. We understand that the Department has devoted additional resources to the askMBS helpline and it will be important to see how this impacts on the experience of practitioners that utilise this service. There are limited avenues in which to address or complain to an external body regarding inconsistent advice from Government on item use.

With the MBS Review now spending a number of years redesigning and reviewing the entire schedule, the issue of clear education and communication from the Department will be critical, if we are to avoid a far more acute series of problems with compliance.

The MBS Review has redesigned items to consider appropriate use, scope and intent. But if this is not communicated clearly, and often, then practitioners will not know what the Government's intent around the use of some of these items will be. This exposes them to significant risk of a future compliance action, through no fault of their own.

To this end, the AMA has consistently called for compliance, education, communication and the MBS Review to work together - so that when the MBS is changed, all parts of Government are clear on what the change means, and it is communicated to the profession, folded in to education programs and time is provided to the profession to adapt. Increased education on the changes made to the MBS, how the items relate to effective and appropriate practice is

critical – but the communication should focus on the MBS being a mechanism of patient reimbursement and not a determinator of practice. Another issue is the fact that with the MBS Online now being the primary mechanism for accessing information regarding Medicare, greater awareness of the changes, and the value of the 'notes' section of the MBS, needs to be carried out, especially as the rate of change increases.

Failure to do so effectively means that the compliance program may be the first point in time that practitioners are aware some of their item use is considered inappropriate, or that their interpretation differs to that of the compliance division of the Department. Failure of Government to improve the education, communication and advice it provides means that the compliance program will not be focused on those intentionally misusing items (as it should) and rather be a poor, and punitive, substitute for guiding appropriate MBS item use. Considering the distress, both emotional and financial, that compliance action brings to bear on practitioners, where it can be avoided through proactive efforts to educate the profession on correct use and intent of items, it should. Currently, the AMA strongly believes there is significant room for improvement here.

Likewise, where compliance action is to go ahead, the AMA strongly believes that greater efforts can be made to seek, and respond, to clinical advice before sending out letters to practitioners.

The AMA has also taken the time to outline some further specific issues and examples below.

Appropriateness of Department of Health's approach to identifying and prioritising potential cases of non-compliance

In recent years the Department appears to have significantly lifted its compliance efforts using the extensive data at its disposal. Not only does the Department seek to target breaches of MBS rules, it is also intent on changing the behavior of practitioners – something that has moved well beyond more traditional compliance approaches.

The Department, when undertaking compliance activity, now focuses on providers who fall well outside the billing patterns of their peers or circumstances where there is significant growth in the use of higher value MBS items. While we support this more targeted approach, there is a need for greater nuance to refine this even further.

The blunt use of metrics, such as those in or above the 80th percentile of users, will overlook the nature of a practitioner's practice, patient demographic, or special interest. While the practitioners identified may only represent a small part of a particular specialty area, word of this compliance activity travels very quickly and is often exposed in the media. This means that the compliance activity will have ramifications beyond its intended target and result in broader changes to practice than may otherwise be warranted.

An excellent example of how not to approach compliance activity is correspondence sent out by the Department with respect to opioid prescribing that was perceived by GPs to be ill targeted and threatening, including the potential for reference to the Practitioner Review Program. Many

practitioners queried the data that was relied upon and the Chief Medical Officer was forced to clarify the campaign and its purpose.

Wherever compliance activity is proposed it must rely on appropriate and reliable data sets and be informed and 'sense tested' by clinicians that understand day to day private practice. This should not only extend to the targeting of compliance, but also the messaging that is used – particularly in circumstances where activity is designed to address concerns about clinical practice.

Appropriateness of the Department of Health's approaches to non-compliance

The AMA has provided advice on the compliance activities undertaken by the Department. This has been taken into account to varying extents and we continue to work to ensure that compliance activities seek to educate practitioners rather than discourage appropriate practice.

The Large Practices Project demonstrated the impact that "word of mouth" and "practice culture" can have on billing behavior and has helped underpin a greater use of education to support practitioners with billing compliance. Minimising billing errors through education helps ensure health funding is spent appropriately and compliance resources are focused on the areas of greatest risk.

The introduction of the Shared Debt Recovery Scheme is an acknowledgement that practitioners may not be solely responsible for non-compliant billing practices. Before the introduction of this scheme any practitioner facing recovery action for non-compliant billing was liable for 100% of recoverable monies, regardless of whether the entity in which they work controlled or influenced their billing. The Shared Debt Recovery Scheme enables an entity exercising undue influence over their practitioners' billings to be held partially accountable by being recognised as a secondary debtor. The processes in place for Shared Debt Recovery in theory seem fair – as both sides have opportunity to make their case before a determination is made and the default contribution percentage can be modified where appropriate. However, to date, the AMA has not been made aware of any determinations of a Shared Debt and so has not been involved in a practical application of the Scheme.

When dealing with compliance matters, timeliness of response and regular updates on the progress of a matter is something that needs to be addressed within the Department. For example, when recovery action was being undertaken in 2017/2018 against practices who had failed to meet the revised requirements of the eHealth Incentive. Practices who had sought an exemption on the basis of compelling circumstances were advised when they submitted their request that the Department was experiencing an unexpected volume of requests and would get back to them in due course. Practices were left for months with no contact from the Department about their request and no avenue for contacting the Department to chase up. The first many knew as to the outcome of their request was receipt of a debt recovery letter months down the track.

At times the recovery letters failed to fully explain the amounts that were being asked to be paid back. For example, one practice from a rural area, couldn't understand why they were

being asked to pay back more for the eHealth Incentive than they received because it hadn't been explained that a proportion of the rural loading they received, on the basis of that incentive, also had to repaid.

Aside from these problems, the Department did respond in a fair and reasonable way, when it became clear that practices were experiencing problems with compliance. In consultation with the PIP Advisory Group, practices were given an extended period in which to cumulatively meet their requirements, processes were put in place to differentiate between those practices who had made a reasonable effort to comply and proportionally adjust their debt accordingly. Practices experiencing technical issues outside their control were given the opportunity to make a case for exemption and arrangements were put in place to enable practices to withdraw from any quarter if they knew they wouldn't meet the requirement for that quarter.

How the outcomes of compliance activities inform future compliance approaches

The consequences of previous "heavy-handed" and accusatory approaches to compliance and recovery are still being felt today in the way that practitioners perceive compliance correspondence.

The AMA has appreciated the move away from random audits. These audits were inefficient, in that while it is acknowledged that 95% of practitioners are doing the right thing, they were all potentially subject to the administrative burden and opportunity costs created by having to review their clinical records and justify their billings. In addition, practitioners perceived they had been set up to fail. For example, often the introduction of a new item would be followed with a random audit. A proportion of practitioners who had taken up using the item were then faced with reviewing 2 years of claims and justifying the appropriateness of doing so.

Very often practitioners were expected to review their records and produce evidence to support their claims within a relatively short time frame for busy practitioners.

While the AMA has welcomed a more data driven approach to compliance, this remains a work in progress that will continue to need further refinement so that it is seen as supportive of good billing practice and does not cause widespread angst for the vast majority of practitioners that are endeavoring to do the right thing.

Following the problems with the approach taken with the opioid letters the Department has continued to work with the profession to ensure appropriate messaging in future letters of a similar nature.

12 DECEMBER 2019