Australian Health Service Alliance

THE AUSTRALIAN HEALTH SERVICE ALLIANCE'S FEEDBACK IN RESPONSE TO THE AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH'S CONSULTATION PAPER: PRIVATE HEALTH INSURANCE REFORMS – SECOND WAVE

The Australian Health Service Alliance (AHSA) appreciates the opportunity to provide feedback to the proposed reforms in Consultations 2, 3 and 4 as described in the Australian Government Department of Health's (the Department's) Consultation Paper (Dec 2020): Private health Insurance Reforms – Second Wave.

The AHSA provides a variety of services to 27 private health insurers across the nation and these services include assistance with establishment and administration of funding arrangements with providers (hospitals, medical practitioners [especially gap cover arrangements], and providers of chronic disease management programs and hospital substitution services), data management services and training and support services for insurer personnel.

As such, the AHSA is able to provide a distinct perspective on the proposed reforms outlined in Consultations 2, 3 and 4 for the Department's consideration.

Consultation 2: Expanding home and community-based rehabilitation care

The AHSA is in favour of the proposed reform of requiring that an appropriate medical practitioner develop a rehabilitation plan (which would include out-of-hospital care as part of the patient's treatment) as appropriate to the patient and that payment of PHI benefits is made contingent on having such a rehabilitation plan be developed in consultation with the patient, consented to by the patient and documented accordingly.

The proposed reform reflects that which is regarded as good clinical practice. The current observed variance in utilisation of hospital-based rehabilitation across the private health sector and the observed variance in utilisation of hospital-based rehabilitation between public hospitals and private hospitals (after consideration of casemix differences) suggests that, in part, such good clinical practice is not widespread. The AHSA agrees with the proposition in the consultation paper that instituting the requirement for rehabilitation plans will reduce such variance and improve value for patients.

To enhance and strengthen the proposed reform, the AHSA suggests the following additional requirements for a rehabilitation plan be instituted:

- A rehabilitation plan must be developed, documented and consented to by a patient prior to the commencement of any rehabilitation care.
- In obtaining informed consent from the patient for the rehabilitation plan, the responsible medical practitioner must discuss options for out-of-hospital care with the patient (which can include care that is not considered multidisciplinary rehabilitation care) and require that the options discussed are clearly documented in the clinical record.

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- In documenting the options discussed and a patient's consent to a rehabilitation plan, the responsible medical practitioner must also document the reason(s) why out-of-hospital care options are not appropriate for a patient if the patient's rehabilitation plan is for the patient to undertake rehabilitation in a hospital setting.

These additional requirements ensures that the consideration and development of rehabilitation plans are comprehensive and patient-centric. Perhaps some lessons can be applied from the public sector, especially as it relates to orthopaedic services, where patient outcomes are comparable and utilisation of hospital-based rehabilitation is consistently lower and utilisation of home- and community-based care consistently greater.

The AHSA request that insurers be permitted greater flexibility to provide funding to clinicians (including specialist rehabilitation physicians and other qualified medical practitioners) to manage patients and provide rehabilitation care to patients in the out-of-hospital setting (including funding for services that are MBS-eligible). Such funding flexibility will strengthen the effectiveness of the above reforms regarding rehabilitation plans. It is expected that, all other things being equal (including on expected clinical outcomes), a patient will choose the option with the lowest expected out-of-pocket cost, and clinicians are more likely to provide out-of-hospital care (and, thus, expand patient access to out-of-hospital care options) if there is sufficient funding available.

Additionally, the AHSA suggests that providers of home- and community-based rehabilitation care be required to capture and monitor (using standardised measures and tools) patient outcomes and that the existing infrastructure of the Australasian Rehabilitation Outcomes Centre can and should be leveraged. Capturing, reporting and making transparent outcomes metrics will better inform ongoing improvement in the performance of the health system and facilitate the dissemination of better practices.

Questions posed in Consultation 2

Which procedures and/or MBS item numbers should have a rehabilitation plan?

- A rehabilitation plan should apply to any patient deemed by the patient's appropriate and responsible medical practitioner to potentially require rehabilitation care. The requirement for a rehabilitation plan should not be linked to any specific procedures or MBS item numbers.

How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?

- A rehabilitation plan should be sufficiently comprehensive and detailed such that the patient (along with the patient's carer/s with the patient's consent) and clinicians contributing to the care of the patient can clearly understand what rehabilitation care is required by the patient and expected to be provided to the patient.
- The plan must describe the required rehabilitation care elements required by the patient noting that rehabilitation care is multidisciplinary. The plan must include the duration, frequency and settings of care.
- Of course, the overall goals for the rehabilitation plan described should be documented.
- As described above, the rehabilitation plan must also document reasons as to why options for out-of-hospital care are not appropriate for a patient if the patient is to undergo hospital-based rehabilitation.

- As described above, the rehabilitation plan must be consented to by the patient prior to commencement of any rehabilitation care – noting that a rehabilitation plan can be amended after its initiation should a patient's care requirements deviate from initial expectations.

What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?

- Given that the process of developing a rehabilitation plan requires that an appropriate medical practitioner consult with a patient, a specific MBS item number (in lieu of an existing consultation MBS item number) could be introduced to the MBS schedule to denote a service that is development of a rehabilitation plan with a patient.
- This MBS item number would, in addition to enabling specific funding, serve as an indicator of the presence of a rehabilitation plan and permit targeted compliance monitoring activities such as periodic audits that may be conducted by insurers or the Department.

It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?

- The plan should be available to all clinicians attending to the patient including the patient's general practitioner.
- The plan should be available to the patient and the patient's carer/s with the patient's consent.
- The plan should be made available to the Department and insurers if requested to permit compliance audits. This also signals that there is a stewardship expectation on medical practitioners on the prudent use of hospital-based rehabilitation.

What arrangements, if any, should be in place to assist medical practitioners identify appropriate home- or community-based rehabilitation services and oblige insurers to fund these services?

- Medical practitioners should be assisted by the hospital, allied health staff and other clinicians in the development of rehabilitation plans. Collectively, these resources can assist in making medical practitioners aware of appropriate home- or community-based rehabilitation services that are accessible to the patient.
- As community-based rehabilitation services appear to be better utilised by public hospitals, medical practitioners may consider utilising similar referral pathways for their patients.
- If the proposed reforms described in Consultation 2 are implemented, health insurers will expand the engagement of providers of home- and community-based rehabilitation services to facilitate access to such services. Many private hospitals are well placed to provide or procure such services through funding arrangements with insurers.

What transition arrangements and timeframe would be appropriate to implement this reform?

- It is estimated that 12-18 months are required to fully implement changes in response to the proposed reform including the additional adjustments described above.
- This time is required to sufficiently expand and create accommodative funding arrangements between insurers and providers and institute any additional administrative structures and processes.

- It is assumed that the time is required for providers of home- and community-based rehabilitation services to increase their resources to meet the likely increase in demand; allow medical practitioners to modify their practices to include the routine consideration and development of rehabilitation plans for patients; and have changes implemented to existing systems and processes to capture and report outcomes from home- and community-based rehabilitation.

What are appropriate metrics for measuring the impact of this proposal?

- Measuring utilisation volume of rehabilitation services in hospital, community and home settings will be required.
- As described above, measuring clinical outcomes using standardised measures – such as extending those routinely captured by AROC (e.g., FIM and FIM efficiency by rehabilitation type) to home- and community-based rehabilitation settings – will be important in informing further improvement of the health system and facilitate the dissemination of better practices.

What is the regulatory burden associated with this proposal?

- Additional documentation obligations will apply to medical practitioners to consult, develop and document rehabilitation plans.
- Provider and insurer systems will require modifications to capture data on utilisation of non-hospital-based rehabilitation care and related funding transactions – e.g., the use of the non-admitted HCP2 designated data construct can be leveraged with modifications. In order to appropriately evaluate outcomes, existing data structures would need to be configured to be better able to link acute care through to hospital-based rehabilitation and home- and community-based rehabilitation.

In the context of this proposal, what changes do you intend to make to your current funding arrangements for home- and community-based rehabilitation care and in-hospital care, and the timing of these changes?

- The AHSA will respond to requests from its participating funds. As stated above, it is estimated that 12-18 months are required to significantly extend existing arrangements and establish new arrangements to accommodate the likely expansion of demand for and supply of home- and community-based rehabilitation.

What is the anticipated change in the number of rehabilitation services delivered in and out of hospital?

- As stated above, there is high variance in the utilisation of hospital-based rehabilitation in the private sector.
- The AHSA expects the proposed reform will reduce the observed high variance with the primary change being the reduction of utilisation of hospital-based rehabilitation in areas where the current utilisation of hospital-based rehabilitation is highest. The AHSA also expects, to a smaller degree, a reduction in the average duration of hospital-based rehabilitation as more patients undertake a greater proportion of their rehabilitation treatment in a home or community setting.
- The AHSA also expects the proposed reform will have resultant effects that will differ according to the type of rehabilitation. It is anticipated that the proposed reform will generate larger changes to orthopaedic rehabilitation than to other types of rehabilitation.
- Using orthopaedic rehabilitation after lower limb joint arthroplasty as an example, it is observed from AHSA's data that there is a large variance in utilisation of hospital-based

rehabilitation – ranging from over 80% of joint arthroplasty patients for a significant proportion of providers to less than 20% for another portion of providers. The AHSA expects that the proposed reform will contribute to a reduction in the observed variance as patients attending to providers utilising hospital-based rehabilitation over 80% of the time will increasingly opt for home- or community-based rehabilitation or no multidisciplinary rehabilitation at all. Thus, the proposed reform may contribute to reducing the 80% utilisation rates for many providers down to below 30 to 40%.

Consultation 3: Out-of-hospital mental health services

The AHSA supports the three-part reform changes described in Consultation 3. The AHSA agrees that the proposed reforms will enable funding arrangements that support more efficient and equitable service provision.

Mental health conditions are varied, often have co-modification factors (e.g., physical conditions impacting an individual; environmental stressors; carer issues; etc.), have variable courses and mental health conditions can be appropriately attended to by a wide range of evidence-based treatment options. For many patients, mental health conditions can be insidious in development, have a chronic effect and travel a relapsing and remitting course with widely variable periods of remission. Thus, existing regulatory constraints on what insurer funding can be put towards funding mental health services does not align well with serving the breadth and scope of mental health care needs of the population.

As alluded to in the Productivity Commission Inquiry Report into Mental Health released last year, existing funding constraints on private health insurers contribute to the inhibition of development of a more patient-centric, clinician-led, integrated mental health system. There are funding gaps to timely access of high quality secondary and tertiary preventative services and treatments. The funding gaps curtail development of supply of such services further eroding timely access. Out-of-pocket costs serve as barriers to access out-of-hospital mental health services – and this includes access to MBS-eligible services from psychiatrists and other clinicians.

The proposed reforms, in permitting more flexible funding (from hospital tables) to be able to be applied to a broader range of out-of-hospital mental health services (that are not MBS-eligible), will assist in improving care and access but the Department should consider additional, complementary changes that will increase the likelihood that improved outcomes (patient outcomes, provider outcomes and system efficiency) are achieved and sustained.

Given the mix and complexity of mental health care services required by a patient population and the breadth of mental health services that may be required by any individual patient, integrated, clinically effective and cost-effective mental health care that is patient-centric and clinician-led requires proposed reforms to add mandatory oversight by a medical practitioner (GP and/or psychiatrist [if applicable] or another relevant medical practitioner) nominated by the patient. If the proposed reforms as described in Consultation 3 are implemented without instituting any additional requirements, there is a material risk of amplifying the existing fragmentation and duplication of health services in mental health care (described at length in the Productivity Commission Inquiry Report into Mental Health) and further diluting doctor-patient relationships and disrupting continuity of care. As a result, the expanded funding of out-of-hospital mental health services would, instead of reducing and substituting for higher-cost, less effective care, result in the outlay being simply additive to current outlays for high-cost care.

The AHSA suggests that mandated inclusion of a medical practitioner (e.g., general practitioner or psychiatrist) nominated by the patient should, at a minimum, take the form of a process by which a patient offered or referred to a mental health service, must nominate a medical practitioner and have the nominated medical practitioner assent to keeping oversight of the patient's out-of-hospital (and in-hospital) mental health services and treatments. The term oversight in this context is, at a minimum, placing a requirement for the nominated medical practitioner to have visibility and awareness of the mental health services provided to and received by the patient. The linking of a patient with a nominated medical practitioner reinforces the doctor-patient relationship underpinning continuity of mental health care and increases the likelihood that patients and their nominated medical practitioners have informed discussions regarding mental health care options. In having a nominated medical practitioner, providers of mental health services will be required to inform and maintain communication and engagement with a patient's nominated medical practitioner regarding care provided to patients and patients' responses to the care provided. The identity of the nominated medical practitioner for a patient should be transparent and available to providers of mental health services with whom the patient engages. Additionally, insurer funding for out-of-hospital mental health services should be contingent on the provider furnishing the identity of the nominated medical practitioner to the insurer – thus, enabling the insurer to undertake policy compliance activities.

In addition to the proposed reforms in Consultation 3, supporting the mechanism described above for a nominated medical practitioner to have oversight of a patient's mental health care and care plan and helping to address the issue of out-of-pocket costs acting as a barrier to access effective and efficient out-of-hospital mental health services, insurers should also be permitted to flexibly apply funding to a wider range of clinicians for a wider range of mental health services.

Insurer funding should be permitted to be made to a patient's nominated medical practitioner for mental health services and oversight/management services provided to a patient including when such services are MBS-eligible. This would further incentivise active participation by medical practitioners in their patients' mental health care.

Out-of-pocket costs related to out-of-hospital non-MBS-eligible mental health services and treatments distort patient choices regarding settings of mental health care and create gaps in access to effective out-of-hospital mental health care. There is a similar distorting effect on patient and clinician decisions regarding the setting of care for MBS-eligible services. Insurers should be permitted to flexibly contribute funding to MBS-eligible mental health services provided by medical practitioners and other clinicians. Controls can be placed on funding by insurers by limiting MBS-eligible out-of-hospital services that qualify for insurer funding through specifying a limited set of MBS item numbers that would qualify for such insurer funding.

In implementing the proposed reforms, additional assurances regarding minimum quality and safety of out-of-hospital mental health service provision are required. The Department should include an appropriate supporting framework of accreditation of providers of out-of-hospital mental health services. The accreditation requirements and obligations, perhaps in a tiered structure, should be applied according to the form and scope of clinical service/s provided and the size, structure and complexity of the service provider. The accreditation requirements should strike an appropriate balance between providing greater assurance of quality and safety and ensuring that the accreditation system is not a significant barrier to supply of services by qualified, safe and effective providers.

Questions posed in Consultation 3

What additional mental health services funded by insurers under this proposal would be of value to consumers?

- In addition to that proposed in Consultation 3, a wider array of MBS-eligible and non-MBS-eligible mental services should be allowed to be flexibly funded by insurers. This includes MBS-eligible mental health services provided by medical practitioners. Out-of-pocket costs for out-of-hospital MBS-eligible services are a material barrier to patients' consideration of and access to out-of-hospital mental health services. These gap payments distort patient and clinician decisions that result in over-utilisation of hospital-based mental health services.
- The breadth of out-of-hospital mental health services permitted to be flexibly funded should extend from early secondary prevention (e.g., funding of symptom-initiated early diagnostic mental health services) through to complex tertiary prevention and treatment services (e.g., crisis management services, chronic disease management programs).

To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

- As outlined above, providers need to meet appropriate accreditation standards and these standards should be set according to the form, scope and complexity of mental health services to be provided.
- At a minimum, the standards set should require that minimum relevant educational and professional qualifications are held by providers of single modality services in sole-practitioner or small group practices.

Are there any mental health services insurers should not be permitted to fund?

- Primary prevention services such as general, non-specific mental wellness-type services or general mental wellness education services should not qualify for funding by insurers from hospital tables.
- Mental health services that do not include the identity of the patient's nominated medical practitioner (as described above) should not qualify for insurer funding.

How should the relevant patient cohort be identified as eligible for services?

- By requiring that insurer funding cannot be applied to primary preventions, the relevant patient cohort would, at a minimum, have symptoms or a diagnosed mental health condition that, in effect, creates the eligibility for insurer-funded mental health services
- Additionally, if the additional proposed change described above of having a requirement for a nominated medical practitioner to have oversight of the patient's mental health care services and/or plan is adopted, this would provide a further level of assurance regarding the appropriateness of mental health services funded by an insurer.

Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?

- Clinicians, including the patient's nominated medical practitioner, should identify and refer to or prescribe the appropriate and relevant mental health care services for the patient after consulting and discussing options with the patient.

What are appropriate metrics for measuring the impact of this proposal?

- In the near term, utilisation metrics (by geography) to track uptake of non-hospital-based mental health services and gauge the form of the impact (if any) on utilisation of hospital-based mental health services is required.

- If the suggestion above of allowing insurer funding for MBS-eligible mental health services provided by medical practitioners is adopted, measuring this utilisation volume would also be required.
- The most appropriate and relevant metrics for measuring the impact of the proposal are standardised measures of patient outcomes (including standardised patient reported outcome measures and patient reported experience measures). It is acknowledged, however, that the infrastructure to capture and report such metrics is not readily available at a national and whole-of-population scale.

What is the regulatory burden associated with this proposal?

- For insurers, the initial resources required to respond to the proposed reforms will be applied to establishing funding arrangements and their administration with a larger array of providers of mental health services. This includes implementing required changes to existing fund administration systems to be able to transact with the larger array of providers. If, in addition to the proposed reforms in Consultation 3, insurer funding is also permitted to be made to MBS-eligible services provided by medical practitioners, these change requirements will require application of additional resources.
- Any likely system changes required to meet additional regulatory data reporting purposes will also need to be accounted for.
- Should the additional proposed change described above of introducing the requirement of a nominated medical practitioner to have oversight of the patient's mental health services is adopted, service providers will need to establish processes and modify their systems to routinely capture, document and communicate information to and from patients' nominated medical practitioners.

In the context of this proposal, what changes do you intend to make to your current funding arrangements for mental health services and the timing of these changes?

- The AHSA will respond to requests from its participating funds. It is estimated that 12-18 months are required to significantly extend existing arrangements and establish new arrangements to achieve adequate national coverage with a larger array of providers of out-of-hospital mental health services and ensure systems will smoothly administer such arrangements.

Consultation 4: Applying greater rigour to certification for hospital admission

The AHSA is of the view that the proposed reforms of establishing a self-regulated industry panel to manage Type C certification disputes and establishing the related escalation pathway to the Professional Services Review agency are not proportionate to the scale of the problem described. Furthermore, existing dispute resolution options could be strengthened and be better utilised to attend to the problem described in Consultation 4.

The overwhelming majority of hospital care with type C certification is attended to without dispute. Of the minority of episodes that require further enquiry, the overwhelming majority of these are resolved rapidly. For the remaining small minority of disputed type C certificates that are not resolved in a timely manner, current escalation processes are available and under-utilised and these can be strengthened.

The capacity and capability of the Ombudsman should be increased. The Ombudsman can be empowered to draw upon additional expertise (such as specialist colleges, the Department, PSR, etc) as needed to mediate resolution of disputes that pertain to type C certification. The Ombudsman can also be tasked with making their determinations (in the form of additional guidelines to the sector) transparent to the community for issues which are repeatedly referred to the Ombudsman.

The AHSA supports the proposed reform of encouraging the development of guidelines for type C procedures by specialist colleges. As these guidelines focus on improving clarity of the form, use and applicability of type C certification (a regulatory construct that governs health insurer funding), the development of guidelines are not solely a clinical matter. Most medical practitioners are not well informed of the regulatory context regarding private health insurer funding and type C certification. Thus, the development of guidelines for type C procedures by specialist colleges should have the close involvement of and input from the Department (and the Ombudsman where relevant) to ensure that any guidelines developed by the specialist colleges have a clear and consistent understanding of the regulatory context of type C certification.

Questions posed in Consultation 4

Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?

- Primary responsibility for accurately completing Type C certificates should continue to reside with the responsible medical practitioner because decisions regarding use of the hospital as the setting for treatment specific to the patient's circumstances resides with the responsible medical practitioner.
- The hospital has contributory responsibility in ensuring the information presented in the Type C certificate aligns with the information in the clinical records held by the hospital.