nib health funds limited
Head Office
22 Honeysuckle Drive
Newcastle NSW 2300
abn 83 000 124 381

t 13 14 63
f 02 4925 1900
e nib@nib.com.au
w nib.com.au

11 February 2021

Department of Health

Via email: phiconsultation@health.gov.au

nib's Response to Consultation 2: Expanding Home and Community Based Rehabilitation Care

nib health funds (nib) supports the suggested reforms to rehabilitation care, and the expansion of rehabilitation services into homes and or community settings. The reforms will allow the expansion of quality rehabilitation for our members, in the right setting, to meet their needs and improve outcomes. They also align with efforts to improve the affordability of private health insurance through more cost-effective models of care.

Current nib initiatives, including programs that allow rehabilitation at home and clinical partnerships with surgeons, show our commitment to this approach.

nib's Clinical Partners program is a partnership between nib and six Newcastle-based orthopaedic surgeons. Under the program, the surgeons are asked to provide recommendations for clinically appropriate, post-recovery treatment, including rehabilitation at home. nib offers a concierge service and a guarantee of no 'out of pocket' expenses to members. The program has been running for more than two years. More than 1,000 nib members have used the Total Knee Replacement (TKR) or Total Hip Replacement (THR) program with our Clinical Partners program.

While nib supports the reforms, we do recommend that the following be considered as part of any final reforms and legislation:

- Development of a clear and distinct definition for rehabilitation and aftercare to ensure delineation between the two (see definition of 'rehabilitation care' below).
- Allowing health funds to have greater control over the benefits payable to providers when treating members.
- Removal of hospital level minimum benefits for service in the PHI Benefit Requirement Rules. This includes any second-tier provisions, as this is not an accessibility issue for patients being treated in alternative settings.
- Rehabilitation plans are only developed by rehabilitation specialists. This will ensure clinical oversight and responsibility, patient safety and efficacy associated with the services received. Treatment for rehabilitation is substitutional and not additive as this leads to inflated costs putting pressure on health insurance premiums.
- Costs for at home services should reflect value-based care to avoid the creation of an artificial cost base or demand to subsidise revenue removed from incumbent hospital services.
- There is a standard approach or definition developed to ensure funding is based on clinical need that is evidence-based, focused on the patient's needs and represents value.

Definition of Rehabilitation Care

The element of the current proposal that we believe needs clarification is the definition of Rehabilitation Care. In particular, there must be a clear delineation between rehabilitation and aftercare.

The Federal Budget announced that private health insurance "will be expanded, allowing patients to recover and rehabilitate in their own homes."[1] The treating acute care medical specialist should make the referral to rehabilitation care following aftercare and the patient's recovery from surgery or illness. Rehabilitation when the patient has not recovered or where there is no residual impairment is low value. While the progress of a patient from aftercare to rehabilitation complies with the statement that "aftercare is different to rehabilitation"[2], it does not adequately address what that difference is and why this is important.

Based on the industry guidelines and clinical practice, aftercare and rehabilitation differ in that:

- aftercare is the normal "recovery from the operation"[3] and
- rehabilitation care is intent on "improving the functional status of a patient with an impairment, disability or handicap within a clinically appropriate timeframe"[4].

Aftercare is covered by a member's product and a benefit paid for when the acute injury, illness or condition occurs. As this is ***not*** rehabilitation care, nib is very supportive of providing this service in an alternative setting under a different funding model.

QUESTIONS FOR ALL STAKEHOLDERS: REHABILITATION SERVICES

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

   nib recommends all procedures and/or MBS item numbers can have a recovery that may lead to a rehabilitation plan to ensure it meets the Guidelines criteria for rehabilitation.[5]

   No patient should receive rehabilitation without a specific rehabilitation plan. Patients who do not need a rehabilitation plan are receiving care as aftercare, as they recover.

   A rehabilitation plan cannot be carried out by a surgeon or GP. It must be carried out by a Rehabilitation Physician, otherwise it is aftercare.

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

   nib suggests the plan should be clear and prescriptive in accordance with good clinical practice and the clinical needs of the patient. There should be the opportunity to revise the plan as the patient's needs change.

   A rehabilitation plan should also be prescriptive and have measurable goals, so that the patient and practitioner know discharge from rehabilitation will occur.

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

   nib recommends the funder undertake an audit to ensure compliance and that benefits paid are in line with the agreed rehabilitation plan. This will ensure the intent of the funded service is realised and contribute to the affordability of private health insurance and healthcare in Australia.

---

[1] Department of Health 2020.
[2] Consultation paper: private health insurance reforms – second wave, pg. 14.
[3] Medicare Benefits Schedule, 2020, AN.10.1 Schedule Fees and Medicare Benefits.
[4] PHI Circular 41/16
[5] PHI Circular 41/16 - rehabilitation must be "evidenced in the medical record by… an individualized multidisciplinary rehabilitation plan"

Prior to rehabilitation services commencing, the plan should also be reviewed by the referring medical specialist, funder, allied health professionals and patient to ensure it is appropriately addressing the patient's needs. The plan should also be developed, evaluated and reported in accordance with the AFRM Standards.[6]

Further, we recommend assessment such as the RAPT tool, clinical outcomes (e.g. range of movement (ROM), validated patient reported outcome measures (PROM)) and goal specific measures (such as the Patient Specific Functional Scale) are provided to the funder to demonstrate the efficacy of treatment.

4. **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?**

   Access to the rehabilitation plan allows all those involved to work together to provide their services and improve the member's health.

   As such, the rehabilitation plan should be made available to the patient, the rehabilitation specialist, the treating health professional, the referring acute care medical specialist and the health insurer.

5. **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?**

   The obligation to fund these rehabilitation services sits within the agreement between health funds and service providers. In addition, such agreements should be made known to medical practitioners so that appropriate access to services can be facilitated.

   There is also an opportunity for health insurers to work more closely with GPs and medical professionals to better support members and their treatment.

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

   We recommend that transition arrangements are as per current agreement arrangements between health funds and providers.

   Implementation is unlikely this calendar year. Health funds will need to determine the impact of the final reforms and to subsequently implement the changes as part of contract discussions.

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

   nib anticipates a decrease in benefit outlay for rehabilitation care that was carried out in hospital. Conversion rates to all forms of rehabilitation care should be monitored and reported publicly to ensure transparency.

   Failure to decrease rehabilitation costs would mean that this reform would fail to address its intent and may lead to increased premiums with no added value to patients.

   Clinical outcomes (including adverse outcomes), such as patient reported outcome measures (PROMs) or experience measures (PREMs), and achievement of patient specific goals should also be used. This will help ensure that any change in benefit outlay is achieved through the delivery of health services that are effective, efficient and focus on the patient's needs.

   In addition, Australian National Subacute and Non-acute Patient Classification[7] (AN-SNAP) data, including the mandatory reporting of all Australian Classification of Health

[6] AFRM Standards, 2019.

[7] https://www.ihpa.gov.au/sites/default/files/australian_national_subacute_and_non-acute_patient_classification_ihpa_fact_sheet_2019.pdf

Interventions (ACHI), should be shared with the health fund for each day of home and community-based rehabilitation to ensure transparency regarding the service delivered.

It is also recommended that APRA report 605 be amended to capture reporting requirements, including claimant episodes and treatment cost information, similar to that introduced for the mental health waiver reporting.

8. What is the regulatory burden associated with this proposal?

Mandatory, regulated costs and benefits paid should be equal to the service provided and benchmarked.

The "rehabilitation services provided in the home or community can be significantly more cost effective than similar services provided in a hospital"[8] and should be equivalent to that provided in the community for the same level of service. A physiotherapist providing medically referred one-to-one assessments and therapy for more than twenty minutes is the same as MBS item 10960 or 81335 as Schedule Fee: $64.20 Benefit: 85% = $54.60 increasing to 50 minutes to Fee: $90.70 Benefit: 85% = $77.10.

The therapy is the same so the benefit should match. The regulation on the minimum benefit may need to change to reflect the benefit amount for the service delivered. There should be no hospital level minimum benefit for the service in the PHI Benefit Requirement Rules including any second-tier provisions, as this is not an accessibility issue for patients.

Medical oversight by the rehabilitation specialist is required to develop the plan on any residual impairment once the patient has recovered from their surgery or illness in aftercare, as well as the monitoring and discharge from rehabilitation back into the community. The Medicare rebate for out-of-care by the rehabilitation specialist should be considered.

Service providers, in the home or community-based, should be accredited as organisations and individuals to provide the rehabilitation allied health therapies needed by patients and prescribed in the rehabilitation plan. This should be different and not as complex as the National Standards for hospitals. As these service providers are in the home or community, modifications to accreditation standards should be made to ensure they are achievable in this context and not limited to licenced hospitals.

9. Service providers: what services would you deliver under this proposal?

nib recommends that nursing care is excluded from the proposal as this is covered elsewhere and is not part of rehabilitation care.

INSURER SPECIFIC QUESTIONS

1. 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?

nib would look to expand the current contractual and funding arrangements held with providers that deliver rehabilitation care out of hospital to meet the developing needs of patients. Timing depends on additional details being provided, including points raised in our response.

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

Based on nib's experience in the transition to rehabilitation at home (RAH) under our Clinical Partners program, we anticipate RAH would be about 50% of members unless

[8] Consultation paper: private health insurance reforms – second wave, 2020 pg. 15.

adequate safeguards were introduced to ensure appropriate use of RAH. Recommend safeguards include:

- prohibiting service providers from making referrals and assessments as this contributes to growth in services provided during aftercare rather than rehabilitation;
- developing a clear distinction between recovery (aftercare) and rehabilitation; and
- ensuring health funds continue to work with providers to meet the needs of patients and that this is not part of any default or 2nd-tier funding. This is to ensure where it is inappropriate, that behaviour can be addressed.

We recommend introducing changes to discourage the use of inpatient rehabilitation otherwise we believe the reforms are unlikely to significantly change inpatient rehabilitation rates.

Should appropriate safeguards be introduced, such as the use of a RAPT assessment to determine what rehabilitation should be applied, we believe a reduction in rehabilitation benefits can be achieved.

In our experience, introducing RAPT assessments with Clinical Partner surgeons has seen inpatient rehabilitation rates fall to levels seen in public hospitals (circa 15-20%), which has reduced outlays and resulted in more efficient care of members.

3. What is the anticipated impact on your overall premium revenue if you implement this proposal?

With appropriate safeguards as outlined above, nib estimates a reduction of rehabilitation benefits would result in reduced premiums. Once the reform details are finalised, we will have a better understanding of potential impacts on premium revenue.

However, without these safeguards, there is a potential increase in rehabilitation spend of between 5%-15%.

4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

nib believes all members who hold full rehabilitation cover as part of their hospital product will be able to access these new benefits. However, further analysis is required based on the final reform to determine the full impact.

Please don't hesitate to contact me on 0428 903 824 or e.close@nib.com.au if you have any further questions.

Yours sincerely,

Ed Close

Chief Executive – Australian Residents Health Insurance