2 February 2024

Department of Health and Aged Care

Via email: MBSClinicalPolicy@health.gov.au

MBS rebates for attended sleep studies in non-hospital settings

Thank you for your letter dated 8 December, inviting the Australasian Sleep Association to comment on the issue of MBS rebates for attended sleep studies. The Australasian Sleep Association (ASA) represents a diverse range of clinicians and researchers working in sleep health and sleep medicine, including specialist Sleep and Respiratory Physicians.

The Association has consulted with members on this issue, and we have deep concerns regarding the proposed changes to the Medicare Benefits Schedule, specifically the re-classification of attended sleep study MBS item numbers (12203 to 12272, not including 12250) as being performed in-hospital only and, therefore, only eligible for a 75% rebate of the Medicare scheduled fee. This alteration could have far-reaching negative impacts on patient care, particularly for those in regional and rural areas, individuals without private health insurance, and patients with physical and mental health comorbidities.

1. **Attended sleep studies can be performed in non-hospital settings:** The Medicare item descriptor for attended sleep studies requires the attendance of a sleep technician. However, it does not specify the setting where the sleep study should be performed. Similarly, the ASA professional guidelines for the performance of sleep studies specify requirements for the physical space and supportive infrastructure needed to perform attended sleep studies. These requirements and the requirements of the Medicare items can be satisfied in non-hospital settings.

2. **Access in regional and rural areas:** Reclassifying sleep study items as hospital-only would disproportionately affect patients in regional and rural areas. These areas already face challenges in healthcare access, and the proposed changes could lead to the closure of existing non-hospital sleep study facilities, thereby increasing travel burdens and expenses for patients seeking these essential services.

3. **Impact on uninsured individuals:** A significant portion of the population relies on the public health system due to the unaffordability of private health insurance. Reducing the rebate for attended sleep studies performed in non-hospital settings would result in increased out-of-pocket expenses, which could lead to a decrease in access to sleep studies due to financial constraints.

4. **Impact on patients with comorbidities:** Individuals with complex health needs, including physical and mental health comorbidities, often require more frequent and comprehensive sleep health services. The proposed reclassification of attended sleep studies as hospital only, with the associated reduction in Medicare rebate, would limit their access to these

crucial services, adversely affecting their overall health and quality of life.

5. **Access to diagnostic testing for people with disorders of hypersomnolence such as narcolepsy**: Specialised vigilance testing to diagnose and guide management of disorders of hypersomnolence are a critical part of managing this patient group who already experience long delays before diagnosis. A limited number of facilities provide this testing, and reclassifying item numbers 12254 through 12272 as hospital-only procedures, and therefore only attracting a 75% rebate, would further limit access to this critical service.

6. **Financial strain on health services:** Performing attended sleep studies is complex and costly. Most services, particularly those in non-hospital settings, run on very narrow margins. Given this, a reduction in rebate from 85% to 75% of the Medicare scheduled fee runs the risk of these services becoming unviable. This is particularly of concern outside metropolitan centres, where non-hospital settings for attended sleep studies are often the only service available.

We have appended below some of the specific feedback we have received from members on this issue in case these comments are helpful to provide further context.

In conclusion, we strongly advocate for attended sleep studies (MBS items 12203 to 12272, not including 12250) to be able to be performed in either hospital (75% rebate) or non-hospital (85% rebate) settings to ensure equitable access to essential sleep health services across Australia. We urge the Department to consider these points carefully in their decision-making process to avoid unintended negative consequences on patient care and public health. We would be happy to arrange a meeting for further discussion if required, and this can be arranged through our CEO, Marcia Balzer (ceo@sleep.org.au, 0430 175 310).

Yours sincerely,

Prof. Garun Hamilton
President

Dr David Cunnington
Clinical Chair

Appendix A – Member feedback

From: Dr John Swieca
The initial negotiations for the 12203 item number did not link the performance of attended sleep studies to licenced hospitals and their associated staffing and cost structures. From the start, issues of access, affordability and service viability have been front to of mind, in making decisions around service delivery and planning.

In the years that have followed, better awareness of the gamut of sleep/wake disorders amongst healthcare practitioners and the general public has lead to a significant rise in referrals to sleep disorders services around the country. Each service needs then to customise its offerings to ensure good clinical oversight, prioritisation and access to appropriate sleep studies occur in a timely manner.

…Our services, under the SleepDoctors Australia banner, have successfully operated outpatient sleep monitoring services, in both metropolitan and regional areas for many years. We support adolescent and adult patients with all studies, including overnight and vigilance testing, with a well-managed, patient-centred focus on providing access, equity and affordability of care. The outpatient settings remove the institutional overheads associated with a hospital setting - which otherwise would make the services unviable.

We have a particular focus on the vulnerable in the community, particularly the young, elderly, disabled and those who drive heavy vehicles. Our sites have overnight carer rooms, so that patients with extra needs can have a familiar face present if required, during the set-up and monitoring phases. The out-of-hospital settings give us and patients the flexibility of providing a non-threatening environment, to ensure optimal clinical outcomes.

In these times, any further impost on the patient, say by way of reduced rebates for all sleep study services, would further imperil patients seeking care for their sleep/wake disorders. The resultant impact on patient wellbeing, the management of chronic cardiometabolic and mental health diseases, and safety on the roads and in the workplaces would be incalculable.

Our dedicated team of scientists and physicians oppose this proposal from the Department in the strongest possible terms.

From: Associate Professor Budhima Nanayakkara
I practice in Orange NSW, a regional town. My work services a significant proportion of the central west NSW, and I run an in-lab non-hospital sleep laboratory, the only in-lab facility west of the Blue Mountains.

These proposed changes will necessarily mean a complete shut down to our in-lab sleep centre, with a complete cessation of a crucial sleep service in rural NSW.

To add a rural focus, which I think is extremely important as our voices are often under-represented to the DoH:

1. There is a disproportionate cardiorespiratory comorbidity profile in rural/regional areas, with reference to AIHW's own statistics. This implies that there is a higher likelihood of complex sleep related breathing disorders, which would not be accurately captured nor treated via conventional home sleep testing paradigms.

2. Regional areas have a higher proportion of older adults, and these patients have a higher likelihood of sleep disorders, particularly non-respiratory sleep disorders with atypical presentations such as REM behaviour disorder that necessarily requires in-patient sleep studies.
3. There is a significant paucity of sleep and respiratory physicians practising in the country.
4. Geolocation studies using Medicare data mapped to the Australian geographic map clearly show that access to rebatable sleep studies is not a concern in metropolitan areas, however remains a significant issue in rural, regional areas - where distance to travel for a home sleep study precludes most patients from attending a take home study.
5. Studies from other countries highlight that OSA severity increases with distance to travel to the sleep centre (a surrogate marker of rurality), there is a significant delay in accessing sleep services that are unsatisfactory to patients, and patient borne costs are significantly greater for real patients, due to the need to travel to the sleep centre.

Most of my patients that attend my sleep centre do so after travelling long distances. Home sleep studies in this setting are not feasible.

I have several examples of patients who have advanced cardiorespiratory disease, who would be unsuitable for home testing.

Hospital based sleep labs can only be provided in a public or private setting. For patients to access private hospitals, they have to be privately insured. This is simply not accessible to a number of our patients. Public hospitals rarely have space to fit a laboratory in, and they require at least 2 physicians trained in sleep to operate it - a very rare comorbidity in the country.

If we use Orange as an example, our level 1 facility was initially associated with a private hospital, however that hospital promptly went into liquidation and is no longer operational. Now our facility exists as a level 1 non-hospital centre. …Our margins are extremely tight and currently the centre runs at a loss propped up by physician consulting income and re-investment of capital. Furthermore, there is simply no space, nor is there money to fund a public hospital-based level 1 sleep lab.

I believe, if the DoH changes the item descriptor to rid non-hospital based in-lab services, this would disproportionately affect those in the country. It would severely disadvantage my patients, and will in my opinion directly impact important patient related outcomes in the country.

From: Professor Ron Grunstein
In 1989, when Item 12203 was first negotiated there was no nexus between the performance of sleep studies and a hospital bed ie. no requirement for nursing staff in attendance and other regulatory conditions of hospitals. It has been like this ever since, providing sleep medicine practitioners the choice to perform the test either in a private hospital or as a non-inpatient setting. Many of the sleep studies performed in Australia since 1989 have been in non-inpatient settings.

(This proposed measure) will harm patients who do not have private hospital insurance from having a sleep study in a non-hospital setting. Depending on how they enforce this it may mean either the complete inability to perform sleep studies in non-inpatient settings (if the item number must be linked to a private bed charge) or a 10% cut in the fee providing facility fees to be charged to disadvantaged or financially constrained patients. It is many years since they have adjusted the item number for true costs and CPI increases increasingly making an important medical procedure non-viable.

…As an example, we perform polysomnography on mentally stable patients with schizophrenia - most of these patients cannot afford private insurance or facility fees in non-inpatient settings. Cutting the item number by 10% will mean we cannot properly investigate patients most who are unsuitable for home sleep studies. There are many more examples the ASA could provide.

From: Professor Robert Adams
This (proposal) would severely disadvantage non-urban patients without private insurance who would be forced onto already very lengthy public waiting lists for in-hospital studies in public hospital labs; or travel large distances back and forth for at-home studies. This is a particular disadvantage for patients in less populated states (SA, WA) where public hospitals performing sleep studies are located only in the capital cities and private hospitals are rare outside the capitals due to smaller rural populations or few non-capital population centres.

…It also further disadvantages other already disadvantaged population groups, such as those with schizophrenia; disabilities who do not require overnight nursing but have conditions that limit mobility or have cognitive deficits; anyone without private insurance who require monitored studies for particular conditions, eg parasomnias, or who have other chronic conditions where recordings beyond Level 2 are indicated.

Finally, it would be very uncommon for a hospital lab, public or private, to have a nurse located in the sleep lab overnight, other than for specific and unusual circumstances.