Injury & Disability Schemes Seminar

Insights and Outcomes

10-12 November 2019 • QT Canberra
BEST PRACTICE TREATMENT WHILST PROTECTING SCHEME SUSTAINABILITY

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WorkSafe philosophy around health service provision

- WorkSafe aims to fund health services that are aligned to best clinical practice.

- Key goals are to ensure the right balance is in place for injured workers to:
  - access high quality services
  - funded at reasonable cost
  - supported by provider controls

allowing injured workers the best opportunity to recover, whilst maintaining WorkSafe’s financial viability.
Competing cost pressures on the scheme

Provider fee pressure – systematic and prolonged lobbying and cost pressure on scheme from a wide range of health and disability providers

Potential for fee increase in one area to flow into others
Principles we consider when setting fees

**Fee setting principles**

- WorkSafe’s fee setting goals:
  - Incentivise best clinical practice
  - Availability of services for injured workers
  - Fees reflect reasonable cost of service provision
  - Benchmarking / understanding of market prices
  - Transparent and consistency in fee methodology
  - Ensure case complexity is not a barrier to treatment
  - Support innovation
  - Discourage over-servicing
  - Administrative ease for providers
  - Engagement with the sector and other funders

Having clear fee setting principles and an open transparent process are critical to defending fees when challenged
Systematic approach to fee setting

All fees are reviewed on a cyclical basis ensuring services are attracting quality providers, review methodology includes:

- Consultation with providers and peak bodies to understand key cost drivers and pain points
- Estimating fees using a bottom-up costing approach allowing for direct costs, overheads and profit
- Wide ranging benchmarking of fees against other funders
- Tenders and commercial negotiations where appropriate
- Strong governance and approval processes
- Fee schedules supported by clear policies and guidelines
- Indexation methodology which best reflects cost movements

Approach underpinned by commercial skills and capability built through recruitment, training, retention and succession planning
Non-fee controls are also critical

Other controls

• Clear policies and guidelines: define the scope of health service, set referral and approval requirements, set limits for service volume and/or cost, all anchored to legislative requirements

• Payment integrity: automated billing controls, exception reporting, cyclical reviews of service categories and provider groups, auditing of outliers

• Payment monitoring: with the ability to drill down to individual products and services, to look at particular claim cohorts and provider groups

Understand and leverage knowledge of other funders and broader health sector to identify emerging issues
Provider behaviour just as important as fee setting

- Understand incentives built into fee structure: simple fee for service models will often encourage over servicing, providers will gravitate toward high margin services.

- Outlier behaviour: need to monitor as some providers will adapt and change as they discover opportunities to maximise profits.

- Provider monitoring: benchmarking provider behaviour and outcomes against each other or best practice guidelines.

- Practice inline with evidence: ensuring that all services are in line with evidence as many providers still fall back on historical practice and personal observation.

Sometime easier to influence provider behaviour through changes to policy or provider management than through fees.
Case studies

• We are now going to look at four case studies which illustrate our approach to achieving best practice treatment whilst protecting scheme sustainability

• These case studies reinforce the importance of having the right funding models, good commercial arrangements and managing provider behaviour

• It is notable that while in each case the trigger for action was a growth in payments, the solution was always there and not related to the payment growth

• With all of the current cost pressures the scheme now faces some payment growth is inevitable and we may need look at low growth areas for opportunities to fund increases that are outside our control
Case study 1: Development of innovative funding arrangements to incentivise better provider behaviour in inpatient rehab

What do these four patients have in common?

Generally paid the same, regardless of severity
Case study 1: Development of innovative funding arrangements to incentivise better provider behaviour in inpatient rehab

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<thead>
<tr>
<th>Challenge</th>
<th>Issues</th>
<th>Response</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Growth inpatient rehab costs</td>
<td>WorkSafe case mix funding model not providing the right incentives</td>
<td>Implemented a granular case mix funding model based on the AN-SNAP classification system that groups together cases that are clinically, functionally and financially similar</td>
<td>Overnight change in provider behaviour with regard to taking on high complexity cases</td>
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<td>Private providers not willing to take on high complexity cases which therefore remain in public hospitals</td>
<td>Rehab consultants going to public system to seek lower impairment cases</td>
<td>Under the new model fees reduce when benchmark lengths of stay exceed national benchmarks</td>
<td>Improved worker outcomes and reduced lengths of stay</td>
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Worker perspective: before these changes workers with severe injuries were getting caught in the public health system without access to best practice rehab treatment
Case study 2: Responding to incentives to over service in spinal surgery

“Despite considerable high-level evidence that most degenerative conditions can be managed with simpler techniques... the routine use of more complex techniques and wide variation persist.”


“If RACS and Specialty Societies are to maintain legitimacy in discussions around issues such as the current review of the MBS item numbers, we must not let the profession down by engaging in inappropriate billing. We must also be willing to call out those who do.”

Julian Smith, Chair, Professional Standards, RACS, Surgical News Nov/Dec, 2015
Case study 2: Responding to incentives to over service in spinal surgery

**Challenge**
- Growth in both number and cost of spinal fusion surgeries
- Highly invasive surgery often resulting in poor outcomes
- Inappropriate billing practices

**Issues**
- Inappropriate referrals: conservative treatment options not explored, over reliance on diagnostic imaging, not evidence based
- Widespread billing issues: billing incorrect items, billing additional items, billing for services not performed

**Response**
- WorkSafe developed a new approach to reviewing spinal fusion surgery requests: streamlined approvals where there is clinical alignment between symptoms and imaging and a multi-disciplinary examination with both a pain specialist and a surgeon when the evidence is unclear
- Development of billing guidelines and pre-approval of billing

**Outcomes**
- Fewer non required fusion surgeries
- Change in billing practice and a reduction in average cost
- Greater uptake of alternative treatment options

Worker perspective: “no one has ever explained my condition to me before ... the multi-disciplinary examination was very informative ... if they do not recommend surgery I will follow their recommendation”
Case study 3: Changes in rTMS service design and fees to improve scheme sustainability and clinical outcomes
Case study 3: Changes in rTMS service design and fees to improve scheme sustainability and clinical outcomes

**Challenge**
- Growth in inpatient psych costs, particularly inpatient rTMS
- Long inpatient stays impacting worker outcomes

**Issues**
- 95% of rTMS are performed in an inpatient setting in Australia; in other countries 95% of rTMS services are outpatient
- Inpatient delivery driven by health insurers inability to fund as an outpatient services
- Inpatient service resulting in inappropriate length of stays and driving poor outcomes for injured workers
- Inpatient cost of service more than double that of outpatient

**Response**
- Worked with rTMS expert to develop a new outpatient service and fee schedule which was implemented in July 2018
- Private health insurers looking to follow WorkSafe’s approach and College of Psychiatrists have recognised that rTMS can be conducted safely as an outpatient procedure

**Outcomes**
- Reduced hospitalisation
- Better outcomes for injured workers
- Significant savings in inpatient psych costs (~60%)

Worker perspective: injured workers can now access this treatment without staying overnight in a psych hospital
Case study 4: Complete review of hearing service commercial arrangements

Photo by JD Mason on Unsplash
## Case study 4: Complete review of hearing service commercial arrangements

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<td>• Strong growth in hearing loss claims to 2011</td>
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<tr>
<td>• Unregulated market focused on maximising profits</td>
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<td>• High cost growth with large liabilities</td>
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<table>
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<tr>
<th>Issues</th>
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<tr>
<td>• No clearly defined minimum functional requirements for a hearing aid to be included on WorkSafe’s approved list</td>
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<td>• Device and audiology provided as bundled service</td>
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<tr>
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<tr>
<td>• Unbundled device and audiology components of service</td>
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<tr>
<td>• Defined minimum functional requirements for a hearing aid to be included on WorkSafe’s approved list</td>
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<tr>
<td>• Direct negotiation with device distributor to create a shortlist of low cost, high quality devices which meet the needs of 95% of workers</td>
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<td>• Conducted a tender for audiology services</td>
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<td>• Non-standard requests subject to clinical panel review</td>
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<td>• Ongoing cycle of commercial review</td>
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<tr>
<td>• Sustained reduction in both the number of new hearing loss claims and the cost of devices and services</td>
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**Work perspective:** injured workers are now getting hearing aids that are appropriate to their condition.
Future opportunities

Service models

• Two tier provider models, including differential pricing based on extra requirements
• Solutions based models with packages of funding for multi-disciplinary services
• Incentivising funding for evidence based services (we are prepared to pay a premium where is there is clear evidence of effectiveness)
• Greater use of clinical panel expertise to develop service models
• Working with other funders to leverage off best practice service models
• Potential partnership approach with providers and funders

Provider partnerships / management

• New partnership service models
• Better provider performance measurement tools
• More active provider management, leading to improved performance and better outcomes
• Ability to pay higher fees for evidence based models achieving better outcomes
• De-identified performance measurement against peers
• Measurement against industry standards
• Real time online portals
• Reduction in provider administration requirements