Outcomes and Savings of the Health Partnership Program

semi-annual report

Jan. 1 to June 30, 2008

Ohio | Bureau of Workers' Compensation

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The Health Partnership Program

The Health Partnership Program (HPP) is BWC's system for managing workers' compensation health care for state-fund employers. BWC implemented HPP in March 1997. The bureau publishes HPP outcomes and savings and, pursuant to Ohio Revised Code (ORC) 4121.44 (H) (3), presents these reports to the governor, the speaker of the House of Representatives and the president of the Senate.

In compliance with sections 4121.44 and 4121.441 of the ORC, HPP comes under the direction of the chief of the Medical Services Division. The division coordinates health-care delivery through provider networks and managed care organizations (MCOs), focusing on utilization, pricing and payment strategies to benefit injured workers and employers.

BWC is responsible for determining compensation and paying indemnity benefits. However, it contracts with MCOs to manage the medical component of workers' compensation claims. MCOs also educate employers and injured workers on HPP, intake *First Report of an Injury, Occupational Disease or Death* (FROI) forms, establish transitional/early return-to-work programs and process bills, including provider payments. BWC monitors MCO performance measures such as return-to-work effectiveness using the Degree of Disability Management (DoDM) model, FROI timing and data accuracy, bill timing and data accuracy.

There are 23 BWC-certified MCOs. BWC publishes an annual *MCO Report Card* to help employers choose an MCO. The sixth biennial MCO Open Enrollment occurred May 2008. Of the approximately 260,000 employers in an active status during that time, 18,000 changed MCOs impacting 34,000 active claims. The transition took effect July 1, 2008.

MCO recertification, pursuant to ORC 4121.44 (B) (2), is under way for the two-year period 2009 to 2010. Negotiations for the 2009 to 2010 *BWC/MCO Agreements* also are under way.

Medical Services Division objectives

Medical Services' goal is to ensure injured workers receive prompt, quality, cost-effective health care to facilitate their safe and prompt return to work and quality of life. The division coordinates health-care delivery through provider networks and MCOs using utilization, pricing and payment strategies to benefit injured workers and employers.

The division's responsibilities include:

- Developing, maintaining and executing a quality and cost-effective medical, vocational rehabilitation and pharmaceutical benefits plan;
- Developing and supporting appropriate managed care processes, including contract management and training;
- Establishing and maintaining a quality pool of medical and vocational service providers to ensure injured workers' access to quality, cost-effective, timely delivery of care;
- Evaluating and processing medical bills, ensuring proper and timely payment consistent with the benefits plan design criteria.

Benefits plan design

To ensure injured workers have access to prompt, high-quality, cost-effective care, the division established an appropriate benefits plan and terms of service with competitive fee schedules to support the provider network.

Medical Services also is revising the benefits plan and corresponding fee schedules to improve medical, vocational rehabilitation and pharmaceutical services. For example, under the pharmacy benefits plan, the division expanded prior authorization drug categories to encompass drugs not typically used to treat workers' compensation injuries. In September 2008, it also made additional changes to limit coverage of certain drugs to their FDA-approved uses. These changes ensure injured worker safety and control spending. The division will institute annual reviews of the plan and fee schedules.

Additionally, on June 27, 2008, BWC's pharmacy consultant issued its final report after a comprehensive review of BWC's pharmacy benefits delivery program. Medical Services will institute reforms, including formalizing and centralizing pharmacy program management, and increasing the number of pharmacies the pharmacy benefits manager (PBM) audits. Further, BWC will use the results of the report to improve the request for proposal for a PBM.

Managed-care processes

The 2008 MCO contract achieved several strategic objectives.

1. A greater portion, 50 percent, of the MCO payment is performance based.
2. The total amount available for payment is fixed, which eliminates the uncertainty and variability of premium-based payment.
3. BWC negotiated an opener in the contract that allows the bureau to renegotiate the contract when it institutes material rule changes. BWC will continue requiring MCO-automated data capture to develop improved performance measures.

Medical Services will complete its comprehensive review and revise the treatment authorization processes, including:

- Completing the Disability Evaluator Panel process analysis and beginning process reform;
- Implementing comprehensive alternative dispute resolution reform;
- Implementing vocational rehabilitation redesign recommendations;
- Streamlining allowed condition determination;
- Creating Ohio-specific disability duration guidelines.

Medical providers

Medical Services is partnering with the Infrastructure and Technology Division (IT) to replace its provider enrollment system. The system maintains provider demographic information, certification, credentialing and billing support services. The divisions will complete full system installation and refinement in 2009 and 2010.

The Medical Services and Communications divisions have implemented a revised provider communication plan, including a new Web offering for medical providers for education and orientation, and physician information packets delivered with provider notice of certification. Medical Services will continue to improve its provider communications and training processes for new and existing providers.

The division also will complete an analysis to determine provider access-to-care levels. This will offer direction for the division's recruitment and retention efforts.

Medical Services will survey providers to identify plans for Workers' Compensation University, and other outreach and educational programs. The division also will identify unnecessary barriers to participating providers.

Finally, Medical Services will identify and institute provider performance measures and noncompliance reforms.

Medical bill payment

Medical Services implemented the Medical Bill Payment Clinical Editing program June 30, 2008. The program allows BWC to identify improperly billed services, enforce billing standards, identify MCO bill payment effectiveness and ensure bill processing consistency. It also provides data capture functionality necessary to help identify utilization outliers.

For inpatient hospital payments, the division implemented Medicare Severity DRGs (MS-DRGs), which were effective for inpatient hospital discharge dates of Jan. 1, 2008, and later. MS-DRG implementation improved medical cost containment and industry billing standardization.

Medical Services also has developed an alternative outlier methodology that will further enhance BWC's inpatient hospital cost-containment efforts. The division will further conduct a cost and feasibility study on implementing an ambulatory procedure classification reimbursement methodology for outpatient hospital services.

In 2008, IT and Medical Services developed a request for proposal for the medical bill payment and managed-care systems vendor. The request for proposal outcome will yield an improved cost-benefit ratio and support upcoming provider payment reforms, including direct provider payment.

The following pages highlight specific HPP measurements.

Selected HPP measurements

All dollar amounts shown in 1,000s.

The figures shown below are limited to the HPP.

Measurement	Time period 7/1/04 to 12/31/04	Time period 1/1/05 to 6/30/05	Time period 7/1/05to 12/31/05	Time period 1/1/06 to 6/30/06	Time period 7/1/06 to 12/31/06	Time period 1/1/07 to 6/30/07	Time period 7/1/07 to 12/31/07	Time period 1/1/08 to 6/30/08
Active employers (1)	251,960	253,247	252,440	252,433	251,591	244,973	238,900	238,064
Active claims (2)	384,861	373,860	367,773	343,128	332,104	319,974	307,572	294,683
FROI timing (3)	19.57	18.89	16.72	18.30	16.19	16.83	16.00	17.15
% of FROIs filed within 7 days of date of injury (4)	66.66%	69.51%	71.78%	73.25%	73.17%	73.84%	74.23%	74.44%
% of claims determined within 14 days of date of injury (5)	64.49%	63.57%	68.29%	67.29%	68.25%	70.55%	69.19%	70.29%
Bill timing (6)	86.98	88.83	81.99	81.95	80.53	80.60	83.27	83.35
LDOS–MCO	72.05	74.43	66.94	67.20	65.76	65.97	67.72	68.63
MCO–BWC	6.43	6.03	6.63	6.41	6.32	6.26	7.10	6.10
BWC–MCO	7.25	7.12	7.18	7.09	7.20	7.12	7.20	7.38
MCO–Provider	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25
Total regular (7) medical payments	$425,292	$448,005	$413,805	$407,462	$379,926	$385,381	$388,302	$427,933
Payments (8) for file reviews and IMEs	$8,416	$9,297	$9,753	$10,191	$10,381	$9,873	$9,452	$10,145
MCO fees (9)	$83,604	$87,385	$83,754	$89,068	$84,588	$88,551	$77,328	$90,999
Total medical payments plus MCO fees	$517,312	$544,687	$507,312	$506,721	$474,896	$483,805	$475,082	$529,077
Total indemnity payments (10)	$541,130	$529,828	$530,231	$543,163	$550,011	$592,531	$610,727	$598,066
GRAND TOTAL Benefits paid (Total medical payments plus MCO fees plus total indemnity payments)	$1,050,026	$1,065,218	$1,027,790	$1,039,693	$1,014,525	$1,066,463	$1,076,357	$1,116,998

(1) Average number of employers in an active, reinstated or debtor in possession status assigned to an MCO during the timeframes noted

(2) Average number of active claims (claims with a payment or application submitted to BWC within the last 13 months) assigned to an MCO during the timeframes noted

(3) Average time, in calendar days, from date of injury to date BWC received a FROI for all FROIs received during the timeframes noted for claims assigned to an MCO

(4) Percent of claims assigned to an MCO where BWC receipt of the FROI is within seven calendar days from the date of injury where FROI was received during the timeframes noted

(5) Percent of claims assigned to an MCO that were determined within 14 calendar days of the date of injury where the determination was during the periods indicated regardless of date of injury or filing date. A claim is considered determined when it is placed in Allow/Appeal or Disallow/Appeal status.

(6) Average time, in calendar days, between the last date of service being billed (LDOS) to a check being issued to the provider for bills processed by the MCOs. This does not include bills for prescription drugs processed through the PBM. It is further broken down into the component steps of the process: LDOS to MCO receipt, MCO receipt (for review and payment determination) to BWC receipt, BWC receipt (for review and final payment determination) to date monies are deposited into the MCO's provider account, and MCO receipt of the final payment information and monies to the MCO issuing the check to the provider. Note: The 1.25 days average for MCOs to issue the check to the provider was based on on-site audits conducted at the MCOs several years ago. BWC is currently conducting a desk audit to calculate the current check issuance timing.

(7) Payments for medical services made on claims assigned to an MCO during the timeframes noted. Amounts include payments on claims associated with bankrupt self-insured claims assigned to the MCOs and payments for prescription drugs processed through the PBM. Regular denotes this category includes payments for physicians, hospitals, therapies, diagnostic testing, etc. It excludes payments made for file reviews and independent medical examinations (IMEs) that are requested to facilitate administrative decisions in the claim.

(8) This category includes payments made for file reviews and IMEs during the time frames noted that are requested to facilitate administrative decisions in the claim.

(9) Payments issued to the MCOs during the time frames noted per the MCO Agreement for their services. MCO contracts are based on calendar years. Fluctuations in the amounts paid to the MCOs between six-month periods are attributable to several factors: 1) changes in the overall amount available to the MCOs from year to year; 2) timing of different types of payments (administrative payments are monthly, outcome payments are quarterly; and, in the past, exceptional performance payments were made annually); 3) change in 2008 where MCOs were "pre-paid" a portion of their outcome payment throughout the quarter. Some payments were made after the end of the contract. For example, the 2004 exceptional performance payment was made in February 2005. The increase of Jan. 1 to June 30, 2008, is due to the introduction of pre-payment of outcome monies.

(10) Payments for salary compensation made on claims assigned to an MCO during the time frames noted: temporary total, living maintenance, wage loss, lump sum settlements, etc. Amounts include payments on claims associated with bankrupt self-insured claims assigned to the MCOs.