

**Common Sense Business Regulation (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

**Rule 4123-6-37.2**

**Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: O.R.C. 4121.441(A)(8); O.R.C. 4123.66

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The rule adopts a discounted hospital outpatient reimbursement methodology based on Medicare’s “Outpatient Prospective Payment System” or “OPPS” methodology, in accordance with O.R.C. 4121.441(A)(8) and *Ohio Hosp. Assn. v. Ohio Bur. of Workers’ Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499.

3.  Existing federal regulation alone does not adequately regulate the subject matter.

4.  The rule is effective, consistent and efficient.

5.  The rule is not duplicative of rules already in existence.

6.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

7.  The rule has been reviewed for unintended negative consequences.

8.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: BWC presented the initial recommendations to the Ohio Hospital Association in July with up meeting in September; BWC presented the methodology to the MCO League and the MCO Business Council in August; and the self-insured division of BWC was presented with the methodology in September. The rule was available for review and public comment on BWC’s Web site from November 24 through December 4, 2009.

9.  The rule was reviewed for clarity and for easy comprehension.

10.  The rule promotes transparency and predictability of regulatory activity.

11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**BWC Board of Directors  
Executive Summary  
BWC Hospital Outpatient Services  
Payment Rule**

## **Introduction**

The Health Partnership Program (HPP) rules were first promulgated in 1996, prior to the implementation of the HPP in 1997. HPP rules establishing criteria for the payment of various specific medical services were subsequently adopted in February 1997.

Ohio Administrative Code 4123-6-37, initially adopted February 12, 1997 and amended March 1, 2004, provides general criteria for the payment of hospital services under the HPP. Ohio Administrative Code 4123-6-37.2 provides specific methodology for the payment of hospital outpatient services. It was initially adopted effective September 1, 2007, and has not been amended since.

## **Background Law**

R.C. 4123.66(A) provides that the BWC Administrator “shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper,” and that the Administrator “may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor.”

R.C. 4121.441(A)(8) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP “to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies” to injured workers, including but not limited to rules regarding “[d]iscounted pricing for all . . . out-patient medical services.”

Pursuant to the 10<sup>th</sup> District Court of Appeals decision in *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499, BWC is required to adopt changes to its methodology for the payment of hospital outpatient services via the O.R.C. Chapter 119 rulemaking process.

## **Proposed Changes**

BWC’s current hospital outpatient services reimbursement rule is based on a cost-plus methodology with a cap, utilizing outpatient cost-to-charge ratios (CCR) from Ohio Medicaid as the basis for determining the cost of hospital outpatient services.

BWC is proposing to move from this retrospective cost-plus reimbursement methodology to a prospective payment methodology for hospital outpatient services for 2010, based on a modified version of Medicare’s Outpatient Prospective Payment System (OPPS).

As more fully set forth in the accompanying document “BWC 2010 Proposed Hospital Outpatient Fee Summary,” for hospital outpatient services with a date of service on or after May 1, 2010, BWC is recommending the following changes to OAC 4123-6-37.2:

1. Adoption of a modified OPSS methodology for hospital outpatient reimbursement methodology;
2. Adoption of payment adjustment factors to be used with modified OPSS;
3. Modification to OPSS “hold harmless” calculation;
4. Modification to payment for children’s hospitals.

## **Stakeholder Involvement**

BWC presented the initial recommendations to the Ohio Hospital Association in July with up meeting in September; BWC presented the methodology to the MCO League and the MCO Business Council in August; and the self-insured division of BWC was presented with the methodology in September. The rule was available for review and public comment on BWC’s Web site from November 24 through December 4, 2009.

## **4123-6-37.2 Payment of hospital outpatient services.**

### **(A) HPP:**

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital outpatient services with a date of service of May 1, 2010 or after shall be as follows:

(1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services shall be equal to the applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered, multiplied by a bureau-specific payment adjustment factor, which shall be 2.53 for children's hospitals and ~~4.89~~ 1.97 for all hospitals other than children's hospitals.

(a) The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered shall be utilized to process bills for hospital outpatient services under this rule; however, the outpatient code edits identified in table 1 of appendix A of this rule shall not be applied.

(b) The annual medicare outpatient prospective payment system outlier reconciliation process shall not be applied to payments for hospital outpatient services under this rule.

(c) For purposes of this rule, hospitals shall be identified as "children's hospitals," "critical access hospitals," "rural sole community hospitals," "essential access community hospitals" and "exempt cancer hospitals" based on the hospitals' designation in the medicare outpatient provider specific file in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered.

(2) Services reimbursed via fee schedule. These services shall not be wage index adjusted.

(a) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall be applied.

(i) Except as otherwise provided in paragraphs (A)(2)(b)(ii) and (A)(2)(b)(iii) of this rule, hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system shall be reimbursed under the applicable medicare fee schedule in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered.

(b) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall not be applied.

(i) Hospital outpatient vocational rehabilitation services for which the bureau has established a fee, which shall be reimbursed in accordance with table 2 of appendix A of this rule.

(ii) Hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system that the bureau has determined shall be reimbursed at a rate other than the applicable medicare fee schedule in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered, which shall be reimbursed in accordance with table 3 of appendix A of this rule

(iii) Hospital outpatient services not reimbursed under the medicare outpatient prospective payment system that the bureau has determined are necessary for treatment of injured workers, which shall be reimbursed in accordance with tables 4 and 5 of appendix A of this rule.

(3) Services reimbursed at reasonable cost. To calculate reasonable cost, the line item charge shall be multiplied by the hospital's outpatient cost to charge ratio from the medicare outpatient provider specific file in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered. These services shall not be wage index adjusted.

(a) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall be applied.

(i) Critical access hospitals shall be reimbursed at one hundred and one per cent of reasonable cost for all payable line items.

(b) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall not be applied.

(i) Services designated as "inpatient only" under the medicare outpatient prospective payment system.

(ii) Hospital outpatient services reimbursed at reasonable cost as identified in tables 3 and 4 of appendix A of this rule.

(4) Add-on payments calculated using the applicable medicare outpatient prospective payment system methodology and formula in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered. These add-on payments shall be calculated prior to application of the bureau-specific payment adjustment factor.

(a) Outlier add-on payment. An outlier add-on payment shall be provided on a line item basis for partial hospitalization services and for ambulatory payment classification (APC) reimbursed services for all hospitals other than critical access hospitals.

(b) Rural hospital add-on payment. A rural hospital add-on payment shall be provided on a line item basis for rural sole community hospitals, including essential access community hospitals; however, drugs, biological, devices reimbursed via pass-through and reasonable cost items shall be excluded. The rural add-on payment shall be calculated prior to the outlier add-on payment calculation.

(c) Hold harmless add-on payment. A hold harmless add-on payment shall be provided on a line item basis to exempt cancer centers and children's hospitals. The hold harmless add-on payment shall be calculated after the outlier add-on payment calculation.

(5) Providers without a medicare provider number.

(a) Providers without a medicare provider number shall be reimbursed for hospital outpatient services at ~~thirty-eight~~ forty-seven per cent of billed charges for all payable line items.

(6) For purposes of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system " and the "medicare outpatient prospective payment system " shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 419 as published in the October 1, 2009 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 410, 416, and 419 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule" 74 Fed. Reg. 60315 - 61012 (2009).

(B) QHP or self-insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital outpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule; or

(2)(a) For Ohio hospitals that annually report a total outpatient cost-to-charge ratio to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio as set forth below plus sixteen percentage points, not to exceed sixty percent of the hospital's allowed billed charges.

To assist QHPs and self-insuring employers in determining reimbursement under this paragraph, the bureau shall make available to QHPs and self-insuring employer the hospital's most recently reported cost-to-charge ratio not later than thirty days following the bureau's receipt of the hospital's most recently reported cost-to-charge ratio from Ohio medicaid.

(b) For Ohio hospitals that do not annually report a total outpatient cost-to-charge ratio to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to fifty-six percent of the hospital's allowed billed charges; or

(3) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Effective: 05/01/2010

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 9/1/07



**Bureau of Workers' Compensation**

Governor **Ted Strickland**  
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**Stakeholder feedback and recommendations for changes to the BWC Ambulatory Surgical Center Fee Schedule - O.A.C. 4123-6-373**

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	Surgical implant reimbursement	Arkansas Best Corporation	Addressing surgical implant reimbursement. The recommendation is a "cost plus" formula (usually cost + 10% or cost + 15%, as high as cost + 25%). Such a formula makes sure that the facility recoups its cost and makes a little extra for administrative efforts.	Implants run from \$370 all the way up to the sky, so a small profit percentage can end up being a very large profit. Some states set a \$1,000 profit limit to avoid craziness.	BWC understands the stakeholder's comment. However, the cost of surgical implants are part of the orthopedic services reimbursement rates, and as such orthopedic services are projected to increase approximately 20 percent. Further, if BWC were to apply a cost plus formula for implants in addition to the surgical rate, then BWC would in essence be reimbursing twice for the device. At this time BWC has determined that BWC's recommendation is appropriate to ensure access to quality care for Ohio's injured workers.	BWC will maintains the current recommendation as proposed.
2	General Comment	Ohio Association of Ambulatory Surgical Centers	<b>(1)</b> Increasing BWC reimbursement percent of Medicare payment above 100% <b>(2)</b> Reimbursement rates for implant intensive procedures <b>(3)</b> Reimbursement for pain management <b>(4)</b> Greater access to surgical options for Injured workers	<b>(1)</b> Medicare payments are some of the lowest received by ASCs <b>(2)</b> Bundling of expensive implants into the surgical procedure <b>(3)</b> States BWC reimbursement will only cover 71% of actual costs <b>(4)</b> Comparison of other states indicates Ohio reimburses less than several other state workers compensation systems (Texas, California, Florida and Illinois)	BWC evaluation concluded that the recommendation is appropriate to ensure access to quality care. Based on the mix of services provided to injured workers during the April-June 2009 there is a projected rate increase of 20 percent for orthopedic services and a 10 percent increase for other services under the 2010 ASC PPS rates.	BWC will maintain the current recommendation as proposed
4	General Comment	Aetna Inc.	No rule change suggestions or recommendations			

# **BWC 2010 Proposed Hospital Outpatient Fees**

## **Medical Services Enhancements**

Prompt, effective medical care makes a big difference for those injured on the job. It is often the key to a quicker recovery and timely return-to-work and quality of life for injured workers. Thus, maintaining a network of dependable medical and vocational rehabilitation service providers ensures injured workers get the prompt care they need. Maintaining a network of hospitals to provide appropriate care is an important element to ensure the best possible recoveries from workplace injuries. It also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical necessity. It facilitates faster recovery and a prompt, safe return to work.

The Medical Services Division has focused on improving its core medical services functions. Our goals are as follows: enhance our medical provider network, establish a better benefits plan, institute an updated and competitive provider fee schedule, improve our managed care processes, and establish excellent medical bill payment services.

## **Hospital Outpatient Fee Schedule**

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. An appropriate outpatient fee schedule is integral to assuring that injured workers are receiving quality care so that they may achieve the best possible recovery from their injuries. Hospital outpatient bills represent about seven percent of the bills BWC processes annually; and about seventeen percent of BWC's overall medical expenses. Hospital outpatient services include emergency department visits which may be the first treatment following an injury; as well as surgery or rehabilitation services intended to return the injured worker to employment. BWC hospital outpatient fee schedule rule was last updated September 1, 2007.

The current methodology is based on a cost-plus methodology with a cap. BWC, in this methodology, utilizes outpatient cost-to-charge ratios (CCR) from Medicaid as the basis for determining the cost of hospital outpatient services. BWC then adds sixteen percentage points to the facility CCR in order to determine the hospital specific payment level. Allowed charges are then multiplied by the CCR plus sixteen percentage points to determine the reimbursement rate. The cap utilized is that the CCR plus sixteen percentage points cannot exceed .60 or sixty percent of allowed billed charges.

The current retrospective cost-based methodology presents a number of challenges for BWC and the workers' compensation system. One key challenge BWC has had to manage is that of not knowing the actual reimbursement rate for an individual service until after the service is rendered to the patient. There is also the disparity in payments among providers, as the operation of the formula generally results in a payment rate for a given service which is neither equitable nor consistent among providers. Additionally, it is difficult to predict expenditures for a benefit period, as the current methodology does not limit charge increases by provider from one benefit period to the next. Lastly, the current system does not encourage facilities to improve their cost structure, given that as particular facilities' cost of providing a service increases as represented by the facility charge, so does the BWC reimbursement rate.

### **2010 Proposed Hospital Outpatient Fee Schedule Recommendation**

BWC is proposing to move from a retrospective cost plus reimbursement methodology to a prospective payment methodology for hospital outpatient services for 2010. Moving to a prospective payment system will address the current fee reimbursement challenges discussed above.

Under a prospective payment system, rates and policies are established in advance and remain constant during the effective period. This characteristic of prospective payment will assist BWC with the key challenge of not knowing rates prior to the delivery of services. Through resolution of this challenge BWC will also be better position to address the additional challenges of the current outpatient hospital rate setting methodology.

As stated under a prospective payment system, rates and policies are established in advance and remain constant during the effective period. A benefit of this characteristic is that all facilities will receive consistent and equitable payments for services during the effective period. Consistent and equitable payments prevent one facility from receiving a reimbursement rate double or even triple that of another facility for the same medical service.

Under the proposed methodology, the Outpatient Prospective Payment System, a wage index adjustment is built into the reimbursement rate. This allows facilities located in a geographical area with a greater wage level to receive a slightly higher reimbursement rate to account for the wage level differences from the national average wage. Utilizing the wage index adjustment ensures that equitable payments are provided and that a provider in a geographical area with higher wage levels is not penalized for costs that are out of the facility's arm of control. Geographical areas are derived from the Core-Based Statistical Areas (CBSAs)

established by the Office of Management and Budget in December 2003. Wage index values are updated yearly as required by the Social Security Act.

Under the prospective methodology, BWC would know prior to a service being rendered the reimbursement amount for that service, which will assist BWC with estimating hospital outpatient expenditures from year to year. BWC will be able to determine rate increases or decreases at various levels, even down to the procedure code level, from one effective period to another. Further, with the aid of historic data from the BWC data warehouse, BWC can examine the utilization rate of classifications of services such as emergency department visits, clinic visits, x-rays and MRIs. BWC, with this data will be able to better estimate hospital outpatient expenditures from year to year.

Lastly, under a prospective payment system providers are encouraged to practice cost containment. Rates are established in advance, which provides facilities the data they can use to determine the best mix of their resources to achieve established budget goals without foregoing the provision of quality services.

### ***Recommended Prospective Payment System***

BWC's recommendation is to adopt a modified version of the Outpatient Prospective Payment System (OPPS) that is currently utilized by The Centers for Medicare and Medicaid Services (CMS). Under the proposed methodology and rate modification the aggregate payments for hospital outpatient services are projected to decrease by twenty-two percent. For services May 1, 2010 and after, the Medical Services Division is recommending the following changes:

1. Adoption of a modified OPPS methodology for hospital outpatient reimbursement methodology
2. Adoption of payment adjustment factors to be used with modified OPPS
3. Modification to OPPS Hold Harmless calculation
4. Modification to payment for Children's Hospitals
5. Modification to billing protocol

#### **1. Proposed Adoption of a modified OPPS methodology**

The CMS OPPS is a prospective payment system that provides payments for hospital outpatient services. Types of services under OPPS include emergency department visits, clinic visits, hospital outpatient surgery, laboratory services, physical and occupational therapy and radiology services. The system utilizes four different reimbursement methodologies:

ambulatory payment classifications (APCs), fee schedule, average sale price and reasonable cost. It is important to note that the use of reasonable cost is limited as it is a retrospective methodology.

BWC believes that the empirical research along with the continued evaluation and maintenance of OPSS provides a solid foundation upon which BWC can build its hospital outpatient methodology. The OPSS is one of the most evaluated and debated reimbursement systems. Each year the provider community, device and drug manufacturer community, and healthcare community have the opportunity to comment on OPSS during CMS' rule making process. Additionally, the Ambulatory Payment Classification (APC) Panel provides recommendations to CMS. Similarly, MedPAC (Medicare Payment Advisory Commission) provides comments and recommendations to both Congress and CMS regarding this OPSS, including its administration and adequacy.

One of the key features of OPSS is that it is a partially packaged system; meaning that some services, supplies or procedures are separately payable and some are packaged or bundled. A partially packaged system allows for adequate payment rates in a healthcare setting where there is wide variation in treatment pathways and resource consumption. For example, there is considerable variation in emergency department visits, even for similar medical conditions. Therefore, a general emergency department visit level payment is provided in addition to payment for ancillary procedures that may be medically necessary such as an x-ray, administration of pain medication, or electrocardiogram. This type of system is preferred over a case rate system where one reimbursement rate is provided for an emergency department visit regardless of the utilization of ancillary procedures which could result in large profits or large losses depending on the case. Therefore, OPSS provides a more adequate payment for hospital outpatient services.

Under OPSS there are adjustments and provisions that have been adopted by CMS over the systems nine year history. Some of the adjustments and provisions were mandated by law and others were added based on CMS research. BWC is proposing to adopt the majority of the adjustments and provisions. The formula for the hold harmless adjustment will be modified and is discussed in detail in section 3 of this document.

A valuable provision of OPSS is the high cost outlier provision. The high cost outlier provision examines the cost of providing service at the procedure code level. Therefore, if the cost of providing a given service meets the outlier provision requirements so that it is deemed significant, then an add-on outlier amount will be added to the reimbursement level for that service. This allows adequate payment for services that are very high cost but are medically necessary for the treatment of injured workers.

Another provision of the system is the rural hospital adjustment. This provision is a result of the Medicare Modernization Act of 2003 (MMA). The law required the CMS perform an analysis to determine if the cost of providing care by rural facilities was significantly different from other facilities, specifically urban facilities. The results of this study brought about the rural hospital adjustment in 2006. Rural sole community hospitals (SCHs) which includes essential access community hospitals (EACHs) receive a 7.1 percent adjustment to eligible services (cost based and fee schedule services are excluded).

Once all provisions and adjustments are taken into consideration the basic reimbursement formula is the OPSS rate times the BWC established payment adjustment factor. The proposed payment adjustment factors are discussed below in section 2, *Proposed Adoption of Payment Adjustment Factors*. BWC will utilize the OPSS Outpatient Code Editor (OCE) which edits and groups line items from the bill into the appropriate reimbursement categories (APC, fee schedule, average sale price, and reasonable cost). Based on this categorization, the BWC designed pricing system will apply the payment adjustment factor appropriate for the type of facility rendering the services.

While, OPSS does provide a solid foundation for BWC's methodology, there are some modifications which will be required. BWC will add necessary Ohio workers compensation components to the payment system, such as fee schedule payment for vocational rehabilitation services; given such services are not included in the base system as they are not utilized or covered for Medicare beneficiaries under Medicare.

Several other workers' compensation jurisdictions (Texas, South Carolina, California, North Dakota, Tennessee, Washington, and West Virginia) have adopted a version of the OPSS. Administration and level of payment vary among the states.

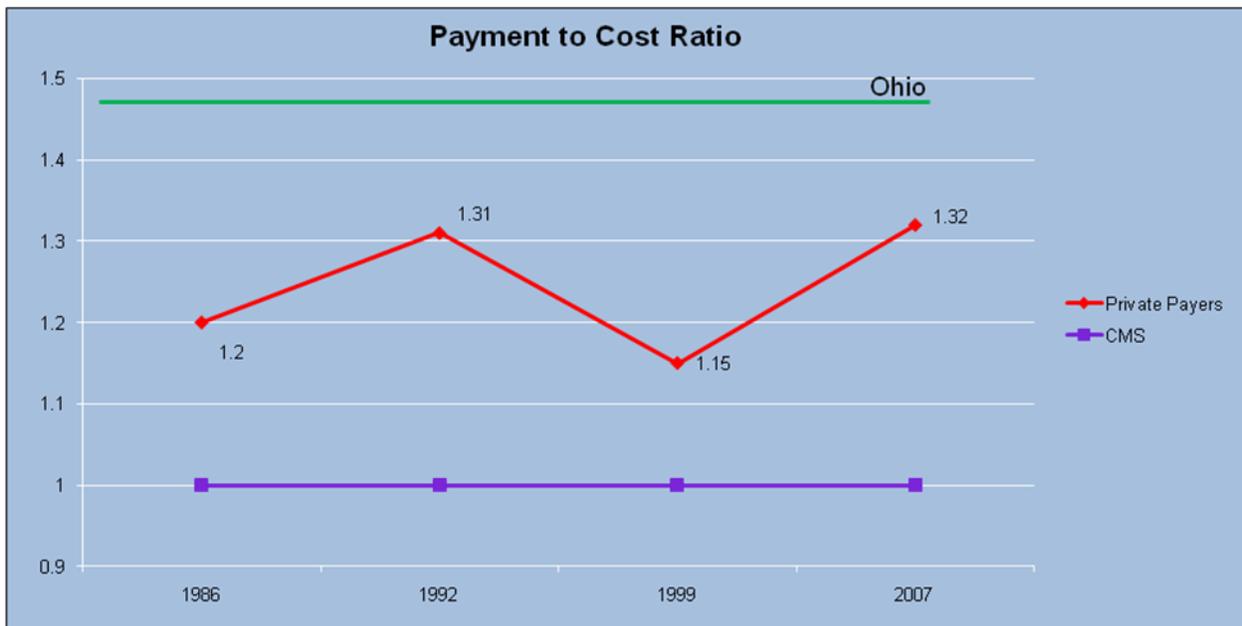
## **2. Proposed Adoption of Payment Adjustment Factors**

There are four reimbursement methodologies utilized within the OPSS: ambulatory payment classifications, fee schedules, reasonable cost and average sale price. Since this is a prospective payment system the use of the reasonable cost methodology is limited. Ambulatory payment classifications (APCs) are groups of clinically similar procedures or services with similar resource consumption. Therefore, the reimbursement rate for APCs and fee schedule items is based on the average resource consumption to provide the service, procedure, test or supply. CMS rates are calculated to reimbursement facilities at 100% of allowed CMS cost.

BWC has set reimbursement considering industry standards, relevant publications, and what we believe will ensure achievement of the guiding principle of injured workers' access to quality care. A key consideration data point was taken from MedPAC's Report to Congress: Medicare

Payment Policy submitted March 2009. Figure 2A-6 – *Three distinct periods in the private payer payment-to-cost ratio*, provides a view of private payer rate levels over the past twenty years. The source for this figure is the MedPAC analysis of data from the American Hospital Association annual survey of hospitals. Although workers compensation is most often categorized as a government payer, it is beneficial to compare reimbursement rates with private payers when the opportunity arises as private payer rates are not often published for public comparison. Figure 2A-6 provides the private payer-to-cost ratios from 1987 to 2007. During this twenty year period there are three distinct periods resulting in a hill and valley effect. In 1987 the payment-to-cost ratio was 1.2, meaning that on average reimbursement rates equaled 120% of the hospital cost for inpatient and outpatient services. The ratio continued to rise through 1992 when the ratio equaled 1.31. Then a shift occurred and the rate decreases to 1.15 in 1999. They once again, rates began to rise and ended at 1.32 in 2007. As part of our rate setting methodology, BWC performed a financial analysis of 2008 hospital outpatient bills. The payment-to-cost ratio for BWC in 2008 was 1.46 or 146% of cost. When comparing BWC hospital outpatient payment-to-cost ratio to this private payer data it is easy to see that BWC currently has reimbursement rates much higher than the national private payer market. Figure one shows the data from MedPACs Figure 2A-6 along with the Medicare payment-to-cost ratio of 1.0 and BWC’s current payment-to-cost ratio of 1.46.

**Figure 1.**



BWC is proposing to adopt a payment adjustment factor of 166% of the OPSS rate as outlined in the fee rule. At this payment level BWC will reimbursement facilities, on average, at 114% of cost just below the national private payer payment-to-cost ratio at its lowest point but yet significantly higher than the current Medicare rate.

Adopting the proposed methodology and payment adjustment factor is projected to result in a decrease of 22% in outpatient reimbursement. While the recommended change in reimbursement methodology will add value to Ohio's workers compensation system, BWC acknowledges that the potential impact of the changes on Providers. Thus, to assist Providers in adjusting to the new payment methodology, BWC is proposing a two year transition plan to phase in the recommended 166% payment adjustment factor.

In year one of the transition (2010) the proposed payment adjustment factor would be 189% of the OPSS rate for hospitals other than Children's Hospitals. For year two of the transition plan (2011) the proposed payment adjustment factor would be 166% of the OPSS rate for hospitals other than Children's Hospitals. The special considerations and payment adjustment factor for Children's Hospitals are discussed in section 4, *Modification to Payment for Children's Hospitals*.

Figure two shows the data from MedPACs Figure 2A-6 along with the Medicare payment-to-cost ratio of 1.0 and BWC's estimated payment-to-cost ratios under the adoption of a BWC modified OPSS during its proposed transition period.

**Figure 2.**



### **3. Modification to the Hold Harmless Provision**

During implementation of the OPSS, CMS provided a transitional period to assist facilities with the migration from cost based payment to prospective payment. The transition period has expired. However, one component of the transition period has become a permanent provision of the system and is called the hold harmless provision. Under this provision, the IPPS exempt cancer centers and IPPS exempt children's hospitals are permanently held harmless; meaning that their current payments cannot be less than the rate that would have been paid prior to the implementation of OPSS by CMS in August 2000. Currently, there is one IPPS exempt cancer center in the state of Ohio and four Children's Hospitals.

Under the CMS version of OPSS, the hold harmless add-on payment is calculated quarterly with reconciliation at year end. However, under BWC regulations all payments must be made at the bill level. Therefore, we have taken the intent of the hold harmless provision and applied it at the bill level. Using the 1996 payment to cost ratio for facilities that qualify for this provision (The James Cancer Center and Children's Hospitals) BWC will calculate the add-on hold harmless payment and apply this in addition to the APC payments received under OPSS. Although BWC is deviating from the exact formula used by CMS, we believe we have captured the intent of the provision and are administering the payment at the appropriate level.

### **4. Modification to Payment for Children's Hospitals**

There are four Children's Hospitals that treated BWC injured workers during 2008. In total for 2008 these encounters represent .11% of the total encounters, .13% of the total charges, and .16% of total reimbursements. Even though these services represent a very small portion of the total hospital outpatient services, the care that these facilities provide are critical. These facilities normally provide service for BWC injured workers with burn care treatments.

Financial analysis showed that reimbursing Children's Hospitals at 166% of the OPSS rate would not adequately reimbursement facilities for their outpatient services. Therefore, BWC is proposing to address this impact by recommending a payment adjustment factor of 253% for Children's Hospitals. This rate will allow the facilities to receive the same level of reimbursement that they receive today under BWC's cost plus reimbursement methodology. *Please note as stated above the OPSS rate for Children's Hospitals also includes the hold harmless add-on payment as discussed above in section 3, Modification to the Hold Harmless Provision.*

### **5. Modification to Billing Protocols**

In order to administer a modified OPSS, BWC must revise some of the current billing protocols. For example, BWC must allow the use of modifiers, modify revenue code usage, allow for HCPCS Level II codes to be reported, and revisit duplicate bill logic. Therefore, as part of this

update to the hospital outpatient reimbursement methodology revision, BWC will revise billing protocols as well. BWC will align with national billing standards thus eliminating current “BWC only” billing regulations.

## **Lessons Learned from Inpatient Hospital Services Reform**

In January 2007, BWC moved from a retrospective cost-based reimbursement methodology to a prospective reimbursement methodology with the implementation of a modified version of CMS’ Inpatient Prospective Payment System (IPPS). This system is most often known by the name DRGs which is the classification system (Diagnosis Related Groups) used as the foundation of the system. For many of the same reasons as stated on this summary, BWC chose to move to prospective payment – i.e. eliminate disparity in payments, encourage cost containment, better estimation of expenditures. Over the past three years, BWC has achieved these goals and has been able to enhance their study of inpatient hospital services.

Although, BWC has realized the goals of the move to IPPS, there were challenges along the way. BWC learned from these challenges, and has incorporated that learning in outlining the OPSS Implementation Plan’s tasks. The result is a 17-month OPSS implementation plan which includes participation from all areas of Medical Services. The OPSS team has aggressively engage MCOs in training and education for the methodology change.

## **Projected Impacts and Outcomes**

With the reimbursement methodology change of this proposed rule, BWC is adjusting hospital outpatient rates to be more in alignment with commercial payers. The projected impact is an overall payment decrease of 22% or approximately \$30 million. The recommended two year transition plan is estimated to allow half, \$15 million, of the impact to occur in year one (2010) and the second half, \$15 million, to occur in year two (2012). Please note that the projected impact is based on 2008 data modeled under the 2009 OPSS rates. Actual changes in hospital cost, injured worker utilization or hospital outpatient services and OPSS rates will modify the realized impact of the implementation of this payment methodology.

The recommended changes will improve consistency in reimbursement rates among facilities. The predictability of reimbursements from year to year will be improved; thus, aiding in rate setting and stability in medical cost experiences of the system. Further, the recommendation will align all BWC fee reimbursement schedules to a prospective payment approach.

## BWC 2010 Proposed Hospital Outpatient Fees (Addendum)

### Revised Payment Adjustment Factor Recommendation

Subsequent to the initial submitted recommendation, BWC on January 12' 2010 received a written response from the Ohio Hospital Association (OHA) regarding the recommendations. In the letter, OHA reiterated many of the concerns the association presented in previous correspondence. Further, OHA indicated that it appreciated BWC's attempt to soften the blow by the transition plan BWC proposed. OHA goes on to further indicate that when CMS implemented the Medicare Outpatient Payment Perspective methodology, Medicare employed a three-year payment transition and that OHA was recommending that BWC extend the payment transition at least through it calendar year 2010 and 2011 periods. After further evaluating and considering the request by OHA, BWC is recommending modifying and extending the original recommendation from a 2 year transition plan to a 3 year transition plan with the following payment adjustment factor (PAF) changes:

<b>Option One: 3-Year Transition Plan with Ending Payment Adjustment Factor ending at 166% of OPPS Rate (-7.2%/-7.4%/-7%)</b>					
Year	Payment Adjustment Factor	Percent of BWC Cost	Percent of Allowed Billed Charges	Estimated Impact from Base Year	Total Percent Change in Reimbursement from Base Year
2010	197%	135%	46.9%	(\$ 10,234,846)	-7.2%
2011	181%	124%	43.2%	(\$ 10,621,261)	-14.6%
2012	166%	114%	39.6%	(\$ 9,957,431)	-21.6%

### ***Projected Impacts and Outcomes***

With the reimbursement methodology change of this proposed rule, BWC is adjusting hospital outpatient rates to be more in alignment with commercial payers. The projected impact with the above revision will still result in an overall payment decrease of 22% or approximately \$30 million. The revised recommended two year transition plan is estimated to allow the estimated impact to be more evenly dispersed over a 3 year period, see "Estimated Savings from Base Year, in chart above. Please note that the projected impact is based on 2008 data modeled under the 2009 OPPS rates. Actual changes in hospital cost, injured worker utilization or hospital outpatient services and OPPS rates will modify the realized impact of the implementation of this payment methodology.

The recommended changes will improve consistency in reimbursement rates among facilities. The predictability of reimbursements from year to year will be improved; thus, aiding in rate setting and stability in medical cost experiences of the system. Further, the recommendation will align all BWC fee reimbursement schedules to a prospective payment approach.

# Ohio BWC 2010 Hospital Outpatient Fee Methodology Proposal

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Anne Casto, Casto Consulting

January 21, 2009

# Introduction and Guiding Principles

- Legal Requirements For Fee Schedule Rule
- Proposed Time-line for Implementation
  - Stakeholder Feedback - July 29 - present
  - Board Presentation – December/January
  - Proposed to JCARR - February
  - Effective Date – May 1, 2010
- Guiding Principle:

Ensure access to high-quality medical care and vocational rehabilitation services by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical/vocational provider network

## Fee Schedule Methodology

- Evaluation of current hospital outpatient services and experiences, considering the need for modification to the reimbursement methodology and/or other policy changes
- Evaluation of the Centers for Medicare and Medicaid (CMS) Outpatient Prospective Payment System (OPPS) and 2010 updates
- Setting payment adjustment factor (payment rate) at the right level
- Develop payment adjustments that accurately reflect market, service, and patient cost differences

# Hospital Outpatient Services Experience

Hospital Outpatient History			
Year	Encounters	Allowed Charges	Reimbursement
2006	278,838	\$261,401,861	\$173,574,333
2007	266,713	\$237,401,671	\$171,881,391
2008	249,534	\$182,981,842	\$156,915,972

- Under the current cost-based system BWC reimbursed
  - 146% of cost
  - 212% of CMS rate

# Current Methodology

- Retrospective reimbursement methodology
  - Cost plus
    - Ohio Medicaid cost-to-charge ratio (CCR) plus 16 percentage points, not to exceed 60% of allowed billed charges
  - Ohio BWC incurs a significant risk by using this type of reimbursement methodology
    - As charges increase so does BWC reimbursement levels
      - No limit on % increase of charges per year
    - There is some protection with the use of a cap (60% allowed billed charges)

## Move to Prospective Payment

- Rates and policies are established in advance
- Rates remain constant during the effective period
- Impacts
  - Promotes predictability of payments
  - Promotes equity and consistency of payments
  - Rate increases are better controlled from year to year
    - Able to project financial impact
  - Encourages facilities to improve efficiency of providing care

# Outpatient Prospective Payment System (OPPS)

- Publically available system
  - Empirically sound
- CMS Prospective Payment System
  - Emergency department visits
  - Clinic visits
  - Hospital outpatient surgery
  - Ancillary services: radiology exams, laboratory tests, therapy visits
- Four reimbursement methodologies
  - Ambulatory payment classifications
    - Cornerstone of the payment system
  - Fee schedule
  - Average sale price
  - Reasonable cost

# Outpatient Prospective Payment System (OPPS)

- Partially packaged system
  - Allows treatment protocol and pathway flexibility required for the outpatient setting
- Well maintained system
  - Yearly maintenance with some components updated quarterly
- Adjustments
  - Wage index
- Provision
  - High cost outlier
  - Hold harmless
  - Rural hospital adjustment

## Other WC States Using CMS' OPPS Model

State	Payment Adjustment Factor
Washington	108% to 162%
California	122%
West Virginia	135%
South Carolina	140%

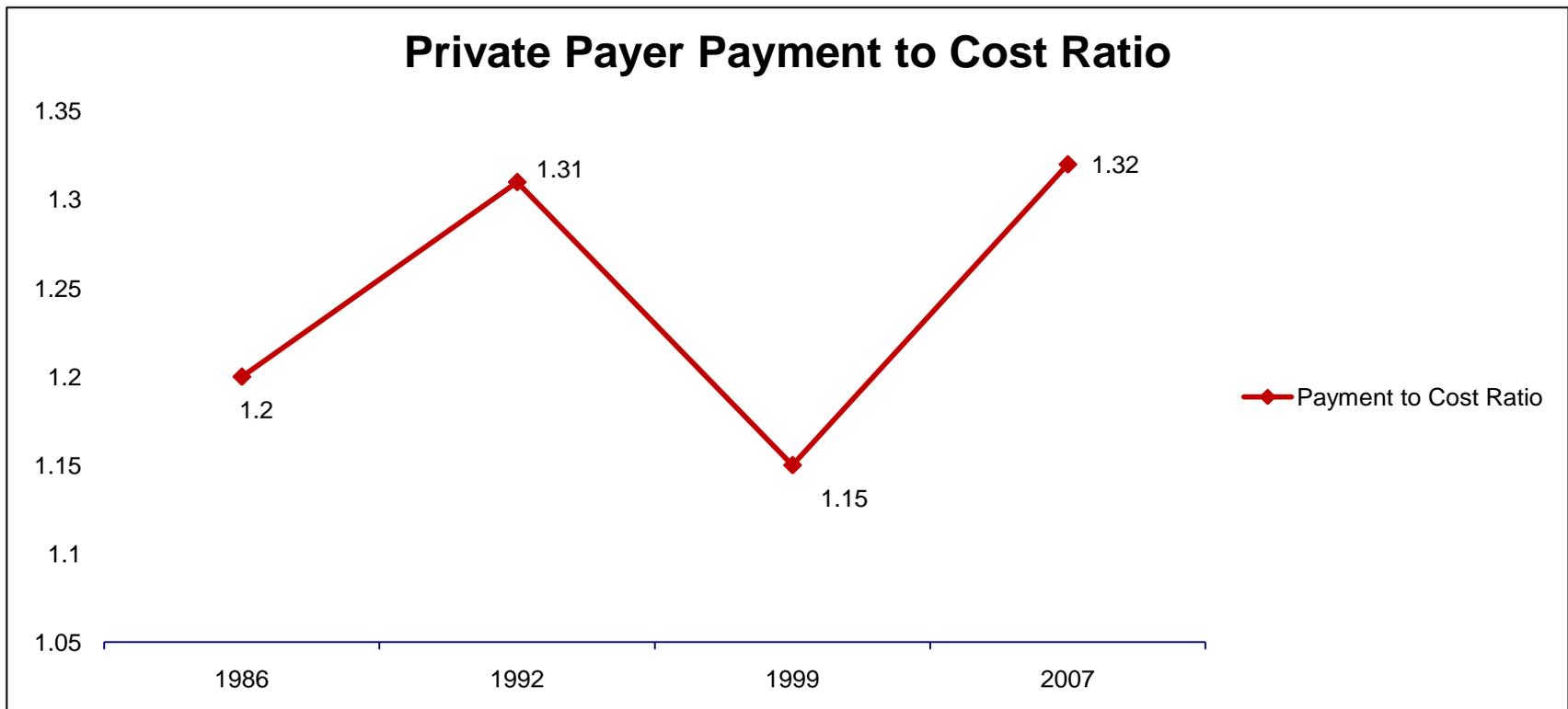
State	Payment Adjustment Factor
Tennessee	150%
North Dakota	165%
Texas	200%

Median = 145%  
 Mean = 148%

# Setting Payment Adjustment Factor for Ohio BWC

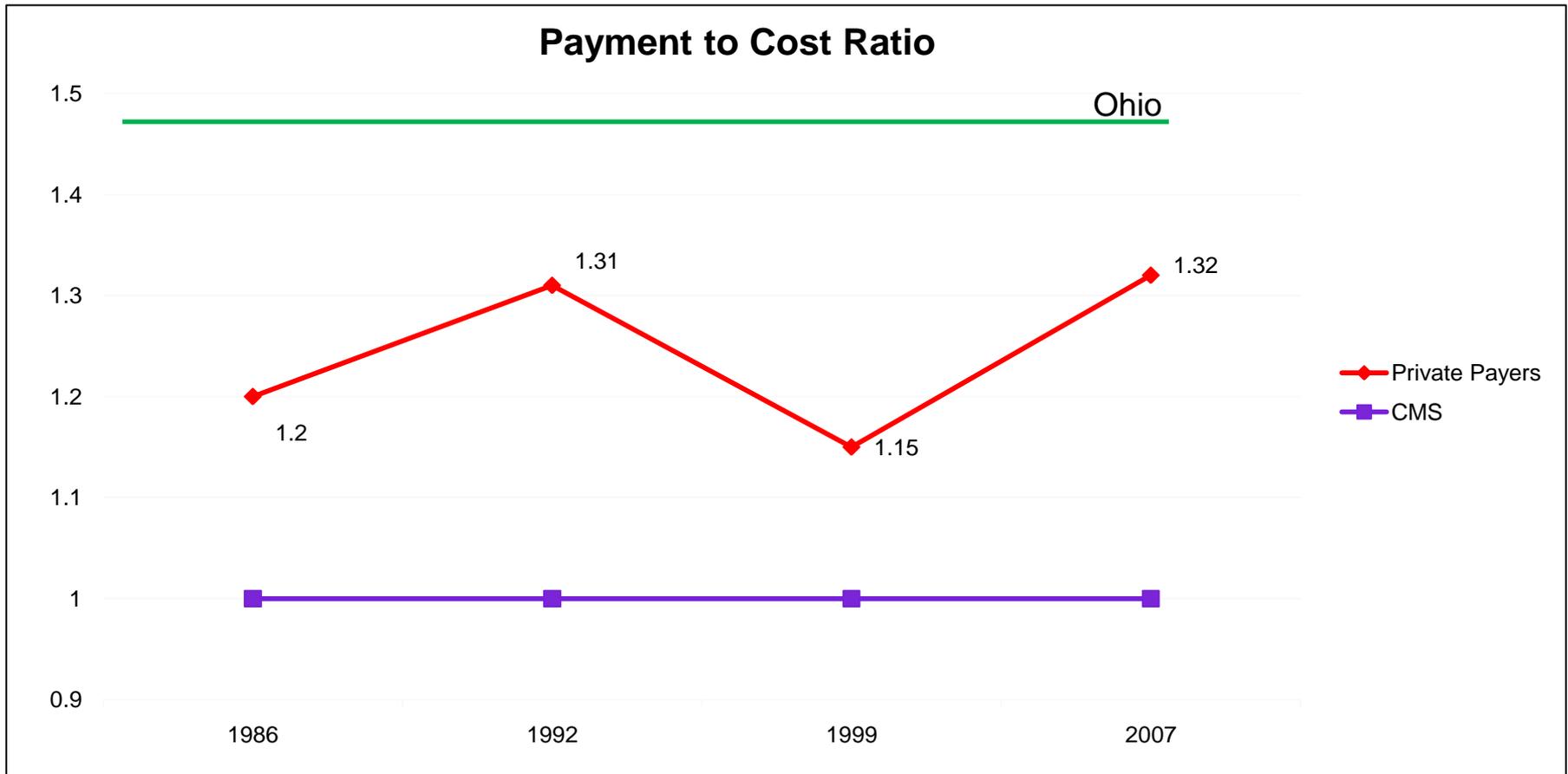
- Financial analysis
  - Percent of cost
  - Percent of allowed billed charges
    - Overall
    - Category of service
    - Type of facility
- Outcome
  - 166% of OPPS rate
    - 114% of cost

# Private Payer Rates

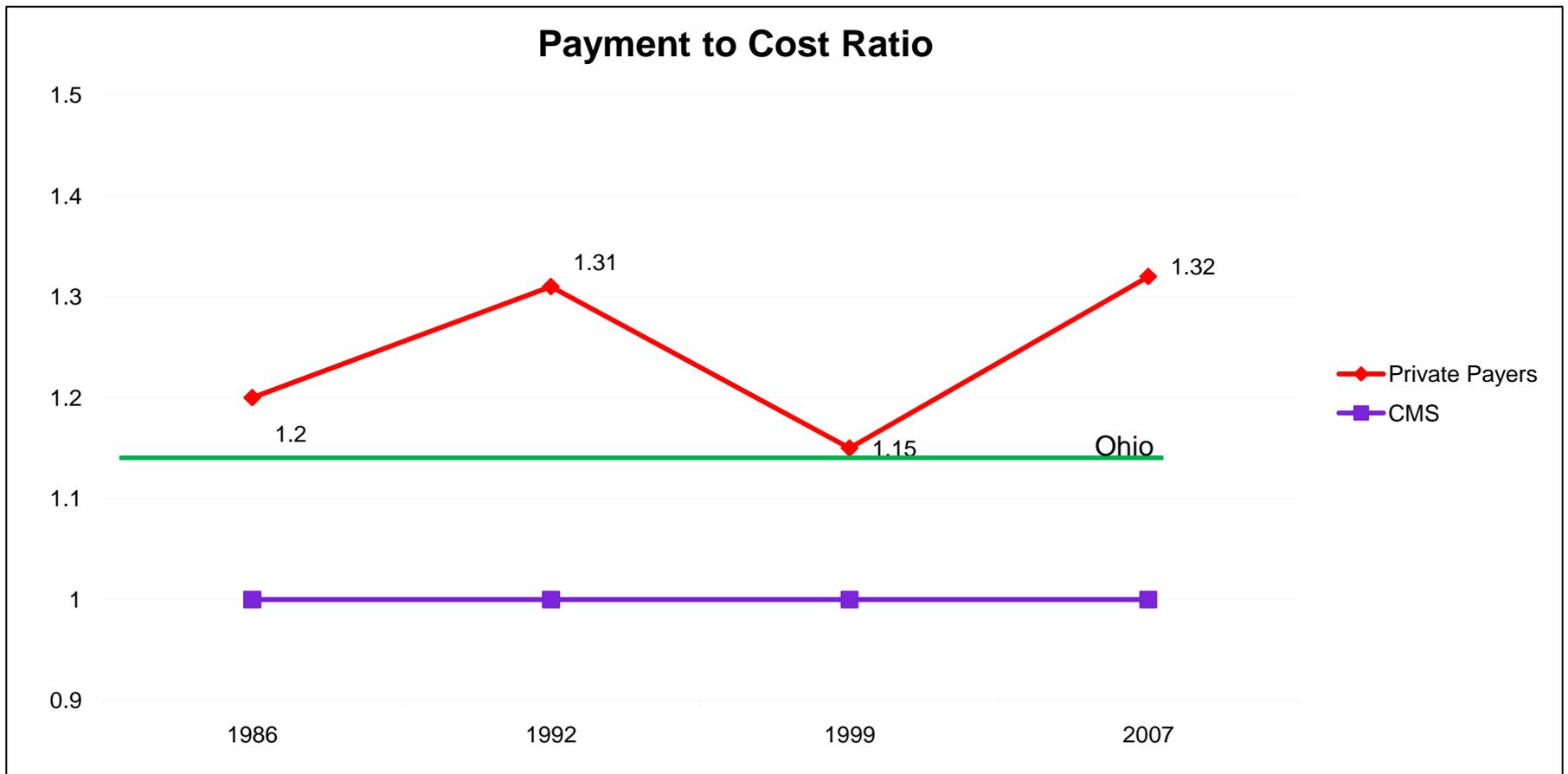


Taken from: MedPAC Report to Congress: Medicare Payment Policy (March 2009), Chapter 2A, figure 2A-6

# Private Payer vs. CMS



# BWC Proposed Rate Impact: Payment to Cost Ratio



# Projected Impact and Concerns

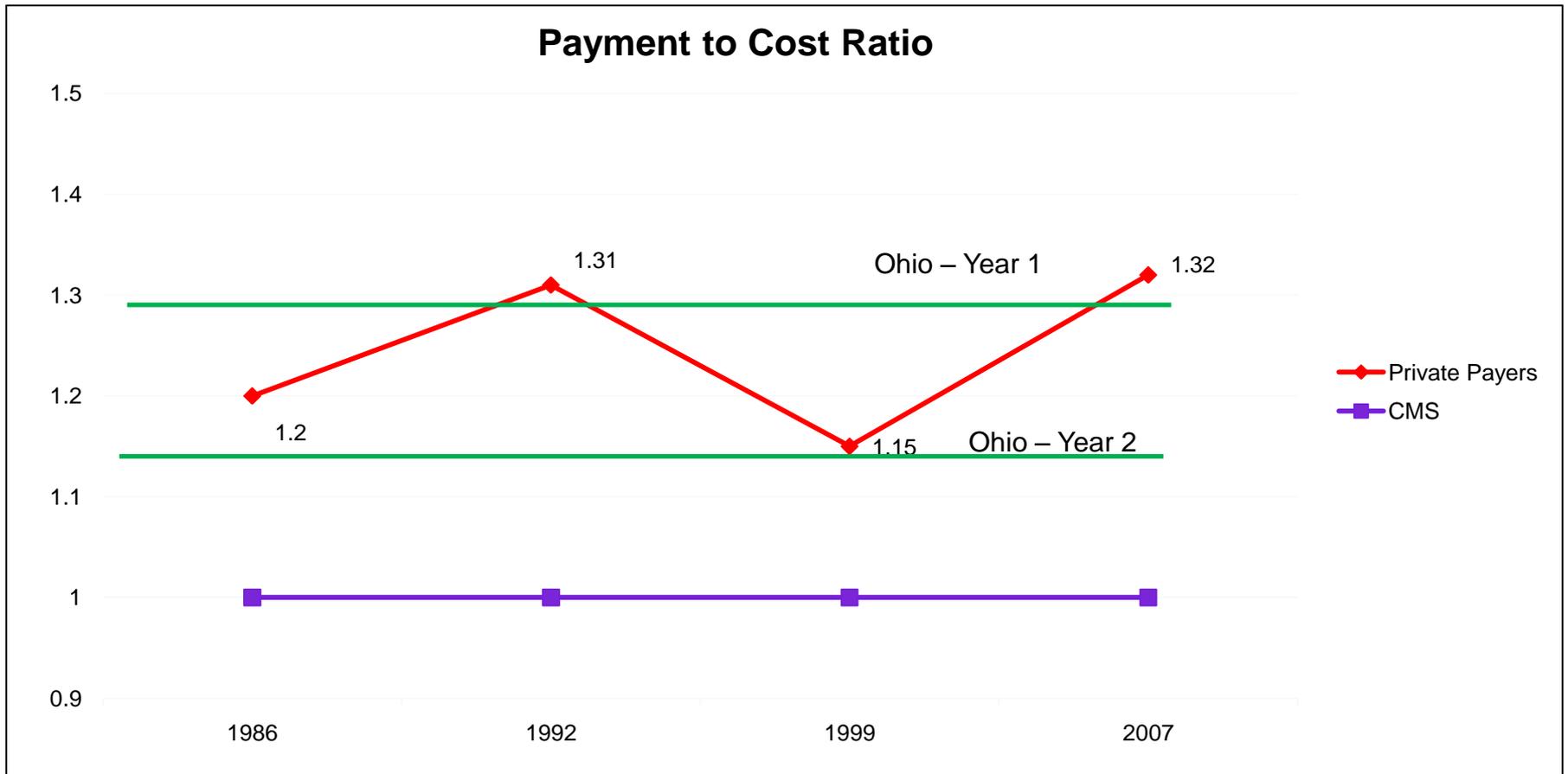
- Children's Hospitals
  - 4 facilities
    - Children's Hosp Medical Center, Cincinnati (6 visits)
    - Children's Hosp Medical Center, Akron (239 visits)
    - Children's Hospital, Columbus (22 visits)
    - Children's Medical Center, Dayton (11 visits)
- 166% of OPPS rate
  - 53% of cost
- 253% of OPPS rate
  - Remain at current reimbursement level

# Projected Impact and Concerns

- Impact estimated at @ \$30 million decrease in reimbursement
- Learning from cost based to DRGs for Inpatient Hospital

Two Year Transition Plan for Hospital Outpatient Services				
Year	PAF	Percent of BWC Cost	Estimated Impact from base year	Estimated % Impact
2010	189% 253%	130%	-\$15,545,477	-11%
2011	166% 253%	114%	-\$15,268,062	-11%

# BWC Proposed Rate Impact: Payment to Cost Ratio



## Recommendation

- Adopt a modified OPPS reimbursement methodology for hospital outpatient setting
- Adopt rates as published in 2010 OPPS final rule
- Apply 253% payment adjustment factor to OPPS rates for Children's Hospitals
- Apply 189% payment adjustment factor to OPPS rates for all other facilities

## Impacts

- Estimated reduction in percent reimbursement: 22% decrease
  - 2010: -11% or -\$15 million
  - 2011: -11% or -\$15 million
- Increase predictability of medical payments
- Improved data for rate setting
- Maintain competitive fee schedule ensuring access to quality care for Ohio's injured workers

**Thank You**

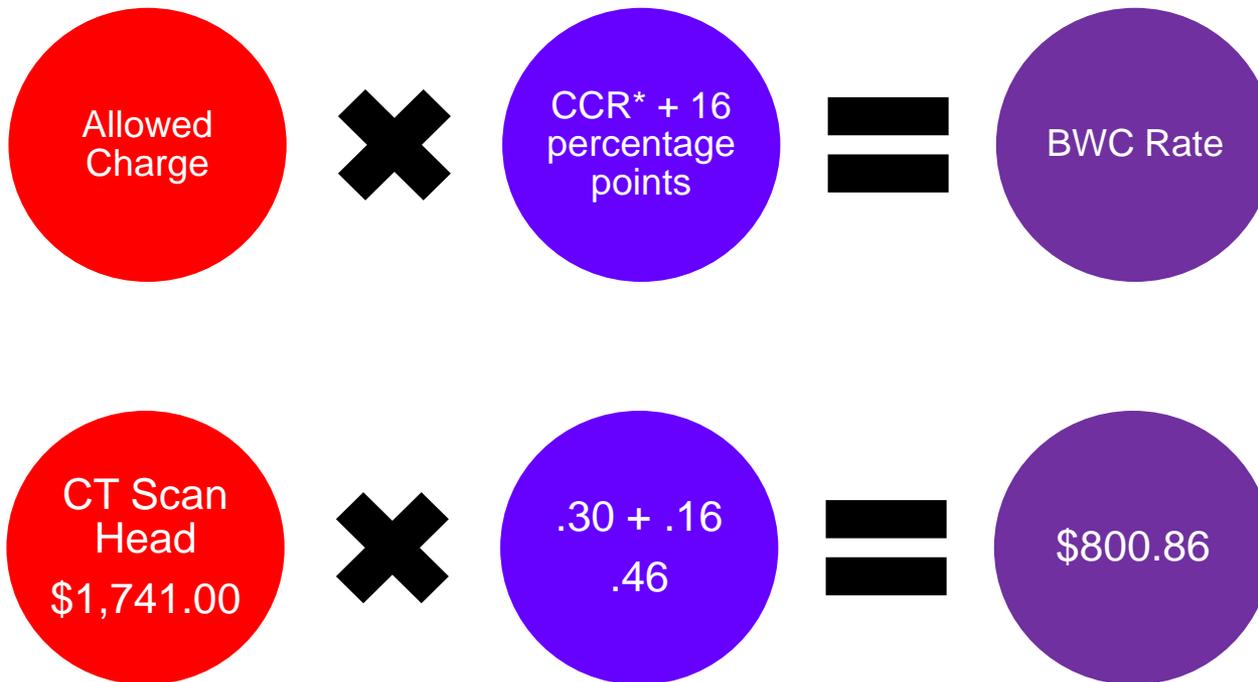
# Appendix

# Proposed BWC Rates Compared to Ohio Medicaid 2010

Code	Description	OH Medicaid 2010*	OPPS 2010	166% OPPS
99203	Mid level clinic visit	\$74.17 \$53.63	\$89.12	\$147.94
99283	Mid level emergency	\$142.49 \$110.55 \$73.69	\$140.18	\$232.69
29880	Knee arthroscopy	\$1,634 \$1,401	\$2,016.77	\$3,347.84
71010	Chest x-ray	\$38.08	\$44.90	\$75.53

\* Ohio Medicaid has multiples levels of reimbursement based on facility type. The categories are teaching, children's and all others with teaching facilities receiving the highest level of reimbursement.

## Current Retrospective Reimbursement Formula



\*CCR – Cost to Charge Ratio

# Predictability, Consistency and Equity of Payments

- Currently BWC cannot predict the payout for services. Payment is determined after the service is delivered based on the hospital's charge

Facility	Service	2009 Charge	2009 Payment	Proposed Rate
Hospital A	Blood count (85025)	\$51.40	\$18.50	<b>\$21.05</b>
Hospital B	Blood count (85025)	\$56.00	\$24.08	<b>\$21.05</b>
Hospital C	Blood count (85025)	\$51.30	\$28.22	<b>\$21.05</b>
Hospital D	Blood count (85025)	\$115.18	\$57.59	<b>\$21.05</b>

# Encourage Facilities to Improve Efficiency of Providing Care

Facility	Service	2009 Charge	2009 Payment	Proposed Rate
Hospital A	Mid-Level ED*	\$255.00	\$147.90	<b>\$264.94</b>
Hospital B	Mid-Level ED	\$435.00	\$204.45	<b>\$264.94</b>
Hospital C	Mid-Level ED	\$584.50	\$210.42	<b>\$264.94</b>
Hospital D	Mid-Level ED	\$705.75	\$310.53	<b>\$264.94</b>
Hospital E	Mid-Level ED	\$573.00	\$343.80	<b>\$264.94</b>
Hospital F	Mid-Level ED	\$703.00	\$393.68	<b>\$264.94</b>

\*ED – Emergency Department

# Control Rate Increases and Predict Financial Impact

Year	Service	Rate	Percent Increase from previous year
2010	Arthroscopy, knee	\$2,016.77	3.7%
2009	Arthroscopy, knee	\$1,943.12	6.0%
2008	Arthroscopy, knee	\$1,833.13	4.1%
2007	Arthroscopy, knee	\$1,759.49	5.3%

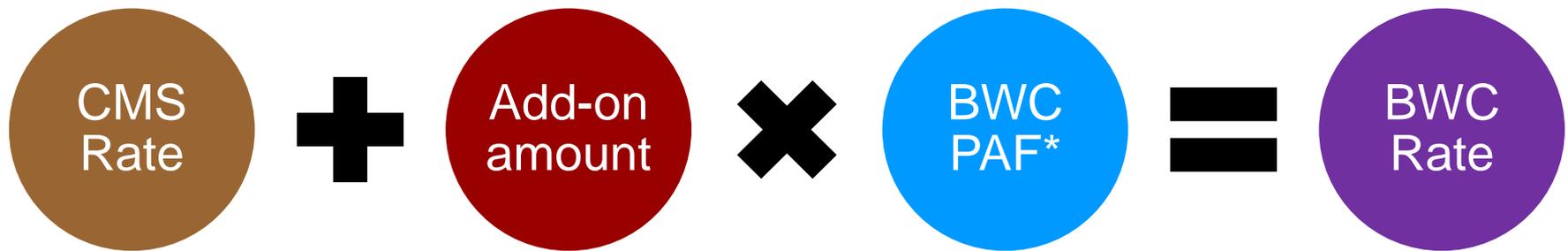
# Reimbursement Formula

## Current Retrospective Reimbursement Formula



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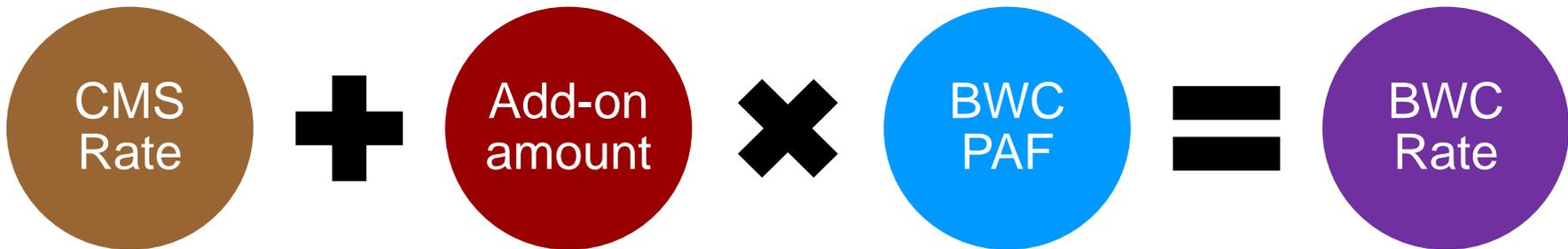
## Proposed Prospective Reimbursement Formula



\* PAF - Payment Adjustment Factor

# Reimbursement Formula

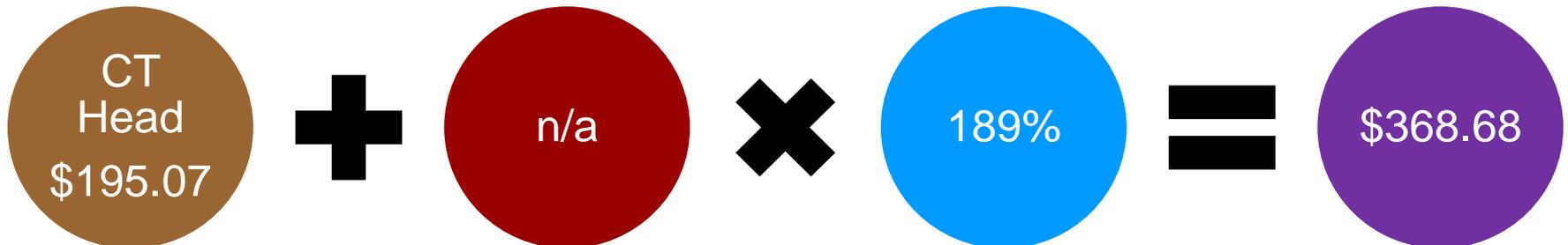
## Proposed Prospective Reimbursement Formula



APC Rate  
Average Sale Price  
Fee Schedule  
Reasonable Cost

Outlier  
Hold Harmless  
Rural Adjustment

253% Children's  
189% All Others



# BWC's Evaluation of CMS' OPPS

- Modification to coverage
  - Allow Medicare non-covered services that are applicable to the injured worker environment to be covered
  - Indicate non-coverage for supplies that are not applicable for the injured worker environment
- Modification to reimbursement formula
  - Modify add-on payment formula for cancer hospitals and Children's hospitals to allow add-on payment at the line item level
- Modification to editing system
  - Deactivated edits that are not applicable to the workers compensation environment

January 12, 2010

To: Robert Coury, Chief, Medical Services and Compliance, BWC  
Freddie Johnson, Director, Managed Care Services, BWC

From: Charles Cataline, Senior Director, Health Policy

Subject: BWC Proposal to Adopt the Medicare OPSS in CY 2010  
**Follow-up on BWC's 12/1/09 Response to OHA's 10/9/09 Comments**

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Thank you for your response to OHA's Oct. 9, 2009, comments on the Bureau of Workers' Compensation (BWC) proposal to change the Health Partnership Program (HPP) outpatient hospital payment methodology to one modeled on the Medicare outpatient prospective payment system (OPSS).

**OHA continues to oppose BWC's plan to adopt the Medicare OPSS as the HPP state reimbursement rate for outpatient hospital services.**

While OHA appreciates the steps BWC is taking to mitigate the negative effects of the imposition of a BWC OPSS on hospitals, OHA remains concerned that the proposal is unnecessary, too expensive, and, in tandem with the large payment cut BWC worked into the pricing formula, likely to threaten some hospitals' ability to care for Ohio's injured workers.

**MEDICARE OPSS**

In its response to OHA's comments about the complexity of the Medicare OPSS, BWC agrees the OPSS is complicated, but contends it is the least so of the various PPS-based outpatient payment methodologies in use, and that it allows BWC to better predict hospital service "costs." BWC states the Medicare inpatient hospital (IH) PPS is also complex, but BWC has employed it for three years without major problems.

OHA agrees the Medicare OPSS is the most used of the various outpatient prospective systems, but BWC misses OHA's point. Employing the "best" of a complicated and expensive lot, especially when there are other less intricate payment systems available, including BWC's current methodology, does not make the proposal any more acceptable. Further, OHA disagrees that the Medicare OPSS in any way allows BWC to better predict the "cost of a service" than other options. **In fact, if matching payment to cost is the bureau's goal, it has already accomplished it with its existing outpatient system, which is based on Medicaid cost.** OHA contends that the Medicare OPSS on an ongoing basis has relatively little to do with the cost of care. Rather, it has evolved into a tool for the Centers for Medicare and Medicaid Services (CMS) to control its budget and providers' payments, regardless of the cost.

January 12, 2009

Robert Coury & Freddie Johnson

Follow-up Comments on BWC's Proposal to Adopt the Medicare OPSS

Page 2

It is for this reason OHA and CMS data consistently show that Medicare pays far below the cost of hospital care, which will also become the case for BWC if it adopts the OPSS as its base rate. OHA appreciates BWC setting a conversion factor at 166 percent of the Medicare rate to lessen the loss, but, for reasons clearly laid out in OHA's Oct. 9 memo, it is not at all apparent that "Medicare plus 66" will cover the actual cost of caring for Ohio's injured workers for many hospitals and may force some out of the system.

OHA also opposed BWC's 2007 adoption of the IH PPS for the same reasons it today opposes the use of the OPSS, and is not convinced BWC has worked out all the bugs related to it. First, other than a general overview, and contrary to what BWC promised when it adopted the IH PPS, OHA's members have not had an opportunity to comment in advance on BWC's annual inpatient updates and hospital-specific pricing factors, and OHA does not agree that the opportunity is presented when Medicare issues its annual proposed rule. Also, to date, each BWC IH PPS update has been accompanied by the need to adjust paid bills after the fact, related to glitches in software and pricing tied to the complexity of the IH PPS and BWC's ability to manage it.

For these reasons, and especially since BWC already has an appropriate and functioning outpatient hospital payment methodology in place, OHA's position remains that **the Medicare OPSS is too difficult to install, too expensive to maintain and essentially inappropriate for the HPP.**

### **HPP STATE PAYMENT RATE AND SI EMPLOYERS**

OHA continues to be concerned with the probability that Self-Insured employers will adopt the HPP OPSS without the means or background to manage it. Regardless of any blithe reassurance by the BWC State-Fund (SF) section that "*SI employers could contract with the [OPSS software and pricing] vendor as well,*" OHA remains convinced that most will not and hospitals will be forced to assume the management of SI outpatient bills at their own expense. While this is not a problem for the HPP, as such, OHA strongly believes BWC must address this inconsistency between SF and SI policy and practice prior to the start of any new payment system, and clearly state how it intends to support any SI employer that decides, as is its right, to also adopt the OPSS.

### **CRITICAL ACCESS HOSPITALS**

OHA assumes that Ohio Critical Access Hospitals would be exempt from the OPSS, as they are with Medicare, but this is not clear from the material we've seen. Will CAHs stay under a cost-plus reimbursement system or is there some other plan for them?

January 12, 2009

Robert Coury & Freddie Johnson

Follow-up Comments on BWC's Proposal to Adopt the Medicare OPPS

Page 3

### **OPPS TRANSITION**

BWC also misses OHA's point about the OPPS' redistributive effect on hospital payments—it is the switch from a cost-based to a PPS methodology that will cause the payment redistribution, not the OPPS itself—and OHA disputes BWC's statement that it *"has not pre-determined or allocated a set amount of funds to be provided in the outpatient setting."* BWC indeed has assumed the principal part in determining how much will be paid in any given year, when it set the payment rate at 166 percent of the Medicare OPPS, a figure OHA believes was reached by backing into a rate that would cut BWC's budget by a predetermined amount: \$30 million/year.

Nonetheless, OHA appreciates BWC's attempt to soften the blow by proposing a one-year transition (OHA does not count the year the system is fully implemented as part of the transition) in which the payment cut would be halved. However, when CMS implemented the Medicare OPPS it employed a three-year payment transition and **OHA recommends BWC extend the payment transition at least through its CY 2010 and 2011 periods.** This extended transition will help hospitals react, re-set budgets, and determine whether they can continue with the program, and allow OHA and BWC to monitor the OPPS' effects on payments and administrative cost.

**Overall, and for the reasons outlined above and in its Oct. 9, 2009, memo, OHA continues to recommend BWC abandon the plan to use the Medicare OPPS** and instead work within the existing HPP outpatient hospital payment system to ensure it meets BWCs budgetary goals. However, if BWC keeps with the plan to implement an OPPS, OHA strongly recommends BWC extend the payment transition by a period of least one year.

Thank you again for the opportunity to comment. If you have any questions or concerns about any of the above, I hope you won't hesitate to contact me at 614.221.7614 or [charlesc@ohanet.org](mailto:charlesc@ohanet.org).

CC/

cc: Marsha P. Ryan, Administrator, BWC  
Ray Mazzotta, COO, BWC  
Anne Casto, Casto Consulting

## **Common Sense Business Regulation (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

### **Rule 4167-3-04.2 Amending of standards**

#### **Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4167.7(A)(2)(b) (PPE)

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The goal is to ensure that employers in the state of OHIO comply with the OAC requirements to provide a workplace safe from recognized workplace hazards and to protect employees safety and health. This also aligns with the mission of the Ohio BWC to “protect workers and employers from a loss as a result of workplace accidents, and to enhance the general health and well-being of Ohioans and the Ohio economy”

3.  Existing federal regulation alone does not adequately regulate the subject matter. YES – Federal OSHA regulations when promulgated are not applicable to the Ohio public employer therefore it is necessary to adopt or amend under RC 4167 so they become rules or standards for the Ohio public sector.
4.  The rule is effective, consistent and efficient.
5.  The rule is not duplicative of rules already in existence.
6.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.
7.  The rule has been reviewed for unintended negative consequences.
8.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: On May 17, 2007, OSHA published a Notice of Proposed Rulemaking (NPRM) (72 FR 27771) entitled "Updating OSHA Standards Based on National Consensus Standards; Personal Protective Equipment." The NPRM set July 16, 2007, as a deadline for submitting comments and for requesting an informal public hearing on the proposed rule. The Agency received approximately 25 comments and 4 requests for an informal public hearing. OSHA then published a Federal Register notice scheduling an informal public hearing for December 4, 2007 (72 FR 50302). The informal public hearing took place as scheduled, and OSHA received testimony from nine witnesses. Thomas M. Burke, Administrative Law Judge, presided at the hearing. At the end of the hearing, Judge Burke set deadlines of January 3, 2008, for submission of post-hearing comments, and February 4, 2008, for the submission of final summations and briefs. Judge Burke closed and certified the record for this rulemaking on June 23, 2008.

9.  The rule was reviewed for clarity and for easy comprehension.
10.  The rule promotes transparency and predictability of regulatory activity.
11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.
12.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

BWC Board of Directors

# Executive Summary

## Occupational Safety and Health Amended Rules for Personal Protective Equipment

### Introduction

Chapter 4167-3-04.2 of the Ohio Administrative Code requires the Public Employment Risk Reduction Program to amend rules promulgated by the Federal Occupational Safety and Health Administration (OSHA). Chapter 4167 was initially enacted in 1992 with the ratification of House Bill 308. The scope of H.B. 308 was to provide on the job safety and health protection to Ohio public employees through the adoption and application of federal safety and health rules and regulations for General Industry, Construction, and Agriculture.

### Background Law

Under House Bill 308, Chapter 4167.07 the administrator is to adopt rules for employment risk reduction standards.

(A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules that establish employment risk reduction standards. Except as provided in division (B) of this section, in adopting these rules, the administrator shall do both of the following: (1) By no later than July 1, 1994, adopt as a rule and an Ohio employment risk reduction standard every federal occupational safety and health standard then adopted by the United States secretary of labor pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, as amended; (2) By no later than one hundred twenty days after the United States secretary of labor adopts, modifies, or revokes any federal occupational safety and health standard, by rule do one of the following: (a) Adopt the federal occupational safety and health standard as a rule and an Ohio employment risk reduction standard; (b) Amend the existing rule and Ohio employment risk reduction standard to conform to the modification of the federal occupational safety and health standard; (c) Rescind the existing rule and Ohio employment risk reduction standard that corresponds to the federal occupational safety and health standard the United States secretary of labor revoked.

### Proposed Change

OSHA is issuing this final rule to revise the personal protective equipment (PPE) sections of its general industry standards regarding requirements for eye- and face-protective devices, head protection, and foot protection. OSHA is updating the references in its regulations to recognize more recent editions of the applicable national consensus standards, and is deleting editions of the national consensus standards that PPE must meet if purchased before a specified date. In addition, OSHA is amending its provision that requires safety shoes to comply with a specific American National Standards Institute (ANSI) standard, and a provision

that requires filter lenses and plates in eye-protective equipment to meet a test for transmission of radiant energy specified by another ANSI standard. In amending these paragraphs, OSHA will require this safety equipment to comply with the applicable PPE design provisions. These revisions are a continuation of OSHA's effort to update or remove references to specific consensus and industry standards located throughout its standards.

### **Stakeholder Involvement**

On May 17, 2007, OSHA published a Notice of Proposed Rulemaking (NPRM) (72 FR 27771) entitled "Updating OSHA Standards Based on National Consensus Standards; Personal Protective Equipment." The NPRM set July 16, 2007, as a deadline for submitting comments and for requesting an informal public hearing on the proposed rule. The Agency received approximately 25 comments and 4 requests for an informal public hearing. OSHA then published a Federal Register notice scheduling an informal public hearing for December 4, 2007 (72 FR 50302). The informal public hearing took place as scheduled, and OSHA received testimony from nine witnesses. Thomas M. Burke, Administrative Law Judge, presided at the hearing. At the end of the hearing, Judge Burke set deadlines of January 3, 2008, for submission of post-hearing comments, and February 4, 2008, for the submission of final summations and briefs. Judge Burke closed and certified the record for this rulemaking on June 23, 2008.

## **Common Sense Business Regulation (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

### **Rule 4167-3-04.2 Amending of standards**

#### **Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4167.7(A)(2)(b) (Acetylene)

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The goal is to ensure that employers in the state of OHIO comply with the OAC requirements to provide a workplace safe from recognized workplace hazards and to protect employees safety and health. This also aligns with the mission of the Ohio BWC to “protect workers and employers from a loss as a result of workplace accidents, and to enhance the general health and well-being of Ohioans and the Ohio economy”

3.  Existing federal regulation alone does not adequately regulate the subject matter. Federal OSHA regulations when promulgated are not applicable to the Ohio public employer therefore it is necessary to adopt or amend under RC 4167 so they become rules or standards for the Ohio public sector.
4.  The rule is effective, consistent and efficient.
5.  The rule is not duplicative of rules already in existence.
6.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.
7.  The rule has been reviewed for unintended negative consequences.
8.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: On August 11, 2009, OSHA published the direct final rule in the Federal Register that revised the Acetylene Standard for general industry by updating references to standards published by standards-developing organizations (see 74 FR 40442). In that Federal Register document OSHA also stated that it would confirm the effective date of the direct final rule, if it received no significant adverse comments on the direct final rule.

OSHA received eight comments on the direct final rule, which it determined were not significant adverse comments. Several of these comments observed that the Compressed Gas Association updated the CGA G-1 standard this year, and recommended that OSHA adopt this new Edition.

9.  The rule was reviewed for clarity and for easy comprehension.
10.  The rule promotes transparency and predictability of regulatory activity.

11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**BWC Board of Directors**  
**Executive Summary**  
**Occupational Safety and Health Amended Rules for**  
**Acetylene**

## **Introduction**

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## **Background Law**

Under House Bill 308, Chapter 4167.07 the administrator is to adopt rules for employment risk reduction standards.

(A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules that establish employment risk reduction standards. Except as provided in division (B) of this section, in adopting these rules, the administrator shall do both of the following: (1) By no later than July 1, 1994, adopt as a rule and an Ohio employment risk reduction standard every federal occupational safety and health standard then adopted by the United States secretary of labor pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, as amended; (2) By no later than one hundred twenty days after the United States secretary of labor adopts, modifies, or revokes any federal occupational safety and health standard, by rule do one of the following: (a) Adopt the federal occupational safety and health standard as a rule and an Ohio employment risk reduction standard; (b) Amend the existing rule and Ohio employment risk reduction standard to conform to the modification of the federal occupational safety and health standard; (c) Rescind the existing rule and Ohio employment risk reduction standard that corresponds to the federal occupational safety and health standard the United States secretary of labor revoked.

## **Proposed Change**

OSHA is revising the Acetylene Standard for general industry by updating references to standards published by standards-developing organizations (i.e., "SDO standards"). The direct final rule stated that it would become effective on November 9, 2009, unless OSHA received no significant adverse comments on the direct final rule by September 10, 2009.

## **Stakeholder Involvement**

On August 11, 2009, OSHA published the direct final rule in the Federal Register that revised the Acetylene Standard for general industry by updating references to standards published by standards-developing organizations. OSHA received eight comments on the direct final rule, which it determined were not significant adverse comments. Several of these commentators observed that the Compressed Gas Association updated the CGA G-1 standard this year, and recommended that OSHA adopt this new edition (Exs. OSHA-2008-0034-0017, -0010, and -

0022). OSHA did not include the 2009 edition of CGA G-1 in the direct final rule because that edition was not made available to OSHA prior to publication of the direct final rule, and, therefore, was beyond the scope of this rulemaking.

#### **4167-3-04.2 Amending of standards.**

In accordance with division (A)(2)(b) of section 4167.07 of the Revised Code, the administrator of workers' compensation, with the advise and consent of the bureau of workers' compensation board of directors, has amended Ohio employment risk reduction standards as referenced by:

(A) U.S. Department of Labor [OSHA, 2007] 29 CFR 1910 - amended; changes to subpart S Electrical. Federal register, vol. 72, No. 30, pages 7136 through and including 7221, February 14, 2007.

(B) U.S. Department of Labor [OSHA, 2007] “29 CFR Parts 1910; 1915; 1917; 1918; and 1926 employer payment for personal protective equipment; final rule.” Federal Register, vol. 72, no. 220, pages 64341 through and including 64430, November 15, 2007.

(C) U.S. Department of Labor [OSHA, 2009] “29 CFR Parts 1910; 1915; 1917; 1918; - amend; Cutting and brazing, Eye and face protection, Foot protection, Head protection, Incorporation by reference, Ventilation, and Welding; Final rule.” Federal Register, vol. 74, no. 173, pages 46350 through and including 46361, September 9, 2009.

(D) U.S. Department of Labor [OSHA, 2009] “29 CFR Parts 1910; Revising Standards Referenced in the Acetylene Standard. Final rule. Federal Register, vol 74, no 216, pages 57883 through and including 57884, November 10, 2009.

Promulgated Under: 4167.07

Statutory Authority: 4121.12, 4121.121, 4167.02, 4167.07

Rule Amplifies: 4167.07

Prior Effective Dates: 12/10/07, 11/03/08

## Medical Services and Safety Committee

Chairman Harris, Directors:

I am very pleased today to provide the Board with an update on our progress in re-tooling the DFWP program. Back in August, 2009, Administrator Ryan tasked the BWC's Division of Safety and Hygiene to lead the Agency's efforts in re-tooling the DFWP. Soon after, DSH assembled a project team and formulated specific objectives, tasks, and timelines for the project.

### Overview:

1. Generally, drug-free workplace programs are geared toward improving workplace safety and productivity by preventing substance abuse among workers.
2. BWC's current DFWP was introduced in 1997 and went through a number of revisions including adding Drug-Free grants as a program support.
3. Over the past twelve years the program was expanded by introducing a small employer program (Drug-Free EZ) and reached close to fourteen thousand employers out of the more than two-hundred thousand employers in our system. This is a small percentage of employers in our system.
4. The discounts and grants associated with the program since its introduction reached 403 million dollars.
5. The recent actuarial evaluation undertaken through the Deloitte study (2009) questioned the effectiveness of the program in meeting its major objectives of preventing workplace injuries and claims.
6. The Deloitte study made the following observations and recommendations:
  - a. The discounts offered are larger than those offered in other states;
  - b. Generally, for policy years '04, '05 and '06, the loss ratios for employers participating in the DFWP are no better than those who did not; and
  - c. To consider combining the DFWP and DF-EZ into a single, simplified program focused primarily on smaller employers.
7. Beyond the Deloitte study findings, since the DFWP is directed toward the prevention of injuries and claims attributed to substance abuse, then it should be treated just like any safety intervention program and should be evaluated accordingly.

The following sections of this presentation provide a summary of the objectives, tasks, timelines, and project progress.

### Project Objective:

Research and develop a compatible, evidence-based, contemporary drug free workplace safety program (DFSP) that is designed specifically to help Ohio employers prevent occupational injuries attributed to substance abuse.

Compatible such that:

1. It will fit the mission and objectives of BWC;
2. It will meet the needs of Ohio employers collectively and individually; and
3. It will be consistent with the occupational safety and health practices as they apply to specific industries, trades, and employers.

Evidence-based such that:

1. Its components and modules will be designed, implemented, and measured objectively to produce the desired outcome of the program; and
2. It adheres to scientific scrutiny. In other words, the program outcomes as they affect the workplace safety; and how that spills outside the workplace, will not be over/under estimated.

Contemporary such that:

1. It is consistent with the latest advances in science and research in this area; and
2. It is consistent with current practices in other states and private sector companies in and out of Ohio.

**Tasks:**

To achieve the objective, the project team undertook the following tasks:

1. Benchmark similar programs including other States and self insured employers;
2. Review and synthesize scientific literature on the design and effectiveness of drug-free workplace programs;
3. Analyze BWC's data on experience of program participants;
4. Engage and solicit input from interested parties including employers, employees, and vendors as well as from experts in the subject area;
5. Develop recommendations for retooling the current DFWP based on results from the above-described tasks;
6. Price the new program accordingly;
7. Introduce program recommendations and draft rules to BWC's BOD; and
8. Launch new program.

**Timeline:**

**Tasks 1 & 2:** Benchmarking and Literature Review (completed in September 2009);

**Task 3:** Data analysis (completed in November 2009);

**Task 4:** Engage and solicit input from stakeholders (two meetings were held on September 28, 2009 and January 7, 2010);

**Task 5:** Develop final recommendations for retooling current DFWP (On-going);

**Tasks 6:** Price program through BWC's Actuarial Division and Deloitte (On-going).

**Task 7:** Program recommendations and draft rules (February and March, 2010); and

**Task 8:** Launch new program (Expected July 1, 2010).

**Progress:**

**1. Benchmarking:**

- a. Drug-free workplace programs in eleven states were evaluated;
- b. The results confirmed the Deloitte Study observation that the discounts offered in Ohio are larger than those offered in other states;
- c. Except for Georgia (7.5%) and Ohio (can reach 20%), discounts in most other states are at 5% or lower;
- d. Ohio's DFWP is the most comprehensive in terms of program details;
- e. No effectiveness evaluations are included in programs;
- f. Three interviews were conducted with representatives from three self-insured employers (Dominion Power, Eaton Corporation, and InvaCare Corporation); and
- g. The self-insured interviews showed that, primarily, DFWPs are treated as one element among the many elements those companies have in their safety management systems.

**2. Literature Review:**

- a. Results are mixed relative to the effectiveness of drug-free workplace programs, however, the majority of the literature suggest that reductions in injuries are not as most expected when these programs gained momentum 15 years ago;
- b. Companies with low injury rates tend to gain less from these programs; and
- c. Workplace injuries that are attributed to substance abuse may be attributed to individual characteristics that are commonly associated with individuals with addictive behavior (deviance proneness).

**3. Data Analysis:**

- a. Data analysis efforts were directed at evaluating claim and injury data for companies that participated in the DFWP since its inception in 1997;
- b. The objective of the analysis was to try to identify certain characteristics among specific industries and employers that make DFWP's more effective in preventing workplace injuries and claims;
- c. For the purposes of controlling data reliability, this effort was limited to the pool of companies that completed the five-year participation period in the DFWP since its inception in 1997;
- d. The analysis included two data sets consisting of:
  - 1) 232 companies that started participating in the DFWP in 2002 and finished in 2006 as well as another control group of 232 companies of similar characteristics (industrial manual, payroll size, and group rating) who did not participate in the program,

- 2) 2,516 companies started participating in the DFWP in 2003 and finished in 2007 as well as another control group of 2,516 companies with similar characteristics (industrial manual, payroll size, and group rating) who did not participate in the program,
  - e. Generally, results from the analysis show that participating in the DFWP did not have a significant effect on the loss ratio, frequency, and severity of injuries/claims for those companies that participated in the program when compared to those who did not;
  - f. Another observation from the data was that most of the companies which started participating in the program in 2002 and 2003 had significant rises in the frequency of injuries/claims in calendar years 2001 and 2002, which indicates that the participation may have been partially motivated by lowering premiums through the program discounts,
  - g. Generally, although not significant, companies who participated in the program showed somewhat better trends in decreasing claims frequency and severity; and
  - h. The analysis could not control for the possibility that some of the companies that were included in the control groups did have some type and/or certain elements of a DFWP on their own without participating in BWC's DFWP.
4. **Involvement of Interested Parties and Subject Area Experts:**
- Two meetings were held at OCOSH for interested parties on September 28, 2009, and January 7, 2010. The following provides a summary of those meetings:
- a. **Interested parties September 28, 2009 meeting:**
    - 1) The objective of the meeting was to solicit input from interested parties in experts in the field about their views of the current DFWP and solicit input relative to improving the program;
    - 2) Thirty-three representatives of employers, employers' trade organizations, vendors, group sponsors, TPA's, ODADAS, NIOSH, and OSU participated in the meeting;
    - 3) The meeting consisted of two sessions, which lasted over six hours between 9:00 am and 4:00 pm with a one-hour lunch break. In the morning session, the participants were presented with the project objectives and were divided into small focus groups to solicit their input relative to various DFWP elements. A matrix for prompting certain questions about the program and for documenting the participants input was designed by the project team for that purpose;
    - 4) During the lunch hour, the team assembled the participants' input from the small focus group and the input was presented to all participants in a large group format for discussion in the afternoon session;

- 5) Additional discussions were held among the participants and the project team in the afternoon session about the many suggestions that were made by the participants in the morning focus group session;
- 6) The participants provided more than a hundred suggestions for the team consideration during this meeting; and
- 7) Afterwards, the project team analyzed and evaluated all of these suggestions according to specific criteria that were developed based on the project objective. Particularly, the team evaluated each input on whether or not that input/suggestion:
  - i. Meets the project objective,
  - ii. Makes the DFWP more effective in the future,
  - iii. Expands the program reach and benefits to employees and employers,
  - iv. Helps in deterring substance abuse in the workplace,
  - v. Helps in expanding the social effect of the program,
  - vi. Helps in assisting employees with rehabilitation in case of a positive.

**b. Interested parties January 7, 2010 meeting:**

- 1) The objective of the meeting was to solicit input from interested parties and experts in the field about their views of the current proposed design of the re-tooled program;
  - 2) Twenty-seven representatives of employers, employers' trade organizations, vendors, group sponsors, TPA's, ODADAS, and NIOSH participated in the meeting;
  - 3) The meeting lasted over three hours between 9:00 am and 12:00 pm;
  - 4) The participants were presented with the proposed Drug-Free Safety Program elements in a large group format;
  - 5) Then, the participants were divided into six small focus groups. Project team members then revolved among the six groups to discuss one element of the various elements in the proposed design of the program; and
  - 6) Then, the project team assembled the participants' input from the small focus groups and the input was presented to all participants in a large group format for discussion.
- c. The BWC and project team would like to express deep gratitude to employers and organizations along with their representatives who participated in the two interested parties' sessions for their input has been of great value to the project;
- d. After both meetings, the participants were provided an anonymous survey to solicit their input about the content, conduct, procedures, processes, and value of the meetings. I am pleased to share that over 90% of the participants expressed

high satisfaction with the professionalism through which those meetings were conducted; and

- e. Throughout the process the project team continued soliciting input from experts in NIOSH, OSU and ODADAS.

### **Proposed Drug Free Program Design**

Based on the above described tasks and activities, the project team is proposing the following improved design to the current BWC DFWP:

1. Rename/rebrand the Drug-Free Workplace Program (DFWP/Drug-Free EZ) using “Safety” as a primary focus and to indicate a significant change in our program;
2. Combine the Drug Free and Drug-Free EZ into one program with two levels:
  - 1) Basic Program Level; and
  - 2) Advanced Program Level;
3. The proposed design to incorporate drug-free into employers’ holistic approach to safety for both levels; and
4. The elements that are included in both Basic and Advanced levels include:
  - 1) Safety,
  - 2) Written substance policy,
  - 3) Employee substance awareness,
  - 4) Supervisor training,
  - 5) Drug and alcohol testing,
  - 6) Employee assistance.

### **Safety Elements Required in Both Levels:**

1. Online Safety Self-Assessment;
2. Accident Analysis Training for Supervisors;
3. Online accident reporting; and
4. Safety services available upon request or as indicated (increasing loss ratios, injury trends, inadequate accident analysis, catastrophic claim, fatality, etc.).

### **Basic Program**

1. Safety elements as described above;
2. Policy template provided by BWC that serves as minimum;
3. Annual employee substance awareness training, content identified by BWC;
4. Annual supervisor training, content identified by BWC, including content on conducting accident investigations;
5. Pre-employment and/or new hire, reasonable suspicion, post accident return-to-duty and follow-up testing;
6. Move from 5-panel to 9-panel drug test plus expanded opiates; and

7. Share list of community helping resources and commitment to employee health in written policy.

### **How Does the New Basic Program Improve Upon Current Program?**

1. More effective because, with its safety elements, it is expected to integrate better into workplace safety;
2. Less costly for employers (fewer hours of substance awareness and supervisor training);
3. Improved testing with expansion into commonly-abused prescription medications including Oxycodone, making the program more current with the nature and extent of the substance abuse problems in the workplace;
4. Easier to implement with BWC providing access to training, possibly through OCOSH and service offices for classes or on-line classes;
5. Better program consistency with BWC specifying elements of training content and written policy;
6. Easier to measure effectiveness with on-line reporting requirements; and
7. Employer permitted to terminate on first positive but encouraged to offer assessment and second chance to help employees.

### **Advanced Program**

Same elements of the Basic Level in addition to:

1. Safety process action plan following online safety assessment;
2. Random drug testing at 25%, which will be applied to total workforce for private employers but only to safety-sensitive functions for public employers; and
3. Employer agrees not to terminate on a first positive, offer expanded assistance including referring and paying for an assessment and additional assistance

### **How Does the Advanced Program Improve Upon Current Program?**

1. More effective because, with its safety elements, it is expected to integrate better into workplace safety;
2. Less costly for employers (fewer hours of substance awareness and supervisor training);
3. Improved testing with expansion into commonly-abused prescription medications including Oxycodone, making the program more current with the nature and extent of the substance abuse problems in the workplace;
4. Easier to implement with BWC providing access to training, possibly through OCOSH and service offices for classes or on-line classes;
5. Better program consistency with BWC specifying elements of training content and written policy;
6. Easier to measure effectiveness with on-line reporting requirements;
7. Employer will not be permitted to terminate on first positive but must agree to more extensive assistance including, but not limited to, referral for assessment, paying for cost

of assessment, second chance to help employees deal with substance problems rather than simply go to work for another employer.

### **Summary**

All of these efforts including consulting the scientific literature, benchmarking, analysis of data, and soliciting input from stakeholders were intended to guarantee the viability and sustainability of BWC's drug free workplace program by improving its effectiveness in reducing the frequency and severity of injuries attributed to alcohol and/or other drug abuse in the workplace. The proposed program design has more emphasis on safety to assist Ohio's employers in making it more effective in reducing accidents and injuries in the workplace.

Furthermore, the proposed program design will allow for collecting better data about the program as it is implemented by employers including the type of drugs that are detected in their workplaces. Better data will allow BWC to improve the program implementation process and highlight its most effective elements in future years.

BWC will continue to develop the necessary cost-lowering tools to help Ohio's employers implement the program efficiently. Also, BWC will continue to monitor and evaluate the program processes and outcomes to improve its effectiveness and value to Ohio's employers.