

BWC Board of Directors
Medical Services and Safety Committee

Thursday, January 21, 2010
Level 2, Room 3 (Mezzanine)
30 West Spring St.
Columbus, OH 43215

Members Present: Mr. James Harris, Chair
Mr. James Hummel
Mr. Thomas Pitts

Members Absent: None

Other Directors Present: Mr. Charles Bryan, Mr. David Caldwell, Ms. Alison Falls, Mr. Kenneth Haffey, Mr. William Lhota, Mr. James Matesich, Mr. Larry Price, and Mr. Robert Smith

CALL TO ORDER

Mr. Harris called the meeting to order at 12:10 PM and the roll call was taken. All members were present.

MINUTES OF DECEMBER 16, 2009

Mr. Harris opened the floor for any proposed changes to the minutes of December 16, 2009. With no changes proposed, Mr. Hummel moved to have the minutes of December 16, 2009 be approved, and Mr. Pitts seconded the motion. The motion passed 3-0.

REVIEW AND APPROVAL OF AGENDA

Mr. Harris opened the floor for any proposed changes to the agenda. With no changes proposed, Mr. Pitts moved to have the agenda approved, and the motion was seconded by Mr. Hummel. The motion passed with a 3-0.

NEW BUSINESS/ACTION ITEMS

1. Motions for Board Consideration

A. For Second Reading

1. Outpatient Hospital Fee Schedule, Rule 4123-6-37.2

Mr. Freddie Johnson, Director of Managed Care Services, and Ms. Anne Casto, President of Casto Consulting, appeared before the Medical Services and Safety Committee for the second reading of the proposed 2010 Outpatient Hospital Fee Schedule (OHFS).

Mr. Johnson noted there were four recommendations in the proposal. First, the 2010 OHFS would go to a prospective reimbursement methodology instead of a retrospective

reimbursement methodology. Second, Medicare's Outpatient Prospective Payment System (OPPS) would be the platform for the Bureau's prospective reimbursement methodology. Third, the recommendation would provide a two tier adjustment factor. Finally, the recommendation calls for a transition period for phasing in the prospective payment methodology. Mr. Johnson noted that, at the December 2009 meeting, staff recommended a two year transition period. Since discussions from that meeting, the transition period has been expanded to a three year period, with payment adjustment factors recommended for each year.

Mr. Johnson noted outpatient hospital based services (OH) represented seven percent (7%) of all invoices processed by the Bureau, resulting in seventeen percent (17%) of total medical expenditures. OH included emergency room visits, which are often the first medical encounters after an injury occurs. OH also includes such services as rehabilitation services and surgical procedures. Mr. Johnson noted the recommendation would not lead to an increase in reimbursements to hospitals, but a twenty-two percent (22%) decrease over the proposed transition period. The recommendation would result in an anticipated \$30 million reduction in annual reimbursements from the current level. If the recommendation is approved, Mr. Johnson said the recommendation would have a tentative effective date of May 1, 2010.

Mr. Johnson believed the proposed 2010 OHFS met the Bureau's guiding principles of ensuring access to high quality care to injured workers with a competitive fee schedule that enhances the provider network. Mr. Johnson reported the Bureau had met with various stakeholders in November and December, 2009, including: the Ohio Hospital Association (OHA), the MCO League; self insured association; and the Ohio Association of Rehabilitation Facilities (OARF). Additionally, Mr. Johnson provided a copy of a letter from the OHA dated January 12, 2010 that noted their concerns with the recommendation. Mr. Johnson said the stakeholder grid did not include the OHA letter due to the lateness in receipt; however, most of the concerns by OHA were already addressed in their earlier correspondence.

Mr. Johnson stated he would not repeat the mechanics of the recommended fee schedule methodology that was done last month. He did report that OH encounters, allowed charges, and reimbursements have been on a steadily decreasing trend between 2006 and 2008. The trend is not unusual for the Bureau as inpatient hospitalizations and ambulatory surgical centers have shown a similar trend. However, while the aggregate dollar totals for OH are in a declining trend, the per-encounter cost is not declining nearly as much. Currently, the Bureau is paying 146% of cost or 212% of the Medicare base rate for OH using a retrospective methodology.

Mr. Johnson reported the retrospective methodology involves a combination of hospital utilization, a hospital's charge structure, and a unique cost to charge ratio for each hospital. The retrospective methodology applies a formula to a service once the service is billed. Mr. Johnson said the cost to charge ratio is applied to the services after the Bureau adds sixteen basis points to the cost to charge ratio. Mr. Johnson reiterated that a cost to charge ratio is a unique factor for each hospital.

Mr. Johnson noted there was significant risk exposure to the Bureau by continuing to use the retrospective methodology. Under this methodology, there is no limit on how much a

hospital can increase charges each year, even with a sixty percent (60%) cap on billed charges. For example, if a hospital bills \$100 for a service, the service would be capped at \$60. However, if the hospital increases the charge to \$200, the cap would allow \$120, or \$20 more than the hospital would have previously been reimbursed. Since everything in the retrospective methodology relates to billed charges, Mr. Johnson said this unpredictability is why a prospective payment methodology is preferred.

Mr. Johnson indicated the Bureau has been moving to a prospective OH methodology for some time. One of the recommendations from the Navigant Consulting 2007 final report was to move to a prospective methodology for the Bureau for its OH encounters. By 2007, the Bureau had moved to a prospective methodology for inpatient hospitalization, and in November, 2009, the Board of Directors adopted the revised CMS prospective methodology for ambulatory surgical centers. Now, in 2010, the Bureau is recommending the prospective methodology be adopted in the OH setting.

Mr. Johnson noted there were two key principles in going to a prospective payment methodology. First, rates and polices are determined in advance during the effective period; second, rates would be constant during the effective period. Mr. Johnson added there were two benefits for the Bureau by going to a prospective payment methodology. First, the methodology promotes predictability, equity, and consistency of payments; second, the methodology encourages facilities to improve efficiencies in providing care. Mr. Johnson reiterated he believed the prospective methodology met the Bureau's goal of ensuring access to quality care to injured workers in a cost effective manner.

Mr. Johnson turned the presentation over to Ms. Casto. Ms. Casto recommended the OPSS be accepted. She noted OH encompassed a variety of services: emergency department, hospital outpatient/same day surgery, radiology, therapy, and other ancillary tests. These procedures come with various levels of complexity. Ms. Casto said Medicare uses four different reimbursement methodologies in the payment system, and OPSS is used in the vernacular to describe the whole system. She did state it is the largest reimbursement methodology of the four is ambulatory payment classifications, (APC). Because OPSS methodology and software are publically available, Medicare OPSS would be used in the Bureau's prospective payment system. Since APCs is the cornerstone of the Medicare system, the term is used somewhat interchangeably with OPSS in the healthcare industry.

Ms. Casto did say there would be times that a reasonable cost would be determined under the retrospective methodology that involved taking a cost and applying a cost to charge ratio. However, that methodology would only be used in rare cases where adequate payment is not made for some services.

Mr. Caldwell inquired about a situation regarding pre-existing conditions: but for the fact the injured worker has a pre-existing condition necessitating an outpatient service that otherwise would not be performed, would the outpatient services be covered. Ms. Casto indicated Mr. Caldwell's question is geared towards admission criteria. Case managers and physicians determine the appropriate treatment and setting, and co-morbidity issues are addressed in the billing system to allow the additional treatment to be reimbursed. However, if the services are fully packaged, no additional reimbursement would be made.

Mr. Hummel inquired if the fully packaged situation was similar to “DRG.” Ms. Casto replied that “DRG” is fully packaged. Mr. Hummel asked if the new prospective methodology would be using cost to charge ratios. Ms. Casto replied a cost to charge ratio would be used in rare instances, for example to calculate if an outlier payment is warranted. Cost to charge ratios are not in the basic prospective payment methodology formula.

Ms. Casto said OPSS was maintained by law and updated yearly based upon historical bill data. She also said some components of OPSS are updated quarterly, such as drug reimbursements, which are part of the OH arena. Finally, there is also a wage index adjustment which allows for sixty percent of the payment rate to be adjusted by the wage index set for the geographical area.

Ms. Casto noted there were three provisions recommended for adoption. First, there is the consideration of a high cost outlier exception, when extraordinary costs exist for treatment of an outlier case. Second, there is a hold harmless provision for cancer and children’s hospitals. Finally, APCs for rural sole community hospitals are adjusted upwards by 7.1%.

Mr. Hummel asked how a high cost outlier is determined. Ms. Casto said every bill submitted to the Bureau would go through that determination systematically.

Ms. Casto said OPSS is reviewed and debated annually. Providers and suppliers have opportunities to make comments each year in the summer before OPSS is updated. Additionally, the Medicare Advisory Committee and the Ambulatory Payment Classification Advisory Board, comprised of members from across the country, also make recommendations each year. Ms. Casto said OPSS is empirically sound, and most importantly, a publicly available system.

Ms. Casto reported the Bureau did examine the seven other states using OPSS for their workers’ compensation systems. The states had a variety of payment adjustment factors, or “PAFs,” and the ultimate recommendation for Ohio to be at a PAF of 166% was between the North Dakota and Texas respective PAFs. Ms. Casto reported that 2008 billings for the Bureau were analyzed in determining the appropriate PAFs under consideration of the following data elements: type of hospital, whether acute care, critical care, or children’s hospital; geographic regions, in which the state was broken down into sixteen regions; and category of services.

Ms. Casto reported the recommended PAF of 166% is expected to lead to 114% of allowed cost, which would be competitive to private payer rates. Ms. Casto reported in a 20 year review by the Medicare Advisory Committee, there was a hill and valley effect of private payer reimbursement rates ranging from 115% to 132%. Currently, the Bureau is at 146%, with Medicare reimbursement at 100%, and this figure is well above private payer rates and Medicare. The proposed PAF of 166%, leading to 114% of allowed cost, would place the Bureau at just below private payer rates in 1999.

Ms. Casto noted there were four children’s hospitals in Ohio providing specialized burn care to injured workers with a small number of encounters annually. Ms. Casto said the proposal recommends keeping children’s hospitals at a PAF of 253%. Additionally, a critical access hospital is the only hospital within a thirty-five mile rural area; if the region

is mountainous or with only secondary road accessibility, the hospital must be the only hospital within fifteen miles. There are thirty-seven sole rural community hospitals in Ohio. In 2008, these hospitals had 11,000 encounters with \$11 million in reimbursements. The encounters represented about four percent (4%) of the total Bureau encounters in 2008. For critical access hospitals, Medicare excludes them from OPPS and pays those service providers at 101% of Medicare cost. Ms. Casto indicated the Bureau considered the Medicare methodology for addressing these providers, and adding a PAF to the 101% figure; however, the critical access hospitals are estimated to have better reimbursements in the Bureau system under the OPPS.

Mr. Harris commented he was pleased to hear the Bureau considered the impact on critical access and rural hospitals. In his experience of dealing with thirteen United Auto Workers locals in eastern and southeastern Ohio, access to a hospital in rural areas was always a concern.

Mr. Johnson then went through projected impacts and concerns. He noted originally the proposal called for a PAF of 253% for children's hospitals in 2010 and 2011, with PAF of 189% and 166% for all other facilities in 2010 and 2011, respectively. Noting the Medical Service and Safety Committee's concerns and the January 12, 2010 letter from OHA, adjustments have been made to the proposal.

Ms. Falls inquired if data has been obtained to show impact and support for going to a prospective payment methodology. Mr. Johnson noted that in the hospital inpatient conversion from a retrospective payment methodology to a prospective payment methodology did not have a transition period like this proposal. However, looking back, the transition in the hospital inpatient area resulted in a savings of \$17.5 million for the Bureau in 2007/8 reimbursements. Mr. Johnson then addressed a concern regarding injured worker access to hospital care. Mr. Johnson examined the number of hospitals in the Bureau's population between 2004 and 2009. The years 2004 through 2007 were considered before implementing a prospective payment methodology for inpatient hospitalization, with 2008 and 2009 years considered after a prospective payment methodology for inpatient hospitalization. Mr. Johnson noted there were 345 hospitals that had at least one workers compensation related in-patient hospitalization between 2004 and 2007, and there were 328 hospitals under the same criteria between 2008 and 2009. Mr. Johnson noted there was a decrease of 17 hospitals, but the question was whether or not there was flight from the Bureau. Mr. Johnson reported that the difference was primarily due to the fact that some hospitals had only one workers' compensation patient in the relevant time period. He also noted that four hospitals did voluntarily terminate their provider agreements with the Bureau in 2008 and 2009. However, these hospitals were absorbed by larger hospitals, and Mr. Johnson and his staff could not find one hospital that voluntarily terminated their provider agreement with the Bureau for any other reason. While there were fluctuations in the numbers, Mr. Johnson concluded the fluctuations were due to the limited number of encounters some hospitals had with the Bureau rather than a change in the payment methodology.

Mr. Johnson noted the Bureau was comfortable with the two year proposal that was presented at the last meeting. However, fully understanding the Medical Service and Safety Committee's concerns, and the OHA request, the proposal has now been extended out to have a three year transition period, with the following PAFs:

Year	Children's Hospitals	All Other Facilities
2010	253%	197%
2011	253%	181%
2012	253%	166%

Mr. Johnson cautioned the Medical Services and Safety Committee that, as the process is implemented, the PAF may have to be adjusted, and that for example, the PAF may not be 181% in 2011. The indicated PAFs are based upon data that is currently available. Outside variables can potentially impact the reimbursement formulas; which can thereby result in a change to the PAF. There are four different payment methodologies involved in OPSS, and there can be changes within the foundation of those methodologies which can impact the number of resources in a given procedure, and the corresponding base Medicare relative value. If the base Medicare relative value changes significantly from what we are currently using, BWC would adjust the PAF to stay within the projected percentage of the BWC cost for that year. However, the PAF used will hold true to the Bureau's goal of providing ensuring access to quality care to injured workers in a cost effective manner. The PAFs provided, according to Mr. Johnson, are a relative valuation unit. Mr. Johnson wanted to make sure the Board of Directors understood the possibility of the recommended PAF changing, but the underlying proxy is the Bureau's cost will hold true to what is proposed, and hospitals will also understand.

Mr. Harris asked Mr. Johnson to come back each year with an update to show how the proposal is working. Mr. Johnson replied that this year there is a methodology and a transition period being introduced. However, in the rule, the PAF is only addressed for one year. Hence, Mr. Johnson would have to return each year to have the PAF approved.

Mr. Hummel asked if the rule could be reviewed if access to care changes. Mr. Hummel said he would like the same type of study that performed for OH as was presented by Mr. Johnson for in patient hospitalization. Mr. Johnson said he would provide that information. Mr. Johnson and his staff agreed with OHA to provide the partnership necessary to understand the impact on OH providers.

Mr. Johnson said the three PAFs selected were based upon the twenty year history of private insurance reimbursement rates. In the first year, the Bureau will be at just above the peak of private insurance rates, and in the second year, the Bureau will be in the middle. In the third year, the Bureau will be just below the lowest level of private insurance reimbursement, but the Bureau would still reimburse higher than Medicare.

In conclusion, Mr. Johnson remarked the recommendation has four parts. First, the recommendation calls for adopted the modified OPSS reimbursement methodology for the OH setting. Second, the recommendation calls for adopting the rates published in the 2010 OPSS final rule. Third, there would be a 253% PAF to the OPSS rate for children's hospitals. Finally, the 197% PAF would be applied to all other facilities. Mr. Johnson noted that, because of working with OHA and internal staff, the proposed rule was ninety-nine percent the same except for making the necessary PAF corrections. The two changes to the original recommended rule were in paragraph (A)(1) of the proposed rule: changing "1.89" to "1.97," and on page three, paragraph (5)(a): changing "38%" to "47%."

Mr. Johnson noted the Bureau understood the impacts to provider practices and hoped the presentation addressed the conscientious concerns of the Board of Directors. Mr. Johnson noted he and his staff will continue moving to improve; if the proposal is determined to not be working by creating chaos or hurting injured worker access, they will not be steadfast. Mr. Johnson said if the recommendation is not implemented, he would come back again to present the issue to the Medical Services and Safety Committee that may delay implementation; however, he and his staff are currently moving towards the May 1, 2010 date.

Mr. Harris thanked Mr. Johnson and Ms. Casto for their presentations, and especially for the work they had done since the first reading to make changes to the recommendation and to address the concerns of OHA.

Mr. Price inquired whether or not there had been any input from the MCO League regarding this proposal. Mr. Johnson responded the Bureau had not received a written formal response from that stakeholder. Mr. Price asked if the concerns of OHA had been addressed in a letter to that organization. Mr. Johnson indicated, due to the late arrival of the letter, no formal written response had been made. However, he did read a brief letter from the organization. In the letter, it was noted that while OHA and the Bureau may not always agree on the direction of the Bureau, but the organization was happy that Mr. Johnson could meet halfway on issues when concerns are presented. Mr. Johnson said OHA and the Bureau had an appropriate partnership that will continue to be nurtured. Mr. Price indicated to Mr. Johnson he was one step ahead of his question, as usual, and essentially the response was that OHA and the Bureau can agree without being disagreeable, and he thanked Mr. Johnson for his presentation.

Mr. Bryan inquired about the end result of the proposal made by Mr. Johnson. Ultimately, he asked, by adopting Medicare's reimbursement system, hospitals will get less money. Mr. Johnson replied that would be the end result. Mr. Johnson clarified that Medicare's basic formula is being used, but the Bureau have the ability to modify as necessary for Ohio's population. Mr. Johnson noted that, by using Medicare's system, their empirical research is not duplicated, and he assured Mr. Bryan that injured worker and employer needs would be in the forefront. Mr. Bryan asked if the proposal to be voted on was for a three year period. Mr. Johnson replied that the Bureau is on a path towards a prospective payment system. The recommendation before the Medical Services and Safety Committee was for a 1.97 payment adjustment factor, which would be valid for one year. The Bureau is presenting this payment adjustment factor recommendation with the understanding of the Board of Directors that there is a three year plan. Mr. Johnson concluded by saying this recommendation would therefore not go unchecked for three years without continued evaluation. Mr. Bryan asked if the proposal was for one year with information. Mr. Johnson answered that the Bureau is letting the Board of Directors know, in principle, what direction the Bureau is moving with the understanding each year may have slight modifications.

Mr. Matesich asked a question regarding the "tinkering" of healthcare by government. Specifically, he inquired how the Bureau would reimburse providers, and how quickly the Bureau could respond, if Medicare is affected by any ongoing federal health care reform issues. Mr. Matesich was concerned that delays in the Bureau responding to any

Medicare reimbursement changes would lead providers to limit services to injured workers and thereby harming injured workers. Mr. Johnson replied that Medicare has budget neutrality. Medicare has adequate funding to do empirical research. Medicare's research is the foundation to the Bureau's reimbursement schedule but not the end decision point. Mr. Johnson added the Bureau has the ability to come back to the Board of Directors to make any necessary revisions, and his department is constantly monitoring the underlying foundation.

Mr. Hummel moved that the Medical Services and Safety Committee recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to rescind current rule 4123-6-37.2 and adopt new rule 4123-6-37.2 of the Administrative Code, "Payment of Hospital Outpatient Services," with the motion consenting to the Administrator rescinding and adopting new rule 4123-6-37.2 as presented. The motion was seconded by Mr. Pitts, and the motion passed 3-0.

2. PERRP adoption of Federal OSHA final rules for personal protective equipment and acetylene, Rule 4167-3-04.2(C)

Mr. Michael Rea, Industrial Safety Administrator of the Public Employer Risk Reduction Program (PERRP) at the Division of Safety and Hygiene(DSH) presented the second reading of PERRP's adoption of Federal Occupational Safety and Health Administration(OSHA) final rules for personal protective equipment and acetylene. These rules are based on national consensus standards in the applicable fields.

With regard to acetylene, the OSHA updated its regulation based on applicable that were developed in 2003. With regard to personal protective equipment, OSHA updated its regulations based on various more recent consensus standards.

Mr. Rea reported there had been no adverse comments to the proposed rules, and no questions were posed at the first reading of the proposed rules at the December meeting of the Medical Services and Safety Committee.

Mr. Harris inquired if the rule changes were merely a formality. Mr. Rea responded in the affirmative, that the rules were being changed to keep current with OSHA standards.

Mr. Pitts moved that the Medical Services and Safety Committee recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend public employment risk reduction program rule 41267-3-04.2 of the Administrative Code, "Amending of standards," with the motion consenting to the Administrator amending rule 4167-3-04.2 as presented. The motion was seconded by Mr. Hummel, and the motion passed 3-0.

DISCUSSION ITEMS

1. Drug-free safety program update

Mr. Abe Al-Tarawneh, Superintendent of BWC's Division of Safety and Hygiene (DSH), appeared before the Medical Services and Safety Committee to discuss project progress

in the development of the Drug-free safety program (DFSP) Appearing with Mr. Al-Tarawneh were Rick Brown, Management Analyst Supervisor in Employers Programs, and Mr. Rich Gaul, Management Analyst Supervisor in DSH. Mr. Brown and Mr. Gaul were leaders in this project.

Mr. Al-Tarawneh began by noting Administrator Ryan had tasked DSH to lead the agency's efforts in re-tooling the Drug Free Workplace Program (DFWP) in August, 2009. Soon after, DSH assembled a project team and formulated specific objectives, tasks, and timelines.

The objective was to research and develop a compatible, evidence based, contemporary Drug Free Safety Program (DFSP) that is designed specifically to help Ohio employers prevent occupational injuries attributable to substance abuse. To achieve this objective, the project team undertook several tasks. First, the project team benchmarked similar programs including other states and self insured employers. Second, the project team reviewed and synthesized scientific literature on the design and effectiveness of drug-free workplace programs. Third, the project team analyzed the Bureau's data on experience of program participants. Fourth, the project team engaged and solicited input from interested parties including employers, employees, and vendors as well as from experts in the subject area, including the National Institute of Occupational Safety and Health and The Ohio State University. Finally, based on the results of the above-described work, the project team developed recommendations for retooling the current DFWP.

Mr. Al-Tarawneh noted the proposed DFSP design involved the following: First, there would be a renaming or rebranding of the DFWP using safety as a primary focus and to indicate a significant change in the program. Second, DFWP and DFWP-EZ would be combined into one program with two levels: the basic program level, or "basic level," and the advanced program level, or "advanced level." Third, the proposed design would incorporate drug-free into employers' holistic approach to safety for both levels. Finally, the elements included in both levels would be safety, written substance abuse policy, employee substance awareness, supervisor training, drug and alcohol testing, and employee assistance.

Mr. Al-Tarawneh noted that there would be four safety elements required in both program levels. First, both programs would require an online safety assessment. Mr. Al-Tarawneh said DSH expects this requirement will prompt employers to recognizing safety issues and will allow the Bureau to understand the employer's safety needs and accordingly provide employers with the assistance they need. Second, both programs would require accident analysis training for supervisors. Although accidents are indicative of safety system failure, the training, possibly in an online format, would address accidents and near misses, why the incidents happened, how to analyze the data, and how to improve the system to prevent such incidents in the future. Third, both programs would require online accident reporting. Mr. Al-Tarawneh said this element would require employers to timely exchange information to allow DSH to better understand accident causation and establish best practices to prevent accidents. Finally, both programs would have safety services available upon request or as indicated; e.g., increasing loss ratios, injury trend analysis, inadequate accident analysis, catastrophic claims, fatality, or other reasons. Mr. Al-Tarawneh noted adding these requirements will require rigorous work by DSH.

Mr. Al-Tarawneh said the basic program would have six elements. First, the safety elements described in the above paragraph would be included. Second, the employer would need to have a drug free policy. Third, annual employee substance awareness training, with content identified by the Bureau, would have to be provided. Fourth, annual supervisor training, with content to be identified by the Bureau.. Fifth, the basic program would require pre-employment and/or new hire, reasonable suspicion, post-accident return-to-duty and follow-up testing. The testing would move from the current 5-panel testing requirement to a 9-panel drug test plus expanded opiates, reflecting the nature and extent of drug abuse in communities. Finally, the basic program would require sharing a list of community resources and a commitment to employee health in the written policy.

Mr. Harris inquired if a plant manager or a plant supervisor would be required to participate in the proposed training. Mr. Harris said from his experience, it is one item to require a frontline supervisor to participate in the training. However, for management to buy into a program, management must be personally involved in the program. Simply put, it is difficult to have management back a program if they are not required to participate at least once a year. Mr. Al-Tarawneh noted that the current drug free workplace program requires implementing various steps of the BWC 10-Step Business Plan for Safety, one of the steps concerns the involvement of top management. With the proposed program, many of the safety requirements including completing the safety assessment, accident reporting and action plan will require upper involvement of upper management. Mr. Al-Tarawneh noted that starting a DFWP requires major decisions with legal ramifications which will require top management commitment to the program. Mr. Lhota agreed with Mr. Harris' concern. Safety is everybody's concern, and everybody has to be involved. Mr. Lhota said the tone for safety is set by top management, and he agreed the program has to start there. Mr. Al-Tarawneh agreed with Mr. Lhota's comment.

Mr. Al-Tarawneh noted three additional requirements for the advanced program beyond those for the basic program. First, the employer would have a safety action plan following completion of the online safety assessment. The action plan would require employers to think of improving or enhancing their safety program to reduce risks. Second, random drug testing of twenty-five percent (25%) of the employees in the private sector; however, the 25% testing rate would only apply to employees in safety sensitive functions for public employers. Mr. Al-Tarawneh said the random drug testing would deter employees from abusing drugs as a whole. Finally, the employer would agree not to terminate on a first positive drug test and offer expanded assistance including referral and payment for an assessment and additional assistance.

Mr. Al-Tarawneh said there were seven notable improvements in the proposed advanced program from the current DFWP. First, the program would be more effective because, with its safety elements, the proposed program is expected to integrate better into workplace safety for the company. Second, the proposed program would be less costly for employers; e.g., there would be fewer required hours of substance awareness and supervisor training, and thus supervisors and employees would have less time devoted to training. Third, there would be improved testing with expansion into commonly abused prescription medications including oxycodone, making the proposed advanced program more current with the nature and extent of the substance abuse problems in the

workplace. Fourth, the proposed program would be easy to implement with the Bureau providing access to training, possibly through OCOOSH, service offices, or online training. Fifth, the proposed program would provide better program consistency with the Bureau specifying elements of training content and written policy. Sixth, there would be better monitoring of the proposed program with online reporting requirements. Mr. Al-Tarawneh believed the Bureau would learn more about what is effective about the program, serve a purpose in detecting drug abuse, and serve a purpose in dealing with employees with a drug abuse problem as well as helping identify the size of the problem. Finally, the proposed program would not allow an employer to terminate an employee on a first positive drug test, but the employer must agree to more extensive assistance including, but not limited to: referral for assessment; paying for the cost of assessment; and providing a second chance to help employees deal with substance problems rather than simply going to work for another employer

In summary, Mr. Al-Tarawneh said all of these efforts including consulting the scientific literature, benchmarking, analysis of data, and soliciting input from stakeholders and experts were intended to guarantee the viability and sustainability of the Bureau's DFWP 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, Mr. Al-Tarawneh said the proposed program design would allow for collecting better data about the program as it is implemented by employers including the type of drugs that are detected in workplaces. Better data would allow the Bureau to improve the program implementation process and highlight its most effective elements in future years. Mr. Al-Tarawneh stated the Bureau would continue to develop the necessary cost-lowering tools to help Ohio's employers implement the program efficiently. Also, the Bureau would continue to monitor and evaluate the program processes and outcomes to improve its effectiveness and value to Ohio's employers.

Mr. Al-Tarawneh said the Bureau would continue to assess the viability, integrity, cost and value of the proposed program and provide better tools, training, and assistance in sustaining the program. Mr. Al-Tarawneh noted the final rules of the proposed program would have a first reading on February with a second reading in March. Mr. Al-Tarawneh expected the safety assessment and online training to be in place by the proposed effective date of July 1, 2010.

Mr. Matesich commended Mr. Al-Tarawneh, Mr. Brown and Mr. Gaul for their presentation. Mr. Matesich inquired what exactly constituted an accident. He noted the U.S. Department of Transportation defined accident as an event that resulted in injury, property damage, or death. In his business, he noted there were muscle sprains/strains that go on for a few days because his employees try to work through them, but there is no accident or injury reported. Mr. Matesich inquired if a sliced hand with stitches would be drug tested, or some other level of injury. Mr. Brown noted there was intelligent testing design that gave employers feedback after closing an accident investigation. If there is no violation of a work rule, the accident was a normal part of a job function, and there was no reasonable suspicion to test the employee, the employer would not be obligated to test the employee under the program. Mr. Brown noted this portion of the program was put into DFWP in 2002 and is currently in place.

Mr. Price noted there were thirty-three stakeholder representatives participating in stakeholder meetings generating over one hundred suggestions. Mr. Price inquired if there was a stakeholder grid available. Mr. Al-Tarawneh indicated the last stakeholder meeting was held on December 7th, and a stakeholder grid would be provided for the first reading of the rule. Mr. Price asked if the proposal as outlined encompasses stakeholder concerns. Mr. Al-Tarawneh answered in the affirmative. Most of the stakeholder comments were very positive. Mr. Brown added that, due to the number of comments, some of the comments were contradictory, and he provided the example of the debate of how many hours of education would be required. Mr. Brown noted smaller employers did not want to be burdened with a high number of educational hours. Mr. Price indicated that there were stakeholder meetings, input was obtained, and while he respected the timeline issue, he wanted to confirm those comments and sharing of ideas were in the forefront presently. Mr. Brown responded in the affirmative.

Mr. Pitts commended Mr. Al-Tarawneh, Mr. Brown and Mr. Gaul for their great work, and he was supportive of the new program. However, he did raise a concern as to why, in the basic program, there is no provision for not terminating an employee for a first positive drug test. Mr. Pitts believed it would be more appropriate that there would be no termination for a first positive drug test if the employee agrees to undergo a remedial program at their own expense. Mr. Gaul responded that there was a very strong discussion across the board on this issue. Employers maintained it was their right and their ability to terminate someone on a first positive drug test. Mr. Gaul realizes accepting the employer's model would lead to passing a problem from one employer to another; hence, for the basic program, that provision was excluded. Mr. Pitts inquired if the advanced program had the provision for no termination upon a first positive test, and Mr. Gaul answered in the affirmative. Mr. Pitts asked if the provision was included in the advanced program because there would be a bigger discount, and Mr. Gaul answered in the affirmative. Mr. Gaul added, while disagreement still exists over that issue relative to the advanced program, the Bureau believed there should be a higher standard to be applied with the advanced level to prevent the program from becoming a screening mechanism to advance into providing a chance to employees who are willing to overcome a drug abuse problem.

Mr. Hummel agreed generally with Mr. Pitts' comments. Mr. Hummel inquired how the Bureau would monitor adherence to the program. Mr. Hummel was concerned the program would be written and then placed on a shelf. Mr. Al-Tarawneh replied that the program require several items to be completed online. Further, Mr. Al-Tarawneh indicated DSH, although a rigorous task, would continue to engage employers involved in the program. Mr. Al-Tarawneh noted employers would have to provide accident reporting and also would be required to file an annual report on the program that would provide data to the Bureau. DSH would be able to respond to the employer as to whether or not the program is being implemented in a proper way.

Mr. Hummel inquired about the annual assessment and whether or not the assessment will give any indication of improvements. Mr. Al-Tarawneh replied that the safety assessment is a diagnostic on how to implement a DFSP for that particular employer. DSH would rely on accident reporting, claims reporting, and the annual reports to continue to work with employers to strengthen the program and DSH would then determine what type of help would benefit that employer. In the advanced program,

accident reporting with a safety action plan is required. These reports will verify the safety assessment as well as what DSH can recommend towards a safety program and a DFSP.

Mr. Hummel noted that, although accident reporting may be required, the program cannot identify how many accidents are being avoided. Mr. Hummel inquired if any baselines on drug testing can be provided, such as how many drug tests came out positive. Mr. Al-Tarawneh responded there has been much discussion about how to determine the effectiveness of the program, whether the program has success only defined by fewer claims or other factors. In his opinion, Mr. Al-Tarawneh believed there were three major results that could come from the program. First, the program may reduce accidents, injuries and claims and assist employers in eliminating or minimizing safety problems in their workplaces areas. Second the program will work as a deterrent to employees abusing drugs and assist in recognizing a drug abuse problem when it exists. Third, the program will provide better data and statistics relative to the nature and extent of drug abuse problems in certain industries and certain regions and communities. Such statistics will be beneficial to other and agencies parties concerned with drug abuse prevention and rehabilitation such as law enforcement. Mr. Al-Tarawneh noted the one hundred comments from stakeholders were placed into a matrix addressing these three criteria.

Mr. Caldwell noted that drug testing is a part of collective bargaining, and he noted in many instances, a first positive drug test becomes a legal matter subject to collective bargaining. Mr. Caldwell inquired if there was any discussion on that point in developing this program. Mr. Al-Tarawneh replied that labor and trade organizations were involved in the stakeholder meetings. However, he did note that only 14,000 employers are currently participating in DFWP, and collective bargaining may be a reason why an employer chooses not to participate. From DSH's perspective, Mr. Al-Tarawneh believed whether or not an employer participates, and the level the employer chooses to participate at, is entirely up to the employer. Ultimately, employers have to determine the agreements they enter. Mr. Brown added the program is intended to be designed as a win-win for employees and employers; however, employers are involved in issues with the National Labor Relations Board, and there are issues in developing a program with collective bargaining. For example, Mr. Brown noted the advanced program would require random drug testing, which collective bargaining may not allow. Mr. Caldwell did note employers would receive discounts to participate in the program. Administrator Ryan noted that most collective bargaining employers are self insured, and the DFSP would deal with state fund risks; while there may be some overlap, the amount would be minimal. Mr. Caldwell asked if the situation could occur, where a state fund risk is involved in collective bargaining, and Administrator Ryan replied in the affirmative. Mr. Harris noted that there are small employer shops with collective bargaining, and drug testing issues are addressed through collective bargaining agreements. Mr. Caldwell noted his interest was whether or not an employer could participate in the program due to collective bargaining.

Ms. Falls noted there was a public forum several months ago, and there was concern the Bureau was moving away from safety and DFWP. Ms. Falls inquired if the Bureau was starting to improve perceptions, and second, whether or not safety council representatives participated in the workgroups in developing the program. Mr. Al-

Tarawneh could not answer the latter question. He did indicate safety was a major aspect of the DFSP to the extent no other program exists in any other state like the DFSP. Mr. Al-Tarawneh noted the safety assessment did not exist in DFWP. Ms. Falls asked further about the perceptions, not what the Bureau is doing. Mr. Al-Tarawneh replied that the Bureau was improving perceptions. Ms. Falls noted many of the people with the perceptions that the Bureau was moving away from safety and DFWP were safety council members. She inquired if there had been any response from safety councils regarding the program. Mr. Gaul replied that many of the participants in the workgroups were members of safety councils, and those members had very positive feedback on including safety in the program. Further, Mr. Gaul noted the program was eliminating the five year period of eligibility that currently exists in DFWP, allowing the program to be continuous. Mr. Gaul said the Bureau supports a drug free work place holistic integration with an employer's safety programs. Mr. Gaul indicated this message was clearly sent to interested parties in the workgroups, and the Bureau will continue to support this message.

Mr. Price asked about the discounts being offered either for the basic or the advanced program. Mr. Price was of the belief that discounts were being done away with altogether. Mr. Al-Tarawneh noted Deloitte is presently looking at pricing the program correctly, and discussions continue on this issue. Mr. Al-Tarawneh noted the advanced program is more rigorous than the basic program, and accordingly, the Bureau may have to offer higher discounts for employers to participate. Mr. Price reiterated he remembered a discussion about discounts being completely removed from consideration. Administrator Ryan stated the Deloitte study never said discounts were inappropriate or should not be proper. Administrator Ryan said private insurers do offer discounts. The problem was the level of discounts and whether the discount programs in place, through evaluation, justified the discount. Administrator Ryan said the Bureau wants DFSP to deliver a sound result. She noted many outside vendors are a part of the program who constructed DFWP only due to the level of discount. Administrator Ryan said the Bureau wants a program that will work, and as Mr. Al-Tarawneh stated, the pricing is being worked on by Deloitte and would be addressed through the actuarial side. Mr. Price said Administrator Ryan's statements were music to his ears, and it was a misunderstanding on his part, but he was glad the issue was clarified. Mr. Haffey indicated there were previous discussions on the stacking of discounts. Administrator Ryan noted she testified in the House and Senate on the issue of discounts. While discounts were not opposed, the stacking and quantity of them was an issue. Mr. Caldwell noted when he and a few other Directors met with members of the General Assembly they may have sent a wrong signal. While discounts for programs in place at that time were being eliminated, Mr. Caldwell did not believe that discounts could not be addressed in other programs. Mr. Caldwell noted his opinion had changed since the beginning of the discussion; he originally thought workplaces could not be made safer without discounts. Mr. Caldwell agreed with Mr. Price that, at the General Assembly, he thought discounts would be eliminated; however, that issue was not set in stone and the Bureau could examine discounts in the future. Administrator Ryan stated, as noted in her testimony, the issue was not about discounts, but utilizing the discounts as an insurance tool. Administrator Ryan said the discounts would not be at their prior levels, and the Bureau was looking at a smaller discount that still permits accommodation of the program.

Mr. Harris hoped the range of comments and questions from the Medical Services and Safety Committee will help Mr. Al-Tarawneh's staff in finalizing the proposal. Mr. Harris inquired if the proposal would be presented in March. Mr. Al-Tarawneh indicated the first reading would be in February.

2. Committee Calendar

Mr. Berno appeared before the Medical Services and Safety Committee to discuss the committee's calendar. Mr. Berno noted the managed care organization referral report was not placed on this month's calendar due to uncertainty in how long some of this day's presentations would require. The report will be on next month's calendar.

Additionally, the first reading of the Medical Services and Provider Fee schedule will be moved to March. A first reading of the DFSP will be during the February meeting. Mr. Berno noted that, due to pricing issues associated with the program, there will be a parallel track with the Actuarial Committee. The Actuarial Committee is expected to hear the first reading of the pricing of DFSP next month, with second readings in both committees to be held in March. Ms. Falls inquired on the parallel processing of DFSP. She indicated pricing was truly an issue for the Actuarial Committee; however, DFSP addresses not only safety issues but also business issues. Mr. Berno replied the question was a good one, and he agreed pricing should stay with the Actuarial Committee; however, he was amenable to work with the applicable committees and the Board of Directors if there was a different way to address DFSP.

Finally, Mr. Berno said he was planning to have a claim process education session for the March meeting.

ADJOURNMENT

Mr. Hummel moved to adjourn the meeting at 2:11 PM, seconded by Mr. Pitts. The meeting adjourned with a 3-0 unanimous roll call vote.

Prepared by Michael J. Sourek, Staff Counsel
January 26, 2010