

BWC Board of Directors
Medical Services and Safety Committee

Thursday, September 23, 2010

Level 2, Room 3 (Mezzanine)

30 West Spring St.

Columbus, OH 43215

Members Present:

James Harris, Chair
James Hummel, Vice Chair
Alison Falls (arrived 12:38 PM)
William Lhota, *ex officio*
James Matesich (arrived 12:43 PM)
Thomas Pitts

Members Absent: None

Other Directors Present: Charles Bryan, David Caldwell, Kenneth Haffey, Larry Price,
Robert Smith

Counsel Present: James Barnes, BWC General Counsel and Chief Ethics Officer
Tom Sico, Assistant General Counsel

Staff Present: Marsha Ryan, Administrator
Abe Al-Tarawneh, Superintendent Division of Safety and Hygiene()
Dr. Robert Balchick, Chief Medical Officer
Joy Bush, Program Development Director
Johnnie Hanna, R. Ph., M.B.A., Pharmacy Program Director
Freddie Johnson, Director Managed Care Services
Tina Kielmeyer, Chief, Customer Services Division
Mamta Mujumdar, Director of Medical Research

Consultant Present: Anne Casto, President, Casto Consulting

Scribe: Michael J. Sourek, Staff Counsel

CALL TO ORDER

Mr. Harris called the meeting to order at 12:30 PM, and the roll call was taken. Ms. Falls and Mr. Matesich were not present, arriving at the times noted above.

MINUTES OF AUGUST 26, 2010 MEETING

Mr. Harris asked for any changes to the minutes of August 26, 2010. With no changes, Mr. Hummel moved to have the minutes of August 26, 2010 be approved, and Mr. Pitts seconded the motion. The motion passed with a 4-0 roll call vote.

REVIEW AND APPROVAL OF AGENDA

Mr. Harris asked for any changes to the agenda. With no changes, Mr. Pitts moved to have the agenda approved, and the motion was seconded by Mr. Hummel. The motion passed with a 4-0 roll call vote.

NEW BUSINESS/ACTION ITEMS

1. Motions for Board Consideration

A. For Second Reading – Pharmacy and Therapeutics Committee Rule 4123-6-21.2

Dr. Bob Balchick, Chief Medical Officer and Mr. Johnnie Hanna, Pharmacy Program Director, presented the second reading of the Pharmacy and Therapeutics Committee ((PTC)), Rule 4123-6-21.2. A copy of the proposed rule, CSBRCSBR form, executive summary, and a stakeholder feedback grid are incorporated into the minutes by reference and were provided to the Medical Services and Safety Committee (MSSC,) prior to the meeting.

Dr. Balchick reported the purpose of the rule permits PTC to be a separate committee; previously PTC was a subcommittee of the Health Care Quality Assurance Advisory Committee ((HCQAAC.)) PTC advises the Bureau's Pharmacy Department and the pharmacy benefits manager. The Pharmacy Department handles 1.2 million prescriptions, at a cost of \$128 million, annually.

From last month's meeting, the rule changed the number of members on the committee to no more than thirteen and no less than five. The change provided flexibility and balance to address MSSC's concerns raised last month. There were three small changes from the first reading in paragraph (A). First, the digits "13" and "5" were spelled out. Second, the phrase "licensed doctors" was changed to "licensed physicians." This change eliminated paragraph (B)(2). Third, the last sentence was changed to read "[a]ny subcommittee recommendations shall be submitted to the [PTC]." The change avoided the perception PTC had no choice in adopting a subcommittee's recommendation. Mr. Harris inquired if the changes were all minor technical changes, and Dr. Balchick replied in the affirmative.

There were 7 shareholder feedback responses, and the Bureau responded to all directly. Several of the comments were positive and complimentary. Several stakeholders inquired about the committee's cost. Each member is paid \$400/meeting, which typically lasts two hours, and this rate would continue this fiscal year. The Bureau appreciates the valued advice each medical professional serving on PTC provides, and the time spent away from their businesses and practices. Another stakeholder comment was raised at this month's HCQAAC meeting. The stakeholder wished HCQAAC to continue reviewing pharmacy therapeutic issues. PTC consists of a diverse group of doctors and pharmacists, three of whom also serve on HCQAAC. The Bureau believed a separate PTC specializing in pharmacy issues would be more efficient, but there would be occasion where medication therapy would overlap with HCQAAC. A third stakeholder comment came from a managed care organization ((MCO.)) The MCO suggested the decisions of PTC should be presented to MCOs for acceptance. PTC is a professional advisory committee, and any recommendations require presentation to BWC as policy or by rule

making procedures, which would require stakeholder feedback. PTC meetings are also public.

Mr. Harris appreciated the presentation, especially stakeholder feedback. Mr. Hummel inquired when the rule would become effective. Dr. Balchick replied the committee has been in existence for many years, but there was a lapse from 2007 to 2009 when the Bureau started making changes in the Pharmacy Department. The meetings have occurred quarterly for the past year, with the next meeting scheduled in December, 2010. Many rules for the PTC were taken from the previous committee.

Mr. Harris moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to adopt Rule 4123-6-21.2 of the Administrative Code, "Pharmacy and Therapeutics Committee," to advise the Administrator and Chief Medical Officer on issues involving medication therapy for injured workers, with the motion consenting to the Administrator adopting Rule 4123-6-21.2 as presented at the meeting. The motion was seconded by Mr. Hummel, and the motion passed with a 5-0 roll call vote, with Mr. Matesich not present.

A. For First Reading

1. HCQAAC Rule 4123-6-22

Dr. Balchick and Ms. Mujumdar presented the first reading of the HCQAAC Rule 4123-6-22. A copy of the proposed, and rescinded, rules, CSBR form and executive summary are incorporated by reference into the minutes and were provided to MSSC prior to the meeting.

Dr. Balchick noted HCQAAC was statutorily required. The function of HCQAAC is to review treatment guidelines. There were no substantive changes to the rule; however, because the rule content was significantly rearranged, and style modified to be consistent with other rules, this rule is being rescinded and recreated with the proposed rule.

The most significant change concerned the governance structure. The previous rule provided for reporting and organizational management by the Chief of Injury Management; however, the responsibility of HCQAAC now rests with the Chief Medical Officer. The rule also has similar construction as the recent PTC as far as membership numbers, terms, voting and meeting frequency. Fees would be \$600/meeting as the Bureau values and respects the time medical professionals serving on HCQAAC spend away from their businesses and practices. Stakeholder feedback was requested on September 15, 2010, and will close on October 6, 2010.

Mr. Pitts recommended, for consistency with the PTC rule, to have the numerical "13" and "5" spelled out. Dr. Balchick replied the change has already been made but the changed copy was not available prior to the meeting. Ms. Falls asked, with the previous rule rescinded, whether functions such as reviewing medical disputes and decertification would continue in the new HCQAAC. Dr. Balchick replied the functions would still continue with HCQAAC; however the term "disputes" is not completely indicative of the function. To the extent HCQAAC will perform peer reviews and analyze treatment guidelines, HCQAAC will be involved in disputes. The intent is now more positive to deal with any issues with providers and MCOs combined. Ms. Falls inquired what rule 4123-6-16 concerned, and Mr. Sico replied this was the Alternative Dispute Resolution, or "ADR,"

rule. Ms. Falls asked if any function of HCQAAC concerns ADR. Mr. Sico replied in the negative; the previous rule had the terminology, but the rule was not applied in this manner. Ms. Falls asked if the old rule was incorrect, and Mr. Sico replied in the affirmative. Dr. Balchick added the ADR process had recently been restructured.

2. 2011 Inpatient Hospital Fee Schedule Rule 4123-6-37.1

Mr. Johnson and Ms. Casto presented the first reading of the 2011 Inpatient Hospital Fee Schedule ((IHFS,)) Rule 4123-6-37.1. Copies of the proposed rule, CSBR form, executive summary, and a powerpoint presentation are incorporated by reference into the minutes and were provided to MSSC prior to the meeting.

Mr. Johnson noted inpatient hospitalizations (IH) comprise less than 1% of all invoices paid by the Bureau between February, 2009 and February, 2010; however, these invoices also represent 11.1% of total medical benefits paid, totaling \$81 million over the same time period. IH are commonly the first treatment following an injury. Mr. Johnson believed the proposed rule ensured access to high quality medical care and provided the road to success to achieve the best possible recovery.

There were three changes in the 2011 IHFS: the IHFS adopts Medicare Severity-Diagnosis Related Groups (MS-DRG) pricing; the payment adjustment factor (PAF) increased from 175% to 180% of Medicare reimbursement rates for outlier claims only; and a Bureau adjustment factor (BAF) of 3.15% was implemented to offset Medicare adjustments made prior to publishing the rule. With regard to BAF, Ohio now addresses changes in the Medicare base formula that were not in the 2010 IHFS. The 2011 IHFS is projected to increase BWC 2011 reimbursements by 5.7%, or \$4.9 million as compared to the estimated 2010 reimbursements. The expected implementation date of the rule is February 1, 2011. The Bureau met with the Ohio Hospital Association, who is supporting the rule, and posted the rule for comment on the Bureau website on September 10, 2010. Notice of the rule has been given to provider associations, self insured employers, employer organizations (Ohio Manufacturer's Association, Ohio Chambers of Commerce), MCOs, the MCO League, Ohio Association for Justice, and HCQAAC.

The fee schedule methodology for the 2011 IHFS had 4 components: evaluation of current inpatient services and experiences, considering the need for annual payment updates and/or other policy changes; evaluation of the Medication Inpatient Prospective Payment System updates; setting the PAF at the right level; and development of payment adjustments that accurately reflect market, service and payment cost differences, especially for Ohio. In terms of inpatient services volume, there was mixed variability with an increase in 2008, decrease in 2009, and an overall decreasing trend. 2007 was the baseline year as the Bureau went from a retrospective to prospective payment methodology. Similarly, IH costs showed the same variability, but with increasing trends in allowed charges, payment and cost. The data showed median payments rose by only 3%, and the Bureau had projected this figure to increase 3-4%. Mr. Bryan inquired if the charge lines on the graphs represent how much a hospital charges, and Mr. Johnson replied in the affirmative.

Mr. Johnson provided an overview of the 2010 calculation formula used to compute reimbursements, and the 2011 recommended change to the current calculation formula. In 2010, the Bureau used the Medicare rate multiplied by a PAF with an added per diem;

in 2011, BWC is proposing to add the BAF prior to applying the PAF and the per diem. Mr. Bryan inquired if Medicare has adjusted reimbursements downward to make their budget, and now the Bureau is making up the Medicare cuts by adding the BAF into the calculation. Mr. Johnson said that while the impact of the recommendation restores Medicare cuts, the recommendations were not made with the focus of making up Medicare cuts. Mr. Johnson indicated that the Bureau does rely on Medicare empirical research and data as a foundation for selected BWC fee schedule development. As part of the process, any changes Medicare makes to its fee schedule publications are evaluated to determine if all of Medicare changes will be adopted. In evaluating the changes Medicare was making to its 2011 inpatient hospital fee schedule, it was determined that the changes did not reflect a change in the actual cost of services, but was due to legal budgetary requirements which Medicare was charged to meet. Additionally, the Medicare changes did not support BWC's goal of ensuring access to quality care. The Bureau believes reimbursements should not be impacted by Medicare's budget responsibilities, rather the Bureau's recommendations are guided by what is the appropriate reimbursement level which will ensure access to quality care. Most providers agreed the Bureau should not adjust fees downward because of Medicare budget issues. Mr. Bryan asked if Medicare will pay the final Medicare proposed rates to the hospital, and Mr. Johnson replied in the affirmative; further indicating that while Medicare pays less in their rates, providers experience a much higher service volume.

Ms. Casto presented the Medicare 2011 Inpatient Updates. She discussed the document and coding adjustment, which is a component of the Transitional Medical Assistance, Abstinence Education and Qualifying Programs Extension Act of 2007. Medicare implemented a budget neutrality safeguard proactively executed to address the move to a severity-adjusted classification system for IH. This change revolved around Medicare case mix; the case mix reflects the types of services-surgical vs. medical, and severity of illness of the patient population. For the Bureau's data, 72% of IH was surgical, 28% for medical, and the Bureau's case mix ratio was 1.9125. This data is a high surgical case mix population, which is expected when 64% of claims are orthopedic, an area with high incidence of surgical intervention. Other insurers typically have a case mix of 1.45-1.47. Beginning last March, the Bureau started considering the Medicare changes from the Affordable Care Act, and there were two changes that caught the Bureau's attention. First in 2008, Medicare was changing to a severity based system. This coding adjustment on future bills (after 2008 and 2009) would be implemented if the case mix index increased larger than expected for Medicare. Medicare, facing budgetary constraints, had paid so much in 2008 and 2009 that Medicare was recouping payments in 2011 to return to budget neutrality. The Bureau case mix index did increase in 2008 from 1.8 in 2007 to 1.9. The Bureau has a dedicated coding staff to verify bill submission was accurate; prepayment reviews show no intentional provider upcoding or enhancing of coding for the Bureau's payment system. The Bureau believes bill submissions are accurate, and confident the case mix is accurate for the Bureau population. The documentation and coding adjustment applies equally to all hospitals even if their individual case mix is different. Community hospitals would most likely have lower case mixes and less severity. For this reason, the Bureau is incorporating the first 2.9% of the 3.15% BAF for 2011.

The second issue for Medicare 2011 updates was the market basket adjustment required by the Affordable Care Act, another cost saving measure. Medicare is providing a yearly

market basket adjustment over the years 2010 to 2019. For 2011, this reduction was 0.25%. This measure looks at each healthcare setting and the price to purchase the same goods in 2011 versus 2010, and the measure's purpose is to extend the life of the Medicare Fund. Clearly, this reduction is irrelevant to the Bureau's goal of providing access to quality care. The Bureau was now proposing a 0.25% of the 3.15% BAF for this reason.

Mr. Harris inquired if the BAF of 3.15% was based on 2.9%+0.25%, and Ms. Casto replied in the affirmative. Mr. Bryan inquired if this BAF represented a cost shifting to all non-Medicare providers, and Ms. Casto replied the situation could be viewed that way. Mr. Bryan asked if she personally believed this statement. She replied Medicare has definitely indicated reduction of their reimbursements, and this reduction will affect the Medicare setting for years to come. Whether community and government payers pick up the difference, that situation is certainly possible. Mr. Matesich inquired if the Bureau was concerned that providers of these services would not treat injured workers, and reduce the provider network. Ms. Casto replied in the affirmative; the access to care is a consideration in making the rule proposal. The Bureau also examines all bill charges and what percentage of costs the Bureau is paying over margin. From 2009 experience, the Bureau is paying 102% of hospital costs. Another consideration is review of Medicare's policies and where does the Bureau stand; if the Bureau were to simply adopt Medicare cost measures, with reimbursements dropping significantly, the Bureau would put the provider mix in jeopardy. Mr. Matesich asked if other states, or private insurers, followed the same methodology. Ms. Casto stated from her experience with Texas, that state did do a large analysis every few years and did look at their community versus the Medicare market. Mr. Hummel inquired if the Bureau ever evaluated access to care from the view of losing providers to having too many providers. Ms. Casto replied the issue was examined but not in the presentation. Mr. Johnson added the Bureau continually examines the number of providers and looks for cause/effect for any changes.

Ms. Casto examined the outlier PAF. Review of the outlier bill metrics showed the Bureau paid slightly below estimated costs, with the outlier PAF set at 175%. For this reason, the Bureau is recommending the outlier PAF be increased to 180% to have a bottom line reimbursement at 102% of a hospital's costs. In regards to the PAF methodology, Ohio has a two tiered system of 120/175% for inliers/outliers. Since 2008, there has been an increase from 5 states to 10 states using this methodology, with PAFs ranging from 120% (California) to 200% (Mississippi). If the Bureau was a one tier PAF system, the PAF would be 128% and would not change the Bureau's rank. The 180% outlier PAF would not move this figure much. The Bureau is as comprehensive as possible and looks at all states to see how they are addressing reimbursements. After summarizing the proposed changes, Mr. Johnson concluded noting total payments for IH have decreased relative to the medical consumer price index while the Bureau is maintaining a vast medical provider network.

Mr. Matesich inquired about the comment posed by Compmanagement Health System. The Bureau admitted the comment's validity and wanted to know the timeline for implementation. Mr. Johnson acknowledged the validity of the statement. The Bureau feel that while the recommendation had merit, that given there is only one facility to which this issue pertain, the solution may be more than necessary to address the one facility. The Bureau does not want to create more complexity in the reimbursement

methodology than necessary. Given that as soon as this IHFS is passed, the process begins again; all comments submitted are re-evaluated to determine if they are appropriate for inclusion as part of the next fee reimbursement recommendations. Thus, the Bureau will evaluate the submitted comment and proposal which has merit for next year to determine if a recommendation should reflect the same.

DISCUSSION ITEMS

1. Customer Services Division Report

Ms. Kielmeyer presented the Customer Services Division report, which focused on 3 areas: Drug Free Safety Program, ((DFSP)) update; Claim Complexity Project; and Lump Sum Settlement (LSS) process update. A one page bullet point synopsis for each topic was presented and incorporated into the minutes by reference and were provided to MSSC prior to the meeting.

The DFSP update had been promised to MSSC, and Ms. Kielmeyer thoroughly referenced all statistical data provided on the synopsis without omission. The exact number of employers participating in DFSP as of July 1, 2010 was 4,752. History of Participation figures deal with where the current participants in DFSP originated; the Bureau was pleased that 70% of current DFSP participating employers were formerly in DFSP's predecessor program (the DFWP) but had exhausted eligibility. The Bureau was also pleased that 13% of current DFSP participating employers are new to the program; a goal of DFSP is attracting more and more new employers each year. Consistent with previous years were the participation by size of payroll. DFSP, and its predecessor, typically had participation by small to medium sized companies, and 64% of employers participating have payroll under \$1 million. Breakdowns by industry classifications were as expected and almost the same as last year, with heavy focus in construction. In terms of participation by select industry classes, the Bureau recognizes there is more work needed; the highest penetration by DFSP into any industry class is 8% (extraction employers). Interestingly, DFSP only has a 3% penetration into transportation industry classified employers, who also have to comply with the federal Department of Transportation requirements. There are several hypotheses being examined why this figure is so low. Additional analysis will be done once the first full year of the program is completed.

Ms. Falls inquired for DFSP's ideal aspirations from the Bureau's perspective. Ms. Kielmeyer replied the Bureau would like to see more and more employers participate in DFSP; ideally, all employers would participate in DFSP, and workplaces would be free from drugs. Studies suggest there is a 60% greater likelihood that someone abusing drugs at work will hurt another in the workplace. We've also discussed in the possibility of using programs like DFSP as a foundational requirement for all alternative rating programs. Mr. Al-Tarawneh concurred with Ms. Niemeyer's statements. Mr. Matesich suggested, for employers in the transportation industry and lower participation in DFSP, to inquire with the industry associations, such as the Ohio Trucking Association, and make presentations of DFSP at seminars. The current economy makes employers look at a practical cost point. While companies must comply with regulations, companies need to see an immediate positive return, or they may not take the additional cost related steps to participate. Staff has been cut to the lowest sustainable levels, to the extent employers cannot respond to increased demand. He suggested patience as a way to sell DFSP. Mr.

Matesich commented an employer not participating in DFSP does not mean the employer does not have any drug free policy, and Mr. Harris agreed.

Ms. Kilmeyer discussed the Claims Complexity project, and summarized this milestone customer service project as provided in the synopsis. Robert Coury, Chief of Medical Services and Compliance, and she share responsibility for the project. The first deliverable from this project was the CAT Event Pilot and Rollout. Unfortunately, the Bureau had the opportunity to use these regional teams 4 times thus far, 3 times were motor vehicle accidents. When an incident leads to more than one injured worker and at least one of the injured has potential for an overnight hospital stay or results in death, the claims are all assigned to one service office, regardless of employer and injured worker location. The team collaborates to obtain all needed evidence to share with all the claims, such as police reports and witness statements. Ms. Kilmeyer believed death claims would be a possible next target area for the Claims Complexity project team to focus.

Ms. Kilmeyer presented the LSS update, and focused on Phase II initiatives underway. The first area of Phase II initiatives were Medicare Set Asides ((MSAs).) The Bureau has been required, as with all insurers and payers of medical care, to consider Medicare's interests as a secondary payer to medical benefits. Medicare has a vigorous review process, especially when dealing with workers' compensation settlements. Medicare reviews or certifies the settlement beforehand to verify the medical portion of the settlement is satisfactory. The MSA portion of the settlement is set apart for future medical payments to be exhausted before Medicare picks up costs. The Bureau is in the process of contracting with several vendors to assist BWC with this new process. The second area of Phase II initiatives deals with rated age; rated age is an issue of life expectancy with Permanent Total Disability and survivor claims when co-morbidities are present. The Bureau is working to secure a contract with a vendor who has experience in this area. Finally, the last area of Phase II is skills enhancement. The Bureau plans a comprehensive evaluation of LSS staff, beginning with supervisors and early next year with staff. The evaluations will concern knowledge of policies and procedures, as well as negotiation skills.

2. Ohio Safety Congress Update

Mr. Al-Tarawneh introduced Ms. Julie Darby-Martin, Management Analyst at the Division of Safety and Hygiene, to present post event analysis of the 2010 Ohio Safety Congress. Ms. Darby-Martin's written report is incorporated by reference into the minutes and provided to the MSSC prior to the meeting. Ms. Darby-Martin thoroughly covered the written report without omission. She thanked volunteers and individuals who provided subject matter expertise in various legal and medical offerings, and looked forward to the 2011 Ohio Safety Congress.

Mr. Harris commented on 74% of the participants were employers of less than 100 employees. He believed the goal of the congress to reach out to the smaller employer community had been accomplished, and he complimented DSH staff.

Mr. Harris also inquired why 5% of vendor participants were dissatisfied. Ms. Darby-Martin replied the first issue was inconsistent traffic flow; there were peaks and valleys where vendors were either too busy or not busy at all. The second issue was vendors could not break down earlier when traffic slowed on the last day. Next year, the Bureau

will expand exposition hours to more accessible times, and session times would be staggered. Additionally, vendors will be allowed to close down once the last session begins.

3. Committee Calendar

Mr. Harris noted the October 21, 2010 meeting had an extensive agenda; consequently, the first reading of the Outpatient Hospital Fee Schedule is being moved to the November 18, 2010 meeting.

ADJOURNMENT

Mr. Hummel moved to adjourn the meeting at 2:07 PM, seconded by Mr. Matesich. The meeting adjourned with a 6-0 unanimous roll call vote.