Texas Worker' Compensation Commission
Health Care Network Advisory Committee (HNAC).

HB 2600.

The 77th Legislature in 2001 enacted HB 2600, an omnibus bill relating to workers' compensation, including Article 2, a *Medical Network Participation Option*. Article 2 commissioned a study to determine the feasibility of establishing regional workers' compensation health care delivery networks that encompass effective cost-control and monitoring mechanisms while ensuring quality medical outcomes.

The Health Care Network Advisory Committee (HNAC) is composed of persons appointed by the Governor, and was statutorily created to advise the Commission with respect to regional workers' compensation health care networks. The HNAC consists of three voting employer representatives, three voting labor representatives, The Texas Workers' Compensation Commission Medical Advisor who serves as chairman, three non-voting health care provider representatives, three non-voting insurance carrier representatives (including a representative from the State Office of Risk Management), and one non-voting actuary. Statutory duties of HNAC include:

* recommendations to the Commission regarding the feasibility of establishing one or more regional networks using a phased implementation and evaluation process;

* development of standards for regional networks; and

* selection of administrators to build and manage the regional networks and to report on their progress.

The Commission was statutorily required to contract on behalf of HNAC, for a study to determine the feasibility of establishing comprehensive, full-service regional workers' compensation health care delivery networks that encompass effective cost-control and monitoring mechanisms while ensuring quality medical outcomes. The contract for the feasibility study was awarded to MedFx, LLC.

Article 2 also provided that the current state standards for Preferred Provider Organizations (PPOs) would serve as minimum requirements for any workers' compensation regional networks that are created.[1] In addition, the HNAC may consider adopting other network standards, including but not limited to:

* standards that ensure broad access to and timeliness of medical care;

* use of treatment guidelines;

* accreditation of regional networks;

[1] See Article 3.70-3C, *Texas Insurance Code*, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997.

* development and adherence to provider eligibility and screening criteria;

* training of health care providers consistent with the Texas Workers' Compensation Commission's (TWCC) rules;

* submission of timely and accurate cost and quality of care data by individual networks;

* availability of board-certified occupational medicine specialists; and

* implementation of medical dispute resolution and change of doctor processes.

Further, Article 2 required the Commission, on behalf of HNAC, to contract with regional networks for the provision of health care in the workers' compensation system. Finally, Article 2 required the HNAC and the Research and Oversight Council (ROC)[2] to establish a report card to measure various aspects of health care delivery in the regional networks, including access to health care, participant satisfaction, health care costs and utilization, health related outcomes, and return-to-work outcomes.

This statutory structure is very different from the managed care organization (MCO) structures used in other states:

* the regional networks are "fee-for-service";

* HB 2600 requires the participation by "public employers", primarily those "state employees" represented by the State Office of Risk Management, and the State University Systems; participation in regional networks by insurers and certified self-insurers is optional; insurers electing to participate have the option of limiting participation to a particular employer or region of the state.

* the injured worker may voluntarily "opt in" and, under certain circumstances, may subsequently "opt out" of the network. There is some concern that this flexibility could result in less certainty in network participation and therefore make it more difficult to negotiate and establish regional network contracts; and

* the Commission (under the direction of the HNAC), contracts directly with network administrators rather than certifying the MCOs and their contracts with insurance carriers and/or employers.[3]

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[2] Funding for the ROC as a separate entity was discontinued in June of 2003; some of the research functions have been transferred to the Texas Department of Insurance.

[3] Requiring the Commission to enter into contracts with networks created some confusion as to the interrelationship of the various system participants and HNAC and the Commission. In essence, the

The statute requires that an employee electing to participate in the network select an initial treating doctor and provides that, at the discretion of the regional network, an employee may select a doctor outside the network if the employee has a pre-existing relationship with the doctor and if the doctor agrees to abide by the rules, terms, and conditions of the regional network. Employees electing to participate in the regional network are entitled to one change from the initial treating doctor to another treating doctor within the network unless the change is for the purpose of securing a new impairment rating or a new determination of. maximum medical improvement. Once in the network, a participating employee can opt out within 14 days after the date he or she begins to receive medical treatment for a work-related injury within the network. Once the 14-day period elapses, the employee is bound to receive all the medical care for that work related injury within the network. However, the employee's network participation can be waived under four circumstances.

* if the insurance carrier waives the employee's election
* if TWCC determines that an employee was coerced to participate in the network
* if the employee moves to another location where there is no network; or
* the insurance carrier disputes the compensability of the employee's injury and network providers are unwilling to provide medical care pending the resolution of the compensability dispute.

Incentives to participate in the network.

Employees: Article 2 of HB 2600 lays out certain statutory benefit incentives for employees to participate including 1) an increase in the maximum cap on income benefits from 100 percent of the State Average Weekly Wage to 150 percent; and 2) a reduction in the retroactive period for income benefits (i.e., the timeframe a worker must be out of work before he or she can receive income benefits for the first week of disability) from four weeks to two weeks. In addition, the feasibility report outlined other incentives such as increased quality of care, faster access to care, more appropriate and less inappropriate caer, better communication between doctors and employers regarding return-to-work opportunities, and access to more information on doctors.

Employers: The feasibility report outlined incentives for employers including earlier return to work of motivated, more productive, and more satisfied employees, reduced workers' compensation costs, and greater information about the quality and value of care provided to their employees.

Commission is choosing and writing the contract that the carriers will have to live by. This places the Commission in the strange position of entering into and enforcing contracts that govern interaction between entities that the Commission regulates. This also subjects the contract to numerous state contracting requirements and prohibitions that may not best serve the purpose.

Insurance carriers: The feasibility report outlined various incentive for carriers including reduced medical costs; potential for reduced cost of medical management; access to quantifiable information regarding network performance, greater information about the quality and value of care that may be applicable to other operations, and better service to employer and employee clients.

Health care providers: The feasibility report outlined various incentives for providers including reduced administrative burdens due to electronic reporting and reduced medical necessity disputes, reduced fee disputes due to negotiated fee structure, ease of confirming workers' compensation coverage, increased patient volume, improved return-to-work coordination with employers, and better feedback on quality of care concerns through the report card process.

Conclusions Reached by MedFx.

The MedFx analysis concluded that the proposed network model is feasible, dependent upon the receipt of satisfactory RFP responses consistent with the financial model and assumptions discussed in the report. MedFx stated that there is significant interest by health care networks in participating in the program. The responses indicate that there are sufficient providers, networks, employers and employees to support one or more pilot programs.

MedFx recommended the implementation of the regional network concept in a pilot program with the following limitations:

* two regional areas as defined for the Austin area and the Houston area

* covering the State Office of Risk Management and the affiliated "state employers" represented by the University of Texas, Texas A&M University and the Texas Department of Transportation.

MedFx noted that the pilot implementation could be broadened to include:

* a limited number of large employers (2-3) in these regions selected on the basis of a demonstrated ability to work with the network to address return to work issues

* a limited number of insurers in addition to SORM, the University systems, and the Texas Department of Transportation, selected on the basis of having sufficient market share in the proposed areas for credible evaluation of results, potential linkage to a selected large employer, and a demonstrated ability to address data collection and communication issues.

The full implementation of the regional network concept envisioned by MedFx would take place in three phases: Phase 1 would involve SORM, the University systems, and the Texas Department of Transportation and the "broadened" group discussed above for two regions. This phase would run for approximately 18 months to demonstrate the

viability of the network concept and the improvements to be achieved by implementing the concept across all employers within the first two regions. The phase requires 18 months to collect sufficient data to demonstrate the improvements that are achievable. Phase 2 would open the two regions to participation by all employers. Phase 3 would extend the participation to all regions in the state. Phases 2 and 3 could take place concurrently.

MedFx developed and recommended network standards and network report card standards for use in evaluating the regional workers' compensation networks under HB 2600 that were approved by the HNAC.

Statutory Revisions Discussed by HNAC.

Following receipt of the feasibility report and the recommendations on the network standards and report card standards, HNAC discussed possible statutory revisions that would provide additional clarity on various aspects of network operations and HNAC involvement.

Status.

The next step for the HNAC is to develop a Request for Proposals (RFP) to solicit network proposals for the pilot. HNAC, MedFx, and the Commission drafted a request for proposals from entities that would be willing to provide one or more regional networks for workers' compensation. The draft was reviewed by SORM in light of lengthy discussions between SORM and the university systems and TxDOT. Based on these, the University of Texas, Texas A&M, and Texas Department of Transportation were asked to make presentations to the full HNAC with respect to their current network systems and outcomes.

HNAC hired a consultant to assist with the RFP draft (Dr. Jeff Harris, Jeff Harris and Associates), who has submitted a draft of an RFP. The HNAC RFP Workgroup has scheduled weekly telephone meetings to discuss the draft RFP. Through discussions of the Workgroup members, it has become clear that additional work is needed with respect to data collection and reporting requirements. Data collection and reporting issues need to be detailed in the RFP so that responses to the RFP will be meaningful and accurately based upon HNAC and Commission expectations. These issues relate to including system participants in the construction of reporting requirements and report cards, educating existing networks, HCPs, and insurance carriers; training on collecting and reporting required data elements, and mandating the use of standardized electronic data submission software. While it was thought that development of evaluation standards and specifications for report cards could come after the RFP, it has become clear that this is work that must be finalized before the RFP can be finalized.

Another issue that remains unresolved is the level of participation that can be expected, given that employees can opt out of the networks. Although MedFx addressed this in their Feasibility Report, questions have been raised as to the possibility of conducting an employee survey regarding participation.

In addition, the average medical cost per claim reported in the presentations by the university systems and TxDOT differ from those contained within the MedFx Feasibility Report, and HNAC and the Commission need to reconcile those numbers.