HOUSE BILL REPORT
HB 1869

As Reported by House Committee On:
Labor & Workforce Development

Title: An act relating to occupational health best practices in industrial insurance through creation of a state-approved medical provider network and expansion of centers for occupational health and education.

Brief Description: Addressing occupational health best practices in industrial insurance through creation of a state-approved medical provider network and expansion of centers for occupational health and education.

Sponsors: Representatives Sells, Santos and Ormsby.

Brief History:
Committee Activity:
Labor & Workforce Development: 2/9/11, 2/15/11 [DPS].

Brief Summary of Substitute Bill

- Requires the Department of Labor and Industries (Department) to establish an industrial insurance health care provider network, and requires providers to meet network standards.
- Requires workers to receive care from a network provider once a network is established in the worker's geographic area, except for the first visit.
- Requires the Department to establish additional best practice standards, and financial and nonfinancial incentives, for second tier providers.
- Requires the Department to establish additional Centers for Occupational Health and Education.

HOUSE COMMITTEE ON LABOR & WORKFORCE DEVELOPMENT

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Sells, Chair; Reykdal, Vice Chair; Green, Kenney, Miloscia, Moeller, Ormsby and Roberts.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: Do not pass. Signed by 5 members: Representatives Condotta, Ranking Minority Member; Shea, Assistant Ranking Minority Member; Fagan, Taylor and Warnick.

Staff: Joan Elgee (786-7106).

Background:

Under the state's industrial insurance laws, employers must either insure through the State Fund administered by the Department of Labor and Industries (Department) or, if qualified, may self-insure. Workers who, in the course of employment, are injured or disabled from an occupational disease are entitled to benefits, including time-loss and medical benefits. For medical care, workers are entitled to necessary and proper medical care from the provider the worker chooses. Providers must hold the appropriate credential from the Department of Health and register with the Department.

In 2002 the Department established the first Center for Occupational Health and Education (COHE). A COHE is a resource within the health care community to help providers manage and integrate the care and recovery of injured workers. The COHE efforts focus on the first 12 weeks of a claim.

The Workers Compensation Advisory Committee (WCAC) is a 10-member committee tasked with studying aspects of the workers' compensation system. Workers and employers are represented on the WCAC. The Medical Industrial Insurance Advisory Committee (Medical Committee) and the Chiropractic Industrial Insurance Advisory Committee (Chiropractic Committee) also advise the Department. The Medical Committee is composed of 12 members from nominations submitted by statewide clinical groups, specialties, and associations, including family or general practice, occupational medicine, and a number of other listed areas. The Director may appoint up to two additional members, for a maximum of 14 members.

Direct practice is a type of primary health care in which providers enter agreements with patients to provide primary care services for a monthly fee. State law regulates direct practice.

Summary of Substitute Bill:

Health Care Provider Network.
Intent is stated that high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income, and lower labor and insurance costs for employers.

Providers.
The Department must establish a health care provider network (network) for workers from both State Fund and self-insured employers. Providers apply by completing an application, which is a contract. The Department must establish minimum standards for providers for acceptance into the network, including:

- current malpractice insurance;
- previous malpractice judgments or settlements that do not exceed a dollar amount, or a specific number or seriousness of malpractice suits over a specific time frame;
- no licensing or disciplinary action in any jurisdiction or loss of privileges by any board, commission, agency, public or private health care payer, or hospital;
- for some specialties such as surgeons, privileges in at least one hospital;
- whether the provider has been credentialed by another health plan that follows national quality assurance guidelines; and
- alternative criteria for providers that are not credentialed by another health plan.

The Department must develop alternative criteria as needed to address access to care concerns in certain regions. The Department may establish additional criteria and terms to monitor quality of care and assure efficient management of the network.

Providers must follow Department billing rules and must consider Department coverage decisions, policies, and treatment guidelines, as well as other industry treatment guidelines appropriate for their patient. Providers may provide reasonable and necessary treatment as ordered by the Board of Industrial Insurance Appeals or a court without removal from the network.

The Department may remove providers from the network or take other appropriate action if the provider fails to meet minimum network standards. The Department may also impose remedial steps and waiting periods for a provider. A provider may be permanently removed from the network when the provider exhibits a pattern of conduct of low quality care that exposes patients to risk of physical or psychiatric harm or death. These patterns include poor health care outcomes; however, the Department may not remove a provider for an isolated instance of poor health and recovery outcomes. The decision to remove a provider is an appealable order. The Department or self-insurer must assist a worker under the terminated provider's care to find a new network provider.

The Department is directed to adopt rules to allow a direct practice to be a network provider. Any rule requiring a provider to bill for services does not apply to a direct practice. The Department may adopt rules requiring a direct practice to provide information so the Department may establish premium rates, and retrospective rating (retro) plan refunds and assessments. In addition, the Department may adopt rules to assure workers are not paying for workers' compensation benefits, other than what is permitted by law. Payment by an employer for direct primary care services does not disqualify an employer from participating in retro, a retro group sponsor from promoting retro, or a plan administrator from administering a retro plan.

Workers.
Once the network is established in the worker's geographic area, an injured worker may receive care from a non-network provider only for the initial office or emergency room visit, and the Department or self-insurer may limit reimbursement to the Department's standard fee.

Advisory Group.

The Department must convene an advisory group made up of representatives from or designees of the WCAC, the Medical Committee, and the Chiropractic Committee to advise the Department on implementation, including the development of best practices treatment guidelines. The advisory group must also recommend the minimum standards for approval or removal of a provider. The Department, in collaboration with the advisory group, must adopt policies for the development, credentialing, accreditation, and oversight of the network.

Podiatry is added to the list of clinical groups, specialties, and associations from which nominations must be sought for the Medical Committee members. The number of members selected nominations is increased to 13 and the maximum membership of the Medical Committee is increased to 15 members.

Second Tier.
With the assistance of the advisory group, the Department must establish additional best practice standards for providers to qualify for a second tier, based on demonstrated use of occupational health best practices. The Department must implement financial and nonfinancial incentives for, and also certify and decertify, second tier providers.

Self-Insurers.
The Department must work with self-insurers and the Department's utilization review provider to implement utilization review for self-insurers to ensure consistent quality, cost-effective care, and to reduce the administrative burden for providers.

Centers for Occupational Health and Education.
The COHEs are placed in statute. The Department must establish additional COHEs, with the goal of extending access to at least 50 percent of injured and ill workers by December 2013, and to all injured workers by December 2015. The Department must also develop additional best practices and incentives that span the entire period of recovery, not limited to the first 12 weeks.

The Department must certify and decertify COHEs based on criteria including:
- institutional leadership and geographic areas covered;
- occupational health leadership and education;
- mix of participating providers necessary to address the needs of workers;
- health services coordination to deliver occupational health best practices;
- indicators to measure the success of the COHE; and
- agreement that the provider must, if feasible, treat certain injured workers if referred by the Department or a self-insurer.

Health care delivery organizations, including hospitals, affiliated clinics and providers, multispecialty clinics, health maintenance organizations, and organized systems of network physicians may apply to the Department for certification as a COHE.

In collaboration with the Department, COHEs must implement benchmark quality indicators of occupational health best practices for individual providers. Providers who do not consistently meet the benchmarks must be removed.

The Department must develop and implement financial and nonfinancial incentives for COHE providers that are based on progressive and measureable gains in occupational health best practices and that are applicable throughout the worker's care. In addition, the Department must develop electronic methods of tracking evidence-based quality measures to indentify and improve outcomes for workers at risk of developing prolonged disability. These methods must also be used to provide systematic feedback to physicians regarding quality of care, to conduct appropriate objective evaluation of COHE progress, and to allow efficient coordination of services.

Other.
The Department is given rule-making authority.

The Department must report to the WCAC and the appropriate legislative committees on December 1 of each year, beginning in 2012 and ending in 2016, on the implementation of the provider network and expansion of the COHEs. The report must include a summary of actions taken, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies, and whether any changes are needed.

Substitute Bill Compared to Original Bill:

The substitute bill adds podiatry to the list of clinical groups, specialties, and associations from which nominations must be sought for the Medical Committee members, and increases the number of Medical Committee members. In addition, the substitute bill adds the provision regarding direct practice.

Appropriation: None.

Fiscal Note: Requested on February 7, 2011.

Effective Date of Substitute Bill: The bill contains an emergency clause and takes effect on July 1, 2011.

Staff Summary of Public Testimony:

(In support) This bill, combined with House Bill 1868, shows most of the work of the Workers' Compensation Workgroup. It is part of the Governor's job creation program. The changes will reduce costs and provide better outcomes for workers. Combined with House Bill 1868, in the form as introduced by the Governor, about $720 million will be saved, with about $500 million in the first year. The new statewide provider network is the centerpiece. With some language changes, the bill can be supported. A provider should be able to make individual decisions in treating a patient and not be concerned about being removed from the list. The COHEs save $500 per claim and produce better outcomes.

(With concerns) Many workers become victims of the system because they do not get the right services. Currently, providers only need a license and a provider number. The bill will set some requirements for providers. High quality medical care can help reduce disability.

Networks could be extremely effective if done right. The bill is not consistent with the Workgroup agreement, which was a compromise. The changes made from the Governor's proposal may reduce the savings somewhat and are of concern. The bill waters down the requirement that providers follow coverage decisions and allows treatment if ordered by the Board of Industrial Insurance Appeals or a court. The parties agreed providers would have a contractual relationship with the Department; appeal rights obviate the contract.

(Opposed) None.

Persons Testifying: (In support) Peter Bogdonoff, Office of the Governor; Jeff Johnson, Washington State Labor Council; Nicole Grant, Certified Electrical Workers of Washington; Kathryn Comfort, Washington State Association for Justice; and Dave Johnson, Washington State Building and Construction Trades Council.

(With concerns) Judy Schurke, Department of Labor and Industries; Linda Maw, True Blue Inc.; Terry Peterson, Comprehensive Risk Management; and Vaughn Mowery, Safeway.

Persons Signed In To Testify But Not Testifying: (In support) Sharon Ness, United Food and Commercial Workers; and Cody Arledge, Sheet Metal Workers Union Local 66.

(With concerns) Melanie Stewart, Washington Pediatric Medical Association; Cori Daigle, Seller Construction; Rick Anderson, Sakuma Brothers; Melissa Johnson, Physical Therapy Association of Washington; Lori Bielinski, Washington State Chiropractic Association; and Chapin Henry and Lisa Thatcher, Qliance Medical Management Incorporated.