HOUSE BILL REPORT
SSB 5418

As Reported by House Committee On:
Labor

Title: An act relating to creating a pilot program to improve care for catastrophically injured workers.

Brief Description: Creating a pilot program to improve care for catastrophically injured workers.

Sponsors: Senate Committee on Commerce & Labor (originally sponsored by Senators Keiser, Braun, Parlette, McAuliffe, Benton and Conway).

Brief History:
Committee Activity:
Labor: 3/26/15, 3/30/15 [DPA].

Brief Summary of Substitute Bill
(As Amended by Committee)

- Requires the Department of Labor and Industries to create a pilot program under which innovative treatment and service interventions for catastrophically injured workers are compared to usual or standardized care.
- Provides for approaches to be piloted by any or all of: (1) A medical management firm; (2) centers of excellence; (3) centers of occupational health and education; and (4) other innovative treatment or services.

HOUSE COMMITTEE ON LABOR

Majority Report: Do pass as amended. Signed by 4 members: Representatives Sells, Chair; Gregerson, Vice Chair; Moeller and Ormsby.

Minority Report: Do not pass. Signed by 3 members: Representatives Manweller, Ranking Minority Member; G. Hunt, Assistant Ranking Minority Member; McCabe.

Staff: Joan Elgee (786-7106).

Background:

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.

Under the state's industrial insurance laws, workers who, in the course of employment, are injured or disabled from an occupational disease are entitled to benefits. Employers insure with the State Fund administered by the Department of Labor and Industries (Department) or, if qualified, may self-insure.

An injured worker may receive care from any provider who is a member of the Department's medical provider network. For the first visit or emergency room visit, however, a worker may also receive care from a non-network provider. The Department or self-insurer, as appropriate, pays providers according to a fee schedule established by the Department.

The Department recently conducted a gap analysis of catastrophic claims. In September 2014, the Department released a report on the gap analysis that included a discussion of: (1) the current health care delivery system for catastrophic injuries, including key strengths; (2) a review of catastrophic claims data; (3) a review of gaps identified or perceived by staff and health care providers; and (4) a set of potential countermeasures for consideration. Gaps were identified in three areas: communication and coordination, data systems, and access to care. The Department has identified next steps to address the gaps. Catastrophic injuries include head trauma, paralysis, and amputation.

Summary of Amended Bill:

The Department must implement a three year pilot program under which innovative treatment and service interventions for catastrophically injured workers are compared in a prospective study and compared to usual or standardized care. The best practices and cost-effective approaches may be piloted by any or all of:

- a medical management firm with substantial experience in handling catastrophic workers' compensation cases;
- centers of excellence deploying collaborative care;
- centers of occupational health and education (COHEs); or
- other innovative treatment or services.

The pilot participants must develop a treatment plan and agreement for each worker that identifies an outcome, the treatment plan, and if applicable, a guaranteed price. The Department may establish minimum treatment protocols and qualifications, including access to adequate medical, professional, and pharmacy providers and a network of health care facilities, suppliers, and services.

Injured workers may elect whether to participate in the pilot program and retain the right to receive care from providers of their choice. Medical provider network requirements for providers apply. The Department has exclusive authority to approve or deny treatment and to pay medical bills in accordance with the fee schedule.

The Department must determine an approach to track outcomes including standardized measures of functional recovery, return-to-work, and quality of life.

The Department must contract with independent researchers for and analysis of costs and outcomes. Pilot participants must provide all information required by the researchers to assess costs and measure outcomes. Information provided to the researchers must also be provided to the Department. The researchers must make regular status reports to the Department and work with the Department to develop and report on criteria to evaluate the pilot program. Topics the criteria must address are specified and include whether the treatment protocols help address gaps, whether pilot participants are achieving stated goals, and feasibility for the Department to adopt processes and practices identified in the pilot program.

Before the end of the three-year period, the Department must terminate the pilot program if it finds the treatment and interventions are causing harm and may terminate the pilot program if it finds that the treatments and interventions are not showing a benefit to workers.

The Department must provide a report to the Legislature each December through 2018 with a final report following the end of the pilot program in 2019.

For purposes of the pilot program, catastrophic injures include acute traumatic brain injuries; major extremity or multiple extremity amputations, fractures, or crush injuries; multiple trauma injuries; severe burns; certain types of paralysis; and any other diagnosis determined by the Department to be catastrophic.

The pilot program provision expires on December 31, 2020.

Amended Bill Compared to Substitute Bill:

The striking amendment:

- changes the structure of the pilot program from a contract with a medical management firm to a comparison with possible pilot participants as compared to usual and standardized care;
- provides that outcomes are identified, rather than guaranteed, and that the price is guaranteed only if applicable;
- makes it explicit that medical network requirements for providers apply;
- provides that the Department pays provider bills, rather than the firm, and does so in accordance with the fee schedule;
- adds the provision allowing the Department to establish minimum treatment protocols;
- adds the requirement that the Department establish an approach to track outcomes;
- adds the requirement that the Department contract with independent researchers and that pilot participants provide information to the researchers and the Department, and provides for the researchers, rather than the firm, to develop and report criteria;
- adds to and modifies topics evaluation criteria must address;
- adds the early termination provision;
- provides for an additional report in 2019 and adds the expiration; and
- modifies the intent section.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Catastrophic injuries are horrible injuries such as amputations and burns. These cases require intensive, active care coordination which includes emotional recovery and impact on the family. A coordinated approach results in a big improvement in quality of life, with lowered costs as a byproduct. Care coordination focuses on outcomes which are best for workers. The Department's gap analysis is concerning. There were more than 20 different findings, such as a loss of continuity with changing claims managers, lack of clarity as to who is the attending physician, and providers not knowing who to contact. About 200 workers sustain catastrophic injuries each year; this bill is a pilot and affects only 30 workers in three years to see if this culture change can make a difference.

This bipartisan bill is about thoughtful innovation and a culture change. This is where health care is going. A Milliman study found Paradigm-managed claims resulted in a five times greater return to work rate and 40 percent lower costs than cases managed by others. The approach would be innovative in Washington but has been successful in other states including Ohio and North Dakota. The model of a guaranteed outcome at a guaranteed cost creates the proper balance of incentives. The firm would be accountable. Timely access to highest quality providers makes the difference. Using a medical management firm would create consistency and would be complementary to what is being done in health care generally. The firm would be chosen through a competitive process. This bill is about partnership between the public and private sector. The pilot is a low-risk approach but with a high probability of success for both employees and employers. Using a medical management firm will make the system more efficient, reducing costs without reducing benefits and will bring competition, which can only help injured workers.

(With concerns) The Department has efforts underway to address the gaps by leveraging existing relationships. These efforts include quick fixes such a creating a single point of contact for providers, and looking at Lean practices, better coordination, improved early mental health and vocational support, and improved communications. The COHEs include staff who do care coordination. The Department is looking at its relationship with Harborview, which has a center of excellence for amputees. Washington is the envy of other states with Harborview Hospital and St. Luke's in Spokane. The COHEs, medical provider network, and opioid guidelines make Washington a model for other states, such as Ohio and North Dakota, which have gaps.

The bill interferes with the collection of data and the Department's relationship with medical experts. Adding another layer is "un-lean." Consider an amendment to make the pilot broader and include COHEs and centers of excellence so different protocols can be tested. The process should be public and an independent researcher should be used, so the information can be used outside of workers' compensation.

(Opposed) The bill is well-meaning and looks good on the surface but it's just a band-aid. The Department has solutions underway to fix the gaps. The state has a successful formula of reviewing evidence-based research and reaching a consensus in an open, transparent process. There is a foundation in place to do this through the COHEs. It is best to progress by working together with all subject matter experts and then disseminating best practices to all providers rather than doing a carve-out in one area. Washington already has centers of excellence, such as the burn center at Harborview and COHEs, which have reduced disability.

(Other) Insuring involvement with the Industrial Insurance Medical Advisory Committee and the Advisory Committee on Healthcare Innovation and Evaluation is important. The ability to learn from the use of a medical management firm is limited since the methods are proprietary. It's problematic that only one entity would be studied. Washington already contracts for nurse case management. The Department should make the payments, as it would be chaotic to have a third party involved. Requiring 10 contracts a year puts the Department at a bargaining disadvantage. Work through the COHEs and medical provider network should continue. The Department can do a pilot, but if legislation is needed, it should be broader so there is a comparison component and sharing of information. There should be an amendment to preserve the medical provider network.

Persons Testifying: (In support) Senator Keiser, prime sponsor; Bob Battles, Association of Washington Business; and Jonathan Seib and Scott Gill, Paradigm Outcomes.

(With concerns) Vickie Kennedy, Department of Labor and Industries.

(Opposed) Dianna Chamblin, Industrial Insurance Medical Advisory Committee and Advisory Committee for Healthcare Innovation and Evaluation; and Louis Lim, Northwest Association of Occupational and Environmental Medicine.

(Other) Joe Kendo, Washington State Labor Council; and Michael Temple, Washington State Association for Justice.

Persons Signed In To Testify But Not Testifying: None.