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Roundtable 3: Thursday, April 10, 2014 (3:30 pm – 4:30 pm)

Balancing the Quality and Cost of Healthcare to Injured Workers

Despite two decades of expanded managed care applications within the workers' compensation arena, medical costs associated with occupational injuries continue to spiral upward and account for a larger percentage of overall claims costs. Moreover, there is a growing perception that the quality of healthcare provided to patients with work-related injuries is somewhat inferior to that provided in a more general healthcare setting. Over time, the industry seems to have lost sight of its ultimate goal – taking care of injured workers while returning much needed labor to the workplace. Too much attention has been placed on managing the transaction rather than the treatment. Fortunately, a shift in thinking is beginning to occur.

Employers are realizing that if more immediate and effective medical treatment becomes the priority, cost savings and increased productivity tend to follow. One way employers are beginning to accomplish this objective is through strategic provider selection and benchmarking. This relatively new and progressive approach enables employers to identify and work with high-value physicians who have proven their ability to deliver quality outcomes. This is in marked contrast to today's prevailing notion that networks should be assembled based on volume discount pricing with little regard to treatment or outcomes. Better medical outcomes are good both for workers and employers. Workers are more likely to return to healthy, productive living while employers experience improved results in claim durations, long-term medical expenses, and total program costs.

This session is designed to explore these issues from an employer's perspective. The panel will take an in-depth look at provider selection and benchmarking. Attendees will see first-hand how they can capitalize on this industry transformation for the betterment of their own programs.

I. Why is quality care at the forefront of network discussions

Since 2006 employers have complained that workers' compensation network solutions did not offer quality care components. Employer concerns, coupled with an evolving health care delivery system due to health reform and an increased focus on quality care and consumer awareness around the need for transparency with outcomes has led to the evolution of workers' compensation medical network programs. Employers are demanding outcomes-based, high-performing medical networks. This section will explore why quality care is that the forefront of medical network discussions.

The role and challenges of standard medical network preferred provider programs

The most common medical network solution deployed in workers' compensation today is a broad-based discount network. The goal of the network is to contract and credential as many providers as possible so that when an injured worker shows up in a doctor's office and the bill is processed, the payer receives a discount below the state fee schedule in most scenarios; or a reduction below usual and customary, per the state bill processing regulation. Medical networks in workers' compensation are known as preferred provider organizations, or PPOs, and have had little, if any, focus on quality and outcomes.

The challenge of this standard discount approach is value. The cost of access to the network discounts is high when you consider that the unit cost of care does not translate to a successful claims outcome. Provider data within PPO networks is fraught with errors which results in injured workers showing up at a medical provider that no longer accepts workers' compensation claimants, the building is closed, or the address is not even a medical provider location. Although a provider is signed up to be part of the workers' compensation network, they do not necessarily adhere to occupational medicine best practices, medical treatment guidelines, management of disability, and compliance with regulatory expectations for providers. Most medical providers enroll in a large number of workers' compensation medical networks and are not familiar with which patients are affiliated with the network and expectations, if any, of the network. Over time networks have lost their influence with providers and the relationship between medical providers and broad-based medical discount networks are void or minimal at best.

Health reform shifts focus to quality and escalating health care costs

Quality care initiatives and improving health care costs are at the heart of health care reform. With health reform there is a renewed focused on quality and management of escalating health care costs via the deployment of improved patient and provider collaboration, engagement, compliance and quality care factors based on physician performance. Health insurers offering private and employer-based solutions have created smaller medical networks including providers delivering the most successful medical outcomes to their plan members. Similarly the federal government offers incentives to Accountable Care Organizations (ACOs); these are essentially network solutions that deliver quality care at lower medical costs. Quality outcomes with health reform include an overall evaluation of patient interaction within and outside the network, patient compliance with care, readmissions and infection rates, billing standards, and overnight stays in hospitals to name a few.

Employer and consumer awareness drives change

For many employers the largest component of their workers' compensation claims costs is medical care. Litigation increases and becomes more challenging when medical concerns involved with a claim are not resolved. Attorneys agree with employers that the inclusion of poor performing providers within a medical network is problematic. Employers are demanding and are ready to implement a medical network inclusive of high-performing medical providers rather than the standard network model of medical providers that are the cheapest and most conveniently located in relation to an injured worker's home or work.

Health care reform positions workers as health care consumers and with this new mindset comes higher expectations: an appreciation for provider selection; transparency of costs and selection; advocacy around the complexities with selecting treatment options, resolving medical conditions and communication with all key stake holders. Injured workers want access to outcomes trends of the medical providers they are expected to use. Alignment with outcomes-based, high-performing medical provider network will improve employer and injured worker engagement with the medical network programs.

II. Litigation considerations

During this section we will explore the role of legal counsel during the development of the outcomes-based, high-performance medical network and oversight after deployment.

Provider benchmarking and outcomes methodology
Healthcare analytics are complex and legal considerations come into play. Past experiences in group health outcomes-based networks offer valuable insight into risks, including the methodology used to score provider outcomes. In workers' compensation it is recommended that claims data, line level bill review data, and subjective scores from the claims team are included. Weighting of the scoring becomes critically important to the process, especially if it leads to inclusion or removal from the network or value-based payments.

Provider selection and exclusion considerations
Legal will sign off on the inclusion of providers into the network and likely suggest formal escalation protocols for provider complaints and challenges to network decisions. Policies and procedures should be clearly documented in this area; made available to key stakeholders; and reviewed at intervals recommended by legal. In many scenarios legal oversees a quality board inclusive of network managers and medical directors, case management and claims to address issues and opportunities for improvement.

Jurisdictional considerations
While some states have not established formal rules relative to outcomes-based, high-performing medical networks in workers' compensation, others are very specific. Legal counsel will review both firm and loose rules and ways in which legal counsel can help the network development team implement a successful program which adheres to state regulatory requirements.

III. Key stakeholder engagement

Successful implementation of outcomes-based, high-performing medical provider networks involves active conversations and input from all key stakeholders. We will discuss the role of each key stakeholder and close with how each group and the collective can be engaged to assist with the development of an outcomes-based, high-performance medical network.

Attorneys
Attorneys will assist with the regulatory requirements specific to the development of and maintenance of a high-performing medical network. This may include input regarding the methodology used for scoring providers at development for inclusion or omission from the network and ongoing performance ratings after implementation. If the network involves value-based payment structures legal will assist with the contractual needs. It is imperative that legal representation is available to address claim scenarios relative to the deployment of the network and challenges that may arise. The goal of the network is to provide quality healthcare for the injured worker which will in turn reduce total claim costs. The attorneys will assist with network rules, policies, and processes which ultimately assist with the claims process and later escalations. Legal will address transparency considerations for medical provider outcome scores and help the network understand risks to consider with deployment.

Claims team
Examiners and nurses are important key stakeholders as they will be educating the injured workers about the network. Their engagement at the implementation stage will assist with developing a product that will be used effectively and improve over time. We will share the value of claims team buy-in which ultimately improves compliance, utilization, and outcomes.

Employers and physicians
The network will not be effective if both employers and physicians do not buy in on the concept that quality health care matters and high-performance outcomes will lead to improved overall claim results. If the network has

value-based payment methodologies, the employer will want to understand reimbursement rates and scoring associated with the payment process. Physicians that believe in value-based reimbursements repeatedly express willingness and desire to be part of these evolving programs. Having physicians engaged at the development stage will improve partnership with the provider, employer and claims team, thus improving the experience for the injured worker.

IV. Transitioning from managed care to healthcare

Transitioning from managed care to healthcare, which is essentially what you do when you move from a broad-based medical discount network to a high-performing, outcomes-based medical network, is a philosophical shift in mindset and work processes. In this section we will discuss a few key components that are critical to the success of the network. While one may believe that inclusion of high-performing providers is all you need for success, the greatest success comes from the advocacy role employers, claims professionals, and providers take with the injured worker, and maintaining a clear focus on successful outcomes.

Value-based health care

Provider benchmarking and outcomes analysis is only part of the healthcare network. It is important for ongoing collaboration, sharing, and dialogue amongst key stakeholders for continued improvement. We recommend semi-annual physician meetings to keep physicians engaged with the network's performance. Sharing quarterly outcomes scorecards with providers assists with network management and physician trending, along with management of the value-based medical reimbursement program. Examples of value-based medical reimbursement include pay for performance or more commonly termed today, pay for outcomes. While these programs are less understood in workers' compensation, our panel has been working in this environment for a number of years and will share examples in place today.

Population health considerations

Providers know the injured workers that are associated with high-performance networks and the protocols which will drive efficiency in their offices. Utilization review and case management needs lessen with high-performing providers, thus they must adhere to evidence-based medical guidelines and disability duration guidelines associated with the network. Relaxing utilization review and care management guidelines is a cost savings for employers; more expensive resources are reserved for the most complex cases, for example injured workers' with unique treatment needs, or when lower scoring providers are delivering care. Providers and case managers alike appreciate the approach to population health and value that quality brings to the process. The skill sets of the medical professionals are completely aligned with the processes and procedures necessary to deliver the most successful outcomes for the patient and claim.

V. Outcomes awareness

The participants in our session will have a first look at the 2013 results for a large national outcomes-based medical network program encompassing over 200,000 physicians and 500,000 claims. We will review trends and comparisons for 1-star medical providers versus 5-star providers specifically in the areas of medical costs, indemnity, open/closure ratios, litigation rates and costs, and total claim outcomes. In many scenarios, presenters address the value of a program without the hard dollar facts. Our attendees will gain an understanding of the cost differences between high-value, outcomes-based medical networks and broad-based medical discount networks.