SORM
State Office of Risk Management

Annual Report on Cost Containment

Fiscal Year 2016

October 17, 2016

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I. Introduction

The State Office of Risk Management is administratively attached to the Office of the Attorney General and is governed by a five-member Board. The Office is charged by law to administer the enterprise risk and insurance management programs, continuity of government operations program, and self-insured workers' compensation program for the State of Texas. Its mission is to enable State of Texas agencies to protect their employees, the general public, and the State's physical and financial assets by reducing and controlling risk in the most efficient and cost-effective manner.

The Office is financed wholly through interagency contracts with other state agencies. The funding program allocates an assessment, similar to a premium, to all participating agencies based on risk profile and other relevant factors identified by the Board.

The State of Texas self-insures for the purposes of workers' compensation through the Office, covering 138 state entities and 122 CSCDs, encompassing approximately 188,000 individual employees. The UT, A&M, and TxDOT are exempted by law and operate their own individual workers' compensation programs. The Office employs professional claims adjusters that handle all aspects of work-related injury claims as required by law and policy. Excluding workers' compensation, there are no other statutory retention programs.

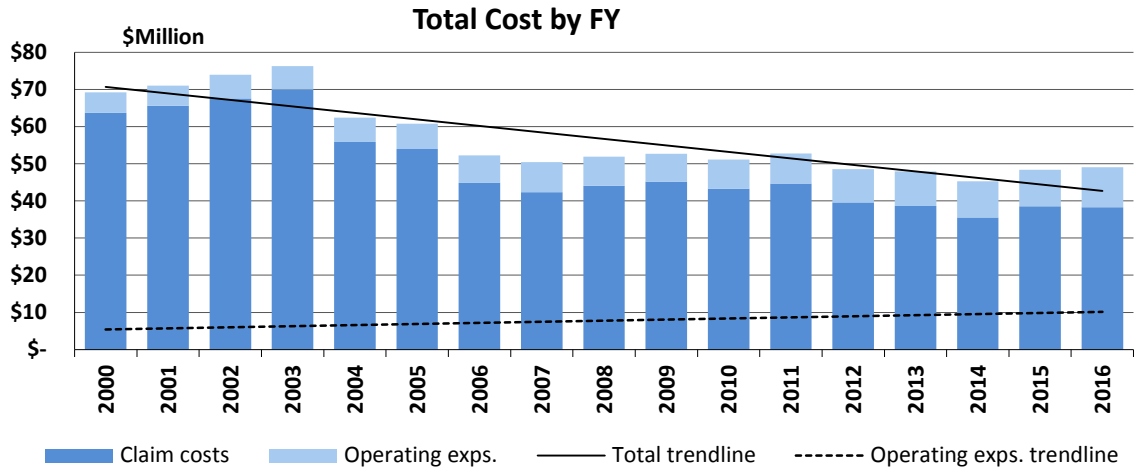
House Bill 1, 84th Legislature, RS, requires the Office to submit an annual report detailing the effectiveness of cost containment measures undertaken during the fiscal year and proposing additional measures to reduce workers' compensation payments in future years. This document is the report on cost containment for fiscal year 2016.

The State Office of Risk Management shall submit a report detailing the effectiveness of various cost containment measures undertaken and proposing additional measures to reduce workers' compensation costs. This report shall be submitted to the legislative and executive budget offices, in the form those offices require, within 45 days after the close of each fiscal year.

II. Summary of Cost Containment Savings

One of the Office's core statutory missions is to provide covered injured employees with access to prompt, high-quality medical care within the framework established by the Workers' Compensation Act. The Office must also ensure it provides appropriate income benefits and medical benefits in a manner that is timely and cost-effective.

The state employee workers' compensation program decreased costs well in advance of the industry as the chart below shows:



A breakdown by cost containment savings for fiscal years FY15 and FY16 is provided below:

Strategy	2015 Savings	2016 Savings
Total Medical Bill Audit Savings*	$ 72,091,862	$ 73,482,124
HCN Savings**	$ 487,732	$ 605,629
PBM Savings	$ 843,696	$ 846,114
UR of Medical Services***	$ 4,440,288	$ 3,506,881
Total Cost Containment Savings	$ 77,863,578	$ 78,440,748

All estimated savings are based on the amount of the original bill at the time of payment.

* This represents the sum of Fee Schedule reductions taken on a bill processed by StrataCare to include duplicate bill savings.

** This represents the sum of Healthcare Network reductions taken on a bill processed by StrataCare.

*** Cost of procedures not performed at time of request, as estimated by the cost containment vendor. (See explanation in "Pre-Authorization of Medical Services" text below).

III. Cost Containment Measures

The Office is consistently placed in the High Performer category by the Division of Workers' Compensation. The Office works to reduce overall medical and indemnity costs through improved claim handling practices, education, and training. The Office continuously evaluates its policies and processes and implements change as needed to meet internal and external needs.

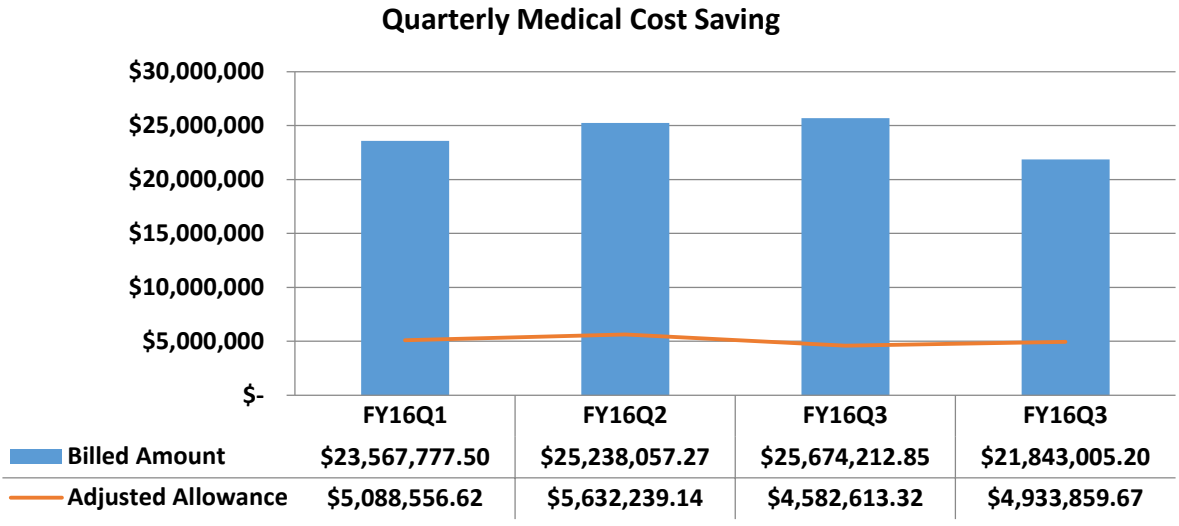
The following discussion summarizes the cost containment measures utilized by the Office during fiscal year 2016.

A. Medical Bill Audits

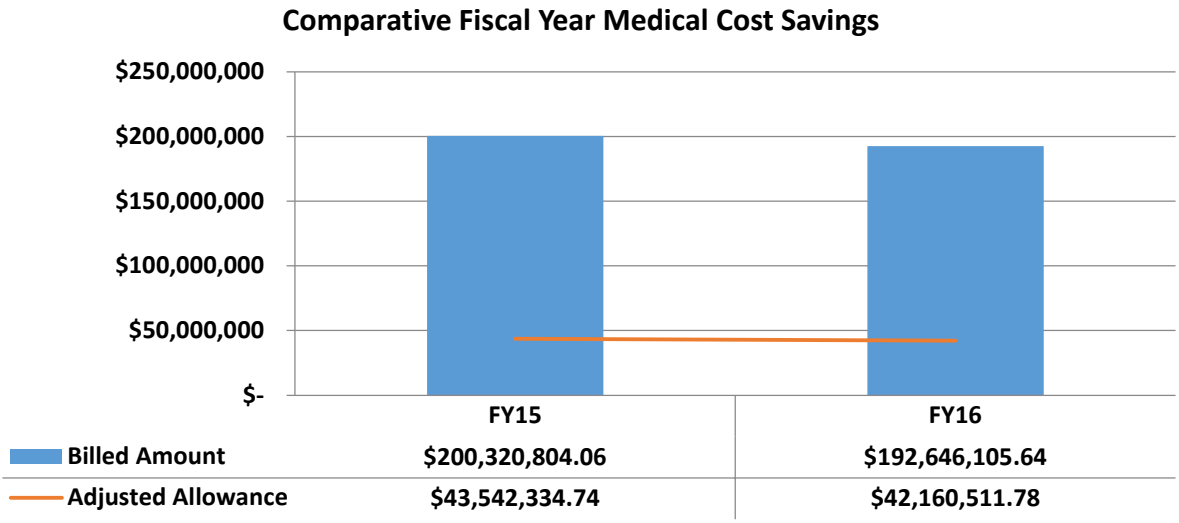
Workers' compensation benefits include medically necessary treatment related to the compensable injury. The Division of Workers' Compensation sets the amount of reimbursement for health care treatment in non-network claims. The amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider.

The Office has a medical cost containment contract with ISG, LLC (StrataCare) to audit bills submitted by health care providers and reduce billed amounts to the maximum allowable rates under the appropriate fee schedule. Bills are also reviewed for medical necessity and relatedness to the compensable injury. Charges reduced as a result of such reviews represent savings from the billed amounts. In the case of the state's self-insured workers' compensation program administered by the Office, these savings accrue to the benefit of the state's taxpayers.

The savings realized during FY16 through the application of the medical fee guidelines and network reductions is shown in the following chart:



The chart below shows the medical cost savings for fiscal years FY15 and FY16:



B. Workers' Compensation Health Care Network

The Office has a medical cost containment contract with Injury Management Organization, Inc., which is a certified workers' compensation health care network, to provide state employees with access to health care with primary and specialty medical providers who are familiar with workers' compensation injuries.

According to the 2016 Workers' Compensation Network Report Card Results by the Division of Workers' Compensation, health care networks have lower medical costs than non-networks and lower utilization in most categories; higher or equal levels of receiving needed care quickly and overall satisfaction with care; higher return-to-work rates, and higher physical and mental functioning scores.

C. Preauthorization of Medical Services

The Texas Workers' Compensation Act and the rules adopted by the Division of Workers' Compensation require health care providers to obtain preauthorization of certain medical procedures from workers' compensation insurance carriers prior to such services being provided. The health care services must be prospectively reviewed and preauthorized as medically necessary before the service is provided to an injured employee. The preauthorization guidelines can vary between non-network and network claims.

The Office's medical cost containment contract with Injury Management Organization, Inc. also includes utilization review services related to preauthorization requests. Preauthorization savings represent the avoidance of expenses related to unreasonable or unnecessary procedures or services prior to their being provided and billed. It should be noted that health care that was not preauthorized may be approved at a later date if there is a change in medical diagnoses or documentation is provided to support the

request or alternative treatment may be approved. Under these circumstances "savings" attributable to preauthorization will not accurately reflect the true cost of treatment.

The following chart displays the FY16 cost-avoidance estimates related to preauthorization:

Preauthorization of Medical Services			
Network Status	**Requested Cost***	**Approved Cost****	**Cost Avoidance**
Network	$ 4,678,227.58	$ 2,929,596.54	$ 1,748,417.58
Non-Network	$ 4,748,894.45	$ 2,988,880.96	$ 1,758,463.61
	$ 9,427,122.03	$ 5,918,477.50	$ 3,506,881.19

*This represents the value of requested services processed through preauthorization.

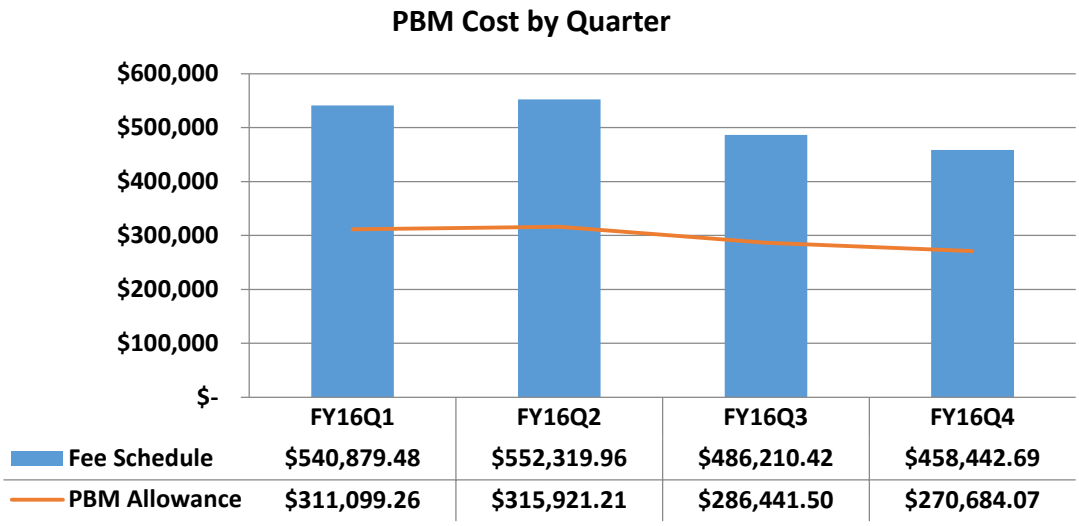
**This represents the value of requested services that were authorized through preauthorization.

D. Pharmacy Benefits Management

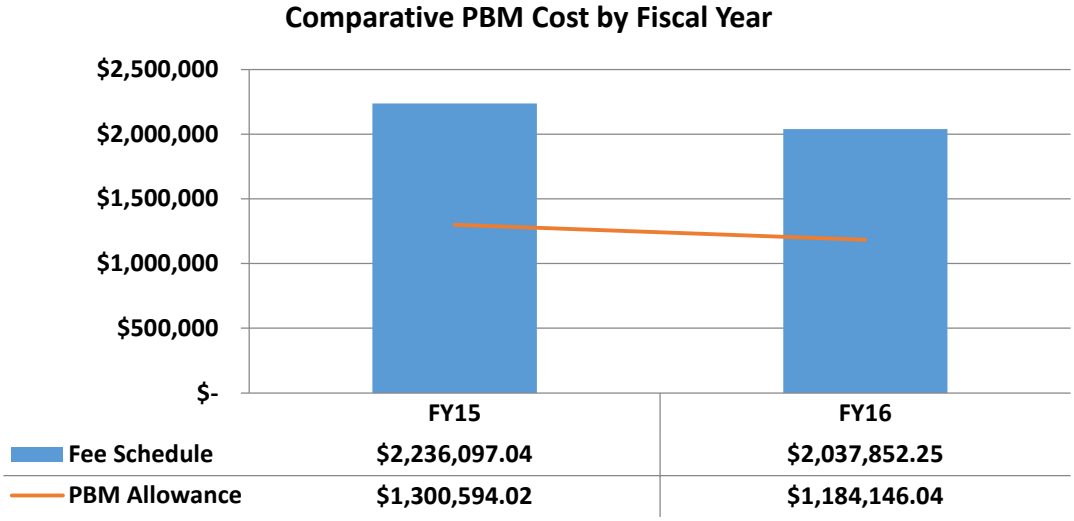
Workers' compensation benefits include medically necessary prescription drugs and over-the-counter medication. The reimbursement fees for prescription drugs are set by the Division of Workers' Compensation.

The Office has a medical cost containment contract with Matrix Healthcare Services, Inc. (myMatrixx), a pharmacy benefit manager, to ensure cost-savings and prompt service for medically necessary medications. The pharmacy benefits manager (PBM) provides a prescription card to all workers' compensation claimants. Participation in this program is entirely voluntary for injured workers. When the prescription card is presented at a participating pharmacy, the pharmacy can quickly provide the necessary medication to the injured worker.

The Office receives a discount below the Pharmaceutical Fee Guideline on the medication obtained through the PBM. The following chart shows the FY16 savings from the voluntary PBM program:



The following chart shows the cost savings related to the PBM program for fiscal years FY15 and FY16:



E. Timely Payment of Medical and Pharmacy Bills

The Office must take final action on medical and pharmacy bills not later than the 45th day after the complete bill was received. SORM must take final action on a request for reconsideration not later than 30 days after the request was received. If the Office does not comply with the payment deadlines, it must pay interest to the health care provider. The Office could also be subject to an administrative fine.

The following chart shows the Office's medical cost containment vendors' average turnaround time in FY16 to audit medical and pharmacy bills:

Bill Type	Average Audit Turnaround Time
Medical & Pharmacy Original	15 Days
Medical & Pharmacy Reconsideration	20 Days
Pharmacy Point-of-Sale	Same Day

F. Provider Refund Requests

A workers' compensation insurance carrier can request a refund from a health care provider when the carrier determines that inappropriate health care was previously reimbursed or when an overpayment for health care is made. The Office conducts post payment audits of medical bills to identify overpayments. Refund requests must comply with the Division of Workers' Compensation's statutes and rules.

G. Timely Payment of Indemnity Benefits

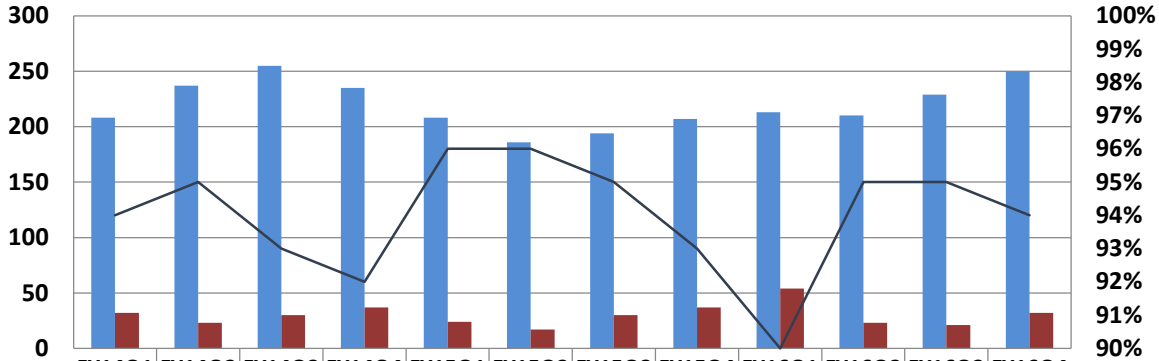
The Office must initiate temporary income benefits (TIBs) by the 7th day after the date of disability or the 15th day after notice of injury. The Office must initiate Impairment Income Benefits (IIBs) by the 5th day after receiving a Designated Doctor's report indicating the injured employee has reached maximum medical improvement. The Office must pay interest if it fails to initiate indemnity benefits on time.

The Office's Indemnity Quality Assurance Department (IQA) conducts indemnity audits on all claims where the claimant is receiving indemnity benefits. The initial audit occurs when (i) the claimant reaches eight days of disability, (ii) the claimant's accrued leave expires, or (iii) impairment income benefits are owed. The purpose of this audit is to verify the accuracy and timeliness of the initial indemnity payments. Because indemnity benefits can change during the lifetime of the claim, IQA continues to conduct audits to confirm the accuracy of any change(s) to the indemnity benefits.

Audit results are reported to the assigned adjuster. If the indemnity benefits the claimant is receiving are not correct, IQA will explain the mathematical error to the adjuster and provide recommendations on how to correct the payment error. IQA conducts a follow-up review to confirm the adjuster has taken appropriate steps to remedy the situation.

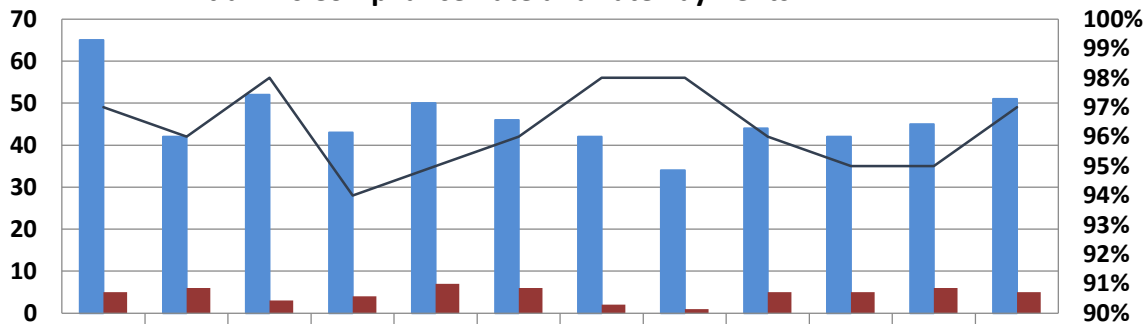
The following charts show the Office's historical compliance rates with the deadlines to initiate initial and impairment indemnity benefits:

Initial TIBs Compliance Rate and Late Payments



	FY14Q1	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
Initial TIBs	208	237	255	235	208	186	194	207	213	210	229	250
Late Payments	32	23	30	37	24	17	30	37	54	23	21	32
Compliance	94%	95%	93%	92%	96%	96%	95%	93%	90%	95%	95%	94%

Initial IIBs Compliance Rate and Late Payments



	FY14Q1	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
Initial IIBs	65	42	52	43	50	46	42	34	44	42	45	51
Late Payments	5	6	3	4	7	6	2	1	5	5	6	5
Compliance	97%	96%	98%	94%	95%	96%	98%	98%	96%	95%	95%	97%

H. Coordination and Outreach to Employers

When SORM receives notice of a claim through RMIS, an email is automatically generated to the employer's claims coordinator. This email explains the information the employer needs to provide to the Office, which includes information required to accurately calculate average weekly wage. Paying timely and accurate indemnity benefits reduces cost by eliminating interest on late payments, reducing and/or avoiding potentially unrecoupable overpayments, and eliminates potential administrative penalties.

I. Recoupment of Indemnity Overpayments

The Office tracks overpayment of indemnity information internally. If IQA identifies an overpayment of indemnity that can be recouped from future indemnity benefits, IQA sends a recommendation on recoupment to the assigned adjuster. Indemnity recoupment must comply with the Division of Workers' Compensation's statutes and rules.

J. Impairment Ratings Reviews

Cost savings are also realized from the review and dispute of incorrect impairment ratings. Under the Act, injured employees may be entitled to impairment income benefits (IIBs) determined by a whole body impairment rating assigned to the injured employee by an examining physician. Both the injured employee and the insurance carrier have the right to dispute an impairment rating. A review of questionable impairment ratings ensures the indemnity benefits paid to injured state employee are accurate and can also reduce overpayment of benefits.

K. Peer Reviews and Required Medical Examinations

The Office utilizes peer reviews of medical services and pharmaceuticals and required medical examinations of injured workers to verify the medical necessity and reasonableness of medical treatments and prescribed pharmaceuticals; to determine whether such treatments and prescriptions are related to compensable injuries; and to ensure that the injured employee receives quality medical care.

These services can be utilized when a determination requires medical expertise beyond what may be expected of a licensed adjuster. The opinions obtained form the basis of actions taken by the Office and establish the factual and medical evidence necessary to defend the Office's determinations through the dispute resolution process. As a result of these opinions more appropriate care is provided to injured workers while delivering savings through the elimination of unnecessary care.

L. Subrogation Recoveries

Subrogation reduces costs in two distinct ways. First, if a workers' compensation claim is based on an injury where a third party's negligence was the primary cause of the injury, the Office can assert a subrogation lien against the third party liability carrier or payer for the amount that has been paid in workers' compensation benefits on the claim. Any monies recovered through subrogation are used for the payment of workers' compensation benefits to state employees.

An additional feature of a subrogation lien is the avoidance of future expenses in an amount equal to the injured workers' direct recovery from the third party settlement that exceeds the worker's compensation lien. Workers' compensation insurance carriers have a statutory right to treat the additional settlement amount as an offset against potential future benefits that may be sought by the claimant. Consequently, until the

claimant exhaust the third party settlement, the Office does not have to pay future benefits.

For FY16, the Office's subrogation efforts created approximately $1.1 million in potential savings:

	FY16
Subrogation Recovery	$634,366.65
Potential Advance Against Future Benefits	$510,312.09

M. Subsequent Injury Fund

The subsequent injury fund is a dedicated account in the general revenue fund that can be used to reimburse an insurance carrier when it has made an unrecoupable overpayment of benefits based on a decision or order from the Division of Workers' Compensation and the decision or order is later reversed or modified. This type of reimbursement can remove either all, or a large portion of, the expenditures the Office made in certain disputed claims. In FY16, the Office received $143,934.02 in reimbursement from the subsequent injury fund.[1]

N. Fraud Detection and Investigation

The Office employs two full-time staff members to investigate potential fraud and abuse as a part of the Office's workers' compensation fraud detection program. The Office investigates both individual and medical provider fraud. The Office has a zero-tolerance policy for fraud and actively pursues administrative and criminal prosecution against those who attempt to receive monies and benefits to which they are not entitled.[2]

O. Risk Assessment and Loss Prevention Services

The accident that does not occur has the least direct cost to the State. While not reported as savings in this report, cost avoidance is inherent as a result of the decline of the number of injuries (both in absolute and relative terms) in the past biennium.

The Executive Director of the Office serves as the state risk manager and is responsible for supervising the development and administration of a system of risk management for the state. The Office maintains guidelines called *Risk Management for Texas State Agencies* (RMTSA), which provide essential information state entities may reference to develop and implement a comprehensive risk management program to reduce property and liability losses, including workers' compensation losses. The guidelines are intended to provide both general and specific direction to state entities to assist them in establishing and maintaining an entity-specific risk management program.

[1] This figure is included in the FY16 subrogation recoveries total.

[2] The Office negotiated a $350,000 settlement with a health care provider to recoup money that was erroneously paid for medical services. $200,000 was paid in FY15. The remaining $150,000 was paid in FY16. That amount is also included in the FY16 subrogation recoveries total.

The Office's risk management specialists serve as consultants to state agencies, conduct risk assessments and assist in developing and implementing risk management programs to prevent and control losses. During risk management program reviews and on-site consultations, particular emphasis is placed on policies, programs, and procedures that promote workplace safety and employee wellness, accident prevention, and loss control.

IV.Proposed Additional Measures

A. Approval and Denial of Medical Bills

The Office's Medical Quality Assurance unit (MQA) has staff with experience auditing medical bills for accuracy and compensability. A restructure of MQA is underway that will transfer responsibility for approval and denial of medical bills from the Claims Operations department to a medical bill audit unit within MQA. This unit will review medical bills that have been re-priced by the Office's medical bill audit cost containment vendor before payment is issued to verify the accuracy of the proposed payment, ensure the medical treatment is related to the compensable injury, and confirm services have received preauthorization approval when required. Medical benefit savings are expected to increase as the Office utilizes the expertise and knowledge of its own staff.

B. In House Medical Bill Audit

Utilizing the expertise of existing staff to audit medical bills before payment is made is an initial step toward the future possibility that the Office will audit and pre-price medical bills in-house. The Office will have to do an extensive evaluation and analysis of the potential reduction in the administrative fees paid to the medical bill audit cost containment vendor and the cost associated with the additional staff that would be required in order to comply with reporting requirements of the Division of Workers' Compensation.