SORM
State Office of Risk Management

Annual Report on Cost Containment

Fiscal Year 2021

October 15, 2021

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SORM
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I. Introduction

The General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Art. I, Rider 6, p. I-83) requires the State Office of Risk Management (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 is the Fiscal Year 2021 (FY 2021) Annual Cost Containment Report.

Background

The Office 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, self-insured workers' compensation program, and continuity of government operations (COOP) program. 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.

Quick Facts

The state employee workers' compensation program covers:

- **144 state agencies and institutions of higher education**
- **122 Community Supervision and Correction Departments**
- **Windham School District within the Department of Criminal Justice**
- **Encompassing approximately 185,000 individual employees**

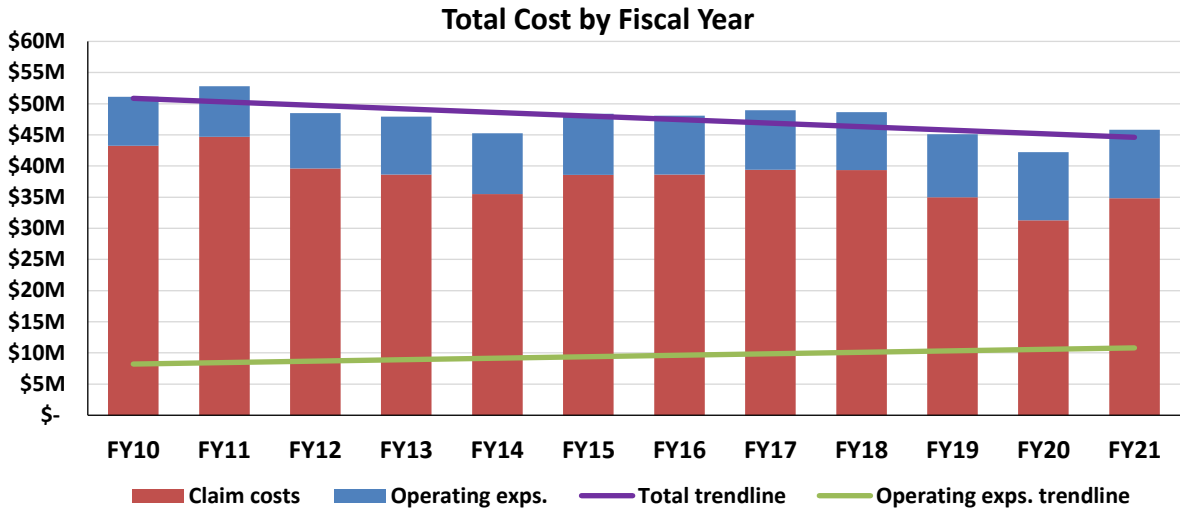
The State of Texas self-insures for the purposes of workers' compensation. No other statutory self-insured retention programs exist. The Office administers workers' compensation claims for the state entities identified in Labor Code Chapter 501. There are also situations in which certain non-state employees are covered by workers' compensation through the Office.

The Texas A&M University System, University of Texas System, and the Texas Department of Transportation are exempted from the Office's workers' compensation program and operate their own individual workers' compensation programs.

II. Cost Containment Strategies

One of the Office's core statutory missions is to provide covered injured state employees with access to prompt, high-quality medical care within the framework established by the Texas 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 following chart shows workers' compensation costs have declined and costs have stabilized:



A. Accident Prevention

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's enterprise risk management program provides risk management services to state agencies, institutions of higher education, and other entities identified by statute.

The Office is required to develop and biennially review the Risk Management for State Agencies (RMSTA) guidelines, which are used by state entities to develop and implement a comprehensive risk management program to reduce property, liability, and workers' compensation losses. The RMSTA guidelines have a direct impact on workers' compensation losses.

The overall goal of the RMTSA is to demonstrate to state entity leadership the need for enterprise risk management (ERM) and recognize that ERM is an integral part of the entity's governance framework and to ensure ERM is a fundamental part of all entity activities.

The RMTSA guidelines outline the best practices of enterprise risk management and the responsibilities of an agency to incorporate these practices, as applicable, into the Enterprise Risk Management Plan. SORM designed and refined the RMTSA in collaboration with stakeholders to help identify and manage risks, processes, and controls that may affect an agency's ability to achieve its mission, strategic goals, and objectives. The RMTSA provides a framework, based on ISO 31000:2018, for improving programs and operations within the agency's mission sets and administrative components.

Pursuant to Texas Labor Code Section 412.013, the Office recently reviewed and updated RMSTA guidelines. The Office's Board of Directors approved and adopted revised Risk Management Guidelines at its July 27, 2021, Board meeting.

B. Risk Management Program Reviews

The Office employs risk management specialists who review, verify, monitor, and approve risk management programs developed by state entities. A Risk Management Program Review (RMPR) can help a state entity determine the best methods for avoiding/controlling the costs of on-the-job injuries and minimizing lost productivity. The Office also conducts on-site consultations to state entities' physical locations and facilities each fiscal year. If risk exposures are identified during a site visit, the Office provides written recommendations on risk prevention and control measures that state entities can implement to prevent or reduce claims and losses and tracks resolution efforts. The Office's goal is to focus on hazards or risks that need to be addressed strategically and proactively to reduce the frequency and severity of workers' compensation claims. Risk factors will vary depending on the geographic location, types of and diversity in the work being performed, and overall risk profile. For workers' compensation specific risks, the number of employees; hiring, selection, and training practices; and day-to-day activities and job specific requirements can have an impact on the frequency and severity of claims.

Injury Frequency

- **FY21 – 3.03%**
- **FY20 – 3.15%**
- **FY19 – 3.22%**
- **FY18 – 3.24%**

The *Incident Rate of Injuries and Illnesses per 100 Covered Full-Time State Employees* provides an objective measure of the results of implementation of covered state entities risk management plans and the results of the Office's risk management program, related specifically to occupational injury. The injury frequency rate is important as it reflects not only the effectiveness of the Office's risk management program in identifying risks to covered state entities, but also reflects covered state entities actions regarding implementation of recommendations to control and correct the conditions that lead to injured state employees.

C. Workers' Compensation Assessment Allocation

The costs of the state employees' workers' compensation program are funded with legislatively appropriated funding as well as authority for collected subrogation recoveries. The Office is financed wholly through interagency contracts with other state agencies. The funding program allocates an assessment, like a premium, to all participating entities.

Texas workers' compensation insurance companies typically set the workers' compensation premium rate per $100 of payroll using industry classifications that are based on the type of business. Loss costs for each classification are intended to cover workers' compensation indemnity and medical benefits and associated expenses. In the private industry, high-risk businesses such as construction, will pay a higher premium per $100 of payroll than low risk businesses with office workers.

The Office does not use classifications in its assessment allocation program. The workers' compensation assessment allocations are based, in part, on the individual loss experience of the state entity. The fewer accidents a state entity has, the more it potentially saves on its assessment.

The rules for the risk allocation program, 28 TAC Chapter 251, Subchapter E, were adopted to:

- Equitably distribute the cost of funding workers' compensation losses, the cost of administering claims, and the cost of providing risk management services to participating state agencies
- Encourage the development and implementation of risk management programs and practices designed to minimize occupational injuries and illnesses; protect state property; and provide appropriate safety and health training for all state employees
- Pool large and small risks to enable catastrophic loss(es) to be spread throughout all participating state agencies
- Encourage compliance with the Office's regulations, policies, and programs.

The effectiveness of the Office's risk management program can also be seen in the low cost per $100 of state payroll and the low cost per covered employee:

	Cost Per $100 of State Payroll	Cost Per Covered Employee
FY 21	$0.48	$230.90
FY20	$0.45	$211.12
FY19	$0.50	$225.11
FY18	$0.57	$252.42

D. Workers' Compensation Claims Handling Practices

The state employees' workers' compensation program provides individual state entities with claims administration and comprehensive claims handling services. The Office also ensures that an injured employee, who suffers a compensable injury in the course and scope of employment, has access to medical care and receives wage replacement (income) benefits.

The Office follows best practices for workers' compensation cost containment. Licensed adjusters manage all aspects of a workers' compensation claim. When an injury occurs, an adjuster promptly conducts a thorough investigation to determine whether the injured state employee has a compensable work-related injury. The assigned adjuster maintains regular and continued communication with injured employee, health care provider, and employer. An active call center provides additional access to a live person during the Office's business hours.

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.

E. COVID-19 Workers' Compensation Claims Handling

COVID-19 Claims Prior to Senate Bill 22

Prior to the enactment of Senate Bill (SB) 22 in the 87th Legislature R.S., under the Texas Workers' Compensation Act, COVID-19 would not be defined as an occupational disease covered under workers' compensation unless there was causal connection to the work and workplace. The connection would require evidence that an employee was exposed, tested positive and contracted COVID-19 in the course and scope of employment rather than other means.

COVID-19 Claims After SB22

Upon enactment of SB22, the legislature created a rebuttable presumption that severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) or coronavirus disease 2019 (COVID-19) injury or death is work-related for certain first responders, such as detention officers, custodial officers, firefighters, peace officers, and emergency medical technicians. To qualify for the presumption, a first responder must meet certain conditions.

SB22 removes the requirement for first responders to show a correlation between COVID-19 and the workplace. It provides a presumption that COVID-19 arose out of the employment due to exposures that may be inherent to these industries. Along with this new presumption, there are specific requirements that the adjusting staff must validate. The fiscal impact of this new legislation, to be codified at Texas Government Code Section 607.054, is unknown at this time.

F. Medical Cost Containment Services

Medical cost containment provides fiscal responsibility with state funds, minimizes costs to employer state entities and injured employees, and reduces costs associated with workers' compensation losses and claims administration.

The Office is contracted with Sedgwick Claims Management Services, Inc. through its subsidiary York Risk Services Group, Inc. doing business as CareWorks Managed Care Services, Inc. (CareWorks) for the following medical cost containment services: (1) certified workers' compensation health care network, (2) utilization review services, and (3) medical bill review services.

The Office is contracted with Matrix Healthcare Services, Inc., dba myMatrixx, for pharmacy management benefits. The Office is also contracted with vendors that provide peer reviews, impairment rating reviews, and required medical examinations, which can result in workers' compensation claims savings.

G. Workers' Compensation Health Care Network

Texas Insurance Code Chapter 1305 requires a workers' compensation network to develop and maintain an ongoing Quality Improvement Program (QIP) designed to monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement objectively and systematically. The annual QIP must address both the quality of clinical care and the quality of services using factors such as, type of services provided, populations served by the network in terms of age groups, disease or injury categories, special risk status, medical outcomes, and return-to-work outcomes.

The Centers for Medicare & Medicaid Services[1] and the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) use value-based measures to evaluate provider and network

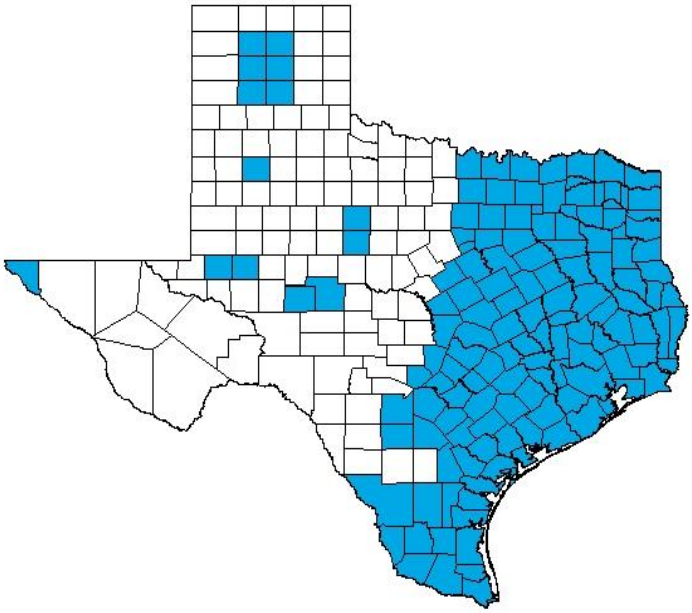
[1] https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter

performance. In its *Workers' Compensation Network Report Card Results,*[2] TDI-DWC concludes that networks tend to perform the same or better than non-network claims based on these factors:

- Medical costs
- Medical utilization
- Satisfaction with care
- Access to care
- Return-to-work
- Health outcomes

Certified workers' compensation network service area requirements are established by TDI.[3] Injured employees in the CareWorks network service area have access to health care with facilities and primary and specialty medical providers who are familiar with workers' compensation injuries and TDI-DWC billing requirements and required forms. The network provides reasonably necessary medical treatment and services while also controlling medical costs and utilization.

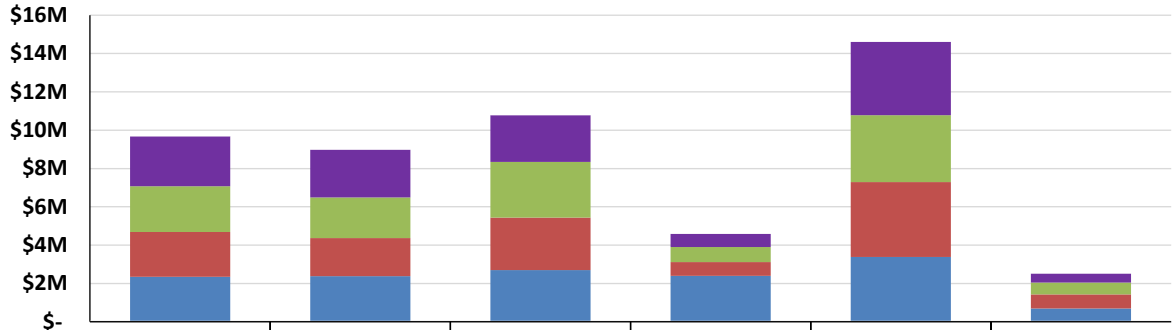
CareWorks Service Map



[2] https://www.tdi.texas.gov/reports/wcreg/documents/netrc2021.pdf
[3] https://www.tdi.texas.gov/wc/wcnet/documents/accessplans.pdf

Pursuant to contract, CareWorks is required to utilize non-network claims data to identify counties where expansion of the network's service area is merited. The following chart demonstrates the network and non-network costs for FY21 and previous fiscal years:

Network and Non-Network FY19 - FY21



Number of Claims	3,662	2,203	3,514	1,509	4,596	770
Q4	$2,605,680	$2,481,907	$2,427,246	$674,805	$3,824,285	$459,212
Q3	$2,393,718	$2,123,870	$2,910,436	$787,684	$3,491,421	$629,434
Q2	$2,325,785	$1,982,270	$2,744,007	$728,797	$3,906,428	$726,014
Q1	$2,353,428	$2,384,077	$2,694,384	$2,389,660	$3,383,454	$697,496

H. Medical Treatment Guidelines

TDI-DWC has adopted treatment guidelines that should be used as a framework to develop treatment for injured employees. Health care providers must consider care above or below the guidelines with the unique factors associated with an injury. Health care that is provided in accordance with the treatment guidelines is presumed reasonable and reasonably required.

Similarly, a workers' compensation health care network can adopt treatment guidelines and individual treatment protocols. The treatment guidelines and individual treatment protocols must be evidence-based, scientifically valid, and outcome-focused and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care.

Treatments and services that exceed, or are not included, in the treatment guidelines may require preauthorization.

I. Preauthorization of Medical Services

The Texas Workers' Compensation Act and the rules adopted by the TDI-DWC require health care providers to obtain preauthorization of certain medical procedures 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.

CareWorks performs utilization review services related to preauthorization requests. Preauthorization savings represent the avoidance of expenses related to unreasonable or unnecessary procedures or services prior to being provided and billed. It should be noted that health care that was not preauthorized may be approved later 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 cost-avoidance estimates associated with CareWorks utilization review of preauthorization for FY21 are:

Requested Cost	$8,953,674
Approved Cost	$7,178,565
Cost Avoidance	**$1,775,109**

J. TDI-DWC Fee Schedules

Workers' compensation benefits include medically necessary treatment, prescription drugs, and over-the-counter medication related to the compensable injury. TDI-DWC sets the amount of reimbursement for health care treatment and services and prescription drugs in non-network claims. The fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The amount of reimbursement for health care treatment and services provided by a network provider is determined by the contract between the network and the provider.

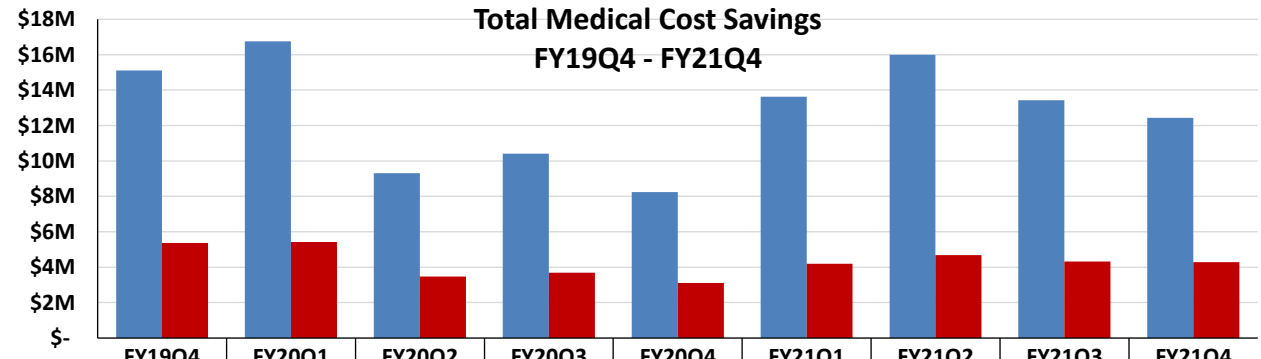
K. COVID-19 Medical Testing

When COVID-19 testing became a routine requirement prior to surgery, providers were not billing consistently. So, the Office developed a reimbursement methodology using CDC guidelines pursuant to CMS-2020-01-R dated April 14, 2020. To determine fair and reasonable, the Office used Medicare's reimbursement rate and multiplied it by 125% (DWC conversion factor) and paid $125.00 per testing occurrence when the testing was reasonable, necessary and related to a work-related exposure.

L. Medical Bill Review

CareWorks audits medical bills submitted by health care providers and reduces billed amounts to the maximum allowable rates under the appropriate fee schedule and/or network contract. Bills are also reviewed for medical necessity and relatedness to the compensable injury. Charges reduced through the application of medical fee guidelines and network reductions represent savings from the billed amounts. In the case of the state employees' workers' compensation program, these savings accrue to the benefit of the state's taxpayers.

The amount of savings realized from medical bill review for FY21 and previous fiscal years is shown in the following chart:



	FY19Q4	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
Billed	$15,117,272	$16,756,062	$9,312,010	$10,403,642	$8,243,226	$13,626,040	$15,989,298	$13,434,137	$12,439,427
Paid	$5,370,099	$5,425,543	$3,470,729	$3,691,876	$3,103,416	$4,199,594	$4,691,990	$4,314,976	$4,281,120
Savings	$9,747,173	$11,330,519	$5,841,281	$6,711,767	$5,139,810	$9,426,445	$11,297,308	$9,119,161	$8,158,306

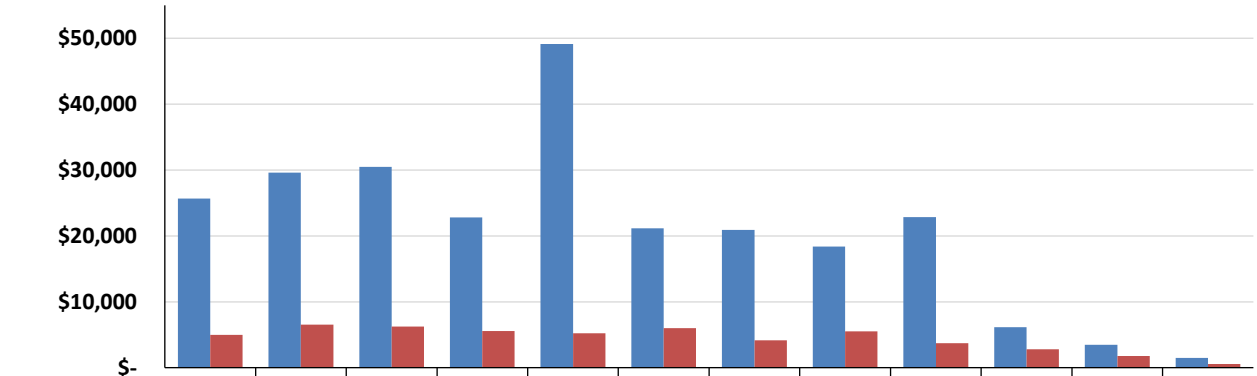
M. Telemedicine and Telehealth Services

The Texas Labor Code and TDI-DWC's rules allow for billing and reimbursement of certain telemedicine and telehealth services in workers' compensation claims. Injured employees may receive these services regardless of their geographic location. Telemedicine services are those provided by a physician licensed in Texas. Telehealth services are those provided by health care professionals other than physicians.

Telemedicine and telehealth services must be on the list of covered services and providers must include specific information on the CMS-1500. The reimbursement rates follow TDI-DWC's fee schedules and network reimbursement schedules.

The following chart indicates there is limited utilization of telemedicine and telehealth services in the workers' compensation program administered by the Office. However, the fee schedule and network reductions result in savings:

Telemedicine and Telehealth Cost
FY21



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Amount Billed	$25,681	$29,580	$30,455	$22,787	$49,115	$21,162	$20,920	$18,380	$22,826	$6,117	$3,466	$1,485
Amount Paid	$4,978	$6,513	$6,233	$5,564	$5,236	$5,993	$4,129	$5,499	$3,700	$2,781	$1,786	$538
Savings	$20,703	$23,067	$24,222	$17,224	$43,879	$15,170	$16,791	$12,880	$19,126	$3,336	$1,680	$948

**The Office attributes the increased utilization of telemedicine and telehealth services to the COVID-19 pandemic.*

N. Pharmacy Benefits Management

Workers' compensation benefits include medically necessary prescription drugs and over-the-counter medication. The Office has a medical cost containment contract with a pharmacy benefit manager (PBM), to ensure cost-savings and prompt service for medically necessary medications. Participation in this program is entirely voluntary for injured workers.

The reimbursement fees for prescription drugs are set by TDI-DWC. The Office receives a discount below the pharmaceutical fee guideline on the medication obtained through the PBM. The following chart shows savings from the voluntary PBM program:

	FY19Q4	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
Fee Schedule	$298,139	$285,500	$251,436	$301,722	$238,484	$208,408	$211,914	$174,584	$129,681
Paid	$178,291	$147,416	$143,132	$186,161	$120,074	$106,704	$110,837	$98,009	$87,300
Total Savings	$119,848	$111,084	$108,304	$115,561	$118,410	$107,704	$101,077	$76,575	$42,381

O. 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 care and pharmaceuticals utilization; 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.

P. Impairment Ratings Reviews

Cost savings are also realized from the review and dispute of incorrect impairment ratings. Under the Workers' Compensation 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.

Q. Subrogation and Subsequent Injury Fund 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's 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.

Second, an additional feature of a subrogation lien is the avoidance of future expenses in an amount equal to the injured worker's direct recovery from the third-party settlement that exceeds the workers' 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 injured worker. Consequently, until the injured worker exhausts the third-party settlement, the Office does not have to pay future benefits.

The General Appropriations Act sets the annual target for the Office's subrogation recoveries. The chart below shows the combined total of recoveries from subrogation, criminal restitution, and the TDI-DWC Subsequent Injury Fund:

	Target	Third-Party Recoveries
FY21	$567,750	$682,644
FY20	$567,750	$813,850
FY19	$567,750	$523,058
FY18	$567,750	$695,339

R. Timely Payment of Medical and Indemnity Benefits

The Workers' Compensation Act requires the Office to provide appropriate income benefits and medical benefits in a manner that is timely and cost-effective. Income benefits must be initiated within certain time frames and notice requirements apply when benefit changes occur. The timeframes for payment or denial of payments for health care services are also set by TDI-DWC. Compliance with these deadlines is important to avoid unnecessary delay in providing benefits to a claimant. The Office must also pay interest if an income benefit or medical bill payment is late. Failure to comply with payment deadlines also subjects the Office to administrative fines.

Labor Code Section 402.075 requires TDI-DWC to assess the performance of insurance carriers during Performance Based Oversight (PBO) assessments at least biennially. PBO measures the timely payment of indemnity benefits and medical billing and the transmission of electronic data to TDI-DWC.

The Office has been identified as a high performer during PBO assessments in 2009, 2010, 2011, 2012, 2014, 2016, 2018, and 2020.

S. Recoupment of Indemnity Overpayments

The Office tracks overpayment of indemnity information internally. If the Office identifies an overpayment of indemnity that can be recouped from future indemnity benefits, a recommendation on recoupment is sent to the assigned adjuster. Indemnity recoupment must comply with the TDI-DWC's statutes and rules.

T. Fraud Detection and Investigation

The Office's Special Investigations Unit investigates 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 actively pursues administrative and criminal prosecution against those who attempt to receive monies and benefits to which they are not entitled.

III. Proposed Additional Cost Containment Measures

Risk Management Information System

The first phase of the Origami risk management information system (RMIS) implementation is the workers' compensation functionality. Workers' compensation claims activities can be streamlined to improve adjusters' productivity levels, compliance with regulatory reporting requirements, and cut claims costs. The RMIS can easily transmit claims activity data to and from external sources; compare claims to drive decision making; and deploy rules-based decision-making tools to automate clerical activities that keep the claims process moving.

Claims analysis is a crucial component to any effective workers' compensation claims management program. Access to detailed, up-to-date, comprehensive data on losses should increase the ability to proactively address risk by comparing claims, assessing severity, and making cause and effect correlations.

The RMIS can integrate with multiple third-party systems such as medical cost containment providers, human resource systems, and accounting and payroll applications. Integration can also allow adjusters to easily utilize the Official Disability Guidelines (ODG) on medical treatment and return-to-work to benchmark outcomes in workers' compensation claims. ODG's Reserve Calculator is a statistical modeling program that incorporates unique factors that may increase claims costs. Adjusters can use risk levels provided by the ODG Reserve Calculator to specifically address high risk claims as well as claims that fall outside the ODG's treatment guidelines, costs, and return-to-work standards.