

DEPARTMENT OF LABOR AND INDUSTRIES

STATE OF WASHINGTON

WORKERS' COMPENSATION ADVISORY COMMITTEE

HEALTH CARE SUBCOMMITTEE MEETING

TRANSCRIPT OF PROCEEDINGS

Friday, February 15, 2013

BE IT REMEMBERED, that a Workers' Compensation Advisory Committee, Health Care Subcommittee meeting was held at 12:00 p.m. on Friday, February 15, 2013, at the Department of Labor & Industries, 7273 Linderson Way SW, Room S117, Tumwater, Washington. Subcommittee members present were: DIANA DRYLIE, Occupational Health Services Manager, who presided over and conducted the meeting; JANET PETERSON; LEAH HOLE-CURRY; ED WOOD; DAVE THREEDY; GARY FRANKLIN, MD, MPH; ROBERT MOOTZ, DC; and appearing telephonically BREEN LORENZ, JOHN MEIER, KAREN GUDE, and SOFIA ARAGON.

WHEREUPON, the following proceedings were held, to wit:

Reported by:
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1 PROCEEDINGS

2
3 Welcome
4

5 MS. DRYLIE: So we are here for a special session of
6 the Workers' Comp Advisory Committee, Health Care
7 Subcommittee. This was called so we could answer some
8 questions about the COHE Expansion RFP. But because we
9 are in the procurement process, I have some very specific
10 language that I have to share that will be captured in the
11 transcription and for us all to be aware of.

12 The purpose of this meeting is to provide an
13 opportunity for members of the Workers' Comp Advisory
14 Committee, Health Care Subcommittee to ask questions about
15 the COHE Expansion RFP. Discussion will be limited to
16 subcommittee members and L & I staff. So no members of
17 the audience or interested parties will be able to speak
18 at this meeting. The meeting is not open for public
19 comment.

20 This meeting is being transcribed, and the
21 transcription will be posted on WEBS.

22 Subcommittee members should either speak up or use
23 the microphone when they have something specific to say.
24 And please introduce yourselves before you speak. Any
25 questions about the RFP must continue to be submitted as

1 outlined in the RFP to the RFP coordinator.

2 Communications directed to parties other than the RFP
3 coordinator may result in disqualification of any bidder.

4 L & I staff will not be available to the public after
5 the meeting to discuss the RFP.

6 And again, we are in the procurement process.
7 Answers to questions concerning the RFP will be considered
8 tentative if they're made in speech here. Official
9 answers will be published in writing and posted on WEBS.
10 This will ensure accurate, consistent responses to all
11 vendors.

12 We do have a quick safety message today. This is a
13 long weekend in front of us, and there are going to be
14 probably more people traveling than usual. So please be
15 aware as you're driving around the state this weekend.

16 I thought it would be helpful for all of us at the
17 table and the subcommittee members on the phone to go
18 ahead and introduce themselves.

19 I'm Diana Drylie. I am the Occupational Health
20 Services Manager here at L & I.

21 MS. PETERSON: And I'm Janet Peterson. I'm the
22 Health Services Analysis Program Manager.

23 MR. WOOD: I'm Ed Wood, member of the Eastern
24 Washington Business and Labor Advisory Board. In fact,
25 I'm the Chair of it. And I am also a member of the

1 WCAC-HC.

2 MR. THREEDY: Dave Threedy, Board of Industrial
3 Insurance Appeals.

4 DR. FRANKLIN: Gary Franklin, Medical Director at
5 L & I.

6 DR. MOOTZ: Bob Mootz, Associate Medical Director at
7 L & I.

8 MS. DRYLIE: And then could the members -- the
9 subcommittee members on the phone please introduce
10 themselves with your full name.

11 MR. MEIER: John Meier, Employer Resources Northwest.

12 MS. GUDE: Karen Gude, United Food and Commercial
13 Workers, Local 1439.

14 MS. PETERSON: Anyone else?

15 Actually, I have a question for those on the phone.
16 Are you able to hear us well enough?

17 MS. GUDE: Yes.

18 MR. MEIER: Yes.

19 MS. PETERSON: Great.

20 DR. FRANKLIN: Can I ask a question? In the bylaws,
21 what does a quorum consist of?

22 MS. DRYLIE: We don't have a quorum at this meeting.
23 The quorum is two members from each caucus. So we are one
24 short.

25 This is not a decision-making meeting, however. So I

1 think we're okay.

2 So we have some specific questions that were raised
3 by members of the subcommittee about the COHE expansion
4 RFP, and we've prepared some materials to directly answer
5 those questions. But we also want to leave this open for
6 discussion. So any subcommittee members who have specific
7 questions, please feel free to bring them in any of the
8 question-and-answer sessions that we have planned.

9 The topics that we have focus on are the business and
10 labor involvement in the COHE expansion RFP, the
11 occupational health management system and kind of the
12 overall scope of that, and then the financial model that
13 we use to reimburse the COHE's, and then question-and-
14 answer opportunities at all of those topics and then at
15 the end as well.

16 So Janet is going to start us off with business and
17 labor involvement.

18 MS. PETERSON: Okay. I just wanted to get back to
19 this topic that we talked about at our October 29th
20 meeting related to the role of the business and labor
21 representatives in reviewing the RFP and providing input
22 on the RFP document as well as evaluating the proposals
23 from the health care organizations that respond to that
24 RFP.

25 And the background is that at the October 29th

1 meeting when we reviewed the proposed conflict of interest
2 statement that was required for participating in this COHE
3 selection process, some of the committee members raised
4 the issue that many of the subcommittees are on the COHE
5 boards. And after that, the L & I staff went over that
6 issue with our contracts office and were advised to pursue
7 alternatives. We intended -- I'm embarrassed to say -- we
8 intended to follow up with the WCAC-HC members at the
9 January meeting that was subsequently cancelled. So that
10 probably explains why we're here today to follow up on
11 this.

12 Okay. So quickly, the alternative that we pursued
13 was that we requested help from the Workers' Comp Advisory
14 Committee caucus chairs on recruiting other business and
15 labor representatives who are neither COHE board members
16 nor employees of health care organizations who potentially
17 might be interested in bidding on the --

18 MS. ARAGON: Hi. This is Sofia Aragon. I just
19 wanted to let you know I was on the line.

20 MS. PETERSON: Great, Sofia. Thank you for joining
21 us.

22 MS. ARAGON: Thanks.

23 MS. PETERSON: Okay. So I'll try to make this brief.

24 We sent letters to Rebecca Johnson and Kris Tefft in
25 mid-November, and by December we had identified and begun

1 orientation briefings with two business and two labor
2 representatives that were suggested by Rebecca and Kris.

3 And, you know, there were pros and cons to these
4 alternatives. One is that we did have fresh eyes, and we
5 -- there was active participation in the process. We felt
6 very positively that the feedback that we got from the
7 business and labor representatives helped us clarify our
8 intent and explain things more clearly in the RFP.

9 On the other hand, I think it is fair to say that the
10 WCAC-HC members would have raised other issues during that
11 process that maybe were not raised by the new
12 participants.

13 So we're using this meeting today to help mitigate
14 that and give the committee members -- subcommittee
15 members the opportunity for feedback. I just want to make
16 sure that you are aware that because we are doing this
17 during the procurement process, that that's why we made
18 sure that all bidders are aware that this meeting is
19 taking place, were allowed to call in to hear the meeting.
20 And we are, of course, using the court reporter to
21 document. So we are making it a little bit more formal
22 than our usual meetings.

23 So I think those are my only comments unless -- are
24 there particular questions on that at this point? I'm not
25 seeing any questions.

1 From the phone?

2 MS. GUDE: No.

3 MR. MEIER: No questions.

4 MS. PETERSON: Great. Thank you.

5 Okay, so I'll pass it back to Diana to talk about the
6 Occupational Health Management System to address some of
7 the questions we've heard on that.

8 MS. DRYLIE: So some of the questions about the
9 Occupational Health Management System were related to what
10 is the scope of the system, what are our expectations and
11 assumptions for what the COHE would do in using the
12 system, and then what's the overall schedule for all of
13 the different functionality to roll out.

14 I will say for both of my presentation topics, I
15 pulled slides primarily from the presentation we made to
16 the Workers' Comp Advisory Committee in December and the
17 Provider Network Advisory Group in January. So these for
18 the most part are slides that have already been presented
19 and are public.

20 So just so that you know, the RCW that came out of
21 Substitute Senate Bill 5801 is the one that requires us to
22 have an occupational health management system. And the
23 scope of the system is to provide systematic feedback to
24 physicians regarding quality of care, to have objective
25 evaluation of progress in the COHE's and to allow

1 efficient coordination of services. This is a system that
2 L & I is designing so that it will support all best-
3 practice programs. However, COHE is the first one that's
4 going to have the opportunity to use this system.

5 We have selected a vendor who will be working with us
6 on creating the system. The vendor is called Consilience.
7 They are a software company that was founded in 2003 and
8 have deployed similar software in five major cities, nine
9 states and internationally. They are focused very much on
10 public use of case-management systems.

11 Some of the things that we were looking for as we
12 were evaluating the proposals that we got from the request
13 for proposal process were making sure that we have
14 technology that would be very flexible, user friendly,
15 that we would be able to modify and use for the COHE's and
16 for all of our best-practice programs. So something that
17 would not require heavy-duty information system
18 intervention in order to make it work for the processes
19 that we have in place and that we have planned for the
20 future.

21 We also wanted to make sure we had a vendor who is
22 used to working with governmental and public agencies,
23 that they knew our stakeholders, our needs, and were able
24 to work with us, and that they were willing to work very
25 closely with us on modifying their system so that it meets

1 all of our needs.

2 The only requirements of a COHE for taking advantage
3 of the OHMS system are that they have a computer with Web
4 access. This is a Web-based application. So it's not
5 something that they have to change any of their
6 information technology to use. They have to have a PC,
7 Macintosh or a Unix/Linux system that has a 56.6k modem or
8 more and has any of the standard Web browsers. So we are
9 not creating something that will require a lot of
10 infrastructure development for the COHE sponsors. We
11 wanted to make sure that this was something they could use
12 with no impact to them and their financial requirements.

13 And then we also have done a lot of work on getting a
14 schedule put together and identifying the specific needs
15 of the COHE's as they move forward. And so if you look at
16 our first release, we have five releases for this system.

17 The first release is focused on health services
18 coordinators and is scheduled to be available on July 1,
19 2013, when the new COHE's come up. And it will allow a
20 health services coordinator to have a dashboard to clearly
21 and easily identify the claims that need their assistance,
22 to do risk scoring so that they can prioritize the claims
23 that they are working on. It will calculate and allow
24 them to modify risk factors. As new information comes in,
25 the risk factors will change, and it will help, again,

1 reprioritize the work the HSC's are doing. It will allow
2 them to document their case notes and their billable
3 activities directly in the system so they won't have to do
4 that through a separate interface or a separate system at
5 L & I, and will allow them to create on-line forms to do
6 the activity prescription on-line to data enter it or do
7 to scales -- functional scales, pain scales. That's all
8 in release 1.

9 The second release is focused again on further
10 enhancements for health services coordinators and some
11 additional functionality for other COHE staff. So this is
12 the point where the provider trainer will have a dashboard
13 to help them identify which providers have received
14 training, which need training. It will also be available
15 for the program and medical directors to know what reports
16 are needed, what their dashboard is -- any of the
17 information that they want to track as they manage the
18 COHE. It will allow the health services coordinators to
19 send messages to L & I staff who are not OHMS users. So
20 an example is early-return-to-work staff, occupational
21 nurse consultants in the field. All of this is to help
22 streamline the communications and make sure everybody is
23 on the same page at the same time and not require the COHE
24 to have stand-alone systems that can't have that
25 functionality.

1 It will also have additional scales and alerts and
2 allow assignments so a provider trainer can be assigned to
3 specific providers.

4 The next release is the first one where COHE-enrolled
5 providers will have the opportunity to go into the system
6 themselves. Again, they would just have to have Web
7 access. So go in through a browser, have access to the
8 system, see the claims that they have, the workers' comp
9 claims in their case load. It will allow referrals to
10 COHE advisers. So if a claim comes in and needs
11 assistance, the system will notify the COHE adviser that
12 there is a claim that somebody wants some help on. Will
13 begin to automate the provider enrollment. So instead of
14 having to do a lot of paper forms, it will be an
15 electronic system. The OHMS system will also enable the
16 COHE's and the L & I staff to have easy access to the
17 automated performance reports that we currently do
18 manually. And this is the start of doing integration with
19 health information exchange and electronic medical
20 records.

21 One note here is that integration for the COHE
22 providers through HIE and EMR is not required of the COHE
23 and is not expected to be paid for by funds under the COHE
24 expansion contract.

25 So this is something that the OHMS system is being

1 designed to allow but is not required of the COHE to fund
2 it.

3 Then release 4 is really focusing on the contract
4 managers at L & I to make sure that they have the tools
5 that they need to help support the COHE's and so that all
6 of the communication can happen electronically and an
7 opportunity to have a knowledge base that can be used by
8 anybody in the COHE. So we can put information in that's
9 of use to COHE providers, to COHE staff, to health
10 services coordinators.

11 And then in the final release, we are focusing on the
12 community outreach aspects of the Centers of Occupational
13 Health and Education and allowing them to create and track
14 events in the system so that they'll be able to focus on
15 the reporting of community outreach.

16 This is also an opportunity to design more of a
17 business intelligence aspect so that people will be able
18 to go in and create reports of their own to see how their
19 behavior, their activity or their COHE is doing in the
20 system, and will have the opportunity to integrate a
21 learning management system so that all of the provider
22 trainer and management -- learning management functions
23 can be incorporated through the OHMS system.

24 So those are my high-level points about the OHMS
25 system. Are there any questions around the table?

1 MR. MEIER: Is this a -- are there -- when you're
2 asking for questions about the table, does -- is this an
3 appropriate time to ask questions about contract
4 requirements in the OHMS system or shall we wait until
5 later to ask those?

6 MS. DRYLIE: No, you can ask now.

7 MR. MEIER: Okay. I'm trying to kind of formulate
8 them as you're moving along.

9 Are there any contract requirements or parts of the
10 RFP that require potential COHE's to do that are -- in
11 terms of interaction with the OHMS system that occur --
12 that are required that are going to be supported in the
13 OHMS system beyond release 1? So is there a contract
14 requirement that requires something that isn't going to be
15 contained in the first OHMS release?

16 MS. DRYLIE: So the way we have created the sample
17 contract through the RFP is that the COHE's will be
18 required to use whatever functionality in OHMS is
19 available. So in release 1, the focus is on all of the
20 work that a health services coordinator would need in
21 order to really take care of the injured workers in their
22 COHE.

23 The second release has some enhancements on that. So
24 there's some additional services and functions that would
25 be available.

1 And as each release rolls out, there's additional
2 functionality that's available. We are not requiring a
3 COHE to use the functionality until it's tested and
4 available to them.

5 Does that answer your question, John?

6 MS. LORENZ: Hi. This is Breen. I'm on the phone.

7 I have a question also. And this is coming from the
8 other side. How is this going to the -- the OHMS
9 implementation going to affect the self-insured as they
10 come on board?

11 MS. DRYLIE: So if people couldn't hear, Breen's
12 question was: How is the implementation going to affect
13 self-insured employers?

14 And my response to that is: We don't yet know.
15 We're going to be working with the Provider Network
16 Advisory Group starting in April to discuss how to
17 incorporate self-insured employers into the system.

18 MS. PETERSON: That's the major topic for the
19 Provider Network Advisory Group -- the next Provider
20 Network Advisory Group meeting.

21 MR. MEIER: Are there any contract requirements that
22 require the contractors or the potential COHE's to develop
23 any kind of interface with OHMS? Or are they just --
24 basically are they logging in sort of like we do with --
25 at least my company does with my claim and account center?

1 MS. DRYLIE: Claim and account center is a very good
2 example. That's the only requirement that they will be
3 able to go in through a Web access, use the system live
4 through the Internet. There is no contract requirement
5 for them to develop any kind of interfaces to their
6 systems.

7 MS. GUDE: Diana, is there any support for technical
8 support for this?

9 MS. DRYLIE: So the question is: Is there any
10 technical support for this?

11 Part of the contract that we have with the vendors
12 actually includes ongoing support of the system. And we
13 will have staff here at L & I who will also be supporting
14 it after the contractors are gone.

15 MR. WOOD: What are the contingencies for the health
16 services coordinators when the OHMS implementation and
17 deployment is delayed or when the system is down and
18 renders the HSC's productivity to be shut down?

19 MS. DRYLIE: So I think that there are two questions
20 in there.

21 MR. WOOD: There is.

22 MS. DRYLIE: The first one is if the system were to
23 be delayed.

24 Right now, it's looking like we will be able to
25 deliver the system on time. The OHMS team is absolutely

1 amazing, and they're doing a great job working with the
2 vendor and getting something up and running for the July
3 1st time frame.

4 If, however, they're not able to achieve that, we
5 will not require the HSC's to use a system that doesn't
6 exist.

7 And then the contingency, both if it were to be
8 delayed and if it were to go down at any particular time,
9 we have -- we would work with our individual COHE's to
10 identify processes that could be put in place. We, of
11 course, have ten years of experience putting together
12 these processes, so we won't discontinue any of those
13 until we know that the OHMS system is able to replace
14 them.

15 DR. FRANKLIN: The vendor seems fantastic, and they
16 have done a lot of other kind of work like this, right?

17 MS. DRYLIE: Yes, that's accurate.

18 MR. WOOD: John, did you have any more?

19 MR. MEIER: No.

20 Well, I guess I will just say that one of the
21 concerns that pops up in my mind, I have dealt with more
22 than one implementation of new technology in my life, and
23 I have yet to actually be involved with one that came in
24 on time, on budget and worked the way that we expected it
25 to. Maybe that's just my experience and no one else's.

1 But when -- you know, it does look like -- and maybe
2 this will serve as sort of where we can move on with the
3 discussion is if there is a significant push towards more
4 let's say HSC billing and the OHMS system is down or not
5 available or not fully functional, it seems like that
6 could have a fairly significant adverse impact on a
7 potential COHE. And I guess, you know, the contingencies
8 that you just mentioned, I'm not sure how that's addressed
9 in those contingencies because if it were a new bidder or
10 a new contract, which I'm sure there will be at least one,
11 we'll have to figure out a way to track all of that
12 themselves? Is that correct?

13 MS. DRYLIE: Well, the benefit of our current system
14 is it's work done by L & I staff. So we provide data
15 extracts, lists of claims, new claims with time loss,
16 claims that have changed to time loss. So we already
17 provide all of that data to the COHE's. And it would be
18 no difficulty to provide that to a new COHE. Actually it
19 would be a little bit easier for us starting the new
20 COHE's than it did starting the original COHE's because we
21 already have all of the queries, all of the programming
22 created.

23 MR. WOOD: I have a question. It says that you're
24 going to train the COHE users on how to use the OHMS
25 system. One question we have is: Will COHE staff be

1 trained at the COHE location or will there be need to
2 travel over here to do it?

3 MS. DRYLIE: So the training will be happening on
4 location with the COHE's. We feel it will be most
5 effective for them to be sitting in their own work
6 location and using the system with people helping them
7 through it. We are not expecting any travel for training
8 of the OHMS system.

9 MR. WOOD: Okay.

10 And this is kind of rhetorical. But if the OHMS
11 system is not available for the July release, how do you
12 anticipate the COHE to identify COHE claims and document
13 HSC work?

14 MS. DRYLIE: We will continue with the processes that
15 we have today or make any other modifications that a COHE
16 needs for us.

17 MR. MEIER: Diana, when a COHE is building their HSC
18 activity, currently -- frankly I'm not sure exactly how
19 they do it right now -- is that -- would the tracking of
20 that billing also be integrated into the OHMS system or is
21 that something that is outside the OHMS system that the
22 contractor would have to develop their -- on their own?

23 MS. DRYLIE: One of the benefits of the OHMS system
24 is that when the HSC's are doing their work live in the
25 system, we will have access to all of those data elements.

1 So we will be able to track their billable activities,
2 their non-billable activities. It's actually going to be
3 a much more robust reporting mechanism than anything we
4 have today.

5 MR. MEIER: And this does come back around to I guess
6 my original question. You have those -- you know, it
7 sounds wonderful. If, you know, contractors are not able
8 to access that for let's say the first three months of the
9 contract because there is some delay, how do you envision
10 sort of the new COHE's being able to meet sort of the
11 benchmarks of the HSC sort of initial evaluation and
12 coordination aspect in the HSC services center?

13 MS. DRYLIE: One of the things that we would look at
14 because of an issue on L & I's side or because of
15 unavailability of the system, if that impacted any
16 performance measures, we, of course, would modify our
17 expectations based on what the COHE is able to do.

18 MR. MEIER: Is there a -- so I can understand that
19 you would modify the requirements or, you know, the
20 benchmarks. How would the new COHE be paid for their HSC
21 activities?

22 MS. DRYLIE: So if the OHMS system were not available
23 and HSC's weren't able to bill through that system, they
24 would bill using the standard L & I processes either
25 through a clearinghouse, through direct-entry billing. We

1 have a lot of systems already in place that support that.

2 MR. MEIER: And that's what they would have. But in
3 terms of the systems that you do have in place, they would
4 have -- you would provide them with access to that?

5 MS. DRYLIE: Yes. Any COHE would have access to the
6 L & I billing systems.

7 Direct-entry billing, for example, is another
8 Web-based system.

9 MR. MEIER: Okay, all right.

10 MS. DRYLIE: And I know that we're a little tight on
11 time. We're about five minutes over for the agenda.

12 Are there any more questions on OHMS?

13 MR. WOOD: I'm fine on OHMS.

14 John, are you fine on OHMS?

15 MR. MEIER: I'm fine on those, yeah.

16 MS. DRYLIE: How about Karen, Breen and Sofia?

17 MS. GUDE: I'm good. Thank you.

18 MS. LORENZ: I'm good.

19 MS. DRYLIE: Sofia?

20 MS. ARAGON: Hi. I'm okay. No questions.

21 MS. DRYLIE: Thank you.

22 So our next topic is the COHE financial model. And
23 some of the questions that came to us in advance were:
24 What have we done with the administrative payments? What
25 are the rates that we have set in place? What's happened

1 with the health services coordinator fees? And then we
2 also created a hypothetical COHE to show what the
3 reimbursement changes would be between if this
4 hypothetical COHE existed in the contract today and had no
5 changes but existed in future contracts so hopefully to
6 help it be a little bit more concrete so people can see
7 what this would mean to a COHE.

8 So the first slide is really about the modifications
9 that we've made to the payment structure for the COHE's.
10 The COHE sponsors as I think everybody knows receive a
11 base administrative fee that covers the non-billable
12 services provided by COHE's. In the current contract
13 period, it is \$34 dollars for an institutional COHE, and
14 \$37 for a community COHE. After doing an in-depth
15 analysis, looking at all of the different roles and FTE's
16 that we were expecting in a COHE, looking at their salary
17 levels, their benefits, the amount of load that we would
18 want to include onto it, we have looked at it and decided
19 to raise that rate to \$41 for the 2013 to 2016 contract
20 period. For a community COHE, that would be an 11 percent
21 increase in the base administrative fee. For an
22 institutional COHE, that's a 21 percent increase.

23 One of the things that you will see is we have gotten
24 rid of the distinction between institutional and
25 community, and we really are focusing just on COHE's

1 providing COHE services so we have a standard rate across
2 the board.

3 For the health services coordination billable
4 activities, we also looked at those fee schedules and
5 wanted to make sure that the payment for health services
6 coordination was appropriate for the level of skill that
7 we're expecting those health services coordinators to
8 have. So in 2011 to 2013 it was \$7.08 in a 6-minute unit.
9 We're raising it to \$8.05, which is more equivalent to
10 vocational services. And that in and of itself is a 14
11 percent increase just on health services coordination
12 services.

13 So the next slide titled "Expansion of COHE services"
14 is something that we presented at the Workers'
15 Compensation Advisory Committee in December, and it just
16 shows the overall view of our estimates on what's going to
17 happen with COHE's and with payment to COHE's in the
18 future. I'm not going to go over this in detail. I think
19 it has too much information in it for this particular
20 meeting. But we want to have it available for you.

21 But some of the big changes to notice are that in the
22 current contract period, we are requiring one health
23 services coordinator FTE to every 3,000 initiated claims
24 in the COHE. In the new cycle because of looking at
25 performance measures and seeing what the health services

1 coordinators have actually been able to do, we have
2 changed that rate so it's one health services coordinator
3 to every 2,350 claims. So each coordinator has fewer
4 claims that they have to track, monitor and intervene on.

5 We have also identified a challenge with having
6 coverage for health services coordinators if they're out
7 on vacation, if they have some illness issues. So we are
8 requiring that any COHE has at least two health services
9 coordinators, primarily for coverage, but also so that you
10 have training opportunities and people growing in these
11 skills.

12 We also have done research and identified that claims
13 touched by a health services coordinator, so billable
14 services provided on claims, is happening in 12 percent of
15 claims in the fiscal year 2013 time frame. And we are
16 hoping that that will increase up to 25 percent. In the
17 early years of COHE, it was in the 20 to 30 percent range.
18 That is when we have good outcomes. So we want to
19 increase that. That's another reason for lowering the
20 case load for the individual health services coordinators.

21 And I won't go in depth into the specific dollar
22 figures because I think it will be more concrete to look
23 at the hypothetical COHE's so you can see an apples-to-
24 apples comparison unless people object to that.

25 So the next slide is something we put together very

1 quickly. I've already discovered an addition error that's
2 been corrected in this version, and there's a typo that I
3 corrected in this version. But please bear with us on
4 this slide.

5 What we did when we created our hypothetical COHE is
6 we looked at our four current COHE's and averaged their
7 experience together. We didn't want to provide you
8 information on any specific COHE because everybody does
9 things slightly differently. So we felt averaging was the
10 fairest way to create a model that you could look at and
11 reflect on the changes. So this hypothetical COHE in the
12 current contract period in a single year would be
13 initiating 7,500 claims. Based on the \$41 per claim, they
14 would receive \$277,000, and they would have three HSC's --
15 three full-time equivalent HSC's.

16 Looking at their current HSC experience, so this is
17 really looking at the level of health services
18 coordination services provided by HSC's today, they would
19 receive \$21,300 for initial evaluation and coordination.
20 So that's that startup health services coordination code.
21 And they would receive \$23,000 for HSC services.

22 One thing to note here is this is related to
23 providing services on 12 percent of claims. And our hope
24 is to move people up to 25 percent.

25 But the total revenue for this hypothetical COHE

1 would be \$321,800 in the current -- in one year of the
2 current contract cycle.

3 So the next two columns are focusing on two slightly
4 different projections of the future. The first one is
5 reflecting only the changes in the payments levels, but no
6 change at all in the health services coordination
7 activities. So this is the same 12 percent of claims
8 receiving the same services. So the same number of
9 claims, the cost of claim increases from \$277,500 to
10 \$307,500. They would have four health services
11 coordinators instead of three. But again, we're assuming
12 no increase in activity. So the extra health services
13 coordinator would not be doing any more claims than the
14 three previous had been doing. They would receive \$40,300
15 for the initial evaluation and coordination, \$26,000 for
16 services, for a total revenue of \$373,800.

17 So you can see that there is a substantial increase.
18 It's 16 percent increase in the payments to the COHE just
19 because of the increased admin fee and the health services
20 coordination fee schedule, assuming absolutely no change
21 in HSC services.

22 The next column is --

23 MR. MEIER: Diana?

24 MS. DRYLIE: Go ahead.

25 MR. MEIER: I do agree with your characterization.

1 But I think it was the last comment that you made there
2 may be a little bit off. And I may end up kicking myself
3 for this because I do think that I have issues that I've
4 made very clear in terms of what I think of, you know, how
5 the costs of COHE's should be captured, and I think
6 billing per claim is not what I think is the right way.

7 There is a difference in the HSC activity simply
8 because you have one more. So there is -- there's an
9 additional -- there is an additional direct expense to the
10 contractor --

11 MR. WOOD: Yes.

12 MR. MEIER: -- you know, hypothetically where they
13 have to have another FTE -- and HSC FTE on staff, you
14 know, using that example. So -- I mean, it's not that
15 there's not anything else that's required; it's required
16 that they have another full-time body in place.

17 MS. DRYLIE: And that's absolutely true. That's why
18 I included the column on the HSC FTE's so that you could
19 see there is an increase in the FTE level. But what I'm
20 showing in the amount of revenue coming in for HSC
21 services is that that extra body is not doing any
22 additional billable services.

23 So I think that that is something for us to be aware
24 of. I don't think we would add a full-time equivalent
25 person and have them not change the amount of work that's

1 being done within the COHE.

2 But if they didn't, there's still a 16 percent
3 increase in the revenue that's generated by that COHE for
4 the administrative payments and the HSC services.

5 Does that make sense?

6 MR. MEIER: It doesn't make sense. I don't quite
7 follow the logic. Because I mean, really, that is -- you
8 know, there is another -- I don't know -- if we load an
9 HSC's cost, we'll just call it \$85,000 a year, I mean, you
10 could see the impact of that. When if you look at the
11 total revenue, if you add the line below that that goes
12 beyond total revenue to -- I don't know -- sort of, you
13 know, net profit, there's a tremendous decrease because
14 you have another full-time person.

15 MS. DRYLIE: And that's true. And let me go ahead to
16 the next column which starts addressing that specific
17 issue.

18 So the next column is assuming that the COHE is able
19 to take that extra staff person and increase the number of
20 claims that they're providing health services coordination
21 services on, which changes the billable activities and
22 more than covers the additional expense for that extra
23 FTE. So all of the stuff at the top is the same. Same
24 number of claims. Same administrative payment to the
25 COHE. Same number of health services coordinators. But

1 if they are able to achieve 25 percent of claims,
2 providing services on 25 percent of claims instead of 12
3 percent, they receive \$167,000 instead of \$40,300 and
4 \$91,000 for HSC services instead of \$26,000, which leads
5 to a total revenue of \$565,500. That's actually a 76
6 percent increase over the current model.

7 Our assumption is not that somebody would start out
8 and automatically be able to achieve a 25 percent increase
9 or the 25 percent of claims, but we do suspect that the
10 COHE's in the future with this extra body would be
11 somewhere between these two models of providing no
12 additional HSC services and providing 25 claim -- services
13 on 25 percent of claims.

14 MR. MEIER: Maybe this will be sort of my last
15 comment.

16 So it looks like there's about a 400 percent increase
17 in the billing that you would expect for the initial
18 evaluation and coordination, about a 300 percent increase
19 in the HSC services under that model?

20 MS. DRYLIE: And let me address that.

21 One of the things I haven't spoken about is that we
22 increased the payment for initial evaluation and
23 coordination by a significant amount. So a lot of that is
24 based on the change in the HSC fee schedule as opposed to
25 a change in volume.

1 MR. MEIER: Do you have any idea how much of that is
2 related to the increase in the fee and not activity?

3 MS. DRYLIE: So I'm now speaking off of the top of my
4 head because I don't have notes in front of me. But I
5 believe the fee went from in the neighborhood of \$50 to
6 the neighborhood of \$120. And I've got nods at the back
7 of the room, so I think that's relatively accurate.

8 MR. WOOD: That's approximate?

9 MS. DRYLIE: Yeah.

10 MR. MEIER: Why? And I ask it as a purely naive
11 question.

12 MS. DRYLIE: One of the things that we wanted to do
13 as we were reviewing the HSC fee schedule was seriously
14 take a look at the services being provided. We asked all
15 of the COHE's to give us I guess what you would call time
16 studies on the amount of time the health services
17 coordinators were spending on initial evaluation and
18 coordination, the amount of time that they were spending
19 on health services coordination services. We took all of
20 the information that they provided to us and identified
21 the fact that the initial evaluation and coordination was
22 taking more time than we had ordinarily thought that it
23 would take. Since it's a bundled service, we then took
24 that information and modified the rate so that it more
25 accurately reflected the work being done.

1 MR. MEIER: I guess I do have one more question.

2 So when you look at the far right-hand column, the
3 2013 through 2016 column, when you have that total revenue
4 of \$565,500, how many FTE's do you think are associated
5 with that? You know, when I'm looking at the RFP -- and I
6 realize these positions don't need to be -- you have
7 medical director. You have -- oh, what is it -- medical
8 director, program director, outreach facilitator provider,
9 and then a trainer. Do you have any sense of -- you know,
10 you have four HSC's, you know, with those other positions.
11 Are we talking one more FTE? two FTE's? Do you have any
12 -- did you have any thoughts about that as you were
13 putting this together?

14 MS. DRYLIE: We did model it, and I believe it's
15 slightly more than one FTE additional. It's between one
16 and two.

17 MR. MEIER: Okay.

18 MS. GUDE: On that HSC services, what are those
19 services?

20 MS. DRYLIE: So health services coordi --

21 MS. GUDE: Are they the same for each -- would you
22 expect them to be the same for each COHE?

23 MS. DRYLIE: So these two items, the initial
24 evaluation and coordination and the HSE services are
25 billing codes that are specific to how the health services

1 coordinators charge us for the services that they provide.
2 The health services coordination services are charged in
3 6-minute increments. So it's the health services
4 coordinator contacting the employer, the injured worker,
5 the provider, doing all of their activities on the claim.
6 They are likely to happen after an initial evaluation and
7 coordination, but they can happen without that if there's
8 just something simple that they have to do on the claim.
9 So there's nothing specific to what the code means other
10 than the HSC is providing their professional services.

11 MS. GUDE: And it wouldn't include like travel or
12 anything for training?

13 MS. DRYLIE: No. Travel and training are not
14 included in the HSC billable services. Those are included
15 in the administrative payment.

16 MS. GUDE: Okay.

17 MR. WOOD: One of the major questions that came --
18 that comes out of the Eastern Washington COHE is that they
19 are looking at around 18,000 claims. And this guideline
20 here that you have under staffing levels for HSC only goes
21 up to four HSC's. And under this guideline -- and it goes
22 7051 to 9401, looking at this, and if we're dealing with
23 18,000 claims, we're looking at eight COHE's -- or eight
24 FTE's. Is that what you're really looking at? Because if
25 it is, this is going -- and I will -- I don't know what's

1 going to happen over here, but in Eastern Washington COHE,
2 it's going to cost them about \$200,000 that they're going
3 to be in the hole.

4 MS. DRYLIE: So I can't speak specifically to any
5 COHE because --

6 MR. WOOD: I am not asking --

7 MS. DRYLIE: -- we are in the procurement process,
8 but I can say that the table in the RFP is intended to be
9 expanded using the same formula that it has there.

10 MR. WOOD: Okay.

11 So is this table then in stone? Is this what they
12 have to do? Is this a requirement that must be fulfilled?

13 MS. DRYLIE: If there are any concerns about language
14 in the sample contract, the bidders have the opportunity
15 in their response to do an exceptions to the contract.

16 And I can't do anything more than that in this
17 meeting. They have to follow the formal RFP process. And
18 that is all documented in the RFP.

19 MR. WOOD: Got it. Okay.

20 MS. DRYLIE: And I do want to make one correction. I
21 looked at the FTE levels for the 2013-2016 time frame, and
22 we're looking at just under one FTE for the staff that are
23 not health services coordinators.

24 Are there any more --

25 MR. MEIER: Just under one -- so less than one FTE

1 for the medical director, program director, outreach
2 facilitator and trainer all combined?

3 MS. DRYLIE: That's correct. And that's based on the
4 time studies that we did with the COHE's.

5 MR. MEIER: Okay.

6 MR. WOOD: That's all I have.

7 Oh, I had one more real quick question. I'm sorry.

8 When we were looking at -- let me go back real
9 quickly here -- where was that chart? Oh, here it is.
10 When we looked at this chart, for the 2013-2016 contract,
11 right? you did raise it, and I understand that to \$41,
12 right? But nowhere in there did I see any talk about or
13 any cost-of-living increase.

14 Because if I'm looking at bidding on something three
15 years away, and I don't see a cost of living in there, I'm
16 not so sure I may or may not bid on it, if you follow my
17 logic. So what do you have on that one?

18 MS. DRYLIE: So right now we do not have a
19 cost-of-living adjustment built into the contract. That
20 is something that we could negotiate in the future. But
21 for this contract period, we're going to have the sample
22 contract which is \$41, again subject to change. But that
23 would be an amendment to the contract.

24 MR. WOOD: Can I just ask: Was there talk around
25 that? Or did we talk about that at all or not?

1 MS. DRYLIE: We hadn't considered putting a
2 cost-of-living adjustment in the contract. L & I hasn't
3 provided cost-of-living adjustments to provider services
4 for several years.

5 DR. MOOTZ: I would assume that the HSC billing codes
6 would be subject to whatever is done with our usual March
7 fee schedule. So that is, we do review it annually to see
8 if we make cost-of-living increases. And if we do it for
9 anything else, it would include that for the HSC's.

10 MS. DRYLIE: All of the incentive payments both to
11 the HSC's and to the providers participating in COHE get
12 reviewed on an annual basis and are updated every July
13 following the process that we use to update all of the
14 provider fee schedules.

15 So we are now in the time frame of any other
16 questions, other topics that people want to cover.

17 MR. MEIER: Diana, it seems -- you know, and when I
18 look at how the money flows through this, it looks like
19 Labor & Industries has made -- I don't know -- made a
20 decision to really emphasize the HSC portion of the COHE.
21 Is that a fair characterization where -- I mean, it looks
22 like it's really pushing that side of the COHE more than
23 anything else.

24 MS. DRYLIE: I would disagree with the "more than
25 anything else." The reason we focused both on the admin

1 fee and the HSC billable services is because we wanted to
2 look at the full package of services provided by the COHE.
3 So when we were looking at the admin fee, we were looking
4 at the provider training, the community outreach, the
5 travel, the medical director, the COHE advisers. And
6 that's why that rate raised the 11 percent or the 21
7 percent. But we were looking at health services
8 coordination services and felt it would be a good thing to
9 encourage the HSC's to be able to spend time providing
10 services on the claims of the injured workers who need
11 their help so that we did include the increase in the HSC
12 fee schedule in order to encourage that work. So I would
13 say we focused on both sides of the equation. And that's
14 why you see changes on both sides.

15 MR. MEIER: Okay, thank you.

16 MS. DRYLIE: Are there any other questions?

17 MS. GUDE: I guess I have one more. And I might have
18 missed it.

19 Why did you guys choose the three year over the two
20 years in the past for the agreement duration?

21 MS. PETERSON: Good question.

22 MS. DRYLIE: So the question is: Why are we doing a
23 three-year contract instead of a two-year contract?

24 Some of it is it's simply for both us and the COHE
25 not to have to renegotiate a contract every two years.

1 And because we have moved to the cost-to-claim payment
2 model, we're no longer tied to the biennial cycle, so
3 there's no reason for us to tie it to an every-two-year
4 contract.

5 MS. GUDE: Okay, thank you.

6 MR. WOOD: That was good.

7 MS. DRYLIE: So I think I'm going to go around the
8 table for the members and ask if there are any last
9 questions. Anything from Ed?

10 MR. WOOD: Go ahead on the phone.

11 MS. DRYLIE: Ed has said that someone on the phone
12 can go first.

13 How about you, Breen?

14 MS. LORENZ: I'm fine. Thank you.

15 MS. DRYLIE: And Sofia?

16 MR. WOOD: She might be gone.

17 MS. DRYLIE: Hearing nothing, I'll move on to Karen.

18 MS. GUDE: No, not at this time.

19 MS. DRYLIE: How about you, John?

20 MR. MEIER: No more questions.

21 I'd just like to thank you guys for throwing together
22 this meeting at the last minute. I know it doesn't happen
23 without a lot of effort.

24 MS. DRYLIE: Thank you very much.

25 And Ed?

1 MR. WOOD: Yeah, I want to echo what John just said.
2 I appreciate the meeting. You've answered some of our
3 major concerns. And I do thank you all for having the
4 meeting.

5 MS. DRYLIE: How about you, Dave?

6 MR. THREEDY: No. I was just curious of what kind of
7 turnout you had at the conference -- the bidders
8 conference.

9 MS. DRYLIE: At the bidders conference. I'm not sure
10 what our final count was at the bidders conference.

11 MS. CAMPBELL (from back of room): There were 11 on
12 the phone, and I think 20 in the room.

13 MS. DRYLIE: So 31 total.

14 Well, I think we are done unless anybody has any
15 last-minute --

16 MS. PETERSON: No more comments?

17 MS. DRYLIE: Thank you all for coming.

18 MS. PETERSON: Thank you --

19 MS. ARAGON: I have a question.

20 MS. PETERSON: Yes.

21 MS. ARAGON: And sorry. But this thing had been
22 addressed earlier, but all of the documents that have been
23 floated to us for comments, those are all final as of now,
24 right?

25 MS. DRYLIE: All of the documents that I sent you for

1 the meeting today are final. Please do not forward the
2 RFP documents to anybody because bidders need to get those
3 official documents through WEBS.

4 MS. PETERSON: If they don't -- the problem with
5 distributing RFP documents other ways is that then if
6 there are updates, the bidder won't necessarily receive
7 them, and that could cause big problems. So we appreciate
8 you encouraging folks to -- everything will be out on
9 WEBS.

10 MS. DRYLIE: We will be posting the agenda, the
11 presentation materials and the transcript from this
12 meeting on WEBS so that all bidders have equal access to
13 the information.

14 Okay. Now I think we're going to call it. Thank you
15 everybody for coming.

16 MS. PETERSON: Thank you so much. Bye. Thanks a
17 lot. Have a good weekend.

18 (Whereupon, at 1:00 p.m.,
19 proceedings adjourned.)
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