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Ohio Revised Code

Section 4121.44 Implementation of qualified health plan system and health partnership program - health care data program.

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Legislation: House Bill 27 - 132nd General Assembly

(A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code.

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau as set forth in section 4121.441 of the Revised Code. To implement the health partnership program and to ensure the efficiency and effectiveness of the public services provided through the program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify managed care organizations for additional periods of two years; and

(3) May integrate the certified managed care organizations with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section;

(4) May enter into a contract with any managed care organization that is certified by the bureau, pursuant to division (B)(1) or (2) of this section, to provide medical management and cost containment services in the health partnership program.

(C) A contract entered into pursuant to division (B)(4) of this section shall include both of the following:

(1) Incentives that may be awarded by the administrator, at the administrator's discretion, based on compliance and performance of the managed care organization;

(2) Penalties that may be imposed by the administrator, at the administrator's discretion, based on the failure of the managed care organization to reasonably comply with or perform terms of the contract, which may include termination of the contract.

(D) Notwithstanding section 119.061 of the Revised Code, a contract entered into pursuant to division (B)(4) of this section may include provisions limiting, restricting, or regulating any marketing or advertising by the managed care organization, or by any individual or entity that is affiliated with or acting on behalf of the managed care organization, under the health partnership program.

(E) No managed care organization shall receive compensation under the health partnership program unless the managed care organization has entered into a contract with the bureau pursuant to division (B)(4) of this section.

(F) Any managed care organization selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a substantial number of the medical, professional and pharmacy providers currently being utilized by claimants.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the managed care organization's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a statewide basis have access to the eligibility and pricing, at a discounted rate, of all prescription drugs.

(5) A tracking system to record all telephone calls from claimants and providers regarding the status of submitted medical bills so as to be able to track each inquiry.

(6) Data processing capacity to absorb all of the bureau's medical bill processing or at least that part of the processing which the bureau arranges to delegate.

(7) Capacity to store, retrieve, array, simulate, and model in a relational mode all of the detailed medical bill data so that analysis can be performed in a variety of ways and so that the bureau and its governing authority can make informed decisions.

(8) Wide variety of software programs which translate medical terminology into standard codes, and which reveal if a provider is manipulating the procedures codes, commonly called "unbundling."

(9) Necessary professional staff to conduct, at a minimum, authorizations for treatment, medical necessity, utilization review, concurrent review, post-utilization review, and have the attendant computer system which supports such activity and measures the outcomes and the savings.

(10) Management experience and flexibility to be able to react quickly to the needs of the bureau in the case of required change in federal or state requirements.

(G)(1) The administrator may decertify a managed care organization if the managed care organization does any of the following:

(a) Fails to maintain any of the requirements set forth in division (F) of this section;

(b) Fails to reasonably comply with or to perform in accordance with the terms of a contract entered into under division (B)(4) of this section;

(c) Violates a rule adopted under section 4121.441 of the Revised Code.

(2) The administrator shall provide each managed care organization that is being decertified pursuant to division (G)(1) of this section with written notice of the pending decertification and an opportunity for a hearing pursuant to rules adopted by the administrator.

(H)(1) Information contained in a managed care organization's application for certification in the health partnership program, and other information furnished to the bureau by a managed care organization for purposes of obtaining certification or to comply with performance and financial auditing requirements established by the administrator, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public or be used in any court in any proceeding pending therein, unless the bureau is a party to the action or proceeding, but the information may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No employee of the bureau, except as otherwise authorized by the administrator, shall divulge any information secured by the employee while in the employ of the bureau in respect to a managed care organization's application for certification or in respect to the business or other trade processes of any managed care organization to any person other than the administrator or to the employee's superior.

(2) Notwithstanding the restrictions imposed by division (H)(1) of this section, the governor, members of select or standing committees of the senate or house of representatives, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4123. of the Revised Code, may examine any managed care organization application or other information furnished to the bureau by the managed care organization. None of those individuals shall divulge any information secured in the exercise of that authority in respect to a managed care organization's application for certification or in respect to the business or other trade processes of any managed care organization to any person.

(I) On and after January 1, 2001, a managed care organization shall not be an insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code.

(J) The administrator may limit freedom of choice of health care provider or supplier by requiring, beginning with the period set forth in division (B)(1) or (2) of this section, that claimants shall pay an appropriate out-of-plan copayment for selecting a medical provider not within the health partnership program as provided for in this section.

(K) The administrator, six months prior to the expiration of the bureau's certification or

recertification of the managed care organizations as set forth in division (B)(1) or (2) of this section, may certify and provide evidence to the governor, the speaker of the house of representatives, and the president of the senate that the existing bureau staff is able to match or exceed the performance and outcomes of the managed care organizations and that the bureau should be permitted to internally administer the health partnership program upon the expiration of the certification or recertification as set forth in division (B)(1) or (2) of this section.

(L) The administrator shall establish and operate a bureau of workers' compensation health care data program. The administrator shall develop reporting requirements from all employees, employers, medical providers, managed care organizations, and plans that participate in the workers' compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the selected managed care organizations and to measure the outcomes and savings of the health partnership program.

(3) Publish and report compiled data on the measures of outcomes and savings of the health partnership program and submit the report to the president of the senate, the speaker of the house of representatives, and the governor with the annual report prepared under division (F)(3) of section 4121.12 of the Revised Code. The administrator shall protect the confidentiality of all proprietary pricing data.

(M) Any rehabilitation facility the bureau operates is eligible for inclusion in the Ohio workers' compensation qualified health plan system or the health partnership program under the same terms as other providers within health care plans or the program.

(N) In areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease

that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code on a fee schedule the administrator adopts.

(O) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan.

(P) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this section and sections 4121.441 and 4121.442 of the Revised Code to provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code through qualified health plans of the Ohio workers' compensation qualified health plan system pursuant to section 4121.442 of the Revised Code or through the health partnership program pursuant to section 4121.441 of the Revised Code. No amount paid under the qualified health plan system pursuant to section 4121.442 of the Revised Code by an employer who is a state fund employer shall be charged to the employer's experience or otherwise be used in merit-rating or determining the risk of that employer for the purpose of the payment of premiums under this chapter, and if the employer is a self-insuring employer, the employer shall not include that amount in the paid compensation the employer reports under section 4123.35 of the Revised Code.

(Q) The administrator, in consultation with the health care quality assurance advisory committee created by the administrator or its successor committee, shall develop and periodically revise standards for maintaining an adequate number of providers certified by the bureau for each service currently being used by claimants. The standards shall ensure both of the following:

(1) That a claimant has access to a choice of providers for similar services within the geographic area that the claimant resides;

(2) That the providers within a geographic area are actively accepting new claimants as required in rules adopted by the administrator.