Introduction

1 BACKGROUND

As part of workers' compensation reform legislation passed in 2011, the Washington Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a performance audit of the state's workers' compensation claims management system.

Engrossed House Bill 2123 (EHB 2123), included the following directive:

> *The audit shall: (a) evaluate the extent to which the Department makes fair and timely decisions, and resolves complaints and disputes in a timely, fair, and effective manner; and communicates with employer and workers in a timely, responsive and accurate manner, including communication about review and appeal rights, and including the use of plain language and sufficient opportunities for face to face meetings; (b) determine if current claims management organization and service delivery models are the most efficient available; analyze organization and delivery for retrospective rating plan participants as compared to nonparticipants to identify differences and how those differences influence retrospective rating plan refunds; and determine whether current initiatives improve service delivery, meet the needs of current and future workers and employers, improve public education and outreach, and are otherwise measurable; and (c) make recommendations regarding administrative changes that should be made to improve efficiency while maintaining high levels of quality service to help address system costs, and any needed legislative changes to implement the recommendations.*

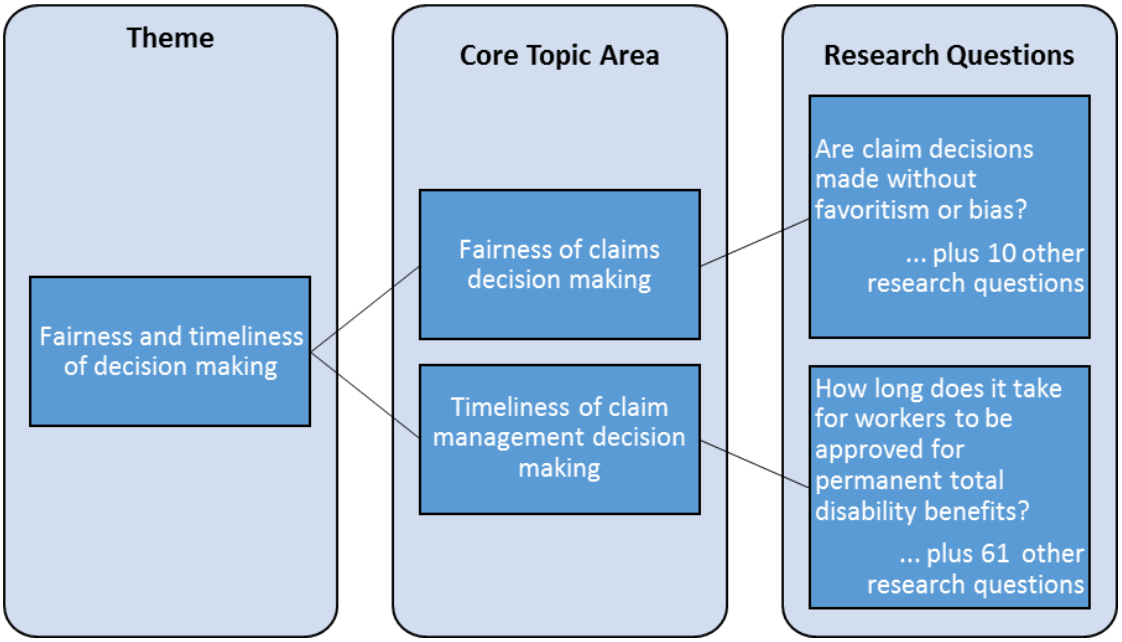
JLARC conducted an audit design, and in August 2013 issued a request for proposals to complete the audit. WorkComp Strategies LLC, a consulting firm with particular expertise evaluating workers' compensation programs, submitted a proposal and was awarded a contract to conduct the audit, and work began in November 2013. An audit team was assembled consisting of staff members from JLARC, the consultant hired by JLARC to design the audit, and the WorkComp Strategies team. The Department of Labor and Industries (L&I) provided a project manager to assist with making personnel and information available to the audit team, and numerous meetings with L&I personnel took place. Additional meetings were conducted with L&I executive staff to discuss the progress of the project.

2 AUDIT DESIGN AND SCOPE

The essential scope of the audit involved the timeliness, fairness, and efficiency of L&I's claims management function. The audit was designed to address the focus areas outlined in the 2011 legislation by answering specific questions within each of seven themes:

1. Fairness and timeliness of decision making
2. Fairness, timeliness, and effectiveness of dispute resolution
3. Timeliness, responsiveness, and accuracy of communications
4. Efficiency of claims management organization
5. Difference of organization between Retro and non-Retro employers
6. Impacts of Retro and non-Retro premium setting differences on Retro plan refunds
7. Analysis of current initiatives

These themes were divided into 15 core topic areas, which together contained 325 individual research questions. An example of these interconnected tasks is shown in the following exhibit:



The work to address these questions involved seven research methods:

1. Stakeholder and staff interviews
2. Documentation research and review
3. Review of claim files
4. Customer opinion survey
5. Best practices survey of panel of claims management experts
6. Data analysis of L&I claims data
7. Comparative data analysis of data from other jurisdictions.

The Summary of Methodology and Appendix 3 describe these methods in additional detail. The approach included investigating not only the administrative structure, but also compiling metrics designed to address several aspects of claims management performance. A small selection of the metrics we examined: How long does it take for claims to be accepted? What portion of claims end up being denied? How long do claims stay open?

We also compared results by certain basic categories of interest, including gender, age, industry type, and employer size, as well as among three key programs involved in the Washington workers' compensation system: State Fund claims; State Fund claims where the employer was a member of the Retrospective Rating program; and claims where the employer was self-insured. We will discuss in detail how these three programs are organized for claims management purposes, and outline performance results. We examined how L&I's performance compares with the following standards: existing statutory and regulatory compliance; best practices generally utilized in workers' compensation programs; performance from other state and provincial programs; and established benchmarks for workers' compensation claims. We analyzed several recent performance improvement initiatives regarding the

Washington workers' compensation system. Finally, as a result of this analysis, the audit addresses opportunities for improvements.

3 RECENT INITIATIVES

This audit reviewed L&I claims management performance primarily between 2010 and 2013. In 2013, L&I launched launch a comprehensive "Claims Evolution" project designed to "improve claims and medical management operations." (Workers' Compensation Advisory Committee Presentation, April 2013). One of the primary focus areas of the effort was to collaborate across programs to promote prompt and safe return to work. L&I has undertaken several initiatives and changes in connection with this effort, including the following listed below. Additionally, in 2015 the Washington State Legislature enacted changes that are designed to improve RTW results. Note that these are not presented in any particular order; they are in various stages of development and implementation, ranging from conceptual design, to limited pilot testing, to partial implementation, to final and full implementation. Some of the initial results indicate that these efforts are promising, but we have not fully evaluated their effectiveness and performance.

- 2015 Washington State Legislature updates:
    - Additional financial incentives added to the Preferred Worker Program; this program encourages employers to hire workers with permanent disabilities, unable to return to their employer of injury. The new employers receive assistance similar to the Stay at Work program, as well as workers' compensation premium assistance and financial bonuses for keeping such workers employed
    - Making the VIP (vocational improvement pilot) changes from 2008 permanent, and making changes to the "Option 2" payment and increasing it from 6 months to 9 months and allowing additional time (up to three months) for those choosing Option 1 to revert to Option 2
- Development of the RTW program:
    - Hiring of an "RTW Partnerships Chief" to manage reform and improvement of the L&I RTW program
    - Pilot implementation of the "Early AWA" initiative, to seek to identify earlier in the claim those workers most likely in need of an AWA determination; early results have been publically discussed
    - Changes to timing in the ERTW program, where the ERTW team contacts employers in claims identified through predictive analytics as being most at risk of not returning to work
    - Development of "standard work" for AWA timing, and use of the GEMBA walk process to monitor this
    - Co-location of WorkSource specialists in some units to assist with helping workers explore available work
    - RTW ToolKit training curriculum, focusing on effective communications and strategies for encouraging early RTW; provided across claims floor, as well as ERTW and ONC staff
    - Many activities done in conjunction with the Vocational Technical Services Group, such as:
        - Process changes made to the Vocational Dispute Resolution Office program including the addition of a new evaluation form that standardized the work and allowed for quality review

        - Investigating promoting retraining plans that involve work place learning
        - Re-formatting the Ability to Work Assessment progress report to include new prompts to assist CMs in managing referrals
- Medical management:
    - Additional ONCs made available to CMs; building from 10 to 20 ONCs has been going on during 2014-15
    - More standardized and issue specific timing of when ONCs would provide services on claims
    - Authority to develop list of "Top Tier" medical providers to exemplify best practices in occupational medicine and to promulgate performance metrics for this group
    - Tightened membership in the Medical Provider Network through an analysis of practice patterns so as to identify and instruct or remove poor performing providers
    - Incentives to providers to utilize FileFast
- CM support: Claims processors hired to field CM calls as needed, and attempt to resolve caller issues if appropriate
- Technology:
    - New CBOB+ report, consolidating numerous accountability reports into a smaller report; available in a web dashboard format for supervisors; this reduces the number of management reports routinely sent to claim supervisors to a more consolidated set of reports
    - Making available across the claim floor Early Claim Solution software used by the FileFast team, which allows recording and entry of additional information in investigating claims
    - Budget request ($9.8 million in upcoming budget cycle) for replacement of core information system (LINIIS mainframe)
- Non-English language initiatives: L&I working to address appropriate operational changes regarding non-English language customers; L&I received a formal complaint from DOJ/DOL in July 2014
- Self-insurance audit reform: development of a new audit process, to include issue based audits; piloting across all SIs in 2015 for "Tier 1" on the issue of wage calculations
- Predictive analytics: Beginning use of analytics to select cases for early interventions using the in-house developed "40 day" model that predicts chances of certain claim characteristics at 40 days of LT developing into much longer term disability