

MPN Public Meeting January 30, 2013 - Summary of Public Comments

NEW MPN APPLICANTS:

- The statute says any provider may qualify as an entity that provides for physician network services.

Comments solicited regarding the potential requirement an entity that provides physician network services must also be regulated by another agency such as the Department of Managed Health Care or Department of Insurance in order to qualify as an MPN applicant.

- Reluctant to support the requirement that an entity that provides for physician network services must also be approved by another agency such as the Department of Managed Health Care or Department of Insurance in order to qualify as an MPN applicant. Concerned that these other agencies may have regulatory influences that would make it more difficult because standards unrelated to workers' compensation may need to be met. Believes that the intent of the law is to make it more efficient for people to put these programs in place.
- The upside of having a requirement that the Department of Managed Health Care or Department of Insurance be involved is you would get the advantage of what these agencies are really good at, such as assessing the risk arrangement and financial policies of these entities that provide for physician network services. A determination needs to be made whether these are legitimate entities in the risk bearing side.
- DMHC looks at financial viability and ability to pay claims. In the MPN the insurer or employer is the financially responsible party and MPN is just the vehicle.
- Not sure how current health plans and physician networks could be an MPN applicant given that the MPN regulations are concentrated on the employee having the appropriate notice and claims being adjudicated appropriately. DWC will still need to ensure that Third Party Administrators and carriers are meeting the MPN notice requirements.

The audience was asked what they thought about having an MPN Application Form:

- Supports an MPN Application Form but it needs to be flexible so that it does not limit the amount you could write.
- Having a form would be helpful. It also makes it easier for smaller MPNs to apply.
- Supports a template MPN Application Form and would also support a template form for an MPN Modification Application.
- Supports an MPN Application Form but would like the ability to electronically submit.

REAPPROVAL PROCESS:

- There must be transparency and accountability. The re-approval process goes to accountability. If re-approval deadlines are not met, then there should be some penalties.
- Employers have the ability to control treatment beyond 30 days provided that the MPN is in good standing; however, if they lose this good standing then employer's lose the ability to control treatment. The default is free choice after 30 days if an employer fails to meet these deadlines.
- Concern that the six month period where re-approval must be submitted is so long it time that the physician list will be inaccurate. There must be a device to update, if necessary, upon approval. At the time of re-approval, all of the old materials already submitted should not be required to be resubmitted.

PETITION PROCESS FOR MPN SUSPENSION/REVOICATION:

- Certainly an injured worker is the most aggrieved party. Do we offer as much information as we can in terms of notice or do we try and restrict access to information?
- A whistleblower should be allowed to intervene. At a minimum, DWC investigations must be sufficient to ensure compliance with the regulatory scheme. There should be some sanction/penalty to prevent abuse.
- If you can't find providers in the MPN website, then the MPN should be revoked. It's a good idea to make sure the MPN lists are updated. However, there are many ways to notify an MPN if you can't find a physician in the MPN. The current regulations require a toll free telephone number be posted on the website or an injured worker can call the claims adjuster. There is a difference between a complaint and a revocable deficiency. There should be some formal process put in place for revocations. There has to be a triage process. Cannot be inundated with complaints that really do not amount to a revocable deficiency.

ADMINISTRATIVE PENALTIES:

- We support consequences. We wish that they were a little more frequent and the Division was a little more responsive. Regulations need to be very clear with respect to entities that provide for physician network service because if an entity that provides for physician network services is in violation, then presumably all the networks in it are also in violation. This could put a lot of hurt in the market place, but it may be appropriate. Market forces will dictate who will make it as an MPN.
- Favors contact person must be kept current and the MPN should be held responsible if it is not.

- Decertification and loss of control of treatment is a big penalty in itself. On top off that, however, we still believe in monetary penalties. Some of it is chump change. Audit penalties should be strong.

MPN AUDITS/INVESTIGATIONS:

- Audits should be random review of MPNs. Consequences should be \$5,000 per violation, that's what the statute says or implies.
- Not clear exactly what will be audited and what the penalty will be for each failure of the audit. If ultimately it's deemed that anything an applicant affirms can be audited that could be quite a few things and could be a financial disincentive. Also, concerned those entities that provide for physician network services do not control the claim.
- The previous discussion of a Form for the MPN's could include an attachment or schedule attesting that the MPN will do all the things that an MPN is accountable for. This can be the basis for an audit at a later date because these are the things that the MPN has committed to do.
- Various relationships need to be identified up front if we are going to have an audit process.
- There should be some differentiations in the levels as far as what the penalties should actually be.
- DWC should take a look at what is being done in Texas Department of Insurance/Division of Workers' Compensation has performance based oversight for all the certified networks.
- Depending out how DWC drafts the audit regulations it can be used as a "shakedown" of the MPNs. But at the same time, he would urge the AD to establish a greater commitment to the Audit process and to engage in serious efforts that they have in the past. The default is free choice of physician after 30 days.

MPN INDEPENDENT MEDICAL REVIEW (IMR process 9768.1):

- Distinction has to do with the ER denying care whereas §9768.1 is a physician denying care.

Yu-Yee Wu agreed in part, but clarified, a denial is not required. There just needs to be a dispute.

OTHER CHANGES/COMMENTS:

Medical Access Assistants:

- There should always be written authorization whenever this person goes out and tries to make an appointment there shouldn't be any delay and if people can't make the time-frame per §9767.5 then the injured worker should be able to go outside the MPN network.
- The statute with respect to Medical Access Assistance seems like an overkill situation. According to the statute it's a 13 hour a day, 6 days a week and the only job duty is to provide assistance. At least two people will need to be hired by each MPN to cover this requirement. Acknowledges this is statutorily required but whatever can be done by regulation to relieve some of this burden would be helpful.
- Concerned that Medical Access Assistants who are trying to help an injured worker may experience problems if the injured worker does not know how to identify the correct MPN. There may be some issue if the injured worker just provides an MPN log number instead of a common MPN name.
- The role of the Medical Access Assistant does not abrogate the role of the primary treating physician or the adjuster. What if a Medical Access Assistant fails to respond to an injured workers' call within 24 hours, does that negate the MPN? There has been a lot of testimony that the MPN should be negated if they fail to cross a "t" or dot an "i". An MPN should be allowed to cure a deficiency. We have to be very specific about the role of the medical assistance.

MPN data integrity:

- When it comes to navigating the MPN system and having a current listing it is the most important thing that can be given to an injured worker. These websites are very frustrating. Requires specific information before you are able to access the list. Free access is where we need to be headed.
- We have to do everything we can so we have monthly updates or quarterly updates Data Quality is very important. As far as the website is concerned, certainly monthly updates of the directory is critical. Real-time would be perfect, but certainly there will be times when a network provider terminates and every effort should be made to make the updates in real-time.
- Data regarding the networks are always lagging. Regulations should emphasize "real-time" updates each listing should bear a date of its last refresh.
- Provider Listing: Goal is to have every single provider be able to treat an injured worker. But there are a lot of nuances in private practice. Perhaps the provider is not currently taking patients because they are currently full, perhaps the provider does not want to take legacy patients, they don't want to take on an injured worker who has just had surgery or don't feel

capable of taking that injured worker, if the provider is in the MPN and treats workers' compensation patients it doesn't necessarily mean they will take every workers' compensation case.

- Real Time is a fallacy. We are dealing with a manual policy. This procedure does not happen instantly.
- Real-time updating needs to be seriously considered. A reasonable amount of time must be given but there are networks out there that are in such bad shape. In this day-and-age there is no excuse not to have data integrity.
- There is so much variability with the data that is out there. I hope we can be measured in our approach to regulations so that the fixes don't prevent certain things from working as well.

Physician Affirmation of participation in MPN

- LC §4616(a)(3) not sure what the legislature was talking about because there are always two networks involved, one is the underlying PPO and the other is the MPN, DWC may want to clarify this point because the two are not the same. Notice to the underlying PPO and its physicians do not constitute notice to the underlying MPN. We suggest that the physician notice be maintained and maintained separately in each one of those MPNs. This will be especially helpful and necessary for the entities that provide for physician network services since each one of their clients maintains the ability to decide which physicians are in or out of that particular MPN network.
- Shareholder, partner, or employee of a medical group is automatically included into the MPN for which that medical group belongs. And if this is the case, that it should also hold true to the ancillary providers. The regulations must clarify this point. If the Division does not take this stand with regards to physicians, then the same must apply with the ancillary providers.
- Notifying every single doctor is overly burdensome. One doctor can be in hundreds of MPNs. One notice saying here are all the MPNs you are in should suffice.
- Any doctor in a Medical Group should be allowed to be in the MPN. It is important that individual doctors be allowed to be in the MPN rather than the Medical group.
- If every single MPN by Log number needs to acknowledge by letter all physicians in there MPN that would be too onerous. The amount of paperwork would be overly burdensome. Suggested an on-line tool so the provider can check on-line to see what MPNs they are participating in. That would not be by log number but by common MPN name.
- Notifying the providers of the agreements they have is an issue that needs to be tackled. Part of the problem is with the providers. There are many providers that don't even have e-mail or regular electronic communication. The idea of providers opting out by way of a separate agreement for each individual MPN would create a nightmare in the whole process, but on the

other hand if the notices are good and communication is good the provider always has the opportunity to terminate a contract and certainly if you give a provider that information I would think that's a reasonable compromise.

Related to this issue are Evergreen Contracts. We solicited comments about the impact of Evergreen Contracts as it relates to Labor Code §4616(a)(3).

- Most physicians will do some workers' compensation but not exclusively, if they sign one contract that has many MPNs, that physician can find himself/herself drowning in workers' compensation paperwork. This also addresses Evergreen contracts. Sign up with a network that just has a few MPNs but a few years down the line that same network may have many MPNs and the physician may want to opt out.
- With regards to Evergreen contracts, a suggestion is to send an electronic message to their existing providers saying, "you've agree to be involved in an MPN, please look at our website that lists all the MPNs you are participating in, if you do not wish to be in an MPN, please notify us." This would be a Negative affirmation to send back. Website is the answer.

Access Standards:

- LC 4616(a)(2) "Medical Treatment for injuries shall be readily available at reasonable times..." this needs to be defined. Also, "areas in which there is a healthcare shortage" needs to be defined.
- §9767.5 suggest using the HCO geocoding model. This should be submitted, not once every four years, but geocoding should be submitted on an annual basis, along with the refresh suggested regarding network changes. Rural areas: may need to be updated in one of the refresh.
- Geocoding just as is done with HCO's measure access against anticipated number of claims not the employees. Insurers don't know the number of employees.
- A regulation cannot be overriding so that it prevents the MPN from addressing the situation that is best suited for an employer who may be faced with unique circumstances.

Quality of Care:

- 4616(b)(2) creates an opportunity for the DWC to create a report card of the MPNs based on their own internal data.
- Standard of care is the MTUS. MPN must be able to provide a minimum level of care.
- Allow room for innovative ways to define quality of care. It is very hard to define, generally it is something to do with the "Efficiency and effectiveness of the care overall." I would rather have our own innovations reviewed and approved, denied or challenged instead of being forced into

a standard that does not allow us to be responsive to employers that may be faced with unique situations.

Payment for approved non-MPN provider:

- If an injured worker is allowed to go outside of the MPN, it is often very difficult and time consuming for the non-MPN doctor to get paid. Oftentimes, the bill needs to be submitted numerous times before payment is made. Someone needs to be held responsible aside from the approved non-MPN doctor for the delays in getting this bill paid.

Treatment restricted to locations listed in the MPN:

- A doctor should be able to treat a patient in a location or address other than the address listed in the MPN. One suggestion is for the MPN to list a doctor's license number that would eliminate the requirement to list tax identification number or address.
- Would it be possible to put in the regulations that if a doctor is in the MPN that they have an automatic "Right of First refusal" to treat in any office.
- A doctor's tax identification number is used because it's a contract.
- The contractual language specifies the location or address where the MPN doctor must treat.

Allow non-MPN doctors to treat:

- The regulations should consider allowing a licensed physician in the State of California to treat a patient if the physician is willing to accept the rate at which the insurance company is willing to pay and as long as the physician abides by the MPN rules.