STATE OF NEW HAMPSHIRE
MANAGED CARE PROGRAMS FOR
WORKERS' COMPENSATION

EVALUATION REPORT
NOVEMBER 1995

State of New Hampshire

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TO HIS EXCELLENCY THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE, THE COMMISSIONER OF LABOR, AND THE COMMISSIONER OF INSURANCE:

We have conducted an evaluation of the rules and procedures of the State of New Hampshire's managed care programs for workers' compensation as directed by Chapter 311:4 of the Laws of 1993 which states:

> The rules and procedures established by the labor commissioner and the insurance commissioner relative to managed care programs shall be the subject of a performance evaluation report prepared by the audit division of the office of the legislative budget assistant and submitted to the president of the senate, the speaker of the house, the governor, the commissioner of labor, and the commissioner of insurance on or before December 1, 1995.

This evaluation was conducted in accordance with generally accepted governmental auditing standards and accordingly included such procedures as we considered necessary in the circumstances.

The objectives of our evaluation were to determine the adequacy of the approval process for managed care programs for workers' compensation and whether the Department of Labor and the Advisory Council on Workers' Compensation are in compliance with State laws and administrative rules relative to managed care programs for workers' compensation.

This report is the result of our evaluation of the information noted above and is intended solely to inform the above-mentioned individuals of our findings and should not be used for any other purpose. This restriction is not intended to limit the distribution of this report, which upon delivery is a matter of public record.

Office of Legislative Budget Assistant
OFFICE OF LEGISLATIVE BUDGET ASSISTANT

November 1995

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STATE OF NEW HAMPSHIRE
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EXECUTIVE SUMMARY

PURPOSE AND SCOPE OF EVALUATION

This evaluation of the State of New Hampshire's managed care programs for workers' compensation was performed pursuant to Chapter 311:4 of the Laws of 1993 and was conducted in accordance with generally accepted governmental auditing standards. It describes and analyzes the rules and procedures used by the Department of Labor and the Advisory Council on Workers' Compensation in approving New Hampshire's managed care programs for workers' compensation.

BACKGROUND

Total workers' compensation claims in New Hampshire increased from $108 million in 1984 to $246 million in 1991 -- a 127.8 percent increase. The National Council on Compensation Insurance reported the average medical benefit paid to each New Hampshire worker increased 40.1 percent between 1988 and 1992 while lost time costs increased 85.7 percent and indemnity costs increased 64.4 percent. The Governor's task force on workers' compensation was established in February 1989 to study New Hampshire's workers' compensation system and recommend changes to gain control over costs.

Chapter 178 of the Laws of 1989 (House Bill 615) established a two year workers' compensation managed care pilot program to evaluate whether workers' compensation costs could be contained through closer monitoring of required medical, hospital, and remedial care while providing prompt and effective care to injured workers. An interim report based on first year pilot program data estimated costs for medical claims under the pilot program were 30 percent lower than claims treated outside the pilot program and physicians' costs were 10 percent lower. No evaluation of complete pilot program data was conducted nor was a final report issued. Chapter 311 of the Laws of 1993 (codified as RSA 281-A:23-a) required employers obtaining workers' compensation through the residual market (those companies unable to obtain workers' compensation insurance from insurance companies) to establish managed care programs for workers' compensation. This law required the labor commissioner to approve managed care programs meeting minimum criteria. Programs must also be ratified by the Advisory Council on Workers' Compensation. The law was made applicable to the voluntary market and self-insureds on January 1, 1994.

EXECUTIVE SUMMARY (Continued)

FINDINGS AND RECOMMENDATIONS

We noted eight observations and recommendations regarding the State's approval and ratification process for managed care programs. Three of these observations and recommendations addressed approval and ratification process weaknesses, two concerned the need for rules, policies and procedures (including program monitoring and review requirements), and three addressed compliance with existing State laws and regulations. In addition to the observations and recommendations noted above, we presented an additional issue related to confusion surrounding financial interest statement filing requirements.

WEAKNESSES OF THE APPROVAL AND RATIFICATION PROCESS

Our review of 19 proposals ratified by the advisory council determined that only two proposals actually met all approval criteria. In many cases, because of insufficient documentation maintained by the department we were unable to determine compliance with statutorily defined timeframes. In addition, the commissioner did not provide written notice of disapproval to applicants. To strengthen the approval and ratification process we recommended the development of a standard application and review checklist, improved documentation of actions and decisions, and retention of all proposals and supporting documentation.

ADEQUACY OF RULES, POLICIES, AND PROCEDURES

As evidenced by the ratification of proposals not meeting minimum approval requirements, existing administrative rules and policies and procedures require review and revision. In addition, several areas warrant development of rules and policies and procedures to formalize the approval and ratification process. To address this issue, we recommended the department and advisory council review their approval and ratification process and revise and adopt rules and policies and procedures as necessary.

COMPLIANCE WITH STATE LAWS AND REGULATIONS

Our evaluation found several areas of non-compliance with State statutes. The advisory council did not hold all monthly meetings or prepare minutes for all meetings as required. In addition, the 1993 and 1994 advisory council annual reports were not available. We recommended the advisory council take action to ensure compliance with these requirements.

DEPARTMENT AND COUNCIL COMMENTS

In commenting on this report, the department and council concurred with all of our observations and recommendations. The complete text of department and council responses follows each observation and recommendation.

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RECOMMENDATION SUMMARY

OBS. NUMBER	PAGE	LEGISLATIVE ACTION REQUIRED YES/NO	RECOMMENDATION	AGENCY RESPONSE
1	20	NO	Develop a standard application; require proposals to follow a standard format; and use a checklist to verify minimum approval criteria are met. Adopt specific rules relative to treatment protocols.	CONCUR
2	22	NO	Date stamp proposals upon receipt at the department and document approvals. Maintain all proposal information including supporting documentation and correspondence.	CONCUR
3	23	NO	Provide written notification of disapproval.	CONCUR
4	24	NO	Review administrative rules to determine areas needing revision and adopt appropriate rules as needed. Develop council members' expertise by offering training on how proposals should be reviewed, including statutory and administrative rule requirements.	CONCUR
5	28	YES	Ensure advisory council meetings are held on a monthly basis as required by law. If such regular meetings are not necessary, seek legislation to change the governing statute.	CONCUR
6	29	NO	Ensure minutes of all council meetings are taken and maintained.	CONCUR
7	31	NO	Review the performance of the workers' compensation system on an annual basis and issue the 1993 and 1994 annual reports.	CONCUR
8	32	NO	Develop policies and procedures for the triennial review process of approved managed care programs, including adopting required administrative rules.	CONCUR
N/A	37	YES	Clarify RSA 21-G:5-a, Statements of Financial Interest for Board and Commission Members	N/A

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STATE OF NEW HAMPSHIRE
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1. INTRODUCTION

We performed our evaluation of the State of New Hampshire's managed care programs for workers' compensation pursuant to Chapter 311:4 of the Laws of 1993. This evaluation was conducted in accordance with generally accepted governmental auditing standards and accordingly included such procedures as we considered necessary in the circumstances.

1.1 SCOPE AND OBJECTIVES

This report describes and analyzes the rules and procedures used for approval of New Hampshire's managed care programs for workers' compensation. Our evaluation focused on Department of Labor and Advisory Council on Workers' Compensation activities related to managed care for workers' compensation occurring after November 1, 1991 (the start date of the managed care for workers' compensation pilot program) and addressed two specific objectives:

- The adequacy of the process by which managed care programs are approved; and
- Whether the Department of Labor and the Advisory Council on Workers' Compensation are in compliance with State laws and administrative rules regarding managed care programs.

1.2 METHODOLOGY

To obtain general background information and develop an overall understanding of managed care programs for workers' compensation, we reviewed reports, articles, and research papers published by professionally-recognized governmental and non-governmental organizations including the National Conference of State Legislatures and the National Council on Compensation Insurance.

To obtain background information about New Hampshire's managed care programs for workers' compensation and to accomplish our evaluation objectives we reviewed State laws (primarily RSA 281-A), Department of Labor administrative rules, organization charts, biennial reports, and files of managed care for workers' compensation providers, Advisory Council on Workers' Compensation annual reports and meeting minutes, a 1993 interim consultant's report on the workers' compensation managed care pilot program, and other miscellaneous documents. We also conducted structured interviews

1.2 METHODOLOGY (Continued)

with State legislators, the chairman and members of the Advisory Council on Workers' Compensation, Department of Labor management and other personnel, Department of Insurance management, workers' compensation administrators in other New England states, and approved providers of managed care for workers' compensation.

1.3 OVERVIEW

1.31 What is Managed Care?

The term "managed care" refers to a health care model that combines the financing of health care with the actual delivery of comprehensive medical services. The goal of managed care is to reduce costs while simultaneously providing quality health care. The managed care model uses a variety of techniques to accomplish these goals.

In a 1994 report, the National Conference of State Legislatures (NCSL) described managed care programs as having one or more of the following elements:

- Use of health maintenance or preferred provider organizations which establish networks of doctors or hospitals who provide medical services;
- Medical fee schedules which establish maximum rates for specific procedures;
- Medical practice protocols which provide standards for treatment of a particular injury;
- Medical bill review which examines medical bills for duplicate billings, consistency with fee schedules, and reasonableness;
- Utilization review which monitors the usage of services through an independent board or firm consisting of medical professionals who review services provided by the managed care program on a case by case basis to evaluate whether medical tests and treatments were medically necessary;
- Centralized claims administration where both health and workers' compensation insurance are handled by a single entity to avoid duplication;
- Case management which provides monitoring the care and recovery of an injured worker to minimize the delays in returning the employee to work; and

1.3 OVERVIEW (Continued)

- Vendor performance tracking which performs audits of all parties to ensure efficient and effective provision of services.

Managed care programs use financial incentives to encourage the use of physicians associated with the program's network of medical care providers. Some programs may allow members to see a physician outside the program's network but may not cover the full cost. To become part of a program's network, physicians and hospitals must meet specific criteria for admission and must agree to the program's conditions. The network system provides the managed care program control over the number of providers, the cost of services provided, and their level of use. Managed care programs compensate their network care providers either on a salary basis or on the basis of a fixed rate per plan member (known as "capitation") rather than the traditional fee-for-service basis.

Patients enrolled in a managed care program are generally required to see a primary care physician who evaluates the patient's condition and either treats the patient or refers the patient to another physician within the network. This is known as "gatekeeping" since the patient must go through his or her primary care physician to be permitted access to the rest of the network. The primary care physician also has responsibility for case management.

Despite the growth and popularity of managed care programs, criticisms regarding choice, quality of care, and cost savings remain. Consumers are concerned with limitations on their choice of physicians because of the network concept or because specialists may not be available through their network. Managed care programs have responded to this concern by enlarging their networks or allowing subscribers to obtain medical care outside the network if the subscriber pays the additional cost. Quality of care criticisms stem from the concern that physicians may not be able to make independent medical decisions. Since physicians' profits are dependent upon keeping costs to a minimum, ordering tests or procedures may result in an erosion of the physicians' profit. These critics believe quality of care may be compromised because of the physicians' focus on their own bottom line. Another criticism is that managed care programs have not been adequately studied to determine if there are actual cost savings attributable to managed care.

1. INTRODUCTION (Continued)

1.3 OVERVIEW (Continued)

1.32 Managed Care for Workers' Compensation

Workers' compensation programs for all employers in New Hampshire are governed by the provisions of RSA 281-A and are enforced by the Department of Labor. In its simplest form, workers' compensation requires employers to provide coverage to employees in exchange for employees giving up the right to sue the employer for suffering a work-related injury or disease. When an employee is injured on the job, costs for lost wages (within defined limits), related medical treatment, and vocational rehabilitation (where appropriate) are paid by the employer on the employee's behalf. Employers provide the necessary workers' compensation coverage in one of two ways -- by purchasing insurance or by self-insuring.

If an employer decides to purchase insurance, he or she pays a premium to an insurance company licensed by the insurance commissioner to sell workers' compensation insurance in New Hampshire. In return for payment of a premium by the employer the insurance company agrees to assume the employer's workers' compensation risk. The premium charged reflects rates established by the insurance commissioner for various classifications of employees within the employer's company or business. The classifications are based on the risk inherent in particular jobs. For example, rates established for heavy equipment operators and prison guards will be significantly higher than those for teachers and office managers. In its simplest terms, the premium is the employee's job rate multiplied by the employee's salary, to which the insurer adds the cost of administering the employer's account (including legal costs) and a profit margin.

An employer who decides to self-insure is agreeing to be legally liable for workers' compensation and related expenses. In other words the employer is assuming the workers' compensation risk. A self-insurer is also responsible for administrative and legal costs associated with the program.

If an employer is unable to obtain insurance in the "voluntary market" the employer must obtain insurance in the "residual market." Employers typically purchase workers' compensation insurance in the voluntary market. The voluntary market is so-called because the insurer can voluntarily accept the employer as a risk or not. However, some employers may not be able to obtain workers' compensation insurance from insurance companies because they are considered to be an unacceptably high risk. As a result, all insurance companies writing workers' compensation insurance within New Hampshire created a mechanism called a "risk pool" to share these high risks. This sharing of risk is known as the "residual market."

The application of the managed care concept to workers' compensation is an attempt to address the myriad of problems states face with their current systems. In many states workers' compensation programs are on the verge of collapse due to rapidly rising medical costs. According to National Council on Compensation Insurance (NCCI) data, the consumer price index (CPI) for

1.3 OVERVIEW (Continued)

medical care increased 45.3 percent between 1988 and 1992 while the CPI for all items increased by only 22.1 percent. The cost of workers' compensation in the United States grew almost 80 percent faster than general medical care between 1985 and 1990. The NCCI attributes this rapid increase to the fact that workers' compensation has no deductible or coinsurance payment for the injured worker, provides unlimited medical care, and the difficulty insurers face implementing effective cost controls. Through managed care techniques, skyrocketing workers' compensation costs may be brought under control.

1.33 Managed Care for Workers' Compensation in New Hampshire

Total workers' compensation claims in New Hampshire increased from $108 million in 1984 to $246 million in 1991 -- a 127.8 percent increase. The NCCI reported the average medical benefit paid to each New Hampshire worker increased 40.1 percent between 1988 and 1992 while lost time costs increased 85.7 percent and indemnity costs increased 64.4 percent.

Alarmed by the rising costs of workers' compensation, the Governor established a task force on workers' compensation in February 1989. By August 1989, this task force issued recommendations to change the workers' compensation system to gain control over costs. The General Court made its own changes to the workers' compensation system that same year.

Chapter 178 of the Laws of 1989 (House Bill 615) established a two year pilot program to evaluate whether workers' compensation costs could be better contained through closer monitoring of required medical, hospital, and remedial care while providing prompt and effective care to injured workers. The law establishing the pilot program also required the labor commissioner to adopt rules relative to:

- Controlling the selection of providers of medical, hospital, and remedial care, while preserving to employees the choice of whether to participate in the program;
- Establishing appropriate fees for medical, hospital, and remedial care;
- Promoting effective and timely utilization of medical, hospital, and remedial care by injured workers; and
- Coordinating the duration of payment of disability benefits with determinations made by qualified participating providers of medical, hospital, or remedial care.

1. INTRODUCTION (Continued)

1.3 OVERVIEW (Continued)

In addition, Chapter 178 of the Laws of 1989 required the labor commissioner to issue an interim report before December 1, 1990 and a final report upon completion of the pilot program regarding the outcome, findings, and recommendations regarding the pilot program and established a six member advisory committee to assist the commissioner in establishing the pilot program.

The Department of Labor contracted with a national consulting firm to examine whether the pilot program reduced workers' compensation costs and issue an interim report. This $55,000 study examined injury data with accident dates occurring during the first year of the pilot program (November 1, 1991 through October 31, 1992). The study's methodology compared the costs for claimants affiliated with the pilot program with claimants outside the pilot program. This interim report, issued in October 1993, found that costs for medical claims under the pilot program were 30 percent lower than claims treated outside the pilot program and physicians' costs were 10 percent lower. In the report, the consultant stated that the findings should be considered "preliminary and tentative." The report continued:

> While there is evidence that the pilot program has reduced costs, the immaturity of the claim experience captured in this analysis and the lack of detailed information on medical treatments for claims not treated under the pilot program were substantial limitations in the present analysis.

No evaluation of complete pilot program data was conducted nor was a final report issued. Based in part on the experience of the pilot program and potential cost savings, Chapter 311 of the Laws of 1993 was passed allowing expansion of managed care for workers' compensation.

Until the passage of Chapter 311 of the Laws of 1993 injured employees were allowed to receive care from any medical care provider they chose. Chapter 311 of the Laws of 1993 (codified as RSA 281-A:23-a) changed this practice by requiring employers obtaining workers' compensation through the residual market (those companies unable to obtain workers' compensation insurance from insurance companies) to establish managed care programs for workers' compensation. This law required the labor commissioner to approve managed care programs meeting the following criteria:

1.3 OVERVIEW (Continued)

- Be sufficiently comprehensive with respect to both geographic location of its provider facilities and its range of medical specialties including reasonable access to treatment;

- Provide treatment outside the network if necessary treatment cannot be provided within the network or in the case of medical emergencies;

- Have processes for determining the professional qualifications of network health care providers;

- Provide for quality assurance measures;

- Provide both in-patient and out-patient case management and rehabilitation case management; and

- Provide reasonable access to a second medical opinion inside or outside the program and methods for resolving conflicting medical opinions.

In addition, the program must be ratified by the Advisory Council on Workers' Compensation. The Advisory Council on Workers' Compensation was established by RSA 281-A:62 and consisted of eight members: one member representing the State Senate, one member representing the House of Representatives, one member representing management's interests, one member representing labor's interests, one member representing workers' compensation carriers' interests, one member representing health care providers' interests, the insurance commissioner or designee, and the labor commissioner or designee. (Effective June 11, 1995 the advisory council was expanded to nine members with the addition of a self-funded employer representative). In addition to discussing problems with administering RSA 281-A and policy goals, the council is required to ratify managed care programs established under RSA 281-A:23-a.

RSA 281-A:23-a applied to the residual market effective June 23, 1993 and was not applicable to the voluntary market and self-insureds until January 1, 1994.

1.3 OVERVIEW (Continued)

1.34 Managed Care for Workers' Compensation in Other New England States

Connecticut

Connecticut established managed care for workers' compensation in March 1993. As of May 30, 1995, 31 managed care programs were approved by the State of Connecticut covering approximately 1,200 employers. In addition, approximately 200 programs have been submitted and are pending approval.

If the Workers' Compensation Commission finds the program meets statutory and internal requirements, the commissioner approves the program. There is no advisory board ratification process. Managed care programs may be submitted by insurance companies, managed care organizations, self-insureds, and employers. The program may be submitted in one of two ways. First, a "template plan" may be filed and approved. The "template plan" contains all required information except for medical care provider network and employer information. The two omitted components are approved at a later date once the program has been marketed to employers. Second, the applicant may submit a full program including the network and employer section for approval. Once the Workers' Compensation Commission determines the program meets all requirements a letter of acceptance is sent to the applicant.

Maine

Maine's workers' compensation system has seen many efforts at reform over the past several years. Previous reform efforts, particularly the capping of rates, resulted in the departure of major insurance companies from the market. Recent workers' compensation reform in Maine has included limiting initial provider choice by injured employees, limiting provider change by injured employees, a medical fee schedule, hospitalization payment regulation, and utilization review. Since 1993, employees have had the right to choose a physician within ten days of the occurrence of an injury. Maine has some preferred provider organizations (PPO) but they are not regulated by the state.

The Maine Workers' Compensation Division is governed by an eight member board which decides all policy. Rules regarding utilization review and treatment protocols have been written but not approved by the board.

Massachusetts

Massachusetts uses quality assessment programs, medical fee schedules, and hospitalization payment regulation. In addition, Massachusetts instituted utilization review and treatment protocols in 1993. A private company handles the assigned risk pool for workers' compensation insurance,

including rate setting. Employers in the assigned risk pool may qualify for a premium discount if they participate in a "qualified loss management program."

The Industrial Accident Board is responsible for workers' compensation enforcement activities and all dispute resolution. The Office of Health Policy handles all utilization review issues including the approval of standards.

Rhode Island

Rhode Island authorized the use of PPOs in 1992. Approximately 2,200 companies have been approved since October 1992 by the Medical Advisory Board (MAB). The MAB was created in May 1992 and consists of ten physicians and one physical therapist.

Employers must submit an application to the Medical Advisory Board to use PPOs to treat injured workers. Information submitted by the employer includes a list of names and business addresses of every health care provider in the network along with specialties, disclosure of any contracts or agreements with health care providers and the frequency of the provision of services, and the geographic area covered by the network. Preferred provider organizations become official after approval by the MAB and filing with the Department of Business Regulation. If a PPO does not receive approval from the MAB, the company is notified of deficiencies. Once PPOs have been approved and filed, they must be renewed every two years. Employees may go outside of the PPO network with the insurer's permission. No insurance discount is given for using a PPO. The MAB also creates and enforces treatment protocols. Rhode Island has also implemented medical fee schedules.

In Rhode Island, all workers' compensation claims are handled by the Department of Labor's Division of Workers' Compensation with the exception of state employees. State employee workers' compensation claims are handled by the Public Employee Retirement Administration's Division of Workers' Compensation. All workers' compensation disputes are handled by the Workers' Compensation Commission.

Vermont

Managed care for workers' compensation in Vermont became mandatory for the assigned risk pool and an option for the voluntary market on January 1, 1995. Employees may exercise their right to be treated by a physician outside the network for independent medical examinations but must first submit a change form stating the reason. A medical fee schedule took effect in April 1995. Vermont does not currently have a mandated utilization review process.

1. INTRODUCTION (Continued)

1.3 OVERVIEW (Continued)

TABLE 1

MANAGED CARE TECHNIQUES IN NEW ENGLAND

STATE	MANAGED CARE PROGRAM	UTILIZATION REVIEW	TREATMENT PROTOCOLS	MEDICAL FEE SCHEDULE
CONNECTICUT	YES	YES	NO	YES
MAINE	NO	YES	YES	YES
MASSACHUSETTS	NO	YES	YES	YES
NEW HAMPSHIRE	**YES**	**YES**	**YES**	**NO**
RHODE ISLAND	YES	YES	YES	YES
VERMONT	YES	NO	NO	YES

NOTE: Medical fee schedule will become effective in New Hampshire on July 1, 1997.

Source: LBA analysis of data provided by New England states, New Hampshire RSAs and administrative rules, and miscellaneous publications.

1.4 REPORT OUTLINE

The remaining sections of this report provide analyses of various aspects of managed care for workers' compensation in New Hampshire. Section 2.1 describes the Department of Labor's review and approval process for workers' compensation managed care programs. Section 2.2 describes the Advisory Council on Workers' Compensation's review and ratification process for managed care programs. Section 2.3 includes observations and recommendations relative to the approval and ratification process, adequacy of rules, polices, and procedures, compliance with State laws and regulations, and program monitoring and review. Section 3 presents some overall conclusions on the current managed care for workers' compensation review process, rules, and procedures. The last section presents an issue regarding the annual statement of financial interest that the General Court may wish to address.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS

The Department of Labor (department) and the Advisory Council on Workers' Compensation (advisory council) are responsible for the review and approval of workers' compensation managed care programs. RSA 281-A:23-a and Administrative Rule LAB 700 clearly describe the review process for those programs. However, we found areas of non-compliance with State statutes and administrative rules and numerous weaknesses in the way the review process is conducted by both the department and the advisory council.

2.1 DEPARTMENT OF LABOR REVIEW AND APPROVAL PROCESS

RSA 281-A:23-a and Administrative Rule LAB 702.02 requires managed care program applicants to submit proposals to the labor commissioner for review. According to this statute and the rule, proposals must contain the following minimum information to be approved:

- Name and business address of all health care providers included in the network;
- Name, business address, education, experience, and training of all managed care facilitators in the program;
- A description of the geographic area for which the proponent seeks approval of the managed care program;
- A description of the program's procedures for determining qualifications of medical providers in the network;
- A description of the program's treatment protocols;
- A description of the program's in-patient and out-patient case management programs;
- A description of the program's procedures to provide reasonable access to a second medical opinion;
- Sample employee information material; and
- Any further information requested by the commissioner in order to determine whether the proposed manage care program complies with the provisions of RSA 281-A:23-a and LAB 700.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.1 DEPARTMENT OF LABOR REVIEW AND APPROVAL PROCESS (Continued)

A proposal may be approved in one of two ways. First, the commissioner may review a proposal within 45 days of receipt to determine if it complies with minimum criteria. If the commissioner finds that the proposal complies with the criteria, it is approved and referred to the council for ratification within five days of approval. Second, if the commissioner fails to either approve or disapprove the proposal within 45 days of receipt, it is automatically deemed to be approved regardless of whether or not it complies with the criteria. Once 45 days have expired and the commissioner has neither approved nor disapproved the proposal, it may be submitted to the advisory council for ratification.

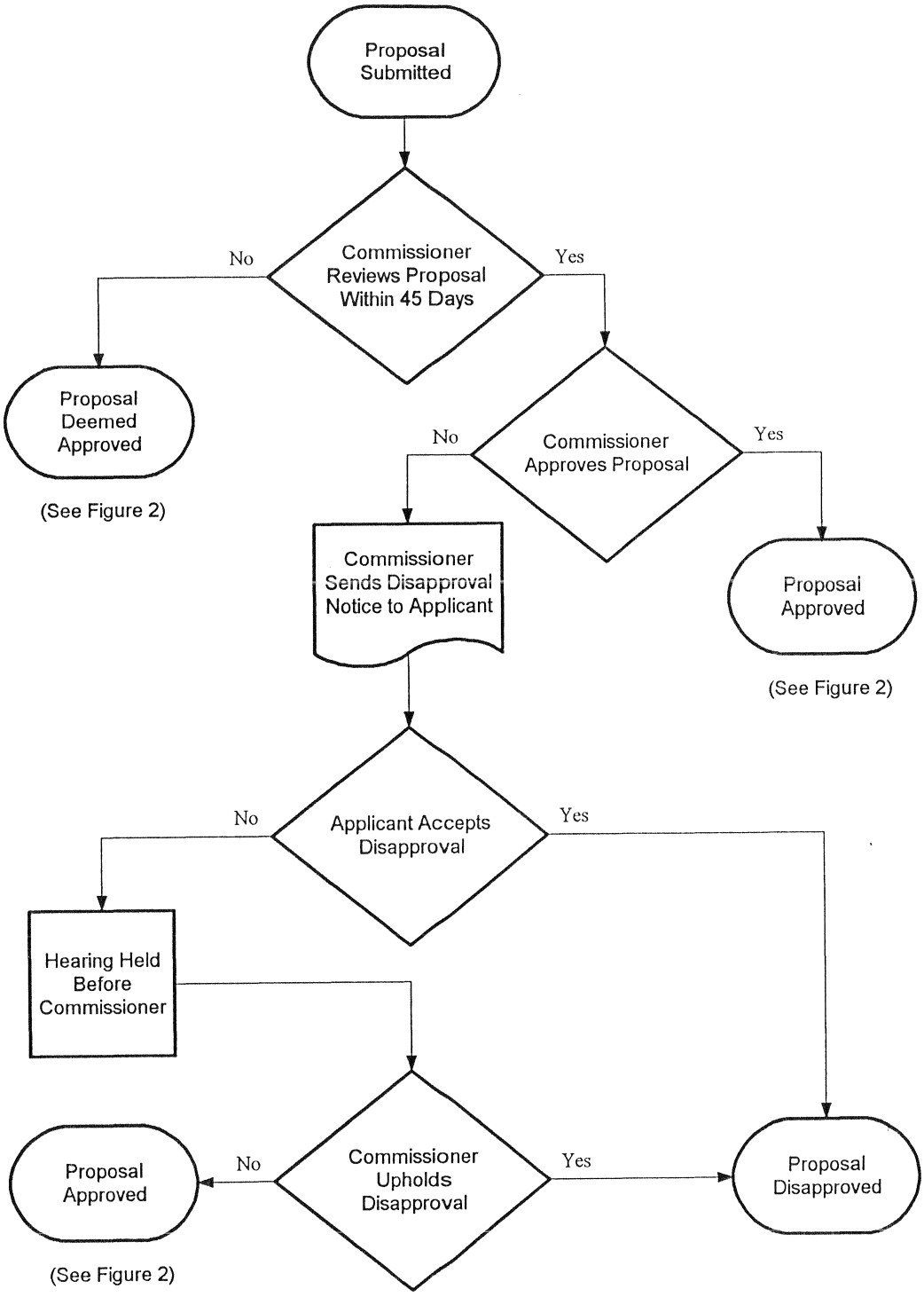
If the commissioner finds a proposal does not comply with minimum requirements, additional information or clarification may be requested or the proposal may be disapproved. The commissioner is required to provide the applicant with written notice of disapproval citing the reason(s) why the proposal did not comply with RSA 281-A:23-a and LAB 702. If the proposal is disapproved and the applicant disagrees, the commissioner's finding may be contested in a formal hearing before the commissioner. At the hearing the commissioner may either uphold the previous disapproval or approve the proposal. If the proposal is approved after a hearing with the commissioner, it must be referred to the advisory council within five days (Figure 1).

2.2 ADVISORY COUNCIL ON WORKERS' COMPENSATION REVIEW AND RATIFICATION PROCESS

As noted in section one, the Advisory Council on Workers' Compensation is established by RSA 281-A:62 and consists of nine members: one member representing the State Senate, one member representing the House of Representatives, one member representing management's interests, one member representing labor's interests, one member representing workers' compensation carriers' interests, one member representing health care providers' interests, one member representing a self-funded employer, the insurance commissioner or designee, and the labor commissioner or designee. In addition to discussing problems with administering RSA 281-A and policy goals, the council is required to ratify managed care programs established under RSA 281-A:23-a. The advisory council may ratify proposals by a majority vote of all its qualified members. Neither the labor nor insurance commissioners may vote on ratification of proposals.

If the advisory council fails to ratify a proposal at its first regularly-scheduled meeting held at least 19 days after the program's approval or deemed approval by the commissioner, the proposal is deemed ratified by the council. If the advisory council declines to ratify a proposal, it must notify the applicant in writing as to why the proposal was not ratified. If the applicant disagrees with the council's decision, the applicant may contest the decision in a hearing before the council (Figure 2).

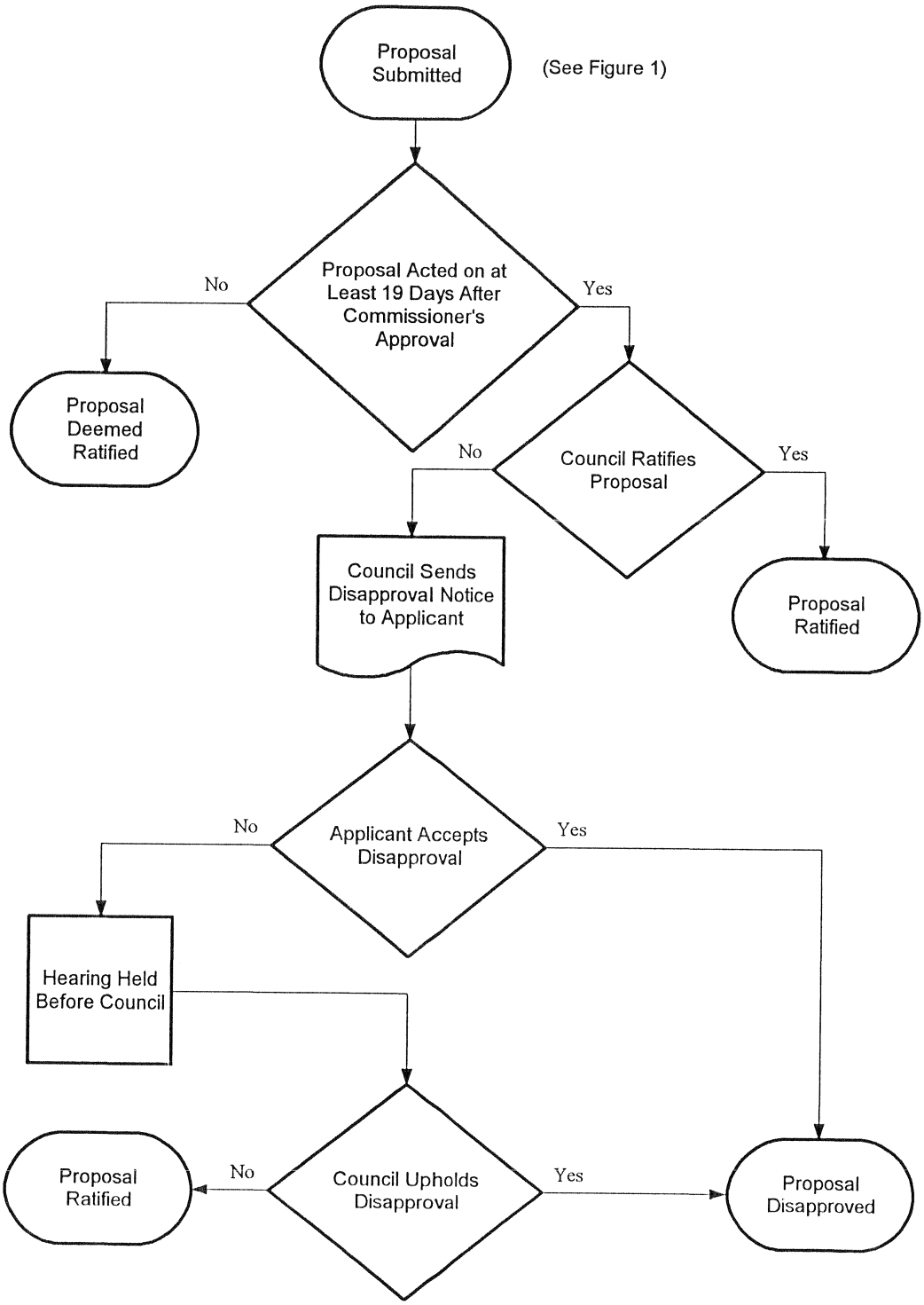
FIGURE 1 DEPARTMENT OF LABOR REVIEW PROCESS



Source: LBA analysis of RSA 281-A:23-a

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

FIGURE 2 ADVISORY COUNCIL ON WORKERS' COMPENSATION REVIEW PROCESS



Source: LBA analysis of RSA 281-A:23-a

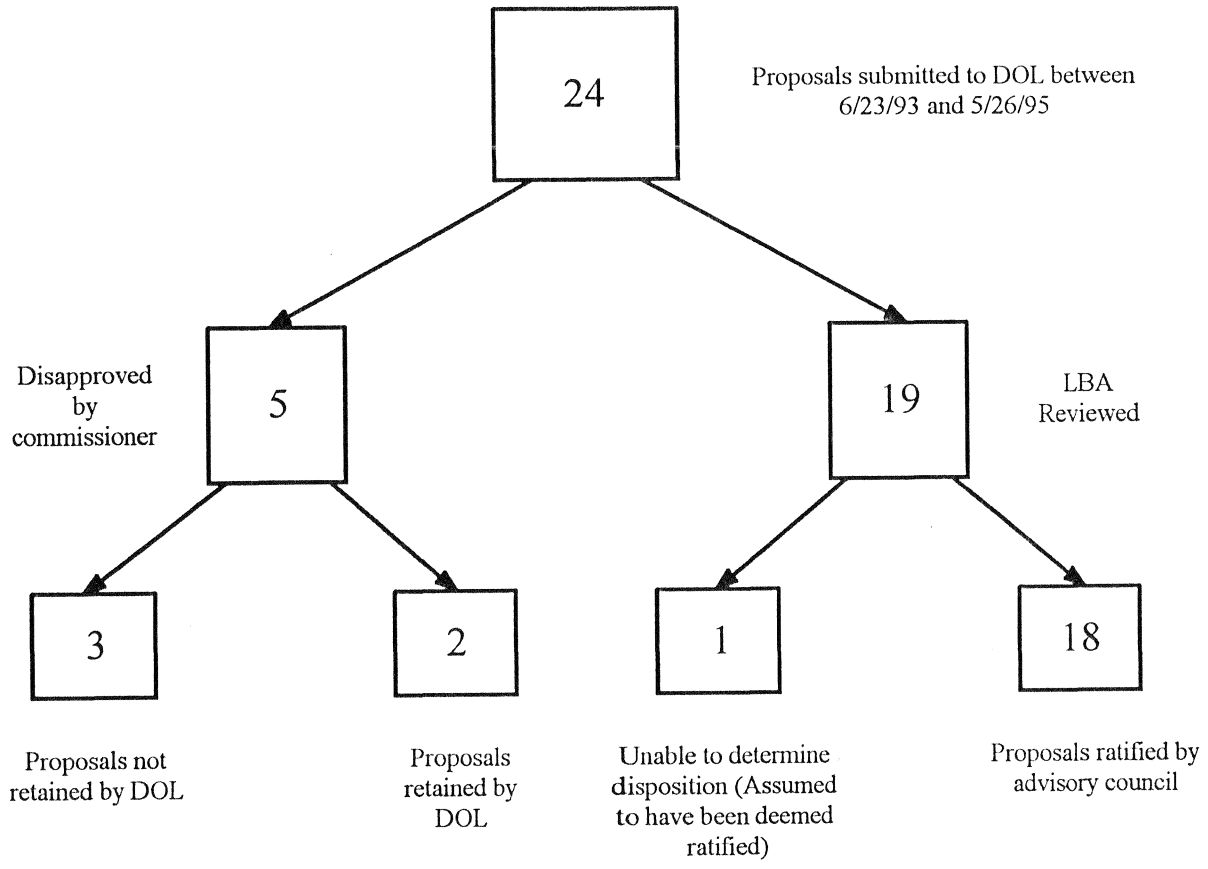
2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.3 OBSERVATIONS AND RECOMMENDATIONS

2.31 Weaknesses of the Approval and Ratification Process

We examined department files for managed care proposals to determine compliance with applicable State laws and administrative rules. Between June 23, 1993, the effective date of RSA 281-A:23-a, and May 26, 1995, 24 managed care proposals from 14 different companies were submitted to the department. Of the 24 proposals, five were disapproved by the commissioner and were not required to be ratified by the council. We reviewed the remaining 19 proposals and determined 18 had been ratified by the council. We were unable to determine the disposition of one proposal from department or council documents and assumed it was deemed ratified (Figure 3).

FIGURE 3 DISPOSITION OF MANAGED CARE PROPOSALS



Source: LBA review of Department of Labor (DOL) files and advisory council minutes.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

OBSERVATION NO. 1

APPROVAL CRITERIA NOT MET

Our review of 19 managed care proposals ratified by the advisory council including one proposal we assumed was deemed ratified, determined that only two proposals actually met all approval criteria. Specifically, our review found:

- Four proposals did not include the names and addresses of all network providers;
- Eight proposals did not provide adequate information for managed care facilitators;
- Four proposals did not provide a description of the geographic area;
- Six proposals did not contain descriptions of procedures for determining qualifications of network providers;
- 16 proposals did not include a description of the program's treatment protocols;
- Six proposals did not contain a description of in-patient and out-patient case management program;
- Six proposals did not contain provisions for providing access to second medical opinions; and
- Nine proposals had no sample employee information materials.

The labor commissioner and council chairman indicated more specific rules are necessary to review treatment protocols.

RECOMMENDATION:

We recommend the commissioner develop a standard application, require proposals to follow a standard format, and review each proposal using a checklist to verify that minimum approval criteria are met. Specific rules relative to treatment protocols should be developed and adopted.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

Auditee Response:

We concur with the observation that some managed care programs were approved without verification of meeting all the minimum requirements as defined by Administrative Rules.

The time frame from implementation of HB 606 allowing for managed care in workers' compensation, was quite limited for advisory council members to organize application and checklist components of this process. We understand the position of the council was to evaluate the quality of the program being presented versus focusing on the technical requirements of this statute, fully based on the limited experience of the council members.

The issue of one caption relates to a description of the program's treatment protocols. Each organization appears to have a different approach to addressing treatment and operational protocols for their health care provider network. Because the rules are not conclusive as to the specific criteria expected for approval, it leads us to conclude that this area of the managed care rules needs to be modified.

We concur with the recommendation for the development of the standard application form for proposals along with the checklist to verify that each proposal includes the required elements before approval. This information can be forwarded then to the advisory council members for their consideration for a ratification vote at the next scheduled meeting. The recommendation regarding a review of items listed has been completed with the proposals located in the Commissioner's Office. These items will be requested from the managed care organizations with an immediate deadline in order to ensure completed minimum requirements can be confirmed through this documentation. The council will also be asked to consider the recommendation from the Department of Labor to hire a Managed Care Coordinator within the Department. Also, given the upcoming recertification (or re-approval) process to be accomplished in 1996, the rules shall be modified further to address the observation above and the complexity of program applications.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

OBSERVATION NO. 2

INSUFFICIENT PROGRAM DOCUMENTATION

We attempted to evaluate whether all 24 proposals were reviewed by the commissioner within 45 days, forwarded to the advisory council within five days, and acted upon at the first regularly scheduled meeting held at least 19 days after the commissioner's approval as required by RSA 281-A:23-a (IV). In most cases we could not determine compliance because of insufficient documentation. In determining compliance with the 45 day requirement, two pieces of information were needed: the receipt date and the date of the commissioner's decision. In examining the department's files, we found that the department does not record the date proposals are received. Some proposals contained a dated cover letter from the applicant. For the sake of this analysis we assumed this was the date of receipt by the commissioner. We could not determine if four proposals met the requirement because we were unable to locate cover letters or any other indication of the date of receipt. We were also unable to determine the date of the commissioner's decision for 14 proposals and assumed they were deemed approved in the absence of evidence to the contrary. We examined the remaining six proposals and determined the labor commissioner acted on them within 45 days of receipt.

To evaluate compliance with the five day requirement, we needed the date of commissioner's approval or deemed approval and the date the proposal was submitted to the council. Five proposals were disapproved by the commissioner and were not required to be submitted to the council. We could not determine the date of submission to the council for 14 proposals because of insufficient documentation. We examined the remaining five proposals and determined they were submitted to the council within five days of approval.

We examined all 24 proposals to determine if they had been acted on at the first council meeting held at least 19 days after approval by the commissioner. Five proposals were disapproved by the commissioner and did not require action by the council. Since the date of the commissioner's approval for 14 proposals could not be determined, we could not determine if these proposals met the requirement. None of the five remaining proposals were ratified at the first council meeting held at least 19 days after the commissioner's approval.

One reason dates of decisions may not have been properly documented was because the process as established by statute and administrative rules was not consistently followed. In 14 cases, the commissioner reviewed proposals and sent them to the council without issuing a compliance finding. Proposals were then discussed at the council meeting and ratified. This process did not provide the two-tiered review as envisioned by statute and administrative rules.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

RECOMMENDATION:

We recommend the commissioner ensure proposals are date stamped when received at the department and approvals are documented through a memo to the advisory council citing the commissioner's findings of compliance with approval criteria and the date of approval. All proposal information including supporting documentation and correspondence should be maintained.

Auditee Response:

We concur with the recommendation that the labor commissioner should ensure proposals are date stamped, dates of approval or disapproval are recorded for each proposal and documentation should be submitted to the council to support such. This procedure was established in May 1995 by the new Commissioner of Labor.

We concur the labor commissioner should document approval through a memo to the advisory council members citing the findings of compliance with the approval criteria and date of approval. All proposal information including supporting documentation and correspondence with regard to approvals are being maintained. This procedure was established by the new Commissioner of Labor in May of 1995.

OBSERVATION NO. 3

WRITTEN NOTICE OF DISAPPROVAL NOT GIVEN IN ALL CASES

Of the 24 proposals submitted to the commissioner for approval, we were able to determine that five proposals were disapproved. The commissioner has not consistently provided written notice of disapproval to applicants as required by statute. Of the five disapproved proposals, we were able to determine that only three applicants received written notification of disapproval and the reasons for disapproval. Department personnel reported that one applicant was notified via telephone of the commissioner's decision and the reasons for disapproval. No file documentation, including the proposal itself, could be located for the remaining disapproved proposal.

RECOMMENDATION:

We recommend the commissioner provide written notification of disapproval to the applicant and cite the reason(s) for disapproval upon making a determination that a proposal does not meet approval criteria.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

Auditee Response:

We concur with the recommendation that if a proposal does not meet the approval criteria the labor commissioner should provide written notification of the disapproval to the applicant and cite the reasons. This procedure was established with the new Commissioner of Labor in May of 1995.

2.32 Adequacy of Rules, Policies, and Procedures

During our evaluation we found a widespread lack of adequate policies and procedures for both the Department of Labor and the Advisory Council on Workers' Compensation. Written policies and procedures, including rules and by-laws, are essential in the governance of any organization. Policies and procedures are basic management requirements that provide assurance of an organization's ability to record, process, and report data, as well as comply with laws and regulations. They may also reduce uncertainty and confusion among organization members and communicate information to outside parties. In addition, they assist with continuity of operations over time. The lack of adequate policies and procedures contributed to the approval of proposals that did not meet minimum criteria and insufficient documentation of department and advisory council decisions and activities.

OBSERVATION NO. 4

ADMINISTRATIVE RULES NEEDED

The department and advisory council lack administrative rules in several areas. RSA 541-A:16 requires all agencies, including State boards, commissions, or other groups, to adopt administrative rules describing their organization and methods of operation and practice.

The commissioner has not established the number of managed care facilitators as required by statute. Facilitators are responsible for managing an injured worker's care and ensuring the worker returns to work as soon as possible. RSA 281-A:23-a (V) requires the commissioner to adopt rules setting the number of managed care facilitators considered to be "sufficient." Administrative Rule LAB 702.01 requires a program to include a "sufficient" number of managed care facilitators, but does not define the number of facilitators that is sufficient. The labor commissioner and council chairman indicated this rule has not been adopted because no data exist to determine a specific ratio. The goals of workers' compensation managed care may not be realized if programs do not have an adequate number of facilitators. Costs may not be contained and employees may not be returned to work as rapidly as possible.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

Although not specifically required by law, we believe existing administrative rules should also address changes to managed care programs. We noted eight proposals during our review that sought substantive changes to a previously submitted or approved proposal. Changes requested most often entailed expansion of the geographic area of coverage for a program. Applicants requesting changes submitted addenda to proposals previously submitted rather than submitting a complete proposal. We found no authorization in statute or administrative rules authorizing the use of addenda. The submittal of addenda made it difficult to ascertain precisely what change was requested, whether the previous proposal met criteria and was approved, or the geographic areas actually covered. Addenda do not provide decision makers with adequate information to make sound decisions.

Our review of the department's administrative rules also indicated no requirement for approved programs to obtain further approval of changes in ownership or network medical care providers. Rules are needed to legally require applicants to gain approval of proposed changes before programmatic changes are made. If changes to managed care programs are allowed without approval by the commissioner and advisory council, the quality of managed care programs offered may be jeopardized. If unauthorized changes are made to approved programs, managed care goals of cost containment and prompt return to work may not be realized.

Several parties reported managed care administrative rules need improvement. Additional areas that may benefit from development of administrative rules include:

- Qualifications of managed care facilitators;
- Public access to applicant's submissions;
- Evaluation and recertification of approved proposals; and
- Decertification of approved managed care programs.

Without administrative rules, the department and advisory council may lack authority to take appropriate action.

Existing administrative rules also revealed insufficient detail related to how the department and council implement the provisions of RSA 281-A:23-a. For example, Administrative Rule LAB 702.02 states applicants must file three complete copies of proposals with the commissioner but does not specify how or where proposals should be filed. In addition, administrative rules do not accurately reflect current practices. Contrary to rules, applicants are asked by the commissioner to submit ten copies of proposals.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

The advisory council does not have any written by-laws governing how council meetings are conducted, how the chairman is selected, when and where meetings are held, rules of order, how proposals and subsequent information should be presented and accepted, how and when applicants may present proposals to the council, or how proposals are reviewed. By-laws are written rules and procedures that govern how a board, commission, or council conducts its business. By-laws also communicate this information to outside parties.

Neither the department nor the advisory council have written policies and procedures guiding their review of workers' compensation managed care proposals. We found no standard application forms, standard format for proposals, or checklists for determining compliance with approval criteria. A former commissioner stated he "sometimes" called proposed network medical care providers to verify they had contracts with the applicant or verified doctors' credentials with the medical society. In addition, several council members indicated proposals were simply "rubber stamped" because neither the commissioner nor council members had the knowledge required to adequately review proposals. Some council members stated they relied on the expertise of the medical doctors on the council or the labor commissioner to review proposals. The commissioner and several council members acknowledged proposals were confusing without a standard application and format.

Although the labor commissioner and council chairman indicated the council is not required to develop rules relative to procedures, we believe they are needed to formalize the review process.

RECOMMENDATION:

We recommend the commissioner and advisory council review current administrative rules to determine areas needing revision and adopt appropriate rules as needed. Specific areas include: number of "sufficient" managed care facilitators; qualifications of managed care facilitators; changes to proposals or approved programs; public access to applicant's submissions; evaluation and recertification of approved proposals; and decertification of approved managed care programs. Rules relative to the organization and methods of operation of the advisory council should also be considered. Formal written policies and procedures should be developed for review of managed care proposals, including a standard application and instructions to applicants, standard format for proposals, and review checklists. Managed care proposals should be reviewed for compliance with approval criteria and only approved when proposals meet minimum requirements. The advisory council should not accept any proposal unless the proposal was deemed approved or the commissioner has issued a written finding. The labor commissioner and council should consider developing council members' expertise by offering training on how proposals should be reviewed, including statutory and administrative rule requirements.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

Auditee Response:

We concur with the recommendation that the Labor Commissioner and Advisory Council should review current Administrative Rules and adopt modifications or additional rules, as necessary. This is currently underway and we expect this procedure to take at least six to eight months before we will accomplish this process with the areas that need modification.

There is a lack of data available to support a policy with a specific ratio of injury management facilitators to the number of cases. We believe the definition should be addressed more specifically. The Council will address this section through modifications to current administrative rules.

We concur with the recommendation that rules should be adopted with regard to substantial changes; i.e. any changes to the programs content, specific but not limited to the necessary components. We believe these sections of the program proposals should be replaced within the program's document or the entire request for approval should be reprinted and submitted. We concur with the recommendation to clarify the process in which changes are to be submitted for consideration however, we need to further define what constitutes "change(s)" to a managed care program. In most cases, the request for approval of a "change" relates to the expansion of a managed care program within one geographic area to a greater geographic area within the State or, in some cases, throughout the State. It is our understanding that no program has been submitted for consideration and approval of changes to program content.

It is our understanding the statute does not specify the council's authority for promulgating rules to define their operational functions and/or by laws specifying the council's procedures. Although we have found it difficult to proceed with rulemaking in the past with other boards (with no rulemaking authority), we will undertake this effort with the Rules Committee over the next 30-60 days. The policy for submission of requests for approval under managed care are specific in the Administrative Rules under Chapter LAB 700. To supplement those rules, please refer to previous work sheets which would include the development of an application and checklist.

We concur with the recommendation for the Labor Commissioner and Advisory Council to review and further develop the application approval and ratification processes under managed care in workers' compensation. Since May of 1995, no managed care request for approval has been submitted to the Advisory Council without prior approval which is documented by the Labor Commissioner. We further concur with the recommendation that the Labor Commissioner and Council should consider developing Council members expertise, by offering training in the evaluation of proposals, including statutory and administrative rule requirements.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

2.33 Compliance With State Laws and Regulations

During our evaluation of the workers' compensation managed care review process, we noted several areas of non-compliance with State laws and administrative rules on the part of both the commissioner and the advisory council.

OBSERVATION NO. 5

MONTHLY MEETINGS NOT HELD

RSA 281-A:62 (II) requires the advisory council to meet on a monthly basis. However, the advisory council held only 40 of 48 (83.3 percent) monthly meetings between July 1991 and June 1995. During fiscal year 1992 the council met every month as required by statute. However, the council met 10 of 12 times in fiscal year 1993, 8 of 12 times in fiscal year 1994, and 10 of 12 times in fiscal year 1995. It should be noted that for some months, such as April 1992, December 1993, and February 1994, two council meetings were held. Both the council chairman and the commissioner stated that monthly meetings were not always held because no issues needed to be addressed. The chairman also reported some meetings may have been canceled due to poor attendance or because issues were already discussed during meetings of the Task Force on Workers' Compensation Reform. If the advisory council does not meet on a monthly basis as required proposals may not be acted upon on a timely basis.

RECOMMENDATION:

We recommend the advisory council and commissioner ensure advisory council meetings are held on a monthly basis as required by law. If the advisory council determines that such regular meetings are not necessary, the council should seek legislation to change the governing statute to provide for more flexibility.

Auditee Response:

We concur that the Advisory Council on Workers' Compensation should meet on a monthly basis; however, it should be noted that during the period in which the Study Committee on Workers' Compensation costs was addressing system wide workers' compensation reform, we believe the spirit of the law governing the advisory council was carried through this task force. Four council members served on the task force and other advisory council members testified before this committee which required regular attendance at most of their (daily) work sessions during fall of 1993 and early 1994.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

Furthermore, there were changes with regard to council member appointments and in 1994, the House member resigned from the council. The Speaker of the House decided not to fill the vacancy and the same House member was reappointed six months following his resignation subsequent to his reelection.

Historically, the council has consistently met on a monthly basis; however, when attendance to ensure a quorum appears unlikely or is confirmed, a few meetings have been postponed to accommodate the scheduling conflicts of these professionals. To ensure compliance with the intent of the law to meet on a monthly basis (or 12 times per year) two meetings the following month are usually conducted subsequent to a cancellation.

We concur with the recommendation to evaluate the appropriateness of modifying the statute to accommodate more flexibility and allow for a more practical approach to compliance.

OBSERVATION NO. 6

MEETING MINUTES NOT ALWAYS PREPARED

We reviewed advisory council minutes for meetings held between July 1991 and June 1995 and determined minutes have not been prepared for all meetings. Of the 40 meetings held during that time period, we initially found minutes for only 29 meetings (72.5 percent). Subsequent to our observation, the department and council provided minutes for another seven meetings. The council chairman characterized council minutes as "spotty." RSA 91-A:2 (II) requires minutes to be promptly recorded and made available within 144 hours of a public meeting. RSA 91-A:3 (III) requires minutes to be prepared and a record of all actions be made available for public inspection within 72 hours of a non-public meeting, unless a recorded vote of two-thirds of the members present determines that revealing the information would adversely affect the reputation of a person other than a member of the board or agency itself. The issues raised and business conducted at all meetings should be documented so that the public has access to this information and are assured that the council is complying with State requirements when ratifying managed care programs. Without prompt preparation of meeting minutes, the details of the meeting may be lost. Minutes are the official representation of all discussions, actions, and decisions made by the council. Proof that managed care proposals were ratified or not may be difficult without meeting minutes. As a result of the lack of advisory council meeting minutes we were unable to verify whether seven proposals were ratified by the council or whether a quorum was present.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

The advisory council ratified four proposals before having legal authority to do so. Effective January 1, 1994, Chapter 311 of the Laws of 1993 authorized the council to ratify manage care proposals. The council ratified four proposals on December 28, 1993 -- three days prior to the effective date. Meeting minutes from February 4, 1994 indicated four proposals were re-ratified. However, the minutes did not name the proposals. A copy of the motion naming the re-ratified proposals was provided subsequent to our observation.

One reason given for the lack of minutes for advisory council meetings was that a recording secretary was not available. Both the commissioner and the council chairman reported it was the Department of Labor's responsibility to provide a recording secretary for council meetings.

RECOMMENDATION:

We recommend the advisory council and commissioner ensure minutes of all council meetings are taken and maintained. The commissioner and the chairman should also ensure that a backup recording secretary is designated for those instances when the primary secretary cannot attend the meeting due to illness, vacation, or other reasons.

Auditee Response:

We concur with this finding that all advisory council minutes are not recorded, prepared and maintained. We have addressed this issue by assigning back up personnel within the Department of Labor to ensure compliance with this responsibility.

We believe consideration should be given to the legislative changes allowing for managed care programs statewide and the mandate of such a program for the assigned risk pool (A.R.P.). The assigned risk pool contract with the servicing carrier included a provision for managed care to be initiated with the contract effective date; thus, no consideration was given to the approval process for this particular managed care program. The advisory council was subject to considerable pressure to approve the A.R.P. vendor in addition to other managed care programs who had employers drafting contractual arrangements for these services as they were pursuing "rate relief" through the endorsement of a 10% rate credit for participation. These programs which were approved and ratified on December 29, 1993, were not effective until January 1, 1994, as the statute indicates. There are minutes confirming ratification of subsequent programs. We concur that not all minutes are available for prior meetings, we are ensuring these are recorded and maintained with additional staff assignments from the Department of Labor and diligence with regard to the distribution of such.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

OBSERVATION NO. 7

ANNUAL REPORTS NOT AVAILABLE

We requested advisory council annual reports for 1991 through 1994 from the council. Although the council provided the 1991 and 1992 annual reports, it was unable to provide the 1993 and 1994 annual reports. The chairman stated that the reports exist but they are located on his computer which had "crashed." We also tried to obtain these reports from alternate sources such as the Department of Labor and the Legislature without success. RSA 281-A:62 (II) provides that the council shall annually review the performance of the workers' compensation system and issue a report of its findings and conclusions on or before January 1 of each year to the Governor, the labor commissioner, the commissioner of insurance, the Speaker of the House of Representatives, the President of the Senate, and appropriate committee chairs of both houses. The Legislature, Governor, and other interested parties may not receive needed information regarding the performance of the workers' compensation system without these reports.

RECOMMENDATION:

We recommend the advisory council and commissioner review the performance of the workers' compensation system on an annual basis and report its findings and conclusions to the appropriate parties. The council should endeavor to issue the 1993 and 1994 annual reports as soon as possible. The commissioner should ensure the council is aware of this requirement and issues future reports on a timely basis.

Auditee Response:

We concur that the Annual Reports of the Workers' Compensation council for 1993 & 1994 were not provided to the auditor. The chairman is recovering these reports from the archives of the software he was utilizing at that time. We expect to provide these reports within the next thirty days.

2. ANALYSIS OF THE APPROVAL AND RATIFICATION PROCESS (Continued)

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

2.34 Program Monitoring and Review

OBSERVATION NO. 8

POLICIES AND PROCEDURES NEEDED FOR PROGRAM MONITORING AND REVIEW

The commissioner is required by RSA 281-A:23-a (VI)(a) to monitor all approved managed care programs to ensure program effectiveness, cost savings, appropriateness of service, and timeliness of service. The commissioner indicated modifications were being made to an injury report form used by employers to report injuries to the department. The department is also in the process of modifying a computer database to track this information. However, we have no clear indication how this information will be used to monitor and ensure managed care programs are cost effective and provide quality care.

This statute also requires the commissioner to review each managed care program within three years of a program's ratification by the advisory council for compliance with approval criteria. After review, the commissioner may withdraw approval if the program is found to no longer meet minimum approval criteria. As best we could determine from the incomplete documentation maintained by the commissioner and advisory council, the first review would not have to be completed until December 1996 as the first proposal was ratified by the advisory council in December 1993. Although the three year time period has not yet expired, we found no evidence the commissioner has begun to develop and adopt policies and procedures governing the review process for approved managed care programs. The commissioner indicated the department may use self-evaluations for managed care providers, surveys of injured employees and medical providers, or consultants to determine compliance with approval criteria. The three year review of approved managed care programs is an opportunity to revisit managed care programs and bring them into compliance with minimum requirements. In this way the workers' compensation managed care program may meet its goals of cost containment and returning the injured employee to work as quickly as possible. A rigorous review process is necessary to ensure these goals are met.

RECOMMENDATION:

We recommend the commissioner develop policies and procedures for the triennial review process of approved managed care programs, including adopting any necessary administrative rules.

2.3 OBSERVATIONS AND RECOMMENDATIONS (Continued)

Auditee Response:

We concur with this observation which recommends the development of policies and procedures for program monitoring and review. As noted in previous worksheets, this Department and the Advisory Council will modify the rules governing managed care programs to further specify requirements pursuant to RSA 281-A:23-a. We concurred previously that the development of a standard application and checklist for the approval process would be effective tools to ensure compliance. The criteria outlined as "Minimum Requirements" in Chapter LAB 700 requires some modification and clarification. Additional rules will be adopted to specify filing criteria, the process of evaluating compliance with the standards for approval and procedures to evaluate program effectiveness, cost savings, appropriateness of service, and timely service delivery.

We will develop and adopt policies and procedures governing the review process of approved programs consistent with the original filing criteria, i.e. the "Minimum Requirements." We concur that some programs were approved but documentation to support such approval was incomplete.

We have redesigned the "Employer's First Report of Injury" to include a section indicating whether (or not) a claim is subject to the provisions of managed care. This will allow us to identify managed care claims individually and provide several data elements for analysis; any additional information will be requested from insurance carriers to be compiled with the Department's data for evaluation by a third party. The Department does not have the capacity to capture all of the data necessary to fully evaluate each managed care program as required by RSA 281-A:23-a (VI)(a); however, this same section does allow for contractual arrangements to conduct such an evaluation.

It is anticipated that development of the aforementioned and adoption of additional administrative rules will require approximately six (6) to eight (8) months of effort by the Council to establish a "rigorous review process."

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3. CONCLUSION

The review process used by the Department of Labor and the Advisory Council on Workers' Compensation for workers' compensation managed care proposals has not been as rigorous as it should be. More rigorous review of proposals by both the commissioner and advisory council is required to ensure proposals comply with the law. However, most proposals were approved by the department and ratified by the council without evidence that all minimum standards were met. The review process can be strengthened by adopting and following more definitive administrative rules, policies and procedures, and by-laws. Furthermore, the review process must be adequately documented. Proper documentation will assist in the administration of program monitoring and re-certification requirements. The department and advisory council should immediately comply with requirements to keep and maintain meeting minutes and hold monthly meetings.

Almost two years have passed since the first workers' compensation managed care proposals were ratified. In the upcoming year, the labor commissioner and advisory council should focus on a comprehensive review of the approval and ratification process, rules and procedures, and minimum requirements before the re-certification process begins. The re-certification process is an ideal occasion to revisit approved programs to assess their quality and ensure sound workers' compensation managed care programs are available.

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STATE OF NEW HAMPSHIRE
MANAGED CARE PROGRAMS FOR WORKERS' COMPENSATION

OTHER ISSUES AND CONCERNS

In this section we present an additional issue encountered during our evaluation. Although we did not develop the issue into a formal observation, we do consider it noteworthy. The General Court may consider this issue deserving of further legislative study or action.

CLARIFICATION OF RSA 21-G:5-a, STATEMENTS OF FINANCIAL INTEREST FOR MEMBERS OF EXECUTIVE BOARDS AND COMMISSIONS

During the course of our evaluation we noted in a preliminary observation that not all members of the Advisory Council on Workers' Compensation filed statements of financial interest. RSA 21-G:5-a (I) states:

> Every member of every executive branch **board, commission, advisory committee, board of directors, and authority, (emphasis added)** whether regulatory or administrative, shall file by July 1 of each year a verified written statement of financial interests in accordance with the provisions of this section, unless the member has already filed a statement in that calendar year. Every member shall file the verified written statement required by this section regardless of whether or not the member is reimbursed for performing the member's duties.

Although the advisory council concurred with our preliminary observation, its response indicated uncertainty as to whether or not its members were subject to this law.

A May 24, 1994 memorandum to members of all executive branch boards and commissions issued by the Attorney General's Office, stated that entities not specifically enumerated by the law were exempt from filing statements of financial interest. For example, as a result of the memorandum, the law is being interpreted to mean that members of advisory councils are exempt from filing financial interest statements while members of advisory committees are not.

Because of ambiguity caused by a reading of the statute, its legislative history, and the attorney general's memorandum, we have not developed a formal observation regarding non-compliance. However, this issue will undoubtedly arise again; therefore, the General Court may wish to clarify the statute. The General Court may also wish to clarify responsibility for monitoring compliance with RSA 21-G:5-a.

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