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# Medical Access in the California Workers' Compensation System

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*Disclaimer: This session is presented for informational and educational purposes only. The views, thoughts, opinions, information, and materials comprising the presentation do not necessarily represent the opinions of my employer, partners, or clients.*

## LEGAL MANDATE

California Labor Code §5307.2 requires DIR to annually study whether injured workers have adequate access to quality health care.



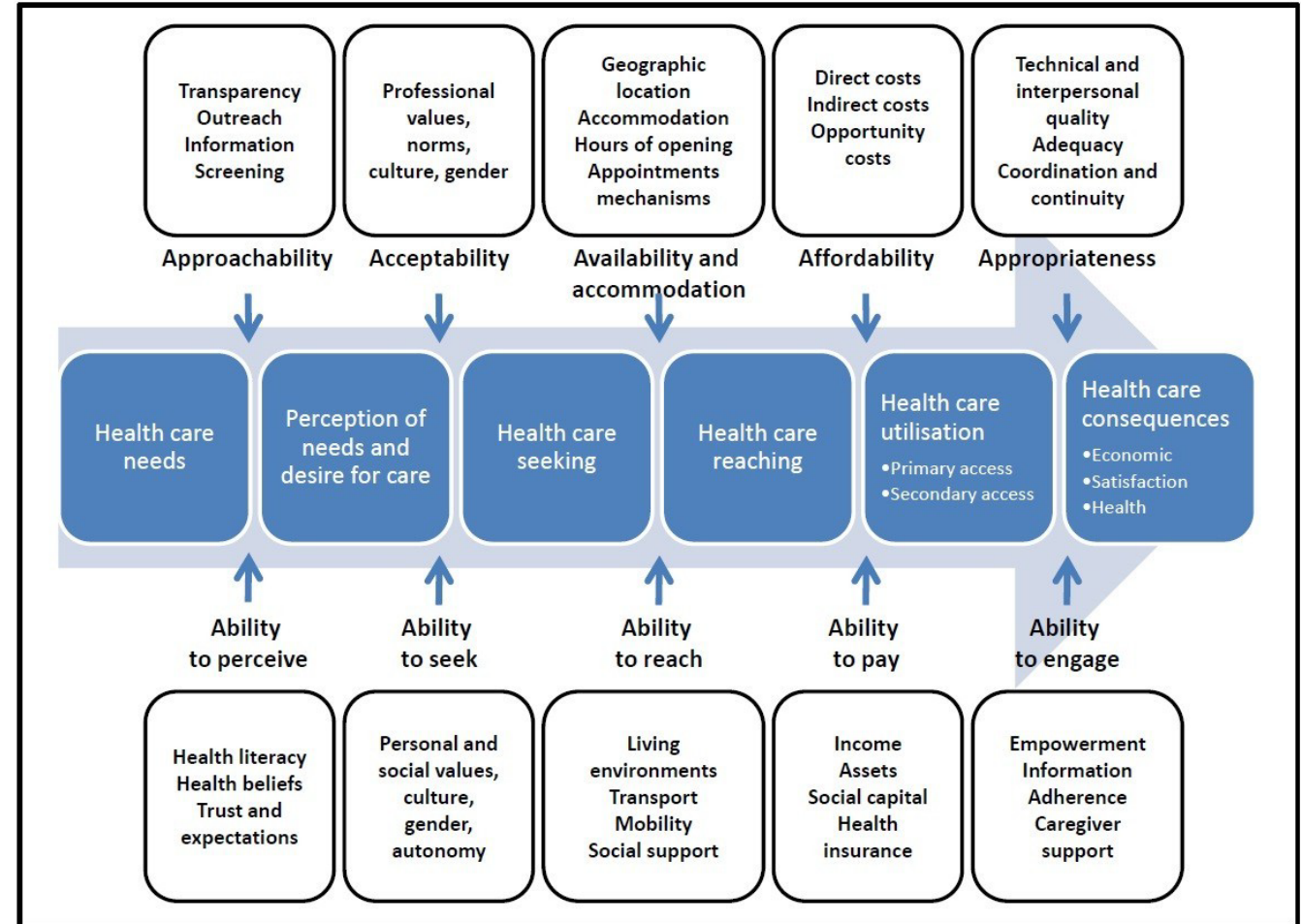
To briefly summarize previous studies of access to care in CA WC system



To present plans for the current access study being led by RAND (PI: Michael Dworsky)

# Access to care is a complex concept that can be challenging to define and measure

- Institute of Medicine<sup>1</sup> defines access as: "the timely use of personal health services to achieve the best possible health outcomes"
- This encompasses numerous steps in process of obtaining care<sup>2</sup>
- Many concepts of access are difficult to observe or measure



# Access measures used in past studies in California address different dimensions of access to care



## Provider Supply

Are enough providers available by specialty and location?

Does payment support participation?



## Utilization & Demand

How many injured workers need care? How many are getting treatment?



## Timeliness

How quickly do workers get care after an injury?



## Distance

How far do workers travel to see a provider?



## Network Adequacy

Do Medical Provider Networks have enough providers?



## Admin Burden

Do UR, IMR, and IBR processes delay or block care?

# Findings from recent studies on access in California



## Provider Supply

↓ since 2010<sup>3-5</sup>  
↑ in NP/PA (especially post-Covid)<sup>6</sup>  
Willingness to participate significant challenge



## Utilization & Demand

↓ in utilization within 12 months of injury<sup>3</sup>  
↑ in bills per provider<sup>3</sup>  
↑ in cumulative trauma injury claims<sup>7</sup>



## Timeliness

Wait times have increased  
~ 5 days to initial visit<sup>8</sup>  
~28 days for some specialty care<sup>8</sup>



## Distance

Rural workers must travel ~3X farther than those living in urban areas<sup>9</sup>



## Network Adequacy

"Realized" network much narrower<sup>9</sup>



## Admin Burden

Reports of significant delays from UR and IMR  
Admin costs estimated at 49%<sup>7</sup>

# Caveats & Limitations of Existing Measures



## Provider Supply

- Denominator challenges
- Cross-specialty or system comparisons difficult



## Utilization & Demand

- Counts of injured workers snapshot
- Utilization = care delivered in system



## Timeliness

- Variation in defining start date
- No way to calculate for those who do not receive care



## Distance

- Typically not measured cumulatively



## Network Adequacy

- Not well studied
- Difficult to measure with existing data



## Admin Burden

- Difficult to measure with existing data
- Denied claims only for care provided/billed to WC

# RAND's new access study is scoped to address some key gaps in the evidence base

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## Gaps in Our Understanding

- Network adequacy;
  - How do networks described in MPN provider directories compare to realized networks (where patients actually receive care)
  - How do MPNs and MSOs influence provider willingness to participate?
- Do UR/IMR drive access challenges?
- How have COVID, telehealth changed access?
- Describe emerging system frictions

## RAND's Plan

- Update a set of core access measures annually
- Examine access and identify challenges by:
  - Geography (DWC region or county)
  - Provider specialty
- Later annual reports will include deep dives to address gaps in the evidence base

# Goals of standard access metrics & analysis



Describe trends in number of providers providing care to injured workers



Describe variation by provider specialty, geography and factors correlated with those gaps, such as differences in fee schedule adjustments.

## EXAMPLE MEASURES

**1. Number of unique WC providers**

**2. Ratio of WC providers to General HC system**

**3. WC providers adjusted for volume**

**4. Providers scaled by WC patients**

**5. Timeliness of first visit**

**6. Distance to Provider**

# Additional goals for each year

## YR1: COVID-19, Telehealth

- Compare access trends and challenges prior to pandemic with more recent patterns of care.
- Describe changes in telehealth encounters following pandemic changes, formal addition to fee schedule in January 2022.

## YR2: UR/IMR/IBR

- Investigate IMR/IBR decisions to describe incidence of these reviews and the corresponding time added, and analyze available information on the frequency and access implications of UR

## YR3: MPNs & MSOs

- Examine and characterize MPNs and listing vs realized networks
- Compare access measures by employer MPN status.
- Investigate the role of management service organizations (MSOs).

## YR4: Update on Telehealth, Final Report

- Update telehealth analysis
- Final report will synthesize project findings and make policy recommendations to improve access

# We will use DWC administrative data sources and public stakeholder materials to study access



## Data Sources

- Workers' Compensation Information System
  - First/Subsequent Reports of Injury
  - Medical Billing Data
- MPN Filings and Provider Directories
- Independent Bill Review (IBR)
- Independent Medical Review (IMR)
- Publicly available information from:
  - CHSWC meeting transcripts, materials
  - DWC advisory committee meeting transcripts
  - Legislative testimony, floor analyses
  - Stakeholder position papers, public comments
  - Reports from stakeholder organizations

## Technical Approach

- Descriptive statistics showing trends and stratified analyses of key metrics
- Efforts to identify causal impacts where possible: can use quasi-experimental designs or other statistical tools
- Natural language processing techniques to incorporate different stakeholder perspectives
- Synthesis of results to identify recommendations to improve access

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Questions?

Thank you!

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