CCSF WORKERS' COMPENSATION COUNCIL

MINUTES

Regular Meeting

September 10, 2018

9:00 a.m.

ROOM 408, CITY HALL

1 Dr. Carlton B. Goodlett Place

CALL TO ORDER

9:00 a.m.

ROLL CALL

Micki Callahan, Human Resources Director		Present
Kelly Kirkpatrick, Acting Budget Director	(Represented by Laura Busch)	Present
Naomi Kelly, City Administrator	(Represented by Peter Goldstein)	Present
Caryn Bortnick, Deputy Director Risk Management Division, Retirement System		Absent
Todd Rydstrom, Deputy Controller, Controller's Office	(Represented by Michelle Allersma)	Present
Lorenzo Donati, Deputy City Attorney		Present

PUBLIC REQUESTS TO SPEAK ON ANY MATTER WITHIN THE JURISDICTION OF THE WORKERS' COMPENSATION COUNCIL APPEARING ON THE AGENDA (Item No. 1)

Speaker: Micki Callahan

Public Comment: None

APPROVAL WITH POSSIBLE MODIFICATION OF MINUTES (Item No. 2)

Action: Minutes approved for the meeting on June 4, 2018.

REPORT FROM THE WORKERS' COMPENSATION DIVISION

Discussion Items: (**Item No. 3)**

Speaker: Peggy Sugarman, Deputy Director, Workers' Compensation Division

Reported on Claims: Claim Costs, Frequency & Fiscal Year Results

Peggy begins by introducing the new staff in the Workers' Compensation Division.

- Daphney Cabingas was promoted to Claims Adjuster
- Gregory Guillen is a new Claims Assistant for George Whittaker
- Lupe Perez was promoted to Acting Supervisor and is the Medical Provider Network administrator
- June Lu has joined the Financial group as an accountant.

Peggy continues by asking Stanley Ellicott to present the Finance and Technology accomplishments.

- Phase One implementation of the Banking Modernization Project is completed. This included our account migration to US Bank and the use of a master zero balance account which allows us to hold our money in an interest bearing account as long as possible and dispersing only as needed in the master account.

- Replaced over 1,000 individually maintained spreadsheets with a new inter-departmental service billing format and methodology.

- Improved the 6 and 9-month reporting to the Controller and Mayer's Office.

- Implemented Bulk Payment Processing functionality in the IVOS claims system to significantly reduce manual processing of checks.

- Automated over 140 monthly department chargeback and loss run reports, reducing manual report processing and ensuring that the departments are getting timely information about what is occurring with their claims.

- Integrated the DSW employee ID into IVOS which enhances the reporting options that preserve confidentiality and minimize the use of SSNs.

- Overhauled the employee import from eMerge HRIS database which improves the quality of the data fed into claim records at claim setup and updates job classifications.

Micki asked if there was a timeline for the implementation of Phase 2 and 3 of the Banking Modernization Project.

Stanley explained phase two and phase three will depend on a number of factors. We will be hopefully activating electronic payments for vendors, injured workers and medical providers. The most complicated of this is the medical provider payments due to the remittance advice explaining how we have adjusted their payment which must be included. This project, which

includes SFMTA, is massive due to the number of systems which need to be integrated including all of the medical codes which need to be uploaded, and the state electronic medical payments guidelines. This program also has to be integrated with FSP. According to US Bank, we will be the first employer to implement this type of electronic payments. There is an anticipated cost savings of over $100,000 per year due to not having to print and mail checks out of Chicago.

Michelle added her congratulation on the accomplishments.

Stanley continued with the Financial Team accomplishments for the fiscal year.

- Issued 1,662 1099s to vendors
- Oversaw 322,439 iVOS financial transactions
- Saved $31.5 thousand in UR fees through audit procedures.
- Accounted for $69.03 million of claim and overhead expenses.
- Issued 165,388 checks (all locations)
- Completed 3 major system integrations: EK Health, Optum and US Bank initiatives.
- Deployed AdHoc reporting platform to allow more robust reporting.

Micki asked if the AdHoc reporting tool was available to departments.
Peter asked if this tool would be available for use at the department level.

Stanley said with the next upgrade to iVOS they would be working on a limited access query option to be distributed to individual departments.

Peggy next introduced Julian Robinson, Claims Manager, who spoke about accomplishments achieved during fiscal year 2017-2018.

- Nurse triage/injury advice hotline is up and running. This can be used by either the injured employee or their supervisor to report a new injury and receive direction on what to do next.
- Bill Review/Utilization Review
  EK Health launched effective 9/1/2017.
  Focus groups where created to identify and solve any ongoing problems.
  Implemented major efficiencies by importing images directly into the iVOS claims system.
- Pharmacy Benefit Management Program launched on 2/26/2018. Doing this helped to enhance oversight of prescriptions and provides network discounts.

  Micki asked if the use of this system had been expanded to the Municipal Transit Authority and the Community College. Julian responded that it had been.

We have issued 4,227 cards for CCSF. This allows the injured worker to get approved drugs quickly and easily.

- Safety efforts continue. WCD assisted departments with federal OSHA reporting and the development of the Office Electronic Learning Management-based ergonomic training partnership with the Department of Public Health, the Work Force Development team in the Department of Human Resources, and Health Service System..

- An interdepartmental networking group has been set up to discuss best Workers' Compensation practices. The original plan was to meet quarterly, but the participants would like to move to a monthly meeting schedule. These meeting allow workers' compensation coordinators from various departments to exchange ideas on the best ways to track workers' compensation claims within their own departments. Also, the future is to build a best practices list for everyone to follow.

- Medical Provider Network Improvements include an updated Memorandum of Understanding which was sent to all providers. This Memorandum of Understanding expands the reporting requirements and expectations for being part of the Medical Provider Network. Also, medical groups must submit a form for each doctor in their group, not just one for the entire group. We have updated and revamped our Medical Provider Network website for easier, more efficient use. The Medical Provider Network Advisory Committee has been expanded to include Claims Adjuster representatives from the City and County of San Francisco, San Francisco Municipal Transit Authority, and Intercare. Two providers have been terminated for non-compliance and there will be more in the future. Finally, the Medical Provider Network Plan was updated to include new regulations and was reapproved by the State.

- We have added new Medical Resources in the form of new ancillary service providers (MedVal, MedPlus, Homelink, Hearing Services, and Dental)

- We have improved out oversight of our third party administrator, Intercare by updating the service instructions and developing and implementing an audit process.

- Professional development is ongoing. All of the City and County of San Francisco Claims Adjusters and 4 of the Claims Assistants have successfully completed the Self-Insured Program Administration Certification and we have approved targeted training through the Insurance Educational Association for career development of our staff.

- The Medicare conditional payment process has become more complicated in cases where Medicare has paid a medical bill that may be related to a claim. The Federal Government has been notifying the City of a payment, then subtracting the amount of the payment from any invoice that the government pays to the City. We have a process to respond to this request but if the federal government doesn't receive or acknowledge that they have received a timely response, they will take the perceived "debt" due to them and reduce any payment going to the City and County of San Francisco by that amount with no regard to which department is paying for the underlying claim. This has caused a problem with departments being shorted on payments from the federal government due to this practice. The Workers' Compensation Department has processes in place to handle these events. A memo has been sent to all the fiscal managers telling them if this happens to contact us at

once so that we follow up.

On September 25, 2018, we received over $21,000 in reimbursements from the federal government from disputed claims.

Micki asked if there was a payment dispute with Medicare regarding Workers' Compensation payment was the federal government withholding payments from other city departments.

Julian answered that that was the case. The federal government was reducing payments to the City and County of San Francisco for the dollar amount Medicare believed was owed to them regardless of where the workers' compensation claim belonged or even if the claim was valid or not.

- An external claims audit was completed on 150 randomly selected files. The audit determined that for timely determination of compensability we were at 98%, timely first temporary disability payment we were at 95%, timely first permanent disability payment we were at 91%, timely salary continuation/disability pay/4850 notices we were at 94%, qualified medical exam/agreed medical exam notices we were at 100% and Supplemental Job Displacement Benefit/Return to Work offer at 97%. It was also noted that "Benefit Notices are very well documented and have all of the mandatory language".

  Micki asked what percentage the state would be looking for to pass the audit. Julian responded that when the state does their audit they give you demerit points for each time they find a mistake and then there are too many it triggers a full audit.

- Julian reported that the WCD's closing ratio was 103.4%, which is above industry standards.

- There was also a successful fraud prosecution against Andrew Giovaninni, who pled guilty to Conspiracy to Commit Workers' Compensation Fraud and Felony Workers' Compensation Fraud. He permanently surrendered his medical license and paid $51,000 in restitution to the Juvenile Probation Department.

  Micki asked if he was in the Medical Provider Network.
  Julian responded that he has been but has been removed.

Peggy continued the presentation from this point:

- Edward Stone and Joseph Carrillo will be receiving a White Helmet Award from the San Francisco Fire Fighters L798 in March 2019 for the work they have done with cancer claims. The White Helmet Award is the high civilian honor presented by the Firefighters Union.

- The Workers' Compensation "Carve-Out" program for the Police and Fire Unions is still under development.

- The audit for Section 111 Medicare reporting processes for compliance was delayed but is currently in process.

- Development of the on-line office ergonomic training in partnership with the Department of Public Health, the Work Force Development team in the Department of Human Resources, and Health Service System is ongoing but nearing completion. This is scheduled to launch in late 2018.

- Data reporting dashboard for departments will be available which will allow departments to access the iVos system to look at claim causes, trends and costs for their department. This initiative has been delayed due to upgrades needed in the iVos system.

- A Request for Qualifications for Document Retrieval/Copy Services, where we subpoena medical records, has been completed and two companies have been selected. A 30% reduction over the state fee schedule is anticipated.

- Peggy and Nonie Devens, RN are participating in the Cannabis Working Group for the City and County of San Francisco.

- Workers' Compensation has moved some claims adjusting functions back in-house from Intercare, our third-party administrator. In 2012 Intercare was handling claims for 27 City Departments. By 2015 Intercare was handling claims for 5 City Departments. By 10/1/2018, Intercare will be handling claims for 4 City Departments as Workers' Compensation welcomes the Recreation and Parks Department in house.

Peggy continues by talking about performance quick facts for the fiscal year. Included in the numbers is a benchmark which is the five year historical average of the number given.

Fiscal Health, which measures how well we budgeted overall, for fiscal year 2017 we spent 94% of the budgeted amount and for fiscal year 2018 we spent 97.5% of the budgeted amount.

Claim Volume, which is the count of new claims for the fiscal year, we had 1794 indemnity claims and 1254 medical claims. Historically we had 1577 indemnity claims and 1088 medical claims.

Claim Cost, which is the average cost of claims closed in period including 4850 disability pay, shows a historical average of $14,934 per indemnity claim and $578 per medical claim. During this fiscal year, the average was $15,678 per indemnity claim and $616 per medical claim. This is slightly up but it also reflects the fact the temporary disability rates goes up annually and medical costs also increased.

Duration, which is the average number of days open for the claims closed in this fiscal year, shows that we are closing claims in 251 days compared to a historical average of 346 days.

Peggy continued by talking about claim analytics. This slide shows a comparison of the claim filing frequency between the past four fiscal years and the current fiscal year. There were decreases in the Public Health, Sheriff, and Recreation and Parts departments. But citywide, there was a 14% increase.

Peggy then introduced two slides depicting the Injury Rate of claims incurred per 100 FTE for the top five departments and a general citywide number. This again shows a slight increase in the number of claims being filed with the Fire Department and the Police Department being down. Citywide, over the last three years the rate of claims per 100 FTE held steady at 11 it did go up to 12 this year. The hope is to get it down to 10 over the coming years.

Micki asked if the Police and Fire Department increase might be due to cancer, back and heart claims.

Lorenzo asked if there was more litigation due to an aging workforce having more injuries. Peggy was unsure, but asked whether this was an issue that the Council would like further investigated.

Peter asked how the injury rates compare to other jurisdictions. Peggy said that the California Workers' Compensation Institute might have these statistics. Micki agreed with this suggestion, especially for the public safety sector.

Peggy continued with a table which shows Payment Per New Claim for the past five fiscal years. This shows how much we are paying in the first year of a claim. This does include Labor Code section 4850 and assault pay.

Peggy continued with the Claim Cause Distribution for the top five departments in the fiscal year for new claims. This gives you the claim causes for the city with the top five departments separated to allow you to see who has the majority of those claims. Claim cause definitions were collapsed into larger aggregate groupings. The slides at the end of the presentation show how these larger groupings were achieved. Exposure includes cancer claims.

The next slide shows open claim stratification by cost. The graph is color coded to show the top five departments and then all other departments. This shows that the Police Department does have the highest dollar amount for claims but there have been several catastrophic claims. Also, we have paid for things like liver transplants this year which drives up medical costs.

The next slide gives the same information in a pie chart format.

Peggy continued with Litigation Statistics. This table shows that citywide 53% of the open claims are represented and 51% are litigated. Recreation & Parks has the highest percentage of represented and litigated claims followed by Water Pollution Control.

Michele asked whether all of the represented claim become litigated. Peggy responded that most of them do.

Micki asked if the percentage of representation indicates that people feel that they will not be treated fairly. Peggy responded that she was not sure but she would look into checking with other cities.

Michele asked how litigation affects the claim. Peggy said that the longer the claim is open, the more expensive it becomes. Also, more body parts might be added to the existing claim.

Micki commented that this would give a higher value to the claim. Lorenzo added that since the claimant's attorney is getting 15% of the settlement they try to get more money.

For department expenditure trends, the report shows a significant deficit for the Police Department due to the catastrophic claims which have occurred this year. There is a trailer bill supplement to help the Police Department cover this. These cost exclude the Labor Code 4850 costs but do include administrative costs. All the other departments are looking great. Even with the deficient in the Police Department, we had a total surplus, which includes estimated allocated overhead of $1.76 million.

Peter asked if this table shows overhead and attorney costs. Peggy responded that is does include overhead but not attorney costs.

The next slide shows where the money is being spent by category. Included are the fiscal year 2017 actuals, fiscal year 2018 actuals. There was an increase overall of 6% which mainly occurred due to an increase in hospitalization costs.

Peggy's last slide shows the Program Overhead. The State Assessment for Self-Insurers was $500,000 more than the year before. That rate comes from the state in December. Our overhead rates did come down a bit from last year due to cost saving initiatives

REPORT FROM THE SFMTA WORKERS' COMPENSATION DIVISION

Discussion Item: (**Item No. 4)**

Speaker: Dan Roach, Municipal Transportation Agency

Dan begins his presentation by reporting on claim volumes. This is a rolling 12 month report. This report is through the end of July, 2018

For Claim Volumes, in July there where 39 indemnity, which is trending down from previous years. Total claims for the fiscal year is 677. In the monthly average, there were 45 indemnity, 8 medical only and 3 first aid.

The next slide shows the re-opened claim, closed claims, and the closing ratio which is an important performance metric for the program. The closed claims are averaging 63 per month for the fiscal year. So the closing ratio has a monthly average of 104%.

Dan continues with a lag time report which is an area where they have been improving. Lag time is the time between when the injury occurs and when the injury is reported to Intercare, their third party administrator. This report can be misleading as cumulative trauma claims are included in this number which increases the number significantly. Frequently when a claim is litigated an applicant's attorney in addition to filing for a specific injury they will file for a cumulative trauma claim which is often a year or more after the fact.

Dan continues by reporting on Financials. The expenditures for the first month of past fiscal year was $1,748,995 and for the same time period in this fiscal year expenditures are at $2,337,141.

Reporting on Stratification by Severity, the chart demonstrates the number of high exposure claims showing paid plus reserve numbers.

For litigation statistics, they are up slightly at 38.33 percent compared to 37.05 percent the prior July. SFMTA categorize all claims with attorney involvement in this number.

Dan discusses Cause Analysis by Frequency. Assaults are trending down and are continued to be worked on. The next highest claim cause is Pulling/Pushing injuries at 64.

Micki asked if the reduction in assaults were due to more barriers. Dan responded that it was a combination of more barriers, additional training of the operators and prosecution of individuals who assaulted the operators. Also there has been an increase in assaults in proof of payment and parking control areas.

Cause Analysis by Severity cost drivers continues to be assault claims and motor vehicle accidents where the employee is either struck by a motor vehicle or involved in a motor vehicle accident.

Dan continued with Cost Analysis, this slide shows the average cost per claim by main cause description. The average total cost per claim is $32 thousand and the average duration open is 30.7 months which is a good benchmark. If they can close their claims in 3 years or less it helps to keep costs lower.

The injury rate per 100 employees is at 10.77 percent, which is a very good number for a transportation agency. That number is down from the 12.57 percent they were at several years ago. This result is due to the proactive efforts of our wellness program and ergonomics training.

Reporting on Claims Denied, Dan states that this reflects their ongoing effort to evaluate the compensability of each claim. Their goal to provide what is due as timely as possible yet continue to dispute what is not due and/or deny it is that is appropriate. So, in July of this year, 10 claims where denied.

Division Statistics show the frequency and severity of claims by division. As a reminder, two thirds of their employees are operators of vehicles which account for three quarters of their claims. So they try to focus the majority of their claims management on mitigating claims for operators.

The next slide shows a drilling down of the number of claims for their transportation division which encompasses all of their operators.

Public Comment: None

OPPORTUNITY TO PLACE ITEMS ON FUTURE AGENDAS

Discussion Item: (**Item No. 5)**

Council Comment:

OPPORTUNITY FOR THE PUBLIC TO COMMENT ON ANY MATTERS WITHIN THE COUNCIL'S JURISDICTION

Discussion Item: (**Item No. 6)**

Council Comment: None

NEXT REGULAR MEETING: Meeting date is December 3, 2018

ADJOURNMENT