

*Workers' Compensation
Medical Services Review Committee
Meeting Minutes
September 19, 2014*

I. Call to order

Director Monagle, acting as Chair of the Medical Services Review Committee, called the Committee to order at 9:00 am on Friday, September 19, 2014, in Anchorage, Alaska.

II. Roll call

The following Committee members were present, constituting a quorum:

Dr. Robert Hall	Dr. William Pfeifer	Jane Griffith
Dr. Mary Ann Foland	Pamla Scott	Tammi Lindsey

Director Monagle noted that member Kevin Smith was excused and member Vince Beltrami was absent.

III. Approval of Agenda

A motion to approve the agenda was made by member Scott and seconded by member Hall. The agenda was approved by unanimous vote.

IV. Approval of Minutes

A motion to approve the minutes from the September 5, 2014 meeting was made by member Scott and seconded by member Pfeifer. A correction was noted to the spelling of member Scott's name. The minutes were approved by unanimous vote.

V. Chair's Report

- Director Monagle informed the Committee that he has not been successful in obtaining paid claims data from healthcare insurers, presumably due to the confidential proprietary nature of their data. Unlike Montana's 2011 reform legislation, HB316 does not authorize the Division to collect this data and provide confidentiality. He stated that the Division may take this up with the bill sponsor next session. The committee recommends including self-insureds in enabling legislation, and building a database for ongoing data analysis.
- The Division has been in communication with FairHealth to provide medical provider billing data, and currently has a Request for Interest Parties (RFI) to determine if there are other vendors who can provide this information. If there are more than 3 vendors, the Division will issue a Request for Alternate Procurement (RAP).

VI. Introduction of Optum

- Director Monagle introduced two representatives from Optum, the State's contracted professional services vendor, Carla Gee and Stephanie Brewer. Optum is a healthcare information company. It will be providing expert advice to the Committee, the Workers' Compensation Board, and the Division. The company has assisted several other states in developing RBRVS fee schedules.
- Optum stated they can model data from the Committee's data sources and advise the Committee on conversion factor impacts, i.e. a conversion factor that would be pricing neutral to the existing fee schedule, or conversion factors that would raise or lower the existing fee schedule. The modeling would take into account pricing and frequency, based on transaction counts per medical procedure.
- There was a general discussion on whether the Division would be maintaining a RBRVS database and producing fee schedules or whether that would be left to the private sector. Director Monagle opined that the Committee will determine the conversion factor(s), and the private sector would be using CMS relative values and said conversion factor(s) to program their systems. It is also possible that the private sector will develop fee schedules for purchase by third parties. Optum reminded the Committee that CPT codes are the property of the AMA and therefore subject to copyright licensing. The Committee will also have to consider rules for gap filling on procedures not included by CMS' relative values.
- Member Scott asked if Optum could produce a list of conversion factors being used by other states that use RBRVS methodology.
- Member Pfeifer opined the Committee would benefit from a database that allows members to plug in different conversion factors and review the result set since the Committee is tasked with reviewing conversion factor(s) on an annual basis. Optum informed the Committee that relative values are updated each year. There are quarterly updates, but usually those updates are for coding changes and not relative value changes.

VII. Introduction of NCCI

- Director Monagle introduced two representatives from the National Council on Compensation Insurance (NCCI), Susan Schulte and Raji Chadarevian.
- NCCI collects both billed and paid data from workers' compensation insurers across the country. In 2010, NCCI started collecting medical data. This data is collected from all carriers that write more than 1% of workers' compensation premium written, which in Alaska encompasses 94% of total premium. Self-insured employers are not included in this data. Director Monagle states that Alaska's self-insured employers cover approximately 20% of total employment.
- NCCI produces a medical data report for each state. Alaska's 2014 medical data report is due out next week.

- There was a general discussion on billed charges vs. paid charges, and whether data from an exclusive workers' compensation dataset would look different from a general health billed charge dataset.
- The Committee would like to see service year 2012 and 2013 data at 70th, 80th, and 90th percentile, and procedure codes that cover 2/3 of dollar spend by medical service category.
- Optum says that they would like to see the full dataset for both years for analysis.

Break 10:15am-10:30am

- There was a general discussion on whether the Committee would like to keep hospital outpatient and ambulatory surgical centers (ASC) as separate medical categories, or whether this data should be blended into a single category. Some states have adopted blended fee schedules and others have kept them distinct. HB316 seems to prescribe a single fee schedule for both, but the Committee could adopt separate conversion factors for both.

VIII. Introduction of FairHealth

- Director Monagle introduced Matt Mayfield from FairHealth. The company is a national not-for-profit corporation that collects non-discounted medical bill data from health insurers from all 50 states, representing over 120 million claims. FairHealth produces data modules, which can be customized to meet end user needs. For Alaska, FairHealth can produce data modules for 3 geozips, or aggregate a data module into a single statewide geozip. FairHealth does not collect prescription drug data, and combines outpatient and ASC data into a single data module. The data can be produced at a desired percentile, and can include information on procedure frequency. FairHealth can also produce an allowed charge data module.

Member Pfeifer asked NCCI if they could provide an expanded data set on hospital inpatient. NCCI can do so, recommending blending years for a more comprehensive dataset.

IX. Introduction of Dr. Hamm

- Dr. Hamm is a private chiropractor from Goldsboro, NC. He is the President of the American Chiropractic Association, and is the co-chair of the AMA Specialty Society RVS Update Committee (RUC), and serves on the editorial review board of the *Journal of the Academy of Chiropractic Orthopedics*. Dr. Hamm addressed the MSRC on the RUC process in establishing relative values adopted by CMS.
- The RUC represents the entire medical profession, with 21 of its 31 members appointed by major national medical specialty societies including those recognized by the American Board of Medical Specialties, those with a large percentage of physicians in patient care, and those that account for high percentages of Medicare expenditures.

- There are 3 components that go into the makeup of the Resource Based Relative Value System (RBRVS): Physician Work (51% RBRVS value), Practice Expense (45% RBRVS value), and Professional Liability Insurance (4% RBRVS value). The values established are specialty blind.
- The Physician Work value is broken down into 3 additional components: Pre-service (initial interview, assessment, treatment plan development), Inter-service (professional services/treatment rendered), and Post-service (follow-up care and consultation). The work value is the same across disciplines, i.e. the same for chiropractors, MD's, surgeons, etc. Other factors considered in the work value are the time to perform the service, the technical skills involved, and the mental effort involved.
- The RBRVS process is initiated by the American Medical Association CPT editorial panel, which develops or revises procedure codes. The procedure codes are then reviewed by the various specialty societies, forwarded on to the RUC and its various subcommittees, and finally on to CMS, which can choose to accept or reject the RUC recommendations.
- The RUC is not involved in setting the conversion, geographic practice cost indices (GPCI's), or sustainable growth rate (SGR) factors adopted by CMS.

Dr. Pfeifer asked whether single or multiple conversion factors should be used. Dr. Hamm responded that a single conversion factor is favored, as the differences in practice costs should already be taken into account by the relative values adopted. The scientific methodology used by the RUC, together with the participation by the specialty societies, is intended to produce relative values that accurately and fairly account for a providers work, practice, and insurance costs.

Lunch Break 11:39am-1:28pm

X. Public Comment

Automated Healthcare Solutions appeared telephonically, confirming that the Committee had received public comment material provided by associate Cathy Wilson. Director Monagle acknowledged that the material had been forwarded on to Committee members. In follow-up to Dr. Pfeifer's recommendation, Director Monagle said he would take NCCI's prescription drug list and price those drugs using various benchmarks to see how they compare. Dr. Pfeifer noted that the material provided by Automated Healthcare shows reimbursement in Oregon at AWP less 50%, and recommended following up to see why that state's reimbursement rate was so low compared to the other states. It was noted that Hawaii's fee schedule is AWP x 140%. Regional costs vary significantly

XI. Summary of Data Requirements

Director Monagle summarized the Committee's decision on data requirements:

- NCCI will be asked to provide 2012 and 2013 data at 2/3 of total amount paid by service category. They will be asked to provide the average billed and

average paid amounts, and billed/paid amounts at the 70th, 80th, and 90th percentiles.

- The Division will continue discussions with FairHealth to obtain data on physician bill rates for the State of Alaska, also at the 70th, 80th, and 90th percentile.
- The Division will recommend statutory language similar to Montana, allowing the establishment of a data call from health insurers, and providing data confidentiality.

XII. Closing Remarks

Director Monagle said the Division may not receive data from NCCI and FairHealth before the next scheduled meeting on October 10th. He asked the Committee whether they want to go ahead and meet on the 10th, or meet again on October 24th. The Committee's consensus was to keep the meeting on October 10th. Member Griffith stated she will not be able to attend that meeting.

Dr. Pfeifer suggested the Division contact other states that recently completed the conversion to RBRVS and share their experience with the Committee.

There was a general discussion on whether the Committee will be making recommendations on regulatory language for critical access hospitals.

Member Griffith asked whether a physician employed by a critical access hospital would be subject to the physician fee schedule, or whether their fee would be billed through the inpatient billing. Optum responded they would see how this is being handled in other states. Optum will also confirm whether the conversion factor for acute care inpatient hospitals is the operating base rate (labor and non-labor) and capital base rates. They believe that most states use a single base rate as a conversion factor, but they will confirm.

Member Pfeifer stated he would like to see a presentation on how outpatient and inpatient rates are paid through APC's, OPSS, and IPPS with DRG's. Optum said they can have a resource available at the next meeting to review inpatient, outpatient, and ASC payment formulas.

Member Griffith inquired how reimbursements for the professional and technical components are handled for radiology procedures performed in physician offices and standalone imaging centers. Optum opined that the Committee will need to define how this is to be treated in the rules associated with the fee schedule. The Committee will look to Optum for guidance on drafting these rules. Member Griffith stated the Committee will have to develop the same rules for pathology and lab work done in physician offices and standalone centers, and for independent diagnostic testing facilities. Optum will check to see how these matters are being handled by other states.

Meeting Adjourned 2:30 pm