Special DMAC Meeting Minutes
June 3, 2024
1:00 pm to 2:30 pm via zoom

Call to Order – Heather Jordon, Executive Deputy Director 1:00 pm

Members Present

Annie Jung, NM Medical Society
Erika Campos, Hospital Services Corp.
Dr. William Ritchie, NM Ortho
Dr. Tomas Granados, Zia Neuropsychology
Dan Girlamo, NM Mutual
Lisa Romero, CorVel
Dr. William Brady
Dr. Eva Pacheco
Dr. Barry Ross

Members Absent

Dr. George Simmons, UNM
Ronda Gilleland-Lopez, Mechanical Contractors
Denise Algire, Albertsons
Robert Lilley, Builders Trust

Internal WCA Staff

Heather Jordan, Executive Deputy Director
Charles Cordova, ERPB
Michael Holt, General Counsel
Diana Sandoval-Tapia, PIO

Agency Comments

Heather - This is a Special DMAC meeting to go over RBRVS for preliminary information. We will have our regular meeting in September 2024 to go over Fee Schedule and Billing Instructions for 2025. General Counsel's email will be posted in the comments section for those that have a more detailed comment or questions.

Resource Based Relative Value Scale (RBRVS) Presentation

Charles – This is a preliminary analysis of 2025 RBRVS Fee Schedule ONLY

Foreword

Before we get started, I would like to be clear that all the values I present in this presentation are preliminary, initial calculations only. As you may remember, our RBRVS model is designed to transition from the old methodology to the new methodology in the way that has the smallest expected impact on aggregate physicians' services costs. As a result, we calculate the fee schedule using the old methodology first, and then use our model to calculate the conversion factors that we anticipate will generate payments comparable to those expected under the old fee

schedule. As of the time we calculated the old methodology fee schedule this year, we were still missing data from a couple of the nearby states, so the calculation was incomplete. Additionally, we use utilization data from NCCI in the RBRVS transition model. While we have gotten preliminary data from them, we expect to get the finalized data later in the year.
As a result, there will likely be some changes to the conversion factors used to calculate our preliminary fee schedule before the final conversion factors are released later in the year. That said, I expect that the impact of those changes should be fairly minor compared to the overall impact of switching to the new model. The RVUs themselves won't change before the end of the year, so whatever changes in the conversion factors happen this year will have a relatively smaller impact than the general implementation of RBRVS. My expectation is that this preliminary look at the fee schedule should at least give a good general idea of what the final fee rates will look like.

With that in mind, let's go over this year's model and results.

RBRVS Updates since Last Year
First, I will not be doing an in-depth presentation of the RBRVS methodology or our transition model this year. I did an in-depth 40-minute presentation on those subjects last year. We uploaded that presentation to the Agency's YouTube page, and I would refer you to it if you would like more information on the math behind the conversion factors.
Next, I would like to note that we selected a new Relative Value Unit gap fill vendor this year. According to our analysis, this had a mostly minimal impact on the final fee schedule, with a couple of exceptions. Most notably, CPT codes 99455 and 99456, which are commonly used for impairment ratings, would have been assigned a rate using the new RVUs. Because there was the potential for unintended interactions with an agency rule that governs billing for impairment ratings, we decided to add an exception for these two codes in the Billing Instructions, and they will remain as "by-report" codes in the 2025 Providers' Fee Schedule.

Preliminary 2025 Conversion Factors by Service Category
These are the preliminary conversion factors for 2025. Again, these are not finalized, but just a first look using currently available data. <read the rates>

Estimated Economic Impact of Preliminary 2025 RBRVS Healthcare Providers' Fee Schedule
The Economic Research and Policy Bureau developed an economic impact model that is designed to closely mirror the fee schedule economic impact analyses that are conducted by NCCI each year. Typically, it estimates the impact on physicians' services to within 0.1% accuracy compared to NCCI. That said, once again, our utilization data that the model depends on is preliminary, and the conversion factors themselves are preliminary, so this isn't the final economic impact.
With that in mind, the predicted impact for the preliminary 2025 fee schedule is a 2.4% total increase in physician's services costs. The bubbles on the right show the increase in maximum allowable payments by service category, weighted by utilization. The predicted impact was spread over a range of service families, with the largest increase being in Medicine, while the smallest increase was in Radiology. Each service category increase is then weighted by its share of payments relative to total payments to get the 2.4% increase. Finally, we apply the price

realization of 80%. Price realization refers to the fact that changes in fee schedule rates do not result in a one-for-one change in payments. The amount of the change in the rates that is then reflected in a change in payments is the price realization. Per NCCI, we apply an 80% price realization factor. This tells us that the predicted increase in total physicians' services costs is an increase of 1.9%. If we express that in terms of total medical costs, it represents an increase of 0.9%, and if we express it in terms of overall loss costs, it represents an increase of 0.5%.

Comparison of Estimated Percentage Change in MAPs by Practice Family RBRVS vs. 7 States

Here we show the economic impact by service category from the last slide in purple, and then compare it to the economic impact if we had used the old methodology to calculate the fee schedule in orange. As you can see, the total predicted change in maximum allowable rates by service category is nearly identical between the two methodologies. While this doesn't mean that individual rates in each service family will be the same after switching to RBRVS, it means that we predict total payments by service category to be the same in aggregate. These numbers do not account for price realization, as that is applied later in the economic impact model.

Comparison of Estimated Percentage Change in MAPs by Practice Family RBRVS vs. 7 States

This line graph compares the 2.4% expected increase in maximum allowable payments from our model to the prior fee schedule analyses that were conducted by NCCI each year. As you can see, 2.4% is a slightly higher increase than most recent years, although it is still fairly smaller than the 4.7% 2022 increase.

Rate Competitiveness

A recent study by the RAND Corporation analyzed 2020-2022 medical claims reported by hospitals across the US to document the variation in hospital prices for the commercially insured population. It collected prices paid by private commercial insurers, and then compared the actual amount paid for a variety of services to the amount allowed by Medicare for those same services. According to the RAND data, in New Mexico, private insurance paid 163.3% more than the Medicare allowed amounts for professional services, on average.

In order to make a comparison to workers' compensation rates, I took each of our maximum rates in the preliminary fee schedule, and calculated how much higher they were than Medicare prices. I then weighed each of them for their utilization, and the sum of those was 215.7%.

Please note that this is not a perfect comparison. The rand data takes actual payments made by private insurance and compares them to Medicare maximum allowable rates, while our number takes our maximum rates and compares them to Medicare maximum allowable rates, so it doesn't account for the any reduction in payments from rate negotiations. That said, this shows that are maximum allowable rates are a fair amount higher than what is being paid by private insurance, and much higher than Medicare, which indicates that our rates are competitive in the New Mexico Market.

Also, please note that the RAND figure is for professional services only, and only those reported by either hospitals or ambulatory surgical centers. It doesn't include private practices that didn't contribute data to the study.

CPT Slicer Tool

DMAC Discussion/Comments

Dr. Pacheco – Price cuts are going to cause technicians to be doing nerve studies and not physicians 95907, 95908 and 95909-95913

Charles – These codes are slightly lower. We do not have the power to control rates.

Dan Girlamo – Are you not addressing hospital ratios?

Charles - Both hospital outpatients and inpatient services are separate and will continue to be done the same way.

Ms. Compos – If the total comes out to an increase, but several of these categories are a significant decrease, does that mean that they are low volume?

Charles – In aggregate, the expected payments for each practice family work out to be the same as they would have under the fee schedule. If one code goes down, then another code must go up to offset the decrease in another area.

Dr. Richie – Are you using the full RBRVS to include the 3 geographic cost indexes? Will all the family codes still be between the 60th and 80th percentile?

Charles – Yes to both.

Dr. Ritchie – It looks like you are prioritizing cost to Insurers and not cost for providers.

Charles – Our primary goal at every stage has been cost neutrality. We want our Dr. switch to result in as close as possible to no change in payments.

Dr. Jung, Dr. Pacheco, Dr. Granados – Still needs clarification on 60th and 80th percentile. Is it for conversion only or does it have anything to do with reimbursement? Is it in the statute?

Mike – Quoted the Statute 52-4-5. It is for conversion and not reimbursement.

Dr. Granados – Thinks we have had an uptick in billing disputes and denials from 3rd party payors and have hired more staff to address. He wants data about how many we have seen this year so far.

Dr. Ross, Dr. Granados – Is there a way to show how many providers are available for certain procedures which should affect the reimbursement amount?

Dr. Brady – What new behavior are you expecting changing to RBRVS?

Charles – The purpose of our transition to RBRVS was to figure out a way that we can transition in a way that has the smallest possible impact on payments and to hopefully not be impacted by legislative decisions in other states. Around 30 states utilize RBRVS.

Public Comment

Dana Grey with Desert States PT– would like the CPT slicer tool.

Adjourn – Heather 2:55 pm