Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING
August 15, 2014
Elihu M. Harris State Building
Oakland, California

In Attendance

2014 Acting Chair, Christy Bouma
Commissioners Daniel Bagan, Doug Bloch, Martin Brady and Shelley Kessler

Absent

Commissioners Sean McNally, Kristen Schwenkmeyer and Angie Wei

Welcome to New Commissioners

Acting Chair Christy Bouma introduced and welcomed new Commissioners Daniel Bagan and Shelley Kessler.

Commission Meeting Procedures

Acting Chair Bouma suggested that audience members review the Rules of Conduct if they intend to make comments to the Commission and that they fill out the form that needs to be submitted which indicates the issues that will be addressed. Acting Chair Bouma stated that remarks by audience members will be limited to two minutes in order to hear from all of those in the audience who wish to address the Commission.

Approval of Minutes from the December 13, 2013 CHSWC Meeting

CHSWC Vote

Commissioner Brady moved to approve the Minutes of the December 13, 2013 meeting, and Commissioner Bloch seconded. The motion passed unanimously

Approval of Minutes from the March 6, 2014 CHSWC Meeting

CHSWC Vote

Commissioner Bloch moved to approve the Minutes of the March 6, 2014 meeting, and Commissioner Bagan seconded. The motion passed unanimously

Report on Department of Industrial Relations

Christine Baker, Director, Department of Industrial Relations
Destie Overpeck, Acting Administrative Director, Division of Workers' Compensation
Dr. Rupali Das, Executive Medical Director, Division of Workers' Compensation

Comments by the Director

Christine Baker stated that prevention is the motto across the Department of Industrial Relations (DIR) as work continues on preventing bad medicine and bad medical care and, in occupational safety and health (OSHA), on reducing injures and assisting in preventing serious accidents.

Director Baker stated that fatalities are down in California. Since Juliann Sum took over the OSHA division, she has been working overtime and the division is transforming and modernizing in order to serve the public by clear enforcement which is conscientious, respectable and accountable. Increased funding has been obtained to fill 27 previously unfunded positions in the Division and authorization has been given to fund 15 new positions in the Process Safety Management (PSM) Unit. The 2014-15 budget adds approximately 5.7 million new dollars for continuing to fill vacancies.

Director Baker stated that a DOSH senior safety engineer and a DOSH attorney have been assigned to oversee and edit new educational materials in the continuing effort to get the word out to employers and workers about what constitutes a safe workplace. The department is reconfiguring staff to better coordinate the work of the DOSH Medical Unit, the DOS Research & Standards Unit, and the Hazard Evaluation System and Information Service (HESIS). In addition, the department is reviewing workload, and updating policies, communications, and productivity measures and organization structure. Director Baker stated that the Division has many responsibilities, from permitting elevators to inspecting rides and amusement parks. Computers are being replaced and training is taking place. The movement is toward a tablet environment so that inspectors can take photographs during inspections.

Director Baker stated that as a result of reengineering, a number of public service improvements have been achieved in the Department. In the Division of Workers' Compensation (DWC), the reorganization of lien filing has been recognized with national awards. In addition, qualified medical Examiner (QME) panels will be on line to parties by the beginning of next year, and the backlog has been eliminated. Director Baker also stated that budgetary problems in DOSH and DLSE were addressed. In a number of areas, there were positions authorized but no funding attached. This is like having a checkbook with no money in the bank and lots of bills. This situation has been corrected in the current budget year by moving employer user fees off of the OSH fund and assessing the refineries directly for a stronger regulatory and compliance effort. Director Baker stated that the department is carrying out the recommendations of the Governor's Refinery Task Force. This is unique in the country, as no other state has done this. Both DIR and DOSH participated together with a number of other agencies including the Cal Environmental Protection Agency (Cal EPA) which leads the ongoing efforts. DIR and DOSH are coordinating and redrafting regulations in order to strengthen and have consistency between refineries and agencies.

Director Baker stated that this July fiscal year, a fee was established to fund Public Workers enforcement. The budget language implementing this provision was signed, and the function was up on the DIR website within weeks. Contractors can now pay their fees online. This takes the pressure off the labor enforcement assessments. This online payment system is for contractors that do public workers only. Non-construction user funding will not be paying for this.

Director Baker stated that in workers' compensation, the largest cost-driver was and still is within the category of medical treatment, and this is where the reform focused. Changes in the management of medical treatment, such as the advent of independent medical review (IMR), and significant changes in the resolution of secondary claims of medical service providers, such as the requirement of filing fees for liens, were intended to make the system more efficient. However, second and third parties were selling liens off, and the courts were being used for settling liens rather than addressing the issues of injured workers. There are still people and organizations that have thrived on the inefficiencies and dysfunction of the system, and now there are people and organizations fighting the changes to the system.

Director Baker stated that there is always room for improvement, and DIR looks to labor and management to assess what the trade-offs are, while labor and management are asking if the reforms delivered the expected improvements. It is really too early to evaluate the impact of the reforms, but highlights of the promising results include:

- Although Senate Bill (SB 863) successfully trimmed 3 percentage points off the rate increase, employers still had to endure an increase of more than 10% in their workers' compensation costs. California has one of the highest costs in the country. Insurance prices had already begun to rise in 2012. After SB 863 was passed, DIR adopted a minimum pure premium rate for January 1, 2013, which was up 11.3% from the rate one year earlier. If SB 863 had not been enacted, indications are that the increase would have been 14.3%.

- Looking at the big picture, medical expenses appear to be under better control. The average amount of paid Ambulatory Surgery Center (ASC) fees in the first six months is 26% lower than the year before. The projection was 25%, so the results were better than the target.

- The average amount paid per episode of spinal surgery involving implantable hardware declined by 56% after the double payment was repealed. That was fraud. The savings from this change will be huge due to the elimination of the incentive to perform these life-threatening procedures without the medical evidence to justify them. The fee currently allowed is sufficiently profitable to assure that treatments will be available to patients who need them but not so profitable as to promote unnecessary surgery. DIR has heard from some patients who were at district offices who have had many surgeries with no positive results. Medical treatment guidelines that are evidence-based are being developed.

- There is promise in the Resource-Based Relative Value Scale (RBRVS) to reduce inappropriate economic incentives and provide a more predictable schedule. An access study is being conducted to ensure that there is not an access problem.

- In the IMR system, nearly half of the applications are for denial of opioids and pharmaceuticals and non-FDA-approved products. Deaths do occur, and delivery of medical treatment has to be more responsible. Pharmaceuticals account for one-fourth of IMRs on injures that occurred in 2013, but two-thirds of IMRs are on injuries that occurred in 2001. This is a pattern across the country. Some claims administrators need to step back and provide approvals where possible so that claims do not go through utilization review (UR) and create unnecessary costs and unnecessary delays of treatment.

- There are still several regulations that need completion; they are being implemented later because of the need to conduct studies to establish the fee schedule. These new fee schedules should help eliminate some of the fraud in the system. DIR teams are doing investigations with district attorneys to pursue fraud issues.

- Lien filings have been reduced by half. The activation fee for old liens has been temporarily enjoyed the U.S. District Court in the case of *Angelotti Chiropractic vs. Baker*. Further trial-level proceedings are stayed while an appeal to the Ninth Circuit is pending. Meanwhile, filing fees are still being received. Besides unclogging the system and the courts and removing the environment conducive to fraud and abuse, the lien filing fee is saving California employers and insurers 270 million dollars per year in litigation costs and untold dollars in nuisance-settlement costs.

- Despite the successes of SB 863, it could not entirely prevent the inevitable rise in premium. Benefits were increased by 30%, but the rise in premium was driven by long-term cost trends that had not been reflected in market prices. Insurance prices had begun to rise in 2012, and after SB 863, the Department of Insurance (DOI) did increase the premium. If SB 863 has not been enacted, the indications are that the increase would have been 14.3%.

- There has been a shift in the decision-making away from the courts, which results in high litigation costs, to physicians who are delivering evidence-based medicine.

Director Baker stated that she wanted to commend and thank the community working with the department, and she stated that she wanted to recognize the DIR team of top-notch professional staff which is dedicated and committed to delivery of a workers' compensation system that is good for workers and cost-efficient for employers.

Report on the Division of Workers' Compensation Regulations

Destie Overpeck, Acting Administrative Director, stated that she would provide an update of Division of Workers' Compensation (DWC) regulations, including:

- At least ten sets of cost-saving regulations have been enacted, and additional regulations are in process. Some recent findings relating to the Senate Bill (SB) 863 completed regulations include:
    - SB 863 reduced Ambulatory Surgery Center (ASC) regulations which went into effect immediately, and facility fees were reduced from 120% to 80% of Medicare's hospital outpatient fee schedule. The Workers' Compensation Insurance Rating Bureau (WCRIB) reported that the average amount paid per ASC episode in the first six months after the change in fee schedules was 26% lower than in the year before the change took effect.
    - SB 863 amended the inpatient fee schedule by repealing the separate and duplicate reimbursement for spinal hardware. The average amount paid per episode of the spinal surgery involving implantable hardware declined by 56% after the separate reimbursement (duplicate payment) for spinal hardware was repealed.
    - SB 863 reduced lien filing by half the number of new liens being filed. Besides saving system costs, this also allows more time for injured workers cases to be heard.

Changes since the last Commission meeting in March 2014:

- **Predesignation/cap on chiropractic visits for primary treating physician (PTP) –** Approved 2/12/14. Final regulations now in effect as of July 1, 2014. New optional predesignation form and notice of personal chiropractor or acupuncturist form; chiropractor as primary treating physician (PTP) - cap of 24 visits.

In Process:

- **Outpatient Fee Schedule** – Public Hearing March 11, 2014 – to coordinate the outpatient fee schedule with the new Resource-Based Relative Value Scale (RBRVS) physician fee schedule (primarily the facility fees for diagnostic tests and clinical visits, which constitute 7% of the total outpatient services in workers' compensation). Filed with the Office of Administrative Law (OAL) on June 3 and effective date of September 1, 2014.

- **Medical Provider Network (MPN) –** Filed with OAL on July 15, 2015. Final approval pending with OAL and should be approved by August 26. Effective date was requested upon filing with secretary of state. It is up to AOL to grant that or make the effective date October 1, 2014. These regulations implement and provide details regarding the SB 863 statutory changes to MPNs. The SB 863 improvements include: allowing an "entity that provides physician network services" to establish MPNs; DWC will approve plans for four years instead of a limited amount of time; geocoding to ensure access is appropriate; posting full provider list online and updating it quarterly; allowing doctors to affirmatively elect to be in MPNs; providing medical access assistants to help find

doctors for injured workers and help them get appointments; and providing an option for DWC to investigate and assess penalties.

- **Copy Services Fee Schedule** – Public hearing on July 1, 2014. Expect to issue revised regulations for 15-day comment period soon. The schedule will reduce friction over payment amount and reduce lien filing because providers will now be able to use the Independent Bill Review (IBR) process.

- **Medical Treatment Utilization Schedule (MTUS)** – (1) hierarchy of evidence had a public hearing on July 1, 2014, and a 15-day revision should be issued today; (2) opioid guidelines posted on DWC forum April 14 – 24, 2014, for pre-rulemaking comments; (3) chronic pain guidelines will be updated and posted on DWC forum. After those dates, the formal rulemaking process for opioid guidelines and the chronic pain guidelines will begin.

- **Workers' Compensation Information System (WCIS) medical bill reporting** – Public hearing on July 14, 2014, with regard to updating medical bill reporting.

- **WCIS penalties** – Posted on DWC forum April 16, 2014; will begin formal rulemaking next.

- **Benefit Notice regulations –** Public hearing scheduled for September 3, 2014.

- **ICD-10 Codes in billing guides for e-billing and medical billing –** Issued notice of rulemaking on July 25, 2014. Ensure that guidelines conform to Medicare billing.

- **Qualified Medical Evaluation (QME) on-line panel request for initial panels in represented cases** – Draft regulations should be on DWC forum within one month. On-line request process will make it easier for the public to efficiently and more quickly get a panel, and it will reduce the workload for the DWC Medical Unit.

Still to do:

- **Interpreter Fee Schedule –** conducting study.

- **Home Health Care Fee Schedule –** conducting study.

- **Audit regulations –** to be updated in the near future.

Update on DWC Medical Unit

Dr. Rupali Das, Executive Medical Director, stated that she would provide an update on Independent Medical Review (IMR) and Independent Bill Review (IBR). In IMR, when medical treatment is denied, delayed or modified, an injured worker or representative can file an

application for IMR with the Independent Medical Review Organization (IMRO), currently Maximus. Maximus then conducts a preliminary review, and the IMR decision is routed to DWC for analysis if eligibility is question. DWC will issue a determination for ineligibility or denial or further review. For those requests that are eligible, medical records are requested from the claims examiner; the physician and the injured worker may submit records as well. Once the medical records are received, the case is assigned to a Maximus physician reviewer, and the final determination letter (FDL) is issued and sent to the injured worker.

Dr. Das stated that applications rose in July 2014 when the IMR process became available for all dates of injury (prior to that, it was only available to new injuries in 2013), and it looked like there was a second spike in April; however, that spike does not truly represent a rise in applications. For April, June and July of 2014, it is actually that only about 55% of the applications are eligible and go through the IMR process; 20% closed because they are duplicates, and an additional 25% are found to be ineligible. Due to the huge volume in applications, which was greater than anticipated, a number of fixes were implemented, which resulted in reduced costs, more reviewers, and an increase in the number of Final Determination Letters issued.

Dr. Das stated that there have been cost reductions. Since a significant reduction was negotiated, the cost is now $420 (instead of $560) for a standard review for non-pharmacy, $390 for standard pharmacy request, and $515 (instead of $685) for an expedited review. This should be a significant benefit to the system.

Dr. Das stated that in response to the increased number of requests, Maximus has tripled the number of physician reviewers since March of 2014, and this has resulted in a greater number of Final Determination Letters being issued. There were over 200 physician reviewers in March 2014, and there are now over 700 physician reviewers. In January, Maximus was issuing about 5,000 Final Determination Letters per month, and now in July, it is issuing around 15,000 Final Determination Letters per month. This is a huge improvement, and this trend is expected to continue; it is expected that the backlog should be eliminated by the end of the next few months; after that, issuing of Final Determination Letters should keep up with the huge volume of applications coming in.

Dr. Das stated that Maximus has access to reviewers in a wide range of specialties. About 41% or the majority of reviewers have occupational medicine specialty, and about 20% have physical medicine and rehabilitation specialty. These specialties are followed by pain management and orthopedic surgery and then internal medicine, acupuncture, spine surgery, family practice, chiropractic and psychology. Most of the previewers are California-licensed. Currently, about 60% of IMR physician reviewers are California-licensed; about 40% are non-California-licensed. It is preferred that specialists making decisions have California licenses; however, Maximus needs non-California-licensed reviewers to handle the huge number of applications coming in so that injured workers can get appropriate care.

Dr. Das stated that not all the data are available and tabulated for 2014. In 2013, 16% of the UR decisions were overturned by IMR, and 84% were upheld by IMR. This relates to individual treatment decisions, not requests, as requests can have more than one treatment request. As

Director Baker discussed, the majority of applications are pharmaceuticals, 45%, with the remaining 55% spread over a number of different types of treatment. Within pharmaceutical requests, narcotics are the most common class of drugs requested, and they have the highest overturn rate. Muscle relaxants are the second most requested, followed by non-steroidal anti-inflammatory agents (NSAIDS), compounded medications, and proton pump inhibitors. Within all pharmaceutical requests, steroid injections overall are the most frequent request. For non-pharmaceutical requests, request for durable medical equipment is the most common form of non-surgical request, followed by physical therapy, diagnostic tests and surgery. Surgical requests usually include a surgical assistant and pre-op and post-operative care. If a denial for surgery is upheld, then everything that goes along with the surgery is not granted. This inflates the number of denials. Dr. Das stated that within the category of surgery, spine surgery is the most common type of surgical request, followed by knee, shoulder, and upper extremities.

Dr. Das stated that an annual report for 2013 with much more detail will be issued soon. Regarding the year of injury, over half of the IMRs requested are for injuries that occurred in after 2010. Pharmaceutical requests do not have a clear pattern over time; non-pharmaceutical requests are much less frequent for injuries that occurred earlier than 2008. Dr. Das stated that a report on the website shows the percentage of pharmaceutical requests being higher for older injuries.

Dr. Das stated that IBR has also seen cost reductions. In 2013, a completed IBR decision was $335, and it is currently $250; in 2013, a terminated (prior to a decision being issued) IBR application was $65, and it is currently $50. The winning party bears the cost, but the physician has to pay an initial cost. IBR requests have stayed steady. The volume is far lower than the IMR volume. Most (about 60%) IBR determinations are being decided in favor of the person filing the request, the physician. Service types in IBR include: physician services, with evaluations being the number one service requested; hospital outpatient departments and Ambulatory Surgical Centers (ASCs); Medical-Legal Fee Schedule disputes; inpatient hospital services.

Dr. Das stated that actions ahead include: 2013 Annual Reports on IMR and IBR; updates to the Medical Treatment Utilization Schedule (MTUS), in relation to the hierarchy of strength of evidence that lays the framework for the MTUS and how a decision can be made when the MTUS does not cover an area, opioid use guidelines, and education for providers and others so that they are aware of the MTUS and how to apply it and how to find the best evidence available if covered by the MTUS; revision of the Physicians' Guide to Workers' Compensation, which has not been updated in about 20 years; and improved QME quality assurance, focusing on board certification of required qualifications as specified in the statute.

Dr. Das stated that in conclusion, she would like to thank DWC staff involved in the updating and analysis of the data.

Comments from Commissioners

Commissioner Bloch stated that as a union primarily representing truck drivers, back injuries are very common among members, so he is happy to hear that work is being done on chronic pain and opioid use. He stated that at the same time, the large number of denials of steroid injections

makes him nervous. He asked if it is known what percentage of UR denials are going to IMR. Dr. Das responded that they have to rely on other data and that data show that 95% of treatment requests are going through and not being denied. Commissioner Bloch stated that he was happy to hear about the steps taken to deal with the backlog and the increased number of determinations and the tripling of physician reviewers, but he wonders whether the steps are dealing with the effects of the changes, and he asked why there is a huge number of applications and whether that is due to the 5% of applications not being denied. Dr. Das stated that the first spike was due to opening up IMR to all dates of injuries, and that spike reflects reality more closely; the second spike was not really a spike, as she previously explained, as the actual number of non-duplicate applications is not reflected. Commissioner Bloch stated that this is a worthy area to investigate going forward.

Commissioner Brady stated that a lot data were presented, and he thanked Dr. Das and DWC staff. He asked if Dr. Das thought that the upward trend in the number of UR decisions upheld would continue. Dr. Das responded that there is no basis to make a prediction about that, but that in other programs, the percentage of denials changes over time because there has been a learning curve about the need to provide documentation and an understanding about what type of documentation to provide. She stated that she also thought that posting decisions online could possibly indicate how to present the cases more appropriately. Commissioner Brady stated that decisions based on evidence-based medicine are being given to injured workers. Dr. Das stated that in terms of the question by Commissioner Bloch about steroid injections, the majority of UR denials are upheld, but that that was not necessarily negative, as a denial might be best for an injured worker over time.

Commissioner Bagan stated that he understood that IBR would take liens out of the system, yet the volume in IBR seems low, and he asked whether there are some factors inhibiting presentation of IBR claims. Dr. Das responded that the number is lower than anticipated, but the ones being filed are justified, and liens could be filed regardless of the actual value of the case. The majority of IBR decisions are in favor of the provider. The costs of filing per provider are small. Since it is a new system, providers may not feel they know what the outcome of filing would be and whether it is cost-effective to file, so they are hesitating to file.

Director Baker stated that there were no fee schedules before and people could bill any amount, but now there are fee schedules available to determine reasonable fees. Commissioner Bagan stated that it was anticipated that there would be a learning curve for physicians, and as they learned to follow treatment guidelines, there would be less IMR applications coming into the system. He wondered if there would be greater education efforts to try to improve adherence to evidence-based guidelines. Dr. Das responded that as MTUS updates are rolled out, there will be increased outreach to providers. This effort will have to be a joint effort with others in the state in order to reach all providers in the state.

Commissioner Kessler stated that she would like clarification about the percentages of the types of reviews by different doctors, and she mentioned that the data showed 2% of reviews for spinal surgery and she wondered what all the issues are around spinal surgery. Dr. Das responded that there are not many requests coming in for spinal implants. Director Baker spoke about a provision in the statute eliminated double payments for spinal implants. The IMR requests for

spinal surgery are not as common as pharmaceutical requests. Spine surgeons are a small percentage of IMR physician reviewers, though they are in the top 10. An orthopedic surgeon can give a qualified opinion on a request for spine surgery. Commissioner Kessler then asked if a copy of the slides would be available. Dr. Das stated that as mentioned, an Annual Report will be available soon. Commissioner Kessler asked if there is an incentive to get certified – or an incentive not to get certified – that might be influencing the number of California-licensed physician reviewers. Dr. Das responded that the main goal is get decisions which follow appropriate guidelines out to injured workers in a timely manner. The priority is for California-licenses reviewers, but non-California reviewers can make qualified decisions as well. Dr. Das stated that the main objective is to get qualified reviewers. In the near future, the backlog will be reduced so much that there may be much less need for non-California-licensed physician reviewers. At this time, it is an advantage that Maximum has access to non-California-licensed reviewers across the country.

Acting Chair Bouma stated that there has been quite a change in the IMR process and she thanked Dr. Das for presenting regularly to the Commission about issues involved and the data available. She asked if there is an opportunity for the Division to find data from other sources on injured workers before they end up in the IMR process. Dr. Das responded that this issue will be addressed by other presenters at this meeting.

Commissioner Bloch stated that the DIR administration has had a great number of challenges and has accomplished a lot. He stated that he would like to have a quick report on the efforts by the Labor Enforcement Task Force (LETF) to combat the underground community, and Director Baker responded that there had been a major meeting the day before with all agencies across the state to focus on the underground economy and human trafficking. She stated that there is a multi-member task force using data and analytics to identify and target employers paying under the table and perpetrating premium fraud by misclassification as well as wage theft across the state. The Governor has a tax recovery program with the Bureau of Equalization. In addition, there are efforts to identify criminal activity. She stated that there will be results and she would like to bring to the next meeting a report on LETF efforts with the construction industry and other industries.

Acting Chair Bouma stated that DIR is a behemoth of an institution so it takes strong leadership to adjust priorities of the organization to make the organization effective, and she thanked Director Baker for her efforts and accomplishments.

Update on RAND Studies: Disability Evaluation and Medical Treatment; Evaluation of Senate Bill 863; Ambulatory Surgery Center; Home Health Care Fee Schedule
Barbara Wynn, RAND
Andrew Mulcahy, RAND

Barbara Wynn stated that she has worked on studies for the Commission over the past years, and she introduced her colleague, Andrew Mulcahy. Ms. Wynn stated that she and Mr. Mulcahy would discuss four studies for the Commission: the Disability Evaluation and Medical Treatment Study that has been in progress for several years; the Evaluation of Senate Bill (SB) 863 Medical

Care Reforms Study; the Ambulatory Surgery Center (ASC) Study; and the Home Healthcare Fee Schedule Study.

Disability Evaluation and Medical Treatment Study
Ms. Wynn stated that she was leading only the medical side of the Disability Evaluation and Medical Treatment Study. There were several major focus areas; the first is determining the factors that accounted for changes in workers' compensation medical spending over time. The research reviewed the trends attributable to inflation versus changes in occupational medicine. The second focus area is establishing a framework for monitoring system performance: looking at trends and changes in cost utilization, administrative burden, and most importantly, access and outcomes, including work-related outcomes. Using that, Ms. Wynn stated that they looked at the specific procedures and trends. The study also focused on prescription drug trends and fee schedule issues. Ms. Wynn stated that there were two examples the study looked at which were the prevalence of discounting where there are contracts between provider and payor and a comparison of the payment amounts that are under the new physician fee schedule with group health payment levels. Ms. Wynn stated that in addition to the studies, they have also provided technical assistance on an as-needed basis.

Mr. Andrew Mulcahy stated that preliminary findings from the Disability Evaluation and Medical Treatment Study were from a range of different analyses, and the preliminary results were in three of the four areas that Ms. Wynn had mentioned. He stated that the study focused the trends in California workers' compensation medical spending and how some of the observable drivers of the medical spending like injury and industry mix might explain those trends. The remaining reasons that are not attributable to these observable trends are likely to be changes in utilization or intensities in care. Mr. Mulcahy stated that the study compared the year-to-year spending trend in California medical spending from 1988 to 2010 to two comparative trends which are the year-on-year change in U.S. personal healthcare spending from Centers for Medicare and Medicaid Services (CMS) national expenditure data and the U.S. workers' compensation medical spending (also from CMS). The conclusion is that the year-over-year change in California workers' compensation is highly volatile in comparison to those other comparison trends. The volatility is partly explained by the events that happen along the timeline. One important point from reviewing these trends is that there is a slow single-digit gradual increase in spending in the two comparison trends.

Mr. Mulcahy stated that they also reviewed other changes in California over this time period which might explain part of the changes in year-over-year spending. The analysis in the study was from 2005 to 2010, but for this presentation, the change from 2007 to 2008 would be discussed. In that one-year period from 2007 to 2008, there is a 9.7% increase in medical spending overall. The expected change in medical spending due to measurable factors would result in changes in prices in the California workers' compensation specific price index and that would result in a 1.8% increase in spending. If the change in medical spending included changes in the injury mix and industry mix, the overall employment level, which were flat during that two-year period, and the claim rate, the expected change in medical spending, in the aggregate, would amount to about a 10%decrease in medical spending. Instead of the decrease, Mr. Mulcahy stated that there was a 9.7% increase in medical spending. The study focuses on the cause of the 19.6% total change which is driven by utilization and intensity rather than any of the

other drivers of medical spending. The key takeaway from this analysis is that there is change in utilization rates of services and the intensity of services that are driving the change in medical spending in the California workers' compensation system.

Mr. Mulcahy stated the next part of the medical treatment study focused on monitoring. On a few different dimensions, the different outcomes that are important are utilization spending, quality, and access measures, and for these analyses, there are a large set of tables in the final report. The measures include access, utilization spending, quality, and a set of work-related outcomes that are in development. The study reports trends separately by type of healthcare service, by geography, by injury type, and by payor. The study had also intended to look at measures by Medical Provider Networks (MPNs) versus no MPNs, but due to the difficulties in the Workers' Compensation Information System (WCIS) data, it was not as easy as anticipated. He stated that RAND is still looking into this issue but does not have results at this time. A few examples of the trends show expenditures over time for a selected set of non-facility healthcare service categories. There are differences in trends, but all of them are generally increases. There are increases in laboratories and technology, increases on a small basis for prescription drugs, and increases for Evaluation and Management (E&M).

Mr. Mulcahy stated that they are dissecting some of the monitoring tables in the study by geography and are noting some key differences across different parts of California. There are also differences in volume of E&M services over the 2007 to the 2010 period. The different regions of California have different base line levels and different trends, and different trends for E&M services as well other service categories can be seen in this report. The report will be tracking quality and access over time and will select the quality measures that use the claims data to code up quality measures to get the accurate numerator and denominator and record these measures over time. There were slight changes in the select set of four quality measures for different injury types including lower back chronic pain and select other injuries. Mr. Mulcahy stated that another component of the study is a more detailed review of trends for specific types of health care services, and one of those is prescription drugs trends. Some of the key descriptive findings of this report are that most claims involve just a handful of prescriptions, modest spending, and a small number of providers. The statistics in the report are for the injuries in 2010 and reflect the first 12 months of experience after injury. Along all of these different dimensions, for the median case, there are three prescriptions in two different therapeutic classes, prescribed by one single prescriber which are all billed on a single day and result in $60 in expenditures. This is a modest expenditure. As is often the case in these healthcare statistics, if one looks at these distributions, one gets larger expenditures. The top 1% of the claims received 43 prescriptions in 8 different therapeutic classes written by five different prescribers in five different bill dates resulting in over $3,000 in prescription drug spending. Utilization and spending varied across different injury types. Differences exist between lower back chronic pain and other injury categories. The median is much lower because a small number of claims are very high in utilization and spending.

Mr. Mulcahy stated that the study reviewed utilization and spending on opioids in particular. Opioids are a commonly prescribed class of drugs. Almost a third of the claims in 2010 have at least one opioid prescription within the first year after injury. Of those, about 10% of the claims have prescriptions from more than one opioid active ingredient prescribed in the first year. Over

half of injured workers received an opioid prescription drug within two weeks of injury. Hydrocodone and Apac (acetaminophen brand name Vicodin) are the commonly most prescribed opioids by far. Oxycodone, the extended release form of Oxycontin, is rarely prescribed; about 6% of opioid claims include oxycodone either as primary ingredient or in combination with other ingredients. The mean and median prices for opioid drugs are $90 and $23, respectively, which is inexpensive and reflects that Hydrocodone is available as a low-cost generic drug. Mr. Mulcahy stated that the study finds a broad prescriber base for opioids. Nearly half the prescribing physicians in the data wrote at least one opioid prescription. On average, opioid prescribers wrote 1.4 prescriptions per claim per year; however, there are outliers where the top 5% of prescribers wrote more than 4.5 prescriptions per claim per year, and the top 1% of prescribers wrote 9.3 prescriptions per claim per year.

Mr. Mulcahy stated that the study has been developing approaches to report on differences across therapeutic classes. Opioids are the most important class, and another important class is muscle relaxants. He stated that it is important to keep the focus on some other therapeutic classes. Data show that the number of prescriptions per claim by opioid analgesics and one-third of the claims; on average, there are about three opioids per prescription in the first year. The other pain medications are more commonly prescribed but have fewer prescriptions per claim per year. Anti-depressants are another type of drug; they are prescribed very seldom, but when they are prescribed, they are prescribed very often.

Evaluation of SB 863 Medical Provisions

Ms. Wynn stated that the new RAND study is an evaluation of the SB 863 medical provisions. The key topic areas of the study are: the medical necessity dispute resolutions process (not just IMR but also changes in the expedited hearings, lien filings, agreed medical evaluator (AME) and qualified medical evaluator (QME) exams), implementation of the new physician fee schedule; and other Official Medical Fee Schedule (OMFS) changes, including the changes in the spinal implant and the reduction in the payment levels to the independent ASCs. The study will also examine the independent bill review process (IBR) and the MPN operational and oversight changes. It is anticipated to be a two-year project, but some of the data may cause the study to be extended to have a more robust analysis. The interim report is due next spring, and it could be used to identify areas that are potentially problematic with unintended consequences. The final report is currently due in the spring of 2016. The separate but related tasks are to look at workers' compensation required reports and the Medical Legal Fee Schedule.

Ms. Wynn stated she plans to look at each of the most important medical provisions separately and do an overall consolidated impact analysis for all provisions because they are so intertwined. She stated that she is not sure what will be teased out or what is attributable to what provision, but what is important is the overall impact of the medical provisions. The specific analytic approach used for individual provisions will vary based on the research questions, when the implementation date was, and the date of availability. The general study approach is to conduct semi-structured interviews with representatives from various stakeholder groups, rely on the WCIS data from 2011-2014 to look at pre-post short term implementation trends, and then supplement these data with other relevant administrative data. Division of Workers' Compensation (DWC) staff and Commission on Health and Safety and Workers' Compensation (CHSWC) staff have helped to identify data that might be available and will continue to help

with the administrative and confidentiality agreement processes to obtain that data. The study will take advantage of other analysis as they become available.

Ms. Wynn stated that the research on the evaluation of the SB 863 is underway and includes a preliminary research design. Yesterday, the study benefitted from input from a technical advisory group that helped with understanding what the intended consequences were in each provision and then what the perceived immediate consequences were. However, within the required time-frame, Ms. Wynn stated that the study will not be able to produce longer-term outcomes on worker health and work-related issues because they take a while to develop. The research questions build on the monitoring system that Mr. Mulcahy presented. The overarching research questions are: what the impact is on worker access to timely and appropriate medical care; and what the impact has been on administrative burden in medical cost containment. The study will be examining topic-specific trends with regards to the following: IMR and IBR and expedited hearings; the volume of those and the timeliness of their resolution; and the types of issues in dispute and how they are resolved. Dr. Das is also researching IMR, but Ms. Wynn will look at IMR through a different lens. For the Resource-Based Relative Value Scale (RBRVS), the study will monitor provider participation rates, payment across service categories, and specialties for select procedures. The study will also analyze utilization rates, and for MPNs, the study will examine out of network care. Both the intended and unintended consequences of the provisions will be considered. The analysis of IMR will focus on learning how many of those decisions where there is a pattern for a particular treatment modality end up changing provider behavior or utilization review (UR) decisions so there is learning that is taking place and a greater adherence to the treatment guidelines on both sides. On the unintended sides, the study will assess whether there are RBRVS implementation issues that need to be addressed through policy changes or whether there are transitional issues that will work themselves out.

ASC Study

Ms. Wynn stated that the third study which is on ASCs has been completed for DIR. It had both CHSWC and DIR staff support. The issue was whether the OMFS should include the ASC facilities for surgeries that are typically performed on an in-patient basis rather than on an ambulatory basis. This was a question that was asked during development of SB 863 that required the director of DIR to submit to the legislature a report on this topic. The currentOMFS policy is that ASC facility fees are based on the Medicare fee schedule for hospital outpatient services, and Medicare has designated a classic procedure that it calls in-patient-only procedures that it has determined for its Medicare-only population which can only performed in an in-patient setting. Recognizing that the worker's compensation population is different, particularly that it is younger, the question is whether some procedures could be done safely in an ambulatory setting. Because Medicare has no facility fee for those in-patient-only services, the OMFS has no facility fee for those services at the present time. However, it does not mean that these services cannot be furnished in an ambulatory setting. The OMFS rules allow the payor to authorize payment at an agreed-upon rate when the payor determines that it is medically appropriate, so it is really a case-by-case determination at this time. The question that the study was asked to examine was whether the OMFS should be expanded to include these patient-only procedures and if so, what would be an appropriate rate for these procedures. If it is safe and appropriate to furnish the procedures in an ambulatory setting, then that has benefits both for the payor, as it should cost less, and for the worker, should provide more convenience.

Ms. Wynn stated that this study focused on 23 procedures that were high-volume in-patient-only procedures for the workers' compensation population, which had very short in-patient lengths of stay. Literature review and data analyses were done to assess the appropriateness. Ms. Wynn stated that there was no indication of strong support for adding any of those procedures to the ASC fee schedule with the possible exception of surgical spinal fusions where there are two levels involved. Currently, there is a single-level cervical spinal fusion that can be done on an ambulatory basis but not multi-level spinal fusion. When instrumentation is involved, Medicare designates them as in-patient-only, but Ms. Wynn stated that the study did find evidence that these procedures are being done on an ambulatory basis for a working-age population. One of the drawbacks is that the literature does not really provide any evidence-based selection criteria, so that up-front, it can be determined whether the patient is a good candidate for ambulatory surgery verses in-patient surgery. Because of the variety of procedures and relationships to the Medicare fee schedule, there are no data readily available to establish an appropriate fee schedule amount if it were to be done in an ambulatory surgery setting. Just an across-the-board reduction in the in-patient rate would not be appropriate because there is a very different length of stay for the average in-patient service versus the candidates for out-patient surgery.

Ms. Wynn stated her recommendations were to retain the current policy that allows for case-by-case determination for both the medical necessity procedure and the setting in which it occurs, and it contains a prior agreement on a reasonable fee amount which can be done on a case-by-case basis rather than through the OMFS and because of the prior agreement that should keep it out of the lien system. Ms. Wynn also identified some concerns including patient protections should be strengthened when ambulatory surgery is performed. In particular, the ASC should have prospective patient-selection criteria so the candidates are appropriate for ambulatory surgery. There should also be informed consent procedures so that the patient is advised that this procedure is done on an in-patient basis. Therefore, the patient will know in advance that he/she is a good candidate for this type of surgery and that most often the surgery is done in a different setting.

Home Health Care Fee Schedule

Ms. Wynn stated that the final study they were presenting on was the Home Health Care Fee Schedule which is undergoing final review with internal and external reviewers. Ms. Wynn stated that DIR asked RAND to examine options for the Home Health Care Fee Schedule that is required by SB 863, and that fee schedule needs to address the full spectrum of home health services. Those can involve skilled nursing and therapy services that are provided by home health agencies or other home care providers; when patients are home-bound, services can include personal care services that require training for home health aides who are employed by home health agencies. However, it can also include unskilled personal care or chore services (which are often called attendant services) that can be provided by untrained individuals and family members. Ms. Wynn stated that establishing a proper allowance is going to be challenging for DWC. The Labor Code requires Medicare-based fee schedules for comparable services; at the same time, per SB 863, in-home health service-based fee schedules for attendant services are specified. In-home services are administered at the county level for disabled and aged persons and allow them to remain in their homes instead of being in institutionalized care. These people are Medicaid beneficiaries. The major challenges are that neither the Medicare-based fee schedule nor the In-home Health Services (IHSS) Fee Schedule covers the full range of

home care services that might be required by injured workers. In particular, Medicare covers home health care only on an intermittent part-time basis when the patient has a need for skilled nursing care or other skilled care. It pays for 60-day episodes which means intermittent visits versus what could be required for the home care population in the workers' compensation population which can be care for 8 hours a day or even 24 hours a day. The IHSS rates are set by the counties and they are typically at minimum wage levels. When they are compared to Bureau of Labor Statistics (BLS) median wage levels for attendant services, they are below the BLS rates. So adequacy of rates is going to be another issue although that is what the current Labor Code specifies. There is lack of good data about what types of home care services are currently being provided to workers' compensation patients. That is often in part because the payor is giving the injured worker money to hire someone; that way they avoid the issues of being the employer who is providing the services. So the worker is paying directly for those services or they are being furnished by a family member. Because neither fee schedule covers all home health service, meshing them together in a coherent and consistent way is going to be very difficult. It is likely going to increase administrative burden, and there is potential for abuse anytime you try to piece something together. Ms. Wynn stated that she believes that these are issues to work through but she is optimistic that they can be worked through, and she stated that the report will be available shortly.

Comments by Commissioners

Commissioner Brady stated that there is a lot of information in these reports. Director Baker had stated earlier that California is such an expensive state for workers' compensation relative to other states in the country, and based on these studies, it seems that California will be the most expensive state for workers' compensation. It is tricky when one starts looking at additional costs including home health care costs and where that can go, but they will need to monitor the costs. Mr. Brady asked about the earlier report on trend lines over time going back to 2006 and 2007 and asked if Ms. Wynn is monitoring any of the class codes over time and how that might be changing. The California labor force seems to be more technology-oriented and service oriented; it is not manufacturing as it once was, and that will change the mix. He asked whether they have looked at trends of that nature. Mr. Mulcahy responded that the first set of results revealed some of the aggregate trends in medical spending; one potential driver in changes to medical spending is shifts in employment, but injury types are changing over time. At this time, they are not integrating that into monitoring analyses, but they are looking separately by injury type, and that answers part of the question that Mr. Brady had. Mr. Brady stated that that would be industry type but not occupation. Ms. Wynn stated that the work-related outcomes they will be controlling for are occupational types. The occupational mix classes are there, and the reason why there is a reduction in expenditures during the recession was because of the reduction in construction workers so there were fewer of those workers. The study controlled for that, and that accounts for various changes.

Commissioner Kessler thanked the presenters for the reports and stated that she would like to receive the reports electronically before the meetings so the Commissioners can review the reports on their own time. Commissioner Kessler asked whether the workers' compensation system required reports and whether medical and legal fee schedules include if someone is denied and chooses to appeal, that is, whether the legal fee schedule includes any post-denial

legal fees for those who wish to pursue an appeal of the denial. Ms. Wynn responded that the medical treatment dispute process for IMR is the appeal process for medical-necessity disputes. In the Medical Legal Fee Schedule following SB 863, the agreed medical evaluator (AME)/qualified medical evaluator (QME) dispute resolution process no longer is used to look at the medical necessity of the current treatment. That medical legal fee schedule is for issues such as causation, apportionment, and permanent disability ratings. It has not been updated for 10 years. This study is trying to take a fresh look at the schedule and make sure that it is appropriate. In the same way, workers' compensation-required reports have not changed for a number of years, so this study will be looking at those reports and how they are used in the legal system.

Commissioner Kessler also asked about UR and the IMR review where the claimant is seeking an IMR and asked what the level of access of transparency is and whether people have an opportunity to see how the decision is made and result that has been achieved. Ms. Wynn stated that they are beginning to evaluate the decisions and how the result is achieved. There is transparency; the decisions by IMR review physicians are posted online, and they are provided un-redacted to the filer. Decisions are also posted on the DWC website, as well as the guidelines that are used, the issue in dispute, and the rationale for the reviewers' decision. Commissioner Kessler thanked Ms. Wynn for the reviews being conducted. Ms. Wynn stated that she was only speaking about the IMR process and there are other issues regarding UR decisions that DWC can fill in.

Commissioner Bagan asked about whether the ASCs and whether more and more surgeries are being done in those settings. Commissioner Bagan stated that the focus appears to be on keeping the current pricing policies in place and strengthening patient selection and safety. He asked if there is medical literature available that says that we should be moving in that direction and that more surgeries should be taking place at ASCs should be taking place. Ms. Wynn responded that as technology is developing and improvements are being made in anesthesia, the trend has been to move services to ambulatory settings. Ms. Wynn stated that she wanted to distinguish between hospital outpatient departments and ASCs. They have different standards and requirements in terms of health and safety standards that they have to meet. Hospital outpatient departments are in the hospital and they have ready access to more emergency services and observation services if the patient has to stay overnight. The Medicare program is tiered coverage. First, there are procedures that can only be done in an inpatient setting and then there is a set of procedures that can be done in an outpatient hospital setting. Then a limited set of procedures can be done in an ASC. For a number of reasons, workers' compensation is allowing anything that can be done in a hospital outpatient setting to be done in an ASC. Therefore, injured workers are already getting the benefit of a more liberal coverage policy in that setting than what is being used by the Medicare program.

Report on Public Self Insured Study
Mark Priven, Bickmore

Mr. Priven stated that a lot of data exists on the insurance world but very little on public self-insurance. The scope of the study covers data on three areas of public self-insurance: benefit

expenditures (medical costs and indemnity costs); claims administration; and solvency. The goal was to look at benchmarking statistics and outliers within each of those three categories.

Mr. Priven stated that for benefit expenditures, the study looked at medical and indemnity costs by type of entity. This was based on information filed with the Office of Self Insurance Plans (OSIP). All self-insurers submit to OSIP at least five years of claims information on a summarized basis. The study looked at the loss rates and found that counties as an entity had higher loss rates than average, with municipalities having an even higher loss rate, and educational entities having the lowest loss rates. This was no surprise, as counties and municipalities tend to have police and fire and other exposures that are much higher than schools.

Mr. Priven stated that the goal of the study was to see whether the higher loss rates were driven by claim frequency or average claim size. The study found that it was both – with educational entities having both less claim frequency and lower average claim size. Municipalities and counties have similar average claim size, but the real difference is the high claim frequency for municipalities. He stated that they also looked at regions, north, central and south, controlling for the different variables. Typical with what is seen in the insurance world, the loss rates in Northern California are lower than average, and the loss rates in Southern California are higher. The high loss rates in the south are due to both higher average claim size and higher claim frequency. In the north, average claim size and frequency were lower than average.

Mr. Priven stated that the study looked at other components to see if there were any significant differences between those that self-insure individually and those in a group, or a Joint Powers Authority (JPA). JPAs have a slightly lower loss rate, though they are not sure why that is. The study did not find a much of a difference between those who use a third-party administrator (TPA) and those who self-administer, and that the difference did not affect loss rates much. For benefit expenditures, the study surveyed a random sample of 40 public self-insurers, several of which provided loss/claim listings, to see what kind of information from the claims listing could be used for benchmarking and shedding light on public self-insurance. They chose claimant age because that has not been looked at much, especially for public self-insurance. A very significant correlation between a claimant's age and the average claim size was found. Age, clearly, is a major driver of cost. The costs were decomposed by age, and it was found that younger claimants had a higher percentage of medical-only claims and a much lower percentage of permanent disability. As the age cohorts got older, the percentage of permanent disability claims increased. Interestingly, the percentage of temporary disability hardly changed among age cohorts. The study found that there were 4% of permanent disability claims for the 20-30 year old cohort versus the 21% of permanent disability claims for the 60-80 year cohort, which is a five-fold difference; this will make a very large difference in average claim size for those cohorts.

Mr. Priven stated that some recommendations for benefit expenditures include: investigate regional differences and investigate claimant age differences; and broaden public information for benchmarking for public entities. In the past, an organization called California Institute for Public Risk Analysis (CIPRA) existed which allowed jurisdictions to benchmark themselves against other cities or other schools, etc., but that information is not easily available any more.

The study presents an additional recommendation to expand OSIP data collection.

Mr. Priven stated that for claims administration, data from the Division of Workers' Compensation (DWC) Performance Audit Reviews (PAR) for the last three years were used. PAR reports are done by adjusting location – it could be an insurance company, a TPA, or whatever; the review is not done on the entire company, but just on one location where they are handling claims. This allows for analysis by region. Mr. Priven stated that the results for claims three years of PAR data were that there were significant differences in PAR score by region. A low PAR score is a good result. The study showed that the LA region scored slightly worse, and that claims adjusted outside of California scored even worse. Regional differences in claims costs and frequency north and south are frequently seen. These new results indicate that region also has an impact on claims adjusters' ability to handle claims well. These audits measure whether temporary disability was paid on time, whether permanent disability was paid on time, whether the correct amount was paid, and so forth. The fact that there is a difference between Northern and Southern California suggests that there is something systemic going on that makes it harder to handle claims well in Southern California, compared to Northern California.

Mr. Priven stated that they also found a difference based on who was doing the adjusting. Insurers were under-performing in terms of their claims audits, and public self-insurers that self-administer have scores were consistently lower than the average and median. When they looked at region and type of insurer, regardless of type of insurer, Southern California was consistently performing worse than the rest of the state. Self-insurers had the best PAR ratings. The regional difference is not based on a couple of bad companies or administrators; it is a systemic pattern across all types of insurers, self-insurers, TPAs, and others. Mr. Priven stated that the study also looked at JPAs and individual self-insurers and did not find much of a difference in performance rating.

Mr. Priven stated that it is very difficult to evaluate medical cost containment. The study found that medical cost containment as a percent of medical has numbers similar to California Workers' Compensation Institute (CWCI) numbers, or around 14%. Bill review as a percent of medical is about two-thirds. Mr. Priven stated that in terms of utilization review, there was much variation by examiner. He stated that it is very difficult for a public self-insurer to decide what is the best strategy based on the data, and he stated that additional study would be very helpful for public self-insurers. Data on the percent of decisions that are rejected and then overturned show very low percentages, as with CWCI data.

Mr. Priven stated that study recommendations included the following:

- Investigate regional differences.
- Investigate differences by administrator type.
- Re-evaluate the scope of PAR.
- Make medical cost containment benchmarking data available.

Mr. Priven stated that the last issue was solvency. If an insurer defaults, the California Insurance Guarantee Association (CIGA) is there to make sure that all the correct benefits are paid for injured workers. If a private self-insurer defaults, then the Self-Insurer's Security Fund (SISF) is

there to cover the costs. Public self-insurers really do not have a backstop; there is no one entity that is there to pay costs. Research on the issue revealed that there have been bankruptcies, but never a default. Injured workers have always received their indemnity and medical benefits. Mr. Priven stated that for JPAs, members are joint and severally liable, and none have ever filed for bankruptcy. He stated that JPAs are considered to be relatively low-risk. Likewise for counties and schools, it would be highly likely that the State would step in and take responsibility for costs. Therefore, the largest exposure was individually self-insured cities and special districts. He stated that if there were going to be a solution, or some collection to protect from insolvency or default, it is important to recognize that not all public entities are the same and that it matters whether the entity is a JPA or individually self-insured.

Mr. Priven stated that the study surveyed 40 public entities regarding solvency to determine their status. The study observed that entities are using actuarial studies and not just booking their case reserves. Actuarial studies are more realistic than case reserves and are the basis for almost all liability estimates. The study found that the actuarial studies do include a liability for claims administration, although they vary from 2.7% to 9.3% of allocated loss and adjustment expense (ALAE). They also do not include a risk margin. He stated that some are discounting for a net present value and some are not; not discounting for present value is more conservative. The discount varied a great deal from one entity to another, from 7% to 28%. Mr. Priven stated that some benchmarking data could be useful so that a public entity could assess whether or not they were an outlier regarding discount rate. About 30% of respondents stated that had experienced a deficit in the past 10 years, but none had gone into bankruptcy, as they collected extra founds to make up for the deficit.

Mr. Priven stated that if the State wanted to regulate the solvency of self-insurers, one finding would be that the Office of Self Insurance Plans (OSIP) would need to collect different information. OSIP does not have the tools needed to evaluate solvency risk. At a minimum, they would need to collect standardized financial and actuarial information. Mr. Priven stated that little information exists for entities to benchmark their financial or actuarial information (risk margins, discount rates, etc.).

Mr. Priven stated that DIR does have the authority as provided for in SB 863 to collect data relevant to benefit expenditures, claims administration, and solvency. He stated that the report is a draft and will undergo peer review.

Comments from Commissioners

Commissioner Bagan asked what percentage of claims was adjusted in the Los Angeles region. Mr. Priven responded that it was very large – in the 40% range.

Commissioner Brady stated that public entities, including the State, represent a fifth of the marketplace and no transactional database exists. He stated that he hoped stakeholders would take the next step in requiring better data.

Commissioner Bloch asked what the experience was in cities like Vallejo and Stockton when they declared bankruptcy. Mr. Priven responded that they did not default on workers'

compensation claims, but he does not know the details of the mechanism which prevented a default. He stated that they could investigate that.

Commissioner Bouma stated that Commissioner Bloch had an earlier question about the implementation of SB 863 and the report which was made available. Commissioner Bloch stated that according to the presentation by Dr. Das, there was a large spike in the number of IMRs when IMR was opened up to all cases (old injuries). The report revealed that almost half of the IMR applications were for pharmaceutical denials. As cases get older in the workers' compensation system, the ratio of IMRs for pharmaceuticals increased. One statistic indicated that for injuries in 2001, two-thirds were for pharmaceutical denials. He stated the report identifies the issue of over-prescription of opioids and pain medications, that the report even called it a "hot button issue." Given that more than 80% of the IMR disputes are in favor of denial, this leads him to believe that there are a lot of workers in the system who have old injuries and chronic pain and who are being denied long-term medications that they have been on. He stated that legislators are getting constituent complaints, and that he is getting complaints from union members. He is concerned that some workers who need these medications are falling through the cracks. Previous RAND studies have asserted that if you do not return to work, there is catastrophic income loss. He stated that therefore, if his assumptions are correct, those workers who do fall through the cracks are ending up on Medi-Cal. He asked if there is any means of assessing what costs are being shifted to the taxpayers through the IMR process.

Director Baker stated that the department would have to do a research proposal to be able to determine that. There had been studies done by the Commission looking at the shift from state disability insurance and workers' compensation, but that was many years ago. They would need to get a proposal and think about how the data might be obtained, if it can be obtained, to determine whether there were any shifts either to group health or another system or whether there are appropriate shifts to other systems. Director Baker stated that opioids are not good for injured workers. There are evidence-based guidelines for opioids and those guidelines are being applied. Commissioner Bloch stated that these are big issues of prescription drugs and cost-shifting. He stated that he wanted to return to the subject of needing to make sure no workers who deserve treatment are falling through the cracks in this system.

Proposal for a Study on the Frequency and Severity of Sharps Injuries Among Non-Healthcare Occupations

Frank Neuhauser, University of California, Berkeley

Frank Neuhauser stated that the proposal was the result of a request from the Legislature to the Commission to study the risk of sharps injuries outside the healthcare setting. Several years ago, California adopted regulations on blood-borne pathogens and this was developed for healthcare workers. The legislators' concern now is that workers in non-healthcare occupations might be at risk for sharps injuries and if so, it would be important to determine the nature of the risk and the extent of the risk and whether the Legislature needs to do something about that.

Mr. Neuhauser stated that the study would look at the nature of the different aspects of risk from sharps injuries, for example, that the person has to have an active infection which stays live on a

needle and that needle can infect another person and that that person can actually develop an infection. He stated that the study will include a literature review. Several data sources provide information on sharps injuries, for example, the Office of Health Planning and the DWC Workers' Compensation Information System (WCIS). The study will provide a determination of the extent of the risk and any recommendations, if appropriate, of whether more extensive regulations are needed.

Comments from Commissioners

Commissioner Brady stated that more data would be helpful and that industry people who work in manufacturing the types of sharps products could provide helpful suggestions regarding the study.

Commissioner Bloch stated that he supports the study as some of the workers his union represents are in solid waste and recycling. Increasingly, workers who sort through the waste stream encounter medical waste and are stabbed by a needle. It is not known besides anecdotal evidence how systemic a problem this is. The study would help determine the scope of the problem and if any regulatory response is required.

CHSWC Vote
Commissioner Bloch made a motion to approve the proposed study on the "Frequency and Severity of Sharps Injuries Among Non-Healthcare Occupations," and Commissioner Kessler seconded. The motion passed unanimously.

CHSWC Report
Eduardo Enz, CHSWC

Eduardo Enz welcomed new commissioners Shelley Kessler and Daniel Bagan on behalf of Commission staff which he stated is looking forward to a close and constructive working relationship. He stated that since the previous Commission meeting, Commission staff has continued working on projects to support and consolidate implementation of Senate Bill (SB) 863 and to monitor and evaluate its effects.

Mr. Enz stated that the Commission has contracted with RAND to conduct the "Evaluation of SB 863 Medical Care Reforms" study. This will be a multi-year study to examine how the changes to medical delivery, dispute resolution and payment are affecting workers and employers. The Commission is currently in the process of finalizing a Memorandum of Understanding (MOU) with RAND on this project. RAND has requested several databases for this study, including those from the Workers' Compensation Information System (WCIS), Electronic Adjudication Management System (EAMS), DWC Disability Evaluation Unit (DEU), and DWC Medical Unit. Additionally, RAND convened a Technical Advisory Group meeting on August 14 to obtain stakeholder input for this study.

Mr. Enz stated that the Commission has also contracted with RAND and the Center for the Study of Social Insurance (CSSI) to conduct the "Disability Evaluation and Medical Treatment Study."

This study will evaluate existing permanent disability (PD) ratings and worker outcomes to assess the accuracy and consistency of PD ratings in California. It will also evaluate and identify potential practices and policies that would improve both the quality and efficiency of the medical care provided under California's workers' compensation system and increase the efficiency of medical benefit administration. An amendment to the MOU with both RAND and CSSI is being finalized at this time. RAND and CSSI have requested access to both the WCIS and DEU databases and to Workers' Compensation Appeals Board (WCAB) records for this study.

Mr. Enz stated that the Copy Service Fee Schedule implementation has been under the purview of DWC Acting Administrative Director during the ongoing rulemaking process, and a public hearing was held on July 1st to elicit further public comment on the new proposed regulations. The proposed fee schedule would establish a $180 flat fee for a set of records, $0.10 per page for copies over 500 pages, a $50 fee for each additional set of records, and a $75 fee in the event of a cancellation. Updates on this fee schedule will be presented until the rulemaking process is completed and the Copy Service Fee Schedule is in place.

Mr. Enz stated that the RAND report for DIR by Barbara Wynn, "Ambulatory Surgical Services Provided Under California Workers' Compensation: Assessment of the Feasibility and Advisability of Expanding Coverage," was posted on the DIR website, and the final report was released in late April. The study outlined two key recommendations: to retain current Official Medical Fee Schedule (OMFS) policies with regard to "inpatient only" procedures performed in an ambulatory setting; and to strengthen inpatient protections when procedures are performed in ambulatory settings.

WOSHTEP and SASH Contracts Approval
Mr. Enz stated that contracts have recently been approved from July 1, 2014, through June 30, 2015, to continue the important ongoing training and educational work of both the Worker Occupational Safety and Health Training and Education Program (WOSHTEP) and the School Action for Safety and Health (SASH) program. The WOSHTEP contract commissions University of California (UC), Berkeley Labor Occupational Health Program (LOHP) and University of California, Los Angeles (UCLA) Labor Occupational Safety and Health Program (LOSH), with participation from University of California, Davis Western Center on Agricultural Health and Safety (WCAHS), to continue the program's innovative work. SASH's contract secures the services of both LOHP and LOSH.

Draft Report for Commission Action
Examination of the California Public Sector Self-Insured Workers' Compensation Program
Mr. Enz stated that the Commission has received a draft of the "Examination of the California Public Sector Self Insured Workers' Compensation Program" study from Mark Priven of Bickmore Services. Mark Priven presented his report earlier today, and Commission staff recommends that we post this report for feedback and comment before final posting within 30 days.

CHWC Vote
Commissioner Brady made a motion to approve to post for feedback and comment and for final posting in 30 days the "Examination of the California Public Sector Self-Insured Program" report, and Commissioner Bagan seconded. The motion passed unanimously.

New Proposed Study
Proposal to Study the Risk of "Sharps" Injuries in Non-Health Care Occupations
Mr. Enz stated that the Commission received a request from Assembly Members Mark Stone and Susan Eggman to undertake a study to collect data about the frequency and severity of "sharps" injuries (needle sticks) among non-health care occupations. Assembly Members are also interested in ascertaining the appropriate level of prevention activities for non-health care settings and the impact of "sharps" injuries on employer insurance costs. Approval to contract with the University of California for up to $17,100 was voted on earlier during the meeting.

Final Reports for Commission Action
Mr. Enz stated that Commission staff has been working on finalizing and posting completed studies. The first report, "California Safety Officer Workers' Compensation Presumption," was done by Mark Priven of Bickmore Services. The final report has been posted on the Commission's website for public comment, and Commission staff recommends that the report be adopted by the Commission today pending final edits.

CHSWC Vote
Commissioner Bloch made a motion to approve for final release and posting pending final edits the report titled "California Safety Officer Workers' Compensation Presumption," and Commissioner Kessler seconded. The motion passed unanimously.

The second report "Inspection Targeting Issues for the California Department of Industrial Relations Division of Occupational Safety and Health," was done by John Mendeloff and Seth Seabury of the RAND Corporation. This report has also been posted on the Commission's website for public comment.

CSHWC Vote
Commissioner Brady made a motion to approve for final release and posting the report titled, "Inspection Targeting Issues for the California Department of Industrial Relations Division of Occupational Safety and Health," and Commissioner Bloch seconded. The motion passed unanimously.

Proposed Activity
Joint Participation in the Celebration for Workers' Compensation, Cal/OSHA and the Commission on Health and Safety and Workers' Compensation
Mr. Enz stated that Commission staff is currently collaborating with staff from the Division of Workers' Compensation (DWC), Cal/OSHA and the Director's Office to coordinate joint participation in an event celebrating 100 years of workers' compensation, 40 years of Cal/OSHA and 20 years of CHSWC. This one-day event is scheduled for Monday, December 15, 2014. It will serve to commemorate past accomplishments, highlight current work, and frame a common vision for the future.

Commissioner Brady stated that the Commission's educational programs, especially in the schools, have been outstanding, and he wanted to say thanks for that support.

CHSWC Vote
Commissioner Brady made a motion to approve that the Commission participate in the event celebrating 100 years of workers' compensation, 40 years of Cal/OSHA and 20 years of CHSWC, and Commissioner Kessler seconded. The motion passed unanimously.

Comments from Commissioners

Commissioner Bloch stated that two interns from the University of California (UC), Berkeley Labor Occupational Health Program (LOHP) have been working on health and safety issues for non-union workers as compared to union workers. They are looking at a salad-processing plant where there was an accident and the injured worker had to wait for over an hour while the employer and the temporary agency were debating which one of them was the responsible for handling the medical care needed. He stated that LOHP has been instrumental in helping make health and safety issues clear, and this in turn helps policymakers revise policy.

Public Comment

Commissioner Bouma stated that the Commission would receive public comments in the order that the required request forms were submitted. She stated that the microphone was the appropriate place to make the remarks and that there would be assistance to help the public to adhere to the two-minute rule for the remarks.

Rick Meechan, an Applicants' Attorney, stated that he represents injured workers. He stated that in June of 2014 there was a conference at the Workers' Compensation Insurance Rating Bureau (WCIRB). A question was asked at the panel about why there were over 1,000 IMRs I workers' compensation for every 1 IMR in our health care system. He stated that no one questioned whether the premise was true, and he asked the Commissioners to reflect on why there was a ratio of 1,000 to 1, why when in July, there were 15,333 IMRs in workers' compensation there would have been 15 in the healthcare system. He stated that this is a broken system and there were reasons why the system is broken. He stated that workers' compensation places form over substance. He stated that workers' compensation is a zero sum game. He stated that workers' compensation carriers have no duty, no privity, with the injured workers; they have no obligation to take care of them. In workers' compensation, any denial, any reason for a denial, will fly. In the healthcare system, the IMR process is for patient protection; it is to help the patient, not the insurance company. He stated that he did not think it was an accomplishment to have 15,000 IMRs in workers' compensation in July; he stated that he believed it was time to start looking at the health of injured workers and improving their health as opposed to denying their care.

Carlos Garcia stated that he was a certified medical interpreter and wanted to talk about the quality of the qualifications of medical interpreters in the workers' compensation system. He stated that as of last year, nationally certified interpreters were recognized by the State, yet to this date, the insurance companies and agencies in California are selecting non-certified interpreters who are interpreting workers' compensation sessions. He stated that they are acting against the

law by providing their own interpretation. The law clearly states that a certified interpreter is one who is qualified. Insurance companies and agencies are not doing this; instead they are sending those non-certified interpreters to interpret. Mr. Garcia stated that he also wanted to talk about HIPPA violations in the workers' compensation system. He stated that when a patient needs the assistance of an interpreter, they fill out a questionnaire. They usually have to do this in the waiting room full of patients who may or may not speak the same language, and there is no conversation that is going on between them too. Mr. Garcia stated that the third thing he wanted to mention was that they desperately need an interpreter fee schedule. He stated that it was long overdue and it would save the State a lot of money. It would also save agencies a lot of time spent on fighting for those things and that it also would improve the attendance of the interpreter when it comes to servicing a patient.

Carolyn Bouchard identified herself as a certified medical interpreter. She stated that several of the doctors she had spoken to wanted her to relay their concern that the number of claims that are being denied is excessively high. They also had concerns that the denials were negatively affecting the procedures that are required in order for the doctor to provide the treatment that the patients need, including diagnostic testing or medications. She stated that the report states that quite a large amount of money is being designated toward chronic pain, yet if patients would receive the prompt care that they require, that would definitely lead to a reduction of further treatments and a reduction of chronic pain. Because of delays, many times the patient has further complications not only in their physical condition but also in their emotional condition. Doctors have also mentioned to her that many times during the IMR process, registered nurses are used, and many times the medical record has not been reviewed on time, which make the process so much more difficult. She stated that even after appeals, the patients do not receive the treatment they require. She also stated that the previous time there was a fee schedule for interpreters was in 1994, which was 20 years ago. Everyone knows that today's economy has changed and expenses have increased, and that it would be impossible for her, as an interpreter, to live in a city like San Francisco. She asked the Commission to consider these issues.

Commissioner Bouma indicated that the two-minute time limit had been reached, and Ms. Bouchard asked for additional time. Commissioner Bouma stated that Ms. Bouchard could fill out another form if she wished to discuss a unique topic, and she would be able to speak, time permitting.

René Garcia stated that he was an independent court-certified interpreter from Los Angeles. He stated that he thought it was important to speak on behalf of independent interpreters who do not own a language service or an agency and very often are not members of a union. He stated that those independent interpreters are primarily the ones working in the workers' compensation system. He stated that from their point of view, the issue of certification is very important, as is compensation and the long-overdue raise in the California court per diem rate, which is the rate of compensation that is called out in most of DIR's references to what interpreters make. He stated that that rate had not been changed in over a decade so using that rate as a touchstone is probably not a great idea. He stated that they were petitioning to have that rate increased, so maybe that will trickle down. In addition, he stated that he wanted to bring to the Commission's attention the notion that the interpreter's business model is going to be impacted by SB 863. That is a welcome condition because the interpreter's business model that is reflected in the statutes

currently states that a half-day is 3.5 hours and that the market rate should be taken into account; all of those conditions do not really reflect the day-to-day work. The 3-hour half-day and 6-hour full day are the way most interpreters work. He stated that the Berkeley study will hopefully call some of these things into light.

Angie Birchfield stated that she is an interpreter and that she wanted to echo the comments already made about how they work in the private sector. She stated that she is the unit chair for the Translator and Interpreters Guild (TTIG), which is affiliated with California Federation of Interpreters (CFI), one of the largest professional associations that represent over 600 interpreters in California. She stated that interpreters would support her prepared comments to the Commission, and if they had not been received by the Commission, they could resubmit them. She stated that they would welcome being able to participate in any part of the studies and to provide feedback from their perspective. She stated that they want to come up with a solution that is doable for everyone involved. They understand that a lot of the insurance carriers are mentioned as certifying their own interpreters. They are concerned about this in light of the stringent process to go through to get certified. She stated that she would like to ask that TTIG and CFI be able to offer comments and feedback on this very important study that affects all of them.

Sarah Larson stated she is a city employee who has worked in mental health system for the past 20 years and has had three separate workers' compensation injuries. She stated that she has noted a lack of emphasis on physical therapy and advocacy of the treatments offered. She has chronic pain and does not want to be on medications. She stated that she is no longer able to get topical analgesics from her workers' compensation doctor because they cannot prescribe them anymore. She stated that she is still working full-time but that she would have had a lot fewer issues with chronic pain had she had physical therapy earlier for one of her injuries; it took four months to see a provider and longer after that to get the physical therapy she needed. She stated that she does not see any emphasis on anti-inflammatories; these are the types of treatment that keep injuries from becoming chronic. She stated that there are going to be more injuries in the tech industry – repetitive stress injuries – it is best not to deal with them through surgery but through physical therapy, which is a lot cheaper. She stated with all the MRIs she has had, she could have had a personal trainer. She stated that it is sad that there was so much emphasis on opioids in dealing with pain because they are not effective. Opioids just hide the pain; they do not deal with the issue. She stated that in order to have an effective system, you have to have (physical) therapists on board.

Debora Marchevsky stated that she was a certified Spanish interpreter. She stated that she was present as part of the interpreter community and that she represents interpreters of all languages spoken in California. She stated that she wanted to direct her comments to the meaning and relevance of market rate in the fee schedule for interpreters. The world is driven by market forces, both nationally and internationally, and only the countries with a free market economy have adequate living standards. She stated that as interpreters, they believe that in a state where 45% of the population does not have English as a first language, the intention to cheapen the value of the interpreter's work would not only affect the outcome for the injured workers but would also affect the local economy at the expense of big business and that effect will only make their fortunes larger. The umbrella of market rate allows discretion for fees for interpreters in the

non-certified languages and can also allow adequate coverage throughout the large, extensive geographic areas in California. Those areas have great demand and very little supply of interpreters. Interpreter organizations have contributed an enormous amount of data to Berkeley Research Group (BRG) which has failed to answer about what to do with the difficulty of demand versus supply. She stated that further cheapening the professional, certified interpreter's fees would only lead to dumbing down the whole profession. No one wants to do the same work for less money. A bad or mediocre interpreter who gets paid little money will have a direct and deleterious effect on medical treatment decisions, medical rating decisions, deposition transcripts, and actions of the board. She stated that as they are all California taxpayers, interpreters ask the State why it favors this scenario. Ms. Marchevsky stated that in closing, they urge the Commission to keep market rate in place to guarantee the Constitutional rights of the injured workers to have equal access to under the law. She stated that this could only happen with skilled and certified interpreters that care about the profession are fairly and adequately compensated.

Steve Zeltzer of Injured Workers National Network stated that he protests the lock-down at this hearing and that the way the Commission has conducted the meeting is like a railroad. He stated that the Commission has not allowed people speak on each of the presentations or ask questions. Commissioner Bouma attempted to remind Mr. Zeltzer of the two-minute limit. Mr. Zeltzer told Commissioner Bouma not to interrupt his presentation. He stated that Commissioner Bouma was the Chair today and he asked to be allowed to speak his two minutes. He stated that this was a big operation here. The Commission is being driven by the insurance industry, and that is exactly why Director Baker says that they want the insurance companies to take over the interpreters. He stated that the insurance companies will decide who calls in the interpreters; the workers cannot and the doctors cannot. He asked why this was so and stated that it is because this is an insurance-driven Commission. He stated that abuses for injured workers in California are going up because their injury treatments are being stalled by IMRs and obstacles that have been put in place by Governor Brown and SB 863. He stated that Commission Chair Angie Wei was not here today, but she was a big supporter of SB 863. He stated it is her workers in California who are not receiving care, and in addition, there is cost-shifting, which was brought up by Commissioner Bloch. He stated workers are going on state disability and social security disability because they are not getting treated by their employers and their insurance companies. He stated that he would call that workers' compensation fraud. He asked where the investigations of workers' compensation fraud by the insurance industry and cost-shifting are and if the Commission is doing an investigation of that. He stated that he previously brought up a RAND study and opiate use growth, but no one looked at whether their treatment was being approved. He asked whether that has something to do with opiate use – giving drugs instead of giving therapy or other treatment. He stated that that was a serious question that has to be addressed, and he stated that it was not being addressed by DIR Director Baker.

Mr. Zeltzer stated that DIR is saying that they are implementing Cal/OSHA reforms. However, the number of Cal/OSHA inspectors is low, lower than other states, states such as Oregon and Washington and that is a scandal. He then stated that DIR drove Ellen Widess out of the agency; that that was purposely done because she instituted some fines and remedies again the Chevron refinery. He stated that they allowed Chevron to operate without enough inspectors. He stated that if there were another explosion there, the agency would be responsible and Director Baker

would be responsible. He stated that an investigation was needed of low-level inspectors and retaliation against workers who made health and safety complaints. Workers are making complaints and getting fired and they are not getting any protection from Cal/OSHA and DIR. He stated that the fact that the Commission left this discussion to the end of the meeting, after listening to all of these reports, is a set-up and is organized to prevent people from speaking out.

Marina Herrera stated that she is a State-certified court, administrative and medical interpreter. She stated that she would like to call attention to page 20 of the DIR report. She stated that she hoped it was just an omission but it seems misleading that it reads that unless an interpreter is certified, the claims administrator will be selecting the interpreter. The regulations specifically say that if a certified interpreter is not available, then a claims administrator could certify the interpreter. This is important because at this time in California, many injured workers are unfortunately receiving sub-par interpreter services. When the certification went into effect, there were not enough tests being given to people who wanted to be certified, and at this moment, there are not enough certified interpreters. She stated that she lives in the area code 925 Tri-Valley, and there are only three certified interpreters but there are not only three encounters per day. The injured worker is the one suffering now. The law says injured workers are entitled to an interpreter; they should be able to hear and speak the same way that an English speaker can, and that is not happening at the moment. She also stated that many interpreters are leaving the profession because they are not receiving adequate reimbursement.

Carolyn Bouchard, a certified medical interpreter, thanked Commissioner Bouma for having her speak again. She stated she also wanted to speak about MPNs. Unfortunately, especially the way things are for interpreters, there has been a monopoly that has been created by one large agency called One Call. Insurance companies are not doing business with California smaller businesses and smaller agencies to provide services of interpretation, and this has had a huge impact on the way services are being provided. As mentioned before, the adjuster or claims administrator has the obligation of furnishing an interpreter who would be qualified; the adjuster has no way of verifying that that person does have the qualifications to be able to provide interpretation. One would expect agencies like One Call to do due diligence in finding a certified interpreter. She stated that she worked briefly with One Call but stopped working with them, and ever since, they have not done any kind of outreach to contact her to see if she would like to provide any of those services. She stated that she knows that they are sending unqualified, uncertified interpreters to appointments that do require a person who will effectively interpret what the patient wants to say, as well as the doctor, and in some cases, even the attorneys. She stated that this is having an impact on California businesses. One Call is based out of Florida, and Parsippany, New York (actually, New Jersey), so it is an out-of-state company which is taking away so much business from Californians and California taxpayers. She stated that she does not think that is fair. When small agencies apply to MPNs, they are told that they need national coverage. She stated that this issue should be looked at.

Mr. Zeltzer stated that he had other issues he wanted to address. Commissioner Bouma stated that she was closing the public comment period. He stated he listed on his request form the topic of Maximus Corporation. Commissioner Bouma stated that he could stop talking on his own power or they could invite someone to help him. He stated that Maximus has to be investigated. He stated that it was chosen without a bid for $40 million. He stated that it is an outside company

with uncertified doctors, unlicensed in California. The company is interested in profit, which is why they could not get supposedly qualified medical examiners. He stated that that was an outrage.

An unidentified member of the audience asked why nobody is actually allowed to ask questions of the Commissioners. She stated that there were a lot of things she did not really understand, like what the acronyms used mean. Commissioner Bouma stated that there would be staff available to brief her if she has questions. Commissioner Bouma stated that they, like her, are receiving the studies and information, and this body acts by soliciting feedback and comments and understanding on what is happening in the various systems that the Commission oversees. She stated that on behalf of the public, the Commission seeks studies to obtain more information so that policy makers can be responsive. As a body, the Commission does not set policy but serves as a connection between the stakeholders in the systems and how their needs are being met, and those who are making laws that govern those systems. She stated that is why there is representation from both labor and management, the constituents in the system, so that they can take information back to stakeholders on how injured workers can get what they need under the workers' compensation system, as well as the health and safety protections they need under occupational safety and health provisions.

The member of the audience stated in response that they still cannot ask questions. Commissioner Bouma stated that she cannot engage in back-and-forth discussion, but she did want to indulge her because it seemed that others in the audience might benefit from a response. She stated that if members of the audience had anything else to say, they could try to speak with Commissioners or Commission staff after the meeting.

Steve Zeltzer asked why there was no injured worker on the Commission. The question was not acknowledged.

Commissioner Bloch stated that he appreciated that people traveled to the meeting to speak about the interpreter fee schedule. He asked what the timing was for a fee schedule. DWC Acting Administrative Director Overpeck responded that DWC is waiting for a study by Berkeley Research Group (BRG) before going forward with rulemaking.

Other Business

None.

Adjournment

The meeting was adjourned at 1:15 p.m.

Approved:

_____ _____

Angie Wei, 2014 Chair Date

Respectfully submitted:

_____ _____

Eduardo Enz, CHSWC Staff Date