

The California Commission on Health and Safety and Workers' Compensation



Workers' Compensation Medical Payment Systems A Proposal for Simplification and Administrative Efficiency

**Prepared for The Honorable Richard Alarcón
Chair, California Senate Committee on Labor and Industrial Relations**

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Introduction

The current system for workers' compensation medical care payments in California is unnecessarily complex, costly, difficult to administer, and, in some cases, outdated.

The lack of fee schedules regarding certain medical services and the delays in updating existing fee schedules create administrative inefficiencies and therefore higher costs.

In addition, medical costs in workers' compensation are increasing significantly. High administrative costs and lack of up-to-date and comprehensive fee schedules increase system vulnerability and unpredictability.

This paper describes the current system and proposes a solution intended to result in system simplification and administrative efficiency.

Recommendation

We recommend that California consider:

- Linking existing California workers' compensation medical fee schedules to Medicare/Medi-Cal fee schedules and updates, and
- Instituting new fee schedules for those medical services that are not currently regulated, such as outpatient facility fees.

California may wish to consider a change to the Labor Code which would establish new fee schedules and automatically update the California workers' compensation medical fee schedules whenever the corresponding Medicare fee schedules are changed, without the need for going through the regulatory process. For pharmaceutical reimbursements, workers' compensation payments would be linked to Medi-Cal's fee schedule.

The only component that would require regulatory action is the multiplier or adjustment that the Division of Workers' Compensation Administrative Director (DWC AD) would apply to the Medicare/Medi-Cal payments. California fee schedules and payment systems would be automatically updated whenever Medicare changes are published or the Medi-Cal fee schedule for pharmaceuticals changes.

(Exhibit I contains proposed legislative language to implement this proposal.)

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Impact

Linking existing California workers' compensation medical fee schedules to Medicare/Medi-Cal fee schedules and updates, and instituting new fee schedules for those medical services that are not currently regulated, such as outpatient facility fees, would result in reduction of workers' compensation medical costs and increased savings to employers in the State of California, to the State, and to local government. In addition, it would simplify the payment systems and improve administrative efficiency.

Summary of Proposal Impact

There are significant potential administrative savings for employers and the State by linking California's workers' compensation medical payment systems to Medicare and Medi-Cal. These savings would result from simplified procedures and increased efficiency.

Conversion of California Fee Schedule or Payment System	Potential Savings to be derived from applying <u>Medicare/Medi-Cal</u> Payment Systems
Administrative Savings	<i>All Employers:</i> Up to \$70.0 million annually (Conservative Estimate)

Other estimated savings depend upon the conversion factor(s) selected:

California Fee Schedule or Payment System	Potential Savings to be derived from applying Medicare Payment Systems (Based on estimates of Incurred Costs) At <u>100% of Medicare</u> Levels (Dependent upon multiplier)
Physician and other Providers Fee Schedule (within the OMFS) The current California RVS-based Schedule is approximately the Medicare Schedule with a 115% multiplier.	<i>All Employers:</i> Cost-Neutral (Assuming use of conversion factor from Lewin study.) ¹

¹ The Lewin Group, "California Workers' Compensation RBRVS Study", October 8, 2002 Draft. WCRI study published in 2002 estimated that the California OMFS was 112% of Medicare's RBRVS.

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<p align="center">California Fee Schedule or Payment System</p>	<p align="center">Potential Savings to be derived from applying Medicare Payment Systems (Based on estimates of Incurred Costs) At <u>100% of Medicare Levels</u></p>
<p>Inpatient Hospital Fee Schedule (Within the OMFS)</p> <p>The current California Inpatient Hospital Fee Schedule is approximately the Medicare Schedule with a 120% multiplier.</p> <p>Please note that “insured” plus “self insured” add up to “all employers” savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers.</p> <p>Annual projected savings are based upon estimates paid for calendar year 2003. Paid estimates were converted to incurred using the current rate of incurred/paid ratios from WCIRB reports (factor of 2)</p>	<p><i>All Employers:</i></p> <p>Up to \$60.0 million annually (of which up to \$24.0 million annually are outlier savings)</p> <p><i>Insured Employers</i></p> <p>Up to \$42.0 million annually (of which up to \$16.8 million annually are outlier savings)</p> <p><i>Self-Insured Employers</i></p> <p>Up to \$18.0 million annually (of which up to \$7.2 million annually are outlier savings)</p> <p><i>State of California</i></p> <p>Up to \$2.2 million annually (of which up to \$0.8 million annually are outlier savings)</p> <p><i>Local Government</i></p> <p>Up to \$8.6 million annually (of which up to \$3.4 million annually are outlier savings)</p>

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<p align="center">California Fee Schedule or Payment System</p>	<p align="center">Potential Savings to be derived from applying Medicare Payment Systems (Based on estimates of Incurred Costs) At <u>100% of Medicare Levels</u></p>
<p>Outpatient Surgery Facility</p> <p>Please note that the application of the APC would result in approximately a 24% higher average reimbursement than the application of the ASC.</p> <p>Please note that the APC is used by Medicare to reimburse hospital outpatient surgeries and covers a broader range of services and generally pays a higher amount than the ASC. The ASC is used by Medicare to reimburse ambulatory surgery centers, covers only a subset of outpatient procedures, and generally pays a lower amount than the APC.</p> <p>Consequently, if the APC were applied to both types of facilities, the savings in the column at right would be realized. If the APC and the ASC were used in the same fashion as Medicare, the savings would fall somewhere between the two estimates. If only the ASC were used, a substantial number of procedures would remain outside the fee schedule, representing approximately 16% of total costs. The exact savings would depend on the distribution of services between the two types of facilities, which is currently not known.</p> <p>Please note that "insured" plus "self insured" add up to "all employers" savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers.</p>	<p>APC (Ambulatory Payment Classifications) savings:</p> <p><i>All Employers:</i> Up to \$1.18 billion in 2004</p> <p><i>Insured Employers</i> Up to \$826.9 million in 2004</p> <p><i>Self-Insured Employers</i> Up to \$354.4 million in 2004</p> <p><i>State of California</i> Up to \$42.5 million in 2004</p> <p><i>Local Government</i> Up to \$170.1 million in 2004</p> <p>ASC (Ambulatory Surgical Center) savings:</p> <p><i>All Employers:</i> Up to \$1.61 billion in 2004</p> <p><i>Insured Employers</i> Up to \$1.13 billion in 2004</p> <p><i>Self-Insured Employers</i> Up to \$483.9 million in 2004</p> <p><i>State of California</i> Up to \$58.1 million in 2004</p> <p><i>Local Government</i> Up to \$232.3 million in 2004</p>

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<p align="center">California Fee Schedule or Payment System</p>	<p align="center">Potential Savings to be derived from applying <u>Medicare</u> Payment Systems (Based on estimates of Incurred Costs) At <u>120% of Medicare</u> Level</p>
<p>Physician and other Providers Fee Schedule (Within the OMFS)</p> <p>The current California RVS-based Schedule is approximately the Medicare Schedule with a 115% multiplier.</p>	<p><i>All Employers:</i></p> <p>Increase of up to \$318 million in 2004</p>
<p>Inpatient Hospital Fee Schedule (Within the OMFS)</p> <p>Please note that the current California Inpatient Hospital Fee Schedule is approximately the Medicare Schedule with a 120% multiplier.</p> <p>Please note that “insured” plus “self insured” add up to “all employers” savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers.</p> <p>Annual projected savings are based upon estimates paid for calendar year 2003. Paid estimates were converted to incurred using the current rate of incurred/paid ratios from WCIRB reports (factor of 2)</p>	<p><i>All Employers:</i></p> <p>Increase of up to \$54.0 million annually (of which up to \$36.0 million annually are outlier savings)</p> <p><i>Insured Employers</i></p> <p>Increase of up to \$37.8 million annually (of which up to \$25.2 million annually are outlier savings)</p> <p><i>Self-Insured Employers</i></p> <p>Increase of up to \$16.2 million annually (of which up to \$10.8 million annually are outlier savings)</p> <p><i>State of California</i></p> <p>Increase of up to \$2.0 million annually (of which up to \$1.2 million annually are outlier savings)</p> <p><i>Local Government</i></p> <p>Increase of up to \$7.8 million annually (of which up to \$5.2 million annually are outlier savings)</p>

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<p align="center">California Fee Schedule or Payment System</p>	<p align="center">Potential Savings to be derived from applying <u>Medicare</u> Payment Systems (Based on estimates of Incurred Costs) At <u>120% of Medicare</u> Levels</p>
<p>Outpatient Surgery Facility</p> <p>Please note that the application of the APC would result in approximately a 24% higher average reimbursement than the application of the ASC.</p> <p>Please note that the APC is used by Medicare to reimburse hospital outpatient surgeries and covers a broader range of services and generally pays a higher amount than the ASC. The ASC is used by Medicare to reimburse ambulatory surgery centers, covers only a subset of outpatient procedures, and generally pays a lower amount than the APC.</p> <p>Consequently, if the APC were applied to both types of facilities, the savings in the column at right would be realized. If the APC and the ASC were used in the same fashion as Medicare, the savings would fall somewhere between the two estimates. If only the ASC were used, a substantial number of procedures would remain outside the fee schedule, representing approximately 16% of total costs. The exact savings would depend on the distribution of services between the two types of facilities, which is currently not known.</p> <p>Please note that "insured" plus "self insured" add up to "all employers" savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers.</p>	<p>APC (Ambulatory Payment Classifications) savings:</p> <p><i>All Employers:</i> Up to \$931.4 million in 2004</p> <p><i>Insured Employers</i> Up to \$652.0 million in 2004</p> <p><i>Self-Insured Employers</i> Up to \$279.4 million in 2004</p> <p><i>State of California</i> Up to \$33.5 million in 2004</p> <p><i>Local Government</i> Up to \$134.1 million in 2004</p> <p>ASC (Ambulatory Surgical Center) savings:</p> <p><i>All Employers:</i> Up to \$1.50 billion in 2004</p> <p><i>Insured Employers</i> Up to \$1.05 billion in 2004</p> <p><i>Self-Insured Employers</i> Up to \$449.8 million in 2004</p> <p><i>State of California</i> Up to \$54.0 million in 2004</p> <p><i>Local Government</i> Up to \$215.9 million in 2004</p>

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<p align="center">California Fee Schedule or Payment System</p>	<p align="center">Potential Savings from applying the <u>Medi-Cal</u> Payment System</p>
<p>Pharmaceutical (Currently within the OMFS)</p> <p>Please note that “insured” plus “self insured” add up to “all employers” savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers.</p>	<p><i>All Employers:</i> Up to \$407.4 million in 2004</p> <p><i>Insured Employers:</i> Up to \$285.1 million in 2004</p> <p><i>Self-Insured Employers:</i> Up to \$122.2 million in 2004</p> <p><i>State of California:</i> Up to \$14.7 million in 2004</p> <p><i>Local Government:</i> Up to \$58.7 million in 2004</p>

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Background

Under California law, certain workers' compensation medical bills are evaluated and paid pursuant to fee schedules established according to specific provisions in the California Labor Code and further detailed in the California Code of Regulations. However, some medical services are not covered under the California workers' compensation fee schedules. (See **Appendix A**)

Medical fees currently regulated by fee schedules

- Inpatient hospital fees (under the Official Medical Fee Schedule)
- Physician and other provider fees (under the Official Medical Fee Schedule)
- Pharmaceutical fees (formula included in the Official Medical Fee Schedule)
- Durable medical equipment fees (formula included in the Official Medical Fee Schedule)
- Medical-legal (forensic) fees (under the Medical-Legal Fee Schedule)
- Fees for an interpreter when required during a medical exam (under the Interpreter Fee Schedule)

Medical fees currently unregulated by fee schedules

- Out-patient surgical facility fees (see **Exhibit III** for what is included in facility fees under the Medicare Ambulatory Surgery Center Schedule)
- Ambulance
- Emergency room fees
- Home health care

California Workers' Compensation Fee Schedules and Updates

Workers' Compensation Official Medical Fee Schedule (OMFS)

California was one of the first states to use a fee schedule for physicians. The Workers' Compensation Official Medical Fee Schedule (OMFS) was originally established to determine reasonable maximum fees for medical services provided by physicians and non-physician health care providers under workers' compensation.²

² The Lewin Group, "California Workers' Compensation RBRVS Study", October 8, 2002 Draft.

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Fee schedules to reimburse providers generally consist of three components: the CPT code, a Relative Value Scale (RVS) containing Relative Value Units (RVUs) that reflect differences in work, resource use, or charges for individual services; and one or more conversion factors. Payment for a service is calculated by multiplying the RVU for a particular CPT code by the relevant conversion factor. (See **Appendix B** for examples)

History

The first medical fee schedule, derived from the California Relative Value Study (CRVS), was developed in the 1950s and updated periodically through the 1970s. Use of the CRVS by private physicians was struck down in 1979 by a ruling from the Federal Trade Commission, which found that the CRVS violated provisions against price fixing. This ruling did not prevent the use of the CRVS by payers, including state workers' compensation programs. The CRVS continued to be used by the state of California through the 1980s until major changes were made in the Official Medical Fee Schedule (OMFS) starting in the late 1980s and early 1990s.^{3 4}

The Official Medical Fee Schedule in use in 1993 was criticized as outdated because it did not cover many common procedures and did not apply to pharmaceutical or hospital charges. The reform legislation directed DWC to update the schedule to address those concerns.

Revisions

Labor Code §5307.1 requires the DWC Administrative Director to adopt and revise a medical fee schedule every two years.

In 1994, California adopted major changes in its OMFS.⁵ These changes included:

- Replacement of the CRVS codes with 1994 Current Procedural Terminology, 4th Revision (CPT) codes defined by the AMA and used for physician payment by most private insurers and the Medicare and Medicaid programs.
- Partial adoption of a relative value scale (RVS) based on a database of physician charges provided by a commercial vendor, Medicode, Inc.

Formulas for establishing fees for pharmaceuticals and durable medical equipment were added to the OMFS effective for service dates after January 1, 1994.

³ Kominski, Gerald F., Nadereh Pourat, and Jeanne Black, "The Use of Resource-Based Relative Value Scales for Provider Reimbursement in State Workers' Compensation Programs", 1999

⁴ Title 8, California Code of Regulations, Section 9791.1

⁵ Kominski et al, 1999

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The Division of Workers' Compensation updated the Official Medical Fee Schedule (OMFS) by adopting changes to the schedule effective April 1, 1999. The In-Patient Fee Schedule and changes to the Medical Legal Fee Schedule were adopted and implemented as part of the overall package of medical regulations.

An additional technical revision was made to the OMFS on July 12, 2002. The revisions include corrections to technical and typographical errors and the re-incorporation of a prosthetics fee schedule.⁶

NOTE: DWC reports that it is planning to propose a Resource Based, Relative Value Scale (RBRVS)-based Official Medical Fee Schedule. The RBRVS was developed by Medicare and the Harvard School of Public Health as a fairer way of reimbursing medical professionals for services. The scale is based on the cost of delivering the service rather than what was historically charged. While the RBRVS-based changes are being developed, DWC recommended an interim revision of the OMFS. This "clean-up", technical revision of the OMFS was submitted to the Office of Administrative Law in April 2002.⁷

Findings

Medical care in California has been dramatically affected by several developments during the 1990s that support the need for a major restructuring of the OMFS.⁸

- Rapid growth in medical costs in workers' compensation.
- Rapid growth of out-patient surgery that may be surpassing inpatient surgery. There is no recommended maximum reimbursement level for ambulatory surgery centers or hospital based outpatient facilities.
- Rapid growth of managed care in California and use of discounted fee-for-service (FFS) payment systems and capitation by managed care firms suggest that the current OMFS is based on charges that are no longer representative of the California market.

In addition, the OMFS also has the following characteristics:

- The RVUs contained in the OMFS are based on a variety of different sources. Many RVUs are still based on the 1974 CRVS, while others are based on values supplied by a commercial vendor in 1993 and 1999. The current OMFS thus represents an assortment of values from disparate sources spanning several decades of medical practice.

⁶ <http://www.dir.ca.gov/DWC/whatsnew.htm>

⁷ Source: www.dir.ca.gov/dwc

⁸ Kominski et al, 1999

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- California's RVS is based on a database of physician charges provided by a commercial vendor. However, Medicare's Resource-Based Relative Value Scale (RBRVS) is based on actual resources used and thus is both more fair and predictable. (See **Appendix C**)
- According to the Kominski study, states have adopted RBRVS-based fee schedules to improve the fairness of their payment systems and to provide a mechanism for updating their fee schedules and payment amounts on a more regular basis. More than 15 states base their workers' compensation provider fee schedule on the RBRVS. (See **Appendix D** for a listing of those states.)
- OMFS is not updated annually as Medicare's RBRVS is.
- Current Procedural Terminology (CPT) codes are developed and updated by the American Medical Association (AMA). The codes are updated annually just before CMS updates the RBRVS. The majority of CPT codes in the California's OMFS were last updated in 1999, which brought them current with the 1997 CPT coding.
- Administrative confusion and costs that result from some California providers: (See **Appendix E**)
 - Submitting medical bills at rates which are usual and customary, rather than fee schedule rates.
 - Utilizing different procedure codes or recently devised codes that are not yet in the fee schedules,
 - Not providing sufficient detail in their report to support the billing.

Recommendation for Physician and Other Providers Fee Schedule

Consider revising the current OMFS for payment for physician and other providers fees to conform with Medicare's RBRVS system and provide for automatic updating. We recommend that the conversion from California's RVS-based system to Medicare's RBRVS system be accomplished as soon as possible without exceeding 120% of Medicare's payment rates.

Impact

Taking the current California RVS-based schedule (which is at 115% of Medicare) to 120% of Medicare would result in an estimated increase of \$318 million in incurred costs in 2004. (Please see **Exhibit IV**.) A 10% increase in the conversion factor would increase incurred costs to medical professionals by approximately \$614 million.

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The Inpatient Hospital Fee Schedule

The Official Medical Fee Schedule, updated effective April 1, 1999, established an Inpatient Hospital Fee Schedule, or IHFS.

The IHFS takes into account cost and service differentials for various types of facilities based on the federal Medicare Fee Schedule. As in Medicare, payment for each hospital differs depending on a number of factors that have an impact on the hospital's costs and services.

Revisions

Two partial revisions to the hospital fee schedule were adopted in 2001.⁹ These changes have been extended until a new fee schedule is adopted.

- The first revision, adopted April 13, 2001, allows for the fees of surgical implantables for DRGs 496-500 to be paid for separately from the DRG overall rate.
- The second change, adopted June 29, 2001, revises payments for outlier cases in certain high-cost procedures in which the hospital's charges are significantly above the norm for that specific procedure at that hospital. It also updated the Hospital Composite Factors and DRG weights.

Findings

The cost-outlier formula used for the workers' compensation In-patient Hospital Fee Schedule has the potential to be manipulated simply by billing at higher rates.

The California workers' compensation program is even more vulnerable to unreasonably high outlier payments for two reasons. (See **Exhibit V** for a full explanation of this issue.)

- First, it is continuing to use FY 2001-02 cost-to-charge ratios that are based on earlier costs and charging practices.
- The California workers compensation program also has more cost outlier payments because it is using a lower cost outlier threshold - \$14,500 compared to the \$33,560 used by Medicare in FY2003. This means that more cases qualify for outlier payments and that the cost outlier payment is up to \$15,248 higher than would be paid under Medicare before considering the lag in cost-to-charge ratios¹⁰

¹⁰ The additional outlier payment of \$15,248 is calculated as 80 percent of the difference between the two thresholds before taking the effect of the wage-adjustment into account.

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An offsetting factor, however, is the continued use of the FY2001 standard DRG payment amounts.¹¹

- Continued use of older DRG weights means payments are inefficiently distributed between different admission groups and do not reflect the latest information on resource use and technological change.
- Continued use of older hospital conversion factors and cost-to-charge ratios means that, based on the latest information, some hospitals are unfairly under compensated while others are over paid for the same service.
- Centers for Medicare and Medicaid Services (CMS) currently has not proposed any changes to the outlier threshold. The threshold is not likely to change until the FY 2004 rates are put into effect.
- The exemption from the fee schedule for implantable hardware is problematic in that it¹²:
 - Adds substantial costs to the system for DRGs where there is no documented inadequacy or inequity in payment
 - Applies to two DRGs (499 and 500) in which there are no spine fusion surgeries and thus for which it is unlikely that implantable hardware is being utilized

Recommendation for Inpatient Hospital Fee Schedule

Consider revising the current Inpatient Hospital Fee Schedule to conform to Medicare's payment rates (or multiplier to be determined) and institute automatic updates of all CMS values. Also, consider repealing DRG exemptions where CMS values exist. This would improve overall administrative efficiency and decrease "gaming" of the system. Please note that this recommendation would eliminate the exemption for implantable hardware for DRGs 496 through 500.

Impact

The following analysis is based on revising the current Inpatient Hospital Fee Schedule to conform to Medicare's payment rates (without a multiplier). The following annual projected savings are based upon estimates for calendar year 2003. See **Exhibit II** and **Appendix A** for methodology, calculations, and impact with other multipliers.

¹¹ Wynn, Barbara O, RAND, "Inflation in Hospital Charges: Implications for the CA Workers' Compensation Program". Testimony before California State Senate Labor and Industrial Relations Committee, January 15, 2003.

¹² Gardner, Laura and Gerald Kominski., "Inpatient Hospital Fee Schedule and Outpatient Surgery Study," Report to the Commission on Health and Safety and Workers' Compensation. December 2001.

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- Overall payments for inpatient services of health facilities will decrease by up to an estimated \$60.0 million each year. Note that this includes “outlier” payments to hospitals that would decrease annually by up to \$24.0 million. Each additional 10% multiplier above the Medicare rate adds approximately 8.5% to total paid amounts.
- The impact to insured employers would be an overall savings for inpatient services of health facilities of up to \$42.0 million each year which includes “outlier” payments to hospitals that would decrease annually by up to \$16.8 million.
- The impact to self-insured employers would be an overall savings for inpatient services of health facilities of up to \$18.0 million each year which includes “outlier” payments to hospitals that would decrease annually by up to \$7.2 million.
- The impact to the State of California would be an overall savings for inpatient services of health facilities of up to \$2.2 million each year, which includes “outlier” payments to hospitals that would decrease annually by up to \$0.8 million.
- The impact to local government in California would be an overall savings for inpatient services of health facilities of up to \$8.6 million each year, which includes “outlier” payments to hospitals that would decrease annually by up to \$3.4 million.

Pharmaceutical Payment System

The current payment system for workers' compensation pharmaceuticals and durable medical equipment is contained within the OMFS. Formulas for establishing fees for pharmaceuticals and durable medical equipment were added to the OMFS effective for service dates after January 1, 1994.

Per Labor Code Section 5307.2 as established by AB 749, the DWC AD “shall adopt, no later than July 1, 2003, and revise, no less frequently than biennially, an official pharmaceutical fee schedule that shall establish reasonable maximum fees paid for medicines and medical supplies provided pursuant to this division.”

Findings

According to the CHSWC report on the Study of the Cost of Pharmaceuticals in Workers' Compensation, pharmaceutical costs are the fastest rising component of benefits paid out by the workers' compensation system. Under the current OMFS, pharmacies are allowed to charge the lower of their customary charge or the fees established by the formulas under the OMFS. The resulting payments via this system are significantly higher than

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limits imposed by other states' workers' compensation systems, other regulatory systems (Medicare, Federal Workers' Compensation) and private negotiated contracts (HMOs, non-occupational insurance).

Workers' compensation systems have high payment rates relative to other systems such as Medi-Cal, Medicare and group health benefits. Within workers' compensation, California's pharmaceutical payment rates are near the highest among the various states reviewed. In addition, other regulatory systems (Medicare, Federal Workers' Compensation), and many private payers' negotiated contracts (HMOs, non-occupational insurance) reimburse at rates significantly below the average state workers' compensation system.

According to the CHSWC report on the Study of the Cost of Pharmaceuticals in Workers' Compensation, employers are paying 40% to 45% more for pharmaceuticals in workers' compensation under the current pharmaceutical fee schedule than other systems in the study.¹³

Medicare excludes self-administered drugs from its pharmaceutical payment system.¹⁴ Unlike Medicare, Medi-Cal does have a fee schedule to reimburse payments for self-administered drugs.

Recommendation for Pharmaceutical Fee Schedule

Consider revising the current pharmaceutical payment system to conform to the Medi-Cal payment system and institute automatic updates.

Impact

The estimated savings for 2004 are

- Up to \$407.4 million for all California employers
 - Up to \$285.1 million for insured employers
 - Up to \$122.2 million for self-insured employers
- Up to \$14.7 million for the State of California, and
- Up to \$58.7 million for local government

(See **Appendix F** for methodology and calculation of estimated savings through 2006.)

¹³ Neuhauser, Frank, Alex Swedlow, Dr. Laura Gardner and Ed Edelstein, "Executive Summary of the Study of the Cost of Pharmaceuticals in Workers' Compensation", report of the study for CHSWC.

¹⁴ Medicare Program Memorandum AB-02-072 dated May 15, 2002.

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Outpatient Surgery Facility Fee Schedule

Currently, California's workers' compensation system has no schedule for outpatient surgery facility fees. In fact, California's Official Medical Fee Schedule (OMFS) which serves as the basis for billing and payment of medical services provided to injured employees states that "Nothing contained in this schedule shall preclude any hospital, any surgery facility or any ambulatory surgical center from charging and collecting a facility fee for the use of the emergency room or operating room of the facility." (OMFS, April 1999 p.1)

AB 749 established Labor Code Section 5307.21 which gives the AD the "sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract."

The development of this fee schedule is discretionary on the part of the DWC AD, with no specific timetable.

However, if the DWC AD chooses to develop an outpatient surgery facility fee schedule, the Labor Code specifies that the AD shall use in the process of developing the fee schedule elements including:

1. A formal analysis of one year of published data collected pursuant to Section 128737 of the Health and Safety Code. [From the new Office of Statewide Health Planning and Development (OSHPD) data requirement.]
2. Any published data collected from providers of outpatient surgery services.
3. Payment data including but not limited to type of payer and amount charged, cost data including but not limited to actual expenses for labor, supplies, etc.
4. Cost data, including but not limited to actual expenses for labor, supplies, etc.
5. Access data.
6. Outcome data.

Findings

- DWC reports that this fee schedule may be impossible to develop because much of the required data do not exist. The requirement cannot be met until data is both collected and made available for analysis, which is likely to be three to six years away.
- The regulations for hospitals to collect outpatient surgery data as specified in Health and Safety Code Section 128737 have not yet been developed. According

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to OSHPD, the regulations are expected to be completed in mid-2003. It is expected that hospitals will be submitting data to OSHPD in 2004.¹⁵

- At the present time, OSHPD anticipates that it will not be collecting either 'paid' data or 'charged' data. However, OSHPD has the flexibility to add new elements based on comments received during the regulatory process. It would be helpful if OSHPD were to collect procedure-specific data on facility costs, charges and paid amounts.
- In addition, facility cost data, access data, and outcome data are not currently available.
- Currently, seven states, including Washington, Oregon, and West Virginia, base their ambulatory surgical facility fee schedules on the Medicare ASC Payment System. (See **Appendix G.**)
- According to a recent CHSWC study, California employers are paying for workers' compensation outpatient facility fees 2.3 times (230%) what Medicare pays for hospital outpatient facilities and 3.7 times (370%) what Medicare pays for free standing out patient surgical facilities.¹⁶

Recommendation for Outpatient Surgery Facility Fees

Given that outpatient charges are rising rapidly, represent a large portion of workers' compensation medical expenditures and that the OSHPD data to create a California-specific schedule are unlikely to be available for years, California could adopt an Outpatient Surgery Facility Fee payment system which would conform with Medicare's Ambulatory Surgery Center (ASC) Payment System or its Ambulatory Payment Classification (APC) system and institute automatic updates.

Either of these options could be adopted with or without a multiplier.

¹⁵ Conversations with Ginger Cox and Irene Ogbonna, OSHPD, who are in charge of developing the data collection procedures and regulations. <http://www.oshpd.state.ca.us/hid/MIRCal/new/index.htm>

¹⁶ Kominski, et. al. 2001

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Impact¹⁷

Using Medicare's ASC fee schedule, the estimated savings for 2004 are

- Up to \$1.61 billion for all California employers
 - Up to \$1.13 billion for insured employers
 - Up to \$483.9 million for self-insured employers
- Up to \$58.1 million for the State of California, and
- Up to \$232.3 million for local government

Using Medicare's APC fee schedule, the 2004 estimated savings are

- Up to \$1.18 billion for all California employers
 - Up to \$826.9 million for insured employers
 - Up to \$354.4 million for self-insured employers
- Up to \$42.5 million for the State of California, and
- Up to \$170.1 million for local government

Please note that the APC is used by Medicare to reimburse hospital outpatient surgeries and covers a broader range of services and generally pays a higher amount than the ASC. The ASC is used by Medicare to reimburse ambulatory surgery centers, covers only a subset of outpatient procedures, and generally pays a lower amount than the APC.

Consequently, if the APC were applied to both types of facilities, the savings in the column at right would be realized. If the APC and the ASC were used in the same fashion as Medicare, the savings would fall somewhere between the two estimates. If only the ASC were used, a substantial number of procedures would remain outside the fee schedule, representing approximately 16% of total costs. The exact savings would depend on the distribution of services between the two types of facilities, which is currently not known. (See **Appendix H** for methodology and calculation of estimated savings at different multiplier levels through 2006.)

Access

A report published by the Medicare Payment Advisory Commission indicates that there are no widespread problems with Medicare's beneficiaries' access to care. In particular the report found that the current medical payments for ASC services are "more than adequate".¹⁸ (See **Appendix I**.)

¹⁷ Please note that "insured" plus "self insured" add up to "all employer" savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers

¹⁸ Medicare Payment Advisory Commission (MedPAC) "Report to the Congress: Medicare Payment Policy", March 2003.

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Administrative Savings

Administrative savings can be expected from several sources:

- DWC administration (including WCAB)
- Insurer/self-insured employer administration (including litigation)
- Provider and hospital administration
- Bill review processes
- Simplification of software systems and updating
- All other system participants:
 - Applicant legal expenses for medical issues
 - Lien claimant legal expenses of medical billing and lien issues
 - Provider billing efficiency because IHFS is standardized to Medicare
 - More efficient allocation of resources
 - Between outpatient and inpatient settings
 - Between hospitals using more recent payment factors
 - Elimination of incentives for excessive surgery in outpatient settings driven by unusually high payment rates

The administrative savings are difficult to quantify. Based on interviews with representatives of the workers' compensation community, we estimate that up to \$70 million can be saved in administrative costs each year.

Stabilizing the Workers' Compensation Industry

Utilizing Medicare and Medi-Cal fee schedules would aid in strengthening the financial position of the California workers' compensation industry and contribute to needed stability.

The Workers' Compensation Insurance Rating Bureau (WCIRB) estimates that insurers are substantially under reserved for past liabilities, one of the main reasons for the current exceptionally high level of insolvencies experienced in the California workers' compensation system. Correcting for under reserved liabilities can lead indirectly to higher premiums for insured employers and lower profits for self-insured employers.

Saving on future medical cost payments on claims that have already occurred, reduces problems with under reserving, strengthening the financial position of insurers and self-insured employers. Improving insurers reserved position tends to reduce upward pressure

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on premiums and can lead indirectly to additional savings for employers beyond the direct savings on future claims.

Adopting Medicare and Medi-Cal fee schedules would have a significant impact on future medical costs of existing workers' compensation cases and therefore upon the reserves set aside for those purposes by insurers and self-insured employers.

As shown in **Exhibit VI**, based on WCIRB estimates, there are \$39 billion in workers' compensation medical benefits system wide that have been incurred but not yet paid. Savings on future medical liabilities suggest that insurers' and self-insured employers' under funded liabilities could be reduced by approximately \$3.35 billion by adopting Medicare and Medi-Cal fee schedules and moving to RBRVS at 120% of Medicare. This is a one-time savings on past liabilities.

Consequently, efforts that reduce future medical costs have an important one-time effect on the solvency of insurers and self-insured employers, the competitiveness of the market, and the pricing of insurance.

Overall Recommendation

There is the potential to accomplish substantial improvement in the efficiency and fairness of workers' compensation medical payments by adopting better-constructed fee schedules that also cover a broader range of services and costs.

We recommend that California consider:

- Linking existing California workers' compensation medical fee schedules to Medicare/Medi-Cal fee schedules and updates, and
- Instituting new fee schedules for those medical services that are not currently regulated, such as outpatient facility fees.

California may wish to consider a change to the Labor Code which would establish new fee schedules and automatically update the California workers' compensation medical fee schedules whenever the corresponding Medicare fee schedules are changed, without the need for going through the regulatory process. For pharmaceutical payments, workers' compensation payments would be linked to Medi-Cal's fee schedule.

¹⁹ Kominski et al, 1999

²⁰ The additional outlier payment of \$15,248 is calculated as 80 percent of the difference between the two thresholds before taking the effect of the wage-adjustment into account.

²¹ Conversations with Ginger Cox and Irene Ogbonna, OSHPD, who are in charge of developing the data collection procedures and regulations. <http://www.oshpd.state.ca.us/hid/MIRCal/new/index.htm>

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The only component that would require regulatory action is the multiplier or adjustment that the Division of Workers' Compensation Administrative Director (DWC AD) would apply to the Medicare/Medi-Cal payments. California fee schedules and payment systems would be automatically updated whenever Medicare changes are published or the Medi-Cal fee schedule for pharmaceuticals changes.

(**Exhibit I** contains proposed legislative language to implement this proposal.)

In addition, we recommend that California consider amending Labor Code Section 139.3 to include "outpatient surgery"²³ to the self-referral prohibitions, which would contribute to reducing unpredictability in the system.

This proposal would:

- Provide savings in State administrative time by reducing the requirement to go through the regulatory process to make regular scheduled updates.
- Provide savings in claims administration time for insurers and third party administrators.
- Eliminate unnecessary over billing in charges.
- Reduce litigation costs for medical billing dispute issues.
- Enable an OMFS schedule that would provide a more predictable payment system that would be based on actual resources used (costs) rather than charges.
- Create a fee schedule that is more grounded in the work that medical providers actually do, using relative values that are determined in a process which allows considerable input from the provider community.
- Provide a mechanism for updating their fee schedules and payment amounts on a more regular basis, tying to actual rates paid.

Conclusion

CHSWC recognizes the efforts to date of the Industrial Medical Council and Division of Workers' Compensation towards restructuring of the California OMFS to a modified version of the Resource Based Relative Value Scale (RBRVS). Without this preliminary work the recommendations in this report could not have been made. We applaud the

²² Per CHSWC staff analysis, it appears that no constitutional problem would be presented regarding the change to the Labor Code language, provided the triggering action is clearly defined in the Labor Code.

²³ "Outpatient Surgery" includes (1) any procedure performed on an outpatient basis in the operating rooms, ambulatory surgery rooms, endoscopy units, cardiac catheterization laboratories, or other sections of a freestanding ambulatory surgery clinic, whether licensed under paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code or not, and (2) the ambulatory surgery facility itself.

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decision of the DWC AD to move in this direction. However, we believe that for administrative simplicity and savings, this transition should be made sooner rather than later and for that reason we have suggested a legislative change. (See **Exhibit I**)

California could consider revising the current Inpatient Hospital Fee Schedule to conform to Medicare's Payment System (or adjusted by a multiplier to be determined) and institute automatic updates to reflect all new CMS values. This would improve overall administrative efficiency, decrease "gaming" of the system, and minimize the vulnerability of the system to unreasonably high outlier payments and reimbursements.

At the present time, there is no California outpatient facility fees schedule and this is the area where California workers' compensation is the most vulnerable to runaway costs. Several states base their maximum payment for the ambulatory surgery facility fees on the Medicare ASC Payment System with a multiplier. California could adopt an Outpatient Surgery Facility Fee payment system which would conform with Medicare's Ambulatory Surgery Center (ASC) Payment System or its Ambulatory Payment Classification (APC) system and institute automatic updates.

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Exhibit I

PROPOSED LEGISLATION

**Estimated Impact of
Updating the Current Workers' Compensation Inpatient Hospital Fee Schedule to
the Medicare Hospital Reimbursement Schedule**

Executive Summary

In order to control medical costs, reduce litigation, and make hospital costs and payments more predictable for insurers, employers, and hospitals, California adopted an Inpatient Hospital Fee Schedule (IHFS) effective for dates of service on or after April 1, 1999. The schedule was subsequently revised on several occasions, most recently in 2001. The IHFS is based on the Medicare Prospective Payment Schedule (PPS) which is updated annually each October 1 (the beginning date of the Federal fiscal year). Concerns have been raised by the legislature and stakeholders about the impact on payors and hospitals of the delays in updating the IHFS to the more current Medicare factors. This study analyzes the impact of updating the IHFS.

Important findings are as follows (all figures expressed as "paid" amounts in calendar 2003):

- Updating the IHFS with the newest Medicare factors maintaining the current California workers' compensation multiplier of 120% would increase hospital inpatient payments by 8.1%, from \$340 million to \$367 million.²⁴
- The payments for ordinary admissions, under the fee schedule (including the portion of "outlier" cases paid under the schedule) would increase by 15.5%, from \$302 million to \$348.8 million.
- The cost of payments above the fee schedule for extraordinary cases, called "outliers", would decline by 51.2% from \$37.9 million to \$18.5 million.
- The percent of cases paid as outliers would decline by 74% from 6.2% to 1.6%.

The most important drivers resulting in these changes are:

- An average 7.0% increase in the weights assigned to Diagnostic Related Groups (DRGs) typical of workers' compensation admissions,
- An average increase of 7.4% in the "Hospital Composite Factor" used to calculate payments for individual hospitals,
- An increase in the "Outlier Threshold" amount from \$14,500 to \$33,560, which decreases the number of outliers and reduces outlier payments.

²⁴ The following increases are expressed in paid dollars. Please note that on an incurred basis, updating the IHFS with the newest Medicare factors maintaining the 120% multiplier, would increase hospital payments by approximately \$54 million.

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Exhibit II

In 1999, a provision was placed in the schedule to adjust inpatient reimbursement to 120% of the Medicare rate. The purpose of the factor was to allay concerns that the new schedule would cause a reduction in participation by hospitals and access problems for workers. Subsequent research has found:

- No access problems for Medicare patients despite the lower payments, and
- Workers' compensation admissions are less resource intensive than Medicare admissions.²⁵

Consequently, we reviewed the impact of reducing and/or eliminating the 120% of Medicare adjustment. The main findings are:

- Eliminating the 120% multiplier while updating the schedule factors to 2003 would reduce costs by 8.8% (\$29.7 million) below expected 2003 costs with no updates.
- Each additional 10% multiplier above the Medicare rate adds approximately 8.5% to total paid amounts.

Hospital In-patient fee schedule calculations

Both the Medicare Prospective Payment Schedule (PPS) for hospitals and California workers' compensation Inpatient Hospital Fee Schedule (IHFS) are based on Medicare's analysis of the resources necessary for each of approximately 500 Diagnostic Related Groups (DRGs) and individual hospital specific characteristics. Medicare updates these annually to reflect the most recent information available. The IHFS is updated less often and consequently uses out of date values that may not reflect as accurate a picture of the resource requirements and relative values of DRGs or inter-hospital cost variation. In this analysis we have estimated the impact on system-wide medical costs of several updates and changes to the IHFS to more closely reflect the most current Medicare values.

Calculating hospital payments under Medicare and IHFS

There are several steps to calculating payments for hospital admissions:

A) Ordinary admissions

1. Each admission is assigned to one of approximately 500 DRGs.

²⁵ Gardner, Laura and Gerald Kominski., " Inpatient Hospital Fee Schedule and Outpatient Surgery Study," Report to the Commission on Health and Safety and Workers' Compensation. December 2001.

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Exhibit II

2. Medicare has assigned a relative weight to each DRG that reflects the average resource demands for patients assigned to that DRG.
3. Medicare has calculated a "composite factor" for each hospital that reflects the relative cost for that hospital compared to all others, adjusting for such factors as location (urban, rural), wages in the geographic area, whether the hospital is a teaching hospital, and additional payments for the portion of inpatient days that are for low-income Medicare and Medicaid patients.
4. The amount paid to the hospital for an "ordinary" admission is
$$\text{DRG weight} * \text{Hospital Composite Factor}$$

B) Outliers: Some cases result in extraordinarily high charges for a hospital because the cases are unusually complex. To cover these cases, Medicare and the IHFS pay these outliers based on the following calculation.

1. Medicare calculates a cost-to-charge ratio for each hospital, reflecting the approximate cost of Medicare services relative to the charges the hospital bills for those services.
2. Medicare estimates a threshold amount each year that is meant to keep outlier payments within a certain percentage of total DRG payments. . Currently it is \$33,560. This threshold is adjusted for each individual hospital based on the hospital wage index.
3. If the (billed amount for an admission * cost-to-charge ratio) exceeds the (payment amount for ordinary admissions + the threshold amount), the hospital is paid 80% of the difference + the amount for an ordinary admission.

Reimbursement under the IHFS differs from the Medicare approach mainly because:

- Reimbursement is increased by a factor of 120% from those used by Medicare.
- The outlier threshold was set below the threshold in use at the time by Medicare.

Each of these factors will be examined below to estimate the impact of moving to or closer to the current Medicare reimbursement factors.

There are several other differences between Medicare's PPS and the IHFS for which we were unable or did not attempt to model the impact of eliminating the differences between PPS and IHFS.

- Several DRGs weights were adjusted by the DWC to reflect what were considered differences between these cases in workers' compensation populations and Medicare populations.

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Exhibit II

- Several DRGs, such as burns and organ transplants, are excluded from coverage under the IHFS schedule because they were considered to be too variable when the outlier formula involved admission days. Using an outlier formula based on costs may reduce the problems and allow these DRGs to be brought back into the schedule.
- For back surgery DRGs (496-500), surgical implants are paid as an additional cost for each workers' compensation admission, but are included within Medicare payment calculation.

Results

Total impact

It is important to keep in mind two issues when considering estimates of the impact of changes to the IHFS on total cost and the percent change in total medical cost. First, we do not have information on the entire population on inpatient charges. Some hospitals do not report charge data, some hospitals are missing key linking data. We extrapolate our findings on the portion that we have data on and assume that the missing hospitals billed amounts are similar to those where we have complete data and had admissions that were similar in their distribution of DRGs.

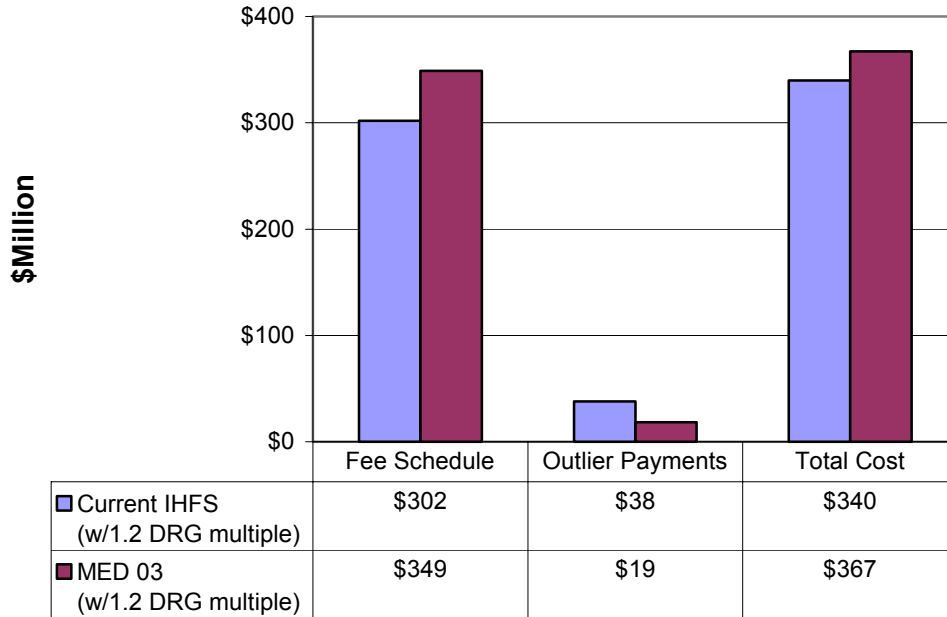
Second, the OSHPD data from which we work includes "charge" but not paid data. We calculate the paid amounts by applying the fee schedule to the charge amount. An unknown portion of hospital admissions are paid under negotiated rates between the payor (employer or insurer) and the hospital. These negotiated rates are likely to be less than the fee schedule amount. Therefore, we may overestimate the size of the total inpatient payments and overestimate the impact of fee schedule changes in both total dollars and percentage change.

Overall, we do not expect these effects to be large.

Updating the IHFS to reflect the new 2003 Medicare factors maintaining the current California workers' compensation 120% multiplier (new DRG categories, new DRG weights, hospital total cost-to-charge ratios, hospital composite factors, and outlier threshold) would result in an increase in total hospital inpatient charges of 8.1%, rising from \$339.8 million to \$367.3 million. (See Chart 1)

Chart 1

Total Hospital Inpatient Cost: Current IHFS and Adjusted to Medicare 2003 Factors (\$million)



Under the new Medicare factors, payments for “ordinary” admissions (first column) increase by 15.5%, from \$302 million to \$349 million. This is a result of both higher DRG weights for typical workers’ compensation diagnoses and, on average, higher composite factors for individual hospitals. Each of these will be explored below.

Outlier payments decline by \$19 million (51%). This mostly reflects a decline in the number of outliers given the higher outlier threshold (\$33,560 v. \$14,500) and to a lesser extent the increases in fee schedule reimbursement levels under the 2003 Medicare rules.

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Exhibit II

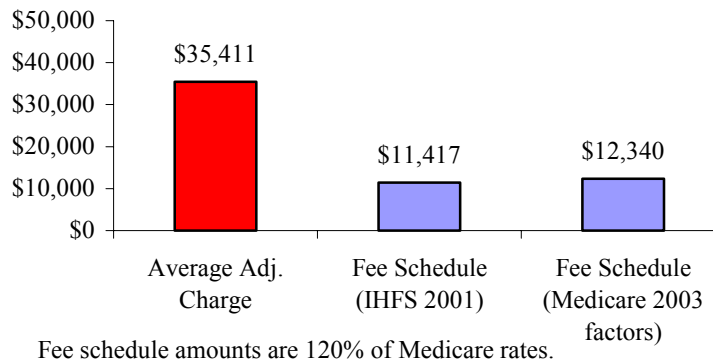
The application of the IHFS has an important effect on the payments made by insurers. Chart 2 shows the average hospital charge for admissions under workers' compensation (adjusted to 2003) and what would be paid on average under the 2001 IHFS and the IHFS updated with 2003 Medicare factors. Both fee schedule calculations include the IHFS provision for paying 120% of Medicare rates. (We will discuss the impact of the adjustment in a later section.)

The average charge per admission is estimated to be \$35,411, while the average paid would be \$11,417 under the current IHFS, and \$12,340 if the IHFS is updated to 2003 factors. The average discount to charged amounts would be 68% and 65% respectively.

In the subsequent sections, we examine the components of the IHFS and Medicare Prospective Payment Schedule (PPS) and quantify the impact of changes in each area on overall costs.

Chart 2

**Average Hospital Charges (adj.)
and Fee Schedules Amounts**



In the subsequent sections, we examine the components of the IHFS and Medicare Prospective Payment Schedule (PPS) and quantify the impact of changes in each area on overall costs.

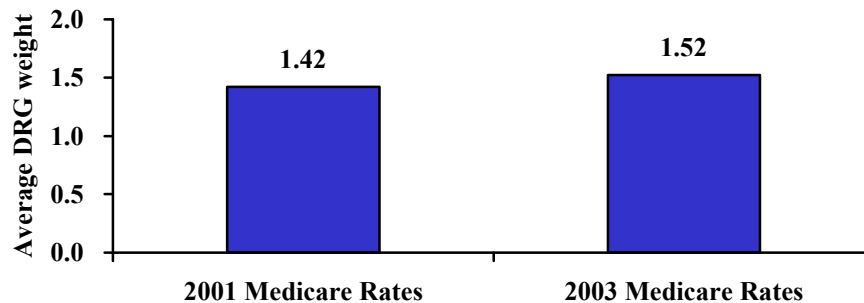
DRG Weights

Based on changes in clinical and hospital practices between 2000 and 2003, Medicare modified the weights for virtually all DRGs. Weights were adjusted both up and down, and some changes were small while others were large. While we did not examine the impact on Medicare admissions, the 2003 DRG weights are higher on average for the mix of admissions treated under workers' compensation.

Chart 3 shows how the new Medicare DRG weights increased the weights for workers' compensation cases by 7.0%.

Chart 3

Average DRG Weight for Workers' Compensation Admissions (weighted by number of admissions)

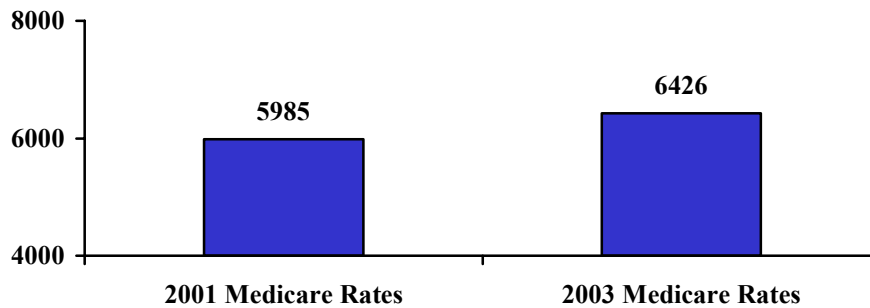


Hospital Composite Factors

The Medicare hospital composite factor takes into account geographical variations in wage rates, whether a hospital is a teaching hospital, and the proportion of low-income patients. Medicare recalculates the individual hospital composite factors annually. For 2003, some were increased and some were decreased. On average, weighted for the number of workers' compensation admissions at each hospital, the composite factor increased by 7.3%, from \$6009 to \$6448. (See Chart 4) If IHFS adopted these new factors, hospital payments for workers' compensation admissions would increase 7.4%, before accounting for the reductions caused by the outlier changes and changes to the DRG weights.

Chart 4

Average Hospital Composite Factor (weighted by number of admissions)



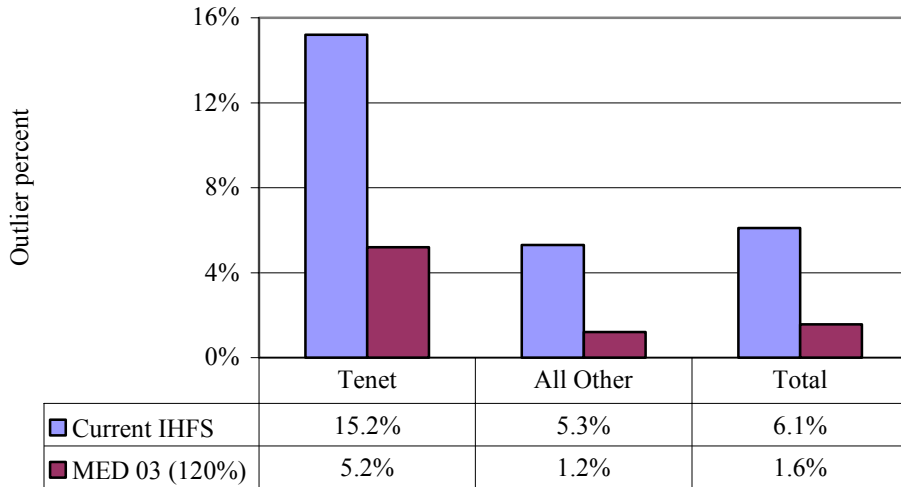
Outlier Threshold and Cost-to-Charge Ratio

Payments for outliers depend on individual hospital outlier thresholds and cost-to-charge ratios. Medicare adjusted both of these factors for the 2003 Prospective Payment System (PPS). Medicare increased the outlier threshold substantially for 2003. The previous outlier threshold used by Medicare was a little over \$21,000. For 2003 it was increased to \$33,560. This has the dual effect of reducing the number of admissions that qualify for outlier payments and reducing the amount paid for the remaining outliers because it reduces the difference between calculated cost of outlier admissions and the threshold.

Chart 5 shows that if the IHFS reflected the current Medicare threshold level, the percent of cases that were paid as outliers would drop from 6.1% to 1.6% using the current IHFS adjustment of 120% of Medicare rates. Outlier payments would drop from 11.1% of all inpatient hospital payments to 5.0%. This percentage of all payments is roughly similar to the goal of Medicare (for Medicare admissions), which is to keep outlier payments between 5% and 6% of all inpatient costs.

Chart 5

Percent of Admissions Paid as Outliers

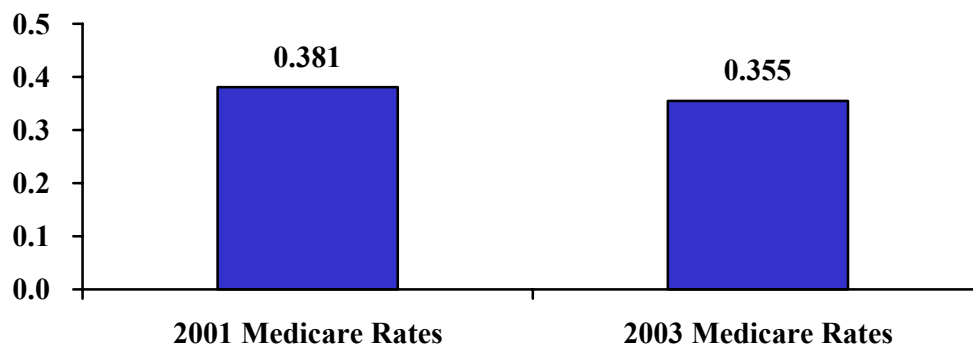


We have added Tenet Hospitals to this chart to demonstrate problems that can arise from the outlier provision. The billing practices of Tenet Hospitals have come under investigation particularly because the percentage of outlier payments exceeds the average of the rest of the industry by a factor of three. Controlling outlier costs is an important component of building an appropriate fee schedule.

A second component of outlier calculations are the cost-to-charge ratio, calculated for each hospital annually by Medicare. Lower cost-to-charge ratios result in lower payments, because hospitals are reimbursed for outliers on a cost basis (billed amount * cost-to-charge). While there are different adjustments for each hospital, between 2001 and 2003, cost-to-charge ratios used by the Medicare program for determining outlier payments, weighted by workers' compensation admissions, declined from an average of .381 to .355, approximately 8.4%.²⁶ (See Chart 6)

Chart 6

Average Hospital Cost-to-Charge Ratio (weighted by number of workers' compensation admissions)



These two effects, a higher outlier threshold and lower cost-to-charge ratio combine to reduce the number of outliers and the payments for outliers. Moving to the current 2003 Medicare outlier threshold and cost-to-charge ratios would reduce the number of outliers by 74% (6.2% to 1.6%) and total outlier payments by 51%, from \$37.9 million, to \$18.5 million. Outlier payments (See Chart 1) drop less dramatically than the number of outliers because the remaining cases are the most expensive.

Changes to the IHFS multiplier factors

When California adopted the IHFS in 1999, a multiplier of 120% of Medicare rates was included as an incentive for hospitals to accept workers' compensation admissions, thus reducing any concern about the scheduled rates causing access problems. A number of states' workers' compensation systems have adopted the Medicare PPS as a basis for hospital payment schedules and some include multipliers to the PPS rates.

²⁶ These cost-to-charge ratios are based on a hospital's most recently settled cost report and do not reflect the hospital's actual cost-to-charge ratio for the applicable year.

California Commission on Health and Safety and Workers' Compensation

**California's Workers' Compensation Medical Payment Systems
A Proposal for Simplification and Administrative Efficiency**

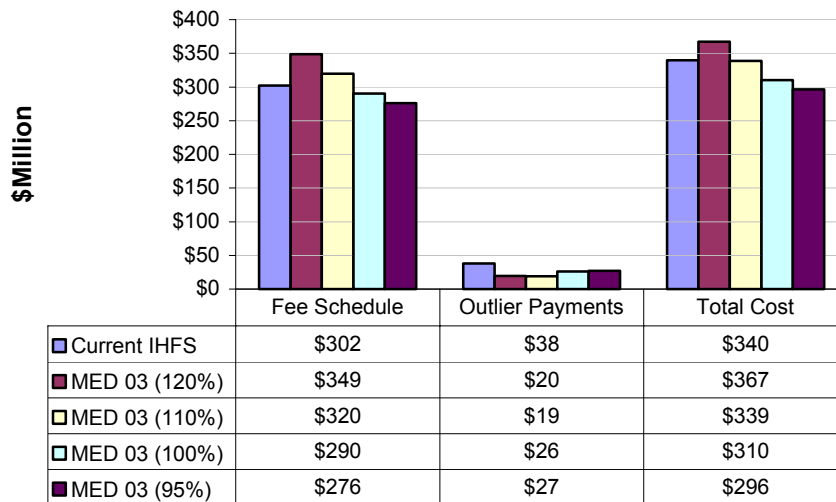
Exhibit II

Recent work has shown that Medicare reimbursement levels have had no negative effect on access for Medicare/Medi-Cal patients even though these patients tend to be more costly than the workers' compensation patients²⁷. (See **Appendix H**). Consequently, it is reasonable to assume no access problems would exist for the workers' compensation population if these admissions are paid at the Medicare rate with a multiplier.

Chart 7 shows the impact of using 120%, 110%, 100% and 95% of Medicare rates on the cost of hospital admissions in workers' compensation. The current multiplier (120%) results in costs that are 16.7% higher than if Medicare levels were used. For each 10% reduction in the Medicare rate, costs drop by 8.5%. The discount to Medicare, using the 95% multiplier results in savings of 4.0% over Medicare and 20.9% relative to the current 120% rate used in the IHFS.

Chart 7

Total Hospital Inpatient Cost: Current IHFS and Adjusted to Medicare 2003 Factors (\$million)



Data and Modeling

The data used in this project are hospital admissions data from the Office of State Health Planning and Development (OSHPD) which maintains a database on all hospital admissions for the state of California, by hospital, by year, with information on the DRG, charge amounts, number of services, days stay, the payor (Medicare, Medi-Cal, workers'

²⁷ Medicare Payment Advisory Commission (MedPac), "Report to Congress: Medicare Payment Policy", March 2003.

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Exhibit II

compensation, private insurance, private pay), and clinical and demographic characteristics of the patient.

The most recent data available were admissions for the year 2000 which included 29,768 admissions paid by workers' compensation. Not all admissions had complete data on the hospital or DRG. Some (547 admissions) did not have 2001 and 2003 Medicare and/or OSHPD identifiers (e.g., new hospitals after 2001, hospitals that went out of business before 2003, or hospital information that could not be matched between Medicare files and OSHPD data.) Also, exempted DRGs (1759 admissions) were excluded from analysis because they are not reimbursed under the IHFS and paid amounts could not be calculated. And some hospitals are exempt from the fee schedule (835 admissions). Some of these excluded admissions overlap. This left us with a pool of 26,882 admissions, approximately 89% of the original OSHPD sample.

The billed amounts for the 2000 admissions were then adjusted to 2003 billed amounts using a medical inflation index from the Bureau of Labor Statistics (7%/year). A model was then constructed to compare fee schedule and outlier payments using the current 2001 IHFS rules against the updated 2003 Medicare hospital composite factors, cost-to-charge ratios, DRG weights and outlier thresholds. By comparing the 2001 and 2003 estimates, we can calculate the impact of changes to the schedule.

The model is also able to calculate various scenarios including:

- Moving to the Medicare 2003 factors, but maintaining other rules specific to the IHFS
- Changing just the outlier threshold calculation
- Various changes to the multiplier (currently 120% of Medicare) applied by the IHFS to calculate reimbursement including:
 - Maintaining 120% of Medicare rates
 - Changing to a factor to 110% of Medicare
 - Matching PPS (100% of Medicare)
 - Changing to a factor of 95% of Medicare

The model was able to isolate the impact of Medicare changes and estimate the impact of each of these changes if they were applied to the IHFS.

Caveats

We are modeling the impact of changes to scheduled payments using a static database of admissions. Changes to reimbursement rates may have a secondary effect on the distribution of patients that are slated for surgery, the DRG under which the admission occurs, or the billing practices of individual hospitals. The direction of these effects on costs is unknown.

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Not all hospital admissions for workers' compensation could be used because data was missing that was necessary for calculations. About 11% of the hospital admissions could not be included. There was no obvious bias in these admissions, at least as far as the data allowed examination. There was no reason to think that this affected the estimates.

The admissions data was drawn from the OSHPD file for 2000 admissions. There may be changes to the distribution of admissions by DRG over the period 2000-2003. We cannot know the direction of this effect. Also, we estimate the billed amounts on the 2003 admissions by adjusting the 2000 billed amounts for a standard measure of medical inflation. Hospital billed amounts may have exhibited higher or lower inflation rates than professional services. Also, the change for individual DRGs, such as the spinal surgeries that are so important to workers' compensation costs, may have seen greater or lesser billing inflation. Again, we cannot know the direction of the overall effect, if any, on the cost estimates.

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Exhibit III

Scope of Outpatient Surgery Facility Services

Per the Code of Federal Regulations, Title 42, Section 416.61, facility services include:

- (1) Nursing, technician, and related services;
- (2) Use of the facilities where the surgical procedures are performed;
- (3) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures;
- (4) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- (5) Administrative, record keeping and housekeeping items and services; and
- (6) Materials for anesthesia.
- (7) Intra-ocular lenses (IOLs).
- (8) Supervision of the services of an anesthetist by the operating surgeon.

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Exhibit IV

Impact on Costs by Moving to 120% of Medicare RBRVS

Memorandum

Date: March 14, 2003 (updated August 25, 2003)
To: Christine Baker
From: Frank Neuhauser
Re: Impact of moving to 120% of Medicare RBRVS

A revenue neutral transition from the OMFS to a Medicare equivalent RBRVS schedule would involve approximately a conversion factor of \$44.73.²⁸ The current (2003) conversion factor for Medicare (not including anesthesia) is \$36.7856. Medicare adjusts the conversion factor to reflect geographic variation in 1) physician practice expense, 2) labor costs, and 3) malpractice insurance. Lewin calculated that the weighted average California adjusted conversion factor was \$40.54 based on a 2001 Medicare conversion factor of \$38.2581.²⁹ Adjusting for the 2001-2003 change in the conversion factor, we estimate that the current GAF adjusted average conversion factor for California is \$38.98 ($36.7856/38.2581 * 40.54$). Consequently, the revenue neutral factor (\$44.73) is 115% ($44.73/38.98$) of the Medicare conversion factor (\$36.7856) adjusted to what Medicare would on average use as a conversion factor in California (\$38.98).

You asked that I calculate the impact of increasing that premium to approximately 120% of the Medicare rate. This would be a conversion factor of \$46.78. The impact would be to increase the cost of physician services by 4.6% or an estimated \$318 million dollars for 2004 on an incurred basis. The additional cost would rise to about \$399 million in 2006.

(See the chart on the following page.)

²⁸ Lewin study for IMC

²⁹ The GPCI adjusted rate is taken from the Lewin study for the IMC. GPCI is an adjustment for the geographical variation in physician labor costs, practice expenses, and malpractice insurance and varies across the U.S, including across nine sub-areas of California.

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Exhibit IV

Calculations for Premiums to the Physician's Payments above Medicare Incurred -- (\$ Billions)			
Calendar Year	2004	2005	2006
Incurred Medical--All Employers	\$13.8	\$15.4	\$17.3
Medical Cost Containment	7.0%	7.0%	7.0%
Incurred Medical net of Medical Cost Containment Expense	\$12.8	\$14.3	\$16.1
Total Incurred Payments to Physicians and Health Professionals (53.9% of total)	\$6.9	\$7.7	\$8.7
Impact of moving to 120% of Medicare RBRVS on Incurred Payments to Physicians	\$0.318	\$0.355	\$0.399

The Lewin study did not include anesthesia when calculating the cost neutral conversion factor for moving to the RBRVS. Currently the OMFS reimburses anesthesia at about double what Medicare pays (\$34.50 vs. \$17.05). Anesthesia currently represents 2.7% of physician payments. If included under RBRVS, and paid at 120% of Medicare, payments would be reduced to anesthesiologists and a cost neutral conversion factor for all other specialties would increase. The increase would be approximately 1% on the cost neutral factor calculated by Lewin.

Calculations are derived from:

- 1) CHSWC background papers on estimated incurred medical costs for 2004-2006.
- 2) WCIRB annual report information on the percent of paid medical that is for physician and related medical professionals.
- 3) Assumes that the portion of physician payments in the paid data reflects the percent in future incurred amounts.
- 4) Lewin study on revenue neutral transition from OMFS to RBRVS

**Inflation in Hospital Charges:
Implications for the CA Workers' Compensation Program**

Barbara O. Wynn

January 2003

*Testimony presented to the California Senate Labor and Industrial Relations
Committee on January 15, 2003*

The RAND testimony series contains the statements of RAND staff members as prepared for delivery. The opinions and conclusions expressed in this written testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research.

Good morning. My name is Barbara Wynn. I am a Senior Health Policy Analyst at RAND, where my work is primarily on payment and quality issues related to federal health programs. RAND is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. Before joining RAND four years ago, I was with the Centers for Medicare and Medicaid Services for 24 years. This is the federal agency that runs the Medicare program. At the time of my departure, my responsibilities included the Medicare payment policies for hospital, physician and ambulatory services, and managed care plans. I was asked to share with you today my assessment of the potential vulnerabilities that the use of charges in the payment methodology poses for the California workers' compensation system. I will concentrate most of my comments on the inpatient hospital fee schedule, but will touch on other potential areas of concern at the end. My statement is based on a variety of sources, including research conducted at RAND. However, the opinions and conclusions expressed are mine and should not be interpreted as representing those of RAND or any of the agencies or others sponsoring its research.

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Exhibit V

Overview of the CA workers' Compensation Inpatient Fee Schedule

The inpatient hospital fee schedule is adapted from the Medicare prospective payment system for inpatient services furnished by acute care hospitals. A pre-determined amount is paid for each admission based on the diagnosis-related group- or DRG- to which the patient is assigned. The DRG assignment takes into account factors such as the patient's principal diagnosis, co-morbidities, and surgical procedures. Each DRG has a relative weight reflecting the average resources or costs required by patients assigned to the DRG relative to patients in other DRGs. Additional adjustments are made to take into account hospital characteristics such as geographic location and area wage differences, involvement in medical education, and commitment to serving low-income patients.

The standard DRG payment is not related to the hospital's charges or costs for a particular patient. Paying a prospectively determined fixed amount provides incentives for efficient delivery of medically necessary services. The assumption is that individual patients will be more or less costly, but that on average the payment will cover the costs of quality care furnished by an efficient hospital. At the same time, the system recognizes that some patients are extraordinarily costly and provides an additional payment to protect the hospital from unreasonable losses on these "cost outlier" patients. As I will discuss in greater detail, the cost outlier payments, which are influenced by a hospital's charging practices and how efficiently it operates, are the area of concern.

While the CA workers' compensation fee schedule is largely derived from the Medicare prospective payment rates, there are several important differences:

- The Medicare program updates its prospective payment system annually each October 1. The CA workers' compensation program uses the payment parameters- DRG relative weights, standard payment amounts, payment adjustments and outlier thresholds, etc. – for federal fiscal year (FY) 2001 (October 2000-September 2001).
- The CA worker's compensation program multiplies the standard amount that Medicare would pay for an inpatient stay by 1.2. In addition, the fixed loss threshold for outlier cases is lower.
- Certain DRGs are exempt from the CA workers' compensation fee schedule.
- In addition to the DRG fee schedule payment, the "hardware" costs for devices implanted during spinal surgeries are reimbursed separately under the CA workers' compensation policies. Medicare includes the costs of the devices in the DRG payment.

Cost Outlier Payments

The DRG system is designed to group patients with similar expected costs. However, the cost of treatment may vary widely among the cases in any DRG and even efficient hospitals may have some cases for which the costs are much higher than the standard DRG payment. The cost outlier payments counter incentives to avoid treating costly patients and protect hospitals from large financial losses. A case is considered extraordinarily costly and eligible for an additional payment if its estimated costs exceed the standard DRG payment plus an outlier threshold. The outlier (or fixed stop-loss) threshold is the loss a hospital must absorb before it is eligible for an additional payment. The additional payment equals 80 percent of the difference between the estimated cost of the case and the sum of the standard DRG payment and outlier threshold.

Outlier payment_{ind} = .80 * (Estimated cost_{ind} - (DRG payment_{ind} + outlier threshold))

A hospital's charging practice can affect the cost estimate for the patient stay. At the time a claim is processed, the *charges* for the stay are known but not the actual *costs* of providing the care. A cost-to-charge ratio is applied to the hospital's charges to estimate the costs for the stay. The higher the hospital's markup, the lower the hospital's cost-to-charge ratio.

Estimated cost_{ind} = Billed charges_{ind} * cost-to-charge ratio_{hosp}

For example, if a hospital has a cost-to-charge ratio of .50 (in other words, costs are 50 percent of charges), the estimated cost of a stay with \$100,000 billed charges is \$50,000. If the hospital's markup is higher (e.g., the billed charges are \$125,000), the estimated costs would still be \$50,000 as long as the cost-to-charge ratio is correct (i.e., .40). Thus, the issue is not the markup *per se* but rather the accuracy of the cost-to-charge ratio. Also, the markup does not indicate whether the hospital's costs are reasonable and the services are medically necessary.

The cost-to-charge ratios are determined from annual cost reports that the Medicare program requires from each hospital. The cost reports contain detailed information on costs, charges, and utilization by service categories. It uses a cost allocation methodology to determine the hospital's costs of providing care to Medicare beneficiaries and to establish the ratio between the hospital's cost of providing Medicare services and its charges for the services.³⁰ The cost-to-charge ratios from each hospital's

³⁰ The Medicare program calculates the cost-to-charge ratio separately for operating and capital-related costs. The CA workers' compensation program combines the two ratios for an overall cost-to-charge ratio that we use in this discussion. Some of the alleged abuse pertains to hospitals with extremely low cost-to-charge ratios (in FY2001, less than .200 for operating costs and .0162 for capital-related costs) that trigger a provision that substitutes a statewide average ratio for the hospital's extremely low cost-to-charge ratio. It appears that a handful of CA hospitals might have triggered the use of the CA average capital ratio (.0364)

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most recently settled cost report are incorporated into the annual updates to the Medicare prospective payment system and used to determine cost outlier payments for discharges occurring in the payment year.

The use of the cost-to-charge ratio to estimate costs is based on several assumptions:

- Charges are uniformly applied to all patients, i.e., the same gross charges apply to all payers.
- Charges are consistently related to costs, i.e., a comparable markup is applied to all services; and,
- Charges increase in relation to costs, i.e., the rate of growth in charges is consistent with the rate of growth in costs.

These assumptions have weakened over the years. While the same gross charges apply to all payers, few actually pay the charged amount. As payers have moved off charge-related payment systems to other payment methodologies such as fee schedules or negotiated rates, charges have become less relevant and more prone to charging practices that will enhance hospital revenues from particular payers. These practices include higher markups on some services than others, e.g. ancillary services where payment is commonly discounted charges, and higher rates of growth in charges relative to costs.

Excessive charge inflation is of particular concern in determining cost outlier payments. When charges increase more rapidly than costs, a hospital's costs in the payment year are a lower percentage of its charges than is reflected in the cost-to-charge ratio used to determine the cost outlier payment. Of necessity, there is a lag between the period covered by the cost report and the year in which the cost-to-charge ratio is applied in the cost outlier determination. However, the lag is greater when, as under current Medicare policies, the cost-to-charge ratios are updated only when cost reports are settled - which can be several years after the hospital's fiscal year has ended.

The Medicare program takes projected charge increases into account in establishing the cost outlier threshold.³¹ The fixed loss threshold, which is re-determined annually, increased from \$17,750 (prior to adjustment for geographic differences in hospital wage levels) in FY2001 and to \$33,560 in FY2003. This large increase is indicative of the substantial charge increases that occurred over the past few years. Unreasonable increases in outlier payments (which result from applying an outdated cost-

in determining their FY2001 cost-to-charge ratio. However, this could be more indicative of low capital costs than unreasonably high markups and, since capital represents about 10% of the payment, it is not likely this is having a major payment impact. Most excessive charge inflation began in 2000.

³¹ HHS, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003

Rates," *Federal Register*, vol. 67, no. 148 (August 1, 2000), 50124 available at www.cms.gov. Overall, Medicare charges per case grew 17.6 percent between FY1999 and FY2001.

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to-charge ratio to claims with substantially higher markups) indicate potential “gaming” by some hospitals. A number of the hospitals with substantial increases in outlier payments are located in CA. For example, ten CA hospitals are estimated (based on their FY2001 charges) to have Medicare outlier payments in excess of 50 percent of their standard DRG payments.³² This may be only the tip of the iceberg since there has been further charge inflation since FY2001. While we expect that these hospitals would also have a high percentage of outlier payments for patients covered by the CA workers' compensation program, we do not have the data to confirm this.

The CA workers' compensation program is even more vulnerable to unreasonably high outlier payments for two reasons. First, it is continuing to use FY2001 cost-to-charge ratios that are based on earlier charging practices. A comparison between the cost-to-charge ratios for a matched set of CA hospitals for which data are available for both FY2001 and FY2003 shows only a slight reduction in the average cost-to-charge ratio from .423 to .415 (Table 1). While the reduction in cost-to-charge ratios implies that CA workers' compensation outlier payments might be higher than they would be using the FY2003 cost-to-charge ratios, these ratios are simple averages and the actual impact depends on how the cost-to-charge ratios have changed in the hospitals where workers' compensation cases are concentrated.

Table 1

Comparison of CA Hospital Cost-to-charge Ratios
Between FY2001 and FY2003

	<u>FY 2001</u>	<u>FY2003</u>
Number of hospitals	369	369
Average cost-to-charge ratio	0.423	0.415
Std. deviation	0.136	0.160
Maximum cost-to-charge ratio	1.206	1.260
Minimum cost-to-charge ratio	0.228	0.218
Source: FY2001 and FY2003 Medicare PPS Impact Files for matched set of hospitals		

³² This is for operating costs only. The ratio is exclusive of additional payments for teaching activities and serving a disproportionate share of low-income patients.

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Table 2

Distribution of CA Hospitals by Change in Markup (%)
Between FY2001 and FY2003

Increase in markup (%)	Number of Hospitals	Average Change in Markup (%)	Average FY2001 cost-to-charge ratio	Average FY2003 cost-to-charge ratio
Reduction	121	-15.3%	0.408	0.511
<5%	60	1.4%	0.393	0.388
5 to <10 %	59	7.3%	0.404	0.377
10 to <15%	47	12.5%	0.430	0.382
15 to < 25 %	39	19.7%	0.409	0.342
25 to < 35%	20	28.8%	0.467	0.363
35 to <60 %	11	45.1%	0.492	0.340
60 to <100 %	7	75.7%	0.539	0.306
100% and higher	5	158.8%	0.911	0.350
All CA Hospitals	369	6.5%	0.423	0.416

Source: FY2001 and FY2003 PPS Impact Files

The pattern of change varied across hospitals- some hospitals had increases in their cost-to-charge ratio while others had decreases. In Table 2, we have grouped hospitals by the increase in their markup.³³ There were 121 hospitals whose charges grew less rapidly than their costs. Hospitals that have had a significant reduction in their cost-to-charge ratio are receiving higher outlier payments using the FY2001 cost-to-charge ratio than they would using the FY2003 cost-to-charge ratios. Five hospitals inflated their

³³ The change in markup is determined by dividing the hospital's FY 2001 cost-to-charge ratio by its FY2003 cost-to-charge ratio and subtracting 1.0. For example, if the average hospital had cost-to-charge ratios of .423 and .416 in FY2001 and FY2003 respectively, its markup increased 6% over the period. There were 27 hospitals with the identical cost-to-charge ratios in both years. This suggests that the cost report data were not updated between the two years.

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charges at more than twice the rate of growth in their costs. Using the average cost-to-charge ratio for this group and assuming that the billed charges on a claim are \$100,000, the estimated costs for the hospital stay would be \$91,100 using the average FY2001 cost-to-charge ratio. The estimated cost is \$35,000 using the FY2003 cost-to-charge ratio.

The CA workers compensation program also has more cost outlier payments because it is using a lower cost outlier threshold- \$14,500 compared to the \$33,560 used by Medicare in FY2003. This means that more cases qualify for outlier payments and that the cost outlier payment is up to \$15,248 higher than would be paid than under Medicare before considering the lag in cost-to-charge ratios.³⁴ An offsetting factor, however, is the continued use of the FY2001 standard DRG payment amounts. Further analytic work is needed to evaluate the impact on total CA workers' compensation payments.

In December, the Medicare program instructed its contractors to audit the financial records and perform medical review of selected outlier cases for any hospital that during October-November 2002 had a significant increase in their average charges per stay and/or a high percentage of outlier payments. Information on the hospitals that have been identified for contractor review should provide more current information than we are able to glean from the PPS impact files on CA hospitals that have significantly increased their markup and pose a particular threat to the workers' compensation program.³⁵ The Medicare program is also planning to issue a regulation by the end of January that should result in a more recent cost-to-charge ratio being used in the future. This type of action would also help address the problem for the CA workers' compensation program, but only if provision were made to adopt the revised cost-to-charge ratios and outlier thresholds on a regular basis.

Until changes are made in the CA workers' compensation program inpatient fee schedule policies, hospitals that have significantly increased their mark-ups will continue to receive excessive cost outlier payments. We have identified three options for consideration that would reduce the lag between the period used to determine the hospital's cost-to-charge ratios and the payment year:

1. An immediate option is to adopt the Medicare FY2003 cost-to-charge ratios and outlier thresholds. This would reduce the lag-time between the cost-to-charge ratios used to determine cost outliers and current markups and could be independent of a decision to provide for automatic updates in the future. Automatic updates raise the issue of whether the standard payment rates

³⁴ The additional outlier payment of \$15,248 is calculated as 80 percent of the difference between the two thresholds before taking the effect of the wage-adjustment into account.

³⁵ CMS Program Memorandum A-02-126, "Instructions Regarding Hospital Outlier Payments," dated December 20, 2002 available at www.cms.gov. The reviews are to begin by February 2003 and be completed by July 2004. The results should provide information on issues related to differential markups for specific services and medical necessity as well as overall charge inflation.

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should similarly be updated and pose administrative and budgetary issues that may require time to address.

2. Another immediate option is to use the data reported to the Office of Statewide Health Planning and Development to adjust the cost-to-charge ratios of hospitals with above-average charge inflation between the period used to establish the current cost-to-charge ratios and the most recent period for which quarterly data are available (currently, Q2 of 2002). While there are some technical issues that would need to be resolved, this option would target those hospitals that are most likely to have inflated cost outlier payments.
3. An intermediate-term option is to explore using the hospital financial data reported to the Office of Statewide Health Planning and Development to compute cost-to-charge ratios for the CA workers' compensation program on a regular basis. The financial data are more recent since they do not have the lags associated with the Medicare financial audits and rulemaking process. For example, annual financial data from 2001 could be used to establish the cost-to-charge ratio and the most recent quarterly data could be used to monitor hospital charge increases and adjust the cost-to-charge ratios of hospitals with significantly above-average charge inflation.

Without having an understanding of the full extent of the problem and an assessment of whether the pending Medicare changes are likely to address the problem for the CA workers' compensation program, it is premature to recommend major policy changes. There is no obvious substitute for using charges to estimate the costs of outlier cases. Charges automatically reflect the volume and mix of services that are provided and using them to identify high cost outlier stays provides the greatest financial protection to hospitals. One issue, however, that warrants additional evaluation is whether the 80 percent marginal cost factor (together with the outlier threshold) is the appropriate level to provide adequate protection without encouraging unnecessary utilization or rewarding high cost hospitals. If the cost-to-charge problem cannot be satisfactorily addressed by reducing the lag time, other options, such as a case-mix adjusted per diem payment- that perhaps declines over time to discourage prolonging stays – should also be considered.

Exempted Services

The CA workers' compensation program exempts about 6 percent of admissions from the inpatient fee schedule, including those for psychiatric, substance abuse and rehabilitation, organ transplants, burns, and tracheostomies. In addition, inpatient services provided by a Level 1 or 2 trauma center to patients with a life-threatening injury are exempt. Payments for exempted services are based on rates the payer has negotiated with the hospital or, in the absence of negotiated rates, the amount the payer and hospital are able to agree on for the individual case. In either case, the hospital's charges are likely to be a factor in determining payment for high cost services –(burns, transplants, and

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tracheostomies.) In hospitals that have a contract with the payer, these high cost services are likely to trigger the contract's stop-loss threshold. When this occurs, payment for the stay is either a negotiated percentage of charges from the "first dollar" or the standard negotiated rate plus a percentage of charges in excess of the stop-loss threshold.³⁶ When a contract is not in place, the hospital's billed charges are frequently the starting point for determining the payment amount. Thus, the workers' compensation program remains vulnerable to high hospital markups as long as these services remain exempt. Consideration should be given to bringing the services that are not exempt from the Medicare prospective payment system for acute care hospitals under the CA workers' compensation inpatient hospital fee schedule.

Consideration should also be given to adding services provided by exempted inpatient psychiatric and rehabilitation facilities to the inpatient fee schedule. While these stays are a relatively small proportion of CA workers' compensation admissions, the program is vulnerable to making unreasonably high payments as long as current payments are influenced by hospital charging practices. There are existing payment systems that might be suitable for adaptation to the workers' compensation program. For example, Medicare recently adopted a per discharge payment system for inpatient rehabilitation stays. The Department of Defense uses a per diem schedule to pay for inpatient psychiatric care furnished by civilian providers. Medicaid programs and workers' compensation programs in other states might also have models that should be considered.

Hospital Outpatient Services

Work performed by Dr. Gerald Kominski and colleagues at the UCLA Center for Health Policy Research using a sample of 1999 claims found that the amounts paid were 54% of the billed amounts for these services.³⁷ The difference was attributable to preferred provider discounts and contracted rates. Often, negotiated rates for hospital outpatient services are a percentage discount on hospital charges. If the discounts have not been increased to counter with the high rates of charge increases by some hospitals, it is likely that there has been a substantial increase in payments to those hospitals. Where a contract is not in place, the hospital's charges are the starting point for determining payment for workers' compensation patients.

AB749 established an outpatient surgery facility fee schedule for services that are not provided under contract but imposed a number of data requirements. Consideration should be given to adopting an existing fee schedule, such as the Medicare payment

³⁶ For example, assume that total billed charges are \$100,000, for which the standard payment is \$25,000. The stop-loss threshold is \$40,000. A contract providing for payment equal to 50% of billed charges beginning with first dollar coverage would result in a \$50,000 payment. A contract providing for 50% of billed charges in excess of the threshold would result in a \$55,000 payment (\$25,000 + 50% of \$60,000).

³⁷ Gerald F. Kominski and Laura B Gardner, "Inpatient Fee Schedule and Outpatient Surgery Study," Final Report to the Commission on Health and Safety and Workers' Compensation. December 2001.

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system for hospital outpatient service, with appropriate modifications to reflect the CA workers' compensation patient population. This would facilitate the adoption of a fee schedule without undue delay and reduce program vulnerabilities associated with payments determined on a charge-related basis.

Estimating the Impact of Changes to Medical Fee Schedules on Insurers' and Self-Insured Employers Reserves

Memorandum

Date: April 15, 2003
To: Christine Baker
From: Frank Neuhauser
Re: Estimating the impact of changes to medical fee schedules on insurers' and self-insured employers reserves

Summary

Insurers and self-insured employers are required to establish liabilities for future payments on claims that have already occurred. As a result inasmuch as most workers' compensation medical benefits are paid well after the injury occurs, insurers and self-insured employers have substantial outstanding liabilities for the medical benefit to be paid in the future on claims that have already occurred. These past liabilities, incurred and estimated under then current statutes, can be affected in important ways by statutory and regulatory changes made in the future. Actions taken that affect the cost of the medical benefit are usually applied as of the date of service, not the date of injury. Consequently, they change the amount of incurred liabilities insurers and self-insured employers must book.

The WCIRB estimates that insurers have \$28 billion in medical benefits that have been incurred but not yet paid. Using the standard formula for making system wide estimates from the insured market, the incurred but not paid liability for the medical benefit is \$39 billion (1.4 x \$28). That means that if you increase (decrease) future medical cost payments on claims that have already occurred by 10%, you increase (decrease) the level of incurred liabilities by the nearly \$4 billion.

The impact of changes to future medical costs can have the following effects:

- Increasing medical costs will increase the reserving problems faced by insurers and self-insured employers. The WCIRB estimates that insurers are substantially under reserved for past liabilities, one of the main reasons for the current exceptionally high level of insolvencies experienced in the California workers' compensation system.
- Correcting for under reserved liabilities can lead indirectly to higher premiums for insured employers and lower profits for self-insured employers.

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Exhibit VI

- Saving on future medical cost payments on claims that have already occurred, reduces problems with under reserving, strengthening the financial position of insurers and self-insured employers.
- Improving insurers reserved position tends to reduce upward pressure on premiums and can lead indirectly to additional savings for employers beyond the direct savings on future claims.

The following analyses estimate the impact of different changes in the pricing of medical costs on the previously incurred, but not paid liabilities of insurers and self-insured employers. The estimates are summarized below.

Estimated Impact of Fee Schedule Changes on Past Incurred, But Not Paid, Medical Benefits			
	Estimated Percentage Change in Total Cost of Medical Benefit	Change in 2004 Incurred Medical	Change in Past Incurred, by not Paid, Medical
Outpatient Fee Schedule (CHSWC)	-8.2%	-\$1.0 billion	-\$3.2 billion
Pharmacy (CHSWC)	-2.8%	-\$0.342 billion	-\$1.1 billion
Total	-11.0%	-\$1.34 billion	-\$4.3 billion
Moving to RVRBS at 120% of Medicare	+2.5%	+0.299 billion	+\$0.950 billion
Total	+2.5%	+\$0.299 billion	+\$0.950 billion

Savings on past, incurred liabilities from changes to the medical fee schedules

The CHSWC analyses suggest that there are substantial opportunities for savings from introducing reasonable fee schedules for outpatient services and pharmacy costs. Estimates of savings on the outpatient facility costs range from 6% to 10.5% of total medical cost, depending on the schedule adopted and the distribution of services between hospital-based outpatient surgery and free-standing ambulatory surgery centers. Savings on the pharmacy benefit, if workers' compensation adopted the Medi-Cal reimbursement schedule, are estimated to be 2.8% of total medical costs. Using the middle of the range for an outpatient schedule, these two changes would save an estimated 11% on current excess payments for medical treatment. These savings are estimated to be approximately \$1.4 billion on costs incurred for claims occurring in 2004, with additional savings in future years.

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Since the changes apply to date of service rather than the date of injury, changing costs would result in similar percentage savings on liabilities incurred on past claims. Considering that outstanding medical liabilities on past claims are \$39 billion, savings of 11% on future medical liabilities suggest that insurers' and self-insured employers' under funded liabilities could be reduced by approximately \$4.3 billion. This is a one-time savings on past liabilities.

Consequently, efforts that reduce unnecessary medical costs going forward have an important one-time effect on the solvency of insurers and self-insured employers, the competitiveness of the market, and the pricing of insurance.

Increases to past, incurred liabilities from changes to the medical fee schedules

The flip side of savings on incurred cost is the impact of increases in medical costs on past incurred liabilities. There have been proposals for increasing payments to physicians and hospitals. Again, since these are traditionally applied as of date of service, the impact of increases applies to the past incurred, but not paid, liabilities of employers and insurers.

For example, SB-228 proposes moving to an RBRVS based fee schedule at 120% of Medicare reimbursement levels. This would increase payments under this schedule by 4.6%. The increase is estimated to be 2.5% of total medical costs or approximately \$299 million for costs incurred on claims occurring in 2004, with additional costs in future years.

Again, these changes apply to date of service. Considering that outstanding medical liabilities on past claims are \$39 billion, an increase of 2.5% on future medical liabilities suggest that insurers and self-insured employers under funded liabilities could be increased by approximately \$0.950 billion. This is a one-time increase on past liabilities.

Impact on State and Local Government:

Some of these benefits (from savings) or liabilities (from cost increases) accrue to state and local government, just as the benefits and liabilities for future incurred costs for jurisdictions are affected. However, the immediate impact is harder to describe since the specifics of the accounting methods may vary, from a pay-as-you-go budget item to an accrued liability that is self-insured, to liability that is fully insured by a third party.

We can estimate the one time impact on the accrued liabilities, regardless of who ultimately pays and under what accounting method. For this we use the same methodology developed for the full CHSWC report. There we estimated the State

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accounted for 3.6% of workers' compensation liabilities and local government for 14.2%. That suggests that savings on the outpatient surgery and pharmacy costs would result in a one-time reduction to state government of its "incurred but not paid" liabilities of \$150 million and to local government of \$590 million.

Conclusion:

Changes to the cost of the medical benefit have important effects on:

- Estimates of the cost of future claims, and thus directly on premiums for employers and costs for self-insured employers
- Past incurred, but not paid, liabilities for medical treatment, and thus indirectly on premiums, the solvency of insurers, and the competitiveness of the market.

Policymakers and stakeholders need to consider carefully both the direct and indirect effects on insurers and insured and self-insured employers. On a one-time basis, the impact of changes to the medical benefit have a large effect on solvency and premiums. This effect is about three times the impact on claims incurred in the first year after implementation of changes to the fee schedules. These large reductions in future liabilities can have an important stabilizing effect on financially weak insurers and self-insurance plans, while large increases in future liabilities can have an important destabilizing effect on the market.

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Medical Fee Schedule Comparisons

Workers' Compensation Services	Current California WC Fee Schedule	Comparable Medicare/Medical Fee Schedule ³⁸	Estimated Savings ³⁹
Professional fees of physician and non-physician providers	Official Medical Fee Schedule (OMFS)	Physician Fee Schedule (RBRVS)	<p>100% Medicare FY 2003 Schedule Cost-neutral (Assuming use of conversion factor from Lewin study)</p> <p>120% Medicare FY 2003 Schedule <u>All Employers:</u> Increase of up to \$318 million in 2004</p>
Inpatient Hospital services	Inpatient Hospital Fee Schedule (contained within the OMFS)	Hospital Inpatient Prospective Payment System	<p>Please note that the following projected savings are based upon calendar year 2003 estimates.</p> <p>100% Medicare FY 2003 Schedule</p> <p><u>All Employers</u> Annual Savings: Up to \$60.0 million, including Outlier Savings of up to \$24.0 million.</p> <p><u>Insured</u> Employers Annual savings: Up to \$42.0 million, including Outlier Savings of up to \$16.8 million.</p> <p><u>Self-Insured</u> Employers Annual savings: Up to \$18.0 million, including Outlier Savings of up to \$7.2 million.</p> <p><u>State of California</u> Annual Savings: Up to \$2.2 million, including Outlier Savings of up to \$0.8 million</p> <p><u>Local Government</u> Annual Savings: Up to \$8.6 million, including Outlier Savings of up to \$3.4 million</p>

³⁸ <http://cms.hhs.gov/paymentsystems/>

³⁹ Please note that "insured" plus "self insured" add up to "all employers" savings. Savings for State of California and Local Government are shown separately, but they are already included in the total for all employers.

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Workers' Compensation Services	Current California WC Fee Schedule	Comparable Medicare/Medi-Cal Fee Schedule ³⁸	Estimated Savings ³⁹
<p>Inpatient Hospital services (continued)</p>	<p>Inpatient Hospital Fee Schedule (contained within the OMFS)</p>	<p>Hospital Inpatient Prospective Payment System</p>	<p>Please note that the following projected savings are based upon calendar year 2003 estimates.</p> <p>120% of Medicare FY 2003 Schedule</p> <p><u>All Employers</u> Annual Increase: Up to \$54.0 million, including Outlier Savings of up to \$36.0 million.</p> <p><u>Insured</u> Employers Annual Increase: Up to \$37.8 million, including Outlier Savings of up to \$25.2 million.</p> <p><u>Self-Insured</u> Employers Annual Increase: Up to \$16.2 million, including Outlier Savings of up to \$10.8 million.</p> <p><u>State of California</u> Annual Increase: Up to \$2.0 million, including Outlier Savings of up to \$1.2 million</p> <p><u>Local Government</u> Annual Increase: Up to \$7.8 million, including Outlier Savings of up to \$5.2 million</p>
<p>Pharmaceuticals</p>	<p>OMFS. (AB 749 mandates the adoption of an Official Pharmaceutical Fee Schedule no later than July 1, 2003)</p>	<p>Medi-Cal pharmacy fee schedule.</p>	<p><u>All Employers</u> Savings: Up to \$407.4 million (in 2004)</p> <p><u>Insured</u> Employers Savings: Up to \$285.1 million (in 2004)</p> <p><u>Self-Insured</u> Employers Savings: Up to \$122.2 million (in 2004)</p> <p><u>State of California</u> Savings: Up to \$14.7 million (in 2004)</p> <p><u>Local Government</u> Savings: Up to \$58.7 million (in 2004)</p>

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Workers' Compensation Services	Current California WC Fee Schedule	Comparable Medicare/Medical Fee Schedule ³⁸	Estimated Savings ³⁹
<p>Hospital Outpatient facility fees</p> <p>Ambulatory surgery centers facility fees</p>	<p>Not covered.</p> <p>Not covered.</p>	<p>Hospital Outpatient Prospective Payment System (using the Ambulatory Payment Classifications [APC])</p> <p>Ambulatory Surgical Centers (ASC)</p> <p>Please note that the application of the APC in California's workers' compensation would result in an average 24% higher reimbursement than the application of the ASC.</p>	<p>NOTE : Please see Appendix H for calculation methodology and details.</p> <p>Using ASC at 100% of Medicare</p> <p><u>All Employers</u> Savings: Up to \$1.61 billion (in 2004)</p> <p><u>Insured</u> Employers Savings: Up to \$1.13 billion (in 2004)</p> <p><u>Self-Insured</u> Employers Savings: Up to \$483.9 million (in 2004)</p> <p><u>State of California</u> Savings: Up to \$58.1 million (in 2004)</p> <p><u>Local Government</u> Savings: Up to \$232.3 million (in 2004)</p> <p>Using ASC at 120% of Medicare</p> <p><u>All Employers</u> Savings: Up to \$1.50 billion (in 2004)</p> <p><u>Insured</u> Employers Savings: Up to \$1.05 billion (in 2004)</p> <p><u>Self-Insured</u> Employers Savings: Up to \$449.8 million (in 2004)</p> <p><u>State of California</u> Savings: Up to \$54.0 million (in 2004)</p> <p><u>Local Government</u> Savings: Up to \$215.9 million (in 2004)</p> <p>Using APC at 100% of Medicare</p> <p><u>All Employers</u> Savings: Up to \$1.18 billion (in 2004)</p> <p><u>Insured</u> Employers Savings: Up to \$826.9 million (in 2004)</p> <p><u>Self-Insured</u> Employers Savings: Up to \$354.4 million (in 2004)</p> <p><u>State of California</u> Savings: Up to \$42.5 million (in 2004)</p> <p><u>Local Government</u> Savings: Up to \$170.1 million (in 2004)</p>

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Workers' Compensation Services	Current California WC Fee Schedule	Comparable Medicare/Medical Fee Schedule ³⁸	Estimated Savings ³⁹
<p>Hospital Outpatient facility fees (Continued)</p> <p>Ambulatory surgery centers facility fees</p>	<p>Not covered.</p> <p>Not covered.</p>	<p>Hospital Outpatient Prospective Payment System (using the Ambulatory Payment Classifications [APC])</p> <p>Ambulatory Surgical Centers (ASC)</p> <p>Please note that the application of the APC in California's workers' compensation would result in an average 24% higher reimbursement than the application of the ASC.</p>	<p>NOTE: Please see Appendix H for calculation methodology and details.</p> <p>Using APC at 120% of Medicare</p> <p><u>All Employers Savings</u>: Up to \$931.4 million (in 2004)</p> <p><u>Insured Employers Savings</u>: Up to \$652.0 million (in 2004)</p> <p><u>Self-Insured Employers Savings</u>: Up to \$279.4 million (in 2004)</p> <p><u>State of California Savings</u>: Up to \$33.5 million (in 2004)</p> <p><u>Local Government Savings</u>: Up to \$134.1 million (in 2004)</p>
Home health care	Not covered.	Home Health Prospective Payment System	
Ambulance	Not covered.	Ambulance Fee Schedule	
Emergency Room	Not covered.	No separate fee schedule. Emergency room facility fees are covered under the Hospital Outpatient Prospective Payment System.	
DME Durable Medical Equipment and Prosthetics	OMFS	Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule	

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Workers' Compensation Services	Current California WC Fee Schedule	Comparable Medicare/Medical Fee Schedule³⁸	Estimated Savings³⁹
<u>Other aspects</u>			
DRG codes	Used in Inpatient Hospital Fee Schedule	Used in Medicare's Hospital Inpatient Prospective Payment System	
CPT codes	Used in OMFS	Used in Medicare's Physician Fee Schedule	

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Appendix B

**Example of Payment Calculations
Under California's Official Medical Fee Schedule (OMFS) and
Medicare's Resource-Based Relative Value Schedule (RBRVS)**

California OMFS Methodology: Payment for a service is calculated by multiplying the Relative Value Unit (RVU) for a particular Current Procedural Terminology (CPT) code by the relevant conversion factor.

Medicare RBRVS Methodology: Payment for a service is derived from the listings of 2003 payment rates by CPTs and geographical locations at <http://cms.hhs.gov/physicians/mpfsapp/step0.asp>

Type of Service Office visit

CPT Code 99203

California OMFS Payment Relative Unit Value (RUV) x Conversion Factor =
9.0 x \$8.50 = \$76.50 payment rate

Medicare RBRVS Payment (for Area 5 – San Francisco County)

Regular Payment Rate: \$113.66

Facility Payment Rate⁴⁰: \$80.95

120% Medicare RBRVS Payment (for Area 5 – San Francisco County)

Regular Payment Rate: \$136.39

Facility Payment Rate: \$97.14

Medicare RBRVS Payment (for Area 99– Rural Counties)

Regular Payment Rate: \$93.68

Facility Payment Rate: \$70.48

120% Medicare RBRVS Payment (for Area 99– Rural Counties)

Regular Payment Rate: \$112.42

Facility Payment Rate: \$84.58

⁴⁰ Facility Payment Rate is applied when the service is performed in an inpatient hospital setting, an outpatient hospital setting, a hospital emergency room, an ambulatory surgical center, and other facility settings as listed in www.medicarenhic.com/physician/ca/factsheetinfo_2003.htm.

MEDICARE PHYSICIAN FEE SCHEDULE

Background

Prior to 1992, Medicare payments for physicians' services were made under the reasonable charge system. Payments were based on the charging patterns of physicians. This system was inherently inflationary and resulted in large unjustifiable differences among types of services, geographic payment areas, and physician specialties. Recognizing this, Congress, in the Omnibus Budget Reconciliation Act (OBRA) of 1989, added section 1848 to the Social Security Act. This section replaced the reasonable charge system with the Medicare physician fee schedule effective January 1, 1992. The law provided for a gradual 5-year transition from the reasonable charge system with the fee schedule becoming fully effective in all areas on January 1, 1996.

Development of Fee Schedule

Section 1848 requires that each of the over 7,000 services paid under the physician fee schedule be divided into 3 components—physician work, practice expenses (rent, employee wages, medical equipment and supplies, utilities, etc.), and malpractice insurance. The law further requires that uniform national relative value units (RVUs) be established for each of the 3 components—physician work (WRVU), practice expenses (PERVU), and malpractice expenses (MRVU)—of every physician fee schedule service. The law prohibits any specialty payment differential. The component RVUs are uniform everywhere, and payments may vary among the 89 geographic fee schedule payment areas only to the extent that the resource costs of providing services vary as measured by the area geographic practice cost indices or GPCIs. The GPCIs are required by law to measure area cost differences compared to the national average for each of the 3 fee schedule components.

Fee schedule payments are the product of the national relative value for a service, the area component GPCIs, and the national dollar conversion factor or CF. The calculation is expressed as follows:

$$\text{Payment}=[(\text{WRVU})(\text{WGPCI})+(\text{PERVU})(\text{PEGPCI})+(\text{MRVU})(\text{MGPCI})][\$CF]$$

The physician work values are primarily based on a study of physician work conducted for CMS by the Harvard School of Public Health. The study valued each service on the basis of the relative physician work—time, effort, skill, risk—required to perform the service. The proposed work values were published in the Federal Register for public comment on June 5, 1991. After reviewing about 95,000 comments, interim final values

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were published in the Federal Register on November 25, 1991. Values for new and revised service codes are established each year through public notice and comment in the Federal Register. The law also requires that a comprehensive review of all work values be done every 5 years. The first 5 year review became effective in 1997, with the second effective in 2002. Values for new and revised codes each year and for the 5 year review are primarily based on the recommendations of the American Medical Association's Specialty Society Relative Value Update Committee or RUC. The RUC's recommendations are subject to review by CMS staff physicians, carrier medical directors, and specialty refinement panels of physicians.

Practice expense and malpractice values were based on a statutory formula from 1992 to 1998. Historical practice expense and malpractice expense percentages, weighted among the specialties providing a service, were applied to the 1991 national average Medicare allowed charge for the service to determine the practice expense and malpractice relative values. In effect, the percentages of Medicare payments for a service representing practice expenses and malpractice expenses in 1991 were passed through to the fee schedule in 1992. Thus, while the work relative values were resource-based, the practice expense and malpractice relative values were still charge-based. Implementation of resource-based practice expense RVUs was begun in 1999 and was fully implemented in 2002. The resource-based practice expense RVUs are based on AMA data on practice expenses, physician time per service, and expert clinical panel review of practice expenses of individual services. Resource-based malpractice RVUs, based on actual malpractice premium data, were implemented in 2000.

The initial dollar conversion factor in 1992 was required to be budget neutral. That is, a conversion factor was calculated that yielded the same total payments for physicians' services in 1992 that would have been made had the previous reasonable charge system been retained. The conversion factor is updated each year taking into account various factors including inflation, increase in the number of beneficiaries, changes in law and regulations, and allowable increases in the volume and intensity of services.

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Appendix D

**States and other Jurisdictions that have used
Medicare's Resource Based Relative Value Scales (RBRVS)
for Reimbursing Provider Fees**

1. District of Columbia
2. Florida
3. Hawaii
4. Kentucky
5. Maine
6. Massachusetts
7. Michigan
8. Minnesota
9. Mississippi
10. Nebraska
11. North Carolina
12. Ohio
13. Oregon
14. Pennsylvania
15. South Carolina
16. Utah
17. Washington
18. West Virginia

Sources: Workers' Compensation Research Institute (WCRI), December 2001; Kominski, 1999

Workers' Compensation Medical Billing and Payment Process

Scope

Under California law, certain workers' compensation medical bills are evaluated and paid pursuant to fee schedules established according to specific provisions in the California Labor Code and further detailed in the California Code of Regulations.

Medical costs regulated by fee schedules

- Provider fees
- Pharmaceutical costs
- Inpatient hospital costs
- Medical-legal (forensic) fees
- Fees for interpreter when required during a medical exam

Medical costs currently unregulated by fee schedules

- Out-patient Facility Fees (AB 749 mandated the creation of a fee schedule but it may be impossible to develop as much of the required data does not exist.)
- Ambulance
- Emergency Room Fees
- Home Health Care
- Inpatient Hospital Diagnosis-based exemptions

Billing Process Overview

The following is an overview of the workers' compensation medical billing and payment process.

Step 1

Injured worker files workers' compensation claim with the employer and obtains medical treatment.

Step 2

Medical provider bills workers' compensation insurer for treatment for injured worker.

Step 3

Decision point: Is workers' compensation claim accepted by insurer?

If 'yes' – Go to *Step 4*

If 'no' – Insurer notifies provider that bill is rejected. At this point, the provider or the injured worker may file an Application for Adjudication of Claim with the

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Division of Workers' Compensation. The provider may choose to bill the injured worker.

Step 4

Claims adjuster or designated agent reviews medical bill. The claims adjuster must pay the bill within 60 calendar days of receipt or object within 30 working days.

Step 5

Decision point: Utilization Review⁴¹ – Is the treatment billed for reasonably required to cure or relieve?

If 'yes' – Go to *Step 8*

If 'no' – Go to *Step 6*

Step 6

Claims adjuster advises the worker's medical provider of the name and phone of the UR medical staff with peer-level credentials to whom the provider may discuss and resolve whether the treatment is 'reasonable and necessary'.

Step 7

Decision point: Is agreement reached between provider and UR medical staff?

If 'yes' – Go to *Step 8*

If 'no' – Medical bill is rejected. Provider may file a lien.

Step 8

Decision point: Is the amount charged correct?

If 'yes' – Go to *Step 9*

If 'no' – Insurer notifies provider that bill is rejected. At this point, the injured worker may file an Application for Adjudication of Claim with the Division of Workers' Compensation. The provider may request reconsideration from the insurer or file a lien against the injured worker's case with the Division of Workers' Compensation.

Step 9

Insurer reimburses medical provider in accordance with the appropriate fee schedule. The provider may be reimbursed fees in excess of those set forth in the fee schedules, provided that the charge is reasonable, itemized, and justified by an explanation of extraordinary circumstances related to the unusual nature of the medical services, or that the payor contracted for a higher amount. If the provider is not satisfied with the

⁴¹ There are many factors affecting the usage of Utilization Review as a cost-control.

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reimbursement, he or she may file a lien at the Division of Workers' Compensation against the injured worker's claim, to be reimbursed from any award the worker may receive.

Billing Process Problems

Several problems have been noted at each stage of the workers' compensation medical billing and payment process.

Step 1) Injured worker files workers' compensation claim with the employer and obtains medical treatment.

Injured workers, employers and medical providers may fail to identify the injury as work-related.

- Treatment is provided by a self-procured or Group Health provider and when the injury is eventually reported as an industrial injury, no report of the previous treatment is ever made to the workers' compensation claim administrator paying for the current treatment. These providers may not be identified or given notice and may file liens years after the industrial claim has been resolved.
- Employers may misdirect injured employees to Group Health or private care due to inadequate description of injury or knowledge of AOE/COE issues.

Step 2) Medical provider bills workers' compensation insurer for treatment.

Some California providers:

- Submit medical bills at rates which are usual and customary, rather than fee schedule rates.
- Utilize different codes or recently devised codes that are not yet in the fee schedules⁴²,
- Do not provide sufficient detail in their report to support the billing. (However, "sufficient detail" has not been defined.)

In addition, many providers bill a second time (or more) within the statutorily provided 60 day payment period. Some payors cite as much as 30% duplicate billing occurs.

⁴² CPT (Current Procedural Terminology) codes are updated every year by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). The California OMFS has not incorporated updated CPT codes since 1997.

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Step 3) Decision Point - Is the workers' compensation claim accepted by the insurer?

- For more complicated medical conditions like heart disease, cancer, depression, or pulmonary disorders, the employment connection is not always apparent.
- The determination of predominant cause in psychological injury cases, as is required by Labor Code § 3208.3 can also require time to substantiate.

Situations like these can lead to litigation over the medical causes of the condition, late lien filings, and/or failed reimbursement.

Step 4) Claims adjuster or designated agent reviews medical bill

- Bill is reviewed and adjusted in keeping with the appropriate fee schedule (along with their many ground rules) or in compliance with a contract agreement. As bills rarely charge the allowable amount and do not always consider the ground rules, this generally results in a reduction.
- Providers submit the same bill to the insurer several times. Sometimes these are mere duplicate bills for services which may or may not have been reimbursed. Others times they are running totals of older services with add-on visits (balance billing). Sorting these out results in untold hours of unproductive resource consumption.
- Billing forms are different for different providers. (AB 749 has mandated uniform billing)
- There has reportedly been a practice among some bill review companies to set performance standards or compensation levels in relation to the number of bills reduced by a given reviewer.
- Lack of enforceable protocols for procedures to determine whether the bills are excessive based on inappropriate or unnecessary treatment.
- Denied bills may lead to litigation or to doctors not getting paid.
- Reimbursement rates can be inappropriately billed and paid when a claim is shifted between group health and workers' compensation payors.
- The cost-outlier formula used for the workers' compensation In-patient Hospital Fee Schedule has the potential to be manipulated simply by billing at higher rates.
- While self-referral is banned in most other instances, there is no such prohibition with regard to out-patient facilities.
- Neither bill reviewers nor outside billing companies are regulated.

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Step 5) Decision Point - Is treatment billed for reasonably required to cure or relieve?

- Many times billings are received that cannot be processed because there is insufficient patient data, an inadequate medical report, or incomplete information.
- Sometimes paperwork is separated during insurer review and the claims adjuster requests additional copies from the medical provider.

Step 6) Claims adjuster advises provider of UR medical staff with whom to discuss if treatment is 'reasonable and necessary'.

- The current utilization review regulations are considered by some to be ineffective.

Step 7) Decision Point - Is agreement reached between provider and UR medical staff?

Step 8) Decision Point - Is the amount charged correct?

- Many times billings are received that cannot be processed because there is insufficient patient data, an inadequate medical report, or incomplete information.
- If the bill is denied and the provider doesn't agree or understand the reasoning he/she may file a lien. Explanation of benefits or explanation of review may not be clear.
- Sometimes paperwork is separated during insurer review and the claims adjuster requests additional copies from the medical provider.

Step 9) Insurer reimburses provider in accordance with the appropriate fee schedule.

Potential for a lien filing is two-fold.

- If the bill is reduced and the provider doesn't agree or understand the reasoning he/she may file a lien for the balance.
- Many times providers will be paid the fee schedule/contracted amount or negotiate a settlement of a lien and then sell the uncollected portion to a third party who then files a lien. Often, this occurs years later.

AB 749 did institute a statute of limitations for filing medical liens that may help with the latter situation.

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Authorities

California Labor Code

The following Labor Code sections apply to the billing and payment of workers' compensation medical expenses:

§5307.1 Official Medical Fee Schedules

§5307.11 Permissible contracts for reimbursement rates outside official fee schedule

§5307.2 Adoption of official pharmaceutical fee schedule

(Effective January 1, 2003 per AB 749)

§5307.21 Outpatient surgery facility fee schedule

Please Note – The Legislature enacted section 5307.21 in AB 749 and then inadvertently enacted another section 5307.21 in AB 486. The two sections are similar – the later enacted section has an additional subsection (d).

§4603.2 Payment by employer; penalties and liabilities for late payment; review of billing

§4603.4 Regulatory authority for payment processing

(Effective January 1, 2003 per AB 749)

California Code of Regulations

Details of workers' compensation medical billing and payments are contained in the following sections of the California Code of Regulations. These regulations may also be accessed at http://www.dir.ca.gov/t8/ch4_5sb1a5_5.html.

California Code of Regulations, Title 8

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director--Administrative Rules

Article 5.5. Application of the Official Medical Fee Schedule (Treatment)

§9790 Authority

§9790.1 Definitions

§9791 Services Covered

§9791.1 Medical Fee Schedule

§9792 Determination of the Fee

§9792.1 Payment of Inpatient Services of Health Facilities

Appendix A Composite Factors

Appendix B Weights and Revised DRG weights

Appendix C Ratio Applied to Revise Certain DRG Weights in California

§9792.5 Payment for Medical Treatment

§9792.6 Utilization Review Standards

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Appendix F

**Estimated Savings from Adopting
Medi-Cal's Fee Schedules for Pharmaceutical Reimbursements
Savings Based on Incurred Costs**

NOTE: Savings are in Thousands of Dollars

Calendar Year	2002	2003	2004	2005	2006
Incurred Medical- All Employers (1)	\$10,900,000				
Medical Cost Containment (2)	7.0%				
Incurred Medical net of Medical Cost Containment Expense	\$10,137,000				
Incurred Pharmacy— All Employers (3) (7.8% of total costs)	\$790,686	\$933,009	\$1,100,951	\$1,299,122	\$1,532,964
Pharmacy Savings- All Employers (4)	\$292,554	\$345,214	\$407,352	\$480,675	\$567,197
Pharmacy Savings- Insured Employers (70% of all employers)	\$204,788	\$241,649	\$285,146	\$336,473	\$397,038
Pharmacy Savings- Self-Insured Employers (30% of all employers)	\$87,766	\$103,564	\$122,206	\$144,203	\$170,159
State of California Pharmacy Savings (5)	\$10,532	\$12,428	\$14,665	\$17,304	\$20,419
Local Government Pharmacy Savings (6)	\$42,128	\$49,711	\$58,659	\$69,217	\$81,676

Please refer to following page for an explanation of the terms and assumptions employed in this analysis.

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Assumptions:

(1) Incurred Medical—All Employers	Incurred Medical for both insured and self-insured employers in California was estimated by WCIRB based on July 1, 2003 pure premium rates.
(2) Medical Cost Containment	Medical cost containment expense in 2002 was estimated to be 7.0% of Incurred Medical (WCIRB, 2003). For the purposes of this estimate this number was held constant for years 2003 through 2006.
(3) Incurred Pharmacy-All Employers	<p>According to WCIRB Annual Report 2003, pharmacy accounted for 7.8% of medical costs. Therefore, to obtain the incurred Pharmacy for all employers for 2002, medical (net of Medical cost containment) was multiplied by 0.078.</p> <p>For years 2003 through 2006 an annual growth in pharmacy costs of 18% was assumed. This is based on:</p> <ol style="list-style-type: none"> 1. Estimates of price and drug mix changes (12%) and the estimated increase in utilization that we see national systems such as Medicare and group health (6%) 2. This is also consistent, or even a little low, compared to the recent increases experienced by Medicare and group health in drug costs, 18-22% annually. <p>(Pharmacy annual growth calculations done by UC Berkeley independent consultant derived from a number of studies and articles reviewed including CHSWC Pharmaceutical Study 2000.)</p>
(4) Pharmacy Savings	Assuming savings of 37% (CHSWC, Pharmaceutical Study 2000, updated using latest Medical Pharmaceutical Fee Schedule: 90% of AWP [average wholesale price] plus \$4.05 dispensing fee.). Savings were estimated in 2002 for purposes of being able to project out through 2006. The most recent data we have for pharmaceutical costs as a percentage of medical paid is for 2002. http://files.medical.ca.gov/pubsdoco/publications/bulletins/ph/archive/word/ph20030201.doc
(5) State of California Pharmacy Savings	For Fiscal Year 2001/02, total workers' compensation medical paid by the State was \$169,232,898 or 3.6% of the wc medical paid by all employers (insured and self insured in California). This percentage was applied to the total incurred pharmaceutical savings calculated for 2002 through 2006. Source: Department of Personnel Administration, State of California Workers' Compensation Cost Report 2001-2002 FY. http://www.dpa.ca.gov/benefits/health/workcomp/wcmain.shtm
(6) Local Government Pharmacy Savings	For Fiscal Year 2001/02, total workers' compensation medical paid by the local government was 14.4% of the wc medical paid by all employers in California. This percentage was applied to the total incurred pharmaceutical savings calculated for 2002 through 2006. Source: DIR Self-Insurance Plans

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Ambulatory Surgery Centers Fee Schedules for Various States

Introduction

Currently in California there is no schedule for outpatient surgery facility fees. In fact, California's Official Medical Fee Schedule (OMFS) which serves as the basis for billing and payment of medical services provided to injured employees states that "Nothing contained in this schedule shall preclude any hospital, any surgery facility or any ambulatory surgical center from charging and collecting a facility fee for the use of the emergency room or operating room of the facility." (OMFS, April 1999 p.1)

As part of the Commission's evaluation on the need for and type of an outpatient surgery schedule, the Commission has prepared a supplement which details other states' methodologies for reimbursement of facility fees of outpatient surgery centers.

The states' workers' compensation payment methodologies for outpatient surgery services vary. A majority of the states either use the Medicare ASC grouping approach or reimburse the ASCs as a percentage of allowed charges. From the states in which we were able to obtain information regarding workers' compensation coverage of outpatient surgeries, seven states – Oregon, Massachusetts, Mississippi, Nevada, Pennsylvania, Washington, and West Virginia – pay based on Medicare ASC methodology. Massachusetts and West Virginia do not adjust the Medicare rates by a multiplier for reimbursing the outpatient surgery center facility charges. Oregon, Mississippi, Nevada, Pennsylvania, and Washington adjust Medicare's rates by a multiple of 150% or 250% as explained below. Nine states- Alabama, Colorado, Florida, Kansas, Kentucky, Minnesota, Nebraska, North Carolina, South Carolina pay based on a percentage of allowed charges. The percentage of charges methodology could be subject to manipulation by aggressive pricing. One of the states which bases its payment on a percentage of allowed charges has plans to move to the Medicare methodology. **(Table 1)**

Please note that the application of Medicare's ASC schedule in California workers' compensation would result in lower reimbursements than the application of Medicare's APC schedule.

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Table 1: Summary of Various States Outpatient Fee Schedule Methodologies

State	Methodology	Percentage of Charges Reimbursed/Medicare multiplier
Alabama	Percentage of charges	70 – 93%
Colorado	Percentage of charges	80%
Florida	Percentage of charges	70% or 80%
Georgia	The lower of billed charges or by ICD-9 code and corresponding reimbursement	N/A
Kansas	Percentage of charges	85, 87.5%, 90%
Kentucky	Percentage of charges	80%
Massachusetts	Medicare ASC group methodology	No multiplier used to adjust Medicare's rates
Minnesota	Percentage of charges	85% or 100%
Mississippi	Medicare ASC group methodology	150% of Medicare rates
Nebraska	Percentage of charges	96%
Nevada	Medicare ASC group methodology ⁴³	Approximately 150% of Medicare rates
North Carolina	Percentage of charges	100%
New York	150% of the rate promulgated by the New York State Health Department for Medicaid patients	N/A

⁴³ Nevada - Medicare's group methodology used for Groups 1 through 6 only

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State	Methodology	Percentage of Charges Reimbursed/Medicare multiplier
Oklahoma	DRG unit value under the Inpatient Hospital Fee Schedule multiplied by a conversion factor of \$920.	N/A
Oregon	Medicare ASC group methodology	250% of Medicare reimbursement rates for 2002
Pennsylvania	Medicare ASC group methodology	N/A
South Carolina	Percentage of charges	87.9%
Washington	Medicare ASC group methodology	250% of Medicare's rates
West Virginia	Medicare ASC group methodology	No multiplier used to adjust Medicare's rates
Wisconsin	Private vendor certified database to set maximum fees of ambulatory fee schedule	

The above table shows that seven states utilize Medicare's ASC schedule with a multiplier. It should be noted that the application of the APC Payment System would result in 24% higher average reimbursement than the application of the ASC.

As can be seen from the above table some states such as Kansas reimburse at different percentages for facility fees. The explanation for the difference in reimbursement amounts in these states, in most cases, depends on the size and location of the hospital. However, for more detailed information please see the information below for the corresponding state.

Different States' Fee Schedules using Medicare Methodology

Massachusetts

- Massachusetts reimburses ASCs according to Medicare's Group 8 methodology. The rates are exactly the same as Medicare's 2002 rates.

1	\$339.18
2	\$454.69
3	\$519.79
4	\$642.66
5	\$730.86
6	\$838.86
7	\$1,014.39
8	\$989.02

Mississippi

- The Mississippi Workers' Compensation Commission has adopted the Medicare Ambulatory Payment Groups (**Medicare Group 9 Methodology**) for classifying payment of facility fees of Ambulatory Surgery Centers. Payment for outpatient surgical services and associated goods rendered by a hospital, ambulatory surgical center, or other outpatient facility which bills for its services on HCFA form UB-92, is the lower of:

- 1) Billed charges; or
- 2) The payment limit set forth in the table entitled AMBULATORY SURGICAL CENTERS (CPT LISTING). The Department has a list of approved procedures and the corresponding appropriate payment group for reimbursement to facilities.

- The payments are based on ASC schedule and are approximately 150% of Medicare payments, as follows:

Payment Group Total Allowable Facility Fee

1	\$ 475.00
2	\$ 637.50
3	\$ 729.00
4	\$ 900.00
5	\$1,024.50
6	\$1,191.00
7	\$1,423.50
8	\$1,401.00
9	\$2,100.00

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Nevada

- The Division adopts, by reference, the complete list of eligible codes for surgical centers for ambulatory patients and the payment groups to which those codes are assigned for services rendered on and after January 1, 1997, established by the Health Care Financing Administration (HCFA), as amended on January 1, 2000.
- The following is the maximum allowable payment for each of the payment groups for fees charged by a licensed surgical center for ambulatory patients: **(Medicare Group 9 Methodology)**
- The payments are based on ASC schedule and are approximately 150% of Medicare payments for Groups 1 through 6 only. Groups 7 through 9 are medical/surgical per diem rates.

Payment Group Maximum Allowable Payment

Group 1 ...	\$490.16
Group 2 ...	\$628.23
Group 3 ...	\$759.40
Group 4 ...	\$938.89
Group 5 ...	\$998.72
Group 6 ...	\$1178.21
Group 7 ...	\$1221.47
Group 8 ...	\$1221.47
Group 9 ...	\$1221.47

Oregon

- Oregon reimburses ASCs at 250% of Medicare's rates for 2002 for Corvallis and Benton
- | | |
|---------|-------------|
| Group 1 | \$853.28 |
| Group 2 | \$1,143.88 |
| Group 3 | \$1,307.68 |
| Group 4 | \$ 1,616.75 |
| Group 5 | \$ 1,838.68 |
| Group 6 | \$ 2,108.00 |
| Group 7 | \$ 2,551.95 |
| Group 8 | \$ 2,485.78 |

Pennsylvania

- A medical fee schedule in use that is based on Medicare reimbursement rates adjusted by the state-wide average weekly wage change.
- Medicare 8 Groups Methodology used.

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Washington:

Washington has recently adopted two schedules for reimbursing facility fees, based on the Medicare ASC schedule and the Medicare Ambulatory Payment Classification Schedule (APC), effective January 1, 2002.

Ambulatory Surgery Center Schedule

Prior to the adoption of a schedule for ASCs, Washington's Department of Labor and Industries, paid ASCs 100 percent of allowed charges. The new methodology selected by the Department is modeled after the approach used by Medicare. This approach groups ASC services into eight groups based on Medicare's assessment of resource use. Each group is assigned a facility rate. Payments to ASCs will be the lesser of the provider's charges to the Department or the group rate for a particular procedure. The Department made several modifications to Medicare's system to make it more appropriate for a workers' compensation population since some procedures were undervalued under the Medicare system. One of the key changes is the addition of a ninth ASC payment group for arthroscopies.

The Department calculated the rates for the nine groups using Medicare group rates for Tacoma (the highest Medicare rates in Washington) for Federal Fiscal Year 2001. The rates will be phased-in over three years; during the first year the rates will be 250 percent of Medicare's, during the second and third years the rates will be 225 and 200 percent, respectively. (see below) The reimbursement will be based on Medicare Group 9 methodology. However, some procedures which have been shown to be undervalued in the current Medicare classification will be reassigned to different groups. The full schedule can be found at <http://www.lni.wa.gov/hsa>

Payment Rates for Modified Medicare Groups:

Payment levels will be phased in over a three-year period as described below. Payments are made at the lesser of billed charges and the fee schedule rate.

Group	January 2002	January 2003	January 2004
1	\$843.10	\$758.79	\$674.48
2	\$1,130.28	\$1,017.25	\$904.22
3	\$1,293.63	\$1,164.26	\$1,034.90
4	\$1,596.63	\$1,436.96	\$1,277.30
5	\$1,817.95	\$1,636.16	\$1,454.36
6	\$2,107.75	\$1,896.98	\$1,686.20
7	\$2,521.40	\$2,269.26	\$2,017.12
8	\$2,481.80	\$2,233.69	\$1,985.50
9	\$2,107.75	\$1,896.98	\$1,686.20

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As a final step in this process, the Department contracted with TUCKER ALAN INC. to conduct an objective evaluation of the proposed methodology and associated rates. Specifically the independent consultant was asked to assess whether the proposed rates are equitable and to comment on the Department's modifications to Medicare's payment policies and payment approach. Some of the key findings of Tucker Alan's analysis were:

- ASCs will experience a 17 percent decrease in payments overall
- The Department's proposed rates for ASCs will continue to be much higher in comparison to available information from private insurers and other states' workers' compensation programs
- Payment levels will continue to exceed costs of providers and provide a fair compensation to ASCs while at the same time providing incentives to deliver services as efficiently as possible

Outpatient Prospective Payment System-Based on Medicare's Ambulatory Payment Classification

Apart from the ASC Schedule, Washington also implemented a hospital Outpatient Prospective Payment System (OPPS) for payment of hospital outpatient services provided on or after January 1, 2002. This new payment method is based on Ambulatory Payment Classification (APC) rather than basing payment on Percent of Allowed Charges (POAC).

According to the Washington Department of Labor and Industries, the previous POAC method provided only limited means to manage outpatient expenditures and has not provided the expected consistency in procedure coding across hospitals. Because the new payment system requires the hospitals to accurately code outpatient services in order to receive proper payment, the department can:

- Better predict costs;
- Promote greater uniformity of procedure coding among hospitals;
- Track expenditures in specific categories;
- Capture better utilization statistics; and
- Provide better analysis of trends.

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Fee Schedules using payments based on percentage charged.

Alabama

- Uses a schedule in which maximum reimbursement is based on a discounted percentage of charges. The discounts range from 7 percent to 30 percent off of the original billed amount depending on the particular facility. Surgery centers are also reimbursed a cost-plus 10 percent for hardware, implants and processes used in authorized workers compensation outpatient surgery cases that cost over \$200. Copies of invoices are to be included with submitted claims.

Colorado

- Outpatient hospital services shall be reimbursed 80% of the original billed charges other than those which require CPT coding. Facility fees for ambulatory surgical centers shall be reimbursed at 80% of billed charges.

Florida

- Florida has maximum reimbursement allowances (MRA) for services and procedures (only about 15 procedures have MRA established) which are commonly used in the treatment of conditions covered by Workers' Compensation. When an ASC's usual and customary charge is equal to or less than the MRA listed for the procedure, the ASC must be reimbursed at 80% of its usual and customary charge or the MRA whichever is less. If an ASC usual and customary charge is greater than the MRA listed for the procedure, the ASC must be reimbursed at 65% of its usual and customary charge or the MRA, whichever is greater. For procedures, which do not have an MRA but are medically necessary for a work related injury reimbursement is limited to 70% of the ASC's usual and customary charge for the procedure. (1992 ASC Reimbursement Manual.)

Kansas

- Uses a schedule in which maximum reimbursement is based on percentage of charges. The discounted rates are 10%, 12.5% or 15% off of the usual and customary charge depending on the size and location of the hospital.

Kentucky

- Reimbursement is at 80% of the original billed amount on the UB-92 form for ASC facilities.

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Minnesota

- The payer's liability for payment shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge for similar treatment, articles, or supplies furnished to an injured person when paid for by the injured person whichever is lower. If a hospital is a small hospital with 100 beds or less, then reimbursed facility fees are reimbursed at 100% of the usual and customary charge.

Nebraska

- Nebraska discounts original billed charges at 4% for the ASCs

North Carolina

- Ambulatory surgical services are to be reimbursed at 100% of the original charges billed.

South Carolina

- Claims for outpatient services rendered at a hospital or ambulatory surgical center are paid at 12.1% off of the total billed charges. When a patient remains in outpatient observation beyond 48 hours the claim is paid according to the inpatient DRG system. (Hospital and Ambulatory Surgical Center Payment Manual 1997)

West Virginia

- West Virginia's schedules are based on Medicare's group 8 methodology. However, West Virginia only uses 6 of the 8 group payment amounts. The other two group payment amounts were not used since those procedures are not routinely part of the Workers' Compensation in West Virginia
- There was no multiplier on top of the Medicare rates utilized for West Virginia's Ambulatory Schedule.

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Fee Schedules using other Methodologies.

Georgia

- Uses a schedule in which the maximum allowable reimbursement is based on the lower of billed charges or the fee set forth in the Payment Schedule.
- The Payment Schedule is based on a ICD-9 coding system which is submitted on UB-92 form. The fees are set and determined by a hospital committee taking Medicare's rates and other research into account.

Oklahoma

- Uses a schedule in which the maximum allowable reimbursement equals: the DRG unit value under the Inpatient Hospital Fee Schedule multiplied by a conversion factor of \$920.

New York

- The reimbursement level for ambulatory surgery charges is set at 150% of the rate promulgated by the New York State Health Department for Medicaid patients.
- The schedule was prepared using the New York State Products of Ambulatory Surgery Methodology.

Wisconsin

- Uses a private vendor certified database to set maximum fees of ambulatory fee schedule. The maximum fees are set at 1.5 standard deviation from mean charges. The mean charges are derived from the ICD-9 Volume III codes from Wisconsin historical data on ASC charges. Therefore anything above the maximum and outside the critical region is not reimbursable. (Glenn Boyle, President of the Midwest Comp Review Services)

References

Ambulatory Surgical Facility Fee Schedules and Reimbursement Policies were obtained on Workers' Compensation websites for the following states:

Colorado www.coworkforce.com/DWC/
Kentucky www.labor.ky.gov/dwc/
Massachusetts www.state.ma.us/dia/
Minnesota www.doli.state.mn.us/workcomp.html
Mississippi www.mwcc.state.ms.us/
Nevada www.dbi.state.nv.us/

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North Carolina www.nccommerce.com/
Oregon www.cbs.state.or.us/wcd/
Pennsylvania www.dli.state.pa.us/landi/cwp/view.asp?
South Carolina www.wcc.state.sc.us/
Washington www.lni.wa.gov/
West Virginia www.state.wv.us/bep/WC/default.HTM

**Ambulatory Surgical Facility Fee Reimbursement Policies that were faxed by
Divisions of Workers' Compensation for the corresponding states:**

Alabama - Faxed by Trevor Perry, July 11, 2001
Florida - Faxed by Nancy M. Rice, January 17, 2003
Nebraska - Faxed by Kathy Arens, July 19, 2001
New York - Faxed by Mary Jane Tetrault, January 2003
Oklahoma - Faxed by Janice Wolf, July 11, 2001
Wisconsin - Authored by Glen Boyle January 2001

Other References:

California: Official Medical Fee Schedules, State of California Workers' Compensation, 1999.

Centers for Medicare and Medicaid Services (CMS), Program Memorandum: Update of Rates and Wage Index for Ambulatory Surgical Center (ASC) Payments Effective October 1, 2001.

Centers for Medicare and Medicaid Services (CMS), Medicare B Ambulatory Surgical Centers in Maine, Massachusetts, New Hampshire and Vermont, All Localities. November 2001.

Centers for Medicare and Medicaid Services (CMS), Ambulatory Surgery Center Facilities – Rate Updates. For fiscal years 2001, 2002, 2003.

Kansas: Workers' Compensation Schedule of Medical Fees, Kansas Department of Human Resources, October 1999.

Washington: <http://www.lni.wa.gov/hsa/conexecsumm.rtf> (Tucker Alan Inc. Independent Consultant Report)

Synopsis of Workers' Compensation Laws and Regulations of Member States, July 1999 and Revised March 2001. <http://www.sawca.com/htm/synopsis.htm>

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Conversations with various individual, pertaining to ambulatory fee schedules in various states' Divisions of Workers' Compensation.

Alabama: Trevor Perry, Administrative Analyst

Colorado: Debra Northrup, Unit Manager, Wayne Whitmarsh, Compensation Insurance Specialist III, Medical Cost Containment Unit

Florida: Barbara Moody, Registered Nurse Specialist, Bureau of Rehabilitation and Medical Services, Nancy M. Rice, Registered Nursing Consultant, Division of Health Quality Assurance, Bureau of Managed Health Care

Kentucky: Venice Higgs, Ombudsman

Mississippi: Sharon Jones, Medical Cost Containment Unit, Division of Workers' Compensation

Nebraska: Kathy Arens, Medical Services Specialist

Nevada: Bob Loritz, Manager, Medical Unit, Nevada Division of Industrial Relations, Christopher Pangallo, Compliance Investigator

North Carolina: Jennifer Gudac, Chief, Medical Fee Examiner

Oklahoma: Janice Wolf, Medical Fee Specialist

Oregon: Jean Zink, Registered Nurse, Medical Reviewer, Department of Consumer and Business Services

South Carolina: Glenn Simpson, Medical Services Director; Kandee Johnson, Paralegal Legal Assistant for the Medical Unit

Washington: Anaya Balter, Medical Program Specialist

West Virginia: Ben Taylor, Medical Policy Manager

**Estimated Savings from Adopting
Medicare's Fee Schedules for Outpatient Surgery Facility Fee Reimbursements**

A series of analyses were conducted to determine anticipated payment amounts for procedure codes in the study's outpatient data set using each of the two leading prospective payment methodologies for reimbursement of facility fees: Medicare's Ambulatory Payment Classifications (APC) system and Medicare's Ambulatory Surgery Center (ASC) payment system.

In order to estimate the savings from the use of the fee schedules, modeling analyses applied used the following approach to creating the series of estimates:

- The "low" estimates consisted of baseline calculations that used the unadjusted categorical reimbursement levels as stated in the current Medicare rules and regulations for each of the fee schedules.
- The "medium"-level reimbursement calculations used a 1.20 multiplier

Adjusters used in Modeling Analyses

	Low	Medium
ASC	Baseline	Baseline + 20%
APC	Baseline	Baseline + 20%

Estimates of Savings from Potential Alternatives

The following exhibit calculates potential 3-year savings based on WCIRB estimates of ultimate (incurred) total medical costs by year of injury, after removing cost containment expenses.

There are two import issues to keep in mind.

- APC is used by Medicare to reimburse hospital out-patient surgeries and covers a broader range of services and generally pays a higher amount than the ASC.

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- The ASC is used by Medicare to reimburse ambulatory surgery centers, covers only a subset of outpatient procedures, and generally pays a lower amount than the APC

Consequently, if the APC is applied to both types of facilities, the savings in the table below would be realized. If the APC and ASC are used in the same fashion as Medicare, the savings would fall somewhere between the two estimates. If only the ASC is used, a substantial number of procedures would remain outside the fee schedule, representing approximately 16% of total costs.

The exact savings would depend on the distribution of services between the two types of facilities, which is currently not known.

Cost containment expenses have been removed from the calculation of costs and savings. In addition, the estimates include consideration of the impact of the wage index used by Medicare to adjust reimbursements.

Analysis of the impact of the geographic variant (wage index) on reimbursements for outpatient procedures:

1. The Kominski/Gardner study calculated the savings from moving to each of the Medicare fee schedules for outpatient surgery:
 - a. ASC for free standing outpatient surgery facilities
 - b. APC for hospital based outpatient surgery facilities
2. The Kominski/Gardner study did not include the impact of the wage index, which varies by geography, on the Medicare reimbursement rate.
3. Here the impact of the wage index on the average reimbursement rate by Medicare is estimated for California outpatient facility payments.
4. Information on the distribution of outpatient surgeries (frequency of cost) by geographic area is not available because there is no consistent data collected on these procedures. However, we have detail on all workers' compensation inpatient admissions from the OSHPD data set. It is reasonable to model outpatient surgeries as being distributed similar to inpatient surgeries, geographically.
5. The geographic variant was modeled by merging information on the 2003 wage index for Medicare with the OSHPD data, then the average wage index was analyzed by both the distribution of admissions by frequency and charge amounts. The results for both estimates were virtually identical, with an average wage index adjustment of 1.22 (admissions) 1.21 (charge amount). A 1.215 adjustment was used.

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6. Medicare applies the wage index to the labor portion of the facility fee:
 - a. 60% of the facility fee for APC
 - b. 34.45% of ASC
7. Therefore, the impact of the geographical wage variant on the average reimbursement under APC and ASC was estimated as follows
 - a. APC is on average higher by $.60 * .21 = .126$, or 12.6% premium in CA.
 - b. ASC is on average higher by $.3445 * .21 = .073$ or 7.3% premium in CA.
8. Applying these numbers to the cost numbers the adjusted savings taken from the Kominski study are:

Percent savings against current paid amounts for services delivered under APC and ASC		
	Kominski	Adjusted for wage index
Low APC	57%	52%
Medium APC	48%	41%
Low ASC	73%	71%
Medium ASC	68%	66%

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Outpatient Savings Estimate - Based on Incurred Costs (In Thousand\$)			
Calendar Year	2004	2005	2006
Incurring Medical--All Employers (1)	\$ 13,800,000	\$ 15,400,000	\$ 17,300,000
Medical Cost Containment (MCC) (2)	7.0%	7.0%	7.0%
Incurring Medical net of MCC Expense	\$ 12,834,000	\$ 14,322,000	\$ 16,089,000
Hospital Costs (3) [29.5% of Incurring Med net of MCC]	\$ 3,786,030	\$ 4,224,990	\$ 4,746,255
Outpatient Facility Costs (4)	\$ 2,271,618	\$ 2,534,994	\$ 2,847,753
APC Savings % (100% of Medicare)	52%	52%	52%
APC Savings % (120% of Medicare)	41%	41%	41%
ASC Savings % (100% of Medicare)	71%	71%	71%
ASC Savings % (120% of Medicare)	66%	66%	66%
Total Savings - All Employers			
Potential Savings: APC% (100% of Medicare)	\$ 1,181,241	\$ 1,318,197	\$ 1,480,832
Potential Savings: APC% (120% of Medicare)	\$ 931,363	\$ 1,039,348	\$ 1,167,579
Potential Savings: ASC% (100% of Medicare)	\$ 1,612,849	\$ 1,799,846	\$ 2,021,905
Potential Savings: ASC% (120% of Medicare)	\$ 1,499,268	\$ 1,673,096	\$ 1,879,517
Total Savings - Insured Employers (70% of All Employers)			
Potential Savings: APC% (100% of Medicare)	\$ 826,869	\$ 922,738	\$ 1,036,582
Potential Savings: APC% (120% of Medicare)	\$ 651,954	\$ 727,543	\$ 817,305
Potential Savings: ASC% (100% of Medicare)	\$ 1,128,994	\$ 1,259,892	\$ 1,415,333
Potential Savings: ASC% (120% of Medicare)	\$ 1,049,488	\$ 1,171,167	\$ 1,315,662
Total Savings - Self-Insured Employers (30% of All Employers)			
Potential Savings: APC% (100% of Medicare)	\$ 354,372	\$ 395,459	\$ 444,249
Potential Savings: APC% (120% of Medicare)	\$ 279,409	\$ 311,804	\$ 350,274
Potential Savings: ASC% (100% of Medicare)	\$ 483,855	\$ 539,954	\$ 606,571
Potential Savings: ASC% (120% of Medicare)	\$ 449,780	\$ 501,929	\$ 563,855

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Outpatient Savings Estimate - Based on Incurred Costs (In Thousand\$)			
Calendar Year	2004	2005	2006
Incurring Medical--All Employers (1)	\$ 13,800,000	\$ 15,400,000	\$ 17,300,000
Medical Cost Containment (2)	7.0%	7.0%	7.0%
Incurring Medical net of Medical Cost Containment Expense	\$ 12,834,000	\$ 14,322,000	\$ 16,089,000
Hospital Costs (3) [29.5% of total costs]	\$ 3,786,030	\$ 4,224,990	\$ 4,746,255
Outpatient Facility Costs (4)	\$ 2,271,618	\$ 2,534,994	\$ 2,847,753
APC Savings % (100% of Medicare)	52%	52%	52%
APC Savings % (120% of Medicare)	41%	41%	41%
ASC Savings % (100% of Medicare)	71%	71%	71%
ASC Savings % (120% of Medicare)	66%	66%	66%
Savings for California Government (5)			
Potential Savings: APC% (100% of Medicare)	\$ 42,525	\$ 47,455	\$ 53,310
Potential Savings: APC% (120% of Medicare)	\$ 33,529	\$ 37,417	\$ 42,033
Potential Savings: ASC% (100% of Medicare)	\$ 58,063	\$ 64,794	\$ 72,789
Potential Savings: ASC% (120% of Medicare)	\$ 53,974	\$ 60,231	\$ 67,663
Savings for Local Government (6)			
Potential Savings: APC% (100% of Medicare)	\$ 170,099	\$ 189,820	\$ 213,240
Potential Savings: APC% (120% of Medicare)	\$ 134,116	\$ 149,666	\$ 168,131
Potential Savings: ASC% (100% of Medicare)	\$ 232,250	\$ 259,178	\$ 291,154
Potential Savings: ASC% (120% of Medicare)	\$ 215,895	\$ 240,926	\$ 270,650

Please see next page for an explanation of terms and assumptions utilized.

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Appendix H

Assumptions

(1) Incurred Medical--All Employers	Incurred Medical for both insured and self-insured employers in California was estimated by WCIRB based on July 1, 2003 pure premium rates.
(2) Medical Cost Containment	Medical cost containment expense in 2002 was estimated to be 7.0% of Incurred Medical (WCIRB, 2003). For the purposes of this estimate this number was held constant for years 2004 through 2006.
(3) Hospital Costs (Inpatient and Outpatient)	Hospital costs were estimated to be 29.5% of total Incurred Medical. Source WCIRB Annual Report 2003, Exhibit 1, Sheet 1. (Assumed the same percentage as in 'paid' medical costs.)
(4) Outpatient Facility Costs	Outpatient facility costs were estimated to be 60% of hospital costs. Source of calculations based on review of OSHPD data on all workers' compensation admissions and WCIRB data on all hospital costs (inpatient and outpatient). (Assumed the same distribution for 'incurred' as observed in 'paid' medical costs.)
(5) Savings for the State of California Government	For Fiscal Year 2001/02, total workers' compensation medical paid by the State was \$169,232,898 or 3.6% of the wc medical paid by all employers (insured and self insured in California). This percentage was applied to the total savings calculated for 2004 through 2006. Source: Department of Personnel Administration, State of California Workers' Compensation Cost Report 2001-2002 FY. http://www.dpa.ca.gov/benefits/health/workcomp/wcmain.shtm
(6) Savings for Local Government	For Fiscal Year 2001/02, total workers' compensation medical paid by the local government was 14.4 % of the wc medical paid by all employers in California. This percentage was applied to the total savings calculated for 2004 through 2006. Source: DIR Self-Insurance Plans

Report to the Congress: Medicare Payment Policy Executive Summary

Executive summary

The Congress has charged the Medicare Payment Advisory Commission with reviewing and making recommendations concerning Medicare payment policies. The Commission's recommendations aim to ensure that Medicare's payment systems set rates that cover the costs efficient providers would incur in furnishing care to beneficiaries. If payments are set too low, providers may not want to participate in the program and Medicare beneficiaries may not have access to quality care. If payments are set too high, taxpayers and beneficiaries will bear too large a burden.

In this report, we review Medicare prospective payment systems (PPSs) for seven sectors: hospital inpatient, hospital outpatient, physician, skilled nursing, home health, outpatient dialysis, and ambulatory surgical center services. We also discuss several broader issues related to Medicare payments:

- Considering the context for Medicare payment recommendations (e.g. how does the growth of Medicare expenditures compare to that of the economy, the federal budget, and the amount paid by other payers; how to characterize the spending impact of our recommendations);
- Assessing Medicare beneficiaries' access to care;
- Deciding how Medicare should deal with payments for new technologies; and
- Examining what health insurance choices are available to Medicare beneficiaries and what characteristics of insurance markets determine those choices.

Context

Understanding the overall context for Medicare payment policies is important for policymakers. Therefore, we have included in Chapter 1 spending trends not just for Medicare but also for private sector payers and other federal health care programs. Over the long term, the rate of increase in per capita spending for Medicare beneficiaries has been similar to that for members of private sector health insurance plans and several government-sponsored plans. Year to year, there are different patterns and fluctuations, but the factors driving health care costs appear to operate similarly for all payers. We also report trends in Medicare's share of health care spending in the United States and of the federal budget, and the share overall health care spending represents of gross domestic product (GDP). Over the next few decades Medicare will constitute a greater proportion of economic output. Similarly, it will create greater pressure within the federal budget and increased cost sharing may stress beneficiary resources. For these reasons, pressures to restrain Medicare's rate of spending growth will likely increase.

When considering a policy direction, policymakers need a clear understanding of how recommendations will affect spending. Therefore, we introduce taxonomy for estimating the fiscal implications of each of our recommendations. Specifically, estimates of spending changes are presented as ranges over one- and five-year periods; the implications for beneficiaries and providers are highlighted. These spending estimates cannot simply be added together to compute an overall estimate. Unlike official budget estimates, they do not take into account the complete package of policy recommendations, the interactions among them, or assumptions about changes in provider behavior.

Assessing payment adequacy and updating payments

In Chapter 2 we recommend payment adjustments for seven different Medicare prospective payment systems. For each system, we assess whether payments are adequate to cover the cost of efficient providers by using indicators such as providers' financial performance under Medicare, changes in the volume of services, the quality of and access to care, providers' access to capital, and market entry or exit. We then address the likely change in efficient providers' costs in 2004. We estimate input price inflation (as measured by a "market basket" index for each sector), allow for technological changes that both improve quality and significantly increase costs, and determine a reasonable expectation for productivity gains. For expected productivity gains, we use the 10-year average change in multifactor productivity in the general economy. Our update recommendations combine these judgments for each payment system. When appropriate, we also make recommendations to improve the distribution of payments among providers within each payment system.

Hospital inpatient and outpatient services

In the hospital sector we make both update and distributional recommendations. These recommendations should be considered jointly as a package because they are so closely interrelated and because some distributional recommendations would help certain hospitals—such as some rural hospitals—that are particularly vulnerable. We find that overall Medicare payments for hospital services are adequate as of fiscal year 2003. Using a margin calculation that encompasses nearly all Medicare payments to the hospitals, and thus is not influenced by cost accounting differences, we estimate a margin for hospital services in 2003 of 3.9 percent (adjusted for changes legislated for fiscal year 2004 that will reduce payments). Other broad indicators, such as trends in volume and access to capital, are also generally consistent with a conclusion of adequate payments. This conclusion, together with consideration of other factors that are likely to affect costs in the coming year—including input price inflation, technological advance and productivity—support an update for 2004 of market basket minus 0.4 percent for

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inpatient services. Because significant technological advances that affect outpatient services are accounted for through new technology provisions in that payment system, we recommend an outpatient update of market basket minus 0.9 percent for productivity improvement. In addition, five policy changes are needed to improve the distribution of inpatient payments:

- Expanding the current transfer policy for patients in certain diagnosis related groups (DRGs) who are discharged to post-acute settings;
- Implementing a low-volume adjustment; re-evaluating the labor share used for geographic adjustment of rates;
- Eliminating the differential in base rates for hospitals in rural and small urban areas;
- Increasing the cap on disproportionate share payments that applies to most rural hospitals.

We recommend expanding the post acute care transfer policy to additional DRGs to better allow payments to follow patient care and to prevent hospitals that cannot discharge patients to post-acute care from being disadvantaged. We have recommended the other four policy changes in previous reports and reiterate them now as part of the comprehensive package that, taken together with the update recommendation, will help maintain the financial viability of the hospital sector. A final important issue is the current indirect medical education adjustment to inpatient payments. That adjustment provides payments above the level justified by the empirical evidence on the relation between teaching activity and hospitals' Medicare costs. The Commission is not satisfied with the current policy, because there is no accountability for the use of the payments above the empirical level. We will explore ways to better target those payments to advance specific Medicare policy objectives through increased accountability.

Physician services

Medicare payment rates for physician services are based on a fee schedule and are updated annually based on the so-called sustainable growth rate system, which ties updates to growth in the national economy and other factors. Under this system, the update for 2003 is a minus 4.4 percent. In assessing payment adequacy we find a mixed picture. The number of physicians billing Medicare has increased and national indicators of access are still good. There are, however, anecdotal reports of access problems in some geographic markets and specialties. A national survey of physicians suggests that physicians are becoming more selective about accepting new Medicare patients—but that is true for private HMO and Medicaid patients as well. Finally, Medicare payment rates

have fallen somewhat relative to payment rates in the private sector, although they are still above levels seen in the mid-1990s.

From this assessment, the Commission concludes that payments would be adequate this year if the Congress were to change current law and require a modest, positive update for 2003 instead of the 4.4 percent payment reduction. Therefore, if the Congress acts, we recommend an update for 2004 that equals the estimated change in input prices for physician services less an adjustment for productivity growth. If the Congress does not require a positive update for 2003, a higher update will be necessary in 2004.

Skilled nursing facility services

Aggregate Medicare payments for skilled nursing facilities (SNFs) are at least adequate for fiscal year 2003. For freestanding SNFs—about 90 percent of providers in this sector—we estimate aggregate Medicare margins to be 11 percent in 2003. Including the 10 percent of SNFs that are hospital-based brings the aggregate SNF margin to about 5 percent. The high margin for freestanding SNFs reflects a decline in costs in recent years in response to incentives in the skilled nursing facility prospective payment system following high cost growth prior to its introduction. Preliminary evidence indicates that the decline in costs has not resulted in a lower quality of care. Because the prospective payment system for skilled nursing facilities is still relatively new, we expect this cost trend to continue into 2004, offsetting increases in input prices and other factors. Therefore, we recommend that the Congress not update payment rates for SNFs for fiscal year 2004.

Because of weaknesses in the current classification system for care in SNFs, however, payments are not distributed appropriately to account for the expected resource needs of different types of Medicare beneficiaries. Resources should be reallocated until the classification system is improved or replaced. As a start, we recommend that the Congress give the Secretary authority to reallocate money currently used as a payment add-on for rehabilitation classification groups to other classification groups so that payment more closely follows patient costs. This reallocation will benefit hospital-based SNFs to the extent that they serve patients with conditions more complex than those of patients in freestanding SNFs; therefore, no separate update for hospital-based SNFs is recommended. However, if this reallocation does not occur in a timely manner, the Congress should provide a market basket update less productivity adjustment of 0.9 percent for hospital-based SNFs only.

Home health services

Current aggregate Medicare payments for home health services are more than adequate relative to costs. For the first time, we now have cost data showing how home health agencies are performing under the PPS. We estimate that the Medicare margin for home health services in fiscal year 2003 will be 23.3 percent, even after accounting for the so called 15 percent payment reduction and the expiration of the current 10 percent rural add-on. Providers have responded to the new PPS by changing the home health product and the cost of providing an episode of home health services is lower as a result. Other broad indicators also suggest that payments are adequate: access to care is generally good, the rate of decline in the number of users has decreased, and the entry and exit of agencies has remained stable for the third year in a row. In the past, we have recommended updates that emphasized stability for this sector because we lacked data on agencies' financial performance and also wanted to give providers time to adapt to the new payment system. Home health agencies have adapted, and we expect them to continue to adapt during the coming year, further reducing the costs of providing an episode of care. Therefore, we recommend that the Congress not update payment rates for home health services for fiscal year 2004. Because of potential challenges that providers may face in rural areas, we also recommend that the Congress extend for one year, at a rate of 5 percent, add-on payments for home health services provided to Medicare beneficiaries who live in rural areas.

Outpatient dialysis services

Current aggregate Medicare payments for outpatient dialysis services for beneficiaries with end-stage renal disease appear to be adequate. Together, payments for composite rate services and injectable drugs—the two main components of payment to providers of outpatient dialysis services—exceeded providers' costs by about four percent in 2001. In addition, other indicators—such as continued entry of for-profit freestanding providers, increases in the volume of services provided, lack of evidence of beneficiaries facing systematic problems in accessing care, continued improvements in the quality of dialysis care, and providers enjoying adequate access to capital—together support the conclusion that Medicare's outpatient dialysis payments are adequate relative to efficient providers' costs. To account for changes in providers' costs in the coming year, the Congress should update the composite rate for outpatient dialysis services for calendar year 2004 by the change in input prices less a 0.9 percent adjustment for productivity gains.

Ambulatory surgical center services

An ambulatory surgical center (ASC) is a distinct entity that exclusively furnishes outpatient surgical services. The current payment rates for ASC services are based on a

cost survey conducted in 1986. Because of the age of the data, our first recommendation in this sector is that the Secretary expedite the collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system. Because there are no recent data on the cost of providing ASC services to Medicare beneficiaries, we looked at market factors and concluded that current payments for ASC services are more than adequate. There has been rapid growth in the number of ASCs; between 1997 and 2001, the number of Medicare-certified ASCs more than doubled. The volume of procedures provided by ASCs to beneficiaries increased by over 60 percent between 1997 and 2001. In addition, as indicated by their rapid growth, ASCs have sufficient access to capital. Current Medicare payments for ASC services are at least adequate to cover next year's expected increase in ASCs' costs. Therefore, we recommend that the Congress not update the payment rates for ASC services for fiscal year 2004.

In addition, although costs in ASCs should be lower than in hospital outpatient departments because ASCs have less regulatory burden and serve less medically complex patients, the ASC rate is currently higher than the outpatient hospital rate for several high volume procedures. Therefore, we recommend the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those same procedures after accounting for differences in the bundle of services covered.

Access to care

A basic goal of Medicare is to ensure that elderly and disabled Americans have access to appropriate, quality health care. Therefore, we plan each year to monitor beneficiaries' access to Medicare-covered services along three dimensions: (1) the health system's capacity; (2) beneficiaries' ability to obtain care; and (3) access to appropriate care. In Chapter 3, we present our analysis for this year and do not find widespread problems in beneficiaries' access to care. Although more selective about accepting patients from a number of payers than in the past, the vast majority of physicians are accepting at least some new Medicare beneficiaries. Post-acute services are generally available, although it has become more difficult to place the most complex patients in skilled nursing facilities. Nonetheless, some issues will require careful monitoring. As in other populations, certain beneficiaries—those in poor health, with low incomes, and without supplemental insurance—report more difficulty than others in accessing appropriate services. Other beneficiaries, even though reporting good access, may not be receiving appropriate services. In addition, shortages of nurses could affect the availability or timeliness of certain services, and demographic trends raise concerns about the capacity of the health system over time.

Payment for new technologies

Medicare has the dual responsibility to pay enough for beneficial new technologies to ensure beneficiaries' access to care, while also being a prudent purchaser of new technologies. In Chapter 4 we examine how this dual role is addressed in the inpatient and outpatient prospective payment systems and how those systems might be improved. The incentives built into prospective payment systems promote the use of new technologies that reduce costs, but they may also slow adoption of new technologies that increase costs. To offset that tendency, the inpatient and outpatient prospective payment systems currently incorporate the costs of new technologies through special payment mechanisms for specific new technologies as well as through an annual review of payment rates. To ensure fair treatment across technologies and payment systems, Med PAC recommends that the clinical criteria currently applied to all new technology applicants under the inpatient PPS, and to new medical device applicants under the outpatient PPS, be extended to new drugs and biological applicants under the outpatient PPS.

Health insurance choices for Medicare beneficiaries

Depending on where they live, Medicare beneficiaries may have a wide array of insurance options beyond traditional fee-for-service Medicare available to them. Those options may include Medicare+Choice comprehensive care plans and private fee-for service plans, cost contract plans, preferred provider plans, and varying forms of supplemental coverage. What options are available, and how and when beneficiaries choose among them, depends on specific market conditions and the circumstances of individual beneficiaries. The determinants of market conditions are both local and national. Although Medicare is a national program, it is only at the local level that medical care is delivered, beneficiaries choose insurance options and delivery systems, and insurers make decisions to enter the insurance market. In Chapter 5 we review the entire spectrum of insurance choices, as a first step in Med Pac's effort to better understand beneficiaries' choices and market conditions.

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