

**California Commission on
Health and Safety and Workers' Compensation**



CHSWC Summary

Findings and Recommendations

Inpatient Hospital Fee Schedule and Outpatient Surgery Study

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**Commission on Health and Safety and Workers' Compensation
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CHSWC Summary of Findings and Recommendations

Introduction

The Commission on Health and Safety and Workers' Compensation (CHSWC) staff have conducted additional research and investigation to substantiate the information in the report prepared by Laura Gardner and Gerald Kominski entitled "Inpatient Hospital Fee Schedule and Outpatient Surgery Study".

Inpatient Hospital Fee Schedule

With respect to the Inpatient Hospital Fee Schedule, staff have reviewed methodologies for further study proposed by California Healthcare Association and Medtronic Sofamor Danek. This December 6, 2001 proposal does not seem to provide the Commission with improved knowledge and will lead to costly analysis and file review. The principal concern of opponents of the study is that workers' compensation patients would be denied access to spinal surgeries if the recommendations were implemented. The concerns are based primarily on two factors:

- 1) Some hospitals (highly specialized in spinal surgeries) serve certain dedicated populations and cannot adjust their prices in order to recover costs.
- 2) If reimbursement levels are reduced, these hospitals will not be able to conduct surgeries on certain workers' compensation populations and access would be affected.

Findings

A review of California Office of Statewide Health Planning and Development (OSHPD) data for 1999 showed that:

- The largest volume provider of the workers' compensation spinal surgeries (DRGs 496-500) is treating less than 5 percent of the total workers' compensation spinal surgery cases.
- The top 28 hospitals by volume of workers' compensation spinal surgeries (DRGs 496-500) have completed approximately 50% of the total workers' compensation spinal surgery procedures. The top 24 hospitals have completed about half of the surgeries which require implants (DRGs 496-498).

Recommendation

A joint task force consisting of CHSWC, Division of Workers' Compensation (DWC), California Healthcare Association, other hospital representatives and an OSHPD representative should be established to recommend a reimbursement methodology for high-technology hardware and/or instrumentation for spine surgery DRGs that will provide predictability, stability, efficiency, and access to care.

Outpatient Facility Fee Schedule

In relation to the Outpatient section of the report, CHSWC recommends that an Outpatient Surgery Fee Schedule be developed and implemented for the California workers' compensation system, phased-in to facilitate implementation.

Further study and analysis could be greatly enhanced by data on provider costs. While there are data for inpatient hospital admissions, there is currently no central repository for medical costs.

Background

At the present time, California doesn't have a schedule for reimbursing outpatient facility fees.

CHSWC conducted a study to identify and measure the costs of outpatient surgery facility fees and the range of estimated savings related to implementing a fee schedule for outpatient surgery facility fees.

Findings to Support a California Outpatient Surgery Facility Fee Schedule

- The outpatient surgical facility fee analysis identified a lack of a stable method of paying for facility fees. Absence of a fee schedule increases exposure to excessive costs.
- The study found great variation of billed and paid amounts across the spectrum of services, resulting in an inability to predict costs.
- In addition, there may be increased administrative costs as a result of case-by-case negotiations for each procedure and a new class of liens and Appeals Board rulings.
- Finally, the current system may result in an uneven playing field that could penalize small employers and payers who lack the buying power to negotiate for the competitive rates achieved by larger groups.

Other States' Experiences with Outpatient Facility Fee Schedules

- The workers' compensation payment methodologies for reimbursement for services of facilities in several states are based on Medicare's Ambulatory Surgery Center Fee Schedule (ASC).

- For example, Washington, Mississippi, Nevada, Pennsylvania and West Virginia have a reimbursement system based on Medicare ASC methodology. All of these states apply the ASC schedule using a multiplier or other adjustment.
- 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.
 - The ASC schedule is used for reimbursing facility fees of freestanding ambulatory surgical centers.
 - Workers' compensation reimbursement payments to ambulatory surgery centers will be the lesser of the provider's charges to the Washington Department of Labor and Industries (L&I) or the ASC schedule group rate for a particular procedure.
 - Washington 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 ASC 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.
 - According to the Washington Department of Labor and Industries, the new ASC based system will enable the department to:
 - Define the minimum standards required for an ASC to provide surgical services to Washington injured workers and crime victims.
 - Revise the payment methodology for ASCs and other non-hospital surgical suites that provide surgical services to Washington injured workers and crime victims. Adoption of a prospective payment method will enable L&I to better manage its ASC and similar expenditures. It will also encourage cost effective use of ASC services.
 - Make L&I's payment for ASC services more consistent with its payment methods for other providers and with other state and federal agencies.
 - Standardize the payment rates for ASCs.
 - Clarify what procedures are covered in an ASC.
- Washington implemented a hospital Outpatient Prospective Payment System (OPPS) for payment of hospital outpatient services provided on or after January 1, 2002 (includes reimbursement of outpatient hospital surgical facility fees and emergency room facility fees). 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.

Alternatives for California

The following illustrate some of the ways in which California could implement an Outpatient Surgery Facility Fee Schedule.

- Utilize Medicare's Ambulatory Payment Classification system (APC)
 - The APC assigns 3,200 surgical procedures to one of 158 distinct APC groups.
 - Services in each APC are similar clinically and in terms of the resources that they require.
 - The APC payment amounts are adjusted to reflect geographical wage variations, using the Hospital Wage Index.
- Utilize Medicare's Ambulatory Surgery Center Fee Schedule (ASC)
 - The ASC Schedule assigns approximately 2,250 surgical codes to eight prospective payment categories for facility fee reimbursement.
 - The ASC payment amounts are adjusted to reflect regional wage variations.
- Either of the two potential alternatives discussed above may be phased in with a multiplier over a period of time to facilitate the transition to using a fee schedule.
- Establish a special task force to research other data sources and propose a methodology for a fee schedule (not excluding those methodologies described above) to be considered by the DWC Administrative Director.

Impact of Potential Alternatives

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) fee schedule.

- Repricing the facility payments to the APC Schedule would result in an average of \$640-an 80% reduction off the original billed charges.
- Repricing facility payments using the ASC Schedule would result in an average reimbursement of \$515-an 88% reduction off the original billed amount.

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 rules and regulations for each of the fee schedules.
- The “medium”-level reimbursement calculations replicated the 1.20 multiplier of the Medicare inpatient fee schedule used in the current state California workers’ compensation Inpatient Hospital Fee Schedule (IHFS).
- The “high”-level reimbursement calculations utilized two methods: The calculations based on the ASC fee schedule used the 1.75 multiplier found as “reasonable” in an Appeals Board decision cited in the report. The calculations based on the APC fee schedule combined the 1.20 multiplier with the addition of a wage index adjustment set at the highest rate in California (49% above the standard baseline rate for the labor component of the payment level).

Adjusters used in Modeling Analyses

	Low	Medium	High
ASC	Baseline	Baseline + 20%	Baseline + 75%
APC	Baseline	Baseline + 20%	Baseline + 20%+ High Wage Index (1.4983)

Estimates of Savings from Potential Alternatives

Savings projections are presented below using both **paid** (Exhibit 1) and **incurred** (Exhibit 2) medical cost estimates because the choice of approach, paid vs. incurred, depends on the purpose and intent of the projections. Paid costs for a given year are those amounts actually spent in that year while incurred costs represent both current expenditures and an estimate of future expenditures for claims originating in a given year¹.

Exhibit 1 (using **paid** medical costs) shows savings estimates from implementing the ASC or the APC schedule by projecting potential 5-year savings for the years 2002 through 2006.

Exhibit 1

(Please Note: All numbers in \$000's)

Calendar Year	2002	2003	2004	2005	2006
Paid Medical--Insured Employers (1)	\$ 3,322,089	\$ 3,527,062	\$ 3,744,682	\$ 3,975,729	\$ 4,221,032
Paid Medical--All Employers (2)	\$ 4,650,925	\$ 4,937,887	\$ 5,242,555	\$ 5,566,021	\$ 5,909,444
Medical Legal Expense (3)	3.7%	3.7%	3.7%	3.7%	3.7%
Paid Medical net of Medical Legal	\$ 4,478,841	\$ 4,755,186	\$ 5,048,580	\$ 5,360,078	\$ 5,690,795
Medical Cost Containment (4)	8.0%	8.0%	8.0%	8.0%	8.0%
Paid Medical net of Medical Legal and Medical Cost Containment Expense	\$ 4,120,534	\$ 4,374,771	\$ 4,644,694	\$ 4,931,272	\$ 5,235,531
Outpatient Costs (5)	\$ 2,060,267	\$ 2,187,385	\$ 2,322,347	\$ 2,465,636	\$ 2,617,766
Outpatient Facility Costs (6)	\$ 206,027	\$ 218,739	\$ 232,235	\$ 246,564	\$ 261,777
High APC Savings %:	33%	33%	33%	33%	33%
Low ASC Savings %:	73%	73%	73%	73%	73%
Potential Savings: High APC	\$ 67,989	\$ 72,184	\$ 76,637	\$ 81,366	\$ 86,386
Potential Savings: Low ASC	\$ 150,399	\$ 159,679	\$ 169,531	\$ 179,991	\$ 191,097
Cumulative Savings: High APC	\$ 67,989	\$ 140,173	\$ 216,810	\$ 298,176	\$ 384,562
Cumulative Savings: Low ASC	\$ 150,399	\$ 310,079	\$ 479,610	\$ 659,601	\$ 850,698

Assumptions for Exhibit 1:

(1) Paid Medical--Insured Employers	Total Paid Medical was estimated to be \$2,947,187,000 in 2000 (WCIRB, 11/7/01). For subsequent years, this number was incremented by an annual growth factor equal to 6.17% to account for the annual medical trend and medical inflation not subject to the fee schedule, per the WCIRB report.
(2) Paid Medical--All Employers	The Paid Medical of the self-insured employer population was estimated to be 40% of that of the insured employer population (11/7/01 letter to Suzanne Marria, Exhibit 5).

¹ The California Workers' Compensation Uniform Statistical Reporting Plan-1995, effective 1/1/2002, defines incurred costs as "the total of all amounts paid and the outstanding medical for a particular claim" (p. 139).

(3) Medical Legal Expense	Medical legal payments were estimated to equal 3.724% of total medical payments (WCIRB, 2001).
(4) Medical Cost Containment	Medical cost containment expense in 1999 was estimated to be 8.0% of Paid Medical net of Medical Legal (CWCI, 2001). For the purposes of this estimate this number was held constant for subsequent years.
(5) Outpatient Costs	Outpatient costs were estimated to be 50% of Paid Medical.
(6) Outpatient Facility Costs	Outpatient facility costs were estimated to be 10% of outpatient costs.

Exhibit 2 calculates potential 5-year savings based on WCIRB estimates of ultimate (**incurred**) total medical costs by accident year of injury based (a) on the methodologies reflected in the Commissioner's approved 2002 pure premium rates, (b) workforce growth information from EDD, and (c) the assumption that the self-insured market is approximately 40% of the size of the insured market. Exhibit 2's incurred medical cost figures have been adjusted to remove medical legal and medical cost containment costs.

Exhibit 2

Calendar Year	(\$000s)				
	2002	2003	2004	2005	2006
Incurred Medical--All Employers (1)	\$ 7,600,000	\$ 8,200,000	\$ 8,800,000	\$ 9,500,000	\$ 10,200,000
Medical Legal Expense (2)	3.7%	3.7%	3.7%	3.7%	3.7%
Incurred Medical net of Medical Legal	\$ 7,316,976	\$ 7,894,632	\$ 8,472,288	\$ 9,146,220	\$ 9,820,152
Medical Cost Containment (3)	8.0%	8.0%	8.0%	8.0%	8.0%
Paid Medical net of Medical Legal and Medical Cost Containment Expense	\$ 6,731,618	\$ 7,263,061	\$ 7,794,505	\$ 8,414,522	\$ 9,034,540
Outpatient Costs (4)	\$ 3,365,809	\$ 3,631,531	\$ 3,897,252	\$ 4,207,261	\$ 4,517,270
Outpatient Facility Costs (5)	\$ 336,581	\$ 363,153	\$ 389,725	\$ 420,726	\$ 451,727
High APC Savings %:	33%	33%	33%	33%	33%
Low ASC Savings %:	73%	73%	73%	73%	73%
Potential Savings: High APC	\$ 111,072	\$ 119,841	\$ 128,609	\$ 138,840	\$ 149,070
Potential Savings: Low ASC	\$ 245,704	\$ 265,102	\$ 284,499	\$ 307,130	\$ 329,761
Cumulative Savings: High APC	\$ 111,072	\$ 230,912	\$ 359,522	\$ 498,361	\$ 647,431
Cumulative Savings: Low ASC	\$ 245,704	\$ 510,806	\$ 795,305	\$ 1,102,435	\$ 1,432,196

Assumptions for Exhibit 2

(1) Incurred Medical--All Employers	Incurred Medical for the self-insured employer population was estimated to be 40% of that of the insured employer population (WCIRB, 11/7/01 letter to Suzanne Marria, Exhibit 5). This amount was then added to Incurred Medical for the insured population to derive total Incurred Medical.
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(2) Medical Legal Expense	Medical legal payments were estimated to equal 3.724% of total incurred medical payments (WCIRB, 2001).
(3) Medical Cost Containment	Medical cost containment expense in 1999 was estimated to be 8.0% of Incurred Medical net of Medical Legal (CWCI, 2001). For the purposes of this estimate this number was held constant for years 2002 through 2006.
(4) Outpatient Costs	Outpatient costs were estimated to be 50% of total Paid Medical.
(5) Outpatient Facility Costs	Outpatient facility costs were estimated to be 10% of outpatient costs.

Estimated Savings from Above Alternatives

- An estimated range of savings using the low and high end reimbursement formula would result in a savings between \$86 million and \$191 million in 2006, using **paid** medical costs, as indicated in Exhibit 1 above.
- An estimated range of savings using the low and high end reimbursement formula would result in a savings between \$149 million and \$330 million in 2006, using **incurred** medical costs, as indicated in Exhibit 2 above.
- The numbers used for a projection of savings depends on the approach used for the estimate of costs. That is, if the purpose of the projections is to estimate the amount to be budgeted for outlays in a given year, both costs and savings should be estimated using paid amounts. If the purpose of the projections is to estimate the total amount that will be spent for a set of claims now and in the future, both costs and savings should be estimated using incurred amounts.
- The above savings estimated that outpatient surgical facility fees are about 5% of total medical costs in California.
- The above cost savings estimates did not include emergency facility fees. Based on conversations with California's State Compensation Insurance Fund, Washington Department of Labor and Industries and an independent consultant, we believe there could be additional savings from these emergency facility fees, which account for an additional 1-2% of total medical costs. Additional savings can range from \$40-\$90 million.
- Estimated savings will depend upon the alternative and the phase-in period selected.

CHSWC Recommendations

Inpatient Fee Schedule

- A joint task force consisting of CHSWC, Division of Workers' Compensation (DWC), California Healthcare Association, other hospital representatives and an OSHPD representative should be established to recommend a reimbursement methodology for high-technology hardware and/or instrumentation for spine surgery DRGs that will provide predictability, stability, efficiency, and access to care.

Outpatient Fee Schedule

- A fee schedule which covers outpatient surgery facility fees should be implemented in the California workers' compensation system.
- A fee schedule which covers emergency room facility fees should also be considered.
- Establish a special task force to research other data sources and propose a methodology for a fee schedule (not necessarily excluding application of Medicare's ASC and APC with a phased-in multiplier) to be considered by the DWC Administrative Director.
- Further study and analysis could be greatly enhanced by data on provider costs. While there are data for inpatient hospital admissions, there is currently no central repository of data on medical costs.

Sources:

Studies

CHSWC Inpatient Hospital Fee Schedule and Outpatient Surgery Study, by Laura Gardner and Gerald Kominski, Final Draft issued December 2001.

Gardner, Laura, Memo “Estimated Savings Related to Implementation of an Outpatient Surgical Facility Fee Schedule”, January 14, 2002.

Websites

Ambulatory Surgical Facility Fee Schedules and Reimbursement Policies were obtained on Workers' Compensation websites for the following states, available via <http://www.comp.state.nc.us/ncic/pages/all150.htm>

Colorado
Kentucky
Minnesota
Mississippi
Nevada
North Carolina
Pennsylvania
South Carolina
Washington
West Virginia

Facsimile Transmission

The following states provided their Ambulatory Surgical Facility Fee Reimbursement Policies via facsimile transmission.

Alabama
Florida
Nebraska
New York
Oklahoma
Wisconsin

Other References:

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

US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Program Memorandum Intermediaries / Carriers: “Update of Rates and Wage Index for Ambulatory Surgical Center (ASC) Payments Effective October 1, 2001”, September 7, 2001..

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>

Washington State Department of Labor and Industries, Health Services Analysis "Quarterly Report on Washington State Workers' Compensation Health Care Expenditures for the Fourth Quarter of 2000", November 2001.

Conversations with various individuals

California:

California Health Care Association and Medtronic Sofamor Danek representatives
State Compensation Insurance Fund representatives
Frank Neuhauser, University of California, Berkeley
Stacey Jones, Consultant
Glenn Shor, Division of Workers' Compensation

Colorado:

Debra Northrup, Unit Manager, Medical Cost Containment Unit

Florida:

Barbara Moody, Registered Nurse Specialist, Bureau of Rehabilitation and Medical Services

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

South Carolina:

Glenn Simpson, Medical Services Director

Washington:

Anaya Balter, Medical Program Specialist