California State Auditor

BUREAU OF STATE AUDITS

California's Workers' Compensation Program:

Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis

Presentation by

California State Auditor

Conference Committee on Workers' Compensation

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This presentation document is only intended to outline selected portions of Report 2003-108.2, *Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis* (January 2004). For a more complete explanation of the points outlined in this document, refer to the report.

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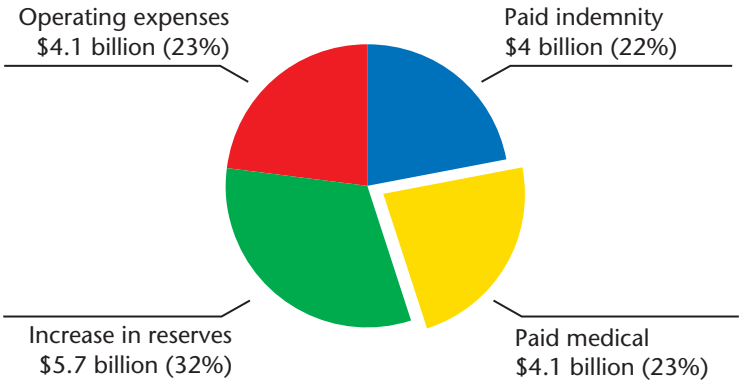
AUDIT SCOPE

BACKGROUND INFORMATION

The Workers' Compensation Insurance Rating Bureau (rating bureau) reported that insurers paid workers' compensation costs of more than $17.9 billion in 2002, with medical costs representing $4.1 billion.

FIGURE 1

Insurers' California Workers' Compensation Costs for 2002*



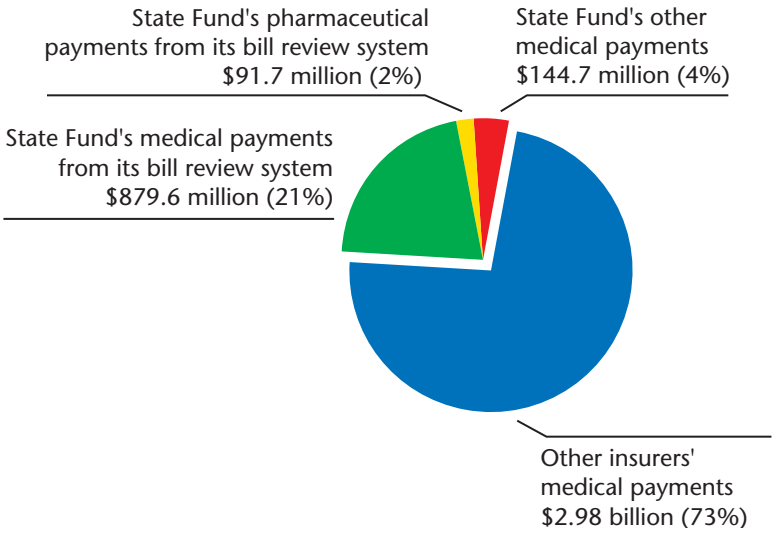
Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

* Total costs for insurers were over $17.9 billion. Some large, stable, or government employers may pay for employees' benefits directly through self-insurance.

Figure 2 shows the paid medical costs State Fund reported to the rating bureau compared to other insurers.

FIGURE 2

Comparison of Medical Payments Reported by State Fund and Other California Workers' Compensation Insurers in 2002*



Source: The Workers' Compensation Insurance Rating Bureau and the State Compensation Insurance Fund.

* Medical payments by all insurers totaled $4.1 billion.

Of the $880 million State Fund paid in medical payments, $203 million was paid to health care facilities in 2002. Payments to these facilities are broken out as follows:

- $56 million to physical rehabilitation facilities.
- $34 million to inpatient hospital facilities when the procedure required an overnight stay.
- $70 million to outpatient surgical facilities in hospitals.
- $43 million to surgical centers when they perform outpatient surgeries.

ANALYSES PERFORMED

- Specific focus of this audit was on the $43 million State Fund paid to surgical centers and the $91.7 million it paid for drugs in 2002. These amounts make up 12 percent of State Fund's total medical costs for that year.

- Requested data from State Fund because it paid 27 percent of all workers' compensation medical costs related to insured employers in 2002.

- Analyzed payments State Fund made to surgical centers and for pharmaceuticals that were included in its medical bill review system in 2002.

- Calculated potential savings of recent reforms using 120 percent of Medicare's Ambulatory Surgical Center (ASC) fee schedule.

- Used ASC fee schedule, which has nine groups, rather than Ambulatory Payment Classification schedule because it has 569 groups.

- Compared State Fund's average payments for prescription drugs in 2002 to the amount California's Medi-Cal program would have paid for the same drugs.

- Determined the Division of Workers' Compensation (division) plans for implementing the new legislation's fee schedule requirements and completing its data collection system, the Workers' Compensation Information System (WCIS).

AUDIT HIGHLIGHTS

- Of the $14.5 million in surgical center payments that we analyzed, State Fund would have saved between $7.8 million to $8.9 million in 2002 had the recent reforms been in place.

- Savings for surgical centers represent about 54 percent to 61 percent, respectively, of the payments in State Fund's medical bill review database that contained sufficient detail for analysis.

- Of the $76 million in pharmaceutical payments that we analyzed, State Fund would have saved $18 million[1] in 2002 had the new reforms been in place during that year.

- Our analysis was limited because the data entered into State Fund's medical bill review file were often incomplete.

- Achievement of savings will depend upon careful implementation of newly legislated reforms.

- The administrative director of the division states that his efforts to implement reforms have been hampered by hiring freezes and budget shortfalls.

- The division continues to lack a comprehensive database to monitor workers' compensation medical payments.

[1] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments effective January 1, 2004, which a preliminary injunction partially blocked. Without the 5 percent reduction, savings are estimated at $14.6 million.

Recent Reforms Will Cause Payments for Outpatient Surgical Facility Services and Prescription Drugs to Drop Sharply

New reforms limit payments for the use of outpatient surgical facilities (facility fees) to 120 percent of Medicare's ambulatory payment classification fee schedule. The reforms also limit payments for pharmaceuticals to 100 percent of the relevant Medi-Cal fee schedule.

OUR REVIEW OF ACTUAL STATE FUND PAYMENTS TO SURGICAL CENTERS SHOWS THE POTENTIAL FOR SAVINGS

Our analysis indicates that had similar reforms been in place during 2002, State Fund could have saved anywhere from $7.8 million to $8.9 million of the $14.5 million paid to outpatient surgical centers we were able to analyze.

> This represents a range of 54 percent to 61 percent, respectively. Our results are similar to the Commission on Health and Safety and Workers' Compensation's projection that the system would save 66 percent on payments for surgical center facility services.
>
> The range reflects an adjustment using the geographic index for the highest and lowest cost areas in California.

We were able to analyze only $14.5 million (or 34 percent) of the $43 million in identifiable payments that State Fund made to surgical centers in 2002. Our analysis was limited because:

1) The medical payment data were incomplete, inconsistent, or too general.

2) Features of the database design made detailed data analysis impossible.

State Fund makes payments to two types of surgical centers: (1) independent surgical centers and (2) surgical centers that contract with a preferred provider organization (PPO) that in turn provides services through its network of medical service providers at negotiated rates.

> **Tables A.1 and A.2 (attached)** show savings for payments to independent surgical centers and through a PPO respectively.
>
> State Fund could have saved between $2.4 million and $2.9 million in payments to the independent surgical centers and between $5.4 million and $6 million in payments through a PPO if the recent reforms had been in place during 2002.

Savings appear to be greater for the payments associated with the PPO because the rates are negotiated and, therefore, do not result in disputes.

In contrast, in the absence of predetermined rates for outpatient surgical centers, State Fund attempts to control costs by unilaterally imposing limits on the fees it pays. According to State Fund it caps payments at 200 percent of Medicare's rates for similar services. In some cases this cap results in disputes that can lead to additional payments. However, when State

Fund makes the additional payments it does not link those payments to the original claims in its medical bill review database. As a result, the payments State Fund ultimately makes to independent surgical centers may be even higher.

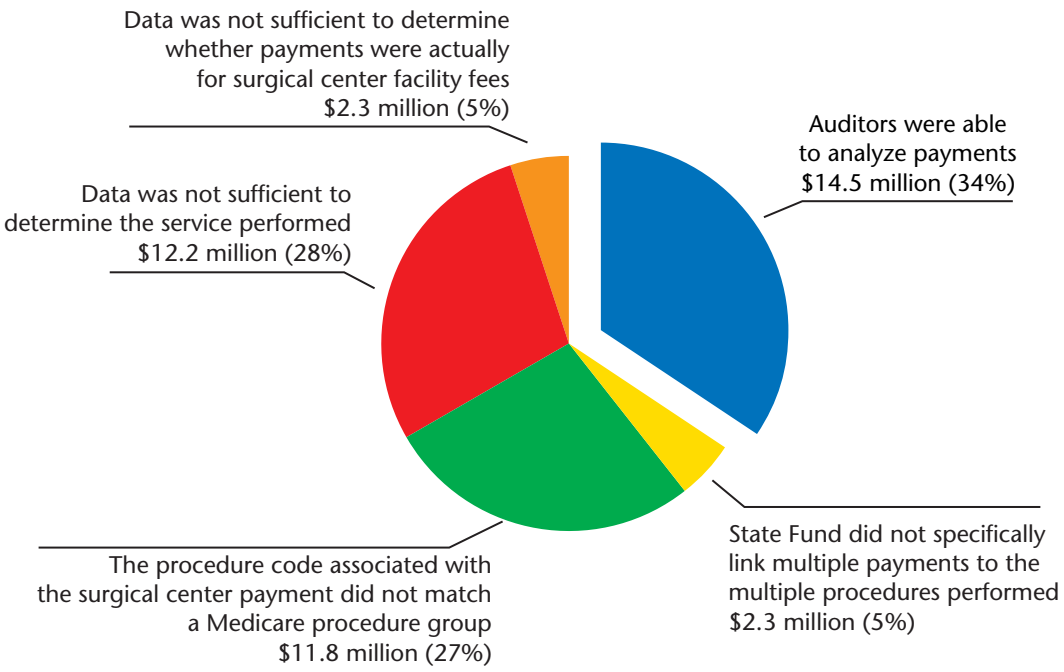
THE CONDITION OF THE MEDICAL PAYMENT DATA LIMITED OUR ANALYSIS

Using the medical payment data included in State Fund's bill review system, we attempted to analyze the approximately $43 million we were able to identify as payments to outpatient surgical centers. However, due to various problems with these data, we were able to analyze just over $14.5 million of the $43 million (or 34 percent).

Figure 3 shows the portions of those payments that we could analyze and those we could not because of problems with State Fund's data.

FIGURE 3

Only a Portion of State Fund's Payment Data for Surgical Centers During 2002 Could Be Analyzed*



Source: The State Compensation Insurance Fund's medical bill review file.

* Segments total $43.1 million. We rounded this amount to $43 million when discussing it throughout the report.

Breakdown of the $43 million is as follows:

- $14.5 million—Payments we were able to analyze.
- $12.2 million—Data was not sufficient to determine the service performed.

- $11.8 million—The procedure code did not match a Medicare procedure code.
- $2.3 million—State Fund did not specifically link multiple payments to the multiple procedures performed.
- $2.3 million—Data was not sufficient to determine whether payments were for surgical center facility fees.

POTENTIAL SAVINGS ALSO EXIST IN PHARMACEUTICALS

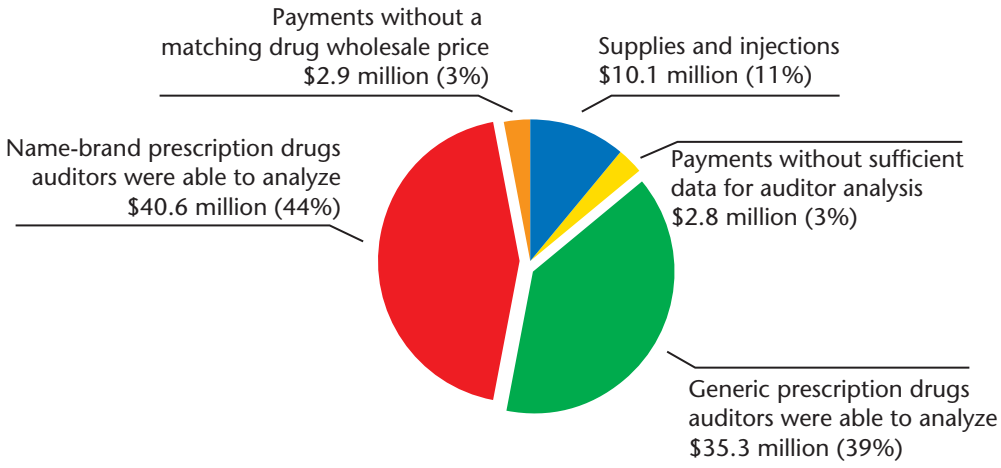
State Fund could have saved another $18 million (or about 24 percent) on the amount it spent on prescription drugs.[2]

State Fund could have saved $6.2 million, or 15 percent, on name-brand prescription drugs and $11.8 million, or 33 percent, on generic prescription drugs in 2002.

STATE FUND'S PAYMENTS FOR PHARMACEUTICALS DURING 2002

FIGURE 4

State Fund's Payments for Pharmaceuticals During 2002



Source: The State Compensation Insurance Fund's medical bill review file.

[2] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments; however, a preliminary injunction partially blocked the reduction. Without the 5 percent reduction, savings are estimated at $14.6 million (19 percent).

State Fund paid $91.7 million for pharmaceutical purchases in 2002. Of this amount:

- $75.9 million was for prescription drugs that appear on a list of drug wholesale prices that the Department of Health Services uses in administering its Medi-Cal program.

- $10.1 million was for supplies and injections that we could not verify would be affected by the new reforms.

- $2.8 million was for items for which data did not allow further analysis.

- $2.9 million was for drugs whose names did not appear on the list of drug wholesale prices.

Of the approximately $76 million State Fund paid for prescription drugs, $41 million was for name-brand drugs and $35 million was for generic drugs.

We based our comparison on the most commonly used payment, adjusted for the January 1, 2004, Medi-Cal reduction—the average wholesale price less 10 percent—plus a $3.55 dispensing fee, less an additional 5 percent.

THE PAYMENT SYSTEM THAT THE NEW LEGISLATION REQUIRES SHOULD PRODUCE SAVINGS IN ADDITION TO THOSE WE IDENTIFIED

- Savings could increase because proper implementation of a Medicare-based fee schedule will set a firm ceiling for payments for surgical center facility fees and should define the supplemental services that State Fund will now compensate under the facility fee.

  For 2002, we found that for 8 percent of the approximately 3,900 payments we analyzed, State Fund paid independent surgical centers solely for the use of the facility an average amount that exceeded 300 percent of the Medicare ASC rate, using the highest wage index in California.

  Although we did not review the individual claim transactions to determine the cause for the higher payments, we expect that most of these instances will no longer occur once payments to surgical centers are limited to 120 percent of Medicare's rate.

- Unlike surgical center facility fees under Medicare, California's payment system in 2002 required State Fund to pay surgical centers a reasonable fee for supplies, drugs, and other services connected with outpatient surgical procedures—in addition to the fee it paid for the use of the facility.

- We found a number of instances in which the amount State Fund paid for supplies, drugs, and other services that Medicare would normally bundle as part of the facility fee, greatly exceeded the amount State Fund paid for the facility fee alone.

  For example, State Fund paid one surgical center a facility fee of $1,126 and an additional $10,303 for drugs and supplies. Using a fee schedule based on 120 percent of Medicare's ASC payment system, State Fund would have paid no more than $631 for the same service.

- Costly litigation and settlements that arise from ambiguities in the former system should be reduced under the new system.

- According to State Fund, under the outpatient fee schedule that the new legislation requires, much of the $27 million it paid to a PPO to control costs could be avoided and added to potential savings.

  In 2002, State Fund paid a PPO almost $27 million for bill review, case management, utilization services, and access to the PPO's network of contract providers.

Savings Depend on Careful Implementation of the Medical Payment Fee Schedules and Monitoring of the Medical Payment System

Uniformly implementing the service-bundling and pricing features of the Medicare Ambulatory Payment Classification (APC) payment system is central to preventing added costs for services performed and achieving all the savings the Legislature intended the reforms to provide.

New law requires the Division of Workers' Compensation's (division) administrative director to adopt and periodically revise an official medical fee schedule that establishes reasonable maximum fees to be paid for a variety of services including outpatient surgical facility services.

- On December 30, 2003, the administrative director posted on the division's Web site a set of proposed emergency regulations to implement the medical fee schedules the new law requires.

- On the same day, the administrative director submitted the proposed regulations to the Office of Administrative Law for review and approval. If approved, the emergency regulations will remain in effect for only 120 days.

- However, the division's administrative director stated that the State's hiring freeze and budget shortfalls have hampered his efforts to implement past and current reforms.

- Although funding for 64 positions is included in the division's fiscal year 2003-04 budget to implement reforms that took effect in 2002, the administrative director stated that he cannot fill the positions until he is able to obtain an exemption to the State's current hiring freeze.

- The 2003-04 budget does not include any funding to implement the reforms that took effect in January 2004.

Another aspect critical to fully implementing the reforms is having access to adequate and reliable medical payment data.

Such data is necessary for two reasons: (1) to monitor the performance of the workers' compensation system in delivering quality care to injured workers at a reasonable cost to employers and (2) to track the effect of the reforms and other policy changes on the system's performance.

The division is currently developing a workers' compensation database that is intended to provide the level of information necessary to analyze and monitor system performance. However, this database has suffered extensive delays because of slow implementation.

THE DIVISION MUST RELY ON INSURERS FOR RELIABLE MEDICAL PAYMENT DATA

The division is developing a Workers' Compensation Information System (WCIS), to collect medical payment and other types of data from insurers and claims administrators.

However, WCIS has been under development for years and is still unable to provide the medical payment data that could be useful to program evaluators and decision makers.

Although the division had identified the data elements it believed it needed to oversee the medical payment system, it was still negotiating in August 2003 the types of data elements that insurers, including State Fund, and claims administrators would report.

The division conducted a survey of seven insurers which revealed that their databases, like State Fund's, appear to lack the ability to extract the detailed data that the division called for; in some cases the insurers reported that they did not even collect important data.

Of the 78 medical data elements that the division had proposed to collect, only seven elements were being collected by all the insurers in the division's survey.

RECOMMENDATIONS

To fully realize the savings from the new reforms to the workers' compensation medical payment system, the division's administrative director must continue to provide the workers' compensation community with the ongoing education and guidance that will ensure the reforms are promptly and effectively implemented.

The division should ensure that the medical payment data it collects in the WCIS provides the specific information the division needs to adequately monitor medical payments for compliance with the payment system and to measure the effectiveness of policy decisions.

> The division needs to clearly define the data elements it requires from insurers and claims administrators. It should obtain medical payment data using a standardized reporting instrument that will ensure that insurers and claims administrators consistently and completely report the data in such a way that it will be useful for the division's analysis and monitoring.

Attachments (Tables A.1 and A.2)

TABLE A.1

Savings on Payments to Independent Surgical Centers in 2002

Medicare Procedure Group	Number of Facility Fees Paid	Average State Fund Payment	120 Percent of Medicare ASC Rate	Total State Fund Paid	Amount Medicare Would Have Paid	Savings
Low End						
1	666	$ 875	$ 397	$ 583,076	$ 264,402	$ 318,674
2	895	1,230	532	1,100,625	476,140	624,485
3	1,158	1,472	609	1,704,073	705,222	998,851
4	986	1,535	752	1,513,318	741,472	771,846
5	83	1,504	856	124,839	71,048	53,791
6	0	NA	986	0	0	0
7	124	2,041	1,187	253,112	147,188	105,924
8	0	NA	1,161	0	0	0
9	0	NA	1,598	0	0	0
Totals	**3,912**			**$5,279,043**	**$2,405,472**	**$2,873,571**
High End						
1	666	875	471	583,076	313,686	269,390
2	895	1,230	631	1,100,625	564,745	535,880
3	1,158	1,472	721	1,704,073	834,918	869,155
4	986	1,535	891	1,513,318	878,526	634,792
5	83	1,504	1,014	124,839	84,162	40,677
6	0	NA	1,168	0	0	0
7	124	2,041	1,407	253,112	174,468	78,644
8	0	NA	1,376	0	0	0
9	0	NA	1,894	0	0	0
Totals	**3,912**			**$5,279,043**	**$2,850,505**	**$2,428,538**

Source: State Fund's medical bill review file and Medicare's ASC rates.

NA = Not applicable.

TABLE A.2

Savings on Payments to Surgical Centers Paid Through a Preferred Provider Organization in 2002

Medicare Procedure Group	Number of Facility Fees Paid	Average State Fund Payment	120 Percent of Medicare ASC Rate	Total State Fund Paid	Amount Medicare Would Have Paid	Savings/(Loss)
Low End						
1	338	$ 963	$ 397	$ 325,576	$ 134,186	$ 191,390
2	1,212	1,212	532	1,468,917	644,784	824,133
3	1,592	2,236	609	3,559,788	969,528	2,590,260
4	1,419	2,036	752	2,888,690	1,067,088	1,821,602
5	147	2,297	856	337,587	125,832	211,755
6	1	1,016	986	1,016	986	30
7	267	2,506	1,187	669,095	316,929	352,166
8	8	1,855	1,161	14,839	9,288	5,551
9	0	NA	1,598	0	0	0
Totals	**4,984**			**$9,265,508**	**$3,268,621**	**$5,996,887**
High End						
1	338	963	471	325,576	159,198	166,378
2	1,212	1,212	631	1,468,917	764,772	704,145
3	1,592	2,236	721	3,559,788	1,147,832	2,411,956
4	1,419	2,036	891	2,888,690	1,264,329	1,624,361
5	147	2,297	1,014	337,587	149,058	188,529
6	1	1,016	1,168	1,016	1,168	(152)
7	267	2,506	1,407	669,095	375,669	293,426
8	8	1,855	1,376	14,839	11,008	3,831
9	0	NA	1,894	0	0	0
Totals	**4,984**			**$9,265,508**	**$3,873,034**	**$5,392,474**

Source: State Fund's medical bill review file and Medicare's ASC rates.

NA = Not applicable.