



Adopting Medicare Fee Schedules

*Considerations for the California Workers'
Compensation Program*

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Prepared for the
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Summary

Background

Medical costs are the fastest increasing component of the California workers' compensation program (CWCP). They have increased from 45 percent of benefit costs in the mid-1990s to an estimated 55 percent in 2003. During this same period, the average medical benefits paid per indemnity claim have been increasing 15 percent annually (CHSWC, 2002).

Currently, the Division of Workers' Compensation (DWC) uses an Official Medical Fee Schedule (OMFS) to set the maximum allowable amounts that may be paid to providers for medical services. The OMFS covers most medical services provided by a physician or other health care provider to whom the patient has been referred. However, maximum allowable amounts have not been established for facility fees associated with surgical procedures performed in hospital outpatient settings and ambulatory surgical centers. Moreover, the DWC has not had the resources to update the existing fee schedules on a regular basis. The portions of the OMFS that apply to inpatient hospital services and to physician and other practitioner services have not been updated since 2001 and 1999, respectively.

The California Senate Labor and Industrial Relations Committee asked the Commission on Health and Safety and Workers' Compensation (CHSWC) to develop proposals for medical cost savings. In response to this request, the CHSWC is recommending that California consider linking the OMFS to Medicare's fee schedules for all services other than pharmaceuticals.

Medicare is the federal health insurance program for the aged, the disabled, and persons with end-stage renal disease. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS). With few exceptions, Medicare uses fee schedules that are regularly updated to pay for medical care provided to its beneficiaries. The fee schedules are intended to relate payments to the resources required to provide the services.

The California workers' compensation program already models its OMFS for inpatient hospital services on Medicare's payment system and has adopted elements of other Medicare fee schedules, such as the global billing periods¹ for surgery and relative values² for orthotics and prosthetics. Because Medicare does not cover most outpatient prescription drugs, the CHSWC is recommending that the California Medicaid (MediCal) program's fee schedule for pharmaceuticals be used. Under the commission's proposal, the only component of the OMFS

¹The global billing period is the period during which the pre- and post-operative care provided by a surgeon is covered by the payment for the surgical procedure.

²As discussed later, most fee schedules include a relative value or weight that measures the resources required for a given service or group of services relative to other services.

that would require regulatory action is the multiplier, or adjustment, to the Medicare rates that would establish the overall payment levels for the California workers' compensation program. Linking the OMFS to the Medicare fee schedule would expand the services covered by the OMFS and shift the administrative burden of ongoing fee schedule refinement and regular updates to the CMS.

The CHSWC asked RAND to identify the issues that would need to be addressed if the OMFS were linked to Medicare fee schedules, including:

- issues that are likely to arise from existing differences between the two fee schedules
- issues surrounding the modifications that might be necessary to tailor the Medicare fee schedules to CWCP patients
- issues regarding the implications of automatic annual updates of fee schedules.

Prior research by other organizations has explored many of the issues that need to be considered in adopting the Medicare fee schedules. Given the limited amount of time available for this study, RAND drew heavily from this previous work and from other information to identify the policy options and potential impact if the link to Medicare fee schedules were to occur. Except for limited analyses of readily available hospital inpatient data, primary data analyses were not within the scope of this study.

This study focuses on the features of the Medicare fee schedule that are at variance with the existing OMFS fee schedule and the issues that should be considered in deciding whether to retain particular features of the OMFS. Some issues, such as whether the fee schedules for physician services should have a single conversion factor or multiple conversion factors that account for current payment differentials, primarily involve a trade-off between redistributing payments across physician specialties and improving the match between payments and the costs of providing services. Other issues, such as whether adjustments are needed to reflect the differences in the populations covered by Medicare and the California workers' compensation program, involve a trade-off between administrative burden and payment accuracy. Administrative burden is minimized if the Medicare fee schedule payment parameters are adopted without modification. However, the populations covered by Medicare and workers' compensation differ from one another, and some modifications may be needed to ensure that payments are generally appropriate.

Other workers' compensation programs have adopted the structure of the Medicare fee schedules, with different multipliers, to the Medicare payment rates. The experience of these programs and their modifications for workers' compensation-specific services could inform the decisions the DWC would need to make in adapting the Medicare fee schedules for the CWCP.

- At least 17 states, the District of Columbia, and the federal workers' compensation program have adopted resource-based relative value scale (RB-RVS) fee schedules (although a number of states have retained service-specific conversion factors) for physician services. Key features

of these fee schedules are detailed in Eccleston et al. (2002); Kominski, Pourat, and Black (1999); and The Lewin Group (2002).

- At least seven states are using the Medicare fee schedule for freestanding ambulatory surgery centers to pay for ambulatory surgery. In addition, one state has implemented a fee schedule for hospital outpatient services based on Medicare's fee schedule (CHSWC, 2003).

Summary of Overall Findings

- Generally, Medicare's fee schedules cover the broad range of services covered by the CWCP (see Table S.1). Some attention, however, needs to be given to individual services that are unique to the CWCP or to providers that are not covered by Medicare, such as acupuncturists and family therapists.
- Linking the OMFS to the Medicare fee schedules shifts the administrative burden of ongoing fee schedule refinement and updates to the CMS. Medicare fee schedules are updated on a regular basis with opportunity for public comment. An independent commission is charged with reviewing and making recommendations concerning Medicare payment policies. In addition, other advisory committees provide CMS with regular input on potential refinements to its various payment systems.
- Medicare fee schedules are more than just a set of prices. Coding standards and payment policies are implicit in the prices and often differ from those currently used by the OMFS or have features that the OMFS lacks. There are a number of individual policy issues that would need to be addressed at the outset of linking the OMFS to the Medicare fee schedules. However, after the decisions are made on these issues, they can be imbedded in the OMFS and should not preclude automatic updates in the future based on Medicare fee schedule updates.
- Medicare fee schedules have evolved over time to become systems that are organized around the *provider* who is furnishing the care and the setting where that care is delivered. When services are provided in a facility setting, separate payments are made to the physician or other practitioner and to the facility. Total payment for many ambulatory procedures varies based on the setting in which those procedures are done. In contrast, the current OMFS establishes maximum payments for services and, except for surgical procedures and emergency room services for which separate facility fees are allowed, the amounts do not vary based on the ambulatory setting in which the services are provided. This situation raises a number of important issues: (1) whether to continue to employ current OMFS rules regarding separate facility fees or establish separate facility fees for all hospital outpatient services; (2) whether to establish the same maximum facility fee payments for hospital outpatient departments and ambulatory surgical centers; and (3) whether to adopt Medicare's payment differentials for services furnished in office and facility settings by physicians and other practitioners. How these issues are addressed will affect both the

incentives for where care is delivered and total California workers' compensation medical care expenditures.

**Table S.1
Overview of Medicare Payment System and OMFS by Type of Service**

Service	Medicare Payment System	OMFS
Inpatient Hospital Acute care hospitals Freestanding rehabilitation hospitals and units of acute care hospitals Freestanding psychiatric hospitals and units of acute care hospitals Long-term care hospitals	Inpatient Hospital Predetermined per-case payment based on the patient's principal and secondary diagnoses, procedures, and age. Predetermined per-case payment based on impairment, functional status, age, complications, and co-morbid conditions. Cost subject to rate of increase limit on aggregate per-discharge costs. Per-diem prospective payment system under development. Pre-determined per-case payment based on patient's principal and secondary diagnoses, procedures, and patient's age.	Inpatient Hospital Already incorporates a modified version of the Medicare system. Exempts certain diagnosis-related groups (DRGs). Currently exempts rehabilitation services. Assessment needed to determine if Medicare system is appropriate for CWCP patients. Currently exempts psychiatric facilities from the OMFS. Medicare's cost-based system is not suitable for CWCP. Currently exempts long-term care hospitals. Assessment needed to determine if Medicare system appropriate for CWCP patients.
Physician and Other Practitioners, Outpatient Rehabilitation, and Non-Hospital Radiology	Resource-based relative value fee schedule; Medicare does not cover some services and providers that are covered by CWCP.	Charge-based relative value fee schedule.
Outpatient clinical laboratory tests	Charge-based fee schedule with national limits applicable to independent laboratories and physician offices; professional component paid under RB-RVS.	Charge-based relative value scale (RVS) applicable to all outpatient lab tests. Separate technical and professional components.
Other Hospital Outpatient Services	Facility fee paid for all services based on 570 clinically coherent groupings of procedures with similar cost.	Separate facility fees payable only for ambulatory surgery and emergency room. Fees exempt from OMFS.
Freestanding Ambulatory Surgical Center Procedures	Facility fee based on nine payment groups for procedures on approved list; if not on approved list, physician payment same as if performed in office setting.	Facility fees currently exempt from OMFS.
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	Charge-based fee schedule	Charge-based RVS. Uses Medicare relative value units (RVUs) for orthotics and prosthetics.
Outpatient Renal Dialysis	Capitated monthly rate	Currently exempts outpatient renal dialysis
Skilled Nursing Facility Inpatient Services	Per-diem rate based on 44 resource-utilization groups	Currently exempts skilled nursing facility inpatient services
Home health agency services	Case mix adjusted payment for 60-day episodes	Currently exempts home health agency services
Ambulance	National fee schedule transition	Currently exempts ambulance services

- The unit of service covered by a Medicare fee schedule payment ranges from a bundled payment for a group of services (for example, Medicare’s predetermined payment for hospital inpatient services covers all facility services provided during the inpatient stay) to a separate payment for each individual item or diagnostic test. While the current OMFS for inpatient hospital services demonstrates that the Medicare bundled payments can be adapted for workers’ compensation patients, Medicare bundled payments for an inpatient stay (e.g., for services delivered in rehabilitation facilities) or an episode of care (e.g., home health care services) should be assessed to determine if the payments are appropriate for workers’ compensation patients.
- Medicare has policies governing which items and services are included in payment for professional and facility fees and which services may be billed separately. As noted earlier, most fee schedules include a relative value or weight that measures the resources required for a given service or group of services relative to other services. These relative weights are consistent with the service definition and may not be appropriate if the OMFS retains different policies on items and services that may be separately billed.
- For most fee schedules, Medicare applies a dollar conversion factor to the relative value for a given service to convert that value into a payment amount. A key question is what the appropriate conversion factor would be for services furnished to California workers’ compensation patients. There is no “gold standard” that can be used to answer that question, and any decisionmaking in this regard should take into account a number of factors: whether there is adequate access to care, the current maximum allowable fees, the relationship between Medicare and private payer fee levels in California, and available information on the cost of providing specific services. A multiplier can be applied to the Medicare conversion factor to establish an overall payment level that is adequate to provide access to high-quality care. Setting the rate too low may create access problems, whereas setting the rate too high may encourage unnecessary utilization and result in excessive program expenditures.
- The OMFS is not adjusted for inflation on a regular basis, and most payments have been frozen for at least several years. The result is lower aggregate expenditures than the expenditures that would have resulted with regular inflation updates. While program expenditures tend to be higher with regular updates, the annual adjustments increase payment equity and predictability and should keep payments in line with the resources required to provide medical services.
- Medicare’s annual update factors are set by law and include policy adjustments as well as an inflation adjustment. The policy adjustments meet Medicare’s programmatic needs and may not be appropriate for updates to the OMFS. Other inflation measures may be more suitable. Input price indices account for changes in the input costs of providing services and would relate payment changes to changes in the costs of providing medical services, and medical price indices account for changes in the amounts paid for medical services by consumers and/or third-party payers. The selection of an appropriate measure depends on the underlying policy goal in making an inflation adjustment.

- The potential payment changes are quite large for some service sectors and may require a transition period to allow providers time to adjust to the new payment levels. Depending on the service sector and whether the OMFS already applies, transition policies that might be considered include
 - thresholds for the maximum change that can occur in a single year
 - blended rates that over several years provide a decreasing proportion of the payment based on the OMFS and an increasing proportion based on the Medicare fee schedule
 - hold-harmless provisions that freeze the current maximum allowable fee until it is less than the inflation-adjusted Medicare fee schedule amount
 - reducing over time the OMFS multiplier that is applied to the Medicare conversion factor.
- While any of the aforementioned transition strategies involve some administrative burden, those that require maintaining procedure-specific information on amounts currently payable under the OMFS are the most burdensome. Transition policies that phase in the payment changes through adjustments in the conversion factor are less burdensome. The annual updating burden will be minimized if the transition policies are established at the outset of linking the OMFS to the Medicare fee schedules.
- The impact on program expenditures of tying the OMFS to Medicare fee schedules would largely depend on the decisions regarding payment levels: the multiplier used to adjust the Medicare conversion factor, the update methodology, and transition policies. Administrative savings should accrue from regular and predictable updates, but the actual level of administrative savings may be affected by the extent to which modifications are made in the Medicare fee schedules to address particular CWCP concerns.
- The decisions regarding payment levels and fee schedule modifications also have major implications for workers' compensation patients' continued access to quality care. The lack of a single statewide database containing all or a representative sample of current California workers' compensation claims makes it difficult to evaluate the impact of policy options. With the potentially large payment changes that are likely to occur in some sectors, ongoing monitoring to watch for any unintended consequences of adopting the Medicare fee schedules is highly recommended. If monitoring is done during the transitional period, potential problems can be identified and addressed promptly, and any necessary mid-course corrections can be made before final payment levels are established.
- Adopting Medicare's patient classifications will allow the DWC to compare costs for comparable services across providers, compare costs with other programs' costs for services, and monitor access and utilization trends for specific services. Such analyses are predicated on obtaining administrative data on an ongoing basis.

Summary of Policy Issues Regarding Specific Fee Schedules

In this section, we summarize RAND's key findings by service sector regarding issues that are likely to arise if the OMFS is linked to the Medicare fee schedules.

Hospital Inpatient Services

The OMFS inpatient hospital fee schedule limits payment to general acute care hospitals to a pre-determined amount per stay based on the diagnosis-related group (DRG) to which the patient is assigned and on a hospital's characteristics. The hospital's characteristics are reflected in a *composite factor*, which establishes the standard payment rate for each stay. The composite rate is further adjusted by a DRG *relative weight*, which reflects the costliness of the average patient in the DRG to patients in other DRGs. The general formula for determining payment for an inpatient stay is:

$$\text{Payment} = \text{DRG relative weight}_{\text{ind}} \times \text{composite factor}_{\text{hosp}}$$

Additional payments are made for high-cost "outlier" cases to protect the hospital from large financial losses on individual patients.

The DRG classification system, most DRG relative weights, and the adjustments embodied in the composite factor (which take into account a hospital's geographic location, teaching activities, and commitment to serving low-income patients) are based on the Medicare payment system for hospital inpatient services. However, there are several important differences between the Medicare payment system and the OMFS:

- The CMS updates Medicare's payment system annually each October 1. The OMFS currently is using outdated payment parameters. Most payment parameters are from federal fiscal year (FY) 2001.
- The OMFS multiplies the standard amount that Medicare would pay for an inpatient stay by 1.2.
- Certain DRGs are exempt from the OMFS or have a different relative weight based on payments by California group health plans.
- In addition to the DRG fee schedule payment, the hardware costs for devices implanted during back and neck surgeries are reimbursed separately under OMFS policies.
- Certain hospitals that are paid under the Medicare prospective payment system (PPS) are exempt under the OMFS because the necessary variables are not readily available to the CWCP.

The OMFS for inpatient hospital services demonstrates that the Medicare fee schedules can be adapted to meet CWCP needs. Building in some time to allow for DWC to become familiar with the annual Medicare changes and their implications for the CWCP and to notify affected

parties of the changes and any clarifications on how the OMFS is impacted would help prevent any unintended consequences of automatic OMFS updates being linked to the Medicare updates.

The automatic update could be based on the Medicare update factors or on an alternative measure that would be independent of Medicare policy adjustments. Inflation measures that potentially could be used are the rate of increase in the hospital “market basket” (an input price index of goods and services used by hospitals to measure price inflation in the costs of an inpatient stay) or the Producer Price Index for hospital services (which measures changes in the prices paid for hospital care). The hospital market basket has the advantage of being an integral part of Medicare’s annual update and would be less burdensome than the Producer Price Index to implement. More-frequent updating of the cost-to-charge ratios used to determine additional payments for high-cost outlier cases would reduce potential abuse from excessive charge escalation.

Currently, the OMFS applies a 1.2 multiplier to the Medicare payment rate. RAND’s analysis of the California Office of Statewide Health Planning and Development (OSHPD) data for 2000 indicates that Medicare payment rates without a multiplier result in an estimated payment-to-cost ratio of 1.19 for CWCP patients. This is higher than the 1.125 national payment-to-cost ratio for private payers (MedPAC, 2003) and suggests that, on average, a multiplier is not needed to cover the estimated costs of care and provide payments that are comparable to those paid by private payers. However, the range in DRG-specific payment-to-cost ratios is substantial, and adjustments may be appropriate for some DRGs. Consistent with current OMFS policy, these adjustments can be expressed as a multiplier (greater or less than 1.0 as appropriate) so that they can be self-implementing if automatic updates are made to the fee schedule.

Other OMFS modifications to the Medicare inpatient payment system should also be reexamined:

- Consideration should be given to either incorporating the additional payments for hardware and instrumentation costs into the DRG payments for back and neck procedures or to reducing the DRG relative weight for the estimated costs that are covered by the DRG payment. The current “pass-through” or additional payments for the hardware costs result in CWCP paying for the hardware twice: once in the DRG fee schedule relative and again in the additional payment for the hardware costs.
- Similarly, consideration should be given to eliminating the exemption for certain types of care provided by acute care hospitals. Including these services under the OMFS would reduce CWCP administrative burden and vulnerability to excessive payments. The payment-to-cost ratios for the exempt DRGs indicate on average that the payment in these cases will be adequate. Moreover, the additional payments for cases that have atypically high costs provide additional protection for the hospital against financial loss.
- Payment-to-cost ratios for rural hospitals are relatively low and consideration should be given to adopting Medicare’s special payment protection for hospitals that are the sole source of care that is reasonably available to patients in their communities. Under Medicare, these

hospitals receive the higher of the fee schedule payment or a hospital-specific rate based on historical costs. This policy could be self-implementing with little administrative burden.

Medicare exempts the following classes of hospitals from the prospective payment system for general acute care hospitals: critical access hospitals, rehabilitation hospitals and units of acute care hospitals, psychiatric hospitals and units of acute care hospitals, long-term hospitals, children's hospitals, and cancer hospitals. Prospective payment systems are in place for rehabilitation facilities and long-term hospitals. Before adopting these fee schedules, further analysis is advisable to determine whether Medicare's new payment systems for these facilities are also appropriate for the CWCP population. Medicare payments for other exempt hospitals – psychiatric facilities, children's hospitals, and cancer hospitals – are based on the reasonable costs of providing services to individual Medicare patients. This payment methodology cannot be readily adopted by the CWCP because it requires a retroactive payment determination based on cost data.

The volume of services provided by specialty hospitals to workers' compensation patients is relatively small. In 2000, these facilities had fewer than 400 CWCP cases (mostly in rehabilitation and psychiatric hospitals) and about \$9.3 million in charges. Two options that might entail less administrative burden than adapting the Medicare fee schedules would be to either (1) continue to exempt these facilities and leave the payment determination to negotiations between the hospital and payer or (2) establish a payment rate based on discounted customary charges. The latter approach could utilize recent OSHPD data to determine an appropriate discount rate on a hospital-specific basis. (For example, if the hospital's cost-to-charge ratio is 0.30, a payment based on 33 percent of billed charges would produce an estimated payment-to-cost ratio of 1.125 [$1.125 \times 0.30 = 0.33$], which is in line with the overall hospital payment-to-cost ratio for private payers.)

RB-RVS Fee Schedule for Physicians and Other Practitioners

The Medicare resource-based relative value scale fee schedule has three basic components:

- The first component consists of relative value units (RVUs) for each medical service based on the resources associated with the physician's work (the time and skill required for the procedure), practice expenses (the staff time and costs of maintaining an office), and malpractice expenses. For some procedures, the RVUs for practice expenses vary based on whether a procedure is performed in the physician's office or in a facility. The RVUs compare the resources required for a particular service to those required for other services. They have been developed for the general patient population and are not specific to the resources required to treat Medicare patients. The RB-RVS tends to provide lower relative values for surgical procedures and higher relative values for evaluation and management services than relative value scales based on historical charging practices (such as the current OMFS).

- The second component of the fee schedule is the conversion factor (CF) that converts the RVUs into a Medicare payment amount for the procedure. The CF determines overall fee schedule payment levels. The Medicare program uses a single CF for all services except anesthesia.
- The third component of the fee schedule is a geographic adjustment factor that adjusts for geographic differences in the costs of maintaining a physician practice. Separate geographic practice cost indices (GPCIs) apply to the RVUs for the three elements of the service: physician work, malpractice expense, and practice expense. For California, there are different adjustment factors for each of nine geographic areas.

Because the structure of the Medicare RB-RVS differs from the current OMFS in a number of ways, several policy choices would need to be made before linking the OMFS to the Medicare fee schedule:

- The level at which the conversion factor should be initially established and the inflation measure that should be used to update that factor in the future
- Whether a geographic adjustment factor should apply
- Whether the site-of-service differential for the practice expense component should be adopted
- Whether anesthesia professional services should be included.

Using results from The Lewin Group (2002) analysis of the impact of adopting the RB-RVS, applying a 1.15 to 1.16 multiplier (depending on the decision with respect to anesthesia) to the Medicare conversion factor would be cost neutral to the maximum allowable fees under the current OMFS. A higher multiplier may be needed to reflect overall fee levels paid by private payers. Potential inflation measures that would be independent of Medicare policy adjustments are the Medicare Economic Index and the Producer Price Index for physician offices and clinics. The Medicare Economic Index would relate payment changes to changes in the costs of maintaining a physician practice. This index is consistent with the RB-RVS concept and has the added advantage of being an integral part of the annual Medicare update to the physician fee schedule. The Producer Price Index would account for market changes in the amounts paid for physician services.

Medicare's geographic adjustment factors and site-of-service differentials are designed to improve the match between fee payments and the resources required to provide the services but would involve additional payment redistributions. Bringing anesthesia under the RB-RVS is also consistent with the goal of relating payments to resources, but, assuming a cost-neutral multiplier of 1.16, this move would reduce payments for anesthesia services by approximately 39 percent. A cost-neutral change from a charge-based to resource-based fee schedule would involve significant payment redistributions for other services as well: evaluation and management (plus 25 percent), surgery (minus 15 percent), and medicine (minus 5 percent). The change for radiology and physical medicine would be less than 1 percent. While the actual impact will

depend on the multiplier that is selected, consideration should be given to phasing in the new payment rates to soften the impact of adopting the RB-RVS on anesthesia and surgery. In any event, monitoring access and utilization to specialty services that would have lower payment levels under the RB-RVS would be important.

Hospital Outpatient and Ambulatory Surgery Center Facility Services

Payments for the facility component of hospital outpatient department and ambulatory surgical center (ASC) services represent about 16 percent of total CWCP medical costs (CHSWC, 2003). Generally, a hospital outpatient department is an integral part of a hospital and is subject to the health and safety standards and licensure requirements that are applicable to hospitals. ASCs are freestanding surgical centers that are either participating in the Medicare program or have been licensed by the State of California. Facility fees paid to either entity for ambulatory surgery and to hospitals for emergency room services are not subject to a fee schedule. The negotiated or contracted rates that are used to pay for these services are often based on discounted charges. In cases in which a contract is not in place, the facility's charges are the starting point for determining payment for workers' compensation patients. Charges are considerably higher than costs; therefore, the program is vulnerable to making unnecessarily high payments. Under Medicare, different fee schedules apply to services provided in hospital outpatient departments and services provided in ASCs.

California Assembly Bill 749 (2002) authorized the establishment of a fee schedule for ambulatory surgical services but imposed a number of requirements that will postpone a fee schedule for a number of years. An alternative would be to adapt the Medicare fee schedules to pay for ambulatory surgery services. Several policy issues would need to be resolved before doing so. The most basic issue is whether the Medicare payment scheme of paying for surgery furnished in hospital outpatient departments using one payment system and paying for surgery performed in freestanding ASCs with a different fee schedule should be adopted or whether the same fee schedule, perhaps with different conversion factors, should be used for both settings.

The current ASC fee schedule has several shortcomings that suggest it might be less burdensome to simply use the hospital outpatient prospective payment system to pay for services in either setting:

- The information used to establish the costs of procedures performed in ASCs is outdated and may not reflect the current costs of performing the procedures.
- Medicare has a relatively narrow list of Medicare-approved procedures that are covered in an ASC, and that list does not include some procedures that are currently paid for in an ASC under the OMFS. The list of approved procedures includes only procedures that can be safely performed in an ASC for Medicare patients and may be more restrictive than necessary for younger and less frail members of the workers' compensation population.
- The Medicare list does not include procedures that are commonly performed in a physician's office in order to discourage a shift of these procedures from physicians' offices to an ASC.

Procedures that are not on the approved list are paid under the RB-RVS as if they were furnished in a physician's office (i.e., no separate facility fee is payable). It appears that ASCs are already paid a facility fee for minor surgical services under the OMFS; therefore, adopting the hospital outpatient fee schedule should not create a new incentive to shift services from physicians' offices to ASCs.

Other issues that would arise if Medicare fee schedules are adapted to pay for ambulatory surgery services are the level at which the conversion factor should be established and whether the same CF should be used for both settings. The Medicare payment system for hospital outpatient services was not designed to cover the full accounting costs of furnishing services to Medicare beneficiaries. The original system was intended to be budget neutral to the prior payment system, which paid approximately 82 percent of amounts reported on the Medicare cost report. This means that the original CF was set to provide an 18 percent discount below reported cost. To some extent, these costs are overstated because the DRG payment for inpatient services encouraged shifting costs to outpatient services. Nevertheless, a multiplier somewhat higher than 1.22 is needed to cover estimated costs and provide an efficient hospital with a positive margin on outpatient services (e.g., a multiplier of 1.27 would provide a 5-percent margin, which is the average hospital margin on patient care services). To be comparable with the rates paid by private payers, i.e., an estimated payment-to-cost ratio of 1.125, the multiplier would need to be as high as 1.37 (1.125×1.22).

In the absence of current cost data, the empirical data needed to inform a decision regarding the appropriate conversion factor for ASC services are limited. Available information suggests ASCs do not need a conversion factor as high as the CF hospitals need for ambulatory surgery. Hospital outpatient departments have higher cost structures than ASCs because they must meet more demanding regulatory requirements, such as the Emergency Medical Treatment and Active Labor Act, and stricter Medicare certification and state licensure requirements (MedPAC, 2003), and they are more likely to incur uncompensated care costs. ASCs are also more likely than hospital outpatient departments to have higher productivity because they specialize in certain procedures, whereas most hospitals perform the full array of surgical procedures.

An examination of Medicare beneficiary characteristics found that hospitals were more likely to perform the same procedures on patients at higher risk (MedPAC, 2003). Setting the conversion factor at an unnecessarily high level would provide incentives for unnecessary utilization. However, available information also indicates ASCs will experience significant payment reductions under a fee schedule. One option is to phase in the payment reductions by setting the initial conversion factor at a relatively high level and reducing it over time. In the interim, monitoring for changes in the settings where care is delivered, analyzing the cost and quality implications of care furnished in alternative ambulatory settings, and analyzing the amounts paid by private payers can be done to better inform decisionmaking on this issue.

In summary, consideration should be given to

- using the structure of Medicare's prospective payment system for hospital outpatient services to pay for procedures performed in both hospital outpatient departments and ASCs

- establishing a higher conversion factor for hospital outpatient services than for ASC services
- phasing in the fee schedule by setting the initial conversion factor at a relatively high level and reducing it over time
- monitoring for changes in access to and quality of care in ambulatory settings.

Another important issue is whether Medicare's fee schedule for hospital outpatient services should also be used to pay for other medical and diagnostic services furnished by hospital outpatient departments. Except for emergency room services, the current OMFS does not expressly authorize separate payment for the facility fee for these services. In contrast, Medicare pays a facility fee for clinic and emergency room care. The OMFS fee schedule pays the same amount for the technical component of diagnostic tests across ambulatory settings, whereas the Medicare payments for these procedures in a hospital outpatient department differ from the amounts payable under the RB-RVS to freestanding diagnostic treatment centers and physician offices. For example, Medicare's payment for a two-view chest X-ray is \$25.34 when it is furnished in a physician's office or freestanding diagnostic treatment center and \$44.95 when it is furnished as a hospital outpatient service. The maximum allowable amount under the OMFS is \$28.50 across all ambulatory settings.

There are two basic policymaking choices concerning medical and diagnostic services furnished in hospital outpatient departments:

- Use Medicare's policies for determining when facility fees are payable. This option would allow facility fees to be charged for both medical and surgical services and would create site-of-service differentials for radiology and other diagnostic tests.
- Retain current OMFS policies regarding when facility fees are payable (surgical procedures and emergency room only). When a facility fee is not payable, the total payment (hospital and physician) would be limited to the same total payment that would be made for an office-based service.

Overall, the benefits of linking the OMFS to existing Medicare fee schedules would be diluted if the program's basic payment policies were not adopted at the same time. The limited amount of readily available data on hospital outpatient services precludes an analysis of the financial impact of the alternative policies. Regardless of the decision, it will be important to monitor where ambulatory care is being delivered in the future and to evaluate the impact of the payment policies on cost, access, and quality of care.

Diagnostic Clinical Laboratory Tests

Currently, the OMFS uses a relative value fee schedule to pay for laboratory tests with separate technical and professional components. Medicare uses the RB-RVS to pay for the professional component and a separate fee schedule to pay for the technical component of laboratory tests. The fee schedule pays the lowest amount of the actual charge billed for the test, a

locally determined fee schedule amount, or a national limitation amount. For most tests, the national limit is 74 percent of the median of the local fees and is typically the controlling payment amount. As with other fee schedules, CMS has an established process for updating the fee schedule on an annual basis. However, the fee schedule has been frozen several times since it was first established, most recently between 1998 and 2002. If the OMFS is linked to the Medicare fee schedule, one decision to be made will be whether to adopt the Medicare inflation factor or to establish an independent adjustment for inflation.

There are also secondary issues regarding how Medicare-unique codes or new codes without an established Medicare fee schedule amount should be handled. Overall, using the Medicare fee schedules would provide a mechanism for updating the codes and fee schedule amounts on an annual basis. A comparison between the aggregate maximum allowable amounts that would be allowed under the current OMFS and the Medicare fee schedule has not been made. This information is needed to estimate a cost-neutral multiplier and analyze the impact of moving from the OMFS to the Medicare fee schedule.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

For the Medicare beneficiary, durable medical equipment (DME) is defined as equipment that can withstand repeated use, that generally serves a medical purpose, and that is intended for use in the home. DME is paid on a fee schedule reflecting local and regional prices for six categories of items that are updated annually based on the rate of change in the Consumer Price Index: All Urban Consumers (CPI-U).

- Payment for inexpensive or routinely purchased items is made on a rental or lump-sum basis using the lower of the actual charge or the fee schedule amount.
- Equipment requiring frequent servicing is reimbursed as a rental.
- Oxygen and oxygen equipment is paid a monthly fee schedule amount with an added payment for portable oxygen equipment.
- Carrier discretion is allowed for customized DME.
- Prosthetics and orthotics are generally reimbursed on a lump-sum payment basis.
- Certain rental items (hospital beds and wheelchairs) are paid at national rates based on the lesser of actual charges or 10 percent of the allowable purchase price for the first three months and then 7.5 percent of the allowable purchase price each month for up to 15 months of continuous use. Thereafter, suppliers must furnish the item at no charge other than maintenance and servicing.

One issue stemming from linking to the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule is whether the range of equipment covered by CWCP is broader than Medicare's coverage such that there are items and equipment that do not have Medicare prices. Analysis of DMEPOS claims would be needed to assess whether these

items and equipment are used in high volumes. If they are high-volume items, a maximum allowable fee would still be appropriate to reduce program vulnerability and the administrative costs of case-by-case pricing, but the fee would need to be established independently of the Medicare fee schedule. For low-volume items, a continuation of current OMFS policies might be sufficient. These policies provide for reimbursing the lower of (1) the provider's customary charge or (2) cost (purchase price plus sales tax, shipping, and handling) plus (a) 20 percent of the cost up to \$15 for supplies and materials other than DME or (b) 50 percent of the cost up to \$25 for DME. A second issue is whether Medicare rules concerning rental versus purchase of equipment and other special policies should be adopted at the same time. Paid claims data would need to be analyzed to determine the impact of adopting the special policies as well as the Medicare fee schedule.

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. While the necessary information to make the changes is readily available, the frequency of the updates may pose an administrative challenge. An annual update with new services excluded from the fee schedule for up to nine months may be sufficient for purposes of the OMFS.

Skilled Nursing Services

Medicare pays for short-term skilled nursing facility (SNF) care following a three-day qualifying hospital stay using a per diem prospective payment rate. A person receiving SNF level of care is defined as needing skilled care or skilled rehabilitative care on a daily basis (five times per week for therapy) that as a practical matter can be provided only on an inpatient basis. Custodial care is not covered under the Medicare program. For Medicare payment purposes, patients are assigned to one of 44 resource utilization groups (RUGs) based on the patient's service needs and expected resource requirements. One issue that should be reviewed before linking the OMFS fee schedule to Medicare fee schedules is whether Medicare's payment for skilled nursing care is appropriate for the levels of care covered by the CWCP.

Medicare's rates are all-inclusive rates that cover all medically necessary services provided by the SNF. The SNF is required to bill directly for all services (whether those services are provided by the SNF or by an outside supplier under arrangements with the SNF) that are not expressly excluded from the provision. A comparable rule would be needed to assure that the CWCP does not pay for services twice – once through the per diem rate and again through an outside supplier (e.g., a physical therapist or pharmacy).

Home Health Services

Medicare makes a prospective payment covering all services other than DME provided during a 60-day episode of care provided by a home health agency. The payment is adjusted for clinical severity, functional severity, and service utilization. However, it also reflects the nature of

the Medicare home health benefit. To be eligible for home health care, a Medicare beneficiary must be homebound and need intermittent skilled nursing care or therapy services. The per episode payment reflects the typical mix of Medicare-covered services provided during the 60-day episode.

Further analysis of the home care services provided to CWCP patients is advisable to determine if the per episode payment reflects the types and duration of home care needed by CWCP patients. If the episodic payment is not appropriate, Medicare's per visit payment for low-volume episodes might be. If fewer than five visits are provided during a 60-day episode, Medicare pays the home health agency (HHA) a per-visit amount that varies by type of visit rather than the per-episode amount. These wage-adjusted rates might be a suitable basis for a per-visit fee schedule. A per-visit payment methodology can provide incentives for excess utilization but, in the absence of a good case mix adjustment, is still preferable to excluding home care from the OMFS. The appropriateness of the per-visit rates for home health aide/homemaker services covered by the CWCP would need to be evaluated because there can be considerable variation in the duration of these visits.

Ambulance Services

CMS implemented a fee schedule for ambulance services in April 2002. Payment is based on the relative value for the service, a geographic adjustment factor, and a uniform conversion factor. Fourteen codes are used to describe the level of service, supplies and equipment used, and mileage. CMS has established a five-year transition period using a blend of old and new payment amounts, but only the new payment system is feasible for the OMFS to consider. The fee schedule rates are to be updated annually based on the rate of increase in the CPI-U. Through FY 2006, Medicare payments under the fee schedule are to be budget-neutral to estimated payments that would have been made under the prior payment system. As a result, the update factor that is applied to the conversion factor may not be appropriate for the CWCP, and consideration should be given to applying only the CPI-U.

Research Agenda

RAND's analysis of the policy considerations involved in linking the OMFS to the Medicare fee schedules highlighted the need for ongoing data collection on the services provided to CWCP patients. In the short run, the lack of readily available data limits the ability to model the impact of moving from the current OMFS to the Medicare fee schedules and to understand how overall OMFS payment levels compare with Medicare payment levels and those of private payers. This information would be helpful in establishing the OMFS conversion factor and in determining transition policies for ambulatory facility fees, laboratory tests, and DMEPOS. The Lewin Group (2002) study provides the needed information on the impact of the RB-RVS, but additional information on private payer fee levels would be beneficial. Other areas in which further analysis would benefit the policymaking process include

- evaluating the impact of adopting the geographic adjustment factor and other policy choices in adopting the RB-RVS for physician and other practitioner services
- modeling the financial implications of alternative fee schedules for ambulatory surgery center facility services and hospital outpatient services
- evaluating whether the bundled payments for inpatient services furnished in rehabilitation facilities, long-term care hospitals, and skilled nursing facilities and for home health episodes of care are appropriate for worker's compensation patients.

In the longer term, additional research is also needed to inform decisions regarding potential refinements to the payment system. Further analyses that would benefit future decisionmaking include

- assessing whether patient characteristics affect where ambulatory surgery is performed and whether there are differences in outcomes across the different settings
- determining the hardware and instrumentation costs that are included in the back and neck DRG payments for inpatient hospital services
- reviewing the medical literature on back and spinal procedures to see if the evidence would support practice guidelines for the procedures and use of new technology hardware and instrumentation.

Linking the OMFS to Medicare fee schedules would expand the services covered by the OMFS and reduce the administrative burden of keeping the rates current by capitalizing on the regular updates that the CMS performs for Medicare. The impact on patient access to quality medical care and program expenditures largely would be determined by the overall level at which payments are set. Ongoing data collection and analysis would be needed to monitor access, cost, and quality of care and to address issues of potential concern. This activity would be needed to assure that linking the OMFS to Medicare fee schedules does not have unintended consequences affecting CWCP patient access to medically appropriate services or program expenditures.