

Testimony

Inflation in Hospital Charges

Implications for the California Workers' Compensation Program

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PREFACE

In January, Barbara Wynn testified at a California Senate Labor and Industrial Relations Committee hearing reviewing the billing practices of hospitals owned by Tenet Health and the implications for the California workers' compensation program. Tenet hospitals are under investigation by the Medicare program for inflating their charges to generate allegedly excessive payments for high-cost inpatients. RAND was asked to provide an assessment of the potential vulnerabilities that excessive charge inflation poses for the California workers' compensation system. Wynn testified that the largest risks are related to payments for extremely high-cost inpatients and for outpatient services.

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

Overview of the CA Workers' Compensation Inpatient Fee Schedule

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

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

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

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

Cost Outlier Payments

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

the loss a hospital must absorb before it is eligible for an additional payment. The additional payment equals 80 percent of the difference between the estimated cost of the case and the sum of the standard DRG payment and outlier threshold.

$$\text{Outlier payment}_{\text{ind}} = .80 * (\text{Estimated cost}_{\text{ind}} - (\text{DRG payment}_{\text{ind}} + \text{outlier threshold}))$$

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

$$\text{Estimated cost}_{\text{ind}} = \text{Billed charges}_{\text{ind}} * \text{cost-to-charge ratio}_{\text{hosp}}$$

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

The cost-to-charge ratios are determined from annual cost reports that the Medicare program requires from each hospital. The cost reports contain detailed information on costs, charges, and utilization by service categories. It uses a cost allocation methodology to determine the hospital's costs of providing care to Medicare beneficiaries and to establish the ratio between the hospital's cost of providing Medicare services and its charges for the services.¹ The cost-to-charge ratios from each hospital's most recently settled cost report are incorporated into the annual updates to the Medicare prospective payment system and used to determine cost outlier payments for discharges occurring in the payment year.

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

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

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

Excessive charge inflation is of particular concern in determining cost outlier payments. When charges increase more rapidly than costs, a hospital's costs in the payment year are a lower percentage of its charges than is reflected in the cost-to-charge ratio used to determine the cost outlier payment. Of necessity, there is a lag between the period covered by the cost report and the year in which the cost-to-charge ratio is applied in the cost outlier determination. However, the lag is greater when, as under current

¹ The Medicare program calculates the cost-to-charge ratio separately for operating and capital-related costs. The CA workers' compensation program combines the two ratios for an overall cost-to-charge ratio that we use in this discussion. Some of the alleged abuse pertains to hospitals with extremely low cost-to-charge ratios (in FY2001, less than .200 for operating costs and .0162 for capital-related costs) that trigger a provision that substitutes a statewide average ratio for the hospital's extremely low cost-to-charge ratio. It appears that a handful of CA hospitals might have triggered the use of the CA average capital ratio (.0364) in determining their FY2001 cost-to-charge ratio. However, this could be more indicative of low capital costs than unreasonably high markups and, since capital represents about 10% of the payment, it is not likely this is having a major payment impact. Most excessive charge inflation began in 2000.

Medicare policies, the cost-to-charge ratios are updated only when cost reports are settled—which can be several years after the hospital’s fiscal year has ended.

The Medicare program takes projected charge increases into account in establishing the cost outlier threshold.² The fixed loss threshold, which is re-determined annually, increased from \$17,750 (prior to adjustment for geographic differences in hospital wage levels) in FY2001 and to \$33,560 in FY2003. This large increase is indicative of the substantial charge increases that occurred over the past few years. Unreasonable increases in outlier payments (which result from applying an outdated cost-to-charge ratio to claims with substantially higher markups) indicate potential “gaming” by some hospitals. A number of the hospitals with substantial increases in outlier payments are located in CA. For example, ten CA hospitals are estimated (based on their FY2001 charges) to have Medicare outlier payments in excess of 50 percent of their standard DRG payments.³ This may be only the tip of the iceberg since there has been further charge inflation since FY2001. While we expect that these hospitals would also have a high percentage of outlier payments for patients covered by the CA workers’ compensation program, we do not have the data to confirm this.

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

The pattern of change varied across hospitals: some hospitals had increases in their cost-to-charge ratio while others had decreases. In Table 2, we have grouped hospitals by the increase in their markup.⁴ There were 121 hospitals whose charges grew less rapidly than their costs.

Hospitals that have had a significant reduction in their cost-to-charge ratio are receiving higher outlier payments using the FY2001 cost-to-charge ratio than they would using the FY2003 cost-to-charge ratios. Five hospitals inflated their charges at more than twice the rate of growth in their costs. Using the average cost-to-charge ratio for this group and assuming that the billed charges on a claim are \$100,000, the estimated costs for the hospital stay would be \$91,100 using the average FY2001 cost-to-charge ratio. The estimated cost is \$35,000 using the FY2003 cost-to-charge ratio.

The CA workers compensation program also has more cost-outlier payments because it is using a lower cost—outlier threshold—\$14,500 compared to the \$33,560 used by Medicare in FY2003. This means that more cases qualify for outlier payments and that the cost outlier payment is up to \$15,248 higher than would be paid than under Medicare before considering the lag in cost-to-charge ratios.⁵ An offsetting factor, however, is the continued use of the FY2001 standard DRG payment amounts. Further analytic work is needed to evaluate the impact on total CA workers’ compensation payments.

In December, the Medicare program instructed its contractors to audit the financial records and perform medical review of selected outlier cases for any hospital that during October-November 2002 had

² HHS, “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates,” *Federal Register*, vol. 67, no. 148 (August 1, 2000), 50124 available at www.cms.gov. Overall, Medicare charges per case grew 17.6 percent between FY1999 and FY2001.

³ This is for operating costs only. The ratio is exclusive of additional payments for teaching activities and serving a disproportionate share of low-income patients.

⁴ The change in markup is determined by dividing the hospital’s FY 2001 cost-to-charge ratio by its FY2003 cost-to-charge ratio and subtracting 1.0. For example, if the average hospital had cost-to-charge ratios of .423 and .416 in FY2001 and FY2003 respectively, its markup increased 6% over the period. There were 27 hospitals with the identical cost-to-charge ratios in both years. This suggests that the cost report data were not updated between the two years.

⁵ The additional outlier payment of \$15,248 is calculated as 80 percent of the difference between the two thresholds before taking the effect of the wage-adjustment into account.

Table 1
Comparison of CA Hospital Cost-to-charge Ratios
Between FY2001 and FY2003

	FY 2001	FY2003
Number of hospitals	369	369
Average cost-to-charge ratio	0.423	0.415
Std. deviation	0.136	0.160
Maximum cost-to-charge ratio	1.206	1.260
Minimum cost-to-charge ratio	0.228	0.218

Source: FY2001 and FY2003 Medicare PPS Impact Files for matched set of hospitals

Table 2
Distribution of CA Hospitals by Change in Markup (%)
Between FY2001 and FY2003

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

Source: FY2001 and FY2003 PPS Impact Files

a significant increase in their average charges per stay and/or a high percentage of outlier payments. Information on the hospitals that have been identified for contractor review should provide more current information than we are able to glean from the PPS impact files on CA hospitals that have significantly increased their markup and pose a particular threat to the workers' compensation program.⁶ The Medicare program is also planning to issue a regulation by the end of January that should result in a more recent cost-to-charge ratio being used in the future. This type of action would also help address the problem for the CA workers' compensation program, but only if provision were made to adopt the revised cost-to-charge ratios and outlier thresholds on a regular basis.

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

⁶ CMS Program Memorandum A-02-126, "Instructions Regarding Hospital Outlier Payments," dated December 20, 2002 available at www.cms.gov. The reviews are to begin by February 2003 and be completed by July 2004. The results should provide information on issues related to differential markups for specific services and medical necessity as well as overall charge inflation.

1. An immediate option is to adopt the Medicare FY2003 cost-to-charge ratios and outlier thresholds. This would reduce the lag-time between the cost-to-charge ratios used to determine cost outliers and current markups and could be independent of a decision to provide for automatic updates in the future. Automatic updates raise the issue of whether the standard payment rates should similarly be updated and pose administrative and budgetary issues that may require time to address.
2. Another immediate option is to use the data reported to the Office of Statewide Health Planning and Development to adjust the cost-to-charge ratios of hospitals with above-average charge inflation between the period used to establish the current cost-to-charge ratios and the most recent period for which quarterly data are available (currently, Q2 of 2002). While there are some technical issues that would need to be resolved, this option would target those hospitals that are most likely to have inflated cost-outlier payments.
3. An intermediate-term option is to explore using the hospital financial data reported to the Office of Statewide Health Planning and Development to compute cost-to-charge ratios for the CA workers' compensation program on a regular basis. The financial data are more recent since they do not have the lags associated with the Medicare financial audits and rulemaking process. For example, annual financial data from 2001 could be used to establish the cost-to-charge ratio and the most recent quarterly data could be used to monitor hospital charge increases and adjust the cost-to-charge ratios of hospitals with significantly above-average charge inflation.

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

Exempted Services

The CA workers' compensation program exempts about 6 percent of admissions from the inpatient fee schedule, including those for psychiatric, substance abuse and rehabilitation, organ transplants, burns, and tracheostomies. In addition, inpatient services provided by a Level 1 or 2 trauma center to patients with a life-threatening injury are exempt. Payments for exempted services are based on rates the payer has negotiated with the hospital or, in the absence of negotiated rates, the amount the payer and hospital are able to agree on for the individual case. In either case, the hospital's charges are likely to be a factor in determining payment for high-cost services (burns, transplants, and tracheostomies.). In hospitals that have a contract with the payer, these high-cost services are likely to trigger the contract's stop-loss threshold. When this occurs, payment for the stay is either a negotiated percentage of charges from the "first dollar" or the standard negotiated rate plus a percentage of charges in excess of the stop-loss threshold.⁷ When a contract is not in place, the hospital's billed charges are frequently the starting point for determining the payment amount. Thus, the workers' compensation program remains vulnerable

⁷ For example, assume that total billed charges are \$100,000, for which the standard payment is \$25,000. The stop-loss threshold is \$40,000. A contract providing for payment equal to 50% of billed charges beginning with first dollar coverage would result in a \$50,000 payment. A contract providing for 50% of billed charges in excess of the threshold would result in a \$55,000 payment (\$25,000 + 50% of \$60,000).

to high hospital markups as long as these services remain exempt. Consideration should be given to bringing the services that are not exempt from the Medicare prospective payment system for acute care hospitals under the CA workers' compensation inpatient hospital fee schedule.

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

Hospital Outpatient Services

Outpatient services typically comprise about 50% to all CA workers' compensation medical services, or about \$1.5 billion in 2000. Physician services, regardless of setting, are subject to the medical fee schedule and are unaffected by hospital charging practices. However, the facility component of hospital outpatient services, which are about 10% of the outpatient component (about \$150 million in 2000) are not subject to a fee schedule. Work performed by Dr. Gerald Kominski and colleagues at the UCLA Center for Health Policy Research using a sample of 1999 claims found that the amounts paid were 54% of the billed amounts for these services.⁸ The difference was attributable to preferred provider discounts and contracted rates. Often, negotiated rates for hospital outpatient services are a percentage discount on hospital charges. If the discounts have not been increased to counter with the high rates of charge increases by some hospitals, it is likely that there has been a substantial increase in payments to those hospitals. Where a contract is not in place, the hospital's charges are the starting point for determining payment for workers' compensation patients.

AB749 established an outpatient surgery facility fee schedule for services that are not provided under contract but imposed a number of data requirements. Consideration should be given to adopting an existing fee schedule, such as the Medicare payment system for hospital outpatient service, with appropriate modifications to reflect the CA workers' compensation patient population. This would facilitate the adoption of a fee schedule without undue delay and reduce program vulnerabilities associated with payments determined on a charge-related basis.

⁸ Gerald F. Kominski and Laura B Gardner, "Inpatient Fee Schedule and Outpatient Surgery Study," Final Report to the Commission on Health and Safety and Workers' Compensation. December 2001.