Hospital Reimbursement Manual

Current Inpatient Per Diem Rates, Effective January 1, 2015

Type of Stay	Current Per Diem Rate
Surgical, Non-Trauma	$3,849.16
Surgical, Trauma	$3,850.33
Non-Surgical, Non-Trauma	$2,283.40
Non-Surgical, Trauma	$2,313.69

Inpatient stays with charges in excess of the stop-loss threshold are reimbursed 75% of the hospital charges. The current stop-loss threshold is $59,891.34, excluding the cost of implants.

- Reimbursement may also be pursuant to a contract amount.

Proposed Inpatient Per Diem Rates, effective date is July 1, 2021 or earlier

If the total charges, excluding implant costs, exceed a threshold ($75,000.00), a multiplier will be applied to the per diem rate.

Type of Stay	Proposed Per Diem Rate
Non-Surgical	$3,000
Surgical	$4,500
Total Gross Charges, excluding implants	Per Diem Multiplier
Less than $75,000.01	None
$75,000.01 to $125,000	2
125,000.01 to $175,000	3
$175,000.01 to $225,000	4
$225,000.01 or more	5

- Reimbursement may also be pursuant to a contract amount.

NCCI estimated impact on Hospital Inpatient Payments: -23.1%
Estimated Impact on Medical Costs: -5.4%

Implant Reimbursement for an Inpatient Stay

Current: Manufacturer's acquisition invoice cost + 60%; When determining the acquisition invoice cost of the surgical implant(s), the hospital shall subtract any and all price reductions, offsets, discounts, adjustments and/or refunds which accrue to, or are factored into, the final net cost to the hospital, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factor described above.

- Reimbursement may also be pursuant to a contract amount.

Proposed: Acquisition invoice cost + 30%; When determining the acquisition invoice cost of the surgical implant(s), the hospital shall subtract any and all price reductions, offsets, discounts,

adjustments and/or refunds which accrue to, or are factored into, the final net cost to the hospital, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factor described above.

- Reimbursement may also be pursuant to a contract amount.

Current Hospital Outpatient Maximum Reimbursement Allowances, Effective January 1, 2015

Scheduled surgical procedures are reimbursed at 60% of usual and customary charges. Usual and customary charges are established by calculating a statewide average charge for a qualifying procedure and multiplying the statewide average charge by .60 to establish the procedure's base rate. The base rate for the procedure is then multiplied by Medicare's wage adjustment factor assigned to the location of the procedure to attain the maximum reimbursement allowance. To qualify for a maximum reimbursement allowance, a procedure must have a minimum of 40 bills during an 18-month period. Services not qualifying for a maximum reimbursement amount are reimbursed at 60% of the individual hospital's charges or the contract amount.

All other hospital outpatient procedures are reimbursed at 75% of the usual and customary charges, except for scheduled, non-emergency clinical laboratory and radiology services and outpatient physical, occupational, and speech therapy services, which are reimbursed based on the maximum reimbursement allowances in the Health Care Provider Reimbursement Manual. Usual and customary charges are established by calculating a statewide average charge for a qualifying procedure and multiplying the statewide average charge by .75 to establish the procedure's base rate. The base rate for the procedure is then multiplied by Medicare's wage adjustment factor assigned to the location of the procedure to attain the maximum reimbursement allowance. To qualify for a maximum reimbursement allowance, a procedure must have a minimum of 40 bills during an 18-month period. Procedures not qualifying for a maximum reimbursement amount are reimbursed at 75% of the individual hospital's charges or the contract amount.

Proposed Hospital Outpatient Maximum Reimbursement Allowances, effective date is July 1, 2021 or earlier

- Retain the base rates for the scheduled (60% of usual and customary charges) and non-scheduled (75% of usual and customary charges) outpatient procedures that are currently in effect. Assign updated Medicare wage adjustment factors to these procedures based on the location to calculate the maximum reimbursement allowances.
- Expand the list of scheduled and non-scheduled outpatient procedures subject to a base rate by reducing the minimum number of bills (40 to 1) for a procedure to qualify for a base rate based upon a 48-month period. The new base rates are based on 60% or 75% of the statewide average charge for a procedure for dates of service from 1/1/2016 to 12/31/2019. Assign updated Medicare wage adjustment factors to these procedures based on the location to calculate the maximum reimbursement allowances.
- Reimbursement may also be pursuant to a contract amount.

NCCI estimated impact on Hospital Outpatient Payments: -3.2%
Estimated impact on medical costs: -0.6%

Implant Reimbursement for an Hospital Outpatient Stay

Current: For scheduled surgical procedures, implants are reimbursed 60% of usual and customary charges, and at 75% of usual and customary charges for non-scheduled surgeries. However, no usual and customary definition or criteria has been established.

- Reimbursement may also be pursuant to a contract amount.

Proposed: Define usual and customary charge for an implant as the acquisition invoice cost multiplied by 2, then multiplied by .60 or .75, depending on if the implant was used in a scheduled surgery. This amount would then be multiplied by Medicare's geographic wage adjustment factor, depending on the location of service, to attain the final maximum reimbursement allowance.

- Reimbursement may also be pursuant to a contract amount.

Ambulatory Surgical Center (ASC)

Current ASC Maximum Reimbursement Allowances, effective January 1, 2016

ASC procedures are reimbursed at 60% of usual and customary charges. Usual and customary charges are established by calculating a statewide average charge for a procedure and multiplying the statewide average charge by .60 to establish the maximum reimbursement allowance. To qualify for a maximum reimbursement allowance, a procedure must have a minimum of 50 bills, representing at least 10 different facilities, during a 24-month period. Procedures not qualifying for a maximum reimbursement amount are reimbursed at 60% of the ASC's charges or the contract amount.

Proposed ASC Maximum Reimbursement Allowances, effective date is July 1, 2021 or earlier

- Retain the maximum reimbursement allowances that are currently in effect.
- Expand the list of ASC procedures subject to a maximum reimbursement allowance by reducing the minimum number of bills (50 to 1) for a procedure to qualify for a maximum reimbursement allowance based upon a 48-month period. The new maximum reimbursement allowances are based on 60% of the statewide average charge for a procedure for dates of service from 1/1/2016 to 12/31/2019. The facility threshold will also be eliminated.
- Reimbursement may also be pursuant to a contract amount.

NCCI estimated impact on ASC Payments: -6.2%
Estimated impact on overall costs: -0.3%

Implant Reimbursement for an ASC

Current: Acquisition invoice cost + 50%; When determining the acquisition invoice cost of the surgical implant(s), the ASC shall subtract any and all price reductions, offsets, discounts, adjustments and/or refunds which accrue to, or are factored into, the final net cost to the ASC, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factor described above.

- Reimbursement may also be pursuant to a contract amount.

Proposed: Acquisition invoice cost + 30%; When determining the acquisition invoice cost of the surgical implant(s), the ASC shall subtract any and all price reductions, offsets, discounts, adjustments and/or refunds which accrue to, or are factored into, the final net cost to the ASC, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factor described above.

- Reimbursement may also be pursuant to a contract amount.

Health Care Provider (HCP) Reimbursement Manual

Current HCP Maximum Reimbursement Allowances, effective July 1, 2017

HCPs are reimbursed 140% of Medicare rates for surgical procedures, and 110% of Medicare rates for non-surgical procedures. The current maximum reimbursement allowances are based upon 2016 Medicare Conversion Factor and Resource Based Relative Value Scale (RBRVS) geographic-specific reimbursement levels.

- Reimbursement may also be pursuant to a contract amount.

Proposed HCP Maximum Reimbursement Allowances, effective July 1, 2021

Update the maximum reimbursement allowances based upon the 2020 Medicare Conversion Factor and Resource Based Relative Value Scale (RBRVS) geographic-specific reimbursement levels.

- Reimbursement may also be pursuant to a contract amount.

NCCI estimated impact on physician payments: +0.9%
Estimated impact on overall costs: +0.2%

Summary of Estimated on Overall Costs of Proposed Methodologies

Combined Hospital Inpatient and Outpatient: -4.0%
Ambulatory Surgical Center: -0.3%
Health Care Provider: +0.2%

ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES
PROPOSED TO BE EFFECTIVE JULY 1, 2021

NCCI estimates that the proposed changes to the maximum reimbursement allowances (MRAs) in the Reimbursement Manual for Hospitals (RMH), 2014 edition, would result in an estimated impact of -2.1% (-$88M[1]) on overall workers compensation system costs in Florida under Scenario 1, and -4.0% (-$168M) under Scenario 2.

Please note that the estimated cost impacts are based on the provisions summarized below which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rules and the impacts stated in this analysis may change accordingly.

Summary of Proposed Changes

The Florida Division of Workers' Compensation (DWC) has requested NCCI to provide cost impacts for two scenarios for updating reimbursement for hospital outpatient and hospital inpatient services. Currently, the MRAs are based on the 2014 edition of the Florida Workers' Compensation RMH effective as of January 1, 2015.

For hospital outpatient services, the current manual contains 3 categories of reimbursement:

Category 1 Scheduled, non-emergency clinical laboratory and radiology services are reimbursed based on the schedule of MRAs listed in the 2016 edition of the Health Care Provider Reimbursement Manual (HCPRM). In addition, any outpatient physical, occupational, and speech therapy service is reimbursed based on the listed MRA in the HCPRM.

Category 2 The MRA for a scheduled surgical service is calculated as the base rate from Appendix C of the RMH, multiplied by the geographic modifier listed for the county of the location of service from Appendix A. For procedures with no specified MRA, the maximum reimbursement is 60% of usual and customary charges (UCC).

Category 3 The MRA for a service other than scheduled surgical service is calculated as the base rate from Appendix B, multiplied by the geographic modifier from Appendix A. For procedures with no specified MRA, other than a scheduled surgical procedure, the maximum reimbursement is 75% of UCC.

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[1] Overall system costs are based on 2019 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. The estimated dollar impact is the percent impacts displayed multiplied by $4,193M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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The options being proposed would update the base rates and geographic modifiers for Category 2 and Category 3 services. The DWC provided 2 options to determine the proposed base rates as follows:

Option 1 Maximum reimbursement for a scheduled surgical service is based on 60% of the median of charges. For services other than a scheduled surgical service, maximum reimbursement is based on 75% of the median of charges.

Option 2 Based on a combination of the current MRAs in the 2014 edition of the RMH and proposed Option 1. Option 2 would supplement the procedure codes and corresponding MRAs in the 2014 edition of the RMH with additional procedure codes and MRAs based on the methodology in Option 1.

For hospital inpatient services, the MRAs are currently based on per diem rates that differ by type of stay:

Type of Stay	Current Per Diem Rate
Surgical, Non-Trauma	$3,849.16
Surgical, Trauma	$3,850.33
Non-Surgical, Non-Trauma	$2,283.40
Non-Surgical, Trauma	$2,313.69

Inpatient stays with charges in excess of the stop-loss threshold are subject to a maximum reimbursement of 75% of charges. The current stop-loss threshold is $59,891.34.

NCCI was asked to evaluate the impact of implementing the following per diem rates for surgical and non-surgical stays. The distinction between trauma and non-trauma would be removed. The stop-loss provision would also be removed. If total charges excluding implants exceed a threshold, a multiplier would be applied to the per diem rate.

Type of Stay	Proposed Per Diem Rate
Non-Surgical	$3,000
Surgical	$4,500
Total Gross Charges	**Multiplier**
Less than $75,000.01	None
$75,000.01 to $125,000	2.0
$125,000.01 to $175,000	3.0
$175,000.01 to $225,000	4.0
$225,000.01 or more	5.0

The Florida DWC is also proposing to add language to the RMH that sets the maximum reimbursement equal to the lesser of the hospital outpatient or hospital inpatient MRA, billed charge, or contract price.

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Actuarial Analysis

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
    - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights. For hospital inpatient services, the observed payments by episode are used as weights.

2. Determine the share of costs that are subject to the fee schedule
    - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported in the Florida DWC medical data, to categorize payments that are subject to the fee schedule.

3. Estimate the price level change as a result of the revised fee schedule
    - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the Florida DWC with dates of service between January 1, 2016 and December 31, 2019.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2017 and 2018 projected to the effective date of the benefit changes.

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Hospital Outpatient Fee Schedule

In Florida, payments for hospital outpatient services represent 18.3% of total medical costs. The overall change in maximums for hospital outpatient services is a weighted average of the percentage change in MRA by procedure code (Proposed MRA/Current MRA). The weights are based on Service Year 2019 observed payments by procedure code for Florida, as reported in the Florida DWC detailed medical data. The current MRAs are calculated as follows:

Current MRA = Base Rate x Geographic Modifier, or a Percentage of Trended Charges

> When there is no MRA, the charges are adjusted to the price levels projected to be in effect on July 1, 2021. The trend factor is based on the U.S. hospital outpatient services component of the medical producer price index (MPPI)[2]. If a procedure code is not listed in Appendix B or C of the RMH, the MRA is based on a percentage of charges. For scheduled surgical services, the MRA is calculated as 60% of the trended charges. For all other services, the MRA is calculated as 75% of trended charges.

The proposed MRAs are calculated as follows:

Proposed MRA = Base Rate (varies under Options 1 and 2) x Geographic Modifier

The estimated impacts[3] for each of the 2 options are then multiplied by a price realization factor of 80% to arrive at an estimated impact on hospital outpatient payments in Florida. These impacts are then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Florida (18.3%) to arrive at estimated impacts on medical costs. These are then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (67%) to arrive at estimated impacts on overall workers compensation costs.

Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 23.3% of total medical costs. The overall change in maximums for hospital inpatient services is a weighted average of the percentage change in MRA by episode (Proposed MRA/Current MRA). The weights are based on Service Year 2019 observed payments by episode for Florida, as reported in the Florida DWC detailed medical data.

The current MRA[4] for each hospital inpatient episode is calculated as follows:

- If total trended charges (excluding charges for implants) are $59,891.34 or less,
  then Current MRA = current per diem allowance x length of stay (LOS),
  otherwise Current MRA = total trended charges (excluding charges for implants) x 75%

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[2] Source: Bureau of Labor Statistics, series ID WPU511104.
[3] NCCI assumed no change for services not subject to the proposed fee schedules.
[4] Currently, 92.9% of payments are associated with episodes with charges in excess of the stop-loss threshold.

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The proposed MRA for each hospital inpatient episode is calculated as follows:

- Proposed MRA = (proposed per diem allowance x LOS) or the total trended charges (excluding charges for implants), whichever is less

Note that implants are excluded from the above MRAs since they are reimbursed separately as a function of acquisition cost.

The charge for each hospital inpatient bill was adjusted to reflect changes from past price levels to price levels projected to be in effect on the proposed effective date of the hospital inpatient fee schedule (July 1, 2021). The trend factor is based on the U.S. hospital inpatient component of the medical producer price index (MPPI)[5].

The estimated impact is then multiplied by a price realization factor of 80% to arrive at an estimated impact on hospital inpatient payments in Florida. This is then multiplied by the percentage of medical costs attributed to hospital inpatient payments in Florida (23.3%) to arrive at an estimated impact on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (67%) to arrive at the estimated impact on overall workers compensation costs.

Summary of Impacts

The estimated impacts from the hospital outpatient and inpatient fee schedule changes, proposed to be effective July 1, 2021, are summarized in the following tables:

Scenario 1:

Type of Service	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs
Hospital Outpatient – Option 1	+12.6%	18.3%	+2.3%
Hospital Inpatient	-23.1%	23.3%	-5.4%
Combined Estimated Impact on Medical Costs (D) = Total of (C)			**-3.1%**
Medical Costs as a Share of Overall Costs (E)			67%
Combined Impact on Overall Costs (F) = (D) x (E)			**-2.1%**

[5] Source: Bureau of Labor Statistics, series ID WPU512101.

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Scenario 2:

Type of Service	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs
Hospital Outpatient – Option 2	-3.2%	18.3%	-0.6%
Hospital Inpatient	-23.1%	23.3%	-5.4%
Combined Estimated Impact on Medical Costs (D) = Total of (C)			**-6.0%**
Medical Costs as a Share of Overall Costs (E)			67%
Combined Impact on Overall Costs (F) = (D) x (E)			**-4.0%**

Additional Considerations

The Florida DWC is also proposing to add language to the RMH that sets the reimbursement equal to the lesser of the MRA, billed charge, or contract price. In the hospital outpatient analysis, NCCI assumed that the proposed MRA would be the MRAs provided by the DWC.

For the hospital inpatient analysis, NCCI assumed that the proposed MRA would be the lesser of the charges or the per diem allowance. The charge for each hospital inpatient episode was adjusted to price levels projected to be in effect on the proposed effective date of the fee schedule change. Assuming medical prices and charges for hospital inpatient services increase over time, inpatient episodes whose MRA is the total charged amount would increase until they reach the per diem allowance. **If adopted, this could result in upward pressure (until the total charged amount reaches the per diem allowance) on Florida WC system costs over time after any initial estimated cost savings.** Additionally, to the extent that the charged amounts increase faster than estimated in this analysis, the MRAs for these episodes would increase. **As a result, if adopted, the actual impact could result in less savings than indicated in this analysis.**

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2021

NCCI estimates that the proposed changes to the maximum reimbursement allowances (MRAs) in the Reimbursement Manual for Ambulatory Surgical Centers (RMASC), 2015 edition, would result in an estimated impact of +1.2% (+$50M[1]) on overall workers compensation system costs in Florida under Option 1 and -0.3% (-$13M) under Option 2.

Please note that the estimated cost impacts are based on the provisions summarized below which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rules and the impacts stated in this analysis may change accordingly.

Summary of Changes

The Florida Division of Workers' Compensation (DWC) proposes to update the list of MRAs contained in Chapter 6 of the RMASC, 2015 edition. NCCI was asked to evaluate the impact of two alternative options:

- The MRAs for Option 1 would be based on the median of charges.
- The MRAs for Option 2 would be based on a combination of the current MRAs in the 2015 edition of the RMASC and the proposed Option 1. Specifically, Option 2 would supplement the procedure codes and corresponding MRAs in the 2015 edition of the RMASC with additional procedure codes and MRAs based on the median of charges; procedure codes with an MRA in the 2015 edition of the RMASC would have no change to the MRA under Option 2.

The Florida DWC is also proposing to add language to the RMASC that sets the proposed maximum reimbursement equal to the lesser of the MRA, the billed charge, or the contract price.

Actuarial Analysis

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
    - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

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[1] Overall system costs are based on 2019 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. The estimated dollar impact is the percent impacts displayed multiplied by $4,193M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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2. Determine the share of costs that are subject to the fee schedule
    - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported in the Florida DWC medical data, to categorize payments that are subject to the fee schedule.

3. Estimate the price level change as a result of the revised fee schedule
    - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the Florida DWC with dates of service between January 1, 2016 and December 31, 2019.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2017 and 2018 projected to the effective date of the benefit changes.

Ambulatory Surgical Centers (ASC) Fee Schedule

In Florida, payments for ASC services represent 9.0% of total medical costs. The overall change in maximums for ASC services is a weighted average of the percentage change in MRA by procedure code (Proposed MRA/Current MRA). The weights are based on Service Year 2019 observed payments by procedure code for Florida, as reported in the Florida DWC detailed medical data. The current and proposed MRAs are calculated as follows:

Current MRA = MRA from Chapter 6 of the 2015 Edition of the RMASC or 60% of Trended Charges

> When there is no MRA, the charges are adjusted to the price levels projected to be in effect on July 1, 2021. The trend factor is based on the U.S. hospital outpatient services component of the medical producer price index (MPPI)[2].

Proposed MRA = MRA provided by the Florida DWC

The estimated impact[3] for each option is then multiplied by a price realization factor of 80% to arrive at an estimated impact on ASC payments in Florida. These impacts are then multiplied by the percentage of medical costs attributed to ASC payments in Florida (9.0%) to arrive at an estimated impact on

[2] Source: Bureau of Labor Statistics, series ID WPU511104.
[3] NCCI assumed no change for services not subject to the proposed fee schedules.

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medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (67%) to arrive at an estimated impact on overall workers compensation costs.

Summary of Estimated Impacts

The estimated impacts from the ASC fee schedule change in Florida, proposed to be effective July 1, 2021, are summarized in the following table:

	Option 1		Option 2
(A) Estimated Impact on ASC Payments	**+24.7%**		**-6.2%**
(B) Price Realization Factor		80%	
(C) = (A) x (B) Estimated Impact after Price Realization	**+19.8%**		**-5.0%**
(D) ASC Share of Medical Costs		9.0%	
(E) = (C) x (D) Estimated Impact on Medical Costs	**+1.8%**		**-0.5%**
(F) Medical Costs as a Share of Overall Costs		67%	
(G) = (E) x (F) Estimated Impact on Overall Costs	**+1.2%**		**-0.3%**

Additional Considerations

The Florida DWC is also proposing to add language to the RMASC that sets the proposed maximum reimbursement equal to the lesser of the MRA, the billed charge, or the contract price. In this analysis, NCCI assumed that the proposed maximum reimbursement would be the MRA provided by the DWC under both options.

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2021

NCCI estimates that the proposed changes to the maximum reimbursement allowances (MRAs) in the Health Care Provider Reimbursement Manual (HCPRM), 2016 edition, would result in an estimated impact of +0.2% (+$8M[1]) on overall workers compensation system costs in Florida.

Summary of Proposed Changes

The Florida Division of Workers' Compensation (DWC) has proposed updates to the MRAs in the HCPRM, 2016 edition. The 2016 edition of the HCPRM, which became effective July 1, 2017, is based on 2016 Medicare Conversion Factor and Resource Based Relative Value Scale (RBRVS) geographic-specific reimbursement levels.

The DWC proposes to update the MRAs in the HCPRM to be based on the 2020 Medicare Conversion Factor and RBRVS geographic-specific reimbursement levels. Note that the MRAs in the current and proposed HCPRMs are limited to no less than the MRAs published in the 2003 HCPRM.

In addition to physician services, the proposed changes would also impact MRAs for the following hospital outpatient services contained in the Florida Workers' Compensation Reimbursement Manual for Hospitals:

- All scheduled, non-emergency clinical laboratory and radiology services
- Outpatient physical, occupational, and speech therapy services

Actuarial Analysis

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
    - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

2. Determine the share of costs that are subject to the fee schedule
    - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported in the Florida DWC medical data, to categorize payments that are subject to the fee schedule.

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[1] Overall system costs are based on 2019 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. The estimated dollar impact is the percent impact(s) displayed multiplied by $4,193M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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- The share is calculated as the greater of the percent of observed payments with a maximum allowable reimbursement (MAR) or 75%. NCCI assumes no change for the share of costs not subject to the fee schedule.

3. Estimate the price level change as a result of the revised fee schedule
   - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the Florida DWC with dates of service between January 1, 2019 and December 31, 2019.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2017 and 2018 projected to the effective date of the benefit changes.

Physician Fee Schedule

In Florida, payments for physician services represent 28.6% of total medical costs. The overall change in maximums for physician services is a weighted average of the percentage change in MRA by procedure code (Proposed MRA/Current MRA). The weights are based on Service Year 2019 observed payments by procedure code and geographic locality for Florida, as reported in the Florida DWC detailed medical data. The overall weighted-average percentage change in maximums for physician services is estimated to be +1.1%. The estimated impact by category is shown in the following table.

Physician Practice Category	Share of Physician Costs	Percentage Change in MRA
Anesthesia	2.1%	0.0%
Surgery	15.0%	+1.2%
Radiology	11.0%	+2.1%
Pathology & Laboratory	0.5%	-0.1%
Evaluation & Management	28.1%	+1.9%
Medicine	27.3%	+0.5%
Other HCPCS*	0.1%	-1.7%
Physician Payments with no specific MRA	15.9%	-
Total Physician Costs	**100.0%**	**+1.1%**

*Healthcare Common Procedure Coding System

A price realization factor of 80% was applied. The impact on physician payments after applying the price realization factor is estimated to be +0.9% (= +1.1% x 0.80).

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The +0.9% impact is then multiplied by the percentage of medical costs attributed to physician payments in Florida (28.6%) to arrive at an estimated impact of +0.3% on medical costs. This is then multiplied by the percentage of overall benefit costs attributed to medical benefits in Florida (67%) to arrive at an estimated impact of +0.2% on overall workers compensation costs.

Hospital Outpatient Fee Schedule

The changes to the HCPRM also impact certain hospital outpatient services. In Florida, payments for hospital outpatient services represent 18.3% of medical costs and hospital outpatient services subject to the HCPRM MRAs represent 3.3% of total hospital outpatient costs. The impact on hospital outpatient services, which is calculated in an analogous manner to the physician fee schedule change, is estimated to be a negligible[2] increase on medical costs and overall workers compensation system costs in Florida.

SUMMARY OF ESTIMATED IMPACTS

The estimated impacts from the medical fee schedule change in Florida, proposed to be effective July 1, 2021, are summarized in the following table:

Type of Service	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs
Physician	+0.9%	28.6%	+0.3%
Hospital Outpatient	Negligible Increase	18.3%	Negligible Increase
Combined Estimated Impact on Medical Costs (D) = Total of (C)			**+0.3%**
Medical Costs as a Share of Overall Costs (E)			67%
Combined Estimated Impact on Overall Costs (F) = (D) × (E)			**+0.2%**

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[2] Negligible is defined in this document to be an impact smaller in magnitude than +/-0.1%.

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