THREE-MEMBER PANEL PUBLIC MEETING RELATING TO

To the adoption of maximum reimbursement allowances for hospital inpatient and outpatient services, Ambulatory Surgical Centers, and health care providers

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Three-Member Panel Meeting
Wed, April 27, 2022 11:00 AM (EDT)

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1. Call to order
   - David Altmaier, Insurance Commissioner and Chairman
2. Opening remarks by the Chairman and Panel Members
3. Maximum Reimbursement Allowances for Hospital Inpatient and Outpatient Services
   - Division of Workers' Compensation
   - Public Comments
4. Maximum Reimbursement Allowances for Ambulatory Surgical Centers
   - Division of Workers' Compensation
   - Public Comments
5. Implant Reimbursements in Hospital Outpatient, Hospital Inpatient, and Ambulatory Surgical Center settings
   - Division of Workers' Compensation
   - Public Comments
6. Maximum Reimbursement Allowances for Health Care Providers
   - Division of Workers' Compensation
   - Public Comments
7. Potential Topics for the 2023 Biennial Report
   - Panel Member Discussion
   - Public Comments
   - Pursuant to subparagraph 440.13(12)(e)4, the Three-Member Panel must submit recommendations on or before January 15, 2017, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.
8. Adjournment

CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

April 14, 2022

TO: Three-Member Panel Members: Insurance Commissioner David Altmaier, Tammy Perdue, Jason Robbins

FROM: Andrew Sabolic, Assistant Director, Division of Workers' Compensation

CC: Tanner Holloman, Director, Division of Workers' Compensation
Brittany O'Neil, Policy Coordinator, Division of Workers' Compensation

SUBJECT: Summary of Agenda Items for April 27, 2022 Meeting

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1. MAXIMUM REIMBURSEMENT ALLOWANCES (MRAs) FOR HOSPITAL INPATIENT SERVICES

It has been nearly 2 ½ years since an Administrative Law Judge issued a Recommended Order nullifying the stop-loss provision contained in the per diem schedule of the 2014 Edition of the Hospital Reimbursement Manual, which is provided below.

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, excluding the cost of implants, in excess of the stop-loss threshold are reimbursed 75% of the facility's charges. The stop-loss threshold is $59,891.34.

Several months after issuance of the Recommended Order a group of hospital representatives approached the Division of Workers' Compensation (DWC) with an alternative inpatient reimbursement methodology. The DWC analyzed this alternative and used it as a foundation to develop a revised reimbursement methodology, which was presented to the Three-Member Panel on December 17, 2020. The Three-Member Panel approved the methodology during that meeting, which is provided below.

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If the total charges, excluding implant costs, exceed a $75,000 threshold, 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*

The DWC would like to note two important things about the above methodology. First, the hospital industry supported this methodology, which, according to an NCCI cost analysis, would reduce overall costs by -2.3% or -$99 million. Second, insurers were skeptical of achieving the estimated costs savings due to the potential for hospitals to increase charges to attain a higher per diem multiplier.

In recognition of the need to reach consensus with all parties on a new reimbursement methodology, several stakeholder meetings were held throughout 2021, and additional information and data was gathered. This process resulted with the DWC developing a new per diem methodology for the Three-Member Panel to consider at a future meeting. Three tiers of per diem rates were established based on the revenue codes reported on the inpatient bill.
Tier 1 – All Other Revenue Codes (non-surgical)
Tier 2 – Operating Room and Anesthesia Revenue Codes (surgical)
Tier 3 – Intensive Care and Coronary Care Revenue Codes

Under this methodology, the inpatient stay would be reimbursed based upon the Tier 1 (non-surgical) or Tier 2 (surgical) rates, except for those days when the patient is in Intensive or Coronary Care. An increased per diem rate would be applied for those days.

On February 7, 2022, the DWC held a meeting with representatives from the hospital and insurance industry and reviewed 6 scenarios with the attendees. Three tiers of per diem rates are established based on the revenue codes reported on the inpatient bill. An inpatient stay would be reimbursed based upon the Tier 1 (non-surgical) or Tier 2 (surgical) rates for the length of stay, except for those days billed for Intensive or Coronary Care. The Tier 3 per diem rate would be applied for those specific days. The DWC developed Scenarios 1-5, while hospital representatives presented Scenario 6 to the DWC. The DWC indicated to the attendees Scenario 4 as the preferred one to present to the Three-Member Panel.

For example, if a patient has an inpatient surgical stay for 7 days; however, for 2 days the patient was in Intensive Care; the reimbursement would equal 2 days multiplied by the Tier 3 per diem rate plus 5 days multiplied by the Tier 2 per diem rate. If no Intensive Care days were present, the reimbursement would equal 7 days multiplied by the Tier 2 per diem rate.

Per Diem Rates and Cost Impacts for Scenarios 1-6

Tier	***Scenario 1*** *Estimated cost impact: -3.8% or -$146 million*	***Scenario 2*** *Estimated cost impact: -2.6% or -$100 million*	***Scenario 3*** *Estimated cost impact: -3.2% or -$123 million*	***Scenario 4*** *Estimated cost impact: -2.6% or -$100 million*	***Scenario 5*** *Estimated cost impact: -1.1% or -$42 million*	***Scenario 6*** *Estimated cost impact: +2.1% or +$81 million*
Tier 1 – All other revenue codes (non-surgical)	*$5,000*	*$6,000*	*$7,000*	*$7,000*	*$8,000*	*$9,500*
Tier 2 – Operating Room and Anesthesia (surgical)	*$10,000*	*$11,000*	*$10,000*	*$11,000*	*$13,000*	*$17,500*
Tier 3 – Intensive and Coronary Care	*$12,000*	*$14,000*	*$12,000*	*$13,000*	*$15,000*	*$19,500*

Following the February 7th meeting, the DWC received alternative per diem rate scenarios from the insurance industry and hospital industry. Those scenarios were provided to NCCI to perform a cost analysis. They are identified as Scenarios 7-10.

Tier	***Scenario 7*** *Estimated cost impact: -6.0% or -$231 million*	***Scenario 8*** *Estimated cost impact: -6.0% or -$231 million*	***Scenario 9*** *Estimated cost impact: -6.0% or -$231 million*	***Scenario 10*** *Estimated cost impact: -2.3% or -$88 million*
Tier 1 – All other revenue codes (non-surgical)	*$4,000*	*$4,000*	*$4,000*	*$7,000*
Tier 2 – Operating Room and Anesthesia (surgical)	*$5,000*	*$9,000*	*$9,000*	*$11,000*
Tier 3 – Intensive and Coronary Care	*$11,000*	*$11,000*	*$11,000*	*$13,000*
Trauma/Burn Add-On	*None*	*None*	*None*	*$2,000*

Similar to Scenarios 1-6, three tiers of per diem rates are established based on the revenue codes reported on the inpatient bill. The insurance industry provided Scenarios 7-9 to the DWC, while the hospital industry provided Scenario 10. Scenarios 7-10 have some distinctions, which are summarized below.

Scenario 7 – This methodology's scenario is the same as Scenarios 1-6, except with different per diem rates. An inpatient stay would be reimbursed based upon the Tier 1 (non-surgical) or Tier 2 (surgical) rates for the length of stay, except for those days when the patient is billed for Intensive or Coronary Care. The Tier 3 per diem rate would be applied for those specific days.

Scenario 8 – Under this methodology, the per diem rate for a Tier 2 (surgical) would only apply for a maximum of 1 day. The remaining days would be reimbursed at the Tier 1 (non-surgical) or Tier 3 (ICU) per diem rate.

For example, if a patient has surgery during an inpatient 5-day stay, the reimbursement would equal 1 day multiplied by the Tier 2 (surgical) per diem rate plus 4 days multiplied by the Tier 1 (non-surgical) per diem rate. If any of the 4 days required ICU, those ICU days would be reimbursed at the Tier 3 (ICU) per diem rate rather than Tier 1.

Scenario 9 – This scenario is the same as Scenario 8, except for comparison purposes, 20% of the surgical stays would be reimbursed for 2 days and the remaining 80% surgical stays would be reimbursed the maximum of 1 day. Any remaining days would be reimbursed at Tier 1 (non-surgical) or Tier 3 (ICU).

Scenario 10 – This scenario is the same as Scenario 4, except if a Trauma or Burn revenue code appeared on the bill, an additional $2,000 per day would be applied to each day for the duration of the stay.

DWC Recommendation to the Three-Member Panel

After considering all the scenarios, the DWC recommends Scenario 4 to the Three-Member Panel. The reasons for recommending Scenario 4 are as follows:

- Scenario 4 meets the statutory criteria the Three-Member Panel must consider when adopting the schedules of maximum reimbursement allowances. Those criteria are cost containment for employers, access to care for injured workers, and adequate reimbursement of providers and facilities.

- Scenario 4 addresses the concern raised by the insurance industry of the potential for hospitals to increase their charges to attain a higher per diem multiplier under the previous methodology approved by the Three-Member Panel at its December 17, 2020 meeting, thus negating the estimated cost savings.

- Scenario 4's estimated cost savings (-$100 million) is nearly equivalent to the cost savings (-$99 million) of the previous methodology approved by the Three-Member Panel, which was supported by various hospital groups.

- Scenario 4's methodology is consistent with the existing per diem reimbursement structure by applying the per diem rates for surgical and non-surgical episodes for the length of stay.

- The insurance industry provided scenarios to reimburse inpatient days on a strict per-day basis, rather than applying a surgical or non-surgical per diem rate for the length of stay. Although the DWC believes these scenarios may have some merit, questions remain concerning the billing impacts and the clinical issues related to reimbursing based on a strict per-day basis rather than the length of stay per diem rates.

- The hospital industry presented a scenario to the DWC to increase reimbursement if a trauma or burn revenue code appeared on the inpatient bill. While a trauma or burn reimbursement add-on may also have merit, questions remain whether a reimbursement add-on falls into the statutory scheme of a per diem rate. In addition, Scenario 4 per diem rates indirectly include costs associated with trauma or burn episodes in an inpatient stay.

- Lastly, the DWC will continue to evaluate inpatient per diem adjustments to present to the Three-Member Panel in future years, and if Scenario 4 is approved, hospital groups and the insurance industry may use the per diem rates as a benchmark to advocate their respective positions to the Legislature for a specific statutory per diem schedule or alternative inpatient reimbursement methodology.

2. MAXIMUM REIMBURSEMENT ALLOWANCES FOR HOSPITAL OUTPATIENT SERVICES

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 allowance 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.

Hospital Outpatient Maximum Reimbursement Allowances Approved by the Three-Member Panel at its December 17, 2020 meeting

- 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 median 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.

After the December 17, 2020 Three-Member Panel Meeting, the DWC received feedback regarding the possible occurrence(s) where a CPT code is billed for which an MRA is not established pursuant to the methodology described above. In collaboration with stakeholders, an additional methodology has been developed to address this possible occurrence. Under this methodology, the MRA for such CPT code will be the median base rate of the CPT codes with established base rates within each clinical subsystem pursuant to the methodology described above.

DWC Recommendation to the Three-Member Panel

The number of hospital outpatient procedures subject to an MRA are:
Current 2014 edition of the Reimbursement Manual for Hospitals
339 at 75% of usual and customary charges
163 at 60% of usual and customary charges
Previously approved by the Three-Member Panel at its December 17, 2020 meeting
1,889 at 75% of usual and customary charges
1,818 at 60% of usual and customary charges
New clinical subsystem
142 at 75% of usual and customary charges
106 at 60% of usual and customary charges

The DWC recommends the Panel re-adopt the methodology approved at its December 17, 2020 meeting and the additional methodology for establishing MRAs based on the median base rate of the CPT codes within each clinical subsystem. According to NCCI, these changes would result in an estimated impact of -0.6% (-$23 million).

3. MAXIMUM REIMBURSEMENT ALLOWANCES FOR AMBULATORY SURGICAL CENTERS (ASCs)

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 median charge for a procedure and multiplying the statewide median 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.

ASC Maximum Reimbursement Allowances approved by the Three-Member Panel at its December 17, 2020 meeting

- 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 median 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.

After the December 17, 2020 Three-Member Panel Meeting, the DWC received feedback regarding the possible occurrence(s) where a CPT code is billed for which an MRA is not established pursuant to the methodology described above. In collaboration with stakeholders, an additional methodology has been developed to address this possible occurrence. Under this methodology, the MRA for such CPT code will be the median MRA of the CPT codes with established MRAs within each clinical subsystem pursuant to the methodology described above.

DWC Recommendation to the Three-Member Panel

The number of hospital outpatient procedures subject to an MRA are:
Current 2015 edition of the Reimbursement Manual for Ambulatory Surgical Centers
90 at 60% of charges
Previously approved by the Three-Member Panel at its December 17, 2020 meeting
1,437 at 60% of charges
New clinical subsystem
70 at 60% of charges

The DWC recommends the Panel re-adopt the methodology approved at its December 17, 2020 meeting and the additional methodology for establishing MRAs based on the median MRA of the CPT codes within each clinical subsystem. According to NCCI, these changes would result in an estimated impact of -0.4% (-$15 million).

4. IMPLANT REIMBURSEMENTS IN HOSPITAL OUTPATIENT, HOSPITAL INPATIENT, AND AMBULATORY SURGICAL CENTER SETTINGS

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.

Approved by Three-Member Panel at its December 17, 2020 meeting: 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.

DWC Recommendation to the Three-Member Panel

The DWC recommends the Panel re-adopt the methodology approved at its December 17, 2020 meeting.

Implant Reimbursement for a 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.

Approved by Three-Member Panel at its December 17, 2020 meeting: 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.

DWC Recommendation to the Three-Member Panel

The DWC recommends the Panel re-adopt the methodology approved at its December 17, 2020 meeting.

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.

Approved by Three-Member Panel at its December 17, 2020 meeting: 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.

DWC Recommendation to the Three-Member Panel

The DWC recommends the Panel re-adopt the methodology approved at its December 17, 2020 meeting.

5. MAXIMUM REIMBURSEMENT ALLOWANCES FOR HEALTH CARE PROVIDERS

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.

Maximum Reimbursement Allowances Approved by the Three-Member Panel on December 17, 2020

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.

Estimated impact on overall costs: +0.2%.

DWC Recommendation to the Three-Member Panel

The rule implementing the updated maximum reimbursement allowances is adopted but did not go into effect because the Legislature failed to ratify the rule. Disagreement arose over the issue of exempting reimbursement manuals from ratification or maintaining the ratification requirement for them. The rule is pending ratification during the 2023 Legislative Session. Consequently, the DWC recommends the Panel re-adopt the methodology approved at its December 17, 2020 meeting.

6. 2023 BIENNIAL REPORT

The DWC is seeking guidance from the Panel and from any public comments on possible topics for the 2023 Biennial Report.

ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES
PROPOSED TO BE EFFECTIVE JULY 1, 2022

NCCI estimates that the changes to the maximum reimbursement allowances (MRAs) in the Reimbursement Manual for Hospitals (RMH), 2014 edition, proposed to be effective July 1, 2022, would result in the following estimated impacts on overall Florida workers compensation system costs under each of the proposed scenarios:

Scenario	Estimated Impact on Overall Costs	
1	-3.8%	(-$146M[1])
2	-2.6%	(-$100M)
3	-3.2%	(-$123M)
4	-2.6%	(-$100M)
5	-1.1%	(-$42M)
6	+2.1%	(+$81M)

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) requested that NCCI provide estimated cost impacts for six scenarios associated with updating the maximum reimbursement for hospital inpatient services. Currently, the MRAs are based on the 2014 edition of the RMH, which became effective January 1, 2015. The MRAs are 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.

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[1] Overall system costs are based on 2020 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. For each scenario, the estimated dollar impact is displayed for illustrative purposes only and calculated as the respective percentage impact multiplied by $3,847M. These figures do 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 impacts assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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NCCI was asked to evaluate the impact of six alternative hospital inpatient scenarios outlined below. The stop-loss provision would be removed in all of the proposed scenarios. The following per-diem rates would apply.

	Per-Diem Rates by Scenario					
Tier[2]	1	2	3	4	5	6
Tier 1 – All other revenue codes	$5,000	$6,000	$7,000	$7,000	$8,000	$9,500
Tier 2 – Operating Room and Anesthesia	$10,000	$11,000	$10,000	$11,000	$13,000	$17,500
Tier 3 – Intensive and Coronary Care	$12,000	$14,000	$12,000	$13,000	$15,000	$19,500

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.

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[2] The tiers would vary based on the revenue codes reported on the inpatient bill. Within each inpatient episode, tier 3 per-diems would apply to all days billed in intensive care or coronary care units, identified by revenue codes of 0200-0219. The acronym "ICU" will be used to collectively refer to intensive care and coronary care units. The remaining non-ICU portion of each inpatient episode would then be categorized as either tier 1 or tier 2. If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply. If the non-ICU portion of an inpatient bill does not contain a revenue code from tier 2, tier 1 per-diems would apply.

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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, 2020 and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the proposed effective date of the benefit changes.

Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 24.5% 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 2020 observed payments by episode for Florida, as reported in the Florida DWC detailed medical data.

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

- If the 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%[3]

The proposed MRA for each hospital inpatient episode under Scenarios 1 through 6 is calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed per-diem allowance x non-ICU LOS

The proposed MRA for each inpatient episode is comprised of two components. Within each episode, any days spent in the ICU are subject to tier 3 per-diem rates. All non-ICU days in a stay will be subject to the applicable tier 1 or tier 2 per-diem rates.

[3] In this analysis, current MRAs are calculated using the stop-loss provision where applicable. In 2019 as a result of the case of Zenith Insurance Company vs DWC a recommendation was issued to the DWC that the formula for calculating inpatient MRAs be adjusted to remove the stop-loss provision. As of this time no final order has been issued by the DWC to remove the stop-loss provision. Therefore, this analysis utilizes the existing formula which includes the stop-loss provision. Currently, 94% of payments are associated with episodes with charges exceeding the stop-loss threshold.

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For example, under Scenario 1 per-diem rates, for an inpatient episode lasting 7 days total with 3 of those days spent in the ICU and the remaining 4 days identified as tier 1, the proposed MRA would be calculated as follows:

- $56,000 Proposed MRA = $12,000 (Scenario 1 tier 3 per-diem rate) x 3
  + $5,000 (Scenario 1 tier 1 per-diem rate) x 4

Note that in cases where the amount charged by the hospital for an inpatient episode is less than the per-diem allowance, it is assumed in this analysis that the hospital will be reimbursed at the full per-diem allowance rather than the lesser charged amount. This is consistent with the reimbursement rules under the current RMH, 2014 edition which state: "If the charges for any day of hospitalization are less than the applicable per-diem allowance established in this Chapter, the hospital shall be reimbursed the per-diem allowance for the day(s) rather than the lesser amount charged by the hospital."

Additionally, note that implants are excluded from the above MRAs since they are reimbursed separately as a function of acquisition cost under both the current and proposed RMH.

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, 2022). The trend factor is based on the U.S. hospital inpatient component of the medical producer price index (MPPI)[4].

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 (24.5%) 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 (64%) to arrive at the estimated impact on overall workers compensation costs.

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

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Summary of Estimated Impacts

The estimated impacts due to the proposed hospital inpatient fee schedule changes are summarized by scenario in the following table:

Service Category – Hospital Inpatient	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs	(D) Medical Costs as a Share of Overall Costs	(E) = (C) x (D) Estimated Impact on Overall Costs
Scenario 1	-24.0%	24.5%	**-5.9%**	64%	**-3.8%**
Scenario 2	-16.8%	24.5%	**-4.1%**	64%	**-2.6%**
Scenario 3	-20.5%	24.5%	**-5.0%**	64%	**-3.2%**
Scenario 4	-16.6%	24.5%	**-4.1%**	64%	**-2.6%**
Scenario 5	-6.9%	24.5%	**-1.7%**	64%	**-1.1%**
Scenario 6	+13.5%	24.5%	**+3.3%**	64%	**+2.1%**

THIS DOCUMENT AND ANY ANALYSIS, ASSUMPTIONS, AND PROJECTIONS CONTAINED HEREIN PROVIDE AN ESTIMATE OF THE POTENTIAL PROSPECTIVE COST IMPACT(S) OF PROPOSED/ENACTED SYSTEM CHANGE(S) AND IS PROVIDED SOLELY AS A REFERENCE TOOL TO BE USED FOR INFORMATIONAL PURPOSES ONLY. THIS DOCUMENT SHALL NOT BE CONSTRUED OR INTERPRETED AS PERTAINING TO THE NECESSITY FOR OR A REQUEST FOR A LOSS COST/RATE INCREASE OR DECREASE, THE DETERMINATION OF LOSS COSTS/RATES, OR LOSS COSTS/RATES TO BE REQUESTED. THE ANALYSIS CONTAINED HEREIN EVALUATES THE DESCRIBED CHANGES IN ISOLATION UNLESS OTHERWISE INDICATED; ANY OTHER CHANGES NOT INCLUDED IN THIS ANALYSIS THAT ARE ULTIMATELY ENACTED MAY RESULT IN A DIFFERENT ESTIMATED IMPACT. I, JON SINCLAIR, FCAS, MAAA, AM AN ASSOCIATE ACTUARY FOR THE NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC. AND THE ACTUARY RESPONSIBLE FOR THE PREPARATION OF THIS DOCUMENT. THIS DOCUMENT IS PROVIDED "AS IS" ON THE DATE SET FORTH HEREIN AND INCLUDES INFORMATION AND EVENTS AVAILABLE AT THE TIME OF PUBLICATION ONLY. NCCI'S FINAL ESTIMATED IMPACT MAY DIFFER FROM WHAT IS PROVIDED IN THIS ANALYSIS IF ADDITIONAL INFORMATION BECOMES AVAILABLE OR IF DATA NECESSARY TO ANALYZE PROVISIONS THAT WERE NOT EXPLICITLY QUANTIFIED PREVIOUSLY BECOMES AVAILABLE.

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES
PROPOSED TO BE EFFECTIVE JULY 1, 2022

NCCI estimates that the changes to the maximum reimbursement allowances (MRAs) in the Florida Reimbursement Manual for Hospitals (RMH), 2014 edition, proposed to be effective July 1, 2022, would result in the following estimated impacts on overall Florida workers compensation system costs under each of the proposed scenarios:

Scenario[1]	Estimated Impact on Overall Costs	
7	-6.0%	(-$231M[2])
8	-6.0%	(-$231M[2])
9	-6.0%	(-$231M[2])
10	-2.3%	(-$88M[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) requested that NCCI provide estimated cost impacts for four scenarios associated with updating the maximum reimbursement for hospital inpatient services in addition to six previously priced scenarios. Currently, the MRAs are based on the 2014 edition of the RMH, which became effective January 1, 2015. The MRAs are 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.

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[1] Estimated cost impacts for scenarios 1 through 6 were provided as part of a previous request completed on 1/11/2022.
[2] Overall system costs are based on 2020 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. For each scenario, the estimated dollar impact is displayed for illustrative purposes only and calculated as the respective percentage impact multiplied by $3,847M. These figures do 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 impacts assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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NCCI was asked to evaluate the impact of the four alternative hospital inpatient scenarios outlined below.

The stop-loss provision would be removed in all of the proposed scenarios. The following per-diem rates would apply.

	Per-Diem Rates by Scenario			
Tier	**7**	**8**	**9**	**10**
Tier 1 – All other revenue codes	$4,000	$4,000	$4,000	$7,000
Tier 2 – Operating Room and Anesthesia	$5,000	$9,000	$9,000	$11,000
Tier 3 – Intensive and Coronary Care	$11,000	$11,000	$11,000	$13,000
Trauma/Burn Add-On	–	–	–	$2,000

For all scenarios, the tiers would vary based on the revenue codes reported on the inpatient bill. Within each inpatient episode, tier 3 per-diems would apply to all days billed in intensive care or coronary care units, identified by revenue codes of 0200-0219. The acronym "ICU" will be used to collectively refer to intensive care and coronary care units.

For the remaining non-ICU portion of each inpatient episode the per-diems would apply in the following way for each scenario:

- **Scenario 7** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to all remaining non-ICU days. If the non-ICU portion of an inpatient bill does not contain a revenue code from tier 2, tier 1 per-diems would apply.

- **Scenario 8** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to a maximum of 1 day. Tier 1 per-diems would apply to any remaining non-ICU days.

- **Scenario 9** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to a maximum of 1 day for 80% of episodes and to a maximum of 2 days for 20% of episodes. Tier 1 per-diems would apply to any remaining non-ICU days.

- **Scenario 10** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to all remaining non-ICU days. If the non-ICU portion of an inpatient bill does not contain a revenue code from tier 2, tier 1 per-diems would apply. Additionally, if an episode is billed with revenue code 0207 or revenue codes 0681-0683, the trauma/burn add-on of $2,000 per day would be applied in addition to any tier 1 through 3 per-diems for the duration of the stay.

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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, 2020 and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the proposed effective date of the benefit changes.

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Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 24.5% 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 2020 observed payments by episode for Florida, as reported in the Florida DWC detailed medical data.

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

- If the 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%[3]

The proposed MRA for each hospital inpatient episode under Scenario 7 is calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed per-diem allowance x remaining LOS

The proposed MRA for each hospital inpatient episode under Scenarios 8 and 9 are calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed tier 2 per-diem allowance x tier 2 LOS[4]
  + proposed tier 1 per-diem allowance x remaining LOS

The proposed MRA for each hospital inpatient episode under Scenario 10 is calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed per-diem allowance x remaining LOS
  + proposed trauma/burn per-diem add-on[5] x LOS

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[3] In this analysis, current MRAs are calculated using the stop-loss provision where applicable. In 2019, as a result of the case of Zenith Insurance Company vs DWC, a recommendation was issued to the DWC that the formula for calculating inpatient MRAs be adjusted to remove the stop-loss provision. As of this time no final order has been issued by the DWC to remove the stop-loss provision. Therefore, this analysis utilizes the existing formula which includes the stop-loss provision. Currently, 94% of payments are associated with episodes with charges exceeding the stop-loss threshold.

[4] For scenario 8, if the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, the tier 2 per-diem would apply to a maximum of 1 day. For scenario 9, if the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, the tier 2 per-diem would apply to a maximum of 1 day for 80% of episodes and a maximum of 2 days for 20% of episodes.

[5] The trauma/burn per-diem add-on only applies to episodes billed with revenue code 0207 or revenue codes 0681-0683.

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Note that in cases where the amount charged by the hospital for an inpatient episode is less than the proposed per-diem allowance, it is assumed in this analysis that the hospital will be reimbursed at the full per-diem allowance rather than the lesser charged amount. This is consistent with the reimbursement rules under the current RMH, 2014 edition which state: "If the charges for any day of hospitalization are less than the applicable per-diem allowance established in this Chapter, the hospital shall be reimbursed the per-diem allowance for the day(s) rather than the lesser amount charged by the hospital."

Additionally, implants are excluded from the above MRAs since they are reimbursed separately as a function of acquisition cost under both the current and proposed RMH.

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, 2022). The trend factor is based on the U.S. hospital inpatient component of the medical producer price index (MPPI)[6].

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 (24.5%) 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 (64%) to arrive at the estimated impact on overall workers compensation costs.

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

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Summary of Estimated Impacts

The estimated impacts due to the proposed hospital inpatient fee schedule changes are summarized by scenario in the following table:

Service Category – Hospital Inpatient	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs	(D) Medical Costs as a Share of Overall Costs	(E) = (C) x (D) Estimated Impact on Overall Costs
Scenario 7	-38.0%	24.5%	**-9.3%**	64%	**-6.0%**
Scenario 8	-38.2%	24.5%	**-9.4%**	64%	**-6.0%**
Scenario 9[7]	-37.8%	24.5%	**-9.3%**	64%	**-6.0%**
Scenario 10	-14.7%	24.5%	**-3.6%**	64%	**-2.3%**

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[7] The estimated impact for scenario 9 is calculated as the weighted average of the estimated impacts assuming up to one tier 2 day (80% weight) or up to two tier 2 days (20% weight) could be reimbursed under episodes reported with a tier 2 hospital revenue code.

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES
PROPOSED TO BE EFFECTIVE JULY 1, 2022

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 -0.6% (-$23M[1]) on overall workers compensation system costs in Florida.

Please note that the estimated cost impact is 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 the cost impact for updating reimbursement for hospital outpatient services.

Currently, the MRAs are based on the 2014 edition of the Florida Workers' Compensation RMH, effective as of January 1, 2015. The manual contains three 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 services 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 2020 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 displayed for illustrative purposes only and calculated as the percentage impact multiplied by $3,847M. 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 proposed RMH manual would make the following changes:

- Update the Appendix A geographic modifiers for all Category 2 and Category 3 services.
- Add base rates for new services in Appendices B and C. Base rates for services listed in the current 2014 edition of the RMH remain unchanged. For all services which are newly added to Appendices B and C in the proposed edition of the RMH, the DWC calculated base rates as 60% of the median of charges for scheduled surgical services and 75% of the median of charges for all services other than scheduled surgical services.
- Add Appendices B.1 and C.1 which include base rates for services not individually listed in Appendices B or C.

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.
    - Any potential impact from the share of costs not subject to the fee schedule will be realized in future claim experience and reflected in subsequent NCCI rate filings, as appropriate.

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.

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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, 2020, and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the proposed effective date of the benefit changes.

Hospital Outpatient Fee Schedule

In Florida, payments for hospital outpatient services represent 17.5% 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 2020 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, 2022. 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 = Proposed Base Rate x Proposed Geographic Modifier

The overall weighted-average percentage change in maximums for hospital outpatient services is estimated to be -6.3%. This impact is then multiplied by a price realization factor of 80% to arrive at an estimated impact of -5.0% on hospital outpatient payments in Florida. This impact is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Florida (17.5%) to arrive at an estimated impact of -0.9% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (64%) to arrive at an estimated impact of -0.6% on overall workers compensation costs.

[2] Source: Bureau of Labor Statistics, series ID WPU511104.

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SUMMARY OF IMPACTS

The estimated impact from the hospital outpatient fee schedule change, proposed to be effective July 1, 2022, is 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	(D) Medical Costs as a Share of Overall Costs	(E) = (C) x (D) Impact on Overall Costs
Hospital Outpatient	-5.0%	17.5%	**-0.9%**	64%	**-0.6%**

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2022

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 -0.4% (-$15M[1]) on overall workers compensation system costs.

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) proposes to update the list of MRAs contained in Chapter 6 of the RMASC, 2015 edition. Note that this analysis is an update to a previous request completed by NCCI[2].

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 to 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 2020 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 displayed for illustrative purposes only and calculated as the percentage impact multiplied by $3,847M. 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.

[2] This analysis is an update to the request completed on September 27, 2021.

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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, 2020 and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the effective date of the benefit changes.

Ambulatory Surgical Centers (ASC) Fee Schedule

In Florida, payments for ASC services represent 9.5% 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 2020 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, 2022. The trend factor is based on the U.S. hospital outpatient services component of the medical producer price index (MPPI)[3].

Proposed MRA = MRA provided by the Florida DWC

The estimated impact[4] is then multiplied by a price realization factor of 80% to arrive at an estimated impact on ASC payments in Florida. The impact is then multiplied by the percentage of medical costs attributed to ASC payments in Florida (9.5%) 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 (64%) to arrive at an estimated impact on overall workers compensation costs.

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

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Summary of Estimated Impacts

The estimated impact from the ASC fee schedule change, proposed to be effective July 1, 2022, is summarized below.

Summary of Estimated Impacts	
(A) Estimated Impact on ASC Payments	-9.0%
(B) Price Realization Factor	80%
(C) Estimated Impact after Price Realization = (A) x (B)	-7.2%
(D) ASC Share of Medical Costs	9.5%
(E) Estimated Impact on Medical Costs = (C) x (D)	**-0.7%**
(F) Medical Costs as a Share of Overall Costs	64%
(G) Estimated Impact on Overall Costs = (E) x (F)	**-0.4%**

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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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