

**Health Care Advisory Panel**  
**Cost Savings Proposal to the Workers' Compensation Task Force**  
**April 4, 2014 – UPDATED May 9, 2014**

The DE Workers' Compensation Health Care Payment System (HCPS) contains several different types of reimbursements within its fee schedule component, such as professional services, anesthesiology, pharmacy, hospitals, and ambulatory surgery centers (ASCs). In 2013, the Health Care Advisory Panel (HCAP) made significant cost-saving reductions to many of the reimbursement types within the overall fee schedule component, which included adopting a Medicare-based relative value methodology to eliminate professional services charges paid at 85 percent of charge (85POC), significantly reducing treatment frequencies throughout the Health Care Practice Guidelines, and adding a mandatory pharmacy formulary, etc. The subsequent actuarial analysis indicated more savings were needed to reduce Delaware workers' compensation insurance rates.

To accomplish this task, the HCAP proposes the following three-component, Medicare-based model:

- 1) Reliance upon Medicare's 1) Resource-Based Relative Value Scale (RBRVS) for professional services, etc.; 2) Diagnosis Related Codes (DRGs) for hospitals; and 3) Ambulatory Payment Classifications (APCs), which is the ambulatory surgery center (ASC) equivalent.
- 2) Develop Delaware data-based conversion factors, which are calculated using Delaware data and Medicare's RBRVS, DRGs, or APCs.
  - a. Conversion factors for professional services are category specific – e.g. Evaluation and Management; Physical Medicine; Health Care Common Procedure Coding system (HCPCS); Laboratory; Radiology; Spine Injections; Surgery; and Uncategorized Medicine.
  - b. Calculate one conversion factor for ambulatory surgery center fees using Delaware data.
  - c. Calculate one conversion factor for hospitals using Delaware data.
- 3) Geozip adjustments.

The Health Care Advisory Panel (HCAP) respectfully proposes the following cost saving initiatives:

**Professional Services, Laboratory, DME, Pathology, etc.**

In 2013, the HCAP established maximum allowable payments for those treatments and services in the itemized schedule for professional services, etc., paid at eighty-five percent of charge (85POC). At that time, OptumInsight, a nationally recognized expert in fee schedule development, used this same three-component, Medicare-based model to create specified fees for the 85POC fees.

**PROPOSAL**

The goals:

1. Accomplish a 33% savings over three years (20% in year 1, 5% in year 2, 8% in year 3) in the itemized schedule of maximum allowable payments ("the fees") for professional services, laboratory, durable medical equipment, pathology, etc.
  - If cost savings measures result in Fee Schedule savings that are greater than what has been anticipated, HCAP or its successor be given the opportunity to modify the percentage reductions of the latter two years as long as the 33% savings is accomplished.
2. Convert the methodology for this schedule of fees to the same Medicare RBRVS-based model employed in 2013 (RBRVS multiplied by the DE specific conversion factors for each geozip).

The process:

1. Engage OptumInsight to use the same Medicare RBRVS-based methodology (RBRVS multiplied by the DE specific conversion factors for the two geozips) and reset the original maximum allowable payments in the schedule of fees, except for the 85POC fees already adjusted in 2013. Note the following:

- In order to accomplish the overall savings, some professional services may be reduced by more than the overall percentage of savings, some by less and some may remain at their current amount.
  - Overall fees will be downwardly adjusted 20% in year 1, 5% in year 2, and 8% in year 3 (see caveat under goal #1). This 3-year reduction is similar to Connecticut’s transition to a Medicare-based RVRBS system, which helped providers better plan and minimized access-to-care issues.
  - The DCRB will not begin to release data from the 9/2013 fee and treatment frequency cuts until 7/2014. Review the future DCRB reports to determine whether or not those changes show a reduction trend more than 33%.
  - Adjusted fees that calculate higher than the current specified fee in the schedule will remain at the current specified fee.
  - Adjusted fees that calculate lower than the current specified fee in the schedule will be lowered to the adjusted fee.
  - Ensure OptumInsight receives appropriate data to perform this function.
2. Establish benchmarks by comparing the fees with appropriate entities, such as Medicare and Pennsylvania (Philadelphia geographical region), for the same treatment or service.
    - Conversion Factors Capped at % Medicare
      - Surgery 300%
      - Radiology 250%
      - Lab/Pathology 200%
      - Medicine 200%
      - Physical Medicine 160%
      - E&M 130%
      - HCPCS 100%
  3. Engage an actuary to evaluate the overall percent of savings, and if necessary, recommend a further percentage reduction that will accomplish a 33% savings.

**Ambulatory Surgery Centers (ASCs) - Hospital-owned and Non Hospital-owned**

Pursuant to 19 Del. C. §2322B(9)(c), the HCAP has been working towards a Medicare-based system of “maximum allowable payments” for treatments in ASCs. Apart from the fee freeze, each ASC currently is paid at a unique percent of charge with an annual billing verification component that adjusts the percent of charge (the starting point was 85%) based on a comparison of the prior fiscal year rate change to the change in the Consumer Price Index for medical. During the current fee freeze, the percentages of charge rates are adjusted based on a comparison of the prior fiscal year rate change to zero.

**PROPOSAL**

The goals:

1. Establish a Medicare APC-based, revenue-neutral schedule of maximum allowable payments applicable to all ASCs with two geozip adjustments.
2. Accomplish a 33% savings in ASC fees over a three year period (20% in year 1, 5% in year 2, 8% in year 3).
  - If cost savings measures result in Fee Schedule savings that are greater than what has been anticipated, HCAP or its successor be given the opportunity to modify the percentage reductions of the latter two years as long as the 33% savings is accomplished.

The process:

1. Engage OptumInsight to calculate a Medicare APC-based fee schedule, develop a conversion factor using Delaware data, and perform a geozip adjustment. Reduce the fees to accomplish a 33% savings. All ASCs would be subject to the new schedule of fees.
  - One of the past barriers has been the inability to validate the DCRB's data, given the way it is reported and the DCRB's position about sharing certain fields. Modify the statute to authorize the Department of Labor to directly collect data from the ASCs, which is a methodology OptumInsight has used in other states.
  - Overall fees will be downwardly adjusted 20% in year 1, 5% in year 2, and 8% in year 3 (see caveat under goal #2).
  - The DCRB will not begin to release data from the 9/2013 fee and treatment frequency cuts until 7/2014. Review the future DCRB reports to determine whether or not those changes show a reduction trend more than 33%.
2. Establish benchmarks by comparing the fees with appropriate entities, such as Medicare and Pennsylvania (Philadelphia geographical region), for the same treatment or service.
3. Engage an actuary to evaluate the overall percent of savings, and if necessary, recommend a further percentage reduction that will accomplish a 33% savings.

### **Hospitals**

Pursuant to the August 7, 2012, revisions to 19 Del. C. §2322B(8), hospitals are paid at a percent of charge with an annual billing verification component that adjusts the percent of charge (the starting point was 80%) based on a comparison of the prior fiscal year rate change to the change in the Consumer Price Index. During the current fee freeze, the percent of charge rate is adjusted based on a comparison of the prior fiscal year rate change to zero.

### **PROPOSAL:**

The goals:

1. Establish a Medicare DRG-based, revenue-neutral schedule of maximum allowable payments applicable to all hospitals, with two geozip adjustments.
2. Accomplish a 33% savings in hospital fees over a three year period (20% in year 1, 5% in year 2, 8% in year 3).
  - If cost savings measures result in Fee Schedule savings that are greater than what has been anticipated, HCAP or its successor be given the opportunity to modify the percentage reductions of the latter two years as long as the 33% savings is accomplished.

The process:

1. From submitted workers' compensation claims data, by geozip:
  - OptumInsight's methodology to calculate the hospital fees is as follows:
    - Assign MS-DRG weight for appropriate year.
    - Sum weights, paid amount for all hospitals in geozip
    - Reduce paid amount by desired savings (20% in year 1, 5% in year 2, 8% in year 3). (See caveat under goal #2.)
    - Further reduce paid amount by desired outlier set-aside. Outlier set-asides are a common practice used to compensate hospitals on a fee schedule of maximum allowable payments for extraordinary injuries (e.g. burns, etc.).

- Divide paid amount by MS-DRG weight total to produce Delaware Geozip base rate (conversion factor).
  - Examine resulting Delaware rates with comparison states adjusting for differences in rules.
  - One of the past barriers has been the inability to validate the DCRB's data, given the way it is reported and the DCRB's position about sharing certain fields. Modify the statute to authorize the Department of Labor to directly collect data from the hospitals, which is a methodology OptumInsight has used in other states.
  - Overall fees will be downwardly adjusted 20% in year 1, 5% in year 2, and 8% in year 3. (See caveat under goal #2.)
  - The DCRB will not begin to release data from the 9/2013 fee and treatment frequency cuts until 7/2014. Review the future DCRB reports to determine whether or not those changes show a reduction trend more than 33%.
2. Establish benchmarks by comparing the fees with appropriate entities, such as Medicare and Pennsylvania (Philadelphia geographical region), for the same treatment or service.
  3. Engage an actuary to evaluate the overall percent of savings, and if necessary, recommend a further percentage reduction that will accomplish a 33% savings.