

Workers' Compensation Task Force
Friday, May 2, 2014
10:00 a.m.

AGENDA

- 1. Approval of minutes**
- 2. Discussion of specific reform proposals from task force members:**
 - a. HCAP proposal on medical fee schedule (attached to agenda)**
 - b. Proposed modification to HCAP proposal from Senator Blevins, Representative Briggs-King, Lt. Governor Denn, Senator Hocker, and Representative Bryon Short (attached to agenda)**
 - c. Adoption of employer-directed care statute (Lee Dotson)**
 - d. Adding language to the statute that sanctions any provider of services and/or insurance company that does not follow the law (Yrene Waldron)**
- 3. NCCI Presentation**
- 4. Public comment**

Health Care Advisory Panel
Cost Savings Proposal to the Workers' Compensation Task Force
April 4, 2014 – UPDATED April 23, 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 20% savings in the itemized schedule of maximum allowable payments ("the fees") for professional services, laboratory, durable medical equipment, pathology, etc.
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 20% savings, some professional services may be reduced by more than 20%, some by less than 20%, and some may remain at their current amount.
- 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.
 3. Engage an actuary to evaluate the overall percent of savings, and if necessary, recommend a further percentage reduction that will accomplish a 20% 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 15% savings in ASC fees.

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 15% 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.
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 15% 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 20% savings in hospital fees.

The process:

1. From submitted workers' compensation claims data, by geozip:
 - Assign MS-DRG weight for appropriate year.
 - Sum weights, paid amount for all hospitals in geozip
 - Reduce paid amount by desired savings (20%)
 - 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.
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 20% savings.

PROPOSED MODIFICATION TO PROPOSAL FROM HCAP

Sen. Blevins, Rep. Briggs-King, Lt. Governor Denn, Senator Hocker, Representative Short

We believe that in addition to the proposal outlined by HCAP, that there should be an absolute limit, expressed as a multiple of the current Medicare reimbursement and uniform across providers and procedures, on the reimbursement for any specific code. Senator Blevins' request at the end of the last task force meeting was that HCAP return to the task force with a "hybrid" proposal, and one of the HCAP members stated that it was understood HCAP was to provide a schedule with "a cap that is tied to some outside, peripheral standard." The HCAP proposal as currently written does not have such a cap, we believe that one is necessary and that HCAP members committed to providing one when the decision was made last month to postpone voting on the issue for a month.