SPARC
Facility vs. Non-Facility RVU Expenses

1. Is this a "Rate Change" or a "Method Change"?
   Method change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology and reimbursement structure for physician/practitioner RBRVS (resource based relative value scale) reimbursement. The OHCA is proposing a methodology similar to Medicare for assigning (Relative Value Units) RVUs based on Facility or Non-Facility place of service. Currently, the OHCA exclusively uses the non-facility RVU.

   The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following method change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for physician/practitioner RBRVS reimbursement are outlined below.

3. Current methodology and/or rate structure.
   Currently, OHCA applies the non-facility RVU to all physician/practitioner RBRVS reimbursed services.

4. New methodology or rate.
   Pay like Medicare for physician services performed in a facility place of service (21-Inpatient Hospital, 22-Outpatient Hospital, 23-Emergency Room, 24-Ambulatory Surgical Center, 31-Skilled Nursing Facility, or 42-Ambulance Air, etc.). The Medicare Physician Fee Schedule has RVUs for some CPT codes for both facility and non-facility places of service. For the CMS developed fee schedule, each code has three components: work RVU, practice expense RVU and malpractice expense RVU. For services performed in a facility the practice expense RVU is typically lower because not as much expense is required for overhead, staff, equipment and supplies. The non-facility RVU is for services performed in the office or home and these RVUs are in most cases higher because the physician practice has greater overhead expense. The OHCA will implement an edit will detect place of service and apply the correct RVU (facility or non-facility), thus applying the correct RVU Practice Expense similar to Medicare. This change will

apply to all rendering physicians/practitioners reimbursed based on the physician RBRVS fee schedule.

For example, CPT code 36557 (Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age):
Note: These values are used for this demonstration only and are not real values.

Work RVU:	5.09
Non-Facility Practice Expense RVU:	21.20
Malpractice RVU:	0.57

Total RVUs (adjusted for Oklahoma region-GPCI): 23.41254
Total RVUs multiplied by the statewide conversion factor 37.8975 results in a fee of $887.28. For state employed physicians, this would be $1,242.19.

In the audit, this service was performed in the hospital setting, and payment should have been:

Work RVU:	5.09
Facility Practice Expense RVU:	2.66
Malpractice RVU:	0.57

Total RVUs (adjusted for Oklahoma region-GPCI): 7.57938
Total RVUs multiplied by the statewide conversion factor 37.8975 results in a fee of $287.24. For state employed physicians, this would be $402.14.

5. Budget estimate.
   The estimated annual change is a budget decrease in the amount of $7,376,605.00 total dollars; $2,615,498.00 state share.

6. Agency estimated impact on access to care.
   This method change should not have a negative impact to access and quality of care to SoonerCare members.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the method change for physician/practitioner RBRVS reimbursement.

8. Effective date of change.
   July 1, 2015.