Testimony on Proposed Amendments to 101 CMR 316.00, 101 CMR 317.00, 101 CMR 318.00
Physician Pricing Regulations
Effective May 1, 2024
October 6, 2023

Introduction

Good Morning. My name is Jacquelin Chalas and I am the Physician Program Manager at the Executive Office of Health and Human Services (EOHHS). I am here to present testimony on the proposed amendments to three EOHHS pricing regulations:

- 101 CMR 316.00: *Rates for Surgery and Anesthesia Services*;
- 101 CMR 317.00: *Rates for Medicine Services*; and
- 101 CMR 318.00: *Rates for Radiology Services*.

The anticipated effective date of the proposed amendments to these regulations is May 1, 2024.

Background

Regulations 101 CMR 316.00, 101 CMR 317.00, and 101 CMR 318.00 are referred to collectively as the "physician pricing regulations." The physician pricing regulations govern the rates of payment used by governmental units for office visits and other general medicine, surgery and anesthesia care, and radiology services rendered to publicly aided individuals by eligible providers, including physicians and mid-level practitioners.

Proposed Amendments

Proposed amendments contain updates to rates, coverage, codes, and a technical correction for physician services as described in detail below.

Rate Updates

1. General Physician Services

The proposed amendments create a fee schedule for the majority of the codes in the physician pricing regulations based on the Medicare resource based relative value system (RBRVS). Based on this methodology, rates are calculated by applying a standard dollar value, defined as a conversion factor (CF), to Medicare-assigned Relative Value Units (RVUs) to derive a rate for each procedure code. RVUs are numerical values assigned to each procedure code to equate the relative complexity of providing that particular service, and reflect expenses associated with

physician work, practice (including non-physician work costs, space costs, and equipment and supply costs), and malpractice in different practice settings. For this rate review, January 2023 Medicare RVUs were used to calculate the MassHealth-specific CFs. If RVUs are not available, EOHHS sets rates for these codes at Individual Consideration (I.C.).

Historically, four conversion factors are calculated for use in the RVU-based rate development: General CF, Policy Group 1 CF, Policy Group 2 CF, and the Anesthesia CF. The General CF is used for calculating rates for the majority of physician services. The Anesthesia CF is used for calculating rates for anesthesia services. The Policy Group 1 CF applies to certain maternal, newborn, and family planning services, screening mammography, colonoscopy screening, and tobacco cessation services. The Policy Group 2 CF applies to global obstetrical delivery services.

For this review, budget neutral conversion factors were calculated for the General, Policy Group 1, Policy Group 2, and magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) services. The proposed General CF is $23.6922, the proposed Policy Group is $33.6125, the proposed Policy Group 2 CF is $29.0649, the proposed MRI/MRA CF is $42.5213, and the proposed Anesthesia CFs are $19.90 per base unit and $1.33 per time unit.

Individual rates calculated based on the 2023 Medicare RVUs and the revised CFs increase or decrease compared to their respective current rates depending on how Medicare RVUs change. Rates that apply to drugs administered in a physician's office refer to the fees listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (Medicare File). For certain codes related to tobacco cessation, behavioral/developmental health screenings, and state-supplied vaccines, rates for these codes are maintained at their current levels.

2. Rates for Policy Groups, EPSDT, and Office Visit Services

For certain policy groups, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and office visit services with rates that would decrease relative to the current rates, EOHHS proposes to hold current rates harmless.

3. Technical Component Rates for MRI and MRA Services

EOHHS is proposing to revise the current methodology for setting rates for MRI and MRA services. In the proposed methodology, a new budget neutral conversion factor was calculated for MRI/MRA services using the total allowed charges for technical component portion of the services and corresponding total RVUs for these services. This is the same methodology used in calculating the Policy Group I and II conversion factors. The budget neutral conversion factor was then applied to corresponding RVUs to calculate new technical component rates for MRI/MRA codes. Professional component rates were calculated using the general budget neutral conversion factor following the standard RVU methodology as described above.

If the final proposed technical component rate for the MRI/MRA service code, calculated as described above, is less than the current technical component rate for the code under the existing Radiology pricing regulation, the current rate is held harmless.

4. Fluoride Treatment Service

The rate for application of topical fluoride varnish service (code 99188) is proposed to be changed from $26.00 to $28.00, which is the current rate for the same service (code D1206) established in 101 CMR 314.00: *Rate for Dental Services*. This proposed rate change for code 99188 is being made to ensure consistency of MassHealth rates for the same service covered under different programs.

5. Rates for Facial Feminization Services

The rates for certain surgery codes when billed as part of facial feminization surgery for the indication to treat gender dysphoria are proposed to be established by using the 2023 Medicare CF of $33.8872, instead of the MassHealth-specific general CF. These codes include: 14301, 14302, 20912, 21120, 21123, 21137, 21139, 21208, 21209, 21210, 21296, 30410, 30420, 30465, 31750, 64716 and 64771. This rate increase is to reflect the complexity and increased clinical and technical skill required to perform these craniofacial procedures as part of facial feminization surgery to treat gender dysphoria.

6. Vaccine Counseling Services

EOHHS added new procedure codes for vaccine counseling, effective for dates of service on and after February 1, 2023, via administrative bulletin AB 23-06. These codes include: G0310, G0311, G0312, G0313, G0314, G0315. These codes are set at the same rate as previously paid for preventive medicine counseling under procedure codes 99401 and 99402 for the same corresponding amount of time. Hence, rates for codes G0310, G0312 and G0315 were set at the then current rate for code 99401. Rates for codes G0311, G0313 and G0314 were established at the then current rate for code 99402. The proposed amendments update the rates for the six vaccine counseling codes by setting their rates at the corresponding proposed rates for codes 99401 and 99402.

Coverage Updates

1. Addition of CARES for Kids Program

The proposed amendments add to the Medicine pricing regulation a new service known as "Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids", a targeted case management (TCM) service, for the highest risk children and youth with medical and behavioral complexities. The CARES service will provide comprehensive, high-touch care coordination for children and their families. This service will be embedded in certain primary care or pediatric specialized settings where medically complex individuals under age 21 receive

medical care. CARES providers will serve as lead entities to coordinate prompt, family-centered, and individualized care across the health, educational, state agency, and social service systems. CARES providers will be providing relevant services in acute outpatient hospitals, community health centers, and large group practices. The code used for CARES TCM service is code T2023 and its proposed rate is $241.88 per member per month. The rate for this service was developed using a model budget that included anticipated enrollment, anticipated staffing needs for CARES providers, an assumed caseload of 250 members per CARES provider team and estimates of other costs for CARES providers.

Coding Updates

The proposed amendments incorporate coding updates related to the physician pricing regulations that were previously issued via Administrative Bulletins 22-09, 22-18, 23-06, 23-07, and 23-21. Additionally, EOHHS anticipates incorporating the 2024 Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) coding changes implemented via Administrative Bulletin into the proposed regulations as a post-hearing change. Lastly, relevant physician pricing regulations will be amended to reflect updated terminology and current policy.

Technical Corrections

Lastly, the proposed amendments update the description for modifier SL under 101 CMR 317.04(3)(r). The modifier "SL" indicates state-supplied vaccine. This modifier is to be applied to appropriate codes to identify administration of vaccines provided at no cost by the Department of Public Health (DPH). Effective January 3, 2023, if the providers receive the vaccine from DPH at no cost, they must bill the code for the vaccine itself, with modifier "SL," and the codes for administration of the vaccine. MassHealth will pay $0 for vaccines billed with the modifier "SL" and will pay the rate established in 101 CMR 317.00 for the administration of the vaccine.

Fiscal Impact

The estimated aggregate annual fiscal impact of the proposed amendments is $13.1 million over base spending of $452.5 million.

This concludes my testimony.

Thank you.