

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access (DVHA)

SUBJECT: Resource Based Relative Value System (RBRVS) – State Plan Amendment (SPA) 11-001

Response to Public Comments received as of December 6, 2010:

The DVHA appreciates all of the thoughtful comments submitted related to the proposed RBRVS methodology change. Many of the comments were similar in nature. In an effort to efficiently respond to all comments, we are providing a response to the major themes that were addressed in the comments. We have numbered each comment received within this document. Our responses often cover more than one comment. We provide a separate comment only where we felt the need to address a specific comment that had not yet been addressed in our response to other comments.

Our response to the comments appears at the front of this document followed by the individual comments themselves. Also as part of our response are five attachments which are posted on DVHA's website with this response and are incorporated by reference. Our adjusted language to SPA 11-001 has also been posted to the DVHA website.

It is the DVHA's intent to implement the RBRVS methodology as described in the December 23, 2010 version of the SPA 11-001 for services with dates of service on or after January 1, 2011.

Response to Comments #1-18:

At the request of commenters, we provided you with our most recent fiscal impact of the new DVHA RBRVS payment methodology by the AMA's current CPT categories on November 22, 2010. We have since updated this fiscal impact based on feedback from commenters and our own additional analysis. This fiscal impact appears in Attachment 2.

We analyzed proposals to reduce the number of conversion factors within the DVHA RBRVS system. Because Vermont legislation has historically required E&M codes to be held at 100% of the 2006 Medicare rates, we felt that we would need to maintain, at a minimum, two conversion factors—one for E&M codes and one for other codes.

Upon further review in an effort to reduce the number of conversion factors necessary, to mitigate the upward and downward swings across provider types, and to ensure access to services most commonly used by Medicaid beneficiaries, we have amended our proposed conversion factors by reducing the number from eight to two (Refer to Attachment 1). Due to budget limitations, we are unable to pay any provider at the full Medicare conversion factor. A higher conversion factor of \$28.6871 will be applied to E&M codes, delivery services, behavioral health services, radiology services and chiropractic services. A lower conversion factor of \$21.3420 will be applied to all other services payable in the RBRVS.

We reviewed the fiscal impact of our proposed changes on radiologists specifically as well as more generally on provider types that bill any radiology services. We found that 87.4% of all payments for radiology services were made to radiologists and only 12.6% of payments were made to providers with other specialties. We recognize that almost all radiologists will see a reduction in payments under the new rate methodology. We appreciate the fact that radiology utilization in Vermont is experiencing a lower growth rate than other states in New England and nationally. But we believe that the actual rates paid for these services must be better aligned with the rates paid to other Medicaid providers. In tight economic times, we felt an adjustment was necessary in radiology rates since these rates are presently paid at 104.2% of the 2011 Medicare rate while all RBRVS

services, on average, are paid at 73.2% of the 2011 Medicare rate (Refer to page 1 of Attachment 2). Under our new methodology, radiologists will be paid at a rate of 73.3% of their Medicare rates, which is almost the same as the rate of 73.6% paid to all providers covered under this methodology (Refer to Attachment 3). The reduction will impact 19 out of 23 radiology providers. The 23 radiology providers are among the 961 providers in our dataset that were paid more than \$10,000 in State Fiscal Year 2010 (Refer to Attachment 4). Of the 23, 11 radiology providers are out-of-state providers.

Among non-radiologists, only 32 out of 194 providers (16.5% of the total) that were paid more than \$10,000 by the DVHA in State Fiscal Year 2010 and billed any radiology services will be negatively impacted by the methodology change. (Refer to Attachment 5.) The reduction in payments to these providers may be due to radiology service billings, other service billings, or both. We have increased the conversion factor paid for radiology services from our previous public notice in an effort to mitigate the payment reduction for radiology services. (Refer to Attachment 1.) But we believe that the reduction proposed is necessary to more fairly align the payment rates among all providers paid within the RBRVS system.

We also reviewed the fiscal impact of our proposed changes on pathology services. We recognize that the reduction in payments to pathology services payable through the RBRVS is significant. However, pathology services payable through the RBRVS methodology represent only 0.9% of all dollars among RBRVS services. Most all pathology services will continue to be paid by DVHA as they have been in the past as a discounted rate off of the Medicare Clinical Lab Fee Schedule.

Finally, we understood the short turnaround time to allow for public comment on this proposed rate change and extended the deadline for public comment from November 17 to December 6.

Response to Comment #19:

We appreciate your concern that the rates that the DVHA can offer are not the most desirable to pay to providers. In this era of limited funds available from the Legislature, however, we are forced to make difficult decisions as to how we reimburse for services. One of our primary goals in updating our payment methodology was to recalibrate rates across the board so that the services paid, although lower than the Medicare RBRVS rates, are more closely aligned than they were in the previous rate schedule.

The percentages we quoted in prior materials and again in Attachment 3 to this response are provider payments reflected as a percentage of what they would be paid by Medicare for the same mix of services.

Response to Comments #20-22:

We appreciate your feedback and, like you, are aiming to reach parity in the payment of physical and behavioral health services. With limited funds available, we have structured payments in a way that payments for behavioral health services in particular would not be negatively impacted by the overall changes in the RBRVS payment methodology. It should be noted that the payments proposed here only impact services paid through fund sources managed by the Department of Vermont Health Access. Programs supported through funding from the Department of Health or other non-DVHA fund sources are not part of this rate methodology change.

Response to Comment #23:

The pediatric correction factor will not be in place effective January 1, 2011. However, we examined the impact of the new RBRVS rate changes on pediatricians in particular. Even after removing the correction factor, most pediatricians will see an increase in payments under the new methodology.

Response to Comment #24:

The dollars represented services delivered prior to the limitation to only the four chiropractic codes. As you see in Attachment 2, all but \$3,000 in non-chiropractic services went away when we moved to the SFY 10 database.

Public Comments received as of December 6, 2010:Comment #1

In response to notice received from you at noon on November 8, 2010, the Vermont Medical Society (VMS) is providing these comments regarding the Department of Vermont Health Access' (DVHA) proposed Vermont Medicaid State Plan Amendment (SPA) to implement the Resource Based Relative Value System (RBRVS) as a pricing methodology for some codes within DVHA's physician fee schedule.

While the VMS strongly supports the department's efforts to improve its fee schedule methodology, the VMS opposes the department's proposed State Plan Amendment for a number of policy reasons, as well as concerns regarding the SPA adoption process. After outlining the VMS's specific policy and process concerns, the VMS will offer an alternative approach for improving the department's fee schedule.

The VMS believes DHVA has provided incomplete information on the proposed policy and that its extremely limited comment period limits the ability for DHVA to receive adequate stakeholder input.

On January 16, 2009, the VMS wrote Susan Besio, Director, Office of Vermont Health Access, requesting the "current percentage relationship between the Medicaid CPT fee schedule and the Medicare physician 2009 fee schedule." After repeated requests, this information was provided to the VMS 21 months later as a part of a large stakeholder group meeting on October 18, 2010.¹

The information provided by DHVA on October 18th did not break out the procedure codes in a manner consistent with the categories in the AMA's manual of current procedural terminology (CPT).² Instead, the department provided information on an extremely limited set of CPT codes³ and it provided an analysis of the mix of CPT codes used by a discrete set of healthcare practitioners.⁴

Based on the information provided by the department, community-based and hospital-based radiologists would receive a proposed 40% reduction in Medicaid reimbursement for the radiological codes (70010 - 79999). However, many other physicians will also be adversely impacted by the 40% reimbursement reduction. For example, clinical oncologists submit claims using radiology CPT codes 77300-77499 when providing life saving radiation treatment for patients with cancer.

By relying on a finite number of "provider types" and then pooling the vast number of non-primary care physicians into a broad category of "specialists" the VMS believes the department's information masks the true magnitude of the reimbursement impact on physician specialties.

The VMS has recently asked the department for an analysis of the amendment's impact on pathology and laboratory CPT codes (80047 - 89356), since it believes their reimbursement will also be significantly reduced. In order to fully understand the impact of the proposed fee schedule, the VMS requests that the department provided an analysis of the relationship between the current Medicaid CPT fee schedule and the proposed fee schedule in a manner consistent with the categories in the AMA's manual of current procedural terminology.

The department's public announcement related to the state plan amendment was made available to the VMS at noon on November 8th. The announcement indicated that DHVA would accept written comments by no later than 4:30 pm November 17th. The department is therefore providing interested parties six and one-half business days for the development and submittal of comment on a highly technical and a significant public policy issue. The public announcement also indicates that there are no public meetings scheduled at this time.

In order to provide a reasonable amount of time to provide informed written comments, the VMS requests that the comment period be extended by at least 30 days beyond the receipt of the additional information it has requested. In addition, the VMS requests that a public hearing be held.

The VMS believes that the proposed state plan amendment is inconsistent with RBRVS as a pricing methodology. In addition, the amendment provides insufficient information to be implemented, since it fails to include the range of CPT codes covered by the proposed conversion factors.

The RBRVS Payment Methodology was implemented in Medicare in 1992 and is based on a formula that includes geographically adjusted relative value units (RVUs) for each procedure (CPT/HCPCS) and a single conversion factor (CF). The current conversion factor for Medicare is \$36.87. Therefore, Medicare's reimbursement for the most common office visit (CPT 99213) in Vermont = \$64.15 (\$36.87 (CF) x 1.74 (RVU)).

In contrast to Medicare's single conversion factor, DVHA is proposing eight different conversion factors for different ranges of codes that would result in Medicaid payment at differing percentages of Medicare. (See chart below.) Evaluation and management codes are required by Vermont law to be paid at 100% of the 2006 Medicare rate which results in payment at 87.7% of the 2010 Medicare rate due to CMS's rebasing of the E&M codes since 2006. DVHA is also proposing separate higher conversion factors for limited OB codes, chiropractic codes and behavioral health codes.

Codes	Proposed Conversion Factor	Percent of Medicare
Evaluation & Management	\$32.37	87.8%
OB codes	\$31.34	85.0%
Behavioral Health codes		
Psychiatrists	\$32.08	87.0%
Other Physicians, APRNs	\$30.97	84.0%
Psychologist PhD	\$28.76	78.0%
Psychologist MA, all other	\$26.92	73.0%
Chiropractic codes	\$32.37	87.8%
All other codes (procedures)	\$24.34	66.0%

The VMS initial analysis is that DHVA's use of eight different conversion factors -- instead of Medicare's use of a single conversion factor -- fundamentally undermines the rationale of the RBRVS system and the use of RVUs and a single conversion factor to determine reimbursement amounts.

In addition, the proposed state plan amendment provides insufficient information to be implemented due to its lack of specific CPT codes associated with each conversion factor. For example, the state plan amendment has a conversion factor of \$31.34 or 85% of Medicare for OB/GYN codes -- implying its application to the full range of OB/GYN CPT codes (56405-59899). However, DHVA informed the VMS that the OB/GYN conversion factor is limited to CPT codes 59400-59899. The remaining OB/GYN CPT codes would presumably be reimbursed with the significantly lower "all other codes" conversion factor of \$24.34 or 66% of Medicare.

The VMS recommends that DHVA adopt a single conversion factor for its proposed RBRVS fee schedule and the conversion factor should be the one used by Medicare. This recommendation is consistent with the requirements of V.S.A. Title 32, § 307(d)(6) which calls for the governor's proposed financial plan for the Medicaid budget to include "recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement."

The VMS believes that the proposed 40% reduction in the radiological codes in combination with other department initiatives would have a deleterious impact on Medicaid beneficiary's access to radiological services.

The Medicaid budget for state fiscal year 2011 (SFY11) includes a number of initiatives intended to reduce Medicaid's expenditures for healthcare services. Included in the adopted Medicaid budget is \$2 million of anticipated savings that will be achieved by requiring prior authorization for selected radiology services. In

SFY09, approximately 19,000 Medicaid beneficiaries received these high-tech imaging services, with a total annual cost of approximately \$9,540,000. The proposal therefore assumes an anticipated reduction of the utilization of high-tech imaging services of 20%.

With respect to CT use in Vermont, the January 15, 2010, Act 49 report from the Vermont Department of Banking, insurance, Securities and Health care Administration on *Recommendations to Improve Utilization and Variation in Health Care Services in Vermont* states on page 23 the following:

"Between the years of 2003-2007, the rate of CT events increased nationally (7.3% growth rate), in the New England region (7.5%), and in the state of Vermont (5.7%). While the rates of CT events increased in Vermont over 5 years, the state has much lower rates than the nation and the adjoining HRR's. The national average for CT events was 63.8 events per 100 people while the Vermont state average was just 41.8."

During the course of the legislature's consideration of the department's high-tech imaging prior authorization request, the VMS repeatedly raise concerns that the anticipated 20% reduction in imaging services in a state with one of the lowest rates the country could result in Medicaid beneficiaries experiencing inappropriate denial of access to diagnostic services.

The materials released by DVHA in support of the state plan amendment identified \$4,703,132 in current payments to radiologists for "all other codes" which the VMS interprets to mean radiological CPT codes in the range of 70010 - 79999. Under the department's proposed 40% reduction in reimbursement, radiologists would receive \$2,900,106 for these same codes – a reduction in payment of \$1,803,026 for an overall reduction in Medicaid reimbursement to community-based and hospital-based radiologists of 38.3%.

The proposed reduction in reimbursement does not seem to factor in the anticipated 20% decrease in utilization the department anticipates achieving in SFY11 through the newly instituted prior authorization requirements. The VMS has grave concerns that with the state's high Medicaid enrollment⁵ the cumulative impact of a 20% decrease in utilization, coupled with a 40% reduction in reimbursement could jeopardize the ability of Vermont to attract and retain community-based and hospital-based radiologists.

Under 42 U.S.C. § 1396a.(30) (A) a state Medicaid program must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

The VMS is also concerned that the proposed 40% reduction in payment for radiological services could result in independent community-based radiology practices having to limit the number of Medicaid beneficiaries they treat in order to meet the costs of operating their practices and the reductions will place further strains on the hospital-based practices.

The VMS recommends an alternative RVU-based transition methodology for the Medicaid professional fee schedule.

V.S.A. Title 32, § 307(d)(6) calls for the governor's proposed financial plan for the Medicaid budget to include "recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement." The VMS recommends that DHVA fully adopt Medicare's Part B RBRVS reimbursement system with its single conversion factor. While the VMS fully supports DHVA's statewide expansion of the Blueprint for Health, failure to increase DHVA's underlying physician fee schedule to the Medicare level will make it difficult for many physicians to fully participate in the Medicaid program.

As a transition strategy, since several of DHVA's proposed conversion factors are between \$30.97 and \$32.37, an alternative would be to have a single conversion factor for the E&M, OB, chiropractic codes and physician provided behavioral health codes; to have a conversion factor for the radiological codes based on the Medicare conversion factor; and to use the proposed conversion factor for all other codes. For the behavioral health codes, all physicians would be paid at the same rate and non-physicians would be paid at a percentage of the physician rate –consistent with Medicare policy.

This transition strategy would create three conversion factors for use with their applicable Medicare's RVU units for payment purposes and the proposal would transition Vermont to the use of a single conversion factor based on the one used by the Medicare program. The state would still drive savings from its reimbursement for radiological codes, since it would drop from the current payment at 106% of Medicare down to 100% of Medicare. The next step in implementing this strategy would be to significantly increase the proposed conversion factor for all other codes, as soon as possible.

Under the federal Patient Protection and Affordable Care Act (PPACA), Medicaid reimbursement to primary care practitioners for evaluation and management codes and some immunization administration codes will be increased for two years on January 1, 2013 to 100% of the Medicare rate. The VMS transition strategy is therefore consistent with the anticipated evolution of the Medicaid fee schedule to one increasingly based on Medicare.

Under the Challenges for Change program enacted during the last legislative session, DVHA has created the Clinical Utilization Review Board (CURB). The board consisting of physicians and other healthcare practitioners has been charged to work with the department's medical director to achieve \$4 million in Medicaid savings in SFY11. It seems reasonable to ask that any additional costs needed to fund this proposed transition strategy be based on a portion of the \$4 million in savings that Vermont physicians and other healthcare professionals are obtaining for the Medicaid program. This would be consistent with shared savings program enacted under the federal Patient Protection and Affordable Care Act.

1 The DHVA analysis indicated that Medicaid's weighted fee schedule is 78.7% of Medicare. DVHA also proposed revising its Medicaid fee schedule to reflect Medicare's RBRVS methodology for 2011 in a manner that is budget neutral in the aggregate.

2 Evaluation and Management 99201-- 99499; Anesthesia 00100 -- 01999; Surgery 10021-- 69990; Radiology 70010 -- 79999; Pathology and Laboratory 80047 -- 89356; and Medicine 90281- 99607.

3 Evaluation and Management 99201-- 99480,90465 -- 90468, 90471-- 90474; OB 59400 -- 59899; Behavioral Health 90801- 90899; 96101 -- 96155; Chiropractic 98940 -- 98943.

4 Primary Care Physicians; Primary Care Nurse Practitioners; OB/GYN Providers; Specialists (Physicians or Nurses Practitioners); Radiologists; Psychiatrists; Psychologists (doctorate level);Psychologists (masters level); Therapists; Optometrists and Opticians; Chiropractors; and Podiatrists.

5 According to the State of Vermont 2008 Health Care Expenditure Analysis, in 2008 Medicaid represented 23.0% of resident health care expenditures.

Comment #2

In its November 17 comment letter to the Department of Vermont Health Access (DHVA) on its Vermont Medicaid State Plan Amendment #11-001 (SPA), the Vermont Medical Society (VMS) stated that DHVA had provided incomplete information on the proposed SPA amendment to implement a Resource Based Relative Value System (RBRVS) as a pricing methodology for some codes within DHVA's physician fee schedule. In addition, the VMS stated that DHVA had provided an inadequate comment period to receive stakeholder input.

In response to these two concerns, on November 19, DVHA Commissioner Susan Besio committed to provide all of the VMS's data requests and she extended the public comment period until Monday, December 6. The VMS appreciates receiving the additional information on November 22 and the extension to the comment period.

The additional information provided even greater support for the fundamental reform of the DVHA physicians' fee schedule. For example, for calendar year 2011 (CY2011), the new information showed that cardiovascular services and integumentary services are currently reimbursed by DVHA at approximately 29% of the Medicare rate and musculoskeletal, respiratory, urinary, and maternity care are currently reimbursed by DHVA at

approximately 40% of Medicare. In Vermont, there has been a significant increase in the number of independent surgical and cardiology practices closing and DHVA's extremely low reimbursement for the services provided by these practices has no doubt has been a contributing factor.

Rather than repeating the points made in the November 17 letter, this letter will address a number of additional reasons for the VMS to oppose the SPA. After outlining these new concerns, the VMS will recommend a revised alternative payment methodology based on the additional information provided on November 22.

The VMS appreciates receiving the DVHA RBRVS model using CY2011 inputs. However, the VMS believes that several of DHVA's assumptions are incorrect or speculative.

DHVA's information related to CY2011 states that "changes reflected in CMS's CY 2011 RRRVS Final Rule have been implemented in this model, including: .. 3. The Medicare conversion factor changed from \$36.0666 to \$37.8729." In fact, the Medicare physician fee schedule final rule, printed in the Federal Register of November 29, indicates that the CY 2011 physician fee schedule conversion factor is \$25.5217, reflecting a 25% Medicare physician payment cut scheduled for January 1, 2011. The current 2010 conversion factor of \$36.87291 has been in place since June 1, 2010 and it is also referred to the DHVA material in a separate location as the conversion factor for CY2011.

Congress is currently working on legislation to extend the 2010 conversion factor through the end of 2011. The VMS is unaware of any reference by CMS to the CY2011 conversion factor of \$37.8729 cited by DHVA in its documentation and the VMS assume the use of \$37.8729 is simply an error. However, with the DHVA material using CY2011 conversion factors of both \$37.8729 and \$36.8729, it is impossible for the VMS to know what conversion factor DHVA used in its CY2011 calculations provided on November 22.

In addition, DHVA's CY 2011 model assumes a Geographic Practice Costs Indicator (GPCI) for work of 0.973. If Congress is able to extend the 2010 conversion factor of \$36.8729 through calendar year 2011, the legislation will likely also included in the a GPCI work floor of 1.0.

The VMS recommends that DVHA revise its information for CY 2011 to correct the use of two different conversion factors for CY2011, as well as reflect the uncertainty regarding the status of the CY2011 conversion factor and the work GPCI.

The VMS agrees with DVHA that a significant change by CMS for CY2011 was rebasing the Relative Value Units (RVUs) for a number of CPT codes, especially the evaluation and management codes. The DHVA information indicates that RVUs for evaluation and management codes will go up by 13% from 2010 to 2011. As a consequence, DHVA's reimbursement for evaluation and management (E&M) codes will drop from 88% of Medicare in CY2010 to 79% of Medicare in CY2011.

In addition, DHVA indicates that the professional fee schedule for all CPT codes will drop from 79.1% of Medicare in CY2010 to 71.9% of Medicare in CY2011. This information demonstrates that DHVA's professional fee schedule is rapidly losing ground in achieving the statutory goal of reimbursement parity with Medicare.

The additional information from DHVA indicates payments for pathology and laboratory services will be cut by 43% and payments for digital mammography services will be cut by 60%.

In the SPA information released by DHVA on October 18, it appeared that only radiological services were facing a significant reduction in their reimbursement under the SPA. And in its November 17 letter, the VMS explained the harm cuts of 42% for radiological services would have on beneficiary's access to necessary imaging services, especially in light of DHVA's parallel effort to reduce imaging services by 20% by requiring prior authorization.

The new information provided by DVHA on November 22 identifies other areas of healthcare services that would undergo cuts of this magnitude. For example, under the SPA laboratory and pathology services face a payment reduction of 43% in CY2011 and what are described by DVHA as HCPCs Codes will see a 55% cut in reimbursement in CY2011.

Understanding the HCPC codes being cut requires reviewing the 90 page document provided by DHVA that lists the reimbursement for each CPT code. On pages 89 and 90 of the document are 22 HCPC "G" codes listed. Out of the \$120,269 in CY2011 savings identified for a total reduction of 55%, the vast majority of the savings are due to a 60% cut in reimbursement for the approximately 3500 digital mammography services provided annually (G0202 w/26mod and G0206). The 60% cuts for mammography images will compound the 42% cuts in reimbursement on radiological services and place additional stress on the availability of these necessary diagnostic services to low-income Vermont women.

The VMS recommends an alternative RVU-based transition methodology for the Medicaid professional fee schedule.

The Resource Based Relative Value Scale (RBRVS) Payment Methodology was implemented in Medicare in 1992 and is based on a formula that includes geographically adjusted relative value units (RVUs) for each procedure (CPT/HCPCS) and a single conversion factor. As mentioned earlier, the Medicare conversion factor for the second half of 2010 is \$36.8729. In contrast to Medicare's single conversion factor, DVHA is proposing eight different conversion factors for different ranges of procedure codes that would result in Medicaid payment at differing percentages of Medicare.

DHVA's use of eight different conversion factors -- instead of Medicare's use of a single conversion factor -- fundamentally undermines the rationale of the RBRVS system and its use of RVUs and a single conversion factor to determine reimbursement amounts. The VMS therefore recommends that the SPA not be described as a "RBRVS Model"

As mentioned in the November 17 letter, V.S.A. Title 32, § 307(d)(6) calls for the governor's proposed financial plan for the Medicaid budget to include "recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement." The VMS recommends that DHVA fully adopt Medicare's Part B RBRVS reimbursement system with its single conversion factor.

The VMS is aware of the projected \$112 million state budget deficit and it recognizes the difficulties of immediately moving the DHVA professional fee schedule to one based on the Medicare professional fee schedule. As a transition strategy, the VMS recommends the following alternative to DHVA's SPA proposal:

1. Adopt a single conversion factor for the E&M codes, the obstetric codes, the chiropractic codes and the physician-provided behavioral health codes (for the behavioral health codes, all physicians would be paid at the same rate and nonphysicians would be paid at a percentage of the physician rate in a manner consistent with Medicare reimbursement policy);
2. Adopt the Medicare conversion factor for the radiological codes, the "G" HCPC codes, and the pathology and laboratory codes; and
3. Adopt a single conversion factor for all the remaining codes.

This transition strategy would create three CPT code-based conversion factors instead of DHVA's proposed eight conversion factors and the strategy would transition Vermont to the use of a single conversion factor based on Medicare. The state would still derive savings from its reimbursement for radiological codes, "G" HCPC codes and, pathology and laboratory codes, since they would drop from their current payment above the Medicare rate to 100% of the Medicare rate.

Under the federal Patient Protection and Affordable Care Act (PPACA), Medicaid reimbursement to primary care practitioners for evaluation and management codes and some immunization administration codes will be increased for two years on January 1, 2013 to 100% of the Medicare rate. The VMS transition strategy is therefore consistent with the anticipated evolution of the Medicaid fee schedule to one increasingly based on Medicare. The next step in implementing this strategy would be to significantly increase the proposed conversion factor to the Medicare level for all the remaining codes, as soon as possible.

Under the Challenges for Change program enacted during the last legislative session, DVHA has created the Clinical Utilization Review Board (CURB). The board consisting of physicians and other healthcare practitioners has been charged to work with the department's medical director to achieve \$4 million in Medicaid savings in SFY 11. The additional costs needed to fund the VMS's proposed transition strategy would be based on a portion of the \$4 million in savings that Vermont physicians and other healthcare professionals obtain for the Medicaid program. This approach is consistent with the shared savings program for Accountable Care Organizations enacted under the federal Patient Protection and Affordable Care Act.

↑ <https://www.cms.gov/PhysicianFeeSched/>

Comment #3

I am writing in opposition to the proposed revision of Medicaid reimbursement methodology regarding payment for radiological services. As one of very few radiologists in the Northeast Kingdom, I believe this to be an undue burden. Medicaid constitutes a significant portion of my reimbursement and will adversely impact provision of services, to the detriment of Medicaid beneficiaries. I question why the comment period is so brief and what the motivation for this might be. Why have radiologists been singled out? I support the comments of the Vermont Medical Society and believe this matter should be given further study to evaluate its impact on radiological services.

Comment #4

I have read the response written by Paul Harrington, Executive Vice President of the Vermont Medical Society, and agree with all of his points regarding this important legislation. I have chosen to add my personal feelings concerning several of these issues.

Mr. Harrington describes - "The VMS is also concerned that the proposed 40% reduction in payment for radiological services could result in independent community-based radiology practices having to limit the number of Medicaid beneficiaries they treat in order to meet the costs of operating their practices and the reductions will place further strains on the hospital-based practices. "

As a radiologist in Bennington, I am very concerned that the proposed Medicaid rate cut will have a significant impact on my ability, and others within my group, to continue to provide quality Radiological services to the many Medicaid beneficiaries in our community. Let's be frank, The people that depend on Medicaid are among the most disadvantaged in our state. This legislation can only make it harder for them to search out and receive the medical care they need. I believe the rate cut to specialists will only be the beginning as the primary care providers will quickly be forced to ration care to the under-served in anticipation of non-payment and denial of service. I realize the governor's race has already been decided, but "This is not the future Vermont needs".

Mr Harrington wrote- With respect to CT use in Vermont, the January 15, 2010, Act 49 report from the Vermont Department of Banking, Insurance, Securities and Health Care Administration on Recommendations to Improve Utilization and Variation in Health Care Services in Vermont states on page 23 the following: "Between the years of 2003-2007, the rate of CT events increased nationally (7.3% growth rate), in the New England region (7.5%), and in the state of Vermont (5.7%). While the rates of CT events increased in Vermont over 5 years, the state has much lower rates than the nation and the adjoining HRR's. The national average for CT events was 63.8 events per 100 people while the Vermont state average was just 41.8."

I agree that there is over utilization of Radiological services. Paying radiologists less for these services may provide a short term budgetary savings but is not a legitimate solution to this problem. The solution lies in changing the practice patterns of those who over-order and over-prescribe. This rate cut in a sense "shoots the messenger". As a radiologist, I am intimately affected by this problem, but to put it simply, 'I just read the studies, I don't order them.'

Mr Harrington also states "The VMS has grave concerns that with the state's high Medicaid enrollment the cumulative impact of a 20% decrease in utilization, coupled with a 40% reduction in reimbursement could jeopardize the ability of Vermont to attract and retain community-based and hospital-based radiologists."

My wife and I moved to Vermont a few years ago as Vermont offers a relatively unique practice environment and is a great place to live and raise a family. Many doctors are also married to other doctors. You could argue that losing a few radiologists might be a fair price to pay for significant budget savings, but my wife leaving the state would be a huge loss to the community and the thousands of patients she cares for.

We as physicians and healthcare administrators should be developing ways to encourage young smart physicians to remain and thrive here, not develop barriers to their moving to or remaining in Vermont.

Lastly, I think that 6 1/2 days is not nearly sufficient to analyze and comment on this highly technical piece of public policy and at least a 30 day extension is needed for further consideration and discussion of possible alternatives.

Comment #5

The University of Vermont Medical Group, which represents approximately 550 physicians jointly employed by Fletcher Allen Health Care and the University of Vermont College of Medicine, is filing the following comments on the State Plan Amendment (SPA) being proposed by the Department of Vermont Health Access (DVHA) that would implement the Resource Based Relative Value System (RBRVS) as a pricing methodology for some codes within DVHA's physician fee schedule. By way of background, the UVM Medical Group employs not only a broad range of specialty care physicians, but also a large cadre of primary care physicians who work at our main campuses in Burlington as well as in ten different primary care practices in our service area. That includes the physicians at our Aesculapius Medical Center, the state's largest primary care practice and the second pilot site for the Blueprint for Health. The proposed fee schedule changes raise a number of technical as well as substantive concerns that have been outlined clearly and articulately by the Vermont Medical Society in its comments on the draft SPA. Rather than repeat those comments, which we generally support, I would like to address one overarching concern: the impact of the proposed changes on specialty care services, many of which are provided by members of the UVM Medical Group to Vermont's sickest and most vulnerable patients when they are referred to us for tertiary and quaternary services.

- The major impact of the proposed reductions would be on radiology services, with a reduction of 40% from today's payments. This is on top of the new "Challenges for Change" prior authorization requirements, which are targeted at reducing Medicaid spending on advanced imaging by about \$2 million, or 20% of current expenditures. These reductions are being proposed despite the fact that Vermont in general, and the Burlington Hospital Service Area (HSA) in particular, are among the lowest utilizers of advanced imaging in the nation, as has been demonstrated by the state's own Act 49 reports.
- Reducing radiology fees for Medicaid beneficiaries by 40% will make it very difficult for community-based radiologists to continue to serve these patients, which presents a very real access issue for patients.
- It also represents a very real financial issue for hospital-based radiology departments, which will likely absorb these patients. Fletcher Allen, for example, is already being paid only 37¢ per dollar of cost of caring for Medicaid patients, and we will now be asked to treat more patients at a significantly reduced payment level.
- The draft SPA's impact on other types of specialists is also unclear, in the absence of a more detailed analysis as requested by the VMS.

In light of these concerns, we join in the VMS's request for additional analytical materials from DVHA as to the impact of the proposed changes before the close of public comments. This would include the impact on all specialty care services, both by provider type and by hospital or HSA.

We also support the VMS's request that the final SPA use a single conversion factor (CF) rather than the eight different CFs being proposed. This would be consistent with Medicare payment rules and the policy behind the RBRVS payment methodology in general, and would mitigate some of the impact on specialty care services.

Comment #6

I am writing to express my dismay at the proposed Medicaid fee cuts to radiology professional services.

This will be a short letter since I just became aware of this issue, and am busy at work.

I work at Springfield Hospital, Windsor County, which I believe should be one of the most Medicaid depend parts of the state, it certainly has one of the highest unemployment rates over many years.

A radical cut in our Medicaid payments would make it much harder to attract good radiologists to our hospital. I retire in two years and we are starting to look for a replacement doctor. Though Vermont has many wonderful things going for it, it also has significant negatives, such as quality of many schools, lack of available jobs for spouse, etc. Which have caused us to lose some good people over the years. There are only so many docs who wish to work in this town, and to be less able to pay them a good, competitive market wage is not something I want.

Radiology / Imaging is at the core of modern medical practice. I don't think there is any question that access for Medicaid patients to quality imaging, in their local hospitals, will become compromised if these radical cuts come into play.

Comment #7

I am writing to express my strong objection to the proposed implementation of the Department of Health Access's RBRVS rate methodology. The RVU system that has been in place in Medicare for some time was an attempt to place relative value on widely differing medical services. Once that relative value was established, Medicare could establish a conversion rate that would apply for all services. While no such system is perfect, the important point is that relative values were established at the outset. If Vermont Medicaid is going to use the RVU system, then it should do so. To have varying conversion factors is to effectively repudiate the RVU system, placing different values on different services, although the services have been given the same number of RVU's by Medicare.

What has been proposed is a massive selective devaluation of radiology services. The proposal says, in effect, we don't value the interpretation of imaging examinations as much as we value other services with the same number of RVU's. One of the stated goals of the proposed implementation is to ensure sufficient access to all services. Perhaps the key word is "sufficient", and the unstated goal is to reduce the number of complex imaging examinations provided for Medicaid beneficiaries by making them less available. If so, I have not heard anyone suggest that that is a good idea in Vermont, where utilization is the lowest in the country. Whatever the motivation, I can't imagine that a 40% cut in payment will have no impact on access. I dare say that there is no area of economic activity where a price decrease of 40% would have zero impact on supply. Obviously there is a price at which it makes no sense for a provider to offer a service. Each practitioner and hospital will have to make that judgment, and I certainly cannot speak for any other radiologist or any hospital. Nonetheless, it is my sense that the tipping point for complex radiological examinations is close to the current Medicare rate. I firmly believe that there is no question that the proposed reduction in the Medicaid fee schedule for radiology will adversely impact access; the only questions are when, how much, and in what form.

If Vermont is to adopt the Medicare RVU system for paying practitioners for services provided Medicaid beneficiaries I suggest that we should embrace the relative values used by Medicare, and establish a conversion factor that rewards all RVU's equally. Furthermore, I would suggest that phasing those changes in over a three year period would be the least disruptive to markets, and would be most likely to maintain the access that Vermont Medicaid patients currently enjoy.

Comment #8

The Vermont Radiological Society (VRS) — a professional organization representing more than 90 radiologists, radiation oncologists, medical physicists, interventional radiologists, radiology residents/fellows and nuclear medicine physicians in the state — appreciates the opportunity to comment on the proposed Vermont Medicaid State Plan Amendment (SPA#11-001). We will address the proposed RBRVS methodology, impact of suggested changes to radiology reimbursement codes, current imaging trends in the state, and an alternative RVU-based solution.

We support DVHA's efforts to implement the RBRVS as a pricing methodology for the physician fee schedule; however, we are concerned that DHVA's adoption of eight different conversion factors is not consistent with the RBRVS implemented by Medicare. VRS supports the adoption of a single conversion factor for the proposed fee schedule, akin to that currently in effect for Medicare.

Proposed changes to the radiology codes within the DVHA's Physician Fee Schedule represent the most dramatic aggregate cut of any healthcare provider class, and have the potential to devastate access to appropriate imaging in Vermont.

Data collected by the Radiology Business Management Association (RBMA) and the American College of Radiology (ACR) underscores this concern. According to their recent survey on proposed Medicare reforms, if reimbursements were reduced by half:

- * 36 percent of practices would consider limiting access to Medicare beneficiaries
- * 25 percent would consider dropping out of the Medicare program
- * 40 percent would consider consolidating service sites
- * 40 percent would consider closing their center

Source:

<http://www.acr.org/Hidden/Economics/FeaturedCategories/WhatsNew/DRAcutsFactSheet.aspx>

As the comment letter from the Vermont Medical Society (VMS) points out, the Medicaid budget for state fiscal year 2011 includes a projected savings of \$2M from the implementation of prior authorization for imaging services. Although prior authorization is a method commonly used for lowering utilization rates, Vermont shows positive trends in the utilization of imaging. Vermont's Department of Banking, Insurance, Securities, and Health Care Administration on *Recommendations to Improve Utilization and Variation in Health Care Services in Vermont* notes that:

“While the rates of CT events increased in Vermont over 5 years, the state has much lower rates than the nation and the adjoining HRR's. The national average for CT events was 63.8 events per 100 people while the Vermont state average was just 41.8.”

The Vermont Radiological Society supports appropriate diagnostic testing, including the American College of Radiology's (ACR) recommendations that no imaging exam should be performed without a clear medical benefit that outweighs any associated risk. The VRS also supports the 'as low as reasonably achievable' (ALARA) concept, which urges providers to use the minimum level of radiation necessary for imaging exams to achieve the desired results. Radiologists in the state are committed participants in the “Image Gently™” campaign for dose reduction in pediatric imaging, and support the recently launched “Image Wisely” adult radiation dose reduction effort.

The fact that Vermont has the lowest utilization for advanced imaging of all 50 states in addition to one of the healthiest populations in the nation suggests that we are doing something right and may already be a “best practice.” We are concerned that an additional cut in Medicaid reimbursements for radiology may not only

further curtail access to MRI and CT, but also have the unintended consequence of curtailing access to all medical imaging, to include mammography. A 20% projected decrease in utilization from new prior authorization requirements coupled with a 40% reduction in reimbursement would likely jeopardize the ability of Vermont to continue to recruit and retain high quality community hospital-based and academic radiologists.

We respectfully urge you to consider the full adoption of the Medicare's Part B RBRVS reimbursement system with its single conversion factor. The VRS supports the alternative transition strategy proposed by the VMS.

Lastly, in order to hear from all stakeholders, the VRS requests an extension of the comment period by at least 30 days. In addition, we request a public hearing since this decision will impact imaging access to the state's most vulnerable citizens.

Comment #9

I am writing to you to voice my concerns over SPA #11-001. While the current Vermont Medicaid fee schedule may be inconsistent, the new methodology results in new inconsistencies that may ultimately affect the ability of Medicaid patients to access needed imaging services in the state. While the use of RVU's and geographic indices in the new methodology in fee calculation is reasonable, the use of multiple conversion factors as the DVHA proposes is not.

The proposed 40% reduction in professional reimbursement for Medicaid patient imaging studies will have a significant impact on my small rural community hospital based radiology practice. If SPA #11-001 is implemented, it will likely significantly impact our ability to recruit well trained and talented radiologists and limit the availability of radiology services for Medicaid recipients in the state.

I think it is necessary for the State to take a closer look at this proposal and its unintended consequences. Please extend the review period for this proposal and consider the input of radiology practices in the state, the Vermont Medical Society and the Vermont Radiological Society.

Comment #10

I wish to point out that such an unprecedented reduction to Radiologist reimbursement may well have the unintended consequence of reducing the ability for us to recruit and retain qualified Radiologists to provide care to Medicaid patients and all Vermonters. With technological advancements Radiologists have emerged as crucial to the provision of quality healthcare and a keystone of the healthcare team. To secure the future it is necessary to retain a "physician magnet" environment in Vermont. I have been practicing Radiology in Vermont for over 30 years and have, with some considerable difficulty, recruited Radiologists to our practice. Our competition for Radiologists is a national marketplace. We have historically been at the low end of reimbursement rates compared to national averages which has been a significant issue in past recruiting and, with the proposed cuts, will undoubtedly be more of an issue in the future. We have so far been able to sell "the Vermont lifestyle" as the tradeoff but this can only go so far in today's economy. With the expected attrition from an aging Radiologist workforce, retirement and turnover (and possibly hastened by this proposed amendment) new manpower will be needed to fill the critical mission we play in the appropriate, efficient, timely and compassionate delivery of health care to Vermonters. Any weakening of the Radiologist workforce will have a negative effect on Vermonters.

There is evidence that advanced imaging can and does not only improve the quality of care, but reduces the cost of care in many situations. There are some areas where there is over utilization of imaging, but the answers to this problem are not to cut Radiologists but to 1) reform tort law to reduce the practice of defensive medicine, 2) reduce imaging self referral, 3) work with Radiologists and referring physicians to encourage utilization of "appropriateness criteria" which we as Radiologists have developed.

To single out Radiologists as the target of drastic cuts is unwise and improper. Therefore, I support the proposal set forth by our Vermont State Medical Society which, rather than the inconsistent and punitive measures

currently being considered, offers the alternative proposal of a **single conversion factor** for all specialties. This is the fair and right path to take.

I also request that the comment period be extended for an additional 30 days as proposed by the VSMS.

Comment #11

I write to you with grave concern regarding the proposed Vermont Medicaid reimbursement cuts for radiologists. Given the relatively high number of Vermonters who fall under the Medicaid umbrella, a 40% cut in reimbursement for such a large percentage of our imaging studies would have a significant negative impact on our practice. As a self-employed private practice radiologist, the proposed rate cuts would not simply be absorbed by a larger corporate entity with little impact on the individual practitioner, but would instead directly and dramatically impact our overall reimbursement. Indeed, the impact would be such that it would threaten our ability to continue serving the Medicaid population in our current capacity and would potentially threaten my own ability to continue practicing medicine in Vermont.

I urge you to strongly consider the alternative proposals made by the Vermont Medical Society regarding this issue. At the very least, an extended comment period with a public hearing would be appropriate, given the draconian nature of the proposed cuts and the potential negative consequences these cuts would have on the quality of medical care in this state.

Comment #12

As a community hospital-based diagnostic radiologist practicing in Addison County, I was quite concerned to learn of the proposed, above-referenced changes in Vermont Medicaid reimbursement. A 40% cut in reimbursement for radiologists will have significant ramifications upon the availability of radiology services for Medicaid recipients in this state. As it stands, Vermont is the healthiest state in the nation and has the lowest utilization of advanced medical imaging of any state. This is because of the fact that Vermont has reasonable and appropriate resource availability and a relatively small but dedicated cadre of radiologists who prioritize "best practice" care over personal enrichment. As far as finances go, re-imbursement for radiologist's services has been completely flat (or declining) over the past ten years. Allowing for inflation, this functionally represents a 25% decrease in payment for a given service rendered over the past decade! (I'll promise you that my practice expenses have not decreased accordingly over the same time period.) To arbitrarily cut one small physician group's re-imbursement by 40% under these circumstances is sure to be fraught with un-intended consequences, many of which will have the final common denominator of decreased access to vital imaging services to that segment of the population that is least able to overcome such hurdles.

Here in Vermont, we have a medical imaging paradigm that works! In fact, most other states are trying to emulate our success. Please don't so under-value the contribution of this state's radiologists, that this well-functioning vehicle of health care delivery is left stripped by the side of the road on jack-stands. Once dissipated, these resources would take decades to rebuild. Please extend the time available for public review of these very important and far-reaching decisions to allow for further discussion. Please take the time and care to consider the input of the Vermont Medical Society and the Vermont Radiological Society as well as the individual physicians "in the trenches".

Comment #13

The Department of Vermont Health Access (DVHA) has recently announced a proposed amendment to implement the Medicare RBRVS system and change its Medicaid Fee Schedule. In the Announcement dated 11/8/10, DVHA stated it intent to implement a pricing methodology based on a "National Standard." And while I agree that the Vermont Medicaid Fee Schedule as currently written is inconsistent, the proposed methodology creates new inconsistencies, is unfair, and is irresponsible.

DVHA has created a new conversion factor model that purports to follow Medicare methodology in fee calculation. And in its utilization of RVU's and geographic indices, that is partially true. But where Medicare

uses a single "conversion factor" (currently set at \$36.87), DVHA proposes no less than eight conversion factors ranging from \$24.34 to \$32.37. This is the essence of inconsistency.

While efforts to create an RVRBS-based system while improving Evaluation and Management reimbursements are admirable, maintaining budget neutrality obviously required slashing the Conversion Factor for procedural codes to the low end \$24.32. As a result, budget neutrality is accomplished at the expense of Vermont Radiologists who will see a 37.2% decrease in fees and a loss of \$1,800,000. Meanwhile, virtually every other type of provider except Radiologists experiences a fee increase up to 3.5%. This is the essence of unfair.

Implementation of the proposed Medicaid Fee Schedule will significantly effect the practice of radiology in Vermont. Medicaid is estimated to comprise near 23% of the payer mix for radiology in Vermont. A 37.2% reduction in radiology payments will reduce radiologist incomes that already lag national averages. This is bound to result in increased difficulty in recruiting and retaining radiologists. If fewer radiologists are willing to practice in Vermont, there will be limits to imaging access for our state's most vulnerable patients. As such, implementation of the proposed Medicaid Fee Schedule would be irresponsible.

The Vermont Medical Society has acted as a voice of reason. They have recommended that DHVA adopt a single conversion factor for its RBRVS Fee Schedule. They have recommended that the impact of the new Medicaid Fee Schedule deserves further study and have asked that the comment period be extended by 30 days. They have also recommended that a public hearing be held prior to implementation. These do not seem unreasonable requests.

I respectfully urge DVHA reassess its course before irreparable harm results.

Comment #14

I am a Vermont radiologist living in Rutland Vermont. I have practiced at Rutland Regional Medical Center for 17 years. I have also taken care of patients regardless of their ability to pay, type of insurance or their socio-economic status. Simply put, I have cared for patients because they need my help.

I am writing to support the Vermont Medical Society's letter to you regarding the proposed radical reimbursement cut to radiologists for care they deliver. Your plan seems to target our sub-specialty without any real analysis of its impact on care to the sickest patients in our community.

Many years ago the State decided to reimburse the professional radiology component at a "certain percentage of Medicare reimbursement." At the time, I believe, that decision was made in conjunction with the knowledge that 95% of radiologists practicing in this State do not own imaging centers and care for this State's sickest and most vulnerable patients in the confines of our local hospitals. Your current plan does not address why you propose such a drastic reduction, nor does it outline how that care will be given if our sub-specialty is unable to maintain its local practice or recruit effectively.

I am hoping that your office will:

- (1) Endorse and accept the Vermont Medical Society proposal to you.
 - (2) Extend the commentary period past the Nov. 17th deadline and allow open, public testimony at a hearing in Montpelier
 - (3) Come up with an impact plan on patients and on physician demographics in this State --as the expertise needed to render complex imaging care becomes increasingly difficult to obtain by this State's sickest and most vulnerable patients.
-

Comment #15

I am a radiologist in Rutland, Vermont and I am writing in response to the proposed Vermont Medicaid State Plan Amendment.

You are surely aware that Vermont has a CT utilization rate which is significantly lower than the national average. Despite this, DVHA has embarked on a plan to further reduce imaging utilization by 20%, through the mechanism of requiring preauthorizations and with the express intent of increasing denials. Our early experience with this program has only confirmed my suspicion that DVHA's priority is to achieve the goal of decreased utilization without a concomitant priority for ensuring the appropriateness of the denials. As an example, your two week window for appealing and resubmitting a denied procedure is deliberately onerous and is far outside the norm for payors.

Now you announce on November 8 that you are imposing a new reimbursement scheme. Your announcement allows only a handful of business days for commenting on this sweeping and complex plan. Although you achieve your goal of a budget-neutral strategy, it is at the expense of imaging, which is anticipated to suffer a 40% loss of reimbursement on top of your established goal of a 20% cut in utilization. It is hard to believe that anyone will find this to be reasonable. The Vermont Medical Society has already spoken out vigorously against this proposal, and they have submitted reasonable suggestions for improving the RBRVS-based plan. I do not intend to reiterate VMS's arguments, but I do find them to be compelling and urge you to study them carefully.

What I want to convey to you is the tremendous degree to which all of medical care depends on imaging. You cannot simply slash spending on imaging without expecting huge and deleterious repercussions. Imaging is the backbone of medical care today. Critical decisions and diagnoses that formerly were an art and a 'best guess' are now based on science and are made with confidence. Because of imaging, surgeries are planned better, treatments are tailored to the individual patient, medications are more likely to be chosen correctly, and patients are better informed about their condition. In Rutland, we have a slightly higher imaging utilization than the rest of Vermont. That makes perfect sense because the population here is older, poorer and sicker than the rest of the state. **This is exactly the population you will be harming with this policy.** The older, poorer and sicker among us need better access to imaging, not a 40% cut in spending and a 20% cut in utilization. Diagnoses will be delayed, medications and surgeries and treatment plans will be made on a 'best guess' basis, patients will be less well informed.

This plan will have a tremendous negative impact on our ability to recruit or retain qualified radiologists in Vermont. That impact will be greatest in precisely the areas of the state with greatest need, because the locations with the greatest need are also the areas with the highest Medicaid payor mix. As much as we love Vermont, the radiologists who work here have to be responsible with our own finances. It's such a small state, we could continue to enjoy living here but simply drive across the border to work in another state where they take better care of their more vulnerable citizens. For me personally, I cannot sustain a loss of income on the order of what you are seeking to impose. I have already begun the process of applying for medical licenses in other states. I sincerely hope I don't have to use those licenses, but it would be irresponsible of me to fail to plan ahead.

Comment #16

I am also a radiologist in Rutland and a former board member of BC/BS TVHP and also Rutland regional board for 16 years. I am aware of all the different aspects of the need for healthcare reform and agree something needs to be done.

I would volunteer my time to develop a meaningful answer to the fiscal issues, but have to caution you that Vermont is too small a state to pursue unilateral reform without losing the good physicians responsible for its high ranking nationally.

I agree entirely with Dr Mitchell and would like the amendment discarded before it hurts the very people medicaid is supposed to serve.

Comment #17

Thanks so much for writing up those requests. In the meantime, I talked to Paul and have some clarification on what we are looking for in general on the breakout of the codes and analysis.

- An analysis of the relationship between the current Medicaid CPT fee schedule and the proposed fee schedule prepared in a manner consistent with the categories in the AMA's manual of current procedural terminology - Evaluation and Management 99201 -- 99499; Anesthesia 00100 -- 01999; Surgery 10021 - 69990; Radiology 70010 -- 79999; Pathology and Laboratory 80047 -- 89356; and Medicine 90281 -- 99607 or an analysis broken down by the complete list of specialties used by DVHA (the list used in 2000 is attached above).

As I mentioned, VMS is requesting additional time (30 days from receipt of the information on 11/8) before the close of the comment period on the state plan amendment, so that we will have an opportunity to review this information and circulate it to physicians.

Comment #18

I am a Board certified radiologist trained at FAHC and in practicing in Rutland, Vermont at RRMC since 1981. I am the President of Rutland Radiologists, Inc. and am writing representing our group of four radiologists. It is only by rumor that I learned about the DVHA proposal to modify the formula by which Vermont health care providers are reimbursed by VT Medicaid. I also have by rumor been informed of an opportunity to comment on the proposal by November 17th. This method of notification seems rather suboptimal. I have received a copy of a slide presentation of Burns & Asso., Inc.

Most physicians are quite familiar with the history and methodology of the Medicare RBRVS system as depicted in the slide show. I do not understand Slide #6 discussing the Vermont transition to the Medicare RBRVS system. VT Medicaid adopted the RBRVS system in determining provider reimbursement some 8 to 10 years ago. At that time VT Medicaid made an instant and complete conversion to the RBRVS system. There was no "transition". There was proper notification and ample opportunity for all health care providers to provide input at that time. After careful deliberation VT Medicaid determined that provider reimbursement rates based upon a percentage of VT Medicare rates was reasonable and also determined that the percentages as listed on Slide 12 in the "Today" column were reasonable and justifiable. For Burns & Asso., Inc. to imply that VT Medicaid is now proposing to "transition" to the Medicare RBRVS is wrong. It was adopted some 8 to 10 years ago. What is being proposed now is a modification of a previously adopted system. The important question is; are the proposed modifications reasonable and justifiable? It is appropriate to periodically review and potentially modify the current reimbursement system when sound and justifiable reasons exist.

At some point in time VT Medicaid decided after careful and thoughtful evaluation that the percentages in the "Today" column were reasonable and justifiable. I would like to believe that sound and justifiable reasoning was used to lead to the proposed modifications. A review of the proposed new percentages indicates most providers would experience a modest positive adjustment of 1-3% with Podiatrists increasing 9.7%, Optometrists increasing 15.3% and Radiologists decreasing by 40.6%.

Nothing has happened in the last ten years that would justify such a drastic modification to Radiology code reimbursements from the previously determined reasonable, justifiable and appropriate levels. The amount of work to provide those services has not decreased and practice expenses have continued to rise. This experience is no different then for other providers. I would appreciate the opportunity to review the justifications and reasoning for the proposed radiologist reimbursement change along with the justifications and reasoning used for the modifications proposed for Primary Care Providers and OB/GYN's for comparison purposes

It is easy to believe that things in medicine have changed sufficiently over the last 8 to 10 years that modifications in the plus 1 to 3 percent range are reasonable and justifiable. It is extremely hard to believe that there has been anything near of a change in the practice of Radiology to have VT Medicaid reasonably believe that a decrease in reimbursement for such services by some 40 percent would be reasonable, justifiable and appropriate.

I would suggest that some of the data in the Burns & Asso., Inc. slide show be checked for accuracy. Slide 14 indicates 21 radiologists receive greater than \$10,000 annually from VT Medicaid. There are between 45 and 50 actively practicing radiologists in Vermont. There are also a number of DHMC radiologists that provide service for VT Medicaid patients. I strongly suspect all of the radiologists in Vermont received greater than \$10,000 annually as do some at DHMC. Also there are about a half dozen Vermont radiation therapists that use 70,000 series codes to bill for services. A number of those likely also collect greater than \$10,000 annually. There also are a number of Vermont cardiologists that use 70,000 series codes to bill for cardiac nuclear medicine studies. A separate data packet was received with the Burns & Asso., Inc. name indicating that some \$4,400,000 is paid annually for radiology services. At least for the Vermont radiologist I would suggest that the amount is rather evenly distributed over the 45 to 50 and not 21.

I look forward to receiving the current reasoning and justifications for the proposed reimbursement modifications for services provider by Primary Care Providers, OB/GYN's and Radiologists. I request that the dead line to submit comments be extended so that I may have the opportunity to respond to your anticipated response to my above request. A public discussion of this important issue is strongly encouraged.

Comment #19

10 years ago, 130% of Medicare was the goal of the IPAs in both Bennington & Rutland for sustainable medical private practices. This was prior to the nationwide cutback in specialty reimbursement by ALL non-governmental insurers AND the more recent lack of any "real" increases in physician medicare payments.

The goal the VMS worked for (1995-2005) was Medicaid parity with NATIONAL Medicare rates as Vermont's reimbursement is in the bottom 20% (quality is in the top 10%, however). During this period, any increase in monies by Medicaid were put solely to the E&M codes in an attempt to help primary care. Finally are the percentages quoted of state or national medicare rates?

After 30 years of private practice in Vermont (ENT or Otolaryngology), the proposed percentages/rates will not allow private practice to continue in Vermont. To attract new physicians, pay their medical school debt, use EMR etc., their EMPLOYERS will have to pay a "National" rate.

Comment #20

I am writing in response to the posting for comments on implementation of the RBRVS pricing methodology for codes within the Department of Health Access fee schedule, which seem to fly in the face of our public policy on parity in access to health care services. I am also concerned about coordination of planning within the Agency of Human Services between DVHA and the Department of Mental Health in addressing services to Vermonters with mental health and substance abuse needs, to prevent further disproportionate impacts and cost shifts.

The proposed significant and disparate reduction, again, for mental health therapists appears to be in conflict with the expectations for redesign of the mental health designated agency provider network directed under Challenges for Change. The reduction also appears to disregard the relationship to other key targets for system savings through reductions in unnecessary utilization of emergency rooms, reductions in psychiatric hospitalization, and reductions in the correctional population.

Each of these savings by their nature assume access to a private provider system. Challenges directed an "integration of some or all of the services provided in the adult outpatient program (AOP) and the community rehabilitation and treatment (CRT) program in order to ensure that adults with mental health conditions have access to a continuum of services." Sec. C27.(a)(1) The premise of the reorganization designated agency system is that it will allow greater flexibility to address all individuals based upon level of need by referral, if not

available "in house." There is an inescapable bottom line involved in the savings expected to be generated: there will be a higher number of clients who will be referred to private providers for outpatient therapy.

If DVHA expects to reduce rates, while DMH is expecting to send more Medicaid clients to the private provider system (along with the Medicaid Blueprint clients... who are already overwhelming the system where the Blueprint is rolled out), then there is a huge disconnect. It will result in a compounding of reduction of necessary services, rather than ensuring "access to a continuum of services," in turn resulting in increased pressures on three key areas targeted in Challenges: inpatient psychiatric hospitalization, utilization of emergency rooms, and corrections.

As one piece of DMH work driven by the legislation, a series of reviews were done on "potentially avoidable" hospital emergency room use by community mental health clients. The elevated risk of such visits was significant: 17 percent of adult outpatient clients and 16 percent of CRT clients had a potentially avoidable emergency room visit, in contrast to four percent of the general population.

A loss in access to mental health supports resulting from repeated rate reductions will only drive such numbers higher, and contradict the potential for savings among these other very high cost sectors. I would urge consideration a more even-handed approach among different health provider categories in the effort to maintain the overall RBRVS cost-neutral implementation.

Comment #21

The Council of Mental Health and Substance Abuse Professionals of Vermont would like to thank you for your work on transitioning Medicaid to a RBRVS (Medicare) based payments.

While it makes sense to support primary care services in communities with increased funding, we have concerns about further variation in the conversions, (payments) for different provider types and service groups.

We are concerned about the variation of percentages associated with the several provider groups who bill behavioral health codes. Based on Parity these vital services should be at the same conversion factor of \$30.97 for medical practitioners and licensed behavioral health clinicians using these codes. While medical practitioners with different license and education levels are level funded (for behavioral health codes), the behavioral health professionals are targeted for reduced funding. These stepped reimbursements on top of established Medicare levels (payment differences) represents additional cuts for PhD, MSW and other Master level clinicians.

It is important to note that Vermont Medicaid outpatient treatment reimbursement rates were reduced in 2006 by 7%. These low reimbursement rates force clinicians to turn Medicaid patients away. Current **access** problems across the state include **Wait lists** at designated agencies and independent practitioners overwhelmed with calls from patients who have called numerous clinicians seeking care. There is a concern that this formula will formalize this problematic reimbursement level and tie it to Medicare.

This current proposal does not support parity. Appropriate parity in payments supports the incoming administration's focus on reducing corrections budgets and further supports increased prevention and timely access to MH/SA services in communities across Vermont. Additionally, even with the small increases proposed and the integration of mental health services into the continuum of care with medical practice, this disparity may slow the realization of the Blueprint goals.

Clinicians previously offered services for Medicaid patients, knowing that the reimbursement rates from private insurance would balance the low Medicaid rates. They can no longer make this adjustment due to the introduction of discounted fees from private, for profit behavioral health care company contracts

We are proposing a common calculation based on the rates before the 7% cuts with these calculations on a par with the other medical specialties billing behavioral health (Mental Health) codes that are crucial elements of integrated care.

Comment #22

On behalf of the Vermont Association for Mental Health, I write to voice our very real concern about the implications of formalizing the changes in reimbursement that occur in the transition of Medicaid to an RBRVS - based system. This is a clear example of how, though parity is the law of the land, it is not taken into consideration in substantive matters like this. It is very disappointing. Medical practitioners appear to have been kept at their previous levels of reimbursement for providing services under behavioral health codes, while behavioral health practitioners with similar degrees and licensure continue to be reimbursed at low rates. This makes no sense under parity. Neither does it make sense given that Vermonters' access to outpatient services, the least expensive preventative form of behavioral health care, has declined precipitously in recent years. This will only make it worse. Reducing incentives for behavioral health professionals to provide care at a time when caseloads are up, waiting lists are higher than they have ever been and plans are being made to increase the demand for services even further, is irresponsible at best. The VAMH urges you to reconsider.

Comment #23

VMS received a question from a pediatric practice about whether a pediatric correction factor was still in effect. Do you know whether this is still the case?

A Pediatrics correction factor for Medicaid was put into place back during to Dean administration of approximately 28%, during the Dr. Dynosaur expansion to help pediatric practices stay afloat since about half of their patients would be covered by the state. You may remember the governor then traveling around the state and telling teachers to take the two person family plan insurance and put their kids on Medicaid. Well lots of people did that, and with income guidelines of covering up to 300% of poverty, many children from families who have other insurance are on the state supported plan. If the " correction factor " for pediatric practices were to be eliminated no Pediatric Practice who sees more than say 30% Medicaid covered children could be economically viable.

I don't see this particular point addressed in the information supplied, but with all the detail I may have missed it. Pediatricians are among the lowest paid specialty nationally and here in Vermont. We all love our work and children, but if the state wishes to cover so many lives pediatricians will either leave the state or restrict access to Medicaid covered kids. Please check my recollection on this pediatric correction factor, but if this is removed it will spell economic disaster for my specialty.

Comment #24

I write to inquire concerning the SPA document, *Comparing DVHA RBRVS Model- CY 2011 Inputs Against CY 2010 Inputs*” *DVHA RBRVS Model Using CY 2010 Inputs (CY 2010 Medicare RVUs, Conversion Factor and GPICIs and DVHA SFY09 Utilization).*

Please turn to page 12 of 13, “Group 11: Chiropractors” and note dollar amounts are listed in Columns A, D, F and H. At this time Medicaid only reimburses chiropractic physicians for CMT codes / services. I am curious why other services are listed as paid.

At your earliest convenience will you contact me concerning the data on Page 12.

No public meetings are scheduled at this time.

To get more information about the RBRVS State Plan Amendment go to
<http://dvha.vermont.gov/administration/draft-versions-of-state-plan-changes>.

Response to RBRVS Public Comments- Attachment 1

This table summarizes the changes to the rate model based on feedback from commenters and additional analysis by DVHA.

1. Both models use a claims database with dates of service in SFY 10.
2. For the Practice Expense RVU component, the Non-Facility RVU will be used for all providers.
3. The Work GPCI was moved back to 1.000 per legislation passed by the Congress.
4. The new model is limited to two conversion factors in response to:
 - a. Input from the public to move toward a single conversion factor like Medicare.
 - b. Input from the public to promote mental health parity.
 - c. Input from the public to mitigate the reduction in payments for radiology services.
5. In order to maintain close to payment neutrality on mental health services, modifier reductions were changed.
 The modifier for Ph.D. Psychologists was lowered from 88% to 86%.
 The modifier for M.S. Psychologists was lowered from 80% to 71%.

		Nov 22 Model (Conversion Factor as Pct of Medicare)	DVHA Nov 22 Conversion Factor	Dec 23 Model (Conversion Factor as Pct of Medicare)	DVHA Dec 23 Conversion Factor	
A	Evaluation & Management codes	Includes CPT 90471-90474, 99201-99480	79.00%	\$29.1296	77.80%	\$28.6871
B	Maternity Care/Delivery Services	Includes CPT 59000-59871	74.00%	\$27.2859	77.80%	\$28.6871
C	Behavioral Health codes Psychiatrists Primary Care Doctors, Primary Care Nurse Practitioners, Specialist Doctors, Specialist NPs Ph.D. Psychologists M.S. Psychologists All Other providers	Includes CPT 90801-90899, 96101-96155	80.00% 80.00% 73.00% 68.00% 60.00%	\$29.4983 \$29.4983 \$26.9172 \$25.0736 \$22.1237	77.80%	\$28.6871
D	Integumentary	Codes in series 10000-19999	60.00%	\$22.1237	57.88%	\$21.3420
E	Musculoskeletal	Codes in series 20000-29999	60.00%	\$22.1237	57.88%	\$21.3420
F	Respiratory	Codes in series 30000-32999	60.00%	\$22.1237	57.88%	\$21.3420
G	Cardiovascular	Codes in series 33000-39999	60.00%	\$22.1237	57.88%	\$21.3420
H	Digestive	Codes in series 40000-49999	60.00%	\$22.1237	57.88%	\$21.3420
I	Urinary	Codes in series 50000-53999	60.00%	\$22.1237	57.88%	\$21.3420
J	Genital Systems	Codes in series 54000-58999	60.00%	\$22.1237	57.88%	\$21.3420
K	Endocrine and Nervous	Codes in series 60000-64999	60.00%	\$22.1237	57.88%	\$21.3420
L	Eye and Ocular	Codes in series 65000-69999	60.00%	\$22.1237	57.88%	\$21.3420
M	Radiology	Codes in series 70000-79999	60.00%	\$22.1237	77.80%	\$28.6871
N	Pathology	Codes in series 80000-89999 and that are payable in the RBRVS	60.00%	\$22.1237	57.88%	\$21.3420
O	Medicine	Codes in series 90000-99999 and not in A or C	60.00%	\$22.1237	57.88%	\$21.3420
P	Chiropractic codes	CPT 98940-98943	79.00%	\$29.1296	77.80%	\$28.6871
Q	Screening Services and Other Select Codes	G0101-G0427, G9041-G9044, Q0035	60.00%	\$22.1237	57.88%	\$21.3420

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
All Groups									
All Codes	\$86,785,296	\$118,563,288	73.2%	\$86,785,074	73.2%	(\$222)	0.0%	\$12,631,503	0.0%
E&M Codes	\$40,658,662	\$52,282,261	77.8%	\$40,665,144	77.8%	\$6,482	0.0%		
Delivery Codes	\$3,359,164	\$4,546,198	73.9%	\$3,536,031	77.8%	\$176,867	5.3%		
Beh Health Codes	\$21,671,701	\$27,669,510	78.3%	\$21,535,084	77.8%	(\$136,617)	-0.6%		
Integumentary	\$577,444	\$1,866,575	30.9%	\$1,080,374	57.9%	\$502,930	87.1%		
Musculoskeletal	\$1,979,762	\$4,153,847	47.7%	\$2,404,247	57.9%	\$424,485	21.4%		
Respiratory	\$295,460	\$627,364	47.1%	\$363,118	57.9%	\$67,658	22.9%		
Cardiovascular	\$462,093	\$1,504,025	30.7%	\$870,528	57.9%	\$408,435	88.4%		
Digestive	\$1,771,838	\$3,369,872	52.6%	\$1,950,481	57.9%	\$178,643	10.1%		
Urinary	\$339,216	\$694,600	48.8%	\$402,036	57.9%	\$62,820	18.5%		
Genital Systems	\$766,805	\$1,635,027	46.9%	\$946,354	57.9%	\$179,549	23.4%		
Maternity Care	\$76,895	\$165,963	46.3%	\$96,060	57.9%	\$19,165	24.9%		
Endocrine and Nervous	\$726,848	\$1,550,845	46.9%	\$897,627	57.9%	\$170,779	23.5%		
Eye and Ocular	\$616,258	\$872,743	70.6%	\$505,144	57.9%	(\$111,114)	-18.0%		
Radiology	\$5,993,138	\$5,754,180	104.2%	\$4,475,601	77.8%	(\$1,517,537)	-25.3%		
Pathology	\$807,474	\$887,911	90.9%	\$513,924	57.9%	(\$293,550)	-36.4%		
Medicine	\$5,530,330	\$9,790,939	56.5%	\$5,666,996	57.9%	\$136,666	2.5%		
Chiropractic	\$804,288	\$938,323	85.7%	\$729,827	77.8%	(\$74,461)	-9.3%		
HCPCS Codes	\$347,920	\$253,105	137.5%	\$146,498	57.9%	(\$201,422)	-57.9%		

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 1: Primary Care Physicians									
All Codes	\$24,338,720	\$32,810,069	74.2%	\$25,116,683	76.6%	\$777,963	3.2%	\$5,808,009	2.6%
E&M Codes	\$21,824,188	\$28,892,277	75.5%	\$22,472,413	77.8%	\$648,225	3.0%		
Delivery Codes	\$205,032	\$260,641	78.7%	\$202,726	77.8%	(\$2,306)	-1.1%		
Beh Health Codes	\$1,234,560	\$1,494,917	82.6%	\$1,163,593	77.8%	(\$70,967)	-5.7%		
Integumentary	\$95,616	\$353,702	27.0%	\$204,723	57.9%	\$109,107	114.1%		
Musculoskeletal	\$56,289	\$186,262	30.2%	\$107,809	57.9%	\$51,520	91.5%		
Respiratory	\$10,220	\$30,752	33.2%	\$17,799	57.9%	\$7,579	74.2%		
Cardiovascular	\$9,486	\$53,150	17.8%	\$30,763	57.9%	\$21,277	224.3%		
Digestive	\$149,015	\$272,898	54.6%	\$157,953	57.9%	\$8,938	6.0%		
Urinary	\$1,880	\$13,977	13.5%	\$8,090	57.9%	\$6,210	330.3%		
Genital Systems	\$27,005	\$71,134	38.0%	\$41,172	57.9%	\$14,167	52.5%		
Maternity Care	\$2,671	\$4,996	53.5%	\$2,892	57.9%	\$221	8.3%		
Endocrine and Nervous	\$12,818	\$39,206	32.7%	\$22,692	57.9%	\$9,874	77.0%		
Eye and Ocular	\$12,359	\$35,819	34.5%	\$20,732	57.9%	\$8,373	67.7%		
Radiology	\$118,481	\$132,916	89.1%	\$103,382	77.8%	(\$15,099)	-12.7%		
Pathology	\$9,803	\$8,633	113.6%	\$4,997	57.9%	(\$4,806)	-49.0%		
Medicine	\$554,558	\$941,413	58.9%	\$544,890	57.9%	(\$9,668)	-1.7%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$14,739	\$17,376	84.8%	\$10,057	57.9%	(\$4,682)	-31.8%		

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F		G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today			Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent			
Group 2: Primary Care Nurse Practitioners										
All Codes	\$2,698,573	\$3,652,050	73.9%	\$2,808,466	76.9%	\$109,893	4.1%		\$253,102	3.7%
E&M Codes	\$2,542,208	\$3,389,608	75.0%	\$2,636,437	77.8%	\$94,229	3.7%			
Delivery Codes	\$0	\$0		\$0		\$0				
Beh Health Codes	\$73,097	\$89,776	81.4%	\$69,828	77.8%	(\$3,269)	-4.5%			
Integumentary	\$7,186	\$26,513	27.1%	\$15,346	57.9%	\$8,160	113.6%			
Musculoskeletal	\$2,460	\$8,553	28.8%	\$4,951	57.9%	\$2,491	101.3%			
Respiratory	\$2,822	\$6,730	41.9%	\$3,896	57.9%	\$1,074	38.1%			
Cardiovascular	\$471	\$2,856	16.5%	\$1,653	57.9%	\$1,182	251.0%			
Digestive	\$21	\$177	11.9%	\$102	57.6%	\$81	385.7%			
Urinary	\$719	\$2,643	27.2%	\$1,530	57.9%	\$811	112.8%			
Genital Systems	\$6,015	\$12,884	46.7%	\$7,457	57.9%	\$1,442	24.0%			
Maternity Care	\$132	\$273	48.4%	\$158	57.9%	\$26	19.7%			
Endocrine and Nervous	\$635	\$3,022	21.0%	\$1,749	57.9%	\$1,114	175.4%			
Eye and Ocular	\$2,616	\$8,067	32.4%	\$4,669	57.9%	\$2,053	78.5%			
Radiology	\$10,176	\$11,365	89.5%	\$8,839	77.8%	(\$1,337)	-13.1%			
Pathology	\$1,089	\$974	111.8%	\$564	57.9%	(\$525)	-48.2%			
Medicine	\$48,813	\$88,375	55.2%	\$51,151	57.9%	\$2,338	4.8%			
Chiropractic	\$0	\$0		\$0		\$0				
HCPCS Codes	\$113	\$234	48.3%	\$136	58.1%	\$23	20.4%			

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 3: OB/GYN Providers									
All Codes	\$5,731,056	\$8,258,966	69.4%	\$6,125,883	74.2%	\$394,827	6.9%	\$589,657	6.2%
E&M Codes	\$1,282,104	\$1,580,191	81.1%	\$1,229,073	77.8%	(\$53,031)	-4.1%		
Delivery Codes	\$2,544,827	\$3,437,871	74.0%	\$2,673,976	77.8%	\$129,149	5.1%		
Beh Health Codes	\$594,950	\$795,461	74.8%	\$619,579	77.9%	\$24,629	4.1%		
Integumentary	\$7,897	\$16,974	46.5%	\$9,825	57.9%	\$1,928	24.4%		
Musculoskeletal	\$334	\$1,085	30.8%	\$628	57.9%	\$294	88.0%		
Respiratory	\$0	\$0		\$0		\$0			
Cardiovascular	\$2,598	\$4,989	52.1%	\$2,887	57.9%	\$289	11.1%		
Digestive	\$31,488	\$51,265	61.4%	\$29,672	57.9%	(\$1,816)	-5.8%		
Urinary	\$15,185	\$45,905	33.1%	\$26,570	57.9%	\$11,385	75.0%		
Genital Systems	\$551,295	\$1,203,132	45.8%	\$696,373	57.9%	\$145,078	26.3%		
Maternity Care	\$59,590	\$132,064	45.1%	\$76,439	57.9%	\$16,849	28.3%		
Endocrine and Nervous	\$3,868	\$10,471	36.9%	\$6,060	57.9%	\$2,192	56.7%		
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$625,734	\$943,877	66.3%	\$734,148	77.8%	\$108,414	17.3%		
Pathology	\$129	\$713		\$413		\$284			
Medicine	\$11,057	\$34,968	31.6%	\$20,240	57.9%	\$9,183	83.1%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$0	\$0		\$0		\$0			

Response to RBRVS Public Comments- Attachment 2
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	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 4: Specialists (Physicians or Nurse Practitioners)									
All Codes	\$23,768,400	\$35,142,314	67.6%	\$24,081,392	68.5%	\$312,992	1.3%	\$4,192,540	1.1%
E&M Codes	\$12,900,149	\$16,066,613	80.3%	\$12,496,612	77.8%	(\$403,537)	-3.1%		
Delivery Codes	\$605,740	\$843,816	71.8%	\$656,320	77.8%	\$50,580	8.4%		
Beh Health Codes	\$965,145	\$1,255,066	76.9%	\$976,891	77.8%	\$11,746	1.2%		
Integumentary	\$401,304	\$1,276,242	31.4%	\$738,689	57.9%	\$337,385	84.1%		
Musculoskeletal	\$1,864,340	\$3,772,780	49.4%	\$2,183,685	57.9%	\$319,345	17.1%		
Respiratory	\$276,769	\$571,749	48.4%	\$330,928	57.9%	\$54,159	19.6%		
Cardiovascular	\$346,485	\$889,309	39.0%	\$514,732	57.9%	\$168,247	48.6%		
Digestive	\$1,568,361	\$2,928,941	53.5%	\$1,695,271	57.9%	\$126,910	8.1%		
Urinary	\$316,416	\$597,793	52.9%	\$346,003	57.9%	\$29,587	9.4%		
Genital Systems	\$119,331	\$253,305	47.1%	\$146,613	57.9%	\$27,282	22.9%		
Maternity Care	\$14,502	\$28,630	50.7%	\$16,571	57.9%	\$2,069	14.3%		
Endocrine and Nervous	\$695,443	\$1,460,184	47.6%	\$845,154	57.9%	\$149,711	21.5%		
Eye and Ocular	\$598,993	\$822,888	72.8%	\$476,288	57.9%	(\$122,705)	-20.5%		
Radiology	\$568,721	\$630,084	90.3%	\$490,079	77.8%	(\$78,642)	-13.8%		
Pathology	\$794,700	\$864,292	91.9%	\$500,252	57.9%	(\$294,448)	-37.1%		
Medicine	\$1,692,833	\$2,846,997	59.5%	\$1,647,842	57.9%	(\$44,991)	-2.7%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$39,168	\$33,625	116.5%	\$19,462	57.9%	(\$19,706)	-50.3%		

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	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 5: Radiologists									
All Codes	\$5,240,437	\$5,209,418	100.6%	\$3,818,169	73.3%	(\$1,422,268)	-27.1%	\$116,790	-26.5%
E&M Codes	\$36,703	\$43,634	84.1%	\$33,939	77.8%	(\$2,764)	-7.5%		
Delivery Codes	\$0	\$0		\$0		\$0			
BH Codes	\$94	\$124		\$101		\$7			
Integumentary	\$26,841	\$74,327	36.1%	\$43,020	57.9%	\$16,179	60.3%		
Musculoskeletal	\$15,802	\$68,330	23.1%	\$39,549	57.9%	\$23,747	150.3%		
Respiratory	\$5,593	\$18,019	31.0%	\$10,429	57.9%	\$4,836	86.5%		
Cardiovascular	\$102,755	\$553,109	18.6%	\$320,139	57.9%	\$217,384	211.6%		
Digestive	\$22,070	\$112,203	19.7%	\$64,943	57.9%	\$42,873	194.3%		
Urinary	\$5,008	\$34,199	14.6%	\$19,795	57.9%	\$14,787	295.3%		
Genital Systems	\$1,170	\$2,757		\$1,596		\$426			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$10,559	\$31,436	33.6%	\$18,195	57.9%	\$7,636	72.3%		
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$4,642,465	\$3,991,182	116.3%	\$3,104,341	77.8%	(\$1,538,124)	-33.1%		
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$77,508	\$78,544	98.7%	\$45,462	57.9%	(\$32,046)	-41.3%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$293,869	\$201,554	145.8%	\$116,660	57.9%	(\$177,209)	-60.3%		

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	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 6: Psychiatrists									
All Codes	\$5,069,067	\$6,212,835	81.6%	\$4,835,342	77.8%	(\$233,725)	-4.6%	\$635,704	-4.1%
E&M Codes	\$788,653	\$1,044,287	75.5%	\$812,246	77.8%	\$23,593	3.0%		
Delivery Codes	\$0	\$0		\$0		\$0			
Beh Health Codes	\$4,268,593	\$5,145,699	83.0%	\$4,009,863	77.9%	(\$258,730)	-6.1%		
Integumentary	\$47	\$119		\$69		\$22			
Musculoskeletal	\$0	\$0		\$0		\$0			
Respiratory	\$0	\$0		\$0		\$0			
Cardiovascular	\$0	\$0		\$0		\$0			
Digestive	\$0	\$0		\$0		\$0			
Urinary	\$0	\$0		\$0		\$0			
Genital Systems	\$0	\$0		\$0		\$0			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$0	\$0		\$0		\$0			
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$26	\$37		\$29		\$3			
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$11,748	\$22,693	51.8%	\$13,135	57.9%	\$1,387	11.8%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$0	\$0		\$0		\$0			

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	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 7: Psychologist (Doctorate Level)									
All Codes	\$2,702,890	\$3,531,163	76.5%	\$2,747,221	77.8%	\$44,331	1.6%	\$5,572	1.6%
E&M Codes	\$266	\$332		\$259		(\$7)			
Delivery Codes	\$0	\$0		\$0		\$0			
Beh Health Codes	\$2,702,565	\$3,530,711	76.5%	\$2,746,893	77.8%	\$44,328	1.6%		
Integumentary	\$0	\$0		\$0		\$0			
Musculoskeletal	\$0	\$0		\$0		\$0			
Respiratory	\$0	\$0		\$0		\$0			
Cardiovascular	\$0	\$0		\$0		\$0			
Digestive	\$0	\$0		\$0		\$0			
Urinary	\$0	\$0		\$0		\$0			
Genital Systems	\$0	\$0		\$0		\$0			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$0	\$0		\$0		\$0			
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$0	\$0		\$0		\$0			
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$59	\$120	49.2%	\$69	57.5%	\$10	16.9%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$0	\$0		\$0		\$0			

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(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 8: Psychologist (Masters Level)									
All Codes	\$11,836,062	\$15,361,960	77.0%	\$11,951,546	77.8%	\$115,484	1.0%	\$236,564	1.0%
E&M Codes	\$3,988	\$4,805	83.0%	\$3,737	77.8%	(\$251)	-6.3%		
Delivery Codes	\$0	\$0		\$0		\$0			
Beh Health Codes	\$11,831,959	\$15,356,862	77.0%	\$11,947,639	77.8%	\$115,680	1.0%		
Integumentary	\$0	\$0		\$0		\$0			
Musculoskeletal	\$0	\$0		\$0		\$0			
Respiratory	\$56	\$114		\$66		\$10			
Cardiovascular	\$0	\$0		\$0		\$0			
Digestive	\$0	\$0		\$0		\$0			
Urinary	\$0	\$0		\$0		\$0			
Genital Systems	\$59	\$179		\$104		\$45			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$0	\$0		\$0		\$0			
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$0	\$0		\$0		\$0			
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$0	\$0		\$0		\$0			
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$0	\$0		\$0		\$0			

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F		G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today			Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent			
Group 9: Therapists										
All Codes	\$2,364,815	\$3,978,648	59.4%	\$2,321,802	58.4%	(\$43,013)	-1.8%		\$4,421	-1.8%
E&M Codes	\$67,151	\$94,618	71.0%	\$73,594	77.8%	\$6,443	9.6%			
Delivery Codes	\$0	\$0		\$0		\$0				
Beh Health Codes	\$615	\$667	92.2%	\$518	77.7%	(\$97)	-15.8%			
Integumentary	\$20	\$133		\$77		\$57				
Musculoskeletal	\$1,085	\$3,979	27.3%	\$2,303	57.9%	\$1,218	112.3%			
Respiratory	\$0	\$0		\$0		\$0				
Cardiovascular	\$0	\$0		\$0		\$0				
Digestive	\$0	\$0		\$0		\$0				
Urinary	\$0	\$0		\$0		\$0				
Genital Systems	\$0	\$0		\$0		\$0				
Maternity Care	\$0	\$0		\$0		\$0				
Endocrine and Nervous	\$0	\$0		\$0		\$0				
Eye and Ocular	\$0	\$0		\$0		\$0				
Radiology	\$0	\$0		\$0		\$0				
Pathology	\$0	\$0		\$0		\$0				
Medicine	\$2,295,944	\$3,879,251	59.2%	\$2,245,310	57.9%	(\$50,634)	-2.2%			
Chiropractic	\$0	\$0		\$0		\$0				
HCPCS Codes	\$0	\$0		\$0		\$0				

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 10: Optometrists and Opticians									
All Codes	\$1,075,886	\$2,196,416	49.0%	\$1,336,232	60.8%	\$260,346	24.2%	\$7,703	24.0%
E&M Codes	\$246,791	\$324,163	76.1%	\$252,134	77.8%	\$5,343	2.2%		
Delivery Codes	\$0	\$0		\$0		\$0			
Beh Health Codes	\$47	\$62		\$50		\$3			
Integumentary	\$0	\$0		\$0		\$0			
Musculoskeletal	\$0	\$0		\$0		\$0			
Respiratory	\$0	\$0		\$0		\$0			
Cardiovascular	\$0	\$0		\$0		\$0			
Digestive	\$0	\$0		\$0		\$0			
Urinary	\$0	\$0		\$0		\$0			
Genital Systems	\$0	\$0		\$0		\$0			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$0	\$0		\$0		\$0			
Eye and Ocular	\$2,290	\$5,969	38.4%	\$3,455	57.9%	\$1,165	50.9%		
Radiology	\$1,685	\$2,132	79.0%	\$1,658	77.8%	(\$27)	-1.6%		
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$825,073	\$1,864,090	44.3%	\$1,078,935	57.9%	\$253,862	30.8%		
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$0	\$0		\$0		\$0			

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 11: Chiropractors									
All Codes	\$807,737	\$942,481	85.7%	\$732,400	77.7%	(\$75,337)	-9.3%	\$331	-9.3%
E&M Codes	\$557	\$667	83.5%	\$519	77.8%	(\$38)	-6.8%		
Delivery Codes	\$0	\$0		\$0		\$0			
Beh Health Codes	\$76	\$165	46.1%	\$129	78.2%	\$53	69.7%		
Integumentary	\$0	\$0		\$0		\$0			
Musculoskeletal	\$0	\$0		\$0		\$0			
Respiratory	\$0	\$0		\$0		\$0			
Cardiovascular	\$0	\$0		\$0		\$0			
Digestive	\$0	\$0		\$0		\$0			
Urinary	\$0	\$0		\$0		\$0			
Genital Systems	\$0	\$0		\$0		\$0			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$0	\$0		\$0		\$0			
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$0	\$0		\$0		\$0			
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$2,816	\$3,326	84.7%	\$1,925	57.9%	(\$891)	-31.6%		
Chiropractic	\$804,288	\$938,323	85.7%	\$729,827	77.8%	(\$74,461)	-9.3%		
HCPCS Codes	\$0	\$0		\$0		\$0			

Response to RBRVS Public Comments- Attachment 2
DVHA RBRVS Model Using CY 2011 Inputs
(CY 2011 Medicare RVUs, Conversion Factor and GPCIs and DVHA SFY10 Utilization)

	A	B	C	D	E	F	G	H	I
	Payments Made by DVHA	Payments Made by Medicare	DVHA Payments as Pct of Medicare	Payments in the Model	Model Payment as Pct of Medicare	Payment Increase/ (Decrease) from Today		Exclusions from RBRVS (passed through with no change)	Total Pct Difference (with exclusions)
						Dollars	Percent		
Group 12: Podiatrists									
All Codes	\$269,892	\$473,989	56.9%	\$322,874	68.1%	\$52,982	19.6%	\$44,535	16.9%
E&M Codes	\$185,869	\$235,819	78.8%	\$183,420	77.8%	(\$2,449)	-1.3%		
Delivery Codes	\$233	\$213	109.4%	\$165	77.5%	(\$68)	-29.2%		
Beh Health Codes	\$0	\$0		\$0		\$0			
Integumentary	\$37,184	\$114,553	32.5%	\$66,303	57.9%	\$29,119	78.3%		
Musculoskeletal	\$39,452	\$112,858	35.0%	\$65,322	57.9%	\$25,870	65.6%		
Respiratory	\$0	\$0		\$0		\$0			
Cardiovascular	\$298	\$612		\$354		\$56			
Digestive	\$0	\$0		\$0		\$0			
Urinary	\$0	\$0		\$0		\$0			
Genital Systems	\$0	\$0		\$0		\$0			
Maternity Care	\$0	\$0		\$0		\$0			
Endocrine and Nervous	\$806	\$1,757	45.9%	\$1,017	57.9%	\$211	26.2%		
Eye and Ocular	\$0	\$0		\$0		\$0			
Radiology	\$5,995	\$7,837	76.5%	\$6,096	77.8%	\$101	1.7%		
Pathology	\$0	\$0		\$0		\$0			
Medicine	\$24	\$24		\$14		(\$10)			
Chiropractic	\$0	\$0		\$0		\$0			
HCPCS Codes	\$31	\$316		\$183		\$152			

Response to RBRVS Public Comments- Attachment 3
Summary of Future Payments as a Percent of Medicare Payments by Provider Type

Provider Type	Shown October 18 (SFY09 data, CY 10 RVUs)		Shown December 20 (SFY10 data, CY 11 RVUs)	
	Payment as a Percent of Medicare		Payment as a Percent of Medicare	
	Today	Projected in CY 2011	Today	Projected in CY 2011
ALL PROVIDERS	78.7%	78.7%	73.6%	73.6%
Primary Care Physicians	84.2%	86.4%	74.2%	76.6%
Primary Care Nurse Practitioners	84.3%	86.4%	73.9%	76.9%
OB/GYN Providers	76.6%	78.7%	69.4%	74.2%
Specialists (Physicians or Nurses)	74.5%	77.1%	67.6%	68.5%
Radiologists	106.9%	66.2%	100.6%	73.3%
Psychiatrists	83.6%	85.4%	81.6%	77.8%
Psycholgists (Doctorate Level)*	74.9%	75.7%	76.7%	78.0%
Psycholgists (Masters Level)*	70.0%	71.3%	80.1%	80.9%
Therapists	66.5%	66.7%	59.4%	58.4%
Optometrists and Opticians	53.2%	68.5%	49.0%	60.8%
Chiropractors	87.8%	82.9%	85.7%	77.7%
Podiatrists	68.2%	77.9%	56.9%	68.1%

* When showing payments to Ph.D. or M.S. Psychologists, the payments are reduced with modifier pricing when computing both Medicare payments and future DVHA payments as follows:

Ph.D. Psychologists	Rate on file discounted 14%	(Rate * .86)
M.S. Psychologists	Rate on file discounted 29%	(Rate * .71)

Response to RBRVS Public Comments- Attachment 4
Fiscal Impact on Specific Providers in the SFY 10 Claims Dataset

Provider Type	Number of Providers Paid > \$10,000 Annually	Percent Losing More than 10% from Today's Payments	Percent Within +/- 10% of Today's Payments	Percent Gaining More than 10% from Today's Payments
ALL PROVIDER TYPES	961	8%	57%	35%
Primary Care Physicians	160	4%	86%	10%
Primary Care Nurse Practitioners	35	0%	97%	3%
OB/GYN Providers	39	10%	41%	49%
Specialists (Physicians or Nurses)	204	8%	64%	27%
Radiologists	23	96%	4%	0%
Psychiatrists	39	8%	90%	3%
Psychologists (Doctorate Level)	44	14%	39%	48%
Psychologists (Masters Level)	301	7%	32%	60%
Therapists	48	0%	92%	8%
Optometrists and Opticians	34	3%	6%	91%
Chiropractors	26	0%	100%	0%
Podiatrists	8	0%	25%	75%

Response to RBRVS Public Comments- Attachment 5

Fiscal Impact on Specific Providers Who Billed for Any Radiology Services in the SFY 10 Claims Dataset

	(1)	(2)	(3)	(4)
Provider Type	Number of Providers Paid > \$10,000 Annually	Total in (1) that Bill any amount of Radiology Services	Providers in (2) that "Win" in the New Payment Methodology	Providers in (2) that "Lose" in the New Payment Methodology*
ALL PROVIDER TYPES	961	217	166	51
Primary Care Physicians	160	32	26	6
Primary Care Nurse Practitioners	35	8	8	0
OB/GYN Providers	39	28	23	5
Specialists (Physicians or Nurses)	204	96	76	20
Radiologists	23	23	4	19
Psychiatrists	39	1	1	0
Psychologists (Doctorate Level)	44	0	0	0
Psychologists (Masters Level)	301	0	0	0
Therapists	48	0	0	0
Optometrists and Opticians	34	21	21	0
Chiropractors	26	0	0	0
Podiatrists	8	8	7	1

*For Radiologists, the loss in payments in the new system is due to radiology codes.
 For other providers, the loss may be due to radiology, to other codes, or a combination of the two.