

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

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W. VA. SECRETARY OF STATE

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: West Virginia Department of Health and Human Resources TITLE NUMBER: 69

CITE AUTHORITY W. Va. Code §16-29D-7

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 3

TITLE OF RULE BEING AMENDED: Implementation of Omnibus Health
Care Act Payment Provisions

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Janya Williams

DATE: October 16, 1991

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: Taunja Willis Miller, Secretary, Department of Health and Human Resources

LEGISLATIVE RULE TITLE: Implementation of Omnibus Health Care Act Payment Provisions

1. Authorizing statute(s) citation W. Va. Code §16-29D-7

2. a. Date filed in State Register with Notice of Hearing:

August 30, 1991

b. What other notice, including advertising, did you give of the hearing?

None.

c. Date of hearing(s): October 1, 1991

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing:
(be exact)

November 6, 1991

f. Name and phone number(s) of agency person(s) to contact for additional information:

David P. Lambert, General Counsel
Public Employees Insurance Agency

348-7850, Ext. 225

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

N/A. The Advisory Committee created by W. Va.

§16-29D-7 was consulted and recommended promulgation.

b. Date of hearing: N/A.

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

N/A.

d. Attach findings and determinations and reasons:

Attached N/A.

DATE: October 16, 1991

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69 CSR 3

TITLE 69
LEGISLATIVE RULES
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 3
IMPLEMENTATION OF OMNIBUS HEALTH CARE ACT PAYMENT PROVISIONS

§69-3-1. General

1.1. Scope. -- This legislative rule implements those provisions of the Omnibus Health Care Act, W. Va. Code §16-29D-1 et seq., 1989, which relate to the establishment of a maximum reasonable and customary fee schedule by the Public Employees Insurance Agency, a division of the West Virginia Department of Administration, and to other reimbursement provisions.

1.2. Authority. -- W. Va. Code §16-29D-7.

1.3. Filing Date. --

1.4. Effective Date. --

§69-3-2. Definitions

2.1. The following words and phrases as used in these rules, unless a different meaning is clearly indicated by the context, shall have the meanings stated below.

2.2. The "Act" means the Omnibus Health Care Act which is codified at W. Va. Code §16-29D-1 et seq, as amended.

2.3. "Claims administrator" means the third party claims administrator for the PEIA, which developed the maximum allowable fee schedule summarized in this rule.

2.4. "CPT-4 Codes" means the listing of current medical procedure terminologies developed by the American Medical Association and used by physicians and other medical providers to describe individual services provided to patients for billing and other documentary purposes.

2.5. "HIAA" means the Health Insurance Association of America.

2.6. "Legitimate uncontested invoice" means a claim for payment for medical services delivered to a beneficiary of a department or division subject to the Act, received by that department or division in a manner prescribed and with all information, whether from the provider, beneficiary, or other third-party payor, stipulated by that department or division, and for which there is no action necessary for coordination of benefits, subrogation or other good cause to establish the legitimacy of the claim.

2.7. "PEIA" means the Public Employees Insurance Agency.

2.8. "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources.

§69-3-3. Purpose

3.1. The purpose of this rule is to summarize the methodology used by the PEIA's claims administrator to develop a maximum allowable fee schedule. The PEIA will use this schedule to reimburse physicians and other health care providers who bill according to CPT-4 Codes for services provided to PEIA insureds. This maximum allowable fee schedule will replace the eightieth (80th) percentile maximum fee schedule previously used by the PEIA, which was developed using 1988 PEIA claims data. Hospitals and other institutional providers will not be reimbursed according to the fee schedule summarized in this rule, but will be paid based on separate maximum institution-specific rates established by the PEIA.

3.2. Adoption and adjustment of the maximum fee schedule by the PEIA shall be accomplished through changes to the current PEIA financial plan or group benefit plan, as required, and not through this rule. This rule is being promulgated to comply with W. Va. Code §16-29D-7, which directs the Secretary to promulgate rules to implement the Act, and provides that methodologies for determination of rates, payments and schedules are subject to legislative rule-making procedures (but that the actual rates, payments and schedules are not).

3.3. This rule also interprets the provisions of W. Va. Code §16-29D-3(i) relating to prompt payment to a health care provider on or after September 1, 1989, for the purchase of health care or health care services by the PEIA, the division of rehabilitation services and the workers' compensation commission.

3.4. This rule is to be read together with the PEIA group benefit plan document and the PEIA financial plan.

§69-3-4. Methodology

4.1. This section summarizes the methodology employed to develop the maximum allowable fee schedule. This rule does not attempt to delineate every task, step, computer function or calculation involved in establishing the fee schedule, but rather provides an overview of the major steps involved.

4.2. The maximum allowable fee schedule was developed from claims data submitted by West Virginia health care providers to the HIAA during the period January 1, 1990 through June 30, 1991.

4.3. HIAA claims data for West Virginia is divided by zip code into six geographic areas. For each area, the data is sorted by CPT-4 Codes.

4.4. Within each area, for each CPT-4 Code, HIAA ranks the claims from lowest to highest charge. HIAA calculates the fiftieth (50th), sixtieth (60th), seventieth (70th), seventy-fifth (75th), and eightieth (80th) percentile charges (as well as other percentiles) for each CPT-4 Code within each area.

4.5. As an illustration of how these percentiles are calculated, assume that a routine office visit to a physician is represented by CPT-4 Code "A." Assume that the geographic areas into which HIAA separates West Virginia claims

data are represented by "1" through "6." For area "1," HIAA ranks all claims submitted by providers in that area for CPT-4 Code "A" from lowest charge to highest charge. The seventy-fifth (75th) percentile for CPT-4 Code "A" in area "1" is that charge level at which the charges for seventy-five percent (75) of the claims submitted are equal to or below. In this same manner, a separate seventy-fifth (75th) percentile charge for CPT-4 Code "A" is calculated for each of the six geographic areas.

4.6. The claims administrator then calculated a statewide or "blended" weighted average fiftieth (50th), sixtieth (60th), seventieth (70th), seventy-fifth (75th), and eightieth (80th) percentile charge for each CPT-4 Code from the percentile charges for each of the six geographic areas. In calculating the average, the percentile charge for each area was weighted by the number of claims for that CPT-4 Code contained in the claims data for that area. For example, the blended fiftieth (50th) percentile charge for a particular CPT-4 Code was calculated by taking an average of the fiftieth (50th) percentile charges for that code for each of the six areas, weighted by the number of claims for that code performed in each area.

4.7. For some CPT-4 Codes, an insufficient number of West Virginia claims existed to enable HIAA to calculate percentile charges. In these instances, the claims administrator used percentile charges from an urban area in one of the following neighbor states: Maryland, Pennsylvania, Ohio, Kentucky, North Carolina. The claims administrator adopted charges from the first of the above states, in the order listed, to have sufficient claims for the particular CPT-4 Code. For example, if insufficient data existed for West Virginia for a particular code, the claims administrator looked to Maryland. If insufficient data existed for Maryland, the claims administrator then looked to Pennsylvania, and so on.

4.8. For some CPT-4 Codes, the claims administrator could not establish percentile charges due to insufficient data even after looking to neighboring states. For these infrequently-performed procedures, an identifier was assigned to indicate no maximum fee has been calculated. A maximum fee will be calculated when and if the PEIA or HIAA receives a sufficient number of claims to calculate a maximum fee.

4.9. After establishing percentile charges according to subsections 4.6 through 4.7 above, for all those CPT-4 Codes for which such percentiles could be calculated, the claims administrator then determined which percentile level, if applied to all CPT-4 Codes, would yield approximately the same total reimbursement as that actually paid by the PEIA for the same period, under the eightieth (80th) percentile maximum fee schedule developed from 1988 PEIA claims data, as adjusted by the PEIA Finance Board. The claims administrator determined that the seventieth (70th) percentile level would yield approximately the same total reimbursement (i.e., be "budget neutral").

4.10. The PEIA plans to establish initially its maximum allowable fees at the seventieth (70th) percentile level as calculated according to this subsection. The PEIA may at some future date adjust these fees, without further amendment of this rule, by: (1) adopting a different percentile level; (2) recalculating the percentiles using more recent HIAA claims data; or (3) making such other changes, not affecting the basic methodology, as may be required by the PEIA Finance Board.

\$69-3-5. Proprietary Nature of Fees

5.1. Consistent with W. Va. Code §16-29D-7 and W. Va. Code §5-16-18, the actual fee schedule(s) used by the PEIA, and any other information or calculations which would identify such fee schedule(s), are not subject to the rule-making procedures of the West Virginia Administrative Procedures Act, W. Va. Code §29A-1-1 et seq. Such fee schedule(s) and related identifying information are proprietary in nature, and will not be published or released by the Secretary or the PEIA, in order to protect and preserve competition among health care providers who may become subject to such schedule(s).

\$69-3-6. Prompt Payment

6.1. The PEIA, the division of rehabilitation services and the workers' compensation commission shall cause to be issued, within sixty-five (65) days after actual receipt by the agency of a legitimate uncontested invoice, a state check in payment for health care or health care services delivered to the respective beneficiaries of such agencies on or after September 1, 1989.

6.1.1. If a state check is issued more than sixty-five (65) days after actual receipt by the agency of a legitimate uncontested invoice, the agency shall pay interest, at the current rate, as determined according to subsection 6.1.1.1., calculated from the sixty-sixth (66th) day after such invoice was actually received by the division or agency up to and including that date on which the state check is mailed to the vendor.

6.1.1.1. The current rate of interest will be determined by the state tax commissioner under the provisions of W. Va. Code §11-10-17(a).

6.1.1.2. Each division or agency shall record by electronic or other means the actual date of receipt on all invoices received, and, if different, the date on which each invoice is deemed to be legitimate and uncontested.

SUMMARY OF PUBLIC COMMENT

On October 1, 1991, the Public Employees Insurance Agency, on behalf of the W. V. Department of Health and Human Resources, conducted a public hearing to receive oral and written comments on proposed amendments to legislative rules entitled "Implementation of Omnibus Health Care Act Payment Provisions," Title 69 C.S.R. Series 3.

One person appeared, Mr. George Rider, Executive Director of the West Virginia State Medical Association. Mr. Rider offered two oral comments. These are summarized, together with the agency response, below.

Mr. Rider's first comment was the following question: If the new fee schedule is budget-neutral, as represented, and the fees for certain health care services have been adjusted upward, does this not mean that other fees had to be adjusted downward?

In response, the PEIA did state that the new fee schedule was designed to be "budget-neutral." This comment was made in a "Statement of Facts and Circumstances Constituting An Emergency," which was filed with the proposed amendments to this rule when they were promulgated as an emergency rule. The Statement also indicated that "[f]ees for certain health care services, most especially primary care services, are now too low." This sentence suggested, correctly, that fees for these primary care services would increase.

However, in answer to Mr. Rider's question, increasing these specific primary care fees does not mean that other fees must be decreased. The reason is that the new fee schedule is not completely budget-neutral, despite the comment in the Statement. The new fee schedule, as a whole, was calculated (according to the methodology described in the rule) to be budget-neutral. In other words, the new fees were established at that percentile of Health Insurance Association of America ("HIAA") charge data that would result in no greater expenditure of PEIA dollars.

However, subsequent to this, a few select fees were adjusted upward. This is because the PEIA had already discovered that these fees were too low and were creating problems of access to care; the PEIA had already committed to health care providers that these fees would be increased to a certain level.

Consequently, increasing these select fees after the new schedule was calculated will require additional claims dollars. It will not result in the adjustment downward of any other fees to offset the increased costs of these upward adjustments.

Mr. Rider's second comment was to ask whether the new fee schedule is, in reality, a first step toward implementation of a Resource Based Relative Value Scale ("RBRVS") reimbursement system. In asking this question, Mr. Rider assumed that certain fees had been adjusted upward and certain others had been adjusted downward.

Again, for the same reasons stated in response to Mr. Rider's first inquiry, the answer is no. Without getting into the details of what constitutes an RBRVS system, it is generally assumed that under such a system that fees for some primary care services will increase and the fees for certain specialty services will decrease. As noted, in the present case, the PEIA made no conscious effort to adjust upward or downward any fees other than the few select primary care fees which were increased for the reasons previously discussed. Specifically, there was no corresponding decrease in fees for specialty services.

Moreover, there was no attempt to determine the "relative value" of different types of medical services. As stated earlier, the new maximum fees were set at a percentile of HIAA charges. The fees for all types of services were set at the same percentile (70th). The fees for a small number of services were then adjusted upward to reflect the prior commitment to providers as indicated.

Mr. Rider's comments were in response to the PEIA's "Statement," and the agency appreciates this opportunity to clarify the Statement. With this clarification, there is no need to amend the rules as originally proposed.

Public Employees Insurance Agency