Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30 -80
Regulation title	Methods and Standards for Establishing Payment Rates; Other Types of Care: State agency fee schedule for RBRVS
Action title	Recalibrate Physician Services Reimbursement by Implementing Site of Service
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

Chapter 879 of the *2008 Acts of the Assembly* Item 306 PP directed DMAS to recalibrate its Resource Based Relative Value System (RBRVS) physician reimbursement rates by implementing a site of service differential payment policy.

12 VAC 30-80-190 is being amended to implement a site of service differential for RBRVS physician rates. Payment for physician services in some cases will be recalibrated to implement different rates for services depending on the site of service, based on the relative value units (RVUs) for a procedure code published by the Centers for Medicare and Medicaid Services (CMS). For procedures that can be performed in either a facility or non-facility, CMS has been publishing separate RVUs for several years and Medicare rates are based on site of service. Different Medicaid rates by site of service will be phased-in over a four year period.

12 VAC 30-80-30 is being amended to remove the long-standing payment reduction applied to physician services when performed in hospital settings, as compared to physicians' offices.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Chapter 879 of the *2008 Acts of the Assembly* Item 306 PP directed DMAS to recalibrate its Resource Based Relative Value System (RBRVS) physician reimbursement rates by implementing a site of service differential payment policy.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal, the environmental benefits, and the problems the proposal is intended to solve.

This proposed regulation is not essential to protect the health, safety, or welfare of citizens. This proposed action modifies the methodology for reimbursing physicians based on the site of the service delivery. There are no expected environmental benefits from this change.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)

The section of the State Plan for Medical Assistance that is affected by this action is the Methods and Standards for Establishing Payment Rates-Other Types of Care (12 VAC 30-80-30 and 80-190).

Currently, the DMAS-portion of the Virginia Administrative Code contains a Resource Based Relative Value System (RBRVS) for computing reimbursement for physician services. (12VAC 30-80-190) This RBRVS method was originally developed by the Centers for Medicare and Medicaid Services for use in the Medicare program for reimbursing physicians. In addition to

this regulation, DMAS also has a secondary regulation (12VAC 30-80-30) that reduced the amount of reimbursement to physicians when services were performed in the hospital setting as compared to the physicians' offices.

Currently, the DMAS methodology uses only the non-facility Relative Value Unit (RVU) in calculating rates. Beginning in 1999, and fully phased in by 2002, Medicare adjusted its physician fees based on the setting in which the service was taking place. Medicare paid a lower fee for a service provided in a facility setting (i.e. outpatient hospital) than for the same service provided in a non-facility setting (i.e. physician's office). As a result of computer system limitations at that time, DMAS did not implement a site of service differential and adopted the non-facility RVU in the calculation of its physician reimbursement fees.

Over time, the gap in the Medicare RVUs, between facility and non-facility sites of service, has widened and the use of site of service differentials has expanded to many more procedure codes. As a result of this growing disconnect between the Medicare physician methodology and the DMAS methodology, DMAS is now paying very different fees for many services than Medicare now pays when the service is performed in the facility setting. In many of these cases, the DMAS fee for a service in a facility setting is much higher than the Medicare fee, sometimes even higher than physicians' charges.

12 VAC 30-80-190 is being amended to implement a site of service differential for RBRVS physician rates. Payment for physician services in some cases will be recalibrated to implement different rates for services depending on the site of service, based on the relative value units (RVUs) for a procedure code published by the Centers for Medicare and Medicaid Services (CMS). For procedure codes that can be performed in either a facility or non-facility, CMS has been publishing separate RVUs for several years and Medicare rates are based on site of service.

Different Medicaid rates calculated by site of service will be phased-in over a four-year period. In FY09, DMAS will add 75 percent of the difference between the facility RVU and non-facility RVU to the facility RVU. In FY10, DMAS will add 50 percent of the difference between the facility RVU and non-facility RVU to the facility RVU. In FY11, DMAS will add 25 percent of the difference between the facility RVU and non-facility RVU to the facility RVU. In subsequent fiscal years, DMAS will use the Medicare facility RVU.

Different rates based on site of service will be implemented in a budget neutral manner. Any savings in total reimbursement to physicians as a result of the implementation of site of service rates will be reallocated proportionately to all physician categories of service as a percentage increase. The annual RBRVS update to physician services will be performed in conjunction with the implementation of site of service.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and

3) other pertinent matters of interest to the regulated community, government officials, and the public.

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

Implementation of site of service will align the DMAS physician methodology more closely to the Medicare physician methodology. This change will increase the efficiency and effectiveness of payments made by DMAS to physician providers. The intent of legislative changes to adjust physician rates will be applied more appropriately. There are no advantages or disadvantages to the citizens of the Commonwealth for this change.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which are more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

No federal requirement exists to mandate this change. Alignment of the DMAS physician methodology to the Medicare methodology by employing site of service differentials will maximize the effectiveness of the methodology.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There are no localities that would be particularly affected by this regulatory action as it will be applied statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the board/agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so by mail, email or fax to Carla Russell, Manager, Div. of Provider Reimbursement, DMAS, 600 E. Broad Street, Suite 1300, Richmond VA 23219 (804/225-4586; fax 804/371-8892) (Carla.Russell@dmas.virginia.gov) . Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last date of the public comment period. Written comments may also be submitted via the Virginia Regulatory Town Hall website (www.townhall.virginia.gov).

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

This reimbursement methodology change is expected to be budget neutral. Any cost savings that accrue to DMAS as a result of this change will be reallocated proportionately to all physician categories of service as a percentage increase.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	There will be no costs to the state to implement this change.
Projected cost of the regulation on localities	There are no projected costs on localities.
Description of the individuals, businesses or other entities likely to be affected by the regulation	Physicians and other practitioners enrolled in the Virginia Medicaid Program.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Approximately 65,290.
All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.	This regulation is intended to be budget neutral in the aggregate for physicians and other practitioners. However, some individual providers may receive reduced reimbursement and others may gain. Individual providers would experience little to no administrative costs as the claim reporting requirements are not affected. The Managed Care Organizations (MCO) may incur administrative costs if the MCOs must make system changes to incorporate the site of service differential.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

This regulatory action is based on specific mandate expressed in the 2008 Appropriation Act, therefore, no alternatives were considered.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

This regulatory action is based on specific mandate expressed in the 2008 Appropriation Act; therefore, limited to no flexibility exists. The impact on businesses would be limited to the MCOs that participate with the Medicaid program. Individual providers would experience little to no impact as the claim reporting requirements are not affected by this change.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

DMAS' Notice of Intended Regulatory Action was published in the September 15, 2008, *Virginia Register of Regulations* (VR 25:1) for its public comment period from September 15, 2008 to October 15, 2008. No comments were received.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
80-30	N/A	Provides for a 50% reduction for designated physician services when such services are performed in a hospital setting as compared to the same services in physicians' offices.	Deletes this reimbursement reduction; site of service will replace the 50-percent reduction to certain physician procedures performed in an outpatient setting.
80-190	N/A	Provides for use of the non-facility Relative Value Unit in calculating physician reimbursement.	Adds the site-of-service differential for the calculation of physicians' services reimbursement. This change is to be phased in by 25% over the next four years so that by FY 2011, DMAS will use the Medicare facility RVU for this reimbursement calculation.