Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-80-30 and 12 VAC 30-80-190
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 of Agency Final Action	September 9, 2009

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

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

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. The only change in this final stage is editorial in nature in 12VAC30-80-190.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Agency Background document with the attached amended State Plan pages Recalibrate Physician Services Reimbursement by Implementing Site of Service (12VAC 30-80-30 and -80-190)) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act and is full, true, and correctly dated.

9/9/09
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

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 numbers, if applicable, and (2) promulgating entity, i.e., 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. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal 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 identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" 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 (CMS) 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 non-facility and 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 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 non-facility RVU and facility RVU to the facility RVU. In FY10, DMAS will add 50 percent of the difference between the non-facility RVU and facility RVU to the facility RVU. In FY11, DMAS will add 25 percent of the difference between the non-facility RVU and 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 there are no disadvantages to the public or the Commonwealth, please 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.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

The only change made in the final stage since the publication of the proposed stage is a non-substantive editorial change in 12VAC 30-80-190.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

DMAS' proposed regulations were published in the June 8, 2009, *Virginia Register* (VAR 25:20) for their public comment period from June 8, 2009 through August 7, 2009. The Agency received no public comments.

All changes made in this regulatory action

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

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. In addition, a non-substantive editorial change was also made in this section.

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.

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, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.