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 30-20-180
Regulation title	Administration of Medical Assistance Services: Definition of a Claim by Service
Action title	Electronic Claims Submission Requirement
Date this document prepared	January 13, 2014

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

This action recommends that the 46,957 fee-for-service Medicaid providers be required to electronically submit their claims for services rendered to Medicaid and FAMIS individuals. Prior to DMAS' emergency regulations, electronic claims submission was voluntary. This action also provides for providers' payments to be provided by electronic funds transfers (EFT). This action also allows for exceptions to these electronic filing/payment requirements when certain specified standards are met. This action does not affect the 8 Medicaid managed care organizations (MCOs) because they do not file individual claims for services but already file electronic encounter data. There are no changes in this final stage over the previous proposed stage.

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 or board taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages regarding Electronic Claims Submission Requirement (12 VAC 30-20-180) 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.

January 28, 2014

Date

/s/ Cynthia Jones

Cynthia B. Jones, 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 citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.

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 the Department of Medical Assistance Services (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. The section of the Virginia Administrative Code that is affected by this action is 12 VAC 30-20-180. (Definition of a claim by service). Chapter 890, Item 300 H of the *2011 Acts of the Assembly* directed DMAS as follows:

> *The Department of Medical Assistance Services shall mandate the electronic submission of claims for covered services rendered by participating providers in the fee-for-service program under the State Plans for Title XIX and XXI of the Social Security Act, and any waivers thereof, as well as the use of electronic funds transfer for the payment of such claims to providers. The department shall implement this requirement in a phased approach beginning with providers enrolling on or after October 1, 2011, with expansion to all existing providers by July 1, 2012. The department shall develop a process by which the individual circumstance of a provider may allow for exclusion from the electronic claims mandate without impact on participation, at the sole discretion of the department. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days from the enactment of this act.*

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 action is not essential to protect the health, safety, or welfare of citizens. It is, however, mandated by law as cited above. It also promotes improved administrative efficiencies for DMAS which will reduce some of its operating costs. These regulations are clearly written and easily understandable by the regulated community.

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 State Plan for Medical Assistance section that is amended by this action is Definition of a Claim by Service (12 VAC 30-20-180). Currently, the State Plan for Medical Assistance has no requirements that providers must submit their claims electronically. It is permitted that providers can file claims electronically but not required. The current Plan also does not provide for providers' payments to be made via Electronic Fund Transfers.

Approximately 84% of all Medicaid claims are currently filed electronically with DMAS. A survey of participating Medicaid providers who submit claims on paper was performed to better understand why claims are filed on paper when electronic filing is available, and to understand any barriers that may exist to filing electronically. The survey found that the main barriers to electronic filing were cost and inadequate technology.

However, a majority of providers indicated that they transact business electronically with commercial carriers and would welcome the change if these barriers could be addressed for Medicaid. In response, DMAS has implemented a Web-based Direct Data Entry mechanism during the 2nd Quarter of FY 2011 that has allowed for electronic claim submission at no cost to the provider and at a lower cost for the Commonwealth to process these claims. The 2011 Appropriations Act language mandating the participation of providers via electronic funds transfer and electronic claims submissions is part of an overall strategy to simplify the claims submission process, increase processing efficiency, lower costs for both the Commonwealth and the Virginia Medicaid provider community, and support collaboration and consistency in business practices with other commercial carriers and Medicare.

It costs DMAS $0.475 to process a hard copy paper claim but only $0.192 to process an electronically submitted claim. If a claim is not completed properly and must be returned to the provider for correction, these costs double. During FY 2011, DMAS spent $3.7 M to process

electronic claims; $1.3 to process paper claims, and; $155,000 to process Direct Data Entry claims.

To comply with the mandate DMAS is amending 12 VAC 30-20-180 (Definition of a claim by service) to add the following language:

All health care providers that enroll with Medicaid on or after October 1, 2011, shall submit electronically all claims for covered services they render in the fee-for-service program under the State Plans for Title XIX and XXI of the Social Security Act, and any waivers thereof. The Department of Medical Assistance Services shall use of electronic funds transfer for the payment of such claims to providers. All other providers shall comply with this electronic submission requirement by July 1, 2012. Any provider who cannot comply may request an exception from DMAS for good cause.

Good cause may include, but is not limited to, (i) the unavailability of the infrastructure necessary to support electronic claims submission in the providers' geographic region; (ii) there is no mechanism for electronic submission for the particular claim type, such as in the case of a Temporary Detention Order (TDO); (iii) the provider is unable to transact business through a banking institution capable of EFT, or; (iv) for financial hardship.

Provisions are also proposed to permit providers to request exemption from this requirement when they can demonstrate good cause. DMAS has granted exemptions to fewer than 15 providers who have requested exemption from the Electronic Funds Transfer. The reasons for these exemptions have been due to the lack of infrastructure to accommodate electronic claims submission and receipt of payments.

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.

The primary advantage to the public and the Commonwealth is expected to be the reduction of administrative costs for the processing of providers' claims for Medicaid and FAMIS. There are no disadvantages of this action to the agency as well as to individual private citizens.

For health care businesses that already electronically file Medicare and other health insurance claims, this action will make it easier for them to file Medicaid claims. For businesses that are not capable of electronically filing (due to lack of infrastructure to support electronic claims submission, for example), provision is made for good cause exceptions to this requirement.

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.

There are no changes in the final stage over those which were proposed.

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 submitted its proposed stage regulations to the Registrar of Regulations for publication in the *Virginia Register of Regulations* dated November 4, 2013, for their comment period through January 6, 2014 (VR 30:5). There were no public comments received.

All changes made in this regulatory action

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

Prior to the existing emergency regulation, DMAS did not have any mandatory electronic claims filing and payment requirements. With the exception of paragraph labeling, this proposed action is the same as the current emergency regulation.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC 30-20-180		As federally required, this VAC section sets out by covered service what constitutes a claim for reimbursement: (i) a bill or entire form for one episode of service, or; (ii) a single line item on a form with multiple other lines.	Additional text is appended to the bottom of the VAC section to detail the electronic filing requirement as well as acceptable examples of good cause reasons for continuing to submit paper claims and for continuing to receive payments in hard copy.