Regulatory Analysis Form

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2002 NOV -4 A 11:25

REVIEW COMMISSION

(1) Agency
Department of Public Welfare
Office of Medical Assistance Programs

(2) I.D. Number (Governor's Office Use)

IRRC Number: 2315

(3) Short Title

Invoicing for Services

(4) PA Code Cite

55 Pa. Code, Chapter 1101

(5) Agency Contacts & Telephone Numbers

Primary Contact: Gail Weidman 705-3705

Secondary Contact: Alice Gustitus 705-3705

(6) Type of Rulemaking (Check One)

____ Proposed Rulemaking
____ Final Order Adopting Regulation
__X__ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

__X__ No
____ Yes: By the Attorney General
____ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

This regulation change to 55 Pa. Code Chapter 1101, Section 1101.68(b)(1) and (3) will permit nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR), the same time frames for submitting claim adjustments and resubmitting rejected claims as are currently allowed for all other provider types.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Section 201 of the Public Welfare Code, 62 P.S. § 201(2).

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(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

No.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

With the implementation of the case-mix reimbursement system on January 1, 1996, the Department no longer does cost settlements for nursing facilities; therefore, there is no need to limit claim adjustments and resubmissions of rejected claims to 180 days. The Department also determined that extending the claim adjustment and resubmission time limits for ICF/MR providers will not impede the audits or cost settlements for these providers. All other provider types are currently permitted 365 days in which to submit claim adjustments and resubmit rejected claims.

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

None.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

Nursing facilities and ICF/MR facilities will benefit by being permitted a longer period of time in which to submit claim adjustments and to resubmit rejected claims. This in turn, will reduce the number of claims to be submitted through the 180-day exception process. The regulation will also reduce the amount of paperwork to be completed by the facilities and reviewed by the Department since each 180-day exception request must be accompanied by documentation explaining the reason for delayed billing.

The Department generates a notification letter for each 180-day exception request that is reviewed. Department paperwork will be decreased because fewer 180-day exception requests will be received.

This change may also reduce the number of appeals resulting from the denial of 180-day exception requests.

There are approximately 835 long-term care facilities in Pennsylvania enrolled in the Medical Assistance Program.

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(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

No adverse effects are anticipated.

(15) List the person, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

Nursing facilities and ICFs/MR participating in the Medical Assistance Program.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The proposed change was discussed before the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC) on February 9, 2000. All input from that Subcommittee was positive regarding the change. The Long-Term Care Subcommittee reported the proposed change to the MAAC at its regularly scheduled meeting on February 24, 2000.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

No significant savings is anticipated. No specific estimate is available because any savings realized by the facilities will be dependent upon each individual facility's billing practices.

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(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

Not applicable.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

This regulation change results in increased costs to the Department estimated at $2.083 million ($0.944 million in State funds) for Fiscal Year 2002-2003. An increased cost of $5.000 million ($2.275 million in State funds) is projected on an annual basis.

Steve Kostoff 9-4-02

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

(Dollar Amounts In Thousands)

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:						
Regulated Community						
Local Government						
State Government	$0	$0	$0	$0	$0	$0
Total Savings	$0	$0	$0	$0	$0	$0
COSTS:						
Regulated Community						
Local Government						
State Government	$944	$2,275	$2,278	$2,278	$2,278	$2,278
Total Costs	$944	$2,275	$2,278	$2,278	$2,278	$2,278
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses	$0	$0	$0	$0	$0	$0

(20a) Explain how the estimates listed above were derived.

The cost estimate for the change in the time limits for submitting nursing facility claim adjustments and resubmission of rejected claims is based on a projected number of claims affected by this change times the projected cost per claim for Fiscal Year 2002-2003. An effective date of January 1, 2003, was assumed for the estimate with fiscal impact of five payment months due to the payment lag associated with long-term care claims.

COSTS:	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
195 Long-Term Care	$944	$2,275	$2,278	$2,278	$2,278	$2,278

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(20b) Provide the past three years expenditure history for programs affected by the regulation.
(Dollar Amounts in Thousands)

Program	FY -99-00	FY - 00-01	FY - 01-02	FY 02-03
MA-Long Term Care Facilities	$693,625	$722,565	$761,877	$824,864

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

Although the regulation may result in some increased costs, the regulation makes time frames for claim submissions and resubmissions uniform for MA providers and therefore should effectively eliminate complaints by long-term care providers that they have been unfairly and disparately treated. The regulations should also reduce the number of appeals and attendant litigation costs for both providers and the Department.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Nonregulatory alternatives were not considered.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No alternatives were considered.

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(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

The regulation is amending invoicing limits by expanding time frames for invoice submission. Providers affected by this regulation favorably support these changes and the regulation will not disadvantage the Commonwealth.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No.

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(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attached copies of forms or reports which will be required as a result of implementation, if available.

This regulation change will decrease the paperwork requirements for nursing facilities, ICF/MR facilities and the Department.

When requesting a 180-day exception, a facility is required to submit documentation to the Department to verify the date an application for Medical Assistance was submitted to the County Assistance Office and to substantiate that the exception request was submitted timely.

By extending the time limitation for submitting claim adjustments and resubmitting rejected claims to 365 days from the last day of the billing period of each month, many of the claims which are now being submitted as 180-day exception requests will not need to be submitted through the 180-day exception review process.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

Not applicable.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The effective date of the regulation will be January 1, 2003.

(31) Provide the schedule for continual review of the regulation.

The revised regulation will be evaluated as an ongoing process. Necessary and appropriate changes will be made in response to letters and recommendations from other offices, agencies and individuals.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2315

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General

BY: _____
(Deputy Attorney General)

_____
Date of Approval

☐ Check if applicable
Copy not approved.
Objections Attached.

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

Department of Public Welfare
(Agency)

LEGAL COUNSEL: Mary Frances Grabowski

DOCUMENT/FISCAL NOTE NO. 14-480

DATE OF ADOPTION: _____

BY: _____

TITLE: Secretary of Public Welfare
(Executive Officer, Chairman or Secretary)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies.

BY: _____ OCT 23 2002
Date of Approval

(Deputy General Counsel)
(~~Chief Counsel, Independent Agency~~)
(~~Strike inapplicable title~~)

☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF FINAL RULEMAKING WITHOUT PUBLICATION AS PROPOSED
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

[55 PA Code CHAPTER 1101]

Invoicing for Services

Statutory Authority

The Department of Public Welfare (Department), by this Order, adopts amendments to 55 Pa. Code Chapter 1101 (relating to invoicing for services) as set forth in Annex A, pursuant to the authority of Section 201 of the Public Welfare Code (62 P.S. § 201(2)).

Notice of proposed rulemaking is omitted in accordance with Section 204(1)(iv) and (3) of the Commonwealth Documents Law (45 P.S. §1204(l)(iv) and (3)), and 1 Pa. Code § 7.4(1)(iv) and (3) because:

- The amendment relates to Commonwealth grants and benefits. The regulation deals with the requirements for claim submissions under the Medical Assistance (MA) Program.

- The Department finds that publication of this amendment as proposed is unnecessary and contrary to the public interest. The purpose of this amendment is to make the time limits for claim submissions uniform for all MA providers by extending the time period for MA nursing facility providers and intermediate care facility for the mentally retarded (ICF/MR) providers (referred to collectively as long-term care providers) to submit claim adjustments and to resubmit rejected claims. By allowing long-term care providers additional time to adjust and correct

their claim submissions, the amendment will enable long-term care providers to receive payment for claims that would have otherwise been denied solely because the providers were unable to submit "clean claims" within the requisite time frames. The Department anticipates that the amendment will also reduce paperwork and administrative expense for both long-term care providers and the Department by decreasing the number of appeals related to rejected claims, as well as requests for regulatory exceptions.

Purpose of Regulation

These amendments give long-term care providers the same time limit for submitting claim adjustments and resubmissions of rejected claims as is currently permitted other MA provider types. These amendments also clarify when a long-term care provider's billing period begins and ends.

Need for Regulation

The Department is the Commonwealth agency responsible for the administration of Pennsylvania's MA Program, which provides coverage of basic health care services to medically and financially needy Pennsylvanians. To ensure timely and efficient processing of MA provider payment claims,[1] the Department has established, through

[1] Pennsylvania's MA Program is one of the largest Medicaid Programs in the nation. During Federal Fiscal Year (FFY) 1998, for example, only three states (New York, California and Texas) had total Medicaid spending that exceeded Pennsylvania. *See* Kaiser Family Foundation, *State Health Facts Online*, Total (Federal and State) Medicaid Spending, FFY 1998 www.statehealthfacts.kff.org. On

the promulgation of regulations, time limits and other requirements for claim submissions, commonly known as the "180-day rule." *See* 55 Pa. Code § 1101.68.

Under the 180-day rule, an MA provider must submit a correct original invoice to be received by the Department within 180 days of the date the provider renders service to an eligible MA recipient. If a provider other than a long-term care provider submits an invoice within the 180-day time frame, but the invoice is pended or is rejected by the Department as incorrectly completed, the provider may resubmit the claim or submit a corrected claim so long as the resubmission is received by the Department within 365 days of the date of service. *See* section 1101.68(b)(3). The current regulation gives long-term care providers less time than other providers to submit a "clean claim." Section 1101.68 specifies that a long-term care provider must submit its original invoice and any resubmissions to be received by the Department within 180 days of the last day of the month in which service was provided. Id. [2]

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average, more than 1.4 million individuals were eligible to receive services each month through the Medical Assistance Program from 58,801 fee-for-service (FFS) providers during the period July 1, 1999 to June 30, 2000 (FY 99-00). MA providers submitted more than 60 million FFS claims for payment to DPW in FY 99-00. DPW approved 83% of the submitted claims, and, on average, paid the providers' claims for payment within 30 days of submission. *See Office of Medical Assistance Statistical Report FiscalYear 1999-2000*, www.dpw.state.pa.us/omap/geninf/statreport/ omapsr9900FFSsrvc.asp (last modified August 23, 2002).

[2] If a provider submits a claim for payment beyond the180-day time period, the Department will reject it unless the provider meets the requirements for an exception to the 180-day rule under section 1101.68(c) and (d). The exceptions to the 180-day rule are limited, and must involve either: 1) a delay in the determination of a patient's MA eligibility (section 1101.68(c)(1)), or 2) a delay in the response to a request for payment from a third party (section 1101.68(c)(2)). In addition, a provider must comply with certain other requirements in order to qualify for an exception to the 180-day rule. These amendments make **no** changes to the existing 180-day exception provisions contained in 55 Pa. Code § 1101.68(c) and (d).

At the time the 180-day rule was first adopted, the Department decided that a shorter time frame for claim submissions for long-term care providers was necessary to have timely information on MA paid days available for auditing and cost settlement purposes. In 1996, the Department adopted the case-mix prospective payment system for nursing facility services. Under this prospective payment system, the Department no longer retrospectively cost-settles payments to nursing facilities. Although the Department does audit nursing facility cost reports under the case-mix payment system, the audits are used solely to set per diem rates and peer group prices for future rate-setting periods, and the Department does not need MA paid days information to conduct these audits. While the Department continues to reimburse ICF/MR providers using a retrospective cost-based payment system, the Department has concluded that extending the claim adjustment and resubmission time limits for ICF/MR providers will not impede the audits or cost settlements for these providers. Consequently, the Department has determined that, under current circumstances, the shorter time frame is no longer necessary and that long-term care providers should be afforded the same time limits for claim adjustments and resubmissions as other MA providers.

When it promulgated section 1101.68 in 1990, the Department stated that the regulation was intended "to reduce the number of unnecessary exception requests by providers, which cause delays in the reimbursement system...to [require providers to] submit claims to the Department as soon as possible to ensure timely reimbursement... [and to] increase invoicing efficiency among the provider community." 20 Pa.B. 6165-

6166 (December 15, 1990). The Department finds that this amendment is fully consistent with the regulation's intended goal.

Requirements

As noted above, the amendment will make the time limits for claim adjustments and resubmissions uniform for all MA providers by extending the time period for long-term care providers to submit claim adjustments and resubmit rejected claims. By allowing long-term care providers additional time to adjust and correct their claim submissions, the amendment will enable long-term care providers to receive payment for claims that would have otherwise been denied solely because the providers were unable to submit "clean claims" within the requisite time frames.

Also, as noted above, the Department anticipates that the amendment will reduce paperwork and administrative expense for both long-term care providers and the Department by decreasing the number of requests for regulatory exceptions, and by reducing the number of appeals related to rejected claims. While exception requests should only be submitted when one of the regulatory exception criteria is met, such requests are sometimes made simply because a claim has been rejected. Since these amendments should decrease the number of rejected claims, they should also decrease the number of exception requests.

Section 1101.68 is being amended to clarify and revise the claim submission requirements for long-term care providers. The amendments change subsection (b)(1) to clarify that long-term care providers have 180 days from the end date of a billing period to submit an original or initial invoice, and clarify when a billing period begins and ends. These revisions do not alter existing Departmental policy, but simply change the language of the regulation to better reflect that policy. In addition, the amendments revise subsection (b)(3) by extending the time limit within which long-term care providers must submit claim adjustments and resubmit rejected claims to the Department from 180 days of the monthly service end date to 365 days of the end date of a billing period.

Affected Organizations

The Department and long-term care providers are affected by these amendments. As a result of the amendments, the Department will extend the time frame for long-term care providers to submit claim adjustments and resubmit rejected claims.

Fiscal Impact

Public Sector

The Commonwealth

The Department will experience increased costs because additional claims will be paid as a result of the extended time frames. However, the Department will also realize savings from claim adjustments returning overpayments. In addition, because the extended time frames should reduce the number of 180-day exception requests and denied claims, the Department's administrative costs related to the processing of 180-day exception requests and the litigation of rejected claims might also be reduced.

Political Subdivisions

County nursing homes may receive additional payments as a result of the extension of the time frames for the submission of claim adjustments and resubmissions. In addition, because the extended time frames should reduce the number of 180-day exception requests and denied claims, county homes' administrative costs related to the submission of 180-day exception requests and the litigation of rejected claims may also be reduced.

Private Sector

Private nursing facilities and ICFs/MR may receive additional payments as a result of the extension of the time frames for the submission of claim adjustments and resubmissions. In addition, because the extended time frames

should reduce the number of 180-day exception requests and denied claims, the facilities' administrative costs related to the submission of 180-day exception requests and the litigation of rejected claims may also be reduced.

General Public

No impact is anticipated.

Paperwork Requirements

This amendment will decrease the amount of paperwork generated by the Commonwealth and by long-term care facilities. Extending the time frame for the submission of claim adjustments and the resubmission of rejected claims to 365 days will decrease the number of 180-day exception requests received by the Department which result from long-term care facilities' failure to meet the 180-day submission requirements.

Effective Date

This amendment shall be effective January 1, 2003.

Sunset Date

A sunset date is not anticipated. Regulations will continue to be reviewed on an ongoing basis by the Department and the MA Advisory Committee.

Public Comments

The regulation was discussed and comments were solicited at the Long-term Care Subcommittee of the Medical Assistance Advisory Committee on February 9, 2000, and at the meeting of the Medical Assistance Advisory Committee on February 24, 2000. These meetings were open to the public. Comments received on the draft regulation were unanimously favorable.

Although this regulation is being adopted without prior notice, interested persons are invited to submit their written comments within 30 days from the date of this publication for consideration by the Department as to whether the regulation should be revised in the future. Such comments should be sent to the Department of Public Welfare, Office of Medical Assistance Programs, Attention: Regulations Coordinator, Room 515 Health and Welfare Building, Harrisburg, Pennsylvania 17105.

Persons with a disability may use the AT&T Relay Service by calling 1-800-654-5984 (TDD users) or 1-800-654-5988 (Voice users).

Regulatory Review

Under Section 5(f) of the Regulatory Review Act, the Act of June 30, 1989 (P.L. 73, No. 19) (71 P.S. Sections 745.1 - 745.15), the Department submitted a copy of this regulation with proposed rulemaking omitted on NOV 4 2002 to the Independent Regulatory Review Commission and to the Chairmen of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. On the same date, the regulation was submitted to the Office of the Attorney General for review and approval under the Commonwealth Attorneys Act. In accordance with Section 5(c) of the Act, this regulation was approved by the Committees on _____, and was approved by the Commission on _____.

The Department of Public Welfare finds:

a. That public notice of intention to adopt the administrative regulations amended by this Order is not required since the regulation relates to Commonwealth grants and benefits; and that publication of proposed rulemaking is unnecessary and contrary to the public interest under Sections 204(1)(iv) and (3) of the Act No. 240 of July 31, 1968, P.L. 767 (45 P.S. § 1204(1)(iv) and (3)) and the regulations thereunder, 1 Pa. Code § 7.4(1)(iv) and (3).

b. That the adoption of this regulation in the manner provided in this Order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

The Department of Public Welfare, acting under the authority of the Public Welfare Code, orders:

a. The regulations of the Department of Public Welfare are amended to read as set forth in Annex A of this Order.

b. The Secretary of the Department of Public Welfare shall submit this Order and Annex A to the Attorney General and General Counsel for approval as to legality and form as required by law.

c. The Secretary of the Department of Public Welfare shall duly certify this Order and Annex A and deposit same in the Legislative Reference Bureau as required by law.

d. This order shall be effective January 1, 2003.

ANNEX A

Title 55. Public Welfare

Chapter 1101. General Regulations

* * * * *

§ 1101.68. Invoicing for Services.

* * * * *

(b) *Time frame.* MA providers shall submit invoices correctly and in accordance with established time frames. For purposes of this section, time frames referred to are indicated in calendar days.

* * * * *

(1) A provider shall submit original or initial invoices to be received by the Department within a maximum of 180 days after the date the services were rendered or compensable items provided. Nursing facility providers and ICF/MR providers shall submit original or initial claims to be received by the Department within 180 days of the last day of a billing period. A billing period for nursing facility providers and ICF/MR providers covers the services provided to an

eligible recipient during a calendar month and starts on the first day service is provided in that calendar month and ends on the last day service is provided in that calendar month.

* * * * *

(3) Resubmission of a rejected original claim or a claim adjustment shall be received by the Department within 365 days of the date of service, except for [long term care providers who shall submit claims or resubmission of claims within 180] nursing facility providers and ICF/MR providers. Resubmission of a rejected original claim or claim adjustment by a nursing facility provider or an ICF/MR provider shall be received by the Department within 365 days of the last day of [the month in which the service was provided. The billing period for long term care providers equals 1 month or the last date of the month in which the service was provided and for which the facility is billing.] each billing period.

* * * * *

Please Return To: last delivery
Independent Regulatory Review Commission
14th Floor, Harristown II

TRANSMITTAL SHEET FOR REGULATIONS SUBJE
REGULATORY REVIEW ACT

I.D. NUMBER:	14-480
SUBJECT:	Invoicing for Services
AGENCY:	DEPARTMENT OF PUBLIC WELFARE

TYPE OF REGULATION

Proposed Regulation

Final Regulation

X Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
11/4/02	Frank L Oliver	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
11/4/02		
11/4/02	Kristi Kreiser	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
11/4/02		
11/4/02		INDEPENDENT REGULATORY REVIEW COMMISSION
		↑ last point of delivery
11-4-02	Pamela Lubold	ATTORNEY GENERAL
		~~LEGISLATIVE REFERENCE BUREAU~~

October 23, 2002