#354

Report To
The Mississippi Legislature

A Review of the Mississippi Division of Medicaid's Claims Processing Effectiveness

January 6, 1997

PEER received complaints from health care providers regarding the Division of Medicaid's alleged untimely and inaccurate processing of claims submitted by health care providers. Three issues were especially significant as the source of provider complaints:

- failure to cross claims over from the Medicare program to the Medicaid program for payment to providers;
- the Division of Medicaid's recouping of claims payments for previously paid claims; and,
- delays in claims payments and adjustments.

EDS, the Division of Medicaid's fiscal agent, has experienced difficulties in processing Medicare "cross-over" claims. Factors contributing to the problem are complex and are the shared responsibility of the federal government, Medicare contractors, providers, and the Division of Medicaid, as well as EDS. Even though the Division of Medicaid and EDS were not solely responsible for most of the problems with crossover claims, these two entities can and should implement corrective actions.

Although the problems stated above contributed to the problem, the Division of Medicaid has acted as required in recovering claims incorrectly paid to providers since 1994. The Medicare cross-over claims in question violated payment time limits established by federal and state law, thus requiring repayment.

Finally, although EDS failed to comply strictly with claims processing performance standards, its performance was only marginally below one standard and met the other standard.

The PEER Committee

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A standing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues which may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

A Review of the Mississippi Division of Medicaid's Claims Processing Effectiveness

January 6, 1997

The PEER Committee

Mississippi Legislature

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
EZELL LEE
Vice-Chairman
WILLIAM CANON
Secretary
HOB BRYAN
BOB M. DEARING
JOHNNIE E. WALLS, JR.

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1233

Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph.D.
Executive Director

REPRESENTATIVES
WILLIAM E. (BILLY) BOWLES
Chairman
ALYCE G. CLARKE
HERB FRIERSON
TOMMY HORNE
MARY ANN STEVENS

OFFICES:
Professional Building
222 North President Street
Jackson, Mississippi 39201

January 6, 1997

Honorable Kirk Fordice, Governor
Honorable Ronnie Musgrove, Lieutenant Governor
Honorable Tim Ford, Speaker of the House
Members of the Mississippi State Legislature

At its meeting of January 6, 1997, the PEER Committee authorized release of the report entitled **A Review of the Mississippi Division of Medicaid's Claims Processing Effectiveness**.

Billy Bowles

Representative Billy Bowles, Chairman

This report does not recommend increased funding or additional staff.

Table of Contents

Table of Contents (Continued)

List of Exhibits

A Review of the Mississippi Division of Medicaid's Claims Processing Effectiveness

January 6, 1997

Executive Summary

Overview

PEER conducted this review primarily in response to complaints from health care providers regarding the Division of Medicaid's alleged untimely and inaccurate processing of claims submitted by health care providers.

The primary factors causing or contributing to the problem of untimely and inaccurate processing of Medicaid claims are complex and are the shared responsibility of the federal government, Medicare contractors, providers, the Division of Medicaid (DOM), and EDS (Mississippi's fiscal agent). Three issues are especially significant as the source of provider complaints:

- failure to cross claims over from the Medicare program to the Medicaid program for payment to providers;
- DOM's recouping of claims payments for previously paid claims; and,
- delays in claims payments and adjustments.

All three areas affect doctors, hospitals, clinics, durable medical equipment suppliers, and others who receive Medicaid reimbursements. Below are the primary questions PEER sought to answer relative to these issues and summary answers.

What problems has the Division of Medicaid experienced in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims? Has the division attempted to resolve such processing difficulties in a timely manner?

EDS, the DOM's fiscal agent, has experienced difficulties in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims. Because of these difficulties, EDS has not paid several cross-over claims or required providers to file manually to receive reimbursement for those claims, a more expensive procedure. The failure to pay cross-over claims accurately and in a timely manner occurred because (stated in order of significance as a cause):

- Although the federal government requires Medicare to cross claims to Medicaid, the federal government failed to develop coordinated federal programs and does not require adequate communication between Medicare and Medicaid fiscal agents;
- EDS failed to investigate its cross-over error reports effectively and to identify providers;
- Providers failed to provide Medicare data to EDS, as required by the Medicaid program agreement, to identify the providers;
- Metra Health failed to process Medicaid eligibility information, which restricted its ability to pass valid claims to EDS; and,
- Blue Cross Blue Shield of Mississippi failed to communicate claims transmission problems to EDS; thus, EDS never received some claims.

Even though DOM and EDS were not the primary causes for most of the problems with the cross-over claims, these two entities should implement corrective actions. To date, neither EDS nor DOM has been effective in addressing many of the problems related to cross-over claims.

What legal authority does the Division of Medicaid have to demand repayment of funds allegedly paid in error by the division to certain health care providers?

In July 1996, EDS, at the direction of DOM, recovered $892,618.31 in claims incorrectly paid to providers since 1994. In some cases providers paid substantial amounts (e.g., the University Medical Center repaid over $400,000). Providers had to repay the state for claims not correctly filed with EDS for services rendered to Medicaid recipients.

State law provides DOM the authority to recover any and all claims payments incorrectly paid. The Medicare cross-over claims, whose repayment DOM demanded, violated payment time limits established by federal and state law. Thus, DOM correctly enforced its authority.

Has the Division of Medicaid's fiscal agent, EDS, processed claims in a timely manner?

EDS failed to comply strictly with claims processing performance standards; however, its performance was only marginally below one standard and met the remaining standard. Claims held over thirty days for additional information to enable processing by EDS accounted for approximately one-half of one percent of the total claims received by EDS, an immaterial amount.

Recommendations

1. The Division of Medicaid and its fiscal agent, EDS, should agressively seek to negotiate agreements with Medicare contractors that will improve information transfers necessary to process Medicaid claims. DOM should request HCFA to participate in these negotiations and to insert specific requirements for information transfer procedures into future contracts with Medicare contractors. These procedures should include a requirement that contractors contact EDS immediately upon encountering problems with information transfer. The DOM also should require its fiscal agents to investigate information transfer problems as they occur and to provide documentation of such investigations to DOM.

2. EDS should follow its own procedures for reviewing and identifying providers listed on its Medicare crossover error reports. EDS should not hesitate to contact Medicare contractors to gain information needed to identify the claims received from the Medicare contractors. If the Medicare contractor is not cooperative, EDS should contact the Medicare contractor's executive-level personnel with the assistance of DOM and/or HCFA to gain the cooperation and information needed to process the Medicaid claims.

3. EDS should notify providers if the Medicare identification number is not supplied to DOM when the provider signs up for the Medicaid program. For six months after that provider enrolls in the Medicaid program without a Medicare identification number, EDS should maintain the provider on a list and make frequent contacts to inquire whether a Medicare number has been obtained. No Medicare claims should be paid by EDS, either electronic crossover or manually filed, unless EDS has accurate Medicare identification information on the provider. If the provider's Medicare identification numbers are not listed on EDS's computer system, EDS should recognize this as a problem and correct the problem prior to paying the claim.

For More Information or Clarification, Contact:

PEER Committee
P. O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
http://www.peer.state.ms.us

Representative Billy Bowles, Chairman
Houston, MS (601) 456-2573

Senator Ezell Lee, Vice-Chairman
Picayune, MS (601) 798-5270

Senator William Canon, Secretary
Columbus, MS (601) 328-3018

A Review of the Mississippi Division of Medicaid's Claims Processing Effectiveness

Introduction

Authority

In accordance with MISS. CODE ANN. § 5-3-57 (1972), the PEER Committee reviewed the Mississippi Division of Medicaid's processing of claims submitted by health care providers.

Scope and Purpose

PEER conducted this review primarily in response to complaints from health care providers regarding the Division of Medicaid's alleged untimely and inaccurate processing of claims submitted by health care providers. Specifically, PEER sought answers to the following questions:

- What problems has the Division of Medicaid experienced in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims? Has the division attempted to resolve such processing difficulties in a timely manner?

- What legal authority does the Division of Medicaid have to demand repayment of funds allegedly paid in error by the division to certain health care providers?

- Has the Division of Medicaid's fiscal agent, EDS, processed claims accurately and in a timely manner?

Method

During the course of its review, PEER:

- analyzed federal and state laws governing DOM and the provision for medical payments for Medicaid-qualified individuals;

- conducted surveys of hospitals and doctors, hereafter referred to as providers;

- interviewed staff for DOM, EDS, Blue Cross Blue Shield of Mississippi, Metra Health, and providers, and citizens;

- analyzed EDS error reports, DOM contract monitoring reports, claims histories, provider contracts, and enrollment information;

- reviewed EDS documentation and DOM memos supporting the recoupment of claims payments from providers; and,

- reviewed documentation and verification of alleged claim errors submitted to PEER by providers and citizens.

Overview

The primary factors causing or contributing to the problem of untimely and inaccurate processing of Medicaid claims are complex and are the shared responsibility of the federal government, Medicare contractors, providers, the Division of Medicaid, and EDS (Mississippi's fiscal agent). Three issues are especially significant as the source of provider complaints:

- failure to cross claims over from the Medicare program to the Medicaid program for payment to providers;

- DOM's recouping of claims payments for previously paid claims; and,

- delays in claims payments and adjustments.

All three areas affect doctors, hospitals, clinics, durable medical equipment suppliers, and others who receive Medicaid reimbursements. Below are the primary questions PEER sought to answer relative to these issues and summaries of the answers.

What problems has the Division of Medicaid experienced in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims? Has the division attempted to resolve such processing difficulties in a timely manner?

EDS, the DOM's fiscal agent, has experienced difficulties in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims. Because of these difficulties, EDS has not paid several cross-over claims or required providers to file manually to receive reimbursement for those claims, a more expensive procedure. The failure to pay cross-over claims accurately and in a timely manner occurred because (stated in order of significance as a cause):

- Although the federal government requires Medicare to cross over claims to Medicaid, the federal government failed to develop coordinated federal programs and does not require adequate communication between Medicare and Medicaid fiscal agents;

- EDS failed to investigate its cross-over error reports effectively and to identify providers;

- Providers failed to provide Medicare data to EDS, as required by the Medicaid program agreement, to identify the providers;

- Metra Health failed to process Medicaid eligibility information, which restricted its ability to pass valid claims to EDS; and,

- Blue Cross Blue Shield of Mississippi failed to communicate claims transmission problems to EDS; thus, EDS never received some claims.

Even though DOM and EDS were not the primary causes for most of the problems with the crossover claims, these two entities should implement corrective actions. To date, neither EDS nor DOM has been effective in addressing many of the problems related to cross-over claims.

What legal authority does the Division of Medicaid have to demand repayment of funds allegedly paid in error by the division to certain health care providers?

In July 1996, EDS, at the direction of DOM, recovered $892,618.31 in claims incorrectly paid to providers since 1994. In some cases providers paid substantial amounts (e.g., the University Medical Center repaid over $400,000). Providers had to repay the state for claims not correctly filed with EDS for services rendered to Medicaid recipients.

State law provides DOM the authority to recover any and all claims payments incorrectly paid. The Medicare cross-over claims, whose repayment DOM demanded, violated payment time limits established by federal and state law. Thus, DOM correctly enforced its authority.

Has the Division of Medicaid's fiscal agent, EDS, processed claims in a timely manner?

EDS failed to comply strictly with claims processing performance standards; however, its performance was only marginally below one standard and met the remaining standard. Claims held over thirty days for additional information to enable processing by EDS accounted for approximately one-half of one percent of the total claims received by EDS, an immaterial amount.

Background

The Federal Medicaid Program in Mississippi

Medicaid is a national health program authorized by Title XIX of the Social Security Act and administered individually by states. The basic objective of the Medicaid program is to provide medical assistance for those in need with limited financial resources. While Medicaid reimbursement is low (almost always considerably lower than the rates for private insurance reimbursement), the alternative is uncompensated care for those uninsured Mississippians with no other means to pay. Additionally, prenatal care and outpatient services, along with other services provided by the Medicaid program, help avert more expensive health services such as inpatient hospitalization. In Mississippi, approximately one million people, or forty percent of the population, do not have private health insurance coverage. Almost half of these people are enrolled in Medicaid, with a portion of their medical expenses being reimbursed by the program.

Medicaid reimbursement covers the cost of many health care services provided within this state, including the entire cost for intermediate care facilities for the mentally retarded and clinical services provided by the State Department of Health. Medicaid provides a major source of income for the University Medical Center as well as other public and private hospitals throughout the state. Additionally, Medicaid patients occupy ninety percent of the nursing facility beds in this state.

The federal government provides matching dollars with which the state administers the program. Currently, the federal government contributes approximately four dollars for each state dollar provided to fund the Medicaid program. For the state fiscal year ending June 30, 1996, the state and federal government spent $1.6 billion providing health and administrative services for Mississippi, with approximately $1.5 billion of that amount for medical assistance.

Administration of Mississippi's Medicaid Program

Each state designates a state agency for the administration of Medicaid. The Legislature enacted MISS. CODE ANN. Section 43-13-107 (1972) that created the Division of Medicaid (DOM), Office of Governor, in 1984 and designated it as the single state agency to administer the Medicaid program in Mississippi. DOM replaced the Mississippi Medicaid Commission. DOM is responsible for formulating program policy and its staff is directly responsible for the administration of the program. DOM contracts with a fiscal agent--currently EDS--which, under the direction of DOM, is responsible for processing claims, issuing payments to providers, and for billing notifications. The federal Health Care Finance Administration (HCFA) is responsible for oversight of the Medicaid program for the U.S. government.

Problems Leading to the Selection of EDS as Mississippi's Medicaid Fiscal Agent

Until January 1, 1992, Blue Cross Blue Shield of Mississippi operated as the fiscal agent for Medicaid for a majority of the years since the program's inception. DOM changed fiscal agents when it awarded the Medicaid contract to First Health Services in December 1990. First Health Services started processing claims January 1992 and shortly afterwards, multiple problems began. By August 1993, DOM monetary sanctions imposed against First Health for not performing within contract standards totaled $4.7 million. While DOM worked with First Health Services to correct numerous problems with processing claims, the problems multiplied and intensified. In October 1993, DOM met with HCFA staff to obtain federal permission to terminate the contract with First Health Services under emergency circumstances.

DOM requested and received permission from HCFA to award the fiscal agent contract to another company without re-bidding--i.e., award the contract to the second place finisher in the original 1990 bid process. DOM determined First Health Services had lost control of the system, had no apparent ability to cure the deficiencies, and there was no time to spare to either cure the problems First Health Services had or rebid the contract for a new fiscal agent. In November 1993, DOM staff put First Health Services on formal notice of default of its contractual obligations and allowed a reasonable time to take corrective action. First Health Services made some changes, but the problems continued. Because any change in fiscal agents requires a substantial amount of time, DOM had already begun negotiations with EDS in November 1993, with the approval of HCFA, to assume fiscal agent services if First Health was unable to cure its problems. In January 1993, HCFA agreed to let DOM replace First Health Services with EDS if First Health Services could not cure its deficiencies. On March 3, 1994, DOM hired EDS and terminated the contract with First Health Services. EDS began processing claims May 4, 1994.

Provider Concerns with Medicaid Claims Reimbursement

PEER based this review of the Division of Medicaid on complaints received from service providers and private citizens regarding the division's processing of claims. In addition, PEER surveyed twenty randomly selected service providers to obtain more information on alleged claims processing problems. Some of the providers surveyed believe that, in spite of the change in fiscal agents from First Health Services to EDS, the Division of Medicaid continues to be untimely and inaccurate in the processing of submitted claims. The concerned providers further assert that these problems are compounded by what they believe are federally established reimbursement rates that are below reasonable billed charges and below other insurance reimbursement rates. Added to these concerns is the frustration providers experienced at being caught in the middle of the state change in fiscal agents, with the result of general discontent with the Medicaid program. Typical of the discontent is the following excerpt of a provider concern communicated in a letter to the DOM Executive Director:

There are just too many problems out here and not with just one provider, many, many providers. . . .EDS is causing some of the smaller providers untold hours in clerical time re-submitting claims that for the most part were submitted correctly the first time. They have misplaced EOB's and required reports for hard copy claims causing the providers to file and file again. EDS has had this contract for two (2) years now and we all wonder when it is going to get better.

Although many of the current complaints with the Medicaid reimbursement program focus on EDS, many of the claims processing issues predate EDS as the state's Medicaid fiscal agent.

To gain additional perspective on the history and causes of claims processing problems, and to identify productive areas of inquiry, PEER contacted the State Auditor's Office. The State Auditor annually reviews DOM's claims processing for financial and federal compliance accuracy, with the results consolidated into the State of Mississippi's *Comprehensive Annual Financial Report*. The State Auditor's Office also reports annually to DOM any EDS claims processing performance deficits found in its review.

The Auditor's reports address the financial accuracy and appropriateness of claims payments and PEER determined that the most effective use of resources would be to concentrate on areas that fell outside of the State Auditor's Office review, but were the source of many of the provider complaints:

- failure to cross claims over from the Medicare program to the Medicaid program for payment to providers;
- DOM's recouping claims payments for previously paid cross-over claims; and,
- delays in claims payments and adjustments.

All three areas affect doctors, hospitals, clinics, durable medical equipment suppliers, and others who receive reimbursement for Medicaid services. The following report sections address each problem area:

- Medicare to Medicaid cross-over claims;
- authority to demand repayment of incorrectly paid claims; and,
- EDS's performance on processing measures.

Medicare to Medicaid Cross-Over Claims

What problems has the Division of Medicaid experienced in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims? Has the division attempted to resolve such processing difficulties in a timely manner?

EDS, the DOM fiscal agent, has experienced difficulties in processing health care claims of Medicaid participants whose claims are also eligible to be paid by the federal Medicare program--i.e., Medicare "cross-over" claims. Because of these difficulties, EDS has not paid several cross-over claims or required providers to file manually to receive reimbursement for those claims, a more expensive procedure. The failure to pay cross-over claims accurately and in a timely manner occurred because (stated in order of significance):

- *Although the federal government requires Medicare to cross over claims to Medicaid, the federal government failed to develop coordinated federal programs and does not require adequate communication between Medicare and Medicaid fiscal agents;*
- *EDS failed to investigate its cross-over error reports effectively and identify providers;*
- *Providers failed to provide Medicare data to EDS, as required by the Medicaid program agreement, to identify the providers;*
- *Metra Health failed to process Medicaid eligibility information, which restricted its ability to pass valid claims to EDS; and,*
- *Blue Cross Blue Shield of Mississippi failed to communicate claims transmission problems to EDS; thus, EDS never received some claims.*

Even though DOM and EDS were not the primary causes for most of the problems with the crossover claims, these two entities should implement corrective actions. To date, neither EDS nor DOM has been effective in addressing many of the problems related to cross-over claims.

The Relationship Between Medicare and Medicaid Claims Processing

Although both Medicare and Medicaid programs are federal programs, the federal government operates and maintains the programs separately. Medicare, while similar to Medicaid, is a national health program authorized by Title XVIII of the Social Security Act but is administered by the federal government through private contractors, not states. The Medicare program is designed to provide medical coverage for the aged. Instead of paying claims for Medicaid recipients who are eligible for the Medicare program, it is more cost beneficial for Medicaid to pay the Medicare insurance premiums. For these Medicaid beneficiaries, the

Medicare program pays a majority of the health expenses incurred for the Medicaid beneficiaries, with Medicaid liable only for the funds equal to the deductible and coinsurance amounts of any Medicare claims filed. In essence, the individual has dual medical insurance coverage with both Medicare and Medicaid.

For individuals who qualify under the above scenario, Medicaid should only pay for claims that Medicare approves and pays. For Medicaid to determine the correct amount it should pay on a claim for a Medicare covered individual, the claim must be electronically transmitted, by the Medicare contractor who paid the Medicare claim, to the Medicaid fiscal agent. Because the claim is electronically transmitted to the Medicaid fiscal agent--i.e., electronically crossed over--the claim is called a cross-over claim (see Exhibit 1, page 9). EDS primarily receives Medicare cross-over claims from three Medicare private contractors (Blue Cross Blue Shield of Mississippi [BC MS], Metra Health, and Blue Cross Blue Shield of South Carolina [BC SC]). Appendix A, page 23, details EDS's responsibilities as the Division of Medicaid's fiscal agent.

Reasons for Cross-Over Claims Problems

Medicare and Medicaid Programs Were Not Designed to Interact

- *The federal government did not design and does not operate the Medicare and Medicaid programs to cooperate, coordinate, or interact in order to process claims between the two programs, creating communication and eventually claims processing problems between Medicare and Medicaid fiscal agents.*

Communication and the individual relationships between the state Medicaid fiscal agents and the Medicare private contractors provide the basis for the ability to pay cross-over claims. EDS must be able to identify the provider that filed the claim to determine:

-- if the provider is approved for the Medicaid program;

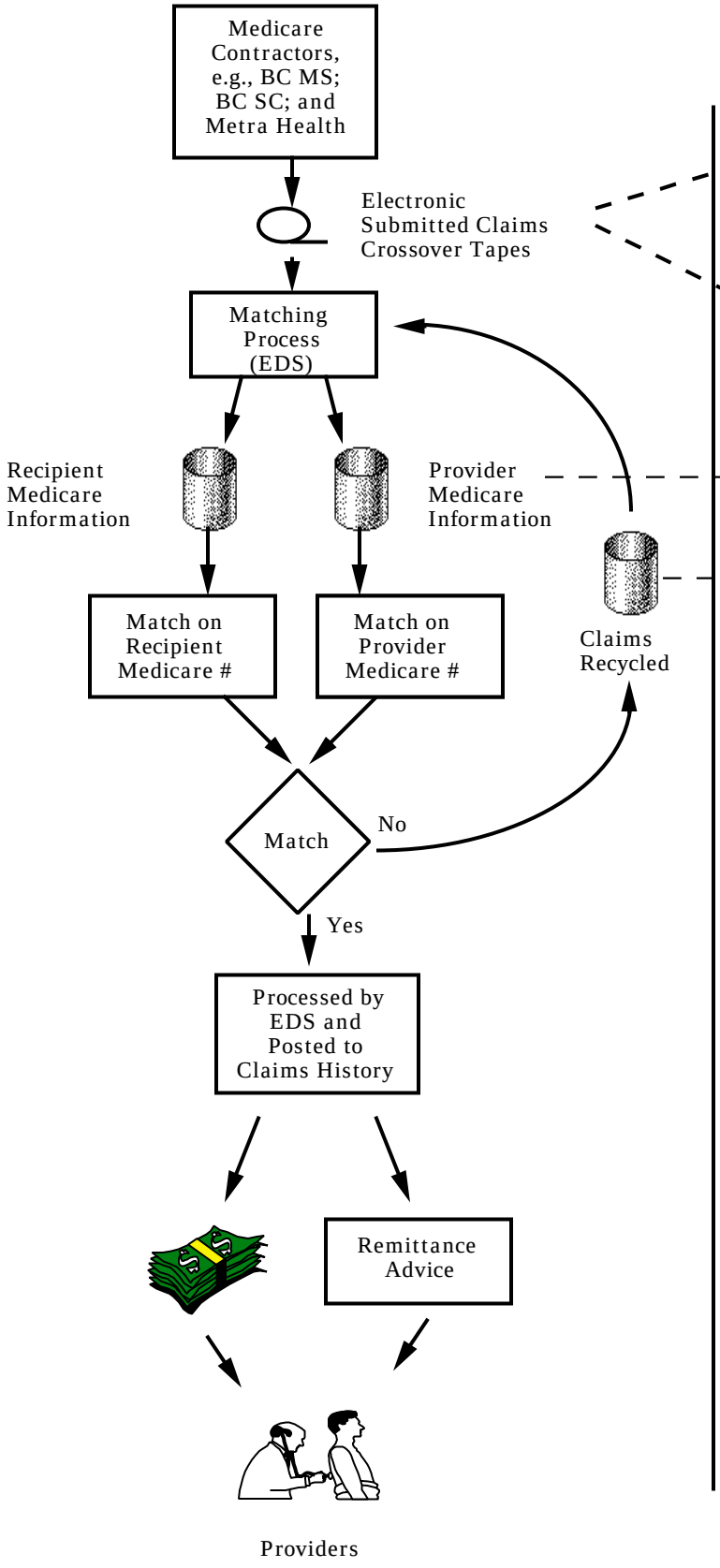
-- whether to process the claim; and,

-- to whom to direct the payment.

HCFA staff, responsible for monitoring both Medicaid and Medicare, believe problems between Medicaid fiscal agents and Medicare contractors are common. Medicaid and Medicare systems were designed and are operated completely separate of each other. For this reason, EDS and Medicare contractors may operate as intended by the separate systems but EDS will still not receive much of the information transferred to it from the Medicare contractors. This creates a problem for Medicaid fiscal agents because they rely on information sent to them from Medicare contractors to pay cross-over claims. Without the correct information from Medicare contractors, EDS cannot pay the cross-over claims.

Exhibit 1

EDS's Medicare Crossover Claims Process



Problems

Metra Health denied claims, because of its inability to process eligibility information, that should have been sent to EDS for processing. (See page 13)

BC MS's computer system did not transfer certain claims during two weeks in 1996. (See page 14)

Providers did not provide EDS with Medicare identification information needed to process claims. (See page 12)

EDS did not effectively implement procedures to identify providers on error reports. (See page 10)

Although not a part of the crossover claims process, one of the primary causes of crossover claims problems is the nature of the relationship between Medicaid and Medicare. The federal government has not coordinated these programs sufficiently and does not requre adequate communication between Medicare and Medicaid fiscal agents.

SOURCE: PEER analysis

The primary communication problem between EDS and Medicare contractors is the fact the state assigns identification numbers when a provider joins the Medicaid program, similar to the process followed by all state Medicaid programs. Medicare contractors also assign their own identification numbers for each provider. No functional relationships exist for these provider numbers, with it possible for each provider to have multiple Medicare numbers. In fact, HCFA acknowledges this problem while stating the need for a national provider identifier:

> *Currently, there is no universally accepted national identification and enumeration system for health service providers. Providers must use multiple identifiers for programs and organizations with which they do business. Data are not readily transportable among systems, and thus, must be collected redundantly. The problems and cost of exchanging provider data are great, hampering coordination of benefits and fraud and abuse efforts.*

EDS receives approximately 50,000 electronic cross-over claims weekly from Medicare contractors with an error rate of approximately six percent, or 3,000 claims. These claims errors occur when EDS cannot identify the Medicare provider numbers and therefore cannot match the claims to the Medicaid identification number. EDS attempts to match Medicare numbers using information supplied by the Medicare contractors and if not found, EDS sometimes contacts the Medicare contractors. Based on a sample, EDS's success rate in identifying provider numbers was low (see following section). However, providers are also responsible for this problem (see page 12).

Certain problems will always exist because of the size and complexity of the Medicare and Medicaid programs. However, the federal Health Insurance Portability and Accountability Act of 1996, enacted in August 1996, requires the Secretary of the Department of Health and Human Services to adopt standards for health information to be electronically exchanged. The act requires adoption of standards within eighteen months of the act, and compliance within twenty-four months after its adoption. One of the standards is a national unique health identifier for each Medicare health care provider. The act requires the use of National Provider Identifiers by December 1, 1997. While this will not immediately address Medicaid providers, it will provide EDS with the pool of standardized Medicare provider numbers with which EDS can identify the provider whose claims are crossed over from Medicare.

EDS Did Not Effectively Implement Procedures to Identify Providers on Error Reports

- *EDS's application of procedures for investigating unidentified providers listed on its self-generated cross-over error reports was not sufficient to identify providers and pay their claims electronically.*

EDS staff did not effectively work its cross-over error reports to identify providers and therefore claims for those providers were not electronically paid.

EDS prints an error report that includes claims received from Medicare contractors where the included provider number is not identified by EDS. EDS should manually review the claims information to determine the unidentified provider and correct the problem of why the provider number was not originally identified. If EDS is unable to identify the provider number after four weeks, then EDS assigns a "dummy" provider number (999999999) to the claim which replaces the original number, denies the claim, and posts the claim to the history for paid and denied claims. If EDS fails to process the claim due to the unidentifiable provider number, then the provider must recognize that Medicare paid the claim but Medicaid did not. The provider must file a manual paper claim, which EDS processes and either denies the claim or pays the provider. If the provider fails to file a paper claim, the provider will not be reimbursed for Medicaid services rendered.

PEER reviewed EDS's October 1996 cross-over error reports to determine EDS's ability to identify providers included on the report. The following two major problems were noted with providers listed on the error report:

1) Providers failed to provide the required information needed by EDS to match the cross-over file electronically and pay the cross-over claims. EDS did not identify those providers and request the Medicare information needed to pay the claims electronically. (See page 12.)

2) When providers requested subunits of the hospital (e.g., psychiatric unit, drug rehab) be added to its files, EDS staff replaced the original, still valid, provider numbers on the computer system with the new numbers, eliminating electronic payments to the provider under the original number.

In two instances, EDS incorrectly replaced valid provider numbers with another provider number instead of adding the number to the provider's file. The two providers were Claiborne County Hospital and Humphreys County Memorial Hospital. On April 19, 1996, Claiborne County requested a subunit of the hospital be added to its Medicaid number so the hospital could get paid for services rendered. Instead of adding the new number, EDS replaced the original hospital number and thereafter the hospital no longer got its Medicare cross-over claims electronically paid. Instead the hospital had to file paper claims manually each time it submitted a cross-over claim. This occurred for the period of April 1996 through October 1996 when PEER discovered the error. Claiborne County's provider number had continuously shown up on EDS's error reports for seven months without EDS identifying the provider number. PEER contacted BC MS, the Medicare contractor, and identified the provider with little effort. EDS should have been able to resolve the problem in a similar manner. During this seven-month period, Claiborne County Hospital manually filed 146 claims for $26,632.51 which EDS processed. However this only included claims discovered by Claiborne County as not paid by EDS and may not have included all cross-over claims. Humphreys County Memorial Hospital had a similar incident happen with its number changed in August 1996 and only corrected after PEER identified the problem. During this three-month period, August 1996 through October 1996, Humphreys County Memorial Hospital manually filed 142 claims for $24,417.94, which EDS processed.

EDS has procedures to identify providers listed on its error report; however, it was apparent EDS did not strictly follow those procedures. These procedures include looking for the Medicare numbers on provider listings supplied by the Medicare contractors. If the number is not found, EDS contacts the Medicare contractors directly to verify the provider number. If the number is found, EDS contacts the provider to verify the number and if correct, the number is added to EDS's system. The reasons stated by EDS's staff that the above problems were not corrected in a reasonable time were because the volume of the report errors does not permit time-consuming detailed reviews and it is ultimately the provider's responsibility to communicate any changes to its Medicare provider number. (See below.)

Some Providers Did Not Give Correct Information to EDS

- *Providers failed to provide correct Medicare identification information to EDS, as required by the Medicaid program agreement. EDS requires this information to pay the provider's claims.*

Because providers failed to provide EDS information as required, EDS did not paid their claims electronically. To participate in the Medicaid program, providers must request and complete a Mississippi Medicaid Enrollment Application. This application requires the provider to submit general information for DOM to approve or deny the provider's participation in the program. Section D, page 3, of the application specifically requests the Medicare number and describes the consequences if the number is not given as follows;

> *SECTION D: MEDICARE CROSS-OVER PAYMENT INFORMATION*
>
> *Instruction: Enter the Medicare number of the individual, facility, (or group for Rural Health Clinics Only) applying for a Medicaid provider number. You must indicate the Medicare number, if you have been assigned one, by your Medicare intermediary.* ***You will not be reimbursed for Medicare cross-over claims unless you supply this number****.*

Beyond requesting this information, EDS and DOM do not have the authority or the responsibility for obtaining the Medicare information from the providers.

During a review of provider numbers listed on the error reports, PEER found a majority of Medicare provider numbers, particularly for doctors, were never supplied to EDS. Written explanations by providers on the applications included "Medicare number in process," "Medicare number applied for but not received," "We will forward this (Medicare number) as soon as we receive it," etc. When PEER contacted the providers, they did not realize the Medicare numbers were never supplied. They only knew all cross-over claims had to be filed manually and they believed this was the fault of EDS. In other cases, the application had a Medicare number different from the one verified by the Medicare contractor, with no further explanation. Metra Health continued to file a provider's claims with EDS even though the provider was no longer eligible for

the Medicaid program because he had failed to file a new application with DOM. EDS subsequently denied those claims. There were also cases of new providers who had not yet been entered into EDS's computer system, yet EDS paid the claims as soon as the Medicare numbers were entered. The above described cases amounted to six hundred and forty-six claims reported on the weekly error report dated October 3, 1996, a substantial amount of the errors on the report.

Providers can get paid for claims denied by EDS because the Medicare provider number is not identified by manually filing a paper claim with EDS. EDS can process the claim based on the Medicaid provider information. For this reason, the provider must file the claims under its Medicaid provider number, instead of the Medicare number which is the basis for cross-over claims. This process reimburses the provider for Medicaid services rendered. However, the state, EDS, and providers all incur additional cost associated with paper claims. The manual paper claims cost providers and EDS considerably more to file and process than electronic claims. This cost would be avoidable if the provider's information had been correct and the cross-over claim had been paid electronically. The state pays EDS a contractual amount based on each claim processed. The state paid EDS for the claims electronically denied and again paid EDS to process the same claim when the claims were filed manually. EDS manually processed 83,005 paper cross-over claims for the period of September 23, 1996, through October 17, 1996. For these claims, the state paid EDS an additional $47,229.85 (83,005 claims at .569 per claim) much of which was for claims reprocessed because the providers failed to supply the correct Medicare numbers to EDS.

Some Contractors Did Not Transmit Claims to EDS

- *Metra Health needs Medicaid recipient eligibility information to identify cross-over claims to send to EDS so that EDS may process the claim. Until August 1995, Metra Health was unable to process all the eligibility information received from EDS, effectively discarding the claims without transferring them to EDS for processing.*

Metra Health processes Medicare claims, submitted for doctor visits, for the area covering the state of Mississippi for the federal government. Metra Health requested EDS to supply Medicaid eligibility information so that its computer system could process cross-over claims. This has occurred since EDS assumed the contract in May 1994. Metra Health needs the Medicaid eligibility information in order to determine whether the patient was Medicaid eligible. If Metra Health determined the patient was not covered by the Medicaid program, Metra Health effectively denies the claim for Medicaid services because the claim is not sent to EDS for processing. Since EDS does not receive the claims information, EDS is unaware the claim was filed. If Metra Health matches the recipient with the files received from EDS, the claim is transferred to EDS where it is processed.

EDS periodically submits five claims eligibility tapes to Metra Health. An error occurred because Metra Health was only able to process one of the five tapes submitted by EDS containing information about the recipient's eligibility. Since the first eligibility tape sent by EDS included the most current information, Metra

Health was able to determine a majority of eligible individuals from the one tape Metra Health was able to process. Additional eligibility information needed by Metra Health was also on the remaining four tapes. Because Metra Health could not read all the tapes, Metra Health denied claims that should have been sent to EDS for processing but were not because Metra Health could not process the eligibility information sent to it by EDS. EDS never processed these claims because they were never received from Metra Health.

In early 1995, EDS discovered the problem and requested Metra Health "turn off" its edit and let EDS determine recipient eligibility. Metra Health was unable to process claims without the eligibility information. In August 1995 Metra Health modified its system to read all five eligibility tapes submitted by EDS. This modification corrected the problem. From May 1994, and possibly earlier, through August 1995, Metra Health never sent some eligible claims to EDS for processing. EDS receives approximately 35,000 claims each week from Metra Health; however, the volume of claims incorrectly denied by Metra Health could not be determined. For these claims, providers had to recognize that EDS did not pay the claims and manually file paper claims to get reimbursed.

- *Blue Cross Blue Shield of Mississippi's computer system did not transfer certain cross-over claims to EDS during a two-week period in 1996. Blue Cross Blue Shield of Mississippi failed to communicate the claims transmission problems to EDS, but Blue Cross reported to providers the claims were transmitted to EDS. EDS never received or processed the claims.*

The first step in the process of EDS paying a cross-over claim is the receipt of the claim from the Medicare contractor. EDS must receive a cross-over claim from a Medicare contractor before EDS will know of the claim's existence. If EDS does not receive the claim electronically from the Medicare contractor, the first time EDS will know of the claim is when the provider files a manual paper claim. In either case, EDS can only be responsible for the cross-over claims that it receives.

During PEER's review of a sample of provider complaints, a particular provider noted EDS had not paid several of its claims. The provider filed most of the claims within the period of July 24, 1996, through August 7, 1996. The provider correctly filed the claims with the Medicare contractor BC MS and expected the claims to cross-over to EDS for Medicaid processing. The provider received a payment report from BC MS stating the claims were paid and crossed-over to EDS. EDS had not received the provider's claims. The provider requested an explanation from EDS on why the claims were not electronically paid. EDS was unable to find the claims in the data transferred from BC MS and therefore was unable to give an explanation. When PEER staff interviewed BC MS staff, the BC MS staff acknowledged its computer system had developed a glitch during that period and many of the claims shown as crossed-overs in fact had never been electronically transmitted. BC MS had computer system problems that prohibited the transfer of cross-over claims to EDS; however, the BC MS reports reported to providers that the claims were crossed-over to EDS. BC MS corrected the problem in early August 1996, with no additional problems found.

While problems will always exist with a program of this size, prompt corrective action minimizes the impact of the problems. In this instance, EDS processed the claims manually filed by the provider. However, the provider attributed the entire problem to EDS, with EDS "somehow losing our claims." The initial documentation reviewed showed EDS received the claims from BC MS, but the documentation from BC MS was incorrect. EDS never received the claims during this period. EDS was unaware of the computer problems at BC MS and therefore was unable to correct the provider's problem. As stated earlier in (see page 8) communication and the individual relationships between the state Medicaid fiscal agents and the Medicare private contractors provide the basis for the ability to pay cross-over claims. In this case communication failed between the Medicare contractor and EDS and as a result, created additional expense for the provider to file its claims manually to get paid.

Authority to Demand Repayment of Incorrectly Paid Claims

What legal authority does the Division of Medicaid have to demand repayment of funds allegedly paid in error by the division to certain health care providers?

In July 1996, EDS, at the direction of DOM, recovered $892,618.31 in claims incorrectly paid to providers since 1994. In some cases providers paid substantial amounts (e.g., the University Medical Center repaid over $400,000). Providers had to repay the state for claims not correctly filed with EDS for services rendered to Medicaid recipients.

State law provides DOM the authority to recover any and all claims payments incorrectly paid. The Medicare cross-over claims, whose repayment DOM demanded, violated payment time limits established by federal and state law. Thus, DOM correctly enforced its authority.

Federal and State Requirements for Claims Payment

DOM had the authority and the responsibility to retrieve claims payments for incorrectly paid claims. Federal and state laws establish certain standards for DOM to pay Medicaid claims. DOM directs EDS to pay claims according to those standards. The federal law (42 CFR § 447.45) states:

> *(d) Timely processing of claims. (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.*

In addition;

> *(II) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or provider receives notice of the disposition of the Medicare claim:*

The Legislature codified this federal law into state law under MISS. CODE ANN. Section 43-13-113 (1972).

The State Auditor's Office annually reviews the Medicaid program for compliance and financial reporting to ensure DOM complies with the federal and state laws above.

Claims Incorrectly Paid Due to Untimely Claims Submission

During the last review, the State Auditor's Office determined EDS was not paying claims within the above-noted federally and state established time limits. EDS's computer system was programmed to allow claims to be submitted by

providers within the thirteenth month after the date of service. This was one month beyond the period allowed by law for regular claims. The State Auditor's Office and DOM later discovered Medicare cross-over claims were allowed the same thirteen-month submission period.

The State Auditor's Office communicated the following finding and recommendation to DOM on April 22, 1996:

> Agency Should Comply With Timely Filing Requirements
>
> Recommendation:
>
> We recommend the Office of the Governor - Division of Medicaid comply with federal law regarding timely filing. The agency should ensure the fiscal agency correct computer edits by using the actual date of service and date of receipt of the claim for determining timely filing requirements have been met prior to payment. We further recommend agency personnel maintain documentation to support approval of claim payments which fall outside the timely filing deadline. This documentation should include evidence of retroactive adjustments.

DOM responded to the findings on May 20, 1996:

> Response: The Office of the Governor, Division of Medicaid, concurs that claims were approved for payment which exceeded the twelve months timely filing requirements.
>
> Corrective Action Plan: CSR DO4224 has been completed. The system's program code was changed to allow only claims that are submitted within 12 months from the date of service to pass the timely filing edits and be approved for payment. A recovery to reprocess all claims that have been paid within the last two years that exceeded the timely filing requirements is currently being analyzed and will be processed within the next two weeks.

DOM subsequently recovered $892,618.31 from providers in July 1996. Of this amount, the University Medical Center repaid over $400,000. EDS contacted all providers requested to repay amounts greater than $10,000 before the recovery was made.

After the recovery of claims paid beyond the twelve-month standard, the State Auditor's Office and DOM discovered Medicare cross-overs were treated the same as all other claims. Federal and state law requires cross-over claims to be paid within six months of the date of Medicare payment notification to the provider. DOM instructed EDS to place an edit in service that denied all cross-over claims over six months old with the edit placed into service on April 18, 1996. However, EDS did not notify providers until August 1996 of an effective date of June 13, 1996, that claims over six months old would be denied. EDS notified the providers three months after EDS put the edit in place. DOM did not request a

recovery for the cross-overs previously paid incorrectly. DOM did not request the recovery because the provider manuals, supplied by DOM to providers, incorrectly stated claims had to be filed within twelve months. This provided a basis to recover violations of the twelve-month rule for the regular claims but provided no basis for the cross-over claims. Based on an interview with HCFA staff, if DOM did not recover incorrectly paid claims, the federal government could withhold that amount from federal funds supplied to the state. Therefore, even though DOM's decision not to recover the incorrectly paid cross-over claims appears reasonable, the federal government could withhold funds from the state equal to all cross-over claims paid beyond the six-month requirement.

DOM's recovery of incorrectly paid claims that violated the twelve-month rule brought DOM into compliance with federal and state law. DOM's authority for such actions is provided by MISS. CODE ANN. Section 43-13-121 (1972):

> *(1) The division is authorized and empowered to administer a program of medical assistance under the provisions of this article, and to do the following:*
>
> . . . . . .
>
> *(j) To recover any and all payments incorrectly made by the division or by the Medicaid Commission to a recipient or provider from the recipient or provider receiving said payments. . . .*

DOM also has the authority to recover the payments that violated the six-month rule for cross-over claims and its failure to do so may make the state liable for those payments. DOM has since contacted the federal government and obtained a reprieve for the collection of incorrectly paid cross-over claims. In a memo dated November 13, 1996, addressed to the DOM Executive Director, the federal government stated:

> *Knowing the history of the claims processing problems that you have experienced with respect to the cross-over claims, we do not intend at this time to make that finding of noncompliance with your State Plan for untimely processing of the claims to date.*

See Appendix B, page 24, for a case study illustrative of a claims repayment demand, the complexity of the issues involved, and the laws governing resolution.

EDS's Performance on Timeliness Measures

Has the Division of Medicaid's fiscal agent, EDS, processed claims in a timely manner?

EDS did not comply with the thirty-day claims processing standard, but did comply with the ninety-day standard.

EDS's contract with DOM requires EDS to adjudicate properly ninety percent of all clean claims (claims that require no additional information in order for the claim to be resolved) within thirty calendar days of receipt and ninety-nine percent of all clean claims within ninety calendar days of receipt. EDS failed to adjudicate ninety percent of all clean claims within thirty calendar days, averaging 86.10%, but exceeded the ninety-nine percent standard of claims adjudicated within ninety calendar days, averaging 99.36%.

PEER received several complaints concerning the timeliness of paying claims and claims adjustments. The federal government established claims payment standards for the Medicaid program. These standards are the same as those of EDS's contract with DOM, plus the fiscal agent must properly adjudicate:

> *. . . all other claims within one (1) year of receipt, except those cases where the DOM approves a longer suspense period; according to SPR guidelines, the Fiscal Agent is required to pay or deny claims within 30 days.*
>
> *Suspended claims - The MMIS should pay or deny all suspended claims within 30 days of original suspended date, except where DOM approves a longer suspense period to obtain PRO certification or eligibility records.*

DOM is responsible for constantly monitoring the performance of its fiscal agent, EDS. DOM performs this function by using monthly Contract Management Reports. Based on information from those reports, EDS performed as illustrated below.

EDS's Compliance with Timeliness Standards
May, June, and July 1996

Description	Standard	Performance
Thirty Days Processing	90%	86.10%
Ninety Days Processing	99%	99.36%
Suspended Claims Over 30 Days	0	Approximately 10,000 lines

SOURCE: EDS monthly Contract Management reports

According to the Contract Monitoring Reports, which the division uses to report the fiscal agent's performance to the federal government, EDS failed to comply strictly with claims processing performance standards, its performance was only marginally below one standard, and it met the remaining standard.

DOM monitors suspended claims, including adjusted claims, based on number of lines instead of claims. Each procedure performed on a recipient is reported on a claim form as a line. In many cases, one claim will include multiple lines (e.g., emergency room, supplies, drugs). EDS usually maintains below 10,000 lines of suspended claims over thirty days old. EDS receives approximately 2 million claim lines monthly for processing. The suspended lines over thirty days account for approximately one-half of one percent of the received amount. Suspended claims over thirty days totaled 19,743 for July 1996, almost double the previous average, because of the timely filing edit related to the six-month cross-over standard discussed earlier.

Recommendations

1. The Division of Medicaid and its fiscal agent, EDS, should aggressively seek to negotiate agreements with Medicare contractors that will improve information transfers necessary to process Medicaid claims. DOM should request HCFA to participate in these negotiations and to insert specific requirements for information transfer procedures into future contracts with Medicare contractors. These procedures should include a requirement that contractors contact EDS immediately upon encountering problems with information transfer. The DOM also should require its fiscal agents to investigate information transfer problems as they occur and to provide documentation of such investigations to DOM.

2. EDS should follow its own procedures for reviewing and identifying providers listed on its Medicare crossover error reports. EDS should not hesitate to contact Medicare contractors to gain information needed to identify the claims received from the Medicare contractors. If the Medicare contractor is not cooperative, EDS should contact the Medicare contractor's executive-level personnel with the assistance of DOM and/or HCFA to gain the cooperation and information needed to process the Medicaid claims.

3. EDS should notify providers if the Medicare identification number is not supplied to DOM when the provider signs up for the Medicaid program. For six months after that provider enrolls in the Medicaid program without a Medicare identification number, EDS should maintain the provider on a list and make frequent contacts to inquire whether a Medicare number has been obtained. No Medicare claims should be paid by EDS, either electronic crossover or manually filed, unless EDS has accurate Medicare identification information on the provider. This policy would prevent providers from receiving Medicaid reimbursement for claims denied by Medicare. If the provider's Medicare identification numbers are not listed on EDS's computer system, EDS should recognize this as a problem and correct the problem prior to paying the claim.

Appendix A

Responsibilities of EDS as the Fiscal Agent for the Division of Medicaid

EDS, as fiscal agent for DOM, has the following responsibilities:

- prepare and distribute all claims reimbursement instructions prepared by DOM staff;
- distribute claims forms unique to Medicaid;
- receive and organize claims for processing, following federal and state regulations;
- process claims in accordance with policies of DOM (see Exhibit 1, page 9);
- reimburse approved providers for covered services provided to eligible Medicaid recipients;
- communicate with providers and recipients regarding claims filed under the Medicaid program in a clear, concise, and timely manner;
- receive and use files of certified eligible Medicaid recipients from the Mississippi Department of Human Services, the U.S. Social Security Administration, and other agents of DOM;
- provide DOM with statistical profiles and other reports necessary for the administration of the program;
- perform on-site audits and desk reviews of cost reports necessary for the determination of reimbursement rates as prescribed in the Mississippi State Plan, developed by DOM and approved by the federal government;
- perform audits as established by DOM to receive payments from other insurance coverage the Medicaid recipient may have; and,
- perform all functions of the fiscal agent as set out in the Request for Proposals issued by DOM, presently in effect.

SOURCE: Division of Medicaid records

Appendix B

A Case Study of the Controversy Created by the Division of Medicaid's Authority to Demand Repayment of Incorrectly Paid Claims

The Division of Medicaid's authority to demand repayment of incorrectly paid claims has created some controversy within the provider community. Illustrative of this controversy is a dispute between Northeast Mississippi Health Care, Inc. (NEMHC) and DOM concerning the Medicaid cost report settlements for fiscal years 1994 and 1995. NEMHC refused to pay the amount DOM claimed was overpaid by the state based on its belief that the claims were not correctly paid by DOM's fiscal agent. NEMHC requested that these, and certain claims not timely filed, be reprocessed by DOM. DOM refused, citing that it has no authority to grant a waiver to NEMHC for processing claims not correctly filed within one year of the date of service or claims not corrected for an error within one year of being filed with the fiscal agent. This case represents both the frustrations of the provider and the strict requirements governing DOM in such cases.

NEMHC's Medicaid claims were reprocessed on several occasions, resulting in a total credit balance of $246,281.70 owed to the state, as of March 6, 1995. NEMHC did not agree it owed this amount, an amount based on total claims paid to NEMHC for the entire year. DOM audited the two years of cost reports, 1994 and 1995, based on federally established regulations. On September 30, 1996, DOM agreed to settle the two years of cost reports for $37,055, including the previously mentioned $246,281.70 credit balance. NEMHC agreed with the settlement amount because NEMHC believed the settlement reflected approximately what it owed. However, NEMHC refused to settle the cost reports unless DOM obtained a waiver from HCFA to allow Medicaid claims filed for dates of service July 1, 1993, through June 30, 1995. to be reprocessed and payments allowed to NEMHC. DOM has not requested a waiver.

NEMHC, along with other providers, experienced claims processing problems for the period July 1, 1993, through mid-1994. Some of these problems can be directly attributed to First Health Services' failure to process claims effectively as the previous fiscal agent for DOM. However, based on a review of claims resubmitted by NEMHC for review by DOM, some claims problems can also be attributed to NEMHC errors in initial claims filings or failure to file corrections for its own and First Health Services errors in a timely manner.

Both DOM and NEMHC are compelled to comply with federal law, 42 CFR §447.45 (d). This section provides two criteria for timely filing and processing of Medicaid claims.

> *(1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.*
>
> . . . . . .
>
> *(4) The agency must pay all other claims within 12 months of the date of receipt. . . .*

Appendix B (Continued)

Both DOM and NEMHC stated they are working with a timeline of two years in which DOM can correct, and/or allow, NEMHC claims. The above-referenced regulation allows a maximum of two years that a claim can be filed and adjudicated. This would only occur if the provider waited until the last day of its twelve-month filing deadline; usually the provider files within a month of the date of service. In most instances, the period that a claim could be reprocessed would be considerably less than two years and would be based on the date each individual claim was filed by the provider.

The federal law only provides for a waiver for performance standards for DOM and its fiscal agent. Neither federal nor state law provides for a waiver of the timely claims filing and processing requirements. While DOM has authority to demand repayment of incorrectly paid claims (as discussed on page 16), DOM has no authority to grant a waiver to NEMHC for processing claims not correctly filed within one year of the date of service or claims not corrected for an error within one year of being filed with the fiscal agent. While HCFA may administratively be able to authorize a waiver, this would not be consistent with federal law and therefore it is not likely that HCFA would grant such a waiver. Based on federal and state laws for the timely payment Medicaid claims, DOM must request NEMHC to repay amounts DOM determines is owed based on DOM's audit of the cost report. NEMHC has no relief for the reprocessing of its delinquent claims. If NEMHC has a specific item DOM did not correctly handle in the audit of its cost report, NEMHC may appeal the disagreement to HCFA. However, not filing claims on time is not subject to HCFA appeal.

SOURCE: PEER analysis.

Agency Response

NOTE: The PEER Committee staff submitted a draft copy of this report to the Executive Director of the Division of Medicaid, Ms. Helen Wetherbee, for her comments. The division's reply, which included detailed responses to specific statements in the draft report, clarified certain issues of the review. Subsequently, PEER staff prepared a revised draft report based on the agency's response prior to the PEER Committee's review and approval, and offered the Executive Director an opportunity to revise the division's response. Ms. Wetherbee chose not to respond to the revised draft report. The Committee approved the report as revised at its meeting of January 6, 1997.

Because the agency's response is not directly responsive to the report in its final form, the PEER Committee recorded in its minutes that this explanation be included in the published report.

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
HELEN WETHERBEE, J.D., M.P.H.
EXECUTIVE DIRECTOR

January 6, 1997

VIA HAND DELIVERY

Senator William Canon, Chairman
Joint Committee on PEER
Attention: Anne Hutchinson
Post Office Box 1204
Jackson, MS 39215-1204

Dear Senator Canon:

The Division of Medicaid will have no further response to the PEER Committee's report as presented on December 31, 1996, other than the report submitted to you on January 3, 1997. I wish the Division's initial response, attached to this letter, along with the PEER Committee's original report, to be submitted to the PEER Committee.

Sincerely,

Helen Wetherbee

Helen Wetherbee, J.D., M.P.H.
Executive Director

HW/std

Attachment: as stated
pc: All PEER Committee Members

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

HELEN WETHERBEE, J.D., M.P.H.
EXECUTIVE DIRECTOR

January 3, 1997

SENT VIA HAND DELIVERY

Honorable William Cannon
Mississippi State Senate
New State Capitol
Jackson, MS 39201

Dear Senator Cannon:

I am writing in response to a draft report and executive summary thereof, prepared by the PEER Committee staff after their investigation of claims payment by the Division of Medicaid and our fiscal intermediary, EDS. It should be understood that we are responding to a draft report shown to us on December 31, 1996. We were given a deadline of noon, January 3, 1997, essentially two working days, in which to prepare this report. We do not, of course, have any knowledge of what changes in the report may have been made since we reviewed it. Nonetheless, we have several general concerns, which are followed by detailed responses to specific statements.

First, the report essentially states that the Division's actions were in accordance with state and federal regulations, and points to the fact that many of the problems have been due to actions by third parties beyond our control. The details are less accurate. Last summer, for example, the division recouped more than $800,000 in claims which were paid more than 12 months after the date of service. This was required by federal regulation, and state audit findings, and was acknowledged as correct in the PEER report. This recoupment, however, did not include cross-over claims (from Medicare). The language on pages 16 and 17 incorrectly suggests that cross-overs were included.

The Division had already implemented "Recommendation 2" before your investigation. We had already determined to handle Medicare cross-overs separately. We wrote HCFA in September, and received a reply in November. This matter is resolved, and this information was available to your reviewers. The letters are attached.

The case study appended to the report is distorted beyond recognition. This case was personally handled by Carol Pangborn, at EDS, who herself worked weekends manually correcting claims which were the responsibility of clinic staff. The problems arose from erroneous reporting by the clinic. Her remarks are included at the end of this letter.

The detailed response of the Division follows:

Page 2 Third Bullet
"Citizens" or recipients cannot submit Medicaid claims.

Page 2 Overview, Second Bullet
DOM has not recouped any cross-over claims

Page 2 Bottom, Bullet One
The federal government does require Medicare to cross over claims to Medicaid.

Page 2 Bottom, Bullet 2
EDS does investigate the error report, but there isn't much that can be done trying to cross reference numbers without additional information.

Page 3 Bullet Two
Metra Health took the initiative upon themselves without DOM input.

Page 5 Paragraph 3,4
The first issue encountered appeared on page 5 where there was an excerpt of a letter from a provider. EDS objects to the statement that this letter is "typical of the discontent" it implies that problems are widespread, affecting all the providers in the state. Although in the paragraph several issues are stated ("untimely and inaccurate in the processing of submitted claims", below average reimbursement rates, and " the frustration providers experienced at being caught in the middle of the state change in fiscal agents") the impression that is left is that many unaddressed issues regarding EDS' performance remain. There are no specific examples of the number of claims that were found that were not processed timely or accurately and there is no detail on what specifically frustrated provider about the change in fiscal agents. In addition, there is no indication as to the date on the letter which would identify how old these issues are. As you are aware, and as is indicated in the report, there were a number of issues that affected the processing of crossover claims, several of which were not in our direct control.

Although provider letter expresses discontent there is no way to determine (with the limited information provided) whether or not this particular providers problems were the result of claims not sent to EDS by BCBS or Metra Health. In reference to the specific comment in the letter regarding EOBs, EOBs were requested from the providers for crossover claims which had exceeded the timely filing deadline. Since our system had no record of ever receiving the claim from the Medicaid intermediary the EOB represented documentation that could be used to determine when the claim was processed by Medicare. This documentation was requested to determine whether sufficient cause for corrective action (as described in the legislation) was warranted for the provider and not intended as a burden for the provider. The primary reason for providers having to refile claims is due to the original paper crossover submission denying for timely filing, therefore requiring the additional documentation (EOB) to determine if an override was warranted.

Page 8 First Paragraph
Medicare does not have to approve and pay on a claim before Medicaid pays.

Page 10 Paragraph 1
This paragraph states that a provider can have multiple Medicaid provider numbers. This is incorrect. A provider can have only one open Medicaid number at a time. A provider is however issued multiple Medicare numbers, one for each physical location they work in.

Page 10 Paragraph 3
Although it is true that claims can not be processed if there is no match found on the Medicare provider number submitted, the fact that claims will also not be processed if there is no match found on a recipients HIC number was omitted. If we were successful in identifying every Medicare provider that hit the mismatch report we would still not be able to resolve 100% of the failed claims due to unidentified recipients.

Page 11 Paragraph 1
This paragraph states that a provider's only recourse to get a crossover claim paid that did not crossover electronically is to file a paper claim. While this is certainly a mechanism for the provider to get his claim processed, EDS has been able, as a result of storing the denied claims in history under the "dummy" provider number, to recycle claims for providers. If the provider notifies us of his Medicare provider number and we have received claims for that Medicare provider number we can electronically reprocesses those claims. EDS has retained all original files from all Medicare intermediaries to enable us to

process the claims without the provider submitting a paper crossover. Paper crossovers are only required if we can find no record of having received the claim from Medicare or if the claim has exceeded the timely filing limit. Based on this, the last sentence in the paragraph which states, "If the provider fails to file a paper claim, the provider will not get reimbursed for Medicaid services rendered", is not true.

Page 18 Paragraph 1
This paragraph references the decision not to recover the crossover claims and indicates a concern that "the federal government could withhold funds from the state equal to all cross-over claims paid beyond the six-month requirement". The letter from HCFA releases the DOM from this responsibility.

Page 18 Last Paragraph
This paragraph references Appendix B regarding the Northeast issues. These are addressed in Appendix B.

Page 18 Paragraph 2
This paragraph references the timeliness of processing, ("averaging 86.10%" within 30 days and "averaging 99.36%" within 90 days). I will recalculate these averages (using the MR-0-30) for the May, June, July time frame to determine whether or not the 3 rates were added and divided by 3 or whether claim volumes for each month were added and then compared to claims processed in an effort to validate these numbers.

Page 20 Last Sentence
This sentence says "DOM does not measure timeliness of adjustments", but we do. They are in the contract management reports. For May 1996, the percentages are 82.64% over 30 days and 45.20% over 90 days.

Recommendations

1. We will pursue this. It should be kept in mind, however, that the Medicare intermediaries have no incentive to cooperate with EDS on crossover issues since they do not receive additional reimbursement for passing the crossover claims to us. This should be considered in light of the fact that the statement was made several times throughout this report that "to date, neither EDS or DOM have been effective in addressing many of the problems related to crossover claims". It's inappropriate to make a statement like that without analyzing how crossovers are processing today. Based on the way crossovers are currently processing

and the lack of phone calls bringing any processing problems to our attention, I would say significant progress has been made and that our efforts have indeed been effective.

2. Addressed by letter from HCFA.

3. EDS will continue to work the crossover error reports.

4. This could cause significant payment delay to the provider on paper crossovers. Since paper crossovers are filed with the Medicaid provider number clearly indicated, the system does not currently check the Medicare cross reference file during the adjudication process. An enhancement to the system could be completed to allow processing in this way, however the benefit is unclear. In addition, Palmetto, which is the DME intermediary, will forward claims to us using other key pieces of identifying information in addition the Medicare provider number, for example the federal tax ID or SSN. During the normal processing of crossover claims if we are unable to match to a Medicare provider number we will use the additional information provided to identify the Medicaid provider for which the claim was submitted. Since social security numbers are a unique identifier as are federal tax ID's, this is an alternative way to process an electronic crossover, thereby eliminating the need for the provider to file a paper claim. If we are restricted from using this additional method for matching crossover claims it will increase the burden on the provider and force them to file a paper claim.

Page 23 Appendix B

The first sentence in this section implies that the problems experienced by NEMHC were related to the timely filing recovery that was done. In reality the problem stems from the fact that NEMHC counted visits on their cost reports for FY '94 and '95 for claims that were not paid by Medicaid. Ms. Pangborn personally spent several weekends researching approximately 1,000 claims submitted for consideration by NEMHC. After reviewing these claims she submitted the claims that could be processed and returned all others with notes of explanation on each claim. Whenever she found that a claim had been previously submitted and denied and had a valid timely filing ICN on the claim she submitted the claim for reprocessing. The reason the balance of the claims were not resubmitted were related to recipient eligibility, exhausted service limits, previously paid claims and failure to submit the claim timely. In a number of instances there was no record that the claim had ever previously been submitted for payment. In addition, there were many instances where the provider indicated a timely filing ICN on the claim,

perhaps in an attempt to get the claim processed, that was invalid. For example, ICNs begin with the last digit of the year the claim was received for processing. Claims received in 1996 contain a "6" in the first digit of the ICN. Some of the claims submitted by NEMHC had ICNs that began with a number higher than six which is not valid.

In closing, the Division submits that the average time for claims processing is ten days from receipt to adjudication. This is good. While the report addresses problems that have occurred, it is clear that many have been beyond the Division's or EDS' control (see for example, comments on pages 3,6,8,12,13 and 14). We do pay cross-over claims. These total about $12.5M per month, or about 8.5% of the medical services payments.

I hope this is helpful.

Sincerely,

Helen Wetherbee

Helen Wetherbee, J.D., M.P.H.
Executive Director

HW/rc

cc: Gwen Combs, DOM
Terry Childress, DOM
Carol Pangborn, EDS

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
HELEN WETHERBEE, J.D., M.P.H.
EXECUTIVE DIRECTOR

September 9, 1996

Mr. Eugene A. Grasser, Jr.
Associate Regional Administrator
Division of Medicaid
Health Care Financing Administration
101 Marietta Tower, Suite 602
Atlanta, GA 30301

Dear Mr. Grasser:

I am writing to ask your assistance in clarifying Mississippi's obligation with respect to the timely filing requirements set forth in federal regulation.

As you are aware, the State Auditor has raised questions about our leniency in over-riding the timely filing edits with respect to Medicaid claims, and claims that are crossed over from Medicare. In response to the first finding, we initiated some adjustments through our MMIS which evoked considerable reaction, and which are now the subject of Congressional inquiry.

The outstanding issue is how to resolve the matter of the 6 month filing limit for claims crossed over from Medicare. You have indicated that the applicable regulation is, indeed, federal, but that you would never impose sanctions for failure to adhere to it. I feel it would be irresponsible of me to rely on a verbal representation, when under the regulatory scheme this agency remains amenable to federal action.

If, however, you would write that HCFA essentially "forgives" the untimely processing of cross-over claims to date, we may put this matter to rest.

I look forward to hearing from you, and hope you will be able to accommodate our request.

Sincerely,

Helen Wetherbee

Helen Wetherbee, J.D., M.P.H.
Executive Director

ATTCH A

HW/rcc

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

November 13, 1996

Refer to:
MS:CROSOVER
DMCD-183-96

Helen Wetherbee
Executive Director
Division of Medicaid
Office of the Governor
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201-1311

Dear Ms. Wetherbee:

I am writing in response to your letter dated September 9, 1996, in which you requested assurance that HCFA will not disallow Federal financial participation (FFP) in Medicaid payments made for cross-over claims that were not processed in accordance with Federally-mandated time limits. As set forth below, HCFA will not disallow FFP for those claims.

The Federal regulation at 42 C.F.R. § 447.45 sets forth State Plan requirements for timely processing of Medicaid claims. Under the regulation, the State Plan must require providers to submit Medicaid claims within 12 months of the date of service, and the State Medicaid agency generally must pay the claims within 12 months of receiving them. 42 C.F.R. § 447.45(c) and (d). The regulation lists exceptions to the 12-month timely payment rule, including the following:

> "If a claim for payment under Medicare has been filed in a timely manner, the Agency may pay a Medicaid claim relating to the same services within 6 months after the Agency or the provider receives notice of the disposition of the Medicare claim." 42 C.F.R. § 447.45(d)(4)(ii)

We interpret this exception to mean that the State may pay a "cross-over claim" for up to 6 months after receiving notice of the Medicare disposition, even when such payment would occur more than 12 months from the date of receipt of the provider's Medicaid claim.

An earlier version of this regulation was codified at 42 C.F.R. § 449.81. That version provided that FFP was not available for claims that were not processed in accordance with timeliness requirements, including cross-over claims that were not paid within the 6-month period.

The provisions regarding FFP were deleted, and HCFA explained that timeliness requirements, including the requirement regarding cross-over claims, would be enforced not by disallowing FFP, but by finding the State out of compliance with its State Plan. See 43 Federal Register No. 161, p.36658, August 18, 1978.

Attck B

Knowing the history of the claims processing problems that you have experienced with respect to the cross-over claims, we do not intend at this time to make that finding of noncompliance with your State Plan for untimely processing of the claims to date.

However, this does not mean that you can disregard the timeliness requirements and deactivate MMIS edits that have been properly designed to enforce the requirements. In order to allay the concerns expressed to us by Senator Trent Lott's staff, and others, we hereby request that you submit copies of the system documentation that describes the architecture of your MMIS edits for these time periods so that we can satisfy ourselves that your agency is working to comply with timeliness requirements while not imposing any undue hardship on providers.

Also, let us remind you of the 2-year time limit within which the State Medicaid agency must file its claim with HCFA for FFP. This statutory requirement (see P.L. 96-272 and 42 U.S.C. § 1320b-2) has been implemented in Federal regulations at 45 C.F.R. § 95.7. Specifically, the State Medicaid agency must file its claim for FFP in an expenditure on a quarterly Form HCFA-64 report within 2 years after the end of the calendar quarter in which any agency of the state (i.e. the state Medicaid agency, a state health agency, a local organization that incurs matchable expenses, etc.) paid the service provider for the Title XIX service.

We hope this clarifies the issue. If you or your staff have any other questions regarding this matter, please contact me or Stan Dickson at (404) 730-2719.

Sincerely,

Eugene A. Grasser
Associate Regional Administrator
Division of Medicaid

PEER Staff

Director

Max Arinder, Executive Director
Ava Welborn

Administration and Support Division

Steve Miller, General Counsel and Controller

Shirley Anderson
Thelisa Chapman
Louwill Davis
Sam Dawkins
Ann Hutcherson
Larry Landrum
Mary McNeill
Bonita Sutton

Evaluation Division

James Barber, Division Manager
Kathleen Sullivan, Division Manager

Mitchell Adcock
Michael Boyd
Ted Booth
Katherine Stark Frith
Barbara Hamilton
Dale Hetrick
Kevin Humphreys
Kelly Lockhart
Joyce McCants
David Pray
Pam Sutton
Linda Triplett
Larry Whiting