Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ELECTRONIC FUNDS TRANSFER FOR MEDICAID PROVIDERS

Richard P. Kusserow
INSPECTOR GENERAL

JUNE 1992

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ELECTRONIC FUNDS TRANSFER FOR MEDICAID PROVIDERS

Richard P. Kusserow
INSPECTOR GENERAL

OEI-01-91-00821

EXECUTIVE SUMMARY

PURPOSE

The purpose of this study is to examine the use of electronic funds transfer for reimbursing Medicaid providers.

BACKGROUND

Electronic funds transfer (EFT) has taken the place of paper checks for over 15 years. It is most commonly employed to make recurring payments, such as salary and retirement benefits.

The Health Care Financing Administration (HCFA) has recently expressed interest in paying providers with EFT. The HCFA sees EFT as another step toward reducing administrative costs and improving provider relations in the Medicare and Medicaid programs.

HCFA's Medicaid Bureau has indicated its intention to support State use of EFT. A draft revision of the State Medicaid Manual shows that HCFA plans to provide enhanced Federal Financial Participation (FFP) for expenses related to EFT and electronic remittance advisories (RAs). [Payers use RAs to inform providers of the status of any outstanding claims the providers have submitted. The RAs show whether each claim has been paid, denied, or suspended for further review.] The HCFA would pay 90 percent of design and development costs and 75 percent of operational costs. In contrast, HCFA pays only 50 percent of the postage costs for mailing paper checks and RAs.

This report details the extent to which State Medicaid programs are currently paying providers with EFT as opposed to paper checks. It also discusses problems with EFT that States have identified and suggests possible solutions.

FINDINGS

Only eight States are using EFT to reimburse Medicaid providers.

Many States see advantages to using EFT. Several States are considering EFT, but few have definite plans to adopt it.

States have identified a diverse set of problems with EFT. Some of these are easy to address, but others are more difficult.

- Three commonly cited obstacles to EFT--loss of cash flow, potential fraud, and initial cost--seem easily surmountable.

- Additional obstacles to EFT may make it harder to implement in some States than in others.

- Greater use of EFT may not create substantial savings unless accompanied by lesser use of paper remittance advisories.

RECOMMENDATIONS

To address the problems and concerns regarding EFT that States have identified, the HCFA should:

Work with the State Medicaid Directors' Association (SMDA) to identify additional problems with EFT facing States and to share other States' solutions to those problems.

Work with the National Automated Clearing House Association (NACHA) both to explore how the Automated Clearing House can be used for Medicaid EFT and RAs and to provide information to States.

Assist States in developing billing agreements for providers who use electronic claims, remittance advisories, and funds transfers. In particular, HCFA could (1) specify wording for billing agreements that would satisfy Federal requirements, and (2) distribute to all States copies of billing agreements used by States that currently employ EFT.

Develop guidelines for provider participation in EFT. These guidelines should identify conditions that States could impose on providers receiving payment through EFT.

COMMENTS

We solicited and received comments on our draft report from HCFA, the Assistant Secretary for Planning and Evaluation (ASPE), SMDA, and NACHA. The ASPE, SMDA, and NACHA were supportive of our recommendations and provided only technical comments. The HCFA concurred with our first two recommendations but did not concur with the last two as originally drafted. In response to HCFA's comments, we modified those two recommendations. They now more accurately reflect our vision of HCFA's role in promoting EFT technology. An explanation of the changes is provided on pages 10-11 and in appendix A.

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INTRODUCTION

PURPOSE

The purpose of this study is to examine the use of electronic funds transfer for reimbursing Medicaid providers.

BACKGROUND

Electronic funds transfer (EFT) has taken the place of paper checks for over 15 years. It is most commonly employed to make recurring payments, such as salary and retirement benefits. About 17,000 banks and other financial institutions and 35,000 businesses use EFT through the national Automated Clearing House (ACH) system.[1]

The Health Care Financing Administration (HCFA) already provides strong incentives for providers to bill the Medicare program in electronic form.[2] It also bore 90 percent of the development costs for each State's Medicaid Management Information System (MMIS)--a powerful computer system for processing claims and maintaining utilization data.[3] The HCFA has recently expressed interest in paying Medicare and Medicaid providers through EFT, which it sees as another step toward automating claims processing. It believes that EFT can reduce administrative costs and improve provider relations in those programs.

In July 1991, at the request of providers and Medicare contractors, HCFA proposed a new payment system for Medicare.[4] The system would give providers the option of receiving payments through EFT rather than by paper check. Providers support EFT because it would relieve them from delivering paper checks to their own banks and eliminate the time they have to wait for checks to clear before drawing upon them. The HCFA supports EFT because each transfer would cost only 3 to 10 cents, as opposed to the first-class postage costs for paper checks (now 29 cents before bulk discounts).[5]

The HCFA plans to use EFT as an incentive to automate other Medicare claims-processing functions. Only providers submitting electronic claims and agreeing to accept electronic remittance advisories (RAs) would be eligible for EFT. (Payers use RAs to inform providers of the status of any outstanding claims the providers have submitted. The RAs show whether each claim has been paid, denied, or suspended for further review.) The RAs will be sent back to providers over the same telephone lines used by providers to submit claims.

Unlike Medicare, Medicaid is a State-operated program. The HCFA does not reimburse providers directly, but reimburses States for a portion of their expenditures. Therefore, HCFA could not institute EFT for the Medicaid program unilaterally. It is in HCFA's interest for States to use EFT rather than paper checks, however, because

a reduction in States' administrative costs would lead to a reduction in Federal reimbursement as well.

The HCFA's Medicaid Bureau has indicated its intention to support State use of EFT. A January 1992 revision of the State Medicaid Manual indicates that HCFA will provide enhanced Federal Financial Participation (FFP) for expenses related to EFT and electronic RAs. The HCFA will pay 90 percent of design and development costs and 75 percent of operational costs. In contrast, HCFA pays only 50 percent of the postage costs for mailing paper checks and RAs.

This report details the extent to which State Medicaid programs are currently paying provider claims through EFT as opposed to paper checks. It also discusses problems with EFT that States have identified and suggests possible solutions.

METHODOLOGY

Data for this report were collected during a related project on point-of-service (POS) claims management systems (OEI-01-91-00820). Telephone interviews were conducted in May and June 1991 with Medicaid claims management staff in every State except West Virginia.[6] We also held less formal telephone discussions with staff from HCFA and the Federal Reserve Bank.

FINDINGS

ONLY EIGHT STATES ARE USING EFT TO REIMBURSE MEDICAID PROVIDERS.

In 42 States, all providers are paid with paper checks. The only States now using EFT are Arizona, Florida, Georgia, Nebraska, New Jersey, North Carolina, Pennsylvania, and Texas. Respondents from Arizona, Georgia, Nebraska, New Jersey, Pennsylvania, and Texas indicated that EFT is available only to a few types of providers.[7] These results are displayed in table 1.

MANY STATES SEE ADVANTAGES TO USING EFT. SEVERAL STATES ARE CONSIDERING EFT, BUT FEW HAVE DEFINITE PLANS TO ADOPT IT.

Respondents from the large majority of States identified at least one benefit of EFT.[8] Not surprisingly, most pointed out that EFT would improve provider relations by speeding up payments and would reduce administrative costs for printing and postage.[9] Respondents from two States also noted that EFT could eliminate lost checks. This could be a significant benefit: Medicaid officials in Idaho have estimated the replacement cost of a single lost check to be $47.[10]

Of the 42 States with no EFT capabilities, only 6 (Arkansas, California, Maine, Maryland, Tennessee, and Utah) have definite plans to add EFT. Three States (Georgia, New Jersey and Texas) that use some EFT have definite plans to expand.

Apart from these nine States, there is little or no movement toward the use of EFT. Nineteen States reported that EFT was under discussion, but 22 others reported no intention to change (table 1).

STATES HAVE IDENTIFIED A DIVERSE SET OF PROBLEMS WITH EFT. SOME OF THESE ARE EASY TO ADDRESS, BUT OTHERS ARE MORE DIFFICULT.

Three commonly cited obstacles to EFT--loss of cash flow, potential fraud, and initial cost--seem easily surmountable.

One of the more easily handled concerns involves cash flow. States fear that EFT will loosen their control over bank balances and promote quicker fund depletion, leading to a loss of interest. There is no reason, however, why EFT must have these effects. Although it is true that EFT eliminates the "float" of funds that occurs while checks are in the mail, the transfers can be scheduled to compensate for that loss. In fact, HCFA has already anticipated this problem with regard to Medicare payments. The new plans call for a three-working-day delay between the time paper checks would have been issued and the time EFTs are actually made. The delay is designed

TABLE 1:

STATE MEDICAID PROGRAMS' CURRENT USE OF EFT AND STATUS OF PLANS TO CHANGE

STATE	USES EFT?	STATUS OF PLANS
Alabama	No	None
Alaska	No	None
Arizona	Yes--Large health plans only	None
Arkansas	No	Definite--For pharmacies only at first
California	No	Definite--All provider types
Colorado	No	Under discussion
Connecticut	No	None
Delaware	No	Under discussion
D.C.	No	None
Florida	Yes--All provider types	None
Georgia	Yes--Hospitals, nursing homes	Definite--Expand to all provider types
Hawaii	No	None
Idaho	No	None
Illinois	No	Under discussion
Indiana	No	None
Iowa	No	None
Kansas	No	Under discussion
Kentucky	No	Under discussion
Louisiana	No	None
Maine	No	Definite--EFT and electronic RAs for all provider types
Maryland	No	Definite--All provider types
Massachusetts	No	None
Michigan	No	None
Minnesota	No	Under discussion
Mississippi	No	Under discussion
Missouri	No	Under discussion
Montana	No	Under discussion
Nebraska	Yes--State institutions only	None
Nevada	No	None
New Hampshire	No	Under discussion
New Jersey	Yes--Hospitals only	Definite--EFT daily for hospitals, weekly for LTC facilities, other provider types
New Mexico	No	Under discussion
New York	No	Under discussion
North Carolina	Yes--All provider types	None
North Dakota	No	None
Ohio	No	None
Oklahoma	No	None
Oregon	No	Under discussion
Pennsylvania	Yes--Capitation providers only	Under discussion
Rhode Island	No	None
South Carolina	No	Under discussion
South Dakota	No	None
Tennessee	No	Definite--Weekly payments
Texas	Yes--Contracted systems only	Definite--Available to more pharmacies
Utah	No	Definite--All provider types
Vermont	No	Under discussion
Virginia	No	None
Washington	No	Under discussion
West Virginia	Did not respond	
Wisconsin	No	Under discussion
Wyoming	No	Under discussion

Source: OIG survey of State Medicaid agencies, June 1991.

specifically "to minimize the loss of interest to the Medicare Trust Fund."[11] States concerned about cash flow problems could impose similar delays. Of course, such delays might limit gains in provider satisfaction. Still, the convenience of EFT and the ability to draw on funds immediately after payment should make EFT attractive to providers anyway.

Another commonly expressed fear is fraud. Federal regulations require States to notify providers that filing false claims and accepting payment for them are violations of law. The regulations specify that this notification must be printed either on the claim form or on the payment check. When prosecuting alleged fraud, many States rely on providers' signatures on these papers to prove that providers were aware of the penalties and knowingly submitted the claims or accepted payment. A number of respondents expressed concern that EFT would eliminate their opportunity to obtain providers' signatures, especially for those who submit claims electronically.

The HCFA and several States, however, do not seem to share this concern. There are a number of ways to collect providers' signatures or an acceptable substitute, even for electronically submitted claims. Thirty-nine States use annual billing agreements, 12 use cover sheets that accompany diskette and tape submissions, and 2 require passwords for on-line claims submission (table 2). Six States rely on check endorsements, either alone or in conjunction with other methods. The HCFA, in its revision to the State Medicaid Manual, has indicated that billing agreements "updated as needed" would satisfy the Federal requirements. It recommends that Medicaid agencies confer with their States' Attorneys General to ensure compliance with State laws.

Some Medicaid officials responded that though EFT may simplify and economize program administration in the long run, it is difficult and costly to implement initially. These officials said their States had neither the staff time nor the money to commit to such an undertaking. Start-up costs are a major obstacle for States wishing to implement any type of advancement in computerized claims processing.[12] The HCFA has anticipated this problem and, as stated earlier, is offering enhanced matching funds as an incentive.

Additional obstacles to EFT may make it harder to implement in some States than in others.

In some States, payments to providers are made not by the Medicaid agency or fiscal agent but by another State agency such as the Treasury or Comptroller's Office. In those States, there may be any number of additional reasons the organizations responsible for payment have shied away from EFT. Whatever the reasons, HCFA might not have sufficient leverage with those other State agencies to bring about a conversion.

Also, there may be circumstances peculiar to individual States that could pose difficult problems. For example, one respondent expressed doubts about the sophistication of

TABLE 2:

METHODS USED BY STATE MEDICAID AGENCIES TO PROVE ACCOUNTABILITY FOR CLAIMS

STATE	CHECK ENDORSEMENT	BILLING AGREEMENT	COVER SHEET	PASSWORD
Alabama	No	Yes	No	No
Alaska	Yes	Yes	No	No
Arizona	No	Yes	Yes	No
Arkansas	No	Yes	No	No
California	No	Yes	Yes	No
Colorado	No	Yes	No	No
Connecticut	No	Yes	No	No
Delaware	No	Yes	No	Yes
D.C.	No	No	Yes	No
Florida	No	Yes	No	No
Georgia	No	Yes	No	No
Hawaii	No	Yes	No	No
Idaho	No	Yes	No	No
Illinois	No	Yes	No	No
Indiana	No	Yes	No	No
Iowa	No	Yes	Yes	No
Kansas	No	Yes	No	No
Kentucky	No	Yes	No	No
Louisiana	No	No	Yes	No
Maine	No	Yes	No	No
Maryland	No	Yes	No	No
Massachusetts		Did not respond		
Michigan	Yes	Yes	No	No
Minnesota	No	Yes	No	No
Mississippi	No	Yes	No	No
Missouri	No	Yes	No	No
Montana	Yes	Yes	No	No
Nebraska	No	Yes	Yes	No
Nevada		Did not respond		
New Hampshire	No	Yes	No	No
New Jersey	No	Yes	No	No
New Mexico	No	No	Yes	No
New York	No	No	Yes	No
North Carolina	No	Yes	No	No
North Dakota	No	Yes	Yes	No
Ohio	Yes	No	No	No
Oklahoma	No	Yes	No	No
Oregon	No	Yes	No	No
Pennsylvania	No	No	Yes	No
Rhode Island		Did not respond		
South Carolina	Yes	No	No	No
South Dakota	No	Yes	No	No
Tennessee	No	Yes	No	No
Texas	No	Yes	No	No
Utah	No	No	Yes	Yes
Vermont	No	Yes	Yes	No
Virginia	No	Yes	No	No
Washington	Yes	Yes	No	No
West Virginia		Did not respond		
Wisconsin	No	Yes	No	No
Wyoming	No	Yes	No	No
Total "Yes"	6	39	12	2

Source: OIG survey of State Medicaid agencies, June 1991.

his State's banks and their ability to accommodate EFT. Clearly, HCFA cannot be responsible for upgrading banks' computer capabilities. Another respondent, this one from California, had other reservations about EFT. Medicaid providers there apparently change addresses and bank accounts at a high rate. Approximately 5 to 10 percent make a change each month. This can negate the benefits of EFT, which is designed to take advantage of regularity in payments. The respondent, however, thought that the problem might be unique to California, which has, he said, "a bank on every corner." Where providers have fewer choices in financial institutions, account changes may be less frequent.

Greater use of EFT may not create substantial savings unless accompanied by lesser use of paper remittance advisories.

Four respondents questioned the ability of EFT to save money without a concurrent switch to electronic remittance advisories (RAs). This is a serious concern.

At first glance, a comparison of the transaction cost per EFT (3 to 10 cents) with the paper and postage costs of each check (about 29 cents) makes EFT appear to be a clear money saver. But because paper checks are now usually packaged with paper remittance advisories, this comparison may be fallacious.

When RAs are printed on paper and mailed to providers, the incremental costs of printing and including a reimbursement check in the same envelope are negligible--apparently even less than the cost of EFT.[13] Therefore, few if any financial gains would result from substituting EFT for paper checks if the State continued to send paper RAs.

The decline of paper RAs may be imminent, however. Several States are already transmitting electronic RAs to at least some providers. In most of those States, the RAs are delivered on computer tape or diskette.[14] In those cases, the RAs must still be mailed or hand-delivered, and a paper check can easily be included. But Hawaii and Kentucky have the ability to send RAs on-line--that is, over telephone lines--and Arkansas plans to add a similar ability in early 1992. States could save money by using EFT for providers who receive on-line RAs.

On-line RAs will soon become an option for many more States. The American National Standards Institute has created a nationwide standard for electronic remittance advisories. States should be able to use this standard to send on-line RAs to providers' financial institutions through the Automated Clearing House--the same network used to send EFT. Providers could arrange to obtain the RAs from their financial institutions in a variety of ways.[15]

EFT could generate savings even without on-line RAs. It is well established that electronically submitted claims are cheaper to process than paper claims.[16] States could follow the Medicare example of using EFT as an incentive to promote electronic

claims submission. In fact, some States now provide electronic RAs only to providers who submit electronic claims, thus creating a similar incentive.

EFT might also save money by allowing States to prepare RAs less frequently. Providers might be satisfied with biweekly or monthly RAs if they still received weekly EFT. If this were true, States now sending weekly RAs could cut associated costs by 50 to 75 percent.

RECOMMENDATIONS

The HCFA has already taken a major step by offering enhanced funding for electronic funds transfer and remittance advisories. But it is unlikely that this step alone will motivate many States to use EFT, given the numerous problems with EFT that the States have identified. To address these concerns, HCFA should:

Work with the State Medicaid Directors' Association to identify additional problems with EFT facing States and to share other States' solutions to those problems.

Work with the National Automated Clearing House Association both to explore how the Automated Clearing House can be used for Medicaid EFT and RAs and to provide information to States.

Assist States in developing billing agreements for providers who use electronic claims, remittance advisories, and funds transfers. Two actions in particular would be appropriate. (1) The HCFA could specify wording for billing agreements that would satisfy Federal requirements, as it has for claim forms and paper checks (42 CFR 455.18-19). This wording could then be added to State-specific billing agreements. (2) The HCFA could distribute to all States copies of billing agreements used by States that currently employ EFT. States choosing to implement EFT could use these current agreements as models.

Develop guidelines for provider participation in EFT. These guidelines should identify conditions that States could impose on providers receiving payment through EFT. Possibilities include requiring electronic claims submission and electronic RAs (as HCFA has proposed for the Medicare program), or limiting changes in bank accounts. In developing these guidelines HCFA should draw on the experiences of the States already using EFT and of the Medicare program.

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on our draft report from two components of the Department of Health and Human Services--the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE). We also solicited and received comments from two independent organizations--the State Medicaid Directors' Association (SMDA) and the National Automated Clearing House Association (NACHA). We reproduce these comments in appendix A; our response to the comments appears below.

Comments from HCFA

The HCFA concurred with our recommendations that it work with SMDA and NACHA to investigate ways to facilitate adoption of EFT. It did not concur, however, with our recommendations to develop a standard billing agreement and a set of rules for provider participation. (The draft version's recommendations are reprinted in HCFA's comments, which are contained in appendix A.) The HCFA reiterated its support for EFT, but stated that it needed further analysis of our findings before agreeing to these recommendations.

The HCFA believed that implementing our recommendations would constitute a nationwide, Federal mandate that State Medicaid programs implement EFT. That was not our intention. We firmly believe that EFT should remain an optional component of the Medicaid program, and that the decision to provide enhanced Federal funding of EFT should be made on a State-by-State basis. We see our recommendations as steps that HCFA should take to help those States *choosing* to adopt EFT to do so in a cost-effective manner.

In response to HCFA's concerns, we have modified our last two recommendations. We no longer call for HCFA to develop a provider billing agreement that would satisfy legal requirements in all States; instead, we call for HCFA to assist States in developing customized billing agreements. Also, we now describe the conditions for provider participation as "guidelines" rather than "rules," and make clear that the ultimate decision on whether to use the guidelines should be left to the States. We believe that by implementing these recommendations, HCFA will move toward its stated goal of supporting State use of EFT. At the same time, HCFA will help ensure that if and when EFT is adopted by States it offers benefits to providers, States, and HCFA.

The HCFA made two technical comments, both calling for further analysis of statements made in the report.

- California providers switching bank accounts. We offered this example simply to illustrate potential problems with EFT. We do not mean to suggest that all

States would face similar problems on the same scale. Therefore, we did not feel that further analysis is necessary.

- Use of electronic RAs. The questions HCFA raises about electronic RAs are excellent and certainly need to be answered in the course of implementing EFT. It is precisely these sorts of questions that we think HCFA should address in consultation with SMDA and NACHA (see our first two recommendations).

Comments from other organizations

The ASPE commented that the State Medicaid Manual revisions referred to as a draft in our draft report have now been finalized. Our report now reflects this update.

The SMDA found our report useful and believes that State Medicaid agencies will support our recommendations to HCFA. We appreciate SMDA's comments and infer that SMDA is willing to work with HCFA as suggested in our first recommendation.

The NACHA expressed support for Medicaid agencies' use of EFT and identified three specific issues for HCFA and the States to consider. We appreciate NACHA's support and believe that these issues should be addressed jointly by HCFA and NACHA.

APPENDIX A

DETAILED COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE TO THE COMMENTS

In this appendix, we present in full the comments on the draft report offered by the Health Care Financing Administration (HCFA), the Assistant Secretary for Planning and Evaluation (ASPE), the State Medicaid Directors' Association (SMDA), and the National Automated Clearing House Association (NACHA). Our response to each set of comments is contained in the section of the report titled "Comments on the Draft Report."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date APR 14 1992

From J. Michael Hudson
Acting Administrator

Subject OIG Draft Report: "Electronic Funds Transfer for Medicaid Providers," (OEI-01-91-00821)

To Inspector General
Office of the Secretary

We have reviewed the subject draft report which discusses the degree to which States have adopted Electronic Funds Transfer (EFT) for payment of Medicaid providers. The report also identified a number of factors which prevented additional States from adopting this funds transfer method.

OIG found that only eight States currently use EFT. OIG indicates these States recognized several advantages through EFT use, including additional administrative savings. In order to promote EFT, OIG recommends that HCFA: (1) work with the State Medicaid Directors' Association and (2) the National Automated Clearing House Association to promote EFT implementation among Medicaid providers; (3) work with State Medicaid agencies to create a standard, fraud-proof billing agreement for providers using electronic claims, remittance advisories and funds transfers, and ensure that this agreement satisfies legal signature requirements on both Federal and State levels; and (4) design reasonable rules for providers receiving EFT which require electronic claims submission and electronic remittance advisories or limiting bank account changes.

OIG's recommendations are geared toward implementing EFT nationwide. Though we concur with the first two recommendations, we do not believe the report provides conclusive evidence that nationwide implementation can actually be accomplished at this time. Since the purpose of further implementation of EFT is to achieve savings larger than those produced by the systems most States currently employ, we believe OIG should investigate the costs and benefits of EFT more thoroughly in accordance with our attached comments. Consequently, we defer concurring with the remaining two OIG recommendations until a more comprehensive report is completed.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Report: "Electronic Funds Transfer for Medicaid Providers," (OEI-01-91-00821)

Recommendation 1

That HCFA work with the State Medicaid Directors' Association to identify additional problems with Electronic Funds Transfer (EFT) facing States and to share other States' solutions to those problems.

Recommendation 2

That HCFA work with the National Automated Clearing House Association both to explore how the Automated Clearing House can be used for Medicaid EFT and RAs [remittance advisories] and to provide information to States.

HCFA Response to Recommendations 1 and 2

We concur with these recommendations, particularly given Secretary Sullivan's current initiative to reduce administrative health care expenses through increased use of electronic data submission. We believe it will be fruitful to work with the State Medicaid Directors' Association on plans for comprehensive Medicaid implementation of EFT. By doing so, we anticipate gaining a better understanding of the difficulties States face and the solutions they find. Working with the National Automated Clearing House Association should further facilitate this process by exploring options for EFT, electronic RAs and transferring information electronically to States.

Recommendation 3

That HCFA work with State Medicaid agencies to create a standard, fraud-proof billing agreement for providers using electronic claims, RAs and funds transfers. The agreement should be written to satisfy legal signature requirements in every State as well as Federal legal requirements.

Recommendation 4

That HCFA design a reasonable set of rules to which providers must agree in order to receive EFT. These rules must include requiring electronic claims submission, requiring electronic RAs, or limiting changes in bank accounts.

HCFA Response to Recommendations 3 and 4

HCFA supports the goals of the OIG report. We currently provide enhanced Federal Financial Participation to those States that wish to develop EFT systems. Giving Medicaid providers those same options would also be consistent with HCFA's long-term goals. However, notwithstanding our conceptual support for EFT, we cannot concur with Recommendations 3 and 4.

OIG's recommendations are geared toward national implementation of EFT for Medicaid. However, we believe EFT implementation on this scale involves a considerably more complex set of issues than discussed within this report. A more thorough analysis of the relative costs and benefits of EFT is also required for each discrete party: the Federal government, States, providers, insurers, etc. While such analysis may be beyond the scope of the original study, we cannot endorse the key finding supporting these recommendations without such effort. Until a more rigorous analysis is provided, we also cannot commit ourselves to developing a standardized billing agreement for providers using electronic claims, electronic RAs and EFT.

OIG needs to examine the variety of State systems and the impact such variety will have on national implementation efforts. Consideration of the multiplicity of State systems, and concomitant effects on potential savings, must be undertaken before the recommendations of this report can be reconsidered. Though the report repeatedly mentions that eight States now employ EFT, there are no definitive statements that EFT has been found to be cost-effective in any of these instances. Moreover, OIG does not discuss the operational experiences of any of these States. Such discussion would be invaluable in determining the benefits of national Medicaid EFT implementation. We believe that a de facto mandating of EFT without further study would be counterproductive, because it would serve to retard rather than foster the interest of States in EFT.

Technical Comments

Page 7, Paragraph at Top of Page
This paragraph contains the following statements:

> Medicaid providers there [California] apparently change addresses and bank accounts at a high rate. Approximately 5 to 10 percent make a change each month. This can negate the benefits of EFT, which is designed to take advantage of regularity in payments. The respondent, however, thought the problem might be unique to California...

OIG does not provide analysis of these statements. The report does not clarify how comparable California is to other States, nor how significantly savings in California are affected by this problem.

Page 7, Paragraph 3
The final sentence of this paragraph reads"...few, if any, financial gains would result from substituting EFT for paper checks if States continue to send paper RAs." Given that use of both EFT and electronic RAs is stated to be necessary to achieve cost-effectiveness, discussion of the costs and impediments to acceptance of RAs among Medicaid providers also seems warranted. Subsequent statements that "the decline of paper RAs may be imminent" and "RAs will soon become options for many more States" do not sufficiently quell concerns.

For example, there should be a discussion of whether providers will have to obtain special equipment to receive electronic RAs. If obtaining equipment is necessary, what are the costs per provider? Is there one preferred system compatible with all State operations, or are multiple options necessary? If different systems must be used, what are the price differentials, and how likely is it that each State's Medicaid providers will take on such additional expenses? Could a national requirement for use of both EFT and electronic RAs have a negative impact on beneficiary access to medical care? These questions need to be addressed.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Electronic Funds Transfer (EFT) for Medicaid Providers," OEI-01-91-00821

Thank you for providing me with an opportunity to review your draft report on EFT for Medicaid providers. I would suggest only one change to reflect a development that has occurred since your report was drafted. The report should be revised to reflect that HCFA's State Medicaid Manual revision concerning the enhanced match for EFT efforts has been finalized. It is currently at the printer and is expected to go out in the next four to six weeks.

Martin H. Gerry

STATE MEDICAID DIRECTORS' ASSOCIATION

March 24, 1992

Mr. Richard P. Kusserow, Inspector General
U.S. Department of Health & Human Services
Washington, D.C. 20201

Dear Inspector General Kusserow:

I have reviewed your draft report entitled, "Electronic Funds Transfer for Medicaid Providers." This report provides a useful analysis of both benefits and potential problems with electronic funds transfer (EFT) systems. Moreover, the report provides useful information on state activities which will be of assistance to those states wishing to explore this technology further. I believe the report's summation of the diversity of state concerns with EFT will be helpful in framing the discussion on how best to resolve those issues.

I believe state Medicaid agencies will support the recommendations contained in the draft report and will support efforts to promote discussion of EFT.

Sincerely,

Ray Hanley

Ray Hanley, Chairman
State Medicaid Directors' Association and
Director, Arkansas Office of Medical Services

An affiliate of the American Public Welfare Association
810 First Street, N.E., Suite 500, Washington, D.C. 20002-4205 (202) 682-0100

America's Largest Electronic Payments Network

NATIONAL AUTOMATED
CLEARING HOUSE ASSOCIATION

April 27, 1992

Mr. Richard P. Kusserow
Inspector General
Department of Health & Human Services
Washington, D.C. 20201

Dear Mr. Kusserow:

Thank you for the opportunity to comment on your draft report entitled "Electronic Funds Transfer for Medicaid Providers". The National Automated Clearing House Association (NACHA) is a trade association representing 42 member Automated Clearing House (ACH) associations whose members comprise over 15,500 depository financial institutions. NACHA establishes the rules for the inter-regional exchange of commercial ACH payments and develops new ACH products and improves existing ones in order to meet the needs of financial institution participants and their customers. NACHA also provides marketing and educational services to its members. The ACH network is a nationwide payments system used by more than 22,500 participating financial institutions, 120,000 corporations, and millions of consumers. In 1991 over 1.7 billion commercial and government ACH transactions with a value of over $6.9 trillion was sent over the ACH network.

NACHA is pleased that the Health Care Financing Administration (HCFA) is encouraging the use of electronic funds transfer for reimbursing Medicaid providers and supports your efforts. Using the ACH for this purpose would be a natural fit. As you indicated in your report, effective April 3, 1992 the NACHA Operating Rules were amended to permit the use of the ANSI ASC X12.85 (Healthcare Claims Payment Order) transaction set to the table of permissible ANSI transactions be used in the CCD+ and CTX transactions. In addition, NACHA's Board of Directors are currently reviewing a proposed rule amendment that would increase the number of addenda records accompanying a CTX from 4,990 to 9,999. One of the reasons this proposed rule change was set in motion was due to a request from the health care industry.

I believe that several issues need to addressed prior to using the ACH to reimburse Medicaid providers. Some of the issues identified include:

Compliance with standards. As mentioned above, the ANSI ASC X12.85 transaction set has been approved for use with CCD+ and CTX. Compliance with these standards are extremely important in ensuring the integrity of the payment system.

Payment remittance information. The ACH network is a payments system that permits payment related information to accompany the payment. The NACHA Operating Rules were recently amended to permit zero dollar corporate payments over the ACH so long as the entry carries an addenda which contains remittance information. If a format other than the ANSI ASC X12.85 is being considered for

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use HCFA would need to receive approval of the proposed format by the NACHA Board of Directors. .At a minimum, proposals for rule changes must be received by NACHA at least one year prior to implementation.

Awareness. The financial industry should be made aware of HCFA's plans to use the ACH for Medicaid payments. NACHA and its regional ACH associations publish newsletters and sponsor workshops that may be avenues for HCFA to keep financial institutions apprised. Support by the financial industry could assist HCFA in getting additional states to adopt electronic funds transfer for Medicaid payments.

NACHA would be more than happy to sit down with you or your staff to discuss HCFA's plans for using the ACH for Medicaid payments. In addition, we would welcome your input to our Bankers EDI Council meeting. The Bankers EDI Council was formed by NACHA to address the needs of the financial community as it relates to financial EDI. If you are interested in interacting with this group, please let me know. If you have any questions or need more information please do not hesitate to contact me. I may reached at 703/742-9190.

Sincerely,

Linda O'Hara
Director of Rules & Operations

APPENDIX B

NOTES

1. National Automated Clearing House Association, ACH: The Electronic Solution, no date.

2. See Health Care Financing Administration, Report to Congress on Electronic Media Claims (RC-90-028), October 23, 1990, p. 3. Until 1986, when Congress imposed a 14-day minimum delay before payment, providers using electronic billing were paid substantially faster. Recently, HCFA has helped develop a standard electronic physician claim form, which providers can use to bill private insurance companies and Medicaid as well as Medicare.

3. Health Care Financing Administration, State Medicaid Manual, Section 11205.

4. "Medicare Program: Revised Procedures for Paying Claims from Providers of Services," 56 Federal Register 31666 (July 11, 1991).

5. The announcement of the EFT proposal in the Federal Register did not estimate the number of providers who were expected to request EFT or the total anticipated savings. Under the proposal, HCFA would also allow payments to be made by wire transfer--a process similar to EFT. However, because wire transfers are more expensive than EFT, providers would have to pay the costs associated with that service.

6. The appropriate Medicaid agency official in West Virginia was unable to participate because of illness. The District of Columbia also participated in the survey and is hereafter referred to as a State.

7. In Arizona, EFT is available only to nine large health plans; in Nebraska, only to State-operated institutions and agencies; in New Jersey, only to hospitals; in Pennsylvania, only to pre-paid health plans; and in Texas, only to providers under contract. In Georgia, EFT was started as a pilot program for hospitals and nursing homes only, but it will soon be available to all provider types. Only Florida and North Carolina currently make EFT available to all provider types.

8. All but 16 respondents mentioned at least one advantage. It should be noted that respondents were not asked to identify advantages and disadvantages of EFT in general, but rather of real-time EFT in particular. Real-time EFT would transfer money to providers immediately after they dispensed services. The advantages of real-time and non-real-time EFT are generally the same. But real-time EFT carries some disadvantages that need not pertain to non-real-time EFT. Because real-time EFT will not likely be an option for

Medicaid programs, these additional disadvantages are not discussed in this report.

9. Twenty-five respondents mentioned provider relations; 13 mentioned reduced administrative costs.

10. This estimate was set about three years ago and has not been adjusted for inflation. The costs represent staff salary and benefits for the time necessary to cancel one check and manually produce another. The State is not assessed charges by the bank for canceling checks.

11. 56 Federal Register 31667.

12. For a discussion of other computerized claims-processing functions, see Office of Inspector General, Point-of-Service Claims Management Systems for Medicaid, OEI-01-91-00820.

13. In Utah, the printing and paper cost of each check is only 1.2 cents. In Oregon, the cost is only 0.75 cents.

14. Twenty-nine States can send RAs on computer tape, and 7 States can send them on computer diskette.

15. Telephone conversation with Karen Lyter, National Automated Clearing House Association, September 12, 1991.

16. Health Care Financing Administration, Report to Congress, p. 2.