Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

POINT-OF-SERVICE CLAIMS
MANAGEMENT SYSTEMS FOR MEDICAID

Richard P. Kusserow
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this study is to examine the potential of point-of-service claims management systems for State Medicaid programs.

BACKGROUND

Point-of-service (POS) claims management systems use computers and telecommunications networks to perform one or more of four related but distinct claims management functions:
- (1) eligibility verification,
- (2) claims submission,
- (3) claims adjudication, and
- (4) utilization review.

POS systems allow all of these functions to be performed in real time--that is, in a matter of seconds--while or before services are dispensed. Theoretically, any type of provider can access POS systems. But most existing systems, which are in the private sector, manage only prescription drug claims.

The HCFA has the authority to provide Federal funding for POS systems if they are enhancements to the States' MMIS. Furthermore, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires the Secretary of Health and Human Services (HHS) to encourage each State Medicaid program to implement POS systems for managing prescription drug claims. The act provides 90 percent Federal Financial Participation (FFP) for the development of these systems and authorizes the Secretary to waive certain paperwork requirements.

Information for this study was gathered through surveys of State Medicaid agencies; discussions with HCFA, trade and professional organizations, and private companies involved in Medicaid and private-sector claims processing; a review of materials prepared by States; and a review of business literature and government studies.

FINDINGS

POS systems have saved money and enhanced program administration in the only two States using them.

- ▶ New York's POS system is saving millions of dollars a year by performing eligibility verification and utilization review.

- ▶ Massachusetts uses its POS system for eligibility verification only. It is also saving millions of dollars annually.

Few States plan to acquire POS systems.

► Several States have had preliminary discussions about developing POS systems, but few have made commitments.

► Eight months after the passage of OBRA 90, only one State had definite plans to implement a POS drug claims management system that incorporates all four POS system functions.

Several barriers have limited States' implementation of POS systems.

► States lack the money required to adopt new systems and do not have sufficient staff to research them. States fear they will miss the OBRA 90 deadline for enhanced Federal funding.

► Combining POS technology with existing claims-processing systems may be difficult.

► State Medicaid officials fear that POS systems would have several negative effects on States and their citizens.

► States and private payers do not use uniform electronic claims formats. This complicates the implementation of POS systems and adds to their cost.

Many States have received inadequate or confusing information about POS systems.

► Key Medicaid systems staff in 19 States did not receive information about POS technology from HCFA.

► Private telecommunications and drug claims-processing companies have been active in promoting POS technology, but they lack experience in Medicaid environments.

► The HCFA has issued unclear policy statements regarding specific requirements for procuring POS systems.

RECOMMENDATIONS

The HCFA should collect information on POS technology and regularly distribute it to States. The HCFA should illustrate alternative methods of using POS technology, offer strategies for procuring cost-effective systems, and facilitate communication between States planning to procure or already using POS systems.

The HCFA should clarify the operational requirements for enhanced Federal funding of POS systems.

The HCFA should promote the development of standard electronic claims formats and their use by State Medicaid agencies. The HCFA, State Medicaid Directors' Association (SMDA), American National Standards Institute (ANSI), and National Council for Prescription Drug Programs (NCPDP) should work together toward these goals.

State Medicaid agencies that develop POS claims processing systems should ensure that they are compatible with standard electronic claims formats as the formats become available.

COMMENTS

We received formal comments on our draft report from HCFA, SMDA, ANSI, NCPDP, and the Assistant Secretary for Planning and Evaluation (ASPE). These comments, and our responses to them, are reproduced in appendix E.

All of these organizations expressed support for our recommendations relating to the development and use of standard claim formats. The HCFA and ASPE disagreed with our original recommendation that HCFA produce and distribute to States a guide to POS systems. Both stated that such an effort was premature. Our revised recommendation better reflects our belief that HCFA should play a continual leadership role in informing States about advances in POS technology. The HCFA also stated that it had satisfied our original recommendations for HCFA to clarify its policies on enhanced Federal Financial Participation for POS systems. We agreed that recent HCFA guidelines make sufficiently clear that funding will continue beyond the OBRA 90 deadline, but we still contend that the operational requirements require additional clarification.

We also received informal comments from several organizations interested in the subject of POS systems for the Medicaid program. Where appropriate, we have incorporated their suggestions into the report.

EPILOGUE

Since our draft report was written in December 1991, there have been several important developments. The NCPDP released a new standard drug claim format that is intended to accommodate Medicaid claims. Work progressed on POS systems in Alabama, Arkansas, and Missouri. California's request for bids on its MMIS contract included specifications for POS claims processing, and other States are expected to follow suit. All major MMIS suppliers are now developing POS technology, meaning that POS systems will likely find increasing use in the Medicaid program.

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INTRODUCTION

PURPOSE

The purpose of this study is to examine the potential of point-of-service claims management systems for State Medicaid programs.

BACKGROUND

Automated Medicaid claims processing has long been a goal of the Health Care Financing Administration (HCFA). Through its technical and financial support of Medicaid Management Information Systems (MMIS) and electronic claims submission, HCFA has helped States reduce their claims-processing costs and increase their ability to detect improper expenditures.

A relatively new claims-processing method, known variously as point-of-service (POS), point-of-sale, on-line, or real-time claims management, is now available. *Point-of-service* and *point-of-sale*, both abbreviated as POS, refer to the site of claims processing. Claims are processed while recipients are in providers' stores or offices. *On-line* refers to the connection, usually through telephone lines, between providers and claims processors during the transactions. *Real-time* simply means instant--claims are processed in a matter of seconds rather than days or weeks after submission. Real-time also implies interactive communication between providers and processors. This new technology is intended to improve the speed and power of claims-processing systems while lowering their costs.[1] A discussion of the potential benefits to Medicaid programs of POS systems is presented in appendix A.

POS claims management systems use computers and telecommunications networks to perform one or more of four related but distinct claims management functions: (1) eligibility verification, (2) claims submission, (3) claims adjudication,[2] and (4) utilization review. Theoretically, any type of provider can access POS systems. But most existing systems, which are in the private sector, manage only prescription drug claims.

The HCFA has the authority to provide Federal funding for POS systems if they are enhancements to the States' MMIS. Furthermore, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires the Secretary of Health and Human Services (HHS) to encourage each State Medicaid program to implement POS systems for managing prescription drug claims.[3] The act provides 90 percent Federal Financial Participation (FFP) for the development of these systems and authorizes the Secretary to waive certain paperwork requirements.

METHODOLOGY

The data presented in this report were gathered through the following methods:

> (1) telephone interviews with Medicaid claims management staff in 50 States;
>
> (2) a mail survey to which 45 State Medicaid agencies responded;
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> (3) telephone interviews with HCFA systems staff in each of the 10 regional offices;
>
> (4) informal discussions with staff from HCFA's Medicaid Bureau;
>
> (5) telephone interviews with representatives from 14 private companies involved in Medicaid and private-sector drug claims processing;
>
> (6) telephone interviews with 7 trade or professional organizations representing pharmacists and other providers;
>
> (7) a review of advance planning documents and other materials concerning POS systems prepared by 8 States;
>
> (8) a review of data collected in surveys conducted by HCFA and the American Public Welfare Association; and
>
> (9) a review of professional and government literature.

We present details on each of these methods in appendix B.

We conducted our research from March through November 1991. Our interviews with States, which contributed the bulk of our data, were completed in June 1991. Where feasible, we have supplemented this final version of our report with more current information.

FINDINGS

POS SYSTEMS HAVE SAVED MONEY AND ENHANCED PROGRAM ADMINISTRATION IN THE ONLY TWO STATES USING THEM.

As we explain in appendix A, POS systems could perform a multitude of claims management functions and produce a number of benefits for the Medicaid program. They could reduce program and administrative expenditures, improve provider relations, offer better program utilization information, and help integrate multiple benefit programs. Unfortunately, their current use by State Medicaid programs is so limited that predictions of their overall value would be highly speculative. Rather than confuse theoretical benefits with actual experience, we focus here on their demonstrated effectiveness in Medicaid environments.

New York's POS system is saving millions of dollars a year by performing eligibility verification and utilization review.

New York's Electronic Medicaid Eligibility Verification System (EMEVS) has been in place since November 1986. All providers, including pharmacists, physicians, hospitals, and clinics, can access the system 24 hours a day through POS terminals or standard telephones. The terminals accept information from providers, call the EMEVS contractor's computers automatically, and respond with visual messages that can be sent to a small printer. Providers without POS terminals use an automated voice response (AVR) system, which prompts them to input information on a touch-tone telephone and responds with audible messages. Human operators are used if the other two systems are not functioning. In addition to eligibility status, EMEVS gives providers information on service restrictions and third-party coverage. The HCFA considered EMEVS to be an enhancement to New York's MMIS, and awarded the State enhanced FFP: 90 percent of development costs and 75 percent of operational costs.

The high start-up and operating costs of EMEVS were justified by its ability to produce even higher savings for the Medicaid program. At least initially, most of the savings resulted from the State's conversion from month-specific to day-specific eligibility. Before EMEVS, New York's only method of terminating eligibility was to stop mailing Medicaid ID cards. If a recipient were terminated from the program on the day after a card was mailed to him, he could receive a full month of benefits that he was not entitled to. Now, however, the State can terminate a recipient's benefits instantly at any point during the month. EMEVS enforces the termination: each time a recipient requests medical services, the provider uses EMEVS to determine whether he is still eligible. The State has calculated that the gross savings from day-specific eligibility are over $10 million per year.[4]

The State has estimated savings from EMEVS in two additional areas. When EMEVS was introduced, New York ceased mailing paper ID cards to recipients every month and began issuing durable plastic ID cards. The annual savings on postage from using plastic ID cards is estimated at $4.5 million.[5] New York has just started to use EMEVS to enforce service restrictions and thresholds. If its initial estimates are correct, the savings from this function will be much higher: perhaps $200 million per year.[6]

EMEVS also monitors and controls services ordered and dispensed by certain high-volume providers. The State may require physicians to "post" prescriptions or laboratory tests to the system as the services are ordered. Pharmacies and laboratories "clear"--i.e., delete--each order from the system as they fill the orders. EMEVS keeps records that allow the State to deny payment for services that were not posted and cleared. This function prevents laboratories from performing extra, unnecessary tests and prevents pharmacies from filling prescriptions that were never written or were written on stolen prescription pads.[7]

Massachusetts uses its POS system for eligibility verification only. It is also saving millions of dollars annually.

In Massachusetts, the Recipient Eligibility Verification System (REVS) has been operational since December 1988. Like New York, Massachusetts secured enhanced FFP from HCFA to develop and operate REVS. The system uses POS terminals, AVR, and human telephone operators to enforce day-specific eligibility. It also sends providers messages about potential third-party coverage, and service restrictions. All types of providers use this system.

Massachusetts estimates that day-specific eligibility saved $8.5 million in REVS's first full year of operation (February 1989-January 1990).[8] The State predicts higher annual savings in future years. It estimates that it saves $800,000 a year by using plastic rather than paper ID cards.[9]

As of October 1991, neither EMEVS nor REVS were performing claims submission, claims adjudication, or prospective drug utilization review (pro-DUR). New York had plans to add limited pro-DUR to EMEVS in November 1991 and full-scale pro-DUR with claims submission in June 1992. Massachusetts was considering expanding REVS to allow pharmacy claims submission and pro-DUR as well.

FEW STATES PLAN TO ACQUIRE POS SYSTEMS.

Several States have had preliminary discussions about developing POS systems, but few have made commitments.

In the summer of 1991, there was a lot of discussion at the State level about improving eligibility policies and eligibility verification systems. Twenty-five States had definite plans for improvement, 19 had discussed it without making definite plans, and only 6

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had no plans at all. Nevertheless, only 10 States had definite plans to develop POS eligibility verification systems.[10] These plans are summarized in table 1. Several other States were making improvements on a more limited scale.[11]

TABLE 1:

STATES WITH <u>DEFINITE PLANS</u> TO IMPLEMENT POS SYSTEMS

State	Eligibility Verification	Claims Submission	Claims Adjudication
Alabama	Multiple provider types; MSE	Multiple provider types	No
Arkansas	Multiple provider types; DSE	Multiple provider types	Pharmacy only
California	Multiple provider types; DSE	No	No
Idaho	Pharmacy only; MSE	No	No
Iowa	No	Pharmacy only	No
Illinois	Pharmacy only; MSE	Pharmacy only	Pharmacy only
Maine	Add AVR only; DSE	Already partially implemented	Multiple provider types
Massachusetts	Already implemented	Pharmacy only	No
Minnesota	Multiple provider types; MSE	No	No
Missouri	Pharmacy only; DSE	Pharmacy only	Pharmacy only
New York	Already implemented	Pharmacy only	No
North Carolina	Multiple provider types; DSE	No	No
Rhode Island	Pharmacy and hospital only; DSE	Pharmacy and hospital only	Pharmacy and hospital only
Texas	Pharmacy only; MSE	Pharmacy only	Pharmacy only

DSE = Day-specific Eligibility; MSE = Month-specific Eligibility; AVR = Automated Voice Response
Source: OIG survey of 50 State Medicaid agencies, June 1991.

Like eligibility verification, electronic claims submission was the subject of much discussion and planning at the State level. Twenty-five States had definite plans to improve their claims submission capabilities, 18 had discussed it without making definite plans, and 7 had no plans to change. Again, however, few States were designing POS systems (table 1).[12]

Only 6 States had definite plans to perform POS claims adjudication (table 1). Another 29 States had discussed POS claims adjudication without making definite plans, while 15 States had no intention to change.

It is more difficult to determine States' plans regarding utilization review, because we asked States only about their plans for utilization review other than drug utilization review.[13] Arkansas and New York planned to impose service limitations using POS systems. Massachusetts will use REVS to transmit the names of primary physicians for recipients enrolled in its managed care program. Kansas, Montana, and New York were investigating ways for providers, when necessary, to obtain prior authorization electronically. The American Public Welfare Association reports that in April 1991, 15 States had POS pro-DUR "under consideration or under development."[14]

Eight months after the passage of OBRA 90, only one State had definite plans to implement a POS drug claims management system that incorporates all four POS system functions.

Congress's vision in OBRA 90 was that many if not all States would procure comprehensive pharmacy claims management systems to perform eligibility verification, claims submission, claims adjudication, and pro-DUR in real time.[15] As of June 1991, only Missouri had announced definite plans to procure that kind of system. Arkansas and Illinois had plans for systems that would perform the first three functions, but not pro-DUR. (A summary of their plans is presented in appendix C, along with a summary of the New York and Massachusetts systems.) Nearly half the States reported that they were considering fully functional POS systems, but few had gone beyond the discussion stage.[16] Iowa had for some time been contemplating such a system, but had not reached the same level of commitment. Rhode Island planned to add POS capabilities, but as part of a total MMIS procurement. Texas had similar plans for its next MMIS. Oregon took its first steps toward developing a comprehensive system by issuing a request for information in April 1991.

SEVERAL BARRIERS HAVE LIMITED STATES' IMPLEMENTATION OF POS SYSTEMS.

States lack the money required to adopt new systems and do not have sufficient staff to research them. States fear they will miss the OBRA 90 deadline for enhanced Federal funding.

Procuring a POS system requires millions of dollars and years of work. Massachusetts's REVS took over a year and $2.5 million to develop and costs $3.5 million a year to operate.[17] New York's EMEVS took about two years and $3.5 million to develop, and costs approximately $6 million a year to operate.[18] When we asked States to assign importance ratings to 12 potential barriers to comprehensive POS system implementation, their number one response was "our state doesn't have the money necessary to procure a comprehensive real-time system, no matter how much it might save in the future." Their number two response was "our staff doesn't have the time to assess, procure, and implement a real-time system." (Table 2 displays the mean ratings for each barrier.) Several respondents noted that even if HCFA provided 90 percent of the funds for development and 75 percent of the funds for operations, their States still could not come up with the rest of the money.

TABLE 2:

STATE RANKINGS OF IMPORTANCE OF VARIOUS FACTORS PREVENTING THEM FROM ADOPTING COMPREHENSIVE POS SYSTEMS

SCALE: 1 = "Not at all a factor;" 5 = "An extremely important factor"

FACTOR	MEAN RATING	NUMBER OF 5'S
Our State doesn't have the money necessary to procure a comprehensive real-time system, no matter how much it might save in the future.	3.55	18
Our staff doesn't have the time to assess, procure, and implement a real-time system.	3.49	15
We are not convinced that real-time systems will save money.	3.14	9
We may go to real time, but we want to wait until the current fiscal agent contract expires to make the process easier.*	2.94	10
We haven't gotten enough guidance from HCFA about why we should implement real-time systems and what the Federal matching rate would be.**	2.92	10
Our current MMIS would not be compatible with a real-time system.	2.86	11
Our staff doesn't have the technical expertise to assess, procure, and implement a real-time system.	2.55	4
Our current fiscal agent contract makes it difficult to add real-time capabilities.*	2.47	5
Our current computer systems are not sophisticated enough for us to benefit from real-time capability.	2.47	8
Current State laws or regulations prohibit us from implementing some or all of the functions that real-time systems would perform.	1.45	2
Real-time systems would hurt our relationship with recipients.	1.45	1
Real-time systems would hurt our relationship with providers.	1.43	2

SOURCE: OIG survey of 50 State Medicaid agencies, June 1991. [N=49 respondents, except as noted.]

* The 15 States without fiscal agents did not respond to these questions.

** All 50 States responded to this question.

Respondents from Arkansas and New York, who have recent experience in planning and implementing POS systems, acknowledge that it is a costly and difficult process. An official from Arkansas told us, "This has been lots and lots of work. It is tremendously time consuming to plan for these changes. . . . It has taken us one and a half years to do this." In New York, EMEVS was developed at a time when staff and money were readily available. Medicaid staff there doubted that many States would face similar surpluses today.

OBRA 90 may have inadvertently compounded the problem. As an incentive for States to adopt POS pharmacy claims management systems quickly, it specified that enhanced FFP would be granted for the systems in FY 1991 and 1992 only. Several States complained, both to us and to HCFA directly, that this time limit would prevent them from developing POS systems rather than encourage them. In fact, however, enhanced FFP for POS systems will be available beyond fiscal year 1992.[19]

Combining POS technology with existing claims-processing systems may be difficult.

Existing Medicaid Management Information Systems (MMIS) are designed to process claims in large batches, not in real time. Changing them to accommodate real-time, POS processing will be expensive and may be difficult because current MMIS operators, whether they are State agencies or fiscal agents under contract, have little or no experience with POS technology. This fact might lead States to work with separate, specialized contractors in developing POS systems, as New York and Massachusetts did. By retaining separate contractors, States would also benefit from competitive bidding--a process that should result in the lowest possible cost for the States.

Hiring a separate POS system contractor could cause problems, however. Medicaid agencies would have to incur the burden and expense of preparing and conducting the contract bid.[20] Furthermore, HCFA's Medicaid Bureau Director has warned: "If States solicit for a separate drug processor it may be necessary to renegotiate the terms of the present fiscal agent (FA) contract, since a large volume and low-processing cost type of claim will be removed from the FA."[21] This would likely result in higher rates for processing the remaining claims.

Apparently, many States interested in POS technology plan to wait until their current fiscal agent contracts expire and then build POS requirements into their next MMIS contracts. Ten States said this was an extremely important factor in their decision not to develop POS systems (table 2). Alabama, Arkansas, and Missouri are already working with their fiscal agents to add POS technology. It may be that the States most likely to hire separate POS system contractors are those without fiscal agents. Illinois is an early example of a State in this position.

State Medicaid officials fear that POS systems would have several negative effects on States and their citizens.

Many respondents noted a potential for POS systems, with their heavy reliance on computers and telecommunications, to create quality control problems. Their concern is well founded. Any such system is vulnerable to natural disasters and industrial accidents.[22]

In addition to asking Medicaid officials about barriers to implementing comprehensive POS systems, we solicited advantages and disadvantages of having POS systems perform each of the four claims management functions. Along with many advantages, which mirrored the benefits of POS systems described in appendix A, we heard a diverse set of disadvantages. Foremost among them, consistent with the discussion above, were the drain on States' funds and staff time. There were several others, however, which help explain why there has been such reluctance to adopt POS technology.

▶ *Eligibility verification*

Although proponents believe that POS systems would be popular with providers, some States feel that asking providers to use a POS system each time they see a Medicaid recipient would be an added burden. Currently, providers in most States can verify eligibility simply by looking at an ID card; they need not make a telephone call as well. Furthermore, providers in fourteen States can already use AVR systems if they doubt the validity of an ID card or if a patient forgets to bring his or her card.

The costs of POS systems in New York, Massachusetts, and Arkansas have been justified by the savings created by conversion to day-specific eligibility. However, several respondents disagreed that day-specific eligibility was desirable. Some worried that by terminating eligibility sooner they would deny medical care to those in need. Others feared that although the care would still be provided at no cost to the patient, the costs would be born wholly by the State or its medical community rather than shared with the Federal Government. A few respondents thought their States' master eligibility files could not be updated fast enough to take advantage of day-specific eligibility, and some thought that certain categories of recipients were guaranteed full-month Medicaid eligibility by other entitlement programs.[23]

Reports from Massachusetts suggest that POS eligibility verification systems can cause problems for recipients.[24] Apparently, recipients there are now less sure whether they are eligible for Medicaid at any given time, because there is no expiration date on their plastic ID cards. Some recipients do not find out they are ineligible until they try to obtain services. Also, REVS can make mistakes, and these mistakes are reportedly difficult to correct. Providers are apparently reluctant to call human operators to verify that recipients identified as ineligible are indeed so. Finally, replacing a plastic REVS card can take weeks or months. In the meantime, recipients must travel to local welfare offices every ten days to receive a temporary paper replacement card.

► *Claims submission*

Many respondents were happy with their current claims submission capacities and did not believe that POS submission would be a major improvement. States not contemplating changes in submission capabilities already have higher rates for electronic submission than states planning or discussing changes.[25] Nine respondents felt that real-time submission offers no advantages over batched electronic submission.

Medicaid officials in three States thought that real-time submission would be an undesirable burden on providers. This burden might fall most heavily on providers of long-term care, who submit dozens if not hundreds of claims on a regular basis. Because their claims are generally simple updates of prior claims, batch submission clearly makes more sense for them than individual, real-time submission. The American Society of Consultant Pharmacists, whose members provide pharmacy services to nursing homes, strongly opposes any requirements for real-time submission and adjudication.

One of the expected advantages of POS claims submission is lower denial rates. But pharmacy claims, which will probably be the first type of claims submitted on-line to Medicaid programs, are already denied less frequently than most other types of claims.[26]

► *Claims adjudication*

Three respondents mentioned an interesting potential problem with POS claims adjudication. Providers would have the opportunity to submit a claim before dispensing services. If the claim were adjudicated instantly and the provider felt that the reimbursement calculated was inadequate, he or she could decide not to provide services. One respondent told us that such a decision would be against the law, even if no reimbursement were claimed.

Several respondents also thought that real-time adjudication would weaken States' cash flow. This fear may be unfounded, because faster adjudication need not lead to faster payment. Even those States with real-time adjudication could maintain their current payment schedules.

Respondents were particularly adamant that POS claims adjudication would be too costly. Most Medicaid claims processing is now performed in the evenings and on weekends, when the demand for State computer time is low. States believe that processing claims during normal business hours would be far too expensive. They are also very concerned about the costs of keeping telephone lines between providers and the State or fiscal agent open during what could be a lengthy adjudication process.

► *Utilization review*

Respondents' concerns about POS utilization review fell along the same lines as concerns about the other functions. Respondents felt that their current methods are adequate, and they worried about increased burdens on providers, increased attempts at fraud, and negative effects on recipients. Several stressed that establishing, for other health care services, the kind of prospective utilization review now available for pharmacy would be prohibitively complicated.

States and private payers do not use uniform electronic claims formats. This complicates the implementation of POS systems and adds to their cost.

POS claims management systems cannot function unless all parties involved--providers, hardware and software developers, telecommunications networks, and bill processors--agree on what information the systems will handle and how it will be organized.[27] Standard formats allow providers to use identical claim forms for all bill processors and to communicate with them by using the equipment and telecommunications networks of their choice. Administrative costs are increased in the absence of standards because each provider-processor pair must "reinvent the wheel." Currently, there is no single electronic format for any type of claim that is acceptable by all State Medicaid agencies.

The National Council for Prescription Drug Programs (NCPDP), a nonprofit agency, has traditionally been looked to by the pharmacy claims-processing industry for standards. Their Universal (paper) Claim Form (UCF) and comparable electronic format (known as "Version 1") are accepted and used by practically every pharmacy, claims processor, and drug benefit administrator in the country, with the exception of government programs like Medicaid. However, UCF and Version 1 were designed before the advent of pro-DUR and other advances in pharmacy claims processing, and they are now obsolete. In February 1991, NCPDP adopted a new electronic format: Version 3.1. This version was strongly opposed by industry components, particularly software developers, because it allowed processors to design their own unique data element needs rather than agree on a common set.

After a year-long controversy, NCPDP replaced Version 3.1 with Version 3.2. This format still allows processors to specify their own data elements, but recommends three fixed sets of data elements; one for standard insurance sector claims, one for worker's compensation claims, and one for Medicaid claims. As of March 1992, this version had won support from the American Society for Automation in Pharmacy, which had led the opposition to Version 3.1. Finally, it appeared that the recommended Medicaid data set would be used by the POS systems being installed in Arkansas and Alabama.

The insurance industry's attempt to establish formats for other types of claims are further along, perhaps because the recent formation of a government agency has been widely used

physician claim form--the HCFA 1500--did not have a standard electronic format until July 1991.[28] A committee of the American National Standards Institute (ANSI) is planning to develop several standards for use in health care claims processing, but as of June 1991 none of their formats had progressed beyond draft status, and none had been tested widely.[29] The "837 Health Claim" standard should be available to the public in October 1992. This standard, which is compatible with physician, hospital, and even pharmacy claims, is designed for batch processing systems. But an ANSI workgroup is investigating ways to make it useable by POS systems.

MANY STATES HAVE RECEIVED INADEQUATE OR CONFUSING INFORMATION ABOUT POS SYSTEMS.

Key Medicaid systems staff in 19 States did not receive information about POS technology from HCFA.

According to HCFA, HCFA regional office staff had informed most if not all States about POS systems by mid-April 1991. Nevertheless, respondents from 19 States reported in May or June 1991 that they had not received information about POS systems from either HCFA headquarters in Baltimore or their local HCFA regional office. It is possible that other Medicaid officials in those States had received the information from HCFA without informing our respondents. Even if this is the case, we find it significant that our respondents--all senior claims systems staff--were unaware of the information. Another explanation of our survey results is that HCFA's information was not useful enough to have been recalled by our respondents. The information that HCFA did provide in most cases consisted of brief letters notifying the States of OBRA 90's POS sections and offering HCFA's initial interpretation of the statute's requirement. It does not appear that HCFA made a concerted effort to explain why States might or might not want to acquire POS systems.

That HCFA did not rush to promote POS systems to States is understandable. Certainly, HCFA's top priority in implementing OBRA 90 concerned the drug rebate rather than the claims-processing provisions. Also, some regional offices apparently saw their proper role as evaluators of proposals brought to them by States, rather than as proponents of any particular technology. Finally, HCFA managers knew that private vendors were already selling POS eligibility verification systems to providers in several States. The costs of these systems were borne entirely by providers, and it was suggested to us that HCFA saw no reason to replace these systems using Federal money.

Lack of guidance from HCFA about POS systems may have kept some States from moving to acquire them. Overall, it was the fifth most important factor restraining States (table 2), and 10 States rated it an "extremely important factor." However, respondents in 31 States *did* receive information about POS systems from either HCFA headquarters, their HCFA regional office, or both. These respondents, not surprisingly, rated lack of guidance from HCFA as a less important factor than did their counterparts who had not received information from HCFA.[30] Regional offices

did not appear to be systematic about providing information. In no region did all respondents either receive or not receive information.

Private telecommunications and drug claims-processing companies have been active in promoting POS technology, but they lack experience in Medicaid environments.

By no means have States been deprived of information about POS systems. Private vendors of POS technology have been more active than any other group in supplying it. Thirty-four States had received information from one or more vendors. In fact, it may have been the vendors who were most responsible for the electronic claims management provisions of OBRA 90 to begin with. They had developed POS technology in anticipation of the Medicare drug benefit and accompanying POS system development. When the drug benefit was repealed along with the bulk of the Catastrophic Coverage Act, the vendors started looking for new markets for their technology. Medicaid programs were a natural target. Congress, in fact, relied on data supplied by two vendors to estimate the cost-benefit of Medicaid POS systems.[31]

The problem with relying entirely on private vendors to supply information about POS systems is that their experience in the private sector is, in many ways, very different from what they would face in operating Medicaid systems:

- Private vendors' claims-processing rates cannot be compared to Medicaid claims-processing rates. Many private vendors process only drug claims, whereas Medicaid programs process far more complicated claims as well.

- Private vendors were able to claim large savings for their clients largely because their clients were previously using only paper claims. Medicaid programs, by accepting a large volume of electronic claims, have already realized much of those savings.

- Private vendors now process a much smaller claim volume than Medicaid programs. For example, PCS, Inc., the oldest and largest drug claim processor, handles 100 million drug claims a year nationwide. In contrast, the annual combined volume of drug claims in the New York, California, and Illinois Medicaid programs alone is over 77 million. One cannot assume that vendors could absorb such an increase in volume with ease.

- Private-sector claims may be easier to process than Medicaid claims, even when only pharmacy claims are considered. Incoming claims of both types must be compared to historical data to check for duplication and other problems. Private-sector processors generally use 3 to 13 months' worth of data for this procedure. State Medicaid programs, on the other hand, use between 8 and 96 months of history, with an average of 24 months. Another factor making Medicaid claims more complex than private sector claims is third-party coverage identification and billing (see appendix A).

The HCFA has issued unclear policy statements regarding specific requirements for procuring POS systems.

For a year after the passage of OBRA 90 it was difficult to determine exactly how HCFA would respond to State requests for enhanced FFP. The HCFA did not issue any final rules or guidelines regarding POS systems until January 1992. In the interim, HCFA's draft policies and informal comments raised questions about which functions POS systems had to perform in order to qualify for enhanced FFP, and whether States had to procure POS systems by competitive bid. With regard to the functional specifications, HCFA's policy remains unclear.

► *Operational requirements*

OBRA 90 made specific reference to "electronic claims management" (ECM) systems, and declared them eligible for enhanced FFP. The enhanced funding, however, was to be provided under the same section of Title XIX as other MMIS enhancements.[32] Operational requirements for funding under that section are written by HCFA and published in the State Medicaid Manual (SMM). Therefore, in specifying what types of POS systems would be eligible for enhanced FFP, HCFA had to reconcile Congress's directive regarding ECM systems for drug claims with its own rules for POS systems in general. Early attempts led to confusion. They included a memorandum in March 1991 and draft additions to the SMM released in April and October 1991:

- *March 1991.* A memo on the subject of Electronic Claims Management (ECM) systems dated March 15, 1991, from the Medicaid Bureau Director to all HCFA Regional Administrators, provided background information on the OBRA 90 legislation and included the following passage:

  The functional requirements listed below must be contained in the State's ECM system in order for [a Request For Proposals or Advanced Planning Document] for the development of an ECM system for drug claims to be approved at the enhanced matching rate of 90 percent. The system *must perform all of the following functions* on line using real-time processing: eligibility verifications, . . . claims data capture . . . and claims adjudication. [emphasis added]

- *April 1991.* A draft SMM addition stated that POS systems that performed eligibility verification alone would be eligible for enhanced FFP. Also eligible would be POS systems that performed eligibility verification and claims submission. The draft, however, specified that ECM systems for drug claims were subject to an entirely different set of rules.

- *October 1991.* The next draft SMM addition included rules for ECM systems. It stated that "OBRA 90 contemplated the use of ECM for adjudicating outpatient drug claims. In fact, you may use an ECM system for adjudicating any or all claims on-line, and in a real time environment." It restricted

enhanced FFP for ECM systems to those that perform all three functions--eligibility verification, claims submission, *and* claims adjudication.

- *January 1992.* The final version of the SMM addition contained two changes from the October 1991 draft with respect to ECM. First, it struck the sentence stating that States "may use an ECM system for adjudicating any or all claims on-line, and in a real time environment." Second, it added language specifying that "an ECM system is limited to processing covered outpatient drugs . . . ." The SMM still does not specifically state whether enhanced FFP is available for POS systems which handle all types of claims, including drug claims, but which do not perform real-time adjudication. Nor does it state whether enhanced FFP is available for POS systems that perform all functions for all types of claims.

It is difficult to reconcile the requirements. For systems that do *not* process drug claims, the rules are clear. To qualify for enhanced FFP, the systems must perform eligibility verification, or eligibility verification *and* claims submission, or eligibility verification *and* claims submission *and* claims adjudication. But OBRA 90 and the March memo indicated that drug claims processing systems had to perform all three functions. What functions must be performed by systems that process drug claims and other claims is unclear.

Another problem for the States relating to POS system functions involves prospective drug utilization review. In addition to providing enhanced FFP for POS systems, OBRA 90 provides funding (at an unspecified level) for up to 10 demonstration projects.[33] The projects would determine the cost-effectiveness of adding pro-DUR capabilities to POS systems. Some States are already convinced that POS systems are not worth having unless pro-DUR is included. These States have chosen to put their POS system development plans on hold, because demonstration project money and POS system money are awarded by two separate HCFA offices. The solicitation for demonstration project applications will not be issued until the spring of 1992. Although States are required to have some form of pro-DUR by January 1993, the Secretary's report to Congress on the results of the demonstration project is not due until January 1994.

▶ *Competitive bidding*

The HCFA's requirements for competition were also unclear for several months after the passage of OBRA 90. The law allows enhanced FFP for drug claim ECM systems "if the State acquires [its system] through [the] applicable competitive procurement process." This was reinforced in a memorandum of understanding between staff of the Senate Special Committee on Aging and the Medicaid Bureau: "The requirement for competitive procurement is specifically intended to preclude States from simply amending existing contracts in the absence of an open, competitive process."[34] The HCFA, however, has for years allowed enhanced FFP for MMIS enhancements, even when they are procured through fiscal agent contract amendments rather than

competitive bid. A few States (Arkansas and Missouri, for example) have already agreed with their fiscal agents on plans for POS system implementation and have secured enhanced funding from their regional offices.

HCFA's interpretation of the OBRA 90 provisions and the Senate Aging Committee's instructions were in flux during the summer of 1991. At a July conference on MMIS developments, an official from HCFA headquarters stated that OBRA 90 required competitive procurement under most if not all circumstances. In the discussion that followed, it became clear that some regional office staff disagreed with his interpretation. In a September letter to HCFA, the chairman of the Aging Committee reversed the Committee's position on the meaning of the competitive requirement provision:

> I believe that it would be consistent with the intent of the legislation to permit a state to amend its current FI [fiscal intermediary] contract to allow the FI to develop and implement the system (in lieu of holding a separate competition for the ECM system) as long [as] state competitive procurement processes for any amendments or change orders are followed.[35]

Finally, on November 7, HCFA released a six-page memo to State Medicaid directors specifying the circumstances under which separate competitive procurement is and is not required. Competitive procurement is mandated for new telecommunications networks, POS devices for providers, and separate drug claims processors. Fiscal agent contract amendments are permitted, when cost justified, for other goods and services.

RECOMMENDATIONS

Their apparent success in New York, Massachusetts, and the private sector indicates that POS systems could be a valuable contribution to health care claims processing. States seeking to reduce administrative costs, having problems stemming from information or communication weaknesses, or needing to improve provider relations might well find solutions with POS systems. The HCFA, as a partial payer of Medicaid program and operating costs, would share in the benefits provided by these systems. Therefore, we recommend that HCFA take several steps to support and facilitate State efforts to investigate and procure POS systems. We also make a recommendation for States that do choose to procure POS systems.

The HCFA should collect information on POS technology and regularly distribute it to States. The HCFA should illustrate alternative methods of using POS technology, offer strategies for procuring cost-effective systems, and facilitate communication between States planning to procure or already using POS systems.

State Medicaid agencies are so focused on day-to-day operations that they have little time even to research POS technology, much less procure it. The HCFA could relieve States from having to conduct this research by doing much of it for them. An obvious way to start would be to request information from each potential vendor of POS systems or parts thereof. The HCFA should not, however, rely solely on information from private vendors because the vendors are naturally more concerned with their own interests than those of the States or of HCFA.

The information HCFA provides should go beyond the general discussion of costs and benefits contained in this report. States will need advice on system architecture options, desirable functional requirements such as response time and network redundancy, and cost containment strategies for requests for proposals. For example, HCFA could distribute copies of advance planning documents, requests for proposals, and contracts from States that have already procured POS systems.

States will also need advance notice of policy changes, technological breakthroughs and lessons learned in other States. To keep States informed, HCFA could emulate the Department of Treasury's Financial Management Service (FMS). The FMS uses newsletters and other publications to promote and publicize technological progress in electronic benefits transfer. The HCFA should also encourage State Medicaid staff to use its recently established electronic bulletin board to share their questions and experiences with counterparts in other States.

Disseminating such information would provide a major opportunity for HCFA to exert leadership in this important field at relatively little cost. We strongly urge that HCFA take advantage of this opportunity.

The HCFA should clarify the operational requirements for enhanced Federal funding of POS systems.

The various documents that have emanated from HCFA since October 1990 have produced confusion. The HCFA should move quickly to resolve it by explaining requirements and available levels of FFP for POS systems that manage drug claims and other claim types. One possible avenue for communicating this policy would be further revisions to the State Medicaid Manual. Another would be releasing a memorandum similar to the one released in November 1991 which clarified the requirements for competitive procurement.

The HCFA should promote the development of standard electronic claims formats and their use by State Medicaid agencies. The HCFA, State Medicaid Directors' Association, American National Standards Institute, and National Council for Prescription Drug Programs should work together toward these goals.

The advent of POS technology presents a great opportunity for HCFA to encourage uniformity in Medicaid claims. Without standard formats, providers and vendors who operate in multiple States will have higher costs than necessary, and these costs will be passed along to the Medicaid program. Furthermore, standard formats would yield uniform claims records, thus allowing the creation of a national Medicaid claims data base. This would greatly facilitate research on utilization of the Medicaid program as a whole.

The HCFA's first task must be to ensure that standard formats exist. For all claims other than pharmacy claims, HCFA should work with the American National Standards Institute (ANSI). This organization has already worked with HCFA in developing standards for Medicare claims and is universally recognized as an industry leader. Bringing the State Medicaid Directors' Association (SMDA) into the format development process would make acceptance of the formats by Medicaid agencies more likely. The ANSI 837 health care claims standard is scheduled for release in October 1992. Therefore, HCFA must act quickly to ensure that it can be used in a Medicaid environment. The HCFA should also work with ANSI in making this standard efficient for POS transactions.

Creating a standard for pharmacy claims has been an arduous process. The National Council for Prescription Drug Programs (NCPDP) seems to have won acceptance for its new standard, Version 3.2. This standard includes a recommended Medicaid drug claim format. The HCFA should work with SMDA, pharmacy and systems directors from each State, provider groups, and systems vendors to promote its use by all Medicaid agencies.

The HCFA could choose to promote the use of standard formats in several ways. It could simply publicize them and advocate their use, devise a set of rewards for POS systems that used them, or even deny enhanced funding for systems that did not use them. One option for HCFA would be to impose a deadline, perhaps six months to a

year in the future, after which State funding requests for POS systems that did not adhere to standard formats would not be approved. Because few States are poised to procure POS systems in the near future, such a deadline would achieve widespread if not total uniformity in POS claims submission formats. It would also, however, give the claims processing industry time to develop the needed standards and would not prevent States that are now procuring POS systems from moving forward.

State Medicaid agencies that develop POS claims processing systems should ensure that they are compatible with standard electronic claims formats as the formats become available.

The existence of standard claims formats is meaningless unless they are widely used. There will likely be ample incentive for States to ensure compatibility of any new POS claims submission systems with standard formats. These systems will probably be much cheaper to develop and operate than systems that require unique claims formats. Even if the cost differential in a particular State proves negligible, however, we believe that uniform formats across States would offer additional advantages as outlined above.

Requiring adherence to standard formats may delay the procurement of POS systems because standards for many types of claims are still under development. Nevertheless, the costs of a delay would most likely be outweighed in the long run by the benefits of standardization. States that are now in the process of procuring POS systems may not wish to wait. We urge these States at the very least to ensure that their systems can be easily modified to accept future standard formats.

COMMENTS ON THE DRAFT REPORT

From within the Department of Health and Human Services, we received comments on our draft report from the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE). We also received comments from the other organizations to which we direct recommendations: the State Medicaid Directors' Association (SMDA), the American National Standards Institute (ANSI), and the National Council for Prescription Drug Programs (NCPDP). We reproduce these comments and provide detailed responses to each in appendix E.

All organizations expressed support for recommendations relating to the development and promotion of standard claim formats. In fact, NCPDP suggested even stronger language. We have left these recommendations intact, but have modified the supporting text of the first to reflect recent advances in format development. We look forward to widespread use of standard formats by Medicaid agencies.

The HCFA and ASPE disagreed with our recommendation to produce a guide to POS systems and distribute it to States. The HCFA believed that this would constitute a "major effort to promote POS" systems and would be premature, given the lack of knowledge about POS systems' utility in Medicaid environment. Both suggested a delay so that the guide could incorporate additional information: HCFA referred to the POS/pro-DUR demonstration projects and ASPE referred to the Secretary's task force on electronic billing. We revised the recommendation to better reflect our intent: that HCFA act as a clearinghouse to provide States with the best and most current information on POS technology. We call for regular distribution of information. We note that both NCPDP and SMDA have offered to assist HCFA in this effort. Because several States are currently contemplating the procurement of POS systems, we do not think it appropriate to delay until the work of the task force and the demonstration projects are complete.

The HCFA disagreed with the recommendations to clarify enhanced Federal financial participation (FFP) guidelines for POS systems. The HCFA states that communications issued since our draft report was written address these recommendations. On one point, we agree with HCFA: it should now be clear that enhanced FFP for POS systems is available indefinitely. We have deleted our recommendation that HCFA publicize this fact. We still believe, however, that HCFA's operational requirements for POS systems are confusing and require clarification.

In addition to the organizations providing formal comments, several other organizations interested in the subject of POS systems for Medicaid provided informal comments, including the following:

- The American Pharmaceutical Association (APhA), American Society for Automation in Pharmacy, and Pharmaceutical Society of the State of New York

commented that New York's Electronic Medicaid Eligibility Verification System (EMEVS) is unpopular with pharmacists in that State because it is not compatible with existing pharmacy computer systems. We understand their concern and note that HCFA's State Medicaid Manual now requires such compatibility for all new POS systems.

- The APhA recommended that HCFA "work with States to develop consensus regarding appropriate methodology for evaluating savings" from POS systems. The APhA was particularly interested in savings resulting from pro-DUR. We note their recommendation in appendix D, "Explanation of Savings Estimates."

- The National Association of Chain Drug Stores suggested that the pro-DUR provisions of OBRA 90 should not be implemented as scheduled because the POS/pro-DUR demonstration projects have been delayed. We did not analyze the implications of the delay and cannot comment on this suggestion except to note that it would require a legislative change.

- The Massachusetts Department of Public Welfare disputed some of the charges made against the Recipient Eligibility Verification System by recipient groups. It was beyond the scope of this report to investigate further, but we have noted this dispute in endnote 24.

- A number of private vendors commented that the draft report inaccurately portrayed the experience (or lack thereof) that private vendors have in Medicaid and the relative complexity of Medicaid versus private sector claims. We made slight changes to the relevant sections in response.

EPILOGUE

Much has happened since our draft report was written in December 1991. We have included some of these recent events in the text. For example, we mention the National Council for Prescription Drug Programs's new standard drug claim format, intended for use in both private-sector and Medicaid programs. We also refer to the Health Care Financing Administration's final version of State Medicaid Manual sections dealing with POS systems.

We are unable to provide complete and up-to-date information on State plans for POS systems. Doing so would require us to repeat our telephone surveys. Nevertheless, we are aware of several important developments.

Work on POS systems continues in the States mentioned in the draft report. In Alabama, a three-county pilot test is planned for April 1992 and full implementation is planned for the summer. There is no firm implementation date in Arkansas, but the summer of 1992 is a possibility. In Missouri, POS eligibility verification began in March 1992. POS pharmacy claim adjudication was scheduled to begin in April, and pro-DUR in July.

California, which in June 1991 had definite plans for POS eligibility verification only, is now going much further. In February 1992 it released a request for bids on a new MMIS. The request included POS pharmacy claim submission and adjudication among the required MMIS functions. Maryland and Nebraska are expected to release similar requests in the coming months.

It appears that the next generation of MMISs will support POS technology. At a March 1992 demonstration of MMIS capabilities in Cheyenne, Wyoming, all major MMIS vendors displayed POS systems that were either operational or under development.

APPENDIX A

THE CASE FOR POS SYSTEMS IN MEDICAID PROGRAMS

Point-of-service (POS) systems consist of a central computer or network operated by a claims processor; telephone lines connecting the processor to providers; and mainframe terminals, personal computers, or POS terminals in providers' offices.* The systems can perform several claims management functions and provide a wide range of benefits.

Computers allow point-of-service communication between providers and Medicaid agencies in several States already. However, as of October 1991, only New York and Massachusetts could be said to have POS systems. What distinguishes EMEVS (New York) and REVS (Massachusetts) from systems in other States is the technology employed and the extent to which the technology is relied upon for proper program administration. Only in New York and Massachusetts did a significant number of providers both send and receive messages from the State in electronic rather than audible form. In other States, most providers are limited to automated voice response (AVR) systems or human operators, and only a few can obtain eligibility information using personal computers or mainframe terminals. In some States, private companies have installed POS terminals in many providers' offices. The terminals are used to obtain on-line eligibility information, as they are in New York and Massachusetts. However, unlike in New York and Massachusetts, providers using private companies' POS terminals must pay a fee each time they obtain information.

This appendix summarizes what POS systems can do, and why it would be advantageous for Medicaid programs to acquire them. The data presented were gathered from our survey of Medicaid agencies. The discussion is based on the survey, our discussions with experts in the public and private sectors, and our review of literature and other documents.

POS systems can reduce State spending on ineligible recipients, recipients with third-party coverage, and inappropriate services. They can also reduce administrative costs.

▶ *Ineligible recipients*

Distinguishing between eligible and ineligible recipients is a necessary but difficult chore for all Medicaid programs. Medicaid coverage, in contrast to Medicare or private health insurance coverage, can be highly transitory. Certain categories of

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*POS terminals, or "boxes," are small, desktop machines. They have keypads for providers to enter information, a small screen to convey messages to providers, and (usually) a slot through which plastic ID cards can be "swiped." They are programmed to dial specific telephone numbers and to communicate with the computers at the other end of the lines.

Medicaid recipients can (and do) lose their eligibility at any time if they experience changes in their financial, marital, or other demographic status. Providers must be made aware of changes in eligibility status, or they will continue to treat ineligible patients and expect reimbursement. Medicaid programs cannot justifiably withhold payment for ineligible recipients if they do not make a reasonable effort to inform providers of the change. Therefore, the sooner Medicaid programs are able to inform providers of eligibility termination, the sooner they will be relieved from making payments for ineligible recipients.

The standard method for identifying eligible recipients in all health insurance programs is to issue an identity (ID) card. Medicaid programs, needing to accommodate frequent eligibility changes, have traditionally printed expiration dates on their ID cards and mailed new cards periodically to recipients who remain covered. Most States, wishing to minimize both the cost of frequent mailings and the cost of extended eligibility, have settled on monthly card issuance. Massachusetts and New York, however, issue durable plastic cards. They use POS systems to enforce eligibility termination on a day-specific basis. Providers in those States no longer determine whether a patient is eligible for Medicaid on the basis of the expiration date printed on the patient's ID card--no date is printed. Instead, providers use the POS systems to obtain the States' most current eligibility information. The States, meanwhile, update their eligibility data bases daily, allowing them to change a recipient's status and communicate that change to providers at any time.

Twenty-three Medicaid agencies gave us information sufficient to estimate the impact of day-specific eligibility in their States. We calculated that if those States implemented day-specific eligibility, they would reduce annual program expenditures by an average of $7.7 million (see appendix D).

▶ *Third-party coverage*

Medicaid is not supposed to pay for health care services until third-party coverage is exhausted. But providers do not always know that third-party liability (TPL) exists, and they bill Medicaid programs when they should bill third-party insurers. This forces Medicaid programs to either pay providers and then try to collect from third parties or return claims unpaid. The former is difficult and ineffective,* and the latter angers providers.

POS systems would give States the ability to notify providers of potential TPL and require providers to submit claims to third parties before Medicaid. It is difficult to

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*U.S. General Accounting Office, Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (HRD-91-60), April 1991.

estimate how much could be saved if POS systems provided TPL information, but it may run into the hundreds of millions of dollars.[*]

► *Inappropriate services*

POS systems are widely used in the private sector to conduct prospective drug utilization review (pro-DUR). Pro-DUR is intended to ensure that patients receive the most appropriate medications for their medical conditions by identifying inappropriate prescriptions before drugs are dispensed.[**] In theory, pro-DUR saves program dollars in two ways: (1) it reduces expenditures on unnecessary or fraudulent prescriptions, and (2) it reduces expenditures on other forms of medical care that are associated with poor drug therapy. Pharmacists are able to perform limited pro-DUR on their own. POS systems, however, assist them greatly by providing complete patient histories that are kept on file by POS system operators. Unfortunately, it is impossible to estimate savings from POS pro-DUR before further research is conducted.[***]

Prospective utilization review for other types of medical care would also be possible with POS systems. However, distinguishing between appropriate and inappropriate services outside of pharmacy is more difficult. It may be some time before the standards necessary for POS utilization review are developed.

► *Administrative savings*

POS systems that incorporate eligibility verification functions allow States to use plastic ID cards. These cards are much cheaper, primarily because they are permanent.

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[*]U.S. General Accounting Office, Medicaid, p. 6.

[**]For information on the problem of mismedication and on drug utilization review in general, see U.S. Senate Special Committee on Aging, The Cost-Effectiveness of Drug Utilization Review: An Annotated Bibliography, October 1990. Before its repeal, the Medicare Catastrophic Coverage Act of 1988 laid the groundwork for a nationwide POS system to conduct pro-DUR for the Medicare population. For a discussion of this legislation and HCFA's response to it, see U.S. Department of Health and Human Services, Office of Inspector General, Medicare Drug Utilization Review (OAI-01-88-00980), April 1989. See also U.S. General Accounting Office, Prescription Drugs: HCFA's Proposed Drug Utilization Review System Ignores Quality of Care Issues (PEMD-89-26BR), July 1989.

[***]PCS, Inc. has developed cost savings estimates for its Quantum Alert pro-DUR program. PCS estimates that every dollar spent on pro-DUR saves approximately $15. Their estimates do not include savings on medical care yielded by preventing adverse drug reactions; therefore, they are conservative. Experts have estimated that 3 to 8 percent of hospitalizations are caused by adverse drug reactions at a cost of $5 billion to $13 billion nationwide. Mismedication also increases other health care expenditures, since it can cause or sustain health care problems. Studies have estimated that up to 7.3 percent of prescriptions have potentially serious errors (see U.S. Senate Special Committee on Aging, pp. 6, 12).

Most states using paper cards issue them 12 times a year.* Plastic cards could conceivably last several years and could be saved by recipients who leave the program in case they are later reinstated.

Forty-four States now issue paper ID cards. In 27 States that provided us with cost information, the average yearly cost for producing and mailing paper cards is $1.53 per eligible per year. In the 4 States that use plastic cards and provided us with cost information, the average cost is only $.50 per eligible per year. By switching to plastic, the States with paper cards could save from $6,000 to $2.2 million a year on card production and mailing, with an average of $570,000 (appendix D).

POS systems that perform eligibility verification, claims submission, and/or claims adjudication would reduce errant and invalid claims. Providers would receive feedback from the systems and then either correct or cancel claims that are rejected. As a result, fewer Medicaid staff would be needed to handle errant claims and respond to provider inquiries.

The types of errors POS systems can detect depend on the functions the systems perform. Eligibility verification systems can eliminate claims submitted for ineligible recipients. Claims submission systems can detect such errors as wrong dates, invalid codes, and typographical errors and can reduce data entry errors by State staff. Real-time claims adjudication systems can detect higher-level problems such as claim duplication or service threshold restrictions.

POS systems that performed claims submission could reduce the volume of paper claims, which would reduce processing costs. States that currently receive a high proportion of claims via modem, disk, or tape have lower processing costs per claim.** Paper claims are more expensive because the State must pay both for data entry and for correcting the errors that are created in the process.

POS systems can improve provider relations.

Many observers have noted the difficulties Medicaid recipients have in accessing services, particularly from primary care physicians. Part of the problem may be that providers are frustrated by the paperwork necessary to receive Medicaid reimbursement. POS systems could relieve some of the administrative burdens associated with treating Medicaid recipients. Providers themselves favor POS systems, according to informal responses we received from provider associations.

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*One exception is Pennsylvania, which issues paper cards every two weeks.

**The correlation between cost per claim and percentage of total claims submitted electronically was -0.56 (for 31 States reporting sufficient data).

Because POS systems can, through a variety of functions, reduce claims denials, providers can be more assured of payment. POS eligibility verification guarantees providers that claims will not be denied because of recipient ineligibility and notifies providers of third-party coverage. POS claims submission allows providers to check and edit claims for simple errors. POS claims adjudication allows providers to find out whether final payment will be made and to adjust their accounts receivable accordingly. In addition, POS utilization review messages inform providers of recipient-specific service restrictions and potential therapeutic or administrative problems.

Medicaid providers have often complained about payment delays. POS systems could reduce the time between service delivery and payment by eliminating delays due to shipping, handling, and data entry. Currently, electronic claims are paid on average a week faster than paper claims.* Given that most electronic claims are now submitted on tape or diskette and that on-line claims would get to the State even quicker, the difference between on-line and paper claims should be even more pronounced. POS claims adjudication would speed things up even further by replacing daily or weekly claims processing cycles with instant, on-line processing.

It is important to note that claims adjudication and claims payment are two separate processes. Even if States used POS systems to adjudicate claims the moment services were delivered, they could still delay payment for those services by whatever length of time they desired. This flexibility could lead to a compromise between providers, who seek the quickest possible payments, and State treasurers, who may seek the longest possible delays.

POS systems can accelerate the flow of information from providers to States, allowing better program administration and planning.

POS claims submission systems would make information available to States much more quickly than traditional claims submission systems. New York now has a problem verifying that patients actually received services that the State was billed for. It can take so long for the claims to be processed that recipients may forget whether the services were delivered or not. If New York's POS eligibility verification system performed claims submission as well, it could produce utilization reports at the end of the day. This would allow staff to verify the services on the following day. A respondent from South Carolina stated that on-line claims submission "could reduce the information float. It now takes a long time, about six months, to recognize the

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*In 47 States responding to our survey, the mean payment time for electronic claims is 10 days, compared to 17 days for paper claims. The difference in payment times ranged from 0 to 23 days. States often reported a range, e.g., 5 to 15 days. We averaged the low and high estimate to assign each State a single payment time for each type of claim. Nevada was excluded from this analysis because it does not accept electronic claims. Maine was excluded because it could not report separate average processing times for paper versus electronic claims. Illinois was excluded because at the time of our survey, owing to fiscal problems, it required 120 days to process all types of claims--an obvious outlier.

need for a policy change and implement it. Three months of that delay could be eliminated if the claims were submitted and adjudicated faster."

POS systems could add Medicaid to the list of programs available through electronic benefits transfer.

Paper-based benefit programs may soon be extinct. The same technology used for POS medical claims management can be used to replace paper checks and coupons with electronic transfers.* States issuing plastic cards for recipients to use in banks and supermarkets could use those cards for Medicaid as well.

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*See U.S. Department of the Treasury, Financial Management Service, From Paper to Plastic: The Electronic Benefit Transfer Revolution, 1990.

APPENDIX B

METHODOLOGY

The data presented in this report were gathered through the following methods (dates for each method are given in parentheses; all occurred in 1991):

1. Telephone interviews with Medicaid claims management staff in 50 States. Interviewees were identified during our conversations with HCFA regional office staff (see below) or by referral from other State Medicaid staff. We interviewed staff from the District of Columbia (referred to in the report as a State) and all States except West Virginia. (May-June)
2. A mail survey to which 45 States responded. We sent a letter and written questionnaire to the Medicaid Director or the MMIS Director in each State. We received at least partial responses from every State except Alaska, Arizona, Arkansas, Delaware, and Ohio. The response we received from Maine came too late to be included in our analysis. (May-July)
3. Telephone interviews with HCFA systems staff in each of the 10 regional offices. The names of the appropriate staff were given to us by HCFA's Medicaid Bureau. (April)
4. Informal conversations with staff from HCFA's Medicaid Bureau. (February-September)
5. Telephone interviews with representatives from 14 private companies involved in Medicaid and private-sector drug claims processing. The companies included Medicaid fiscal agents (Consultec, EDS Federal, The Computer Company, Unisys), drug processors (Argus, PAID Prescriptions, PCS, Perform Cost Management Services), telecommunications specialists known as "switches" (Envoy, General Computer Corporation, National Data Corporation), and pharmacy computer systems manufacturers (3PM, Condor, QS1). (July)
6. Telephone interviews with seven trade or professional organizations representing pharmacists and other providers. The organizations included the American Hospital Association, American Medical Association, American Pharmaceutical Association, American Society for Automation in Pharmacy, American Society of Consultant Pharmacists, National Association of Chain Drug Stores, and National Association of Retail Druggists. (March)
7. A review of advance planning documents and other materials prepared by eight States (Alabama, Arkansas, Illinois, Massachusetts, Missouri, New Jersey, New York, and Oregon) concerning point-of-service systems. (May-September)
8. A review of data collected in surveys of State Medicaid programs conducted by HCFA and the American Public Welfare Association (APWA). The HCFA survey addressed drug utilization review, and the APWA survey addressed recent MMIS improvements. Both surveys were conducted in the spring and summer of 1991. (July)
9. A review of professional and government literature. (February-September)

Between writing our draft report in December 1991 and preparing this final version, we conducted additional discussions with States, industry organizations, and private vendors. Their input is reflected in the final report.

APPENDIX C

EXISTING AND PROPOSED MEDICAID POS SYSTEMS

State	System Functions	Equipment and Services Needed	Estimated Cost	Estimated Savings	Start Date	Status (as of 9/91)
Arkansas	Eligibility verification (day-specific) and claims submission for all provider types; claims adjudication for pharmacists	Plastic card production and distribution, POS terminals, initial and ongoing programming of terminals	$8 million over 4 years to develop and operate (includes work by new contractor, fiscal agent, and State)	$10 million gross savings over 4 years	2/92	APD approved; bids received for card production, POS terminal supply, maintenance, programming
Illinois	Eligibility verification (month-specific), claims submission and adjudication for pharmacists; pro-DUR anticipated	Telecommunications "switch" to link providers and state-operated MMIS	$200,000 to develop; $1.65 million over 5 years to operate	$7 million gross savings over five years	1/92 (pilot study)	Vendor selected; contract award pending HCFA approval
Massachusetts	Eligibility verification (day-specific) for all provider types	Plastic card production, telecommunications network, POS terminals	$19 million over 3.5 years to develop and operate	$30.4 million gross savings over 3.5 years	1/89	System operational; expansion contemplated
Missouri	Eligibility verification (day-specific), for all provider types; claims submission, adjudication, and pro-DUR for pharmacists	Programming of state-operated MMIS, maintenance of pro-DUR data base (providers will pay for equipment and line charges)	$507,000 to develop; $3,000 per year to operate (not including conversion to day-specific eligibility)	$2.25 million gross savings annually from day-specific eligibility alone	8/92	APD approved; project work to start 10/91
New York	Eligibility verification (day-specific) and utilization review and control for all provider types; "post and clear" for pharmacy and laboratory orders	System design, plastic card production, telecommunications network, POS terminals, evolution resources	$38 million over first 7 years to develop and operate; $30 million over next 6 years to operate	$18 million gross savings annually; $200 million annual gross savings possible from service restriction enforcement	11/86	System operational; contractor secured through 1996; additional functions contemplated

SOURCE: Advance Planning Documents and additional information supplied to OIG by each State in September 1991.

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APPENDIX D

EXPLANATION OF SAVINGS ESTIMATES

Day-specific eligibility

Our model of savings from day-specific eligibility (DSE) is nearly identical to that used by Massachusetts in its first-year evaluation of REVS. Although this model is convenient because it relies on readily available program statistics and is logically sound, it does have some limitations. These limitations are described at the end of this section.

For each State, the total annual program savings resulting from DSE equals the total number of cases closed because of DSE times the average savings per closing. The average savings per closing equals the average number of days between the closing and the end of the month in which the closing occurs times the average expenditure per eligible per day. In any given year, the average expenditure per eligible per day equals that year's total Medicaid spending that is subject to DSE divided by the total number of eligibility days that year for the entire Medicaid recipient population. The number of eligibility days for the population equals the number of full-year eligibles times 365, plus the total number of months of eligibility for partial-year eligibles times 30.42 (365 ÷ 12 = 30.42). This set of equations yields the formula

$$S = \frac{cdx}{365f + 30.42m}$$

where S = Total annual savings from DSE
    c = Total number of closings from DSE
    d = Average days saved per closing
    x = Total expenditures subject to DSE
    f = Number of full-year eligibles
    m = Number of months of eligibility for partial-year eligibles.

We obtained the values of f and m for each State for Federal FY 1990 from HCFA's Division of Medicaid Statistics. The Division also provided each State's total expenditures by type of service, which we used to calculate x (see below). We obtained the value of c from our mail survey of States. They provided, for either the Federal or the State fiscal year most recently concluded, the "number of persons eligible for Medicaid benefits at some point during this year who became ineligible, either permanently or temporarily, later this year." We assigned d a fixed value of 15 days, assuming a random distribution of case closings throughout each month.

To calculate x, we subtracted from each State's total expenditures its expenditures on the following services: inpatient hospital (general and mental health), intermediate care facility (mentally retarded and all others), skilled nursing facility, and HMO

premiums. Day-specific eligibility is not likely to affect expenditures on these services, either because they are paid for in advance of case closing (*e.g.*, HMO premiums) or because patients needing these services are not likely to lose Medicaid eligibility (*e.g.*, inpatient hospital).

Twenty-three States were able to supply values for c: AL, CA, CT, FL, GA, ID, KY, LA, MO, MS, NC, ND, NH, PA, RI, SD, TX, UT, VA, WA, WI, WV, and WY. (NY also provided a value of c, but was not included in this calculation because it already uses DSE.) We calculated values of S that ranged from under $100,000 (WY) to over $30 million (CA, PA, and TX). The sum of all S's equaled $177,468,677, yielding an arithmetic mean of $7,716,029. The median State was Mississippi, with S = $4.5 million.

There are two primary limitations to the model developed by Massachusetts and used here. The first is that it assumes no effect of eligibility termination on medical service utilization patterns. It is possible that recipients who were aware of impending case closings would "load up" on services such as physician visits and prescription refills before their eligibility expired. Massachusetts might be able to obtain better estimates of the effect of DSE if it were able to track the utilization patterns of recipients before and after they left the program. The second limitation is that the model does not account for differences in service utilization patterns between different categories of recipients. Elderly and disabled recipients are likely to have the highest medical bills, but they are least likely to lose Medicaid eligibility. Therefore, though we believe that this model can produce reasonable estimates of potential program savings from DSE, we would not recommend that States rely entirely on it when comparing the costs and benefits of POS systems. The American Pharmaceutical Association has recommended that "HCFA should work with States to develop consensus regarding appropriate methodology for evaluating savings." Certainly, consensus in this area would be helpful.

Plastic ID cards

Our mail survey asked States to report their annual expenditures for producing and mailing eligibility cards. To compute potential savings from conversion to plastic ID cards, we first divided the cost for producing and mailing cards in States already using plastic cards (DC, MD, MA, NY) by the total number of unduplicated eligibles in those States. (The number of unduplicated eligibles in each State for Federal FY 1990 was provided by HCFA's Division of Medicaid Statistics.) We averaged the results from the four States and obtained a mean cost per eligible of $0.4978. We then multiplied, for each State using paper ID cards, the total number of eligibles by $0.4978 to estimate each State's cost if it were to use plastic cards. We subtracted this cost from the current cost to obtain a savings estimate for each State. For example, Alabama spent $600,000 for paper cards in one year for 431,240 eligibles. At $.4978 per eligible, it would have spent only $215,620. Savings for Alabama, therefore, were estimated to be $384,380.

These savings estimates represent ongoing, long-term savings on card production and mailing only. We did not consider the substantial start-up costs involved in procuring equipment to manufacture plastic cards and providing them to all current recipients. Nor do our estimates include the costs of the POS system required by plastic cards. Also, our estimate assumes that the rate of card loss is constant across all States, regardless of the type of card used.

APPENDIX E

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), the American National Standards Institute (ANSI), and the National Council for Prescription Drug Programs. We also present our response to each set of comments.

Memorandum

Date   MAR 6 1992

From   Gail R. Wilensky, Ph.D.
        Administrator

Subject   OIG Draft Report - "Point-of-Service Claims Management Systems for Medicaid,"
           (OEI-01-91-00820)

To   Inspector General
        Office of the Secretary

We have reviewed the subject draft report which discusses the potential of point-of-service (POS) claims management systems for State Medicaid programs. In general, we found this report to be quite useful, in that it has added to our understanding of POS claims management systems in the Medicaid environment.

The Office of Inspector General (OIG) found that, although POS systems have great potential for improving the administration of Medicaid programs across the country, several barriers exist that impede broader adoption of these systems. The findings suggest that POS is a concept whose time is not yet here, at least for Medicaid.

To address their findings, OIG recommends that HCFA should: (1) prepare a guide to POS technology and distribute it to States; (2) make each State aware of possible exceptions to deadlines for Federal funding set by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90); (3) clarify the operational requirements for enhanced Federal funding of POS systems; and (4) promote the development of standard electronic claims formats and their use by State Medicaid agencies. OIG also recommends that State agencies develop POS claims processing systems that are compatible with available standard electronic claims formats.

We agree with all these recommendations in principle and have already begun to implement several of them. However, we believe it would be premature to commit ourselves to preparing a guide to POS technology for Medicaid programs. OIG's findings are not sufficiently conclusive to justify a major HCFA effort to promote POS at this time. Our specific comments on the report's recommendations are attached for your consideration.

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

Attachment

Comments of the Health Care Financing Administration
on the OIG Draft Report: "Point-of-Service Claims Management Systems
for Medicaid," (OEI-01-91-00820)

Recommendation 1

That HCFA should prepare a guide to Point-Of-Service (POS) technology and distribute it to States. The guide should explain the costs and benefits of POS technology, alternative methods of using POS systems, and strategies for procuring cost-effective systems.

HCFA Response

We do not agree with this recommendation at this time. The report states, and we agree, that our current knowledge of the utility of POS in Medicaid is limited. Presently, the benefits of POS systems for Medicaid are only speculative. The findings of this report are not conclusive enough to justify, at this time, a major effort to promote POS. Also, as the report itself indicates, States presently have few financial and staff resources to devote to these efforts.

We suggest that development of a POS guide be deferred until the current Electronic Claims Management (ECM) outpatient drug claim demonstrations have been completed and assessed. These studies are congressionally mandated under Section 4401(c)(1) of OBRA 90, and require the Secretary to report to Congress on the completed demonstrations by January 1, 1994. The study is expected to provide useful information which will define the pros and cons of POS systems for Medicaid. In the meantime, we will keep POS systems on the agendas of any HCFA-sponsored, Medicaid-oriented systems conferences and workshops.

Recommendation 2

That HCFA should make each State aware, through the State Medicaid Manual or other appropriate vehicles, that enhanced funding will be available under pre-existing authority beyond the deadline set by OBRA 90.

Recommendation 3

That HCFA should clarify the operational requirements for enhanced Federal funding of POS systems.

HCFA Response (to Recommendations 2 & 3)

OIG has expressed concern that HCFA funding policy regarding POS and ECM systems is confusing. These concerns, however, are based upon a review of draft materials. HCFA has clarified and resolved these problems. Since our actions were taken on our own initiative and not based on the OIG report, we technically disagree with both these recommendations.

Our final policy is contained in two documents. One is the Medicaid Management Information System (MMIS) section of the State Medicaid Manual. This issuance sets funding policy for ECM without specific reference to the deadlines set by OBRA 90.

In addition, we also issued an all State Medicaid Directors letter on November 7, 1991. This letter clarified issues raised by the OBRA 90 provisions related to procurement of POS ECM systems, including competition.

Recommendation 4 .

That HCFA should promote the development of standard electronic claims formats and their use by State Medicaid agencies. HCFA, the State Medicaid Directors' Association, the American National Standards Institute, and the National Council for Prescription Drug Programs should work together toward these goals.

Recommendation 5

That State Medicaid Agencies that develop POS claims processing systems should ensure that they are compatible with standard electronic claims formats as the formats become available.

HCFA Response (Recommendations 4 & 5)

We agree with these recommendations. We have already taken several steps in the direction suggested. As this report states, some of the most controversial formatting issues seem to be near resolution. We wish to note HCFA is fully committed to the American National Standards Institute (ANSI) standard setting process. In fact, we publicly expressed our support for ANSI at the Secretary's Administrative Cost Forum in November 1991.

HCFA will participate in workgroups dealing with POS, and will endeavor to see Medicaid agency interests are also represented. We point out that a State Medicaid Director already is a member of the Steering Committee for the Workgroup on Electronic Data Interchange. This Committee has been charged by the Secretary with promoting the use of electronic claims submission in the health care industry.

Further, POS formatting issues will be put on the agenda of our Systems Technical Advisory Group. When States submit requests for funding POS systems, formatting issues will be addressed as Advance Planning Documents (APDs) are reviewed. APDs are the basis of Medicaid funding decisions.

OIG RESPONSE TO HCFA COMMENTS

We agree that it is probably premature for HCFA to conduct a "major effort to promote POS." The primary intent of our recommendation to HCFA to produce and distribute a guide to States was for HCFA to take the lead in collecting and disseminating information. We never meant to imply that HCFA should unconditionally promote POS systems at this time. The HCFA correctly notes that more information will be available when the pro-DUR POS demonstration projects have been conducted and evaluated. We have therefore modified our recommendation to better reflect HCFA's role as an information clearinghouse. We believe it is now consistent with that outlined by the Assistant Secretary for Planning and Evaluation in his comments (see below).

We stress, however, that HCFA should take immediate and continuing steps to distribute information on POS systems. Keeping POS on the agenda of conferences and workshops is not sufficient because, in an era of diminishing Federal and State travel funds, there is no guarantee that such meetings will be held or widely attended. In the text supporting our recommendation we suggest less expensive methods of sharing knowledge.

We agree that HCFA's policies are clear regarding ongoing availability of enhanced Federal Financial Participation (FFP) and assume that State officials are aware of the policies. We have deleted the draft recommendation on that subject. We disagree that the State Medicaid Manual explains the operational requirements with sufficient clarity. In particular, we wonder what rules would apply to POS systems that performed all functions (including adjudication) for pharmacy claims but more limited functions for other claims. We urge HCFA to make these rules explicit.

The HCFA comments that "when States submit requests for funding POS systems, formatting issues will be addressed. . . ." Given the unanimous support expressed by readers of our draft report for standardizing claim formats, we hope that HCFA will devise review criteria that provide strong incentives for adhering to these standards.

TO: Richard P. Kusserow
           Inspector General

FROM: Assistant Secretary for
           Planning and Evaluation

SUBJECT: OIG Draft Report: "Point-of-Service Claims Management
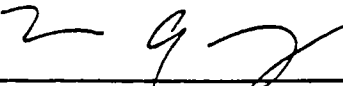   Systems for Medicaid," OEI-01-91-00820

Thank you for providing me with an opportunity to review your
draft report on POS claims management systems for Medicaid
providers. I found the report informative with regard to both
the potential benefits of POS claims management systems for
Medicaid and the problems perceived by states considering such
systems. Clearly, the financial and staff resources states would
have to commit represent the principal impediment to their
adopting the technology. In addition, states have raised
significant concerns that some of the advantages POS systems
typically offer may not materialize in the Medicaid context for
both programmatic and practical reasons.

Recommendations

In light of the very limited Medicaid experience with POS systems
and their still speculative value to states, I believe that the
recommendation that HCFA prepare a guide to POS technology of the
scope you describe and distribute it to the states is premature.
While movement toward POS systems is consistent with Secretary
Sullivan's initiative to reduce administrative costs, in part by
promoting increased use of electronic systems, development of a
HCFA guide should be deferred, perhaps until the contributions of
the task force on this subject, whose work is still underway, can
be incorporated. In the meantime, I believe that HCFA should, to
the extent possible, facilitate the exchange of information among
states with respect to their experience in adopting POS systems.

Regarding your recommendation that HCFA clarify the operational
requirements for enhanced FFP, I believe that HCFA's final State
Medicaid Manual instructions, issued since your draft report was
written, do just that. The instructions also treat efforts
related to POS system implementation as MMIS improvements, for
which enhanced FFP is available on an on-going basis under the
law; the effect of construing these activities as MMIS improve-
ments is to render the OBRA 90 two-year limit on enhanced FFP
(which applies only to POS for drug claims processing)
immaterial. Relatedly, under the final instructions, a broader
set of POS systems will meet the requirements for enhanced FFP.

Finally, I concur with the recommendation that HCFA promote the development of standard electronic claims formats and their use by state Medicaid agencies. I also concur with the recommendation that state Medicaid agencies developing POS claims processing systems should ensure that they are compatible with standard electronic claims formats, as the formats become available.

Martin H. Gerry

OIG RESPONSE TO ASPE COMMENTS

We agree that HCFA's preparation of a guide to POS systems is not appropriate at this time and that "HCFA should, to the extent possible, facilitate the exchange of information among states. . . ." In response, we have modified our recommendation and call for HCFA to collect information on POS systems and regularly distribute it to States.

March 24, 1992

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

Dear Inspector General Kusserow:

I have reviewed your draft report, "Point of Service Claims Management Systems for Medicaid." I believe your report accurately reflects both the benefits and drawbacks of Point of Service (POS) technology, from the state perspective. Your report also reflects the confusion surrounding the issue of federal payments for POS system development and operation. I do believe, however, that the report should place more emphasis on OBRA 90 provisions, which has proven to be a source of much confusion regarding when enhanced FFP is available.

In general, I believe state Medicaid agencies will support the recommendations of the draft report. State agencies, despite current fiscal and other resource limitations, remain very interested in improving the administrative efficiencies of their programs in the context of improving provider participation and client access. The State Medicaid Directors' Association is willing to work with the Health Care Financing Administration to disseminate information on cost effective technologies and to resolve outstanding issues of state and federal concern.

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

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OIG RESPONSE TO SMDA COMMENTS

We appreciate the SMDA's support for our findings and hope that the States do indeed support our recommendations. We feel that our report adequately addresses the confusion caused by OBRA 90 (p. 8), especially in light of HCFA's more recent actions and their comments on our report.

ASC X12-ELECTRONIC DATA INTERCHANGE (EDI)

Accredited Standards Committee
operating under the procedures of the
American National Standards Institute

X12N Insurance Subcommittee
Lee Barrett - Chairman
The Travelers
One Tower Square - 5 FP
Hartford, CT 06183
TEL: 203 277-7647   FAX: 203 277-2107

Document No.:

February 16, 1992

Mr. Richard P. Kusserow
Inspector General
Office of Inspector General
Department of Health and Human Services
Washington, DC 20201

Dear Mr. Kusserow:

I have reviewed the draft report entitled "Point of Service Claims Management Systems for Medicaid" and have these comments. On Page 11 of the report there's one section which discusses the fact that "states and private payers do not use uniform electronic claims format". I would agree that this is a major problem since there are over 400 electronic claims formats in use in the U.S.

The Workgroup on Electronic Data Interchange, which was initiated after the Louis Sullivan Summit in November 1991, and is co-chaired by Joseph Brophy of Travelers and Bernard Tresnowski of Blue Cross Blue Shield Association, is addressing the issue of standardardized billing, electronic claims, eligibility and payment including electronic remittance advice(ERA) and electronic funds transfer(EFT). Their report is scheduled for submission in July 1992.

In regard to the American National Standards Institute(ANSI) X12N Insurance Subcommittee efforts, there has been significant progress made since becoming a subcommittee in Feb. 1991. The following health care transactions have been approved as draft standards, as of this letter:
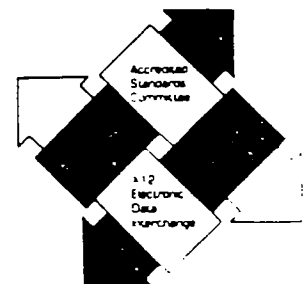
    1)   835 Health Payment ERA/EFT
    2)   834 Enrollment

These additional health care transactions have been approved to send to the X12 membership for ballot:

    1)   837 Health Claim - Anticipated formal approval is 10/92

The following health care transactions are under development:

    1)   Eligibility - Anticipated approval 2/93
    2)   Computerized Patient Record - Work to start 6/92

ASC X12-ELECTRONIC DATA INTERCHANGE [EDI]

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Hartford, CT 06183
TEL: 203 277-7647   FAX: 203 277-2107

Document No.:

Please note that approval of all transactions under X12 are as Draft
Standards for Trial Use(DSTU) for a period of 2-3 years prior to ANSI
final approval. The standard however, is fully approved by all parties
and incorporated into vendor translators as a DSTU.

As you can see, much work has been accomplished on health standards within
X12 over the past year. HCFA has also become a more active participant in
the process and has worked closely to modify the 835 Health Payment
transaction to meet their requirements and those of the intermediaries.
The X12 process, although consensus based, has been responsive to HCFA's
needs and requirements and will continue to do so. HCFA has also
indicated their intention to migrate towards ANSI X12 standards and to
continue to be actively involved in the standards development process.

In summary, I feel that the report is well written and the need for POS
Claims Systems is apparent throughout the entire health care industry.
Standards are developing at a rapid pace within the ANSI environment, and
I would strongly encourage Medicaid/HCFA and all interested parties to
continue to work with the ANSI process to develop the standards and move
to a singular standards platform. ANSI X12 is working with other
standards organizations such as NCPDP to as well migrate towards ANSI. We
believe this co-development between standards organizations through ANSI
will occur in the near future.

If you would like any additional information on ANSI X12, the process, or
any other items mentioned above in this letter please call me at
203-277-7647. Thank you for providing me the opportunity to review the
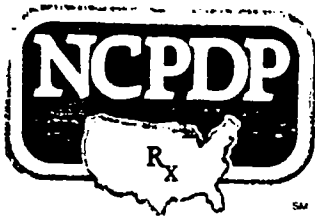report in advance and to provide my feedback.

Sincerely,

Lee Barrett
Chair, ANSI X12N Insurance Subcommittee

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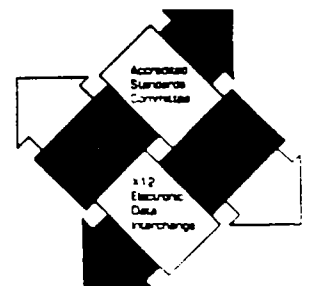
OIG RESPONSE TO ANSI COMMENTS

We have incorporated the additional information provided by ANSI's comments into our report. As noted in our recommendations, we agree that HCFA should continue to work with ANSI in developing standard claim formats.

National Council for Prescription Drug Programs

February 13, 1992

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

RE: Draft OIG Report (OEI-01-91-00820)   POINT-OF-SERVICE CLAMS
                                      MANAGEMENT SYSTEMS FOR MEDICAID

Dear Mr. Kusserow:

The National Council of Prescription Drug Programs (NCPDP) is a non-profit organization of over seven hundred members representing prescription drug providers, insurers, service organizations, government agencies and others interested in prescription drug program administration standardization. NCPDP is gratified by your office's recognition of our role in the drug delivery industry and is pleased to provide official comment on the above cited report.

NCPDP applauds the Office of the Inspector General's continued interest in the delivery of high quality and cost efficient prescription drug therapy to the American public and more specifically within government programs. Past OIG reports such as those on Medicare Drug Utilization Review (OAI-01-88-0980), The Clinical Role of the Community Pharmacist (OEI-01-89-89160) and the draft-comment process you utilize in their production, have brought forward great insight into many drug delivery issues. The insights your office has presented have benefited numerous people charged with oversight and management of both private and public drug delivery programs. Further, your insights are in many cases, a clear predecessor to and influence on activities within the drug delivery industry which result in direct benefit to drug therapy recipients throughout our nation. This report on Point-of-Service Claims Management Systems for Medicaid continues your offices tradition of thorough and thoughtful research into important subjects and the clear presentation of recommended actions. At the outset of our comments, we wish to commend the work of your entire office and the staff charged with production of this report whom we have found to be most receptive, accessible, and sincerely interested in presentation of a complete and accurate report.

General Comments:

Since 1977, NCPDP has provided a forum where the diverse interests of the drug delivery industry can find a common ground where voluntary agreement on standards can improve efficiencies for everyone involved. Our success to date has been unprecedented in health benefit delivery and we appreciate the recognition of this provided within your report. As some of the statements in the report are necessarily dated, the primary focus of our general comments will be to update your office on our standardization activities.

As your report section on Recommendations (page 18) notes, "creating a standard for pharmacy claims has been an arduous process." NCPDP's role within the drug delivery industry has never been an easy one, nor has NCPDP been immune from controversies which are often associated with insightful leadership within diverse groups. We are happy to report however, that we continue to be thoroughly gratified by the unyielding support, encouragement and dedication of the vast majority of our membership and colleague trade organizations.

Despite the periodic controversies which can surround our mission, and recent significant challenges we have faced, NCPDP continues to be clearly recognized as the preeminent authority on the creation of standards for the prescription drug program delivery industry. Attesting to this fact are; 1) the vast array of organizations and companies which have already provided written statements of support and implementation planning for our new Telecommunications Standard Version 3.2, 2) the ninety seven percent affirmative vote to make V3.2 an official standard that occurred at our February 11th annual meeting, and, 3) the continued investment in our voluntary standard setting processes being made by companies throughout the drug delivery industry.

Although as of the writing of your report NCPDP was engrossed in a difficult process of consensus building, we feel that our work at that point was somewhat more positive than your report indicated. In the report our efforts were termed "promising", but the report also stated:
> "If NCPDP is unable to produce an acceptable Medicaid-compatible format in a reasonable period of time, HCFA may need to create its own Medicaid standard."

As previously stated, our recent efforts to overcome industry criticisms of the Version 3.1 replacement for our obsolete initial telecommunications standard have been successful. The success of this effort was made possible by a thorough industry wide examination of a draft for comment and increased involvement of a number of interested organizations in the NCPDP work group process. NCPDP listened to the industry, responded to their criticisms and built industry wide consensus. NCPDP actively solicited this increased input and involvement. Our standards development process has always been an open one and everyone involved has always been interested in additional constructive assistance. NCPDP and its member companies have made significant investment in our standards through their costly support of un-reimbursed volunteer work groups. Despite the controversy it was clear that no reasonable organization within our industry ever intended to prevent our development of a useable standard. There was never any doubt that we would meet with success. NCPDP's mission is dependent on building consensus and we are dedicated to that mission.

The report's suggestion that HCFA might create its own standard may be ill advised. Recent experience with related standards for the Medicaid rebate program appears to show that HCFA would have benefited from a closer working relationship and early involvement with NCPDP and our existing standards. The NCPDP Medicaid Work Group is now actively engaged in work with industry representatives and HCFA officials aimed at solving some related Medicaid Rebate program standard problems. We hope this work effort will be more formally encouraged by HCFA officials. Perhaps, to save tax dollars, government agencies should make use of volunteer assistance that can serve them in meeting program goals. NCPDP offered early assistance in the rebate area. We also continue to offer our assistance in the creation of Medicaid POS standards. We would heartily welcome the "cooperation...from HCFA" that your report suggests.

NCPDP has long been interested in helping the Medicaid program to the recognize value of NCPDP standards. A finding of the report indicates that the private side members of NCPDP and our standards do not have significant Medicaid experience. This fact is not for a lack of trying nor a lack of applicability. NCPDP has spent much time on Medicaid and other government drug program efforts. Many members of NCPDP are thoroughly familiar with MMIS system standards, Medicaid benefit delivery hurdles, and the functional environment of state Medicaid benefit delivery that HCFA must work within. We feel the expertise available within our membership and our organizations experience in the standard development process are invaluable resources simply waiting for state and federal government gratis consumption.

Our primary comment is that the report could realistically recommend that:

> *State and federal agencies involved in the development of point of sale systems must be required to make use of available standards as well as the existing standard setting processes and organizations if they plan to utilize federal funds for system development or operation.*

Anything less than this type of mandate will cause needless government program development expenditures. In addition, any less of an effort by the government will cause disruption of private side drug delivery processes and increased costs in an American health care delivery system than can little afford it. Not only are standards meaningless if not widely used. The lack of the use of standards creates inefficiencies and information processing problems that can impact all related benefit processors. Finally, an probably most important, any less of an effort may damage the Medicaid recipients access to and quality of care due to provider dissatisfaction with a public program that already faces many provider relations challenges.

A finding of the report indicates that a lack of state resources and expertise are the primary reasons for state inaction on state of the art POS system development. NCPDP and ANSI are standard setting organizations with proven effective processes and a wealth of expert resources. These resources are *not* "more concerned with their own interests than those of the States or of HCFA".' In fact, many participants in our organization's standard setting processes, are as dedicated to quality cost effective public programs as many government employees. The report

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' OIG report, third paragraph, page 17.

may be doing a disservice to Medicaid by suggesting otherwise.

More to the primary point of the report, we are convinced that your office is fully on target in suggesting that HCFA pursue nearly any available vehicle to encourage and assist states in moving drug program processing to point-of-sale management systems. Numerous statements in the report indicate that state Medicaid officials do not grasp the true advantages of POS processing and that they are quite often misguided in their perception of some potential pitfalls. In the interests of time we will not provide a detailed counter argument to each of the problems cited under the finding *"State Medicaid officials fear that POS systems would have several negative effects on States and their citizens."* We would be happy to provide such a level of detailed rebuttal if your office is interested.

NCPDP offers its assistance in the educational process that appears to be required in Medicaid agencies. We pledge to assist HCFA in the development of the guide suggested by your first recommendation. In addition to promoting standards, the second part of NCPDP's mission is to provide a continuing source of reliable information (on drug program administration) that supports the diverse interests of our membership. We find this educational charge to be extremely important when we work with novice POS processors. In fact, some industry criticisms of past NCPDP standardization activities have had as a root, the theme that NCPDP should do more to educate processors about the importance of standardization in the POS process. We feel we could assist HCFA in communicating the value of POS processing and standardization. We also feel capable of providing help in the development of strategies for cost effective state implementation of this technology. As another aside we shall not fully detail herein, we do feel there is a strong potential that states may spend needlessly on duplication of MMIS modifications needed to support POS processing as your report mentions. We pledge to assist states in the development of NCPDP standards that meet their needs for cost effective implementation.

To some extent, the report also appears to extend some misunderstanding of POS system value and capabilities through the statements on page 13 and elsewhere. Many private side vendors using POS technology also process other complex health claims with thoroughly integrated systems much like MMIS. Although some large private side drug administration processors process only drug claims that are in somewhat smaller volumes than large Medicaid programs, numerous insurers integrate POS processing with other claims that are as voluminous and complex as states face in Medicaid. Only a few years ago, most claims processors in the drug area where also dependent on batch oriented claims adjudication systems. These systems have not always been totally abandoned and completely replaced when POS drug processing was implemented.

The statement that private side drug claims are easier to process than Medicaid drug claims may not be correct. The example cited, that of duplicate checking, is definitely incorrect and indicates some misunderstanding of POS processing. Private vendors check less history in duplicate edits because long history checking is unnecessary in a POS environment. Medicaid agencies check far more history due to the slower process of paper claims submission and adjudication as well as the resultant manual claims suspense relief processing present in batch systems.

In fact, if any example of more complex processing needs to be cited, Third Party Liability (TPL) adjudication requirements in Medicaid may temporarily be the best example. The temporary appropriateness of this example of complexity may be short lived as TPL processing in pharmacy among private vendors through POS is beginning to show some activity. Pharmacy providers have never really faced the level of true other carrier liability adjudication influence affecting many other provider types. Medicaid states may be the first widespread implementation of this difficult area where we agree that POS processing should potentially save significant amounts. NCPDP is interested in assisting Medicaid in finding workable solutions for the TPL area.

Another area of complexity in which Medicaid may be at the forefront is online-realtime or prospective Drug Utilization Review (DUR). NCPDP work groups have anticipated the Medicaid programs need for sophisticated mechanisms to implement, track and measure the effectiveness of this form of DUR. Our work groups on DUR and telecommunications have added significant capability for these processes in the new Version 3.2. We look forward to working with state agencies and researchers that are engaged in the OBRA-90 mandated studies of DUR. Interest in this area has also been piqued on the private side through the anticipated Medicaid activity. The DUR information transmission and measurement capabilities initially developed in NCPDP standards for Medicaid have now been extended in Version 3.2 to all types of claims covered by our recommended transaction data sets. With regard to complexity, the history analysis necessary for successful POS-DUR will likely be more significant than Medicaid duplicate checking.

It might be successfully argued that the complexity of private side drug processing with numerous benefit designs, recipient cost sharing mechanisms, and reimbursement rules already occurring within the major private side administrators is far more complex than Medicaid. The complexity of Medicaid should not be an impediment to POS implementation.

To conclude our general comments, we sincerely agree with your recommendations that HCFA, NCPDP, the American National Standards Institute (ANSI) and the State Medicaid Directors Association (SMDA) should work together toward the goal of developing standard electronic claims formats for state Medicaid use. At our annual meeting this past week, the board of trustees voted to make a two year commitment to ANSI membership and to support our involvement in their standard setting process. During this time, NCPDP will actively pursue how our successful drug standards may be brought in line with ANSI initiatives. We pledge to continue ongoing efforts to work with government organizations and will initiate contact with SMDA. We strongly encourage more active state program involvement in our standard setting processes. NCPDP welcomes additional commentary on our new Medicaid transaction data sets contained in the Version 3.2. Please note that these new standards for Medicaid were created with the help and involvement of a number of large state fiscal agent organizations. NCPDP is actively assisting the Arkansas Medicaid Fibs development of POS drug processing. We shall continue to provide our expertise and consultative assistance to any state agency, fiscal intermediary, processor or government agency that requests help.

We strongly agree that HCFA must encourage standard use although we tend toward stronger wording. The suggestions that a set of rewards for standard use or that enhanced funding be

denied for systems that do not use standards are perfectly appropriate in our opinion. History shows that simple encouragement by HCFA may not be enough to bring about uniformity in Medicaid. The definite financial value that exists in moving states to POS processing can be emphasized most effectively if the federal government provide direct financial incentives and dis-incentives to state agencies.
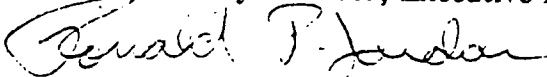
NCPDP looks forward to working more closely with the Medicaid program on POS implementation and of developing POS system capabilities to more positively influence drug therapy quality and cost efficiency.

Thank you again for the opportunity to provide comment. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,

LeeAnn Cleverly-Stember, Executive Director

& Ronald P. Jordan, Medicaid Work Group Chairman & Board Member

cc: Regional Inspector General - Mark R. Yessian, Ph.D.
      OIG Report - Lead Program Analyst - David Schrag

OIG RESPONSE TO NCPDP COMMENTS

We have updated our report's sections on NCPDP standards to reflect the promulgation of Version 3.2. We hope that NCPDP is successful in securing the claims processing industry's commitment to using it. We have deleted language suggesting that HCFA create its own standard claims format and hope that HCFA's and the States' needs can be met with Version 3.2.

We have chosen not to use stronger language in our recommendations on standard claim formats to HCFA and the States. While we believe that standards are an essential component of cost-effective POS systems, we also believe that they are more likely to win acceptance in an atmosphere of cooperation than one of requirements and penalties.

In saying that private vendors "are more concerned with their own interests than those of the States or of HCFA," we do not suggest that they seek to undermine public programs. Nor do we suggest that private vendors should not supply information on POS technology; in fact, we suggest that HCFA seek it out. We merely suggest that private companies are first and foremost responsible to their shareholders and to seeking profits. As these profits may come at the expense of the Medicaid program, we warn HCFA and the States against relying too heavily on private vendors' advice.

With regard to the relative complexity of private versus public health claims, we made a slight modification to the examples given on page 13. We note that regardless of how much history checking is necessary in a POS environment, States currently use more history than private plans. This will continue to be true unless States make deliberate efforts to adjust their policies as they move to POS systems.

APPENDIX F

NOTES

1. For overviews of POS claims management, see "Electronic Claims: A Revolution in Progress," *ComputerTalk for the Pharmacist*, September/October 1988, pp. 15-20, 22-26; and W. A. Lockwood, Jr., "The New Era of Paperless Claims," *American Pharmacy*, n.s. 30, no. 1 (January 1990), pp. 20-22.

2. Adjudication involves checking a claim for errors, verifying that the service is covered, and determining the amount that should be paid.

3. P.L. 101-508, Sec. 4401(a)(3), adds the following language as Sec. 1927(h)(1) of Title XIX of the Social Security Act: "the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment."

4. The State estimated savings of $2,538,112 over three months in 1990 (New York State Department of Social Services, *Day Specific Savings Quarterly Report Based on Disenrollments During Period: 07/90-09/90*, April 2, 1991, p. 4.) We multiplied this figure by 4 to yield a 12-month estimate of $10,152,448. New York City residents are not yet subject to day-specific eligibility, because the city's master eligibility file cannot be updated frequently enough. The State estimates that if New York City residents were also subject to day-specific eligibility the savings would rise to $22,880,454 per quarter ($91,521,816 per year). The State's methodology is described in the report cited above. The Office of Inspector General has reviewed the report and we believe the logic to be sound and the estimate to be reasonably accurate. We did not, however, conduct an independent analysis of the original data nor of the assumptions that underlie the model used for estimating savings. Therefore, although we have no reason to doubt the validity of New York's estimate, we can neither vouch for its precision nor affirm that it is based on the best possible model.

5. Telephone conversation with EMEVS Director, New York Department of Social Services, July 17, 1991.

6. New York State Department of Social Services, "Electronic Medicaid Eligibility Verification (EMEVS) Overview," no date [1989?], p. 2. The service threshold function is described as follows: "The Department will implement a service limits systems [sic] which is expected to save over $200 million annually. Doctors, dentists, laboratories, pharmacies and clinics will be required to call

[EMEVS] at the time of service to ascertain in addition to the eligibility of a client, the client's status with respect to the number of services the client has received in one year. A positive response from EMEVS will result in an authorization record generated and transmitted to the fiscal agent who will require this authorization before paying a Medicaid claim."

7. A group of pharmacists sued New York State on the grounds that EMEVS's post and clear function discriminated against them and that it imposed unreasonable delays in payment. The State won. *Sutphin Pharmacy, Inc.* v. *Perales*, U.S. District Court, Southern District of New York, No. 90 Civ. 7609 (WCC), July 26, 1991.

8. Commonwealth of Massachusetts, *Operational Evaluation Report for the Department of Public Welfare's Recipient Eligibility Verification System*, October 1990, p. A15. This estimate includes total Medicaid savings, without regard to Federal matching rates. The State estimates an additional $3.2 million in savings on 100 percent State-funded health care expenditures. A description of Massachusetts's methodology and its limitations is contained in appendix E.

9. Commonwealth of Massachusetts, *Operational Evaluation Report*, p. A21.

10. We define a POS system as one that operates in real-time and uses advanced technology such as POS terminals or personal computers at the providers' locations. We exclude systems that operate in batch mode or are limited to automated voice response (AVR). Batch mode systems cannot process claims while recipients are still in contact with providers, and AVR systems cannot perform functions beyond eligibility verification.

11. Seven States (Indiana, Michigan, Mississippi, Nevada, New Jersey, Oklahoma, and Pennsylvania) are adding automated voice response systems for eligibility verification. Kansas, Maryland, and Massachusetts have plans to improve their existing eligibility verification systems. Montana, North Dakota, and South Dakota plan to make other improvements in their eligibility systems.

12. Eleven States have definite plans to improve their claims submission capabilities without implementing true POS claims submission. Four (District of Columbia, Georgia, Nebraska, and North Dakota) will begin to allow on-line batch claims submission or will try to increase the percentage of claims that are submitted on-line. Seven (Delaware, Idaho, Kansas, Montana, Nevada, New Jersey, and South Dakota) will try to increase the percentage of claims that are submitted on disk or tape.

13. Shortly before OIG, the American Public Welfare Association (APWA) and HCFA conducted their own surveys of State Medicaid programs. Their survey instruments included questions about plans to develop POS pro-DUR, so ours did not. However, some States gave us information about their plans to implement POS pro-DUR anyway, and the other surveys' results did not

address the issue of definite plans versus preliminary discussions. Because of differences in survey methodology and in interpretation of questions and responses, it is difficult to combine the responses from the three surveys.

14. J. Horvath, *Medicaid Management Information Systems: Provider Participation, Cost Containment Initiatives: State Characteristics*, American Public Welfare Association, Summer 1991, p. 19.

15. Pro-DUR is not among the functions of POS systems that OBRA 90 requires the Secretary to encourage. OBRA 90 does, however, require the States to implement pro-DUR (not necessarily as a component of POS systems) by 1993, and authorizes up to 10 demonstration projects to evaluate pro-DUR as a POS system function. It seems clear, therefore, that Congress envisioned pro-DUR as a natural, if not necessary, component of POS systems.

16. This is an approximation based on the OIG, APWA, and HCFA surveys.

17. Commonwealth of Massachusetts, *Operational Evaluation Report*, p. A26.

18. Telephone conversation with EMEVS Director, New York Department of Social Services (DSS), July 17, 1991, and personal communication from DSS, February 25, 1992. The $3.5 million development cost included $2 million for the purchase of point-of-service terminals for provider offices.

19. Congressional leaders, informed of States' complaints, admitted that the time limit was undesirable. They introduced a technical amendment to repeal it. However, HCFA then informed Congress that enhanced funding for POS systems would be available after FY 1992 whether or not OBRA 90 were amended. Enhanced FFP would be granted under the same authority, HCFA said, as it was before OBRA 90, when it was granted for EMEVS and REVS. Congress dropped the technical amendment.

20. For example, Arkansas's bid for POS device and plastic ID card technology resulted in a protest by the losing bidder, adding even more time and expense to the effort.

21. Memo from Director, Medicaid Bureau, to all HCFA Regional Administrators, March 15, 1991, p. 3.

22. M. J. Richter, "Staying Connected: Disaster Recovery for Government Telecommunications," *Governing*, September 1991, pp. 37-50. The potential for breakdowns was confirmed by a respondent from New York, who added that in comparison to traditional claims-processing systems, POS systems can make "bigger mistakes faster."

23. Examining the Medicaid eligibility requirements of other benefit programs was beyond the scope of this inspection. However, if other programs do indeed

mandate whole-month eligibility, States will not be able to implement day-specific eligibility. This subject is deserving of future study.

24. In response to an OIG request, the Massachusetts Law Reform Institute (MLRI) surveyed legal services programs throughout Massachusetts. Four programs responded. The text presented in this paragraph is based on a summary of those responses prepared by MLRI. In comments to our draft report, the Massachusetts Department of Public Welfare disputed some of the positions expressed by MLRI's respondents.

25. In 8 States with no intention of changing their claims submission procedures, an average of 57 percent of claims are submitted electronically. In 31 States that were discussing or had definite plans to change, the average is 43 percent. (These figures are drawn from data we obtained in our survey of State Medicaid agencies.)

26. Pharmacy claims experienced a low denial rate (9.3%, n=27 States) in comparison to hospital claims (21.8%, n=25), physician claims (23.9%, n=25), and miscellaneous claims (17.3%, n=24). Only nursing home claims were denied less frequently (8.0%, n=24). (These figures are drawn from data we obtained in our survey of State Medicaid agencies.)

27. A bill processor is responsible for evaluating a claim and determining how much, if anything, should be paid. In the Medicaid environment, a bill processor could be the Medicaid agency itself, a designated fiscal agent, or another private contractor selected to operate the POS system.

28. Telephone conversations with chair of HCFA 1500 work group, April 18 and September 3, 1991.

29. Telephone conversation with chair of ANSI ASC X12 Insurance Sub-Committee, April 3, 1991. See also ANSI ASC X12 Insurance Sub-Committee Minutes, Tarpon Springs, Fla., June 2-8, 1991.

30. For 31 respondents that had received information from HCFA, the mean rating for lack of guidance was 2.51. For 19 respondents that had not received information from HCFA, the mean rating for lack of guidance was 3.57. (1 = "not at all a factor; 5 = "extremely important factor.")

31. Telephone conversation with professional staff, Senate Special Committee on Aging, February 27, 1991.

32. Section 1903(a)(3) of Title XIX of the Social Security Act.

33. See Sec. 4401(c)(1).

34. Comments submitted to the Health Care Financing Administration by the Office of the U. S. Senate Special Committee on Aging, Senator David Pryor, Chairman, *Implementation Issues Regarding the Medicaid Prudent Pharmaceutical Purchasing Provisions of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508)*, April 1991, p. 11.

35. Letter from Chairman, U.S. Senate Special Committee on Aging, to Administrator, Health Care Financing Administration, September 13, 1991.