Program Memorandum
Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-02-028 **Date: APRIL 30, 2002**

CHANGE REQUEST 2089

SUBJECT: Sending Payee Information From Multi-Carrier System (MCS) to the Healthcare Integrated General Ledger Accounting System (HIGLAS)

Background

The Federal Financial Management Improvement Act of 1996 requires that Federal agencies implement and maintain financial management systems that comply with Federal management systems requirements. The CMS and other Federal agencies are required to follow the Joint Financial Management Improvement Program (JFMIP) guidelines in implementing accounting systems. The JFMIP has identified seven financial accounting functions of an integrated government financial management system. These functions are General Ledger Management, Payment Management, Receipt Management, Core Financial System Management, Funds Management, Cost Management, and Reporting Functions.

In order to comply, CMS will install Commercial Off-The-Shelf (COTS) software that contains modules for general ledger, accounts payable, accounts receivable, budget, procurement, grants, etc. This COTS will be the financial software application that supports HIGLAS, for which there are two parts. One part will replace CMS's current administrative accounting system Financial Accounting Control System (FACS). The second part and the subject of this Program Memorandum (PM), programmatic benefit accounting, will replace the benefit accounting processes used by Medicare contractors.

Action Requested

Several interface transactions must be created to support CMS with the implementation and maintenance of HIGLAS. The interfaces needed for transmission of claims and payment calculations have already been implemented. This PM addresses the HIGLAS need for two additional interfaces that would support the payment function of HIGLAS for beneficiaries and providers.

Establish Provider Interface for Update Transactions to HIGLAS

In determining the type of provider data needed to be stored in HIGLAS, the HIGLAS team focused on the actual use of the data needed for financial purposes. Pricing factors, such as provider specialty will have already been determined when the claim information is received by HIGLAS from the Medicare contractors. However, besides provider number, name, and address changes, information about a provider's payment status and banking use will impact HIGLAS. Examples of other types of provider data HIGLAS will need are:

- Courts or the IRS ordered withholdings,
- Payment medium – Electronic Funds Transfer (EFT) or paper checks,
- Provider specialty,
- Group information, and
- Banking institution used for EFT.

In addition, HIGLAS will need to store additional data to support other functions, such as Chief Financial Officer reporting and 1099s.

The MCS maintainer will develop an extract of the file(s) that contain provider data. This file or files are used to support the payment of claims activities. The extract will be mapped to a HIGLAS specific flat file rendering of the American National Standards Institute (ANSI) X12N 274 Health Care Provider Information.

Establish Beneficiary Interface for Update Transactions to HIGLAS

As with the provider data, the HIGLAS team focused on the actual use of the data needed by HIGLAS when determining the type and amount of information to be stored for Medicare beneficiaries. When the claim information is received by HIGLAS from the Medicare contractors, the eligibility, deductible, coinsurance, and claim pricing information will have already been determined. This information will not change after claim adjudication. Data such as beneficiary name, address, HICN, date of death, representative payee can change while the claim is on the payment floor and will have an impact on HIGLAS. Included in the file of claim replies the Common Working File (CWF) hosts send to Medicare contractors nightly are trailer records. The systems edit the trailer records to determine if the Medicare contractor beneficiary file needs to be updated. CWF information concerning changes to beneficiary address, name, HICN, data of birth, date of death, representative payee, etc. will be sent to HIGLAS. Temporary address information, with effective and ending dates will also be sent to HIGLAS.

The MCS maintainer will develop an extract of their file(s) that contain the beneficiary data. This file or files are used to support the payment of claims activities. The extract will be mapped to a HIGLAS specific rendering of the ANSI X12N 271 Health Care Eligibility Benefit Response, flat file format. The HIGLAS 271 will be use the ANSI X12N 271 as the base starting point for common data dictionary terms.

Data Mapping

Logistics Management Institute (LMI) is contracted to CMS to provide support for HIGLAS. LMI will document the MCS cross walk mapping effort from the extract files to the HIGLAS 274 and 271. The resulting detail system level mapping will supplement these documents. The LMI will make the system specific documents available to the maintainer by early May.

The HIGLAS 274 and 271 files will be produced only for the Empire pilot carrier for the October 2002 release. Each file will be transmitted in payee number order. This data will be created on a daily basis as a part of the Medicare contractor batch processing cycle. A record will be written to each file only for those payees (beneficiary and provider) that have incurred changes that would impact the HIGLAS payee database. After pilot site testing of this interface with HIGLAS, a file will be produced on an as needed basis by carriers during their transition to HIGLAS. There will be a phased implementation of HIGLAS over an extended period of time. Therefore, the standard system must be capable of operating in a dual mode. The standard system must operate as it currently does for Medicare contractors that are not interfacing with HIGLAS but will be transitioning to HIGLAS in the future and interfacing with HIGLAS for the transitioned carriers.

Error processing will be done at the file (i.e., batch level) and at the field level. Error correction processing will be required at the file level. If the transmitted file is deemed corrupt by HIGLAS it will be rejected and retransmission will be required. Individual transactions that fail edit checks will need to be corrected by Medicare contractors in HIGLAS based on HIGLAS error diagnostic reports.

Additional error handling procedures will be developed during pilot site testing.

Extract File Control

Creation of the extract file will be controlled by the Medicare contractor and data center interfacing with HIGLAS. The MCS maintainer should only provide the capability to create the files for contractors interfacing to HIGLAS. In providing this capability, the MCS maintainer does not need to maintain identification of which contractors are using this interface. In this release no MCS functions should be disabled or changed.

The *effective date* for this PM is October 1, 2002.

The *implementation date* for this PM is October 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2003.

If you have any questions, contact Maureen Hoppa at (410) 786-6958.