



August 24, 2010

The Honorable Secretary Kathleen Sebelius
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Exceptions to the Medicare Timely Filing Period

Dear Secretary Sebelius:

This letter responds to the request for written comments regarding two proposed exceptions to the Medicare one year timely filing provision in section 6404 of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010. HMS is a leader in coordination of benefits and cost containment for healthcare programs. We assist 42 Medicaid agencies and over 100 Medicaid health plans in doing their due diligence to determine third party liability and pursue recoveries when appropriate. Because of our long history and extensive experience in coordinating benefits we are writing to offer our comments to the Centers for Medicare and Medicaid Services (CMS) during this rulemaking process.

HMS supports the exceptions to the Medicare one year timely filing period as proposed by CMS in the Federal Register on July 13, 2010. As a third party liability contractor, we are very much aware that in cases in which a beneficiary is dually eligible for Medicare and Medicaid, benefit coordination resolution can often exceed a one year time frame due to the complexity of the process and numerous data sources that need to be validated. Because of this, HMS is concerned about the unintended consequences the reduction in the maximum time period for submission of Medicare claims can have on Medicaid agencies in terms of decreased cost recovery opportunities for cases in which Medicaid should not have paid primary on a claim.

As CMS moves to finalize these exceptions, we would like to pose some additional items for consideration that are specifically related to the second (dual eligible) proposed exception.

The second exception requires CMS or one of its contractors to determine that three conditions are met in order for the time in which a provider or supplier can file a claim be extended. These conditions are: (1) at the time of service the beneficiary was not entitled to Medicare; (2) the beneficiary subsequently received notification of Medicare entitlement

effective retroactively to or before the date of furnished service; and (3) the state Medicaid agency recovered their payment for the furnished service from the provider or supplier 11 months or more after the date of service. HMS proposes that CMS consider allowing the exception to apply if any of these conditions are met as opposed to all of the conditions.

We have approached this exception from the vantage point of the individual Medicaid programs and their legal requirement to be the payor of last resort. Our experience has proven that there are a number of factors that may result in only some of the above criterion being met but not all, thus leaving the Medicaid agency and provider with no recourse to appropriately coordinate benefits.

For example, the first condition does not take into consideration when the beneficiary is entitled to Medicare coverage at the time of service but this information is not communicated to the Medicaid agency. The discrepancy between entitlement and notification is the primary challenge in Medicaid's efforts to coordinate benefits with Medicare. We often assist Medicaid agencies in identifying cases in which Medicare coverage may be unknown to the Medicaid agency (and the provider or supplier) at the time of service due to a delay in receiving Medicare coverage data. This delay results in the Medicare coverage information not being available for coordination efforts prior to the claim being paid by Medicaid. For this reason, HMS recommends that CMS consider expanding this condition to include cases in which Medicare coverage is *unknown* to the Medicaid agency at the time of service.

Additionally, errors in the eligibility process often occur which prevent notification of Medicare coverage. A recent example of this is the retroactive eligibility of several thousands of Social Security Disability Income (SSDI) eligible individuals with retroactive spanning over two decades. CMS should consider also granting temporary exceptions for when this occurs.

The second condition assumes that because the beneficiary is notified about retroactive Medicare coverage that the provider of service and the Medicaid agency is concurrently notified, which is not always the case. Because this is a direct communication between the Medicare program and its beneficiary, CMS should address how providers and the Medicaid program will evidence dual eligibility to the Medicare Administrative Contractors in an effort to meet this condition.

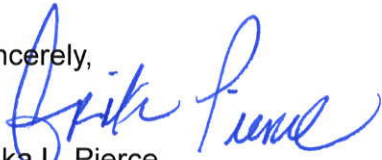
The third condition could be interpreted to mean that the Medicaid agency must recover their payment from a provider or supplier prior to the provider or supplier billing Medicare. We believe it could be a better practice to notify providers of the Medicaid agencies intention to recover prior to performing the actual recovery. Once a provider or supplier has confirmed payment from Medicare, the provider or supplier can reimburse the Medicaid agency. This is done so the provider is not without payment and remains paid for

the services rendered. It is also necessary because many states have Medicare review and recovery billing periods which may not always fall within the eleven month time period proposed.

HMS also recommends that CMS define "retroactive Medicare," for the purpose of these proposed exceptions. We understand retroactive Medicare to be the extension of benefits to a date in the past but believe that confirmation or clarification of this definition should be issued by CMS. Additionally, in states which have a contract with the Social Security Administration to determine eligibility for Medicaid at the same time a determination is made for receipt of Social Security Income (SSI) benefits (1634(a) States), CMS should clarify if Medicare retroactivity will include requests for prior month premium payments.

For the reasons outlined above, we recommend CMS alter the exception to allow for these additional considerations. HMS appreciates the opportunity to provide comments to CMS as it addresses this issue. Should you have any questions, please feel free to contact David Hancock at 919-424-2802 or at dhancock@hms.com

Sincerely,



Arika L. Pierce,
Director of Federal Government Relations