AMMIS Financial Services Operations Manual

11/06/2014

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Version 4.0

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Financial Services Operations Manual
Version:	4.0
Location:	https://pwb.alxix.slg.eds.com/alxix/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/OperatingProcs/Financial
Owner:	HPES/Alabama Medicaid
Author:	
Approved by:	
Approval Date:	

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for Change	Changes (Section, Page(s) and Text Revised)
03/08/2008	1.0		Final Version Approval	
08/12/2009	2.0		CO 6970	Update to Section 5, pages 18 and 19.
03/09/2010	3.0		CO 7451	Update Section 9, page 29, to reflect the following: Cease printing/mailing of RAs
11/06/2014	4.0		Updates to reflect current processing	

1.3 RELATED DOCUMENTATION

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

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2 INTRODUCTION

The information contained within this manual will assist staff members with the administration of the Alabama Medicaid Management Information System (AMMIS) and account support.

2.1 FINANCIAL SERVICES UNIT FUNCTIONS

The Financial Services unit consists of the following:

- Banking Services
- Provider Adjustments
- Provider Cash Receipts

2.2 FINANCIAL SERVICES FORMS

All forms referenced in this document can be found in iTRACE under the functional area.

2.2.1 Financial Services Tasks

The following list identifies the tasks most frequently performed by the Financial Services unit:

- Enter provider payout (expenditure) and recoupment (account receivable) transactions and track to completion.
- Produce annual 1099 documents that are sent to providers and 1099 tapes that are sent to the Internal Revenue Service (IRS) and State Department of Revenue.
- Issue corrected 1099 documents as requested and notify the Agency, the State Department of Revenue, and IRS of the corrections.
- Open and maintain separate bank accounts for Medicaid fund disbursements and money returned to the Medicaid program.
- Process mass adjustments to claims.
- Produce warrants (checks).
- Receive and deposit refund checks daily for providers.
- Reconcile bank accounts.
- Research and enter individual claim adjustments.
- Research money returned and enter cash transactions to post the returned funds to the correct claims in history or open accounts receivable.

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2.3 INPUT, PROCESSES, AND OUTPUT

2.3.1 Input

The table below documents the inputs to the Financial Services area:

Common Financial Services Input

Input	Source	Purpose
Claim Adjustment request	Agency Contractor staff	To make a change to a paid claim. This can result in: • An Additional Payment • A claim specific account receivable • A data change that creates neither an additional payment nor an AR.
Bank statements and transaction files	Agency Bank	Used in conjunction with AMMIS financial reports and manual process logs to reconcile all deposits and disbursements from the Medicaid bank accounts.
Check payment database	AMMIS financial processing cycle	To produce checks and Electronic Funds Transfer (EFT) transactions to pay providers for services rendered.
Mass adjustment request	Agency Contractor	Identifies a large volume of claims that require the same adjustment correction: *Examples:* Retroactive provider rate change. Retroactive procedure price change. Retroactive patient liability change for a recipient.
Money	Agency	Deposits made to the Medicaid disbursement account used to pay Medicaid checks and EFTs issued to providers.
Payout transaction (expenditure)	Agency Contractor	To pay a provider an additional lump sum of money that is non-claim specific: *Example:* The State owes the provider additional money at the conclusion of an annual hospital cost settlement audit.
Provider earnings database	AMMIS	Used to produce annual 1099 documents that are sent to providers and 1099 tape files that are sent to the IRS.

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Input	Source	Purpose
Recoupment transaction (account receivable)	State Contractor	To recover a lump sum of money from a provider that is non-claim specific: ***Examples***: A Surveillance Utilization Review (SUR) review identifies the provider over-billed and must repay money. The provider owes the State money at the conclusion of an annual hospital cost settlement audit.
Refund check	Provider	To refund money to the Medicaid program due to an overpayment on an account by sending in a check to Financial Services.
Returned Medicaid warrant (check)	Post Office Provider	An original Medicaid issued check that the provider does not accept or is returned from the post office marked as undeliverable.

2.3.2 Processes

Processes accomplished in the Financial Services unit include the following:

- 1099 reporting
- Bank reconciliation
- Financial balancing
- Payment Release
- Individual claim and mass adjustments
- Non-Claim Expenditures and Accounts Receivables
  - Non-Claim Expenditures
  - Non-Claim Account Receivables
- Provider Cash Receipts
  - Refunds
  - Voids and stale dates
- Provider Payments
  - Each of these items are described in the individual sections in the manual.

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2.3.3 Output

The table below documents the outputs from the Financial Services unit:

Common Financial Services Output

Output	Source	Purpose
1099 documents and tape files	AMMIS	To notify providers, the IRS, and the State Department of Revenue of the total amount of Medicaid dollars paid to each provider.
Reports, including Remittance Advices (RAs)	AMMIS	To provide summaries, statistics, and comprehensive audit trails for all Medicaid dollars paid and received.
Warrants (checks) and EFTs	AMMIS	Instruments of payment to providers for services rendered.

2.4 FINANCIAL AREA RESPONSIBILITIES

The following responsibilities for the Financial Services unit were extracted from section 3.07 of the Invitation To Bid (ITB):

General

1. Operate the Claims Reporting and Financial component of the Alabama MMIS, including improvements as they are implemented.
2. Support all claims reporting functions, files, and data elements necessary to meet the requirements of this ITB.
3. Support all financial application functions, files, and data elements to meet all requirements in the ITB.
4. Transmit payment invoices to the State by paper and electronically.
5. Complete the payment cycles within established time frames so that provider payments can be electronically transmitted or mailed in a timely manner.
6. Process and generate capitation payments for HMO and managed care providers.
7. Process and generate case management fees for the PCCM Program and the Recipient Lock-In Program.
8. Process and generate capitation payments for Prepaid Inpatient Health Plan (PIHP). *(NOTE: This requirement was excluded in the GAP session. To further clarify, the financial team manually keys from a list provided by State. An expenditure transaction for each of the PHP districts and the amount is keyed. That is how these capitation payments are made.)*
9. Update the claims history file/database with the check number, financial cycle date, and amount paid information by the first business day following each financial cycle.
10. Prevent processing of checks and EFTs for those test transactions processed through the Integrated Test Facility (Model Office and UAT).
11. Perform all internal balancing activities to ensure accurate disbursement of payments.

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12. Provide on-line access to claims and financial information.
13. Provide training and instructions in an on-line user manual to State staff on accessing claims and financial information, initially and on an ongoing basis, as requested by the State.
14. Provide payment data from the provider claims, adjustment, accounts receivable, and transaction processing activities to Medicaid.
15. Process and generate provider and recipient claims history requests.
16. Provide systematic update capabilities to claims and financial history.
17. Provide a contingency plan for processing payments in the event that there is an interruption of the payment cycles.
18. Maintain a claim control and inventory system approved by the State.
19. Provide the State with imaged and/or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and facsimile copies of all electronic transactions processed.
20. Produce and transmit a monthly paid claims extract file to the State's peer review organization to support retrospective hospital utilization reviews. (Note: This is a function of the Claims Subsystem.)
21. Utilize EFT to deposit payments to provider accounts.
22. Apply check number file to claims history.
23. Identify all checks to be pulled for stop payment.
24. Receive and deposit all returned provider checks.
25. Review provider 1099 earnings reports and resolve any discrepancies.
26. Establish capability to split-release provider payments as directed by the State.
27. Make written recommendations on any area in which the Contractor thinks improvements can be made.
28. Provide to Medicaid, two (2) months prior to Operations, a detailed allocation by cost centers for Contractor activities on which percentages of the administrative fees are allocable at ninety percent (90%), at seventy-five percent (75%), and at fifty percent (50%) federal financial participation. Such allocation shall be in accordance with the requirements of federal regulations for Alabama MMIS, Section 11276 in Part 11 of the State Medicaid Manual and in a manner prescribed by the State.

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Reports

1. Produce internal control reports documenting workload by location, providers, recipients, or claim types on a weekly, monthly, and annual basis, and make available to Medicaid on request.
2. Produce all required claims operations reports, and make available on-line or deliver to the State within established timeframes and State-specific distribution procedures.
3. Produce all required financial/fiscal management operations reports, and make available on-line or deliver to Medicaid within established time frames.
4. Produce and make available on-line or deliver to Medicaid all required Federal and State financial reports within established time frames.
5. Produce reports necessary for the State to monitor accounts receivable, recoupments, and other financial transactions.
6. Produce reports necessary to meet the requirements of the Federal Cash Management Improvement Act of 1990.
7. Submit to designated State staff a monthly report listing separately all Contractor or State identified inappropriate and/or incorrect provider payments. *(NOTE: This requirement was excluded in the GAP session.)*

Recipient Explanation of Medical Benefits (REOMBs) (Note: This is a function of the Claims subsystem.)

1. Generate and distribute REOMBS (based on 42 CFR 433.116 and Claims Processing Policy PA-029 requirements) to a selected sample of recipients monthly according to a sampling plan approved by Medicaid. Confidential services shall be excluded from the REOMBs. REOMBs shall be mailed promptly, but in no case shall the delay exceed forty-five (45) calendar days from the date of claims payment and/or ten (10) days from the REOMBs requested date. REOMBs shall be sent to each recipient, in a specified sample, who received services during a specified time period, except for those services specifically excluded by Medicaid. REOMBs shall contain a stamped return envelope or business reply envelope. These requested REOMBS will be ordered in different samplings on a yearly basis. REOMBS are to be returned to the requesting individual, including a copy of the REOMBS mailing list. The sample size shall be up to one thousand three hundred (1,300) per month. The cover letters for the REOMBs will change specific to the information given by the requestor.
2. Generate special targeted REOMBs to be sent to recipients who have received services from a specific provider for a specified time period. Targeted REOMBs are to be mailed promptly, but in no case shall the delay exceed ten (10) days from the REOMBs requested date. Targeted REOMBs shall contain a stamped return envelope or business reply envelope. Targeted REOMBs are to be returned to the requesting individual, including a copy of the REOMBs mailing list. A cover letter will be prepared for each requested targeted REOMB specific to information given by the requestor. A maximum of four (4) targeted providers per month is anticipated.

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3. Receive returned REOMBs at a separate post office box used specifically for the receipt of such REOMBs. Review and sort returned REOMB responses into the following three categories: (1) services were received, (2) services were not received or amount paid by the recipient did not match co-payment, or (3) recipient has questions or is not sure about the Medicaid payment or services. Attempt to clarify suspicious or questionable responses through the use of a follow-up letter and/or a call to the recipient. All responses that remain suspicious or unusual after follow-up shall be referred to the Associate Director, Investigations. REOMBs which do not require follow-up correspondence shall be microfilmed/imaged and forwarded to the state for record keeping purposes.

Explanation of Payments (EOPs)

1. Produce and distribute provider RAs in an electronic format approved by the State, within State-established timeframes.
2. Support multiple formats for the EOPs, including the ASC X12N 835 format, by provider type and claim type, electronically, and on-line access by State staff.
3. Provide the capability for the provider or vendors to download 835 EOPs through the web.
4. Produce the remittance advice statements/EOPs in a format approved by the State. The remittance advice shall be clear and in a readable format, such that the information is easily located and interpreted by the user.
5. Produce all claims text and data information on the RA in a format which is understandable to providers. Medicaid's Interactive Web portal allows providers to view RAs on-line. RAs are stored for six months on the interactive database. RAs can also be printed, saved to a personal computer, or viewed from the web portal.
6. Print or display third party resource data on provider EOPs for claims denied for potential TPL insurance.
7. Provide additional copies of RAs to providers for a State approved charge.
8. Make RAs available via internet in a readable format.

Provider Earning Statements (1099s)

1. Generate and distribute a consolidated 1099 earnings report to providers.
2. Create 1099 file.
3. Generate and submit a 1099 tape to the IRS and the State Department of Revenue.
4. Capture and store 1099 data.
5. Respond to provider inquiries regarding 1099 discrepancies.
6. Research, revise and reissue any 1099s which are in error.

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Banking

1. Establish and maintain a separate depository account for the receipt of funds from Medicaid for provider payments. As warrants are presented for payment or electronic fund transfers are made, the contractor shall ensure that funds are transferred from the Depository Account to the Disbursement Account. Remaining funds shall be invested in standard overnight repurchase agreements. Furnish the necessary bank information to accommodate Federal requirements for sharing interest on undistributed funds. All bank charges on this account shall be the responsibility of the contractor.
2. Establish and maintain a separate disbursement account for the purpose of paying Medicaid providers. All bank charges to this account shall be the responsibility of the contractor.
3. Establish and maintain a separate interest bearing account for deposit of income earned on repurchase agreements. All deposits to and interest earned on this shall accrue to and be paid to Medicaid at least monthly. All bank charges on this account shall be the responsibility of the contractor.
4. Establish and maintain a separate interest bearing account for deposit of refunds from Medicaid providers. All deposits to and interest earned on this account shall accrue to and be paid to Alabama Medicaid at least monthly. All bank charges on this account shall be the responsibility of the contractor.
5. Prepare a solicitation for bids for banking services to be approved by Alabama Medicaid. Solicit bids from Alabama banks with net assets over one billion dollars ($1,000,000,000) to determine the best possible interest arrangement for Medicaid funds. Select the bank which offers the highest overall return on all accounts and finalize banking arrangements following written approval of said arrangements by Alabama Medicaid.
6. Pay providers by Electronic Funds Transfer (EFT). Deliver to its bank the necessary EFT file to cover all or any portion of the provider payroll, as directed by Alabama Medicaid, for the timely release of funds. Release all EFT provider payments the day the funds are received from Alabama Medicaid and all paper checks within twenty-four (24) hours of receipt of funds from Medicaid unless otherwise directed.
7. For each financial cycle performed, provide electronically to the State automated itemized invoices detailing, in a manner and timeframe prescribed by Medicaid and consistent with federal reporting requirements, benefits paid (including interim payments), adjustments made, and the administrative fees charged. If the Contractor, for any reason, makes payment to a provider for an amount different from that shown on the register, the State shall be notified immediately of the change and the reason thereof.
8. Submit on a monthly basis one (1) hard copy and one (1) electronic copy of the check/EFT register of all manual payments issued from the disbursement account for the current month.

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9. Submit on a monthly basis two (2) hard copy listings and one (1) on-line copy of all void transactions for the current month. Funds from these voids that are not reissued shall be returned to the State by the tenth calendar day of the following month. Sixty (60) calendar days after the date of check/EFT transaction, void all transactions that have not been paid.
10. Submit on a monthly basis a full reconciliation of the depository account, the benefit disbursement account and investments in repurchase agreements. The purpose of such reconciliation is to fully account for all monies outstanding for provider payrolls. The reconciliation shall include an analysis of the account, listing in numerical sequence all checks/EFT transactions issued. This listing shall indicate whether the checks/EFT have been paid, voided, canceled or are still outstanding. Provide a daily account analysis indicating the ledger and collected cash balances in the account on each day during the month.

Accounts Receivable

1. Provide the capability to link Accounts Receivable transactions (e.g. Medicaid providers and recipients, TPL, and for Drug Rebate manufacturers, liens, etc.) to the corresponding claims in the MMIS and process adjustment transactions, where appropriate. For each MMIS functional area that generates Accounts Receivable transactions, provide the following capabilities:
   - Case tracking functions to maintain claims that are in the process of review and evaluation to determine if a payment is due from a third party (Note: This is a function of the TPL subsystem.)
   - Identification and tracking of contingent receivables when the State believes that an amount is owed but the specific amount or the collect ability of the amount has not yet been determined
   - An Accounts Receivable file for providers to maintain amounts that have been determined to be owed to the Agency and are also likely to be collected.
2. Monitor the status of each provider accounts receivable, and report after every provider payroll to the State in aggregate or individual accounts as specified by the State, both on paper and on-line.
3. Monitor outstanding provider accounts receivable, issue collection notifications, apply recoveries or write-off transactions where appropriate, and report the outstanding accounts receivable to the State after every provider payroll.
4. Monitor the status of each recipient accounts receivable and report monthly to the State in aggregate or individual accounts as specified by the State, both on paper and on-line. (Note: This is part of the Recipient AR Subsystem.)
5. Monitor recipient accounts receivables, issue collection notifications, and report the outstanding accounts receivables to the State monthly. (Note: This is part of the RECIPIENT AR Subsystem.)
6. Accept, store, and report information on those individuals or entities subjected to Tax Intercept. (Note: This is part of the Recipient AR Subsystem.)
7. Generate letters to those subject to Tax Intercept. (Note: This is part of the Recipient AR Subsystem.)

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8. Generate Tax Intercept tape for the State Department of Revenue which contains name, social security number, reason for debt, and amount of debt. (Note: This is part of the Recipient AR Subsystem.)
9. Monitor compliance with written procedures to meet state and federal guidelines for collecting accounts receivables.
10. Create an aging statement after every provider payroll for outstanding accounts receivables.
11. Receive requests to process cost settlements and recoveries from the State.
12. Enter accounts receivable transactions into the MMIS Claims History, as directed by Medicaid.
13. Verify input and monitor status of outstanding accounts receivables.
14. Provide access for the State to post payments to accounts receivable subsystem.
15. Provide an interface with the Drug Rebate system as described in Section 3.10.
16. Update provider accounts receivable balances after every provider payroll.
17. Generate accounts receivable balance reports.
18. Receive, track, process, and report provider recoupments.

Adjustments

29. Enter all Medicaid requested adjustment transactions into the MMIS.
30. Process audit payments/credits as directed by Medicaid.
31. Process Medicaid-established individual (a single claim for a single individual) and gross adjustments (entire caseload) to managed care providers on the provider payroll following receipt of the request from Medicaid.
32. Perform mass (adjustments which correct many claims due to a change in the system) and gross lump sum adjustments (provider adjustments), when directed by Medicaid.
33. Identify and correct any erroneous payments resulting from changes in patient liabilities, individual nursing facility rates, or Long Term Care (LTC) File.
34. Process credit adjustments and recoupments and apply to claims history.
35. Identify and process adjustments resulting from system-caused errors or contractor negligence. Notify Medicaid and providers of such adjustments within Medicaid agreed-upon time frame.
36. Process adjustments to original and adjusted claims and maintain records of all previous processing.
37. Adjust provider 1099 and claims history based on returned checks, HPES issued manual checks, audit adjustments and provider personal checks.
38. Deliver to the State a report listing lump-sum adjustments after every provider payroll.
39. Create facsimiles of electronic adjustments and image paper adjustment requests and make available on-line via provider ID, RID or transaction number.

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2.5 PEFORMANCE EXPECTATIONS

The following performance expectations for the Financial Services unit were extracted from section 3.07 of the Invitation To Bid (ITB):

1. Produce to the State all required financial reports no later than noon on the first business day following the adjudication cycle.
2. The percentage of EFT payments to total payments per payment cycle must remain above the Alabama Cash Management Improvement Act standard, currently ninety-five percent (95%) of total dollars.
3. Produce to the State the electronic transmittal of invoices, in a format established by Medicaid, no later than 10:00 a.m. local time on the first business day following the adjudication cycle.
4. Process monies received from providers for services paid for recipients retroactively determined to be ineligible, SUR recoupments, returned checks, provider checks and any other checks received. Checks from third party payers will be forwarded to the State for processing.
5. Perform two (2) payment cycles per month, on demand cycle, or on a schedule established by Medicaid.
6. Process State-established individual and gross adjustments for Managed Care capitation payments prior to monthly capitation processing.
7. Provide Medicaid with imaged or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all facsimile copies of electronic transactions processed within ten (10) business days, upon request.
8. Generate, image, make available on-line, RAs by the first business day following each payment cycle.
9. Generate recipient and provider history printouts within one (1) business day of receipt of requests.
10. Produce to the State and/or make available online claims inventory, operations, and other reports after each claims processing payment cycle.
11. RAs shall be imaged and available on-line the first business day following each payment cycle.
12. Enter provider refunds within fifteen (15) business days of receipt.
13. Produce and transmit a monthly paid claims extract file to the State’s peer review organization to support retrospective hospital utilization reviews within ten (10) business days of the last payment processing cycle of the month.
14. Produce and mail (or transmit electronically) provider 1099 earnings reports to providers no later than January 31, each year.
15. Produce and mail federal and state 1099 tapes in accordance with federal and state regulations no later than January 31, each year. Reissue any 1099's which are found to be in error.
16. Produce and submit to the State and make available online after each provider payroll reports on accounts receivable collections and outstanding balances in aggregate and/or individual accounts, as approved by the State.

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17. Produce and submit to the State and make available online monthly reports on recipient accounts receivable collections and outstanding balances in aggregate and/or individual accounts as approved by the State. (Note: This is a function of the Recipient AR Subsystem.)
18. Generate and send Tax Intercept tape to the State Department of Revenue no later than last business day of the year. (Note: This is a function of the Recipient AR Subsystem.)
19. Generate and mail Tax Intercept notification letters to recipients by October 15 of each year. Approximately two thousand five hundred (2,500) letters are mailed to recipients annually. (Note: This is a function of the Recipient AR Subsystem.)
20. Process adjustments entered on-line in the next adjudication cycle.
21. Process all State-approved mass adjustments in the next adjudication payment cycle.
22. Provide copies of bank statements and reconciliations of the depository account and disbursement account no later than twenty-five (25) calendar days following the end of each month.
23. Provide reconciliations of the provider refund account and the income earned account no later than ten (10) calendar days following the end of the month.
24. Create accounts receivable records and produce and mail (or submit electronically) third party invoices on a schedule approved by Medicaid. Create pre-production reports for review by State staff prior to creation of accounts receivable records and claims. Reports shall be available on COLD for State review and approval. Within two (2) business days of State approval of reports, Contractor shall create accounts receivable records for State approval. Within two (2) business days of receipt of approval of accounts receivable records, Contractor shall produce paper and electronic billings for State approval prior to mailing Contractor shall mail/transmit post-payment billings within four (4) business days of State approval of the billings. Invoices shall not be added to accounts receivable or distributed prior to State approval. Approximately seven thousand (7,000) invoices are mailed or submitted electronically per month. Pre-production reports, accounts receivable entries, and claims facsimiles (or hard copy claim facsimiles) shall be available for on-line viewing. (Note: This is a function of the TPL Subsystem.)

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3 1099 REPORTING

All dollars paid to Medicaid providers must be reported to State and Federal taxing authorities according to Medicaid regulations. At enrollment, every provider must report his Federal Employer Identification Number (FEIN) or Social Security Number (SSN) for correct income reporting to tax authorities. AMMIS maintains the provider information on the Provider Master File and accumulates all dollars paid and recovered from providers on the Provider Earnings file.

After the last payment cycle for a calendar year, the 1099 process creates individual 1099 forms. The 1099 forms are mailed to providers no later than January 31st of each calendar year for the previous years' earnings. During this process, a magnetic tape with identical information is created and sent to the IRS and the State Department of Revenue. These tapes are delivered no later than January 31st of each calendar year for the previous years' earnings.

NOTE:
During the third quarter of each calendar year, it is important to review the 1099 process. This will ensure that any changes that are required by the IRS in the 1099 form, magnetic tape specifications, or record layouts are identified and sufficient time is allocated to make the modifications in AMMIS.

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4 BANK RECONCILIATION

Each month, the bank produces bank account statements and sends them to Financial Services. The Cash Financial Clerk (s) reviews the statements and compares them to information produced in AMMIS financial reports. A monthly report of bank account status and the results of bank statement account reconciliation for each open bank account is prepared. Account reconciliation is typically completed within 15 days of receipt of account statements and no discrepancies are left unresolved. Completed monthly reports are delivered to the Agency.

4.1 DEPOSITORY AND DISBURSEMENT ACTIVITY

Financial Services completes the bank reconciliation procedures each month for the Master Funding and Disbursement accounts.

Financial Services receives the reconciliation from Regions Bank by the 15th day of each month. Regions Bank sends a Depository and Disbursement statement along with a CD-ROM of cleared checks to verify transactions. The Cash Financial Clerk then performs the following tasks:

1. Obtain the following items to use each month to prepare the Depository and Disbursement account reconciliation:
    - Current month's bank statements.
    - Listing of manual checks.
    - Listing of voided checks.

      If an original check was not voided, and a replacement check was issued, make sure the check number was keyed correctly. If the check number was keyed incorrectly, add the check to the next month's void sheet that is sent to the bank. This check is also considered a reconciling item.
    - Returned EFT payments.
    - The following bank reports:
        - Bank Reconciliation Report from Regions Bank.
        - Diagnostic Summaries Report.
2. Send a listing of new issues and a listing of voided checks to Regions Bank.
3. Verify the deposits and the EFT totals on the statements.
4. Obtain the deposit amount.
5. Obtain the new issue amount.
6. Obtain the void amount from the Bank Reconciliation Report.
7. Prepare the reconciliation and deliver it to the Agency, along with a copy of the Bank Reconciliation Report in Paid Date order, and another copy of the Bank Reconciliation Report in Check Number order.

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4.2 REFUND ACCOUNT

Financial Services completes the following bank reconciliation procedures each month for the Refund account:

1. Obtain the reconciliation statement that Regions Bank sends to HPES and a complete reconciliation statement by the 15th day of each month.
2. Compare the daily refund deposits using the actual deposit slips against the Regions Bank statement to ensure that all deposits were posted accurately. The total daily refund deposits should match the total deposit balance on the Regions bank statement, excluding the total interest paid.

NOTE:

If the amounts do not match, the bank is immediately notified. This process will not continue until the discrepancies are corrected.

3. Post the weekly processed refund amounts, taken from the report for the reconciliation month, on the Daily Cash Receipt Log.
4. Obtain a total processed refund amount, using the weekly amounts posted, on the Daily Cash Receipt Log.
5. Obtain totals for any refund transactions not posted to the AMMIS within three months of deposit.

NOTE:

Refund transactions may age to three months or more if HPES has requested the provider submit additional documentation for the refund request and the provider has not yet responded.

6. Obtain the weekly excess refund amounts from the Financial Exception report for the reconciliation month on the Daily Cash Receipt Log.
7. Obtain totals for any refund transactions that are over three months old which have been processed by the AMMIS.
8. Obtain the total interest paid amount from the bank statement for the reconciliation month.
9. Obtain the processed refund amount, by invoice category, from the Approved to Pay reports produced from the financial cycles for the reconciliation month.
10. After all of the totals in items 3 through 9 are obtained, the monthly refund letter is generated by performing the following steps:
    - List the daily refund deposits and the total refund amount.
    - Add the monthly interest earned to the total refund amount which determines the total amount.
    - Add to the amount derived from adding the daily refunds and the interest earned (in the previous bullet item) the Total (Month) Balance from the previous months' Refund Letter to determine the current (Month) Balance.

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- Using the current (Month) Balance, determine the Total Check amount by adding or deducting the following items:

NOTE:

The Total Check amount is turned over to the Agency each month with the completed Refund Letter by obtaining a cashier's check from Regions Bank, drawn on the Refund Account.

  - Deduct the total processed refund amount (refer to item 4).
  - Deduct the refunds over three months old total amount (refer to item 5).
  - Deduct the total excess refund amount (refer to item 6).
  - Add the refunds over three months that processed total amount (refer to item 7).
  - Deduct the total interest paid amount (refer to item 8).

11. Document the Uncashed Checks total amount for stale dated checks, if applicable, on the Refund Letter.
12. Document the total amount for HPES computer generated checks that were returned to HPES by providers and not reissued.

NOTE:

These checks in items 11 and 12 were originally issued through the Disbursement Account, therefore the refund checks for these funds are drawn on this account.

13. Document the Interest Earned from the Depository Bank statement.

NOTE:

The total Interest Earned amount is turned over to the Agency each month with the completed Refund Letter by obtaining a cashier's check from Regions Bank, drawn on the Depository Account.

14. Deliver the Refund Letter, AMMIS report documenting voided checks and uncashed checks, and the applicable cashier's or manual checks to the Agency by the 10th of each month following the reconciliation month.

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5 FINANCIAL BALANCING

The AMMIS balances when the Financial Cycle is complete. Financial compares the amount of money actually paid on the checks/EFT's to the records that are brought into the cycle (claims, adjustments, cap, payouts, etc...) minus recoupments made (AR's, Liens). If the two amounts do not balance, then the cycle abends. The cycle is stopped and the problem is identified and resolved before proceeding.

Reports are generated based on the balancing of financial and claims information. The number of claims and total dollars recorded as paid, denied, recouped, or paid out in transactions (from the claims and financial cycles) are compared to the categories for the output.

The Cash Financial Clerks then compares the Alabama Invoice to the Approved to Pay and the Payment Register totals to further confirm that the financial cycle is balanced.

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6 PAYMENT RELEASE

After the financial checkwrite cycle, money must be deposited into the Medicaid depository bank account on which provider checks are drawn. The Agency will determine the fund groups to be held and released. Once this determination is made, the Agency will contact Financial Services at HPES and the process will begin to release and hold fund groups. Provider checks can be released and mailed to the provider when the fund transfer is complete. .

NOTE:
The customer can view electronic invoices on FEITH the first morning following a financial cycle. (This only applies to business days.)

The State divides the payments into fourteen fund groups and each fund group is reviewed to determine which payments will be held in the event of a fiscal pend. The fund groups are as follows:

- Alabama Department of Senior Services (ADSS)
- Department of Public Health (DPH)
- Department of Human Resources (DHR)
- Drugs
- Hospitals
- Mental Health
- Non-Institutional
- Nursing Homes
- Other State Agencies
- Disproportionate Share Hospital Enhanced(DSH)
- Pregnancy Related
- Targeted Case Management (TCM)
- Medicaid Emergency Psychiatric Demonstration (MEPD)
- Electronic Health Record Meaningful Use (EHRMU)t

The State notifies HPES which fund groups to release when they have made their decision. As funding becomes available for held fund groups, the same release pattern is followed to control release of the fund groups for that financial cycle.

A separate financial cycle for On Demand payments will run on a requested day of the week determined by the State. A separate invoice is produced for this cycle. The release process is exactly the same as the Main Financial cycle payments.

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HPES Financial Services will complete the following steps in order to process a Funds Request:

1. Locate the financial cycle jobs and reports.

   Obtain the Approved to Pay Report, the invoices, and the Payment Register to determine the checkwrite totals for the cycle. These cycle reports provide category total amounts.

2. Ensure the invoices match the total Payment Register amount. Produce invoices, Payment Register, and AMMIS financial reports on the first workday following the adjudication cycle.

3. The Cash Financial Clerk enters the Agency fund group release decisions for the financial cycle on the EFT Release panel. The EFT release program will run automatically. The Financial SE provides the file to the Cash Financial Clerk. The Cash Financial Clerk FTP's the file to the bank.

NOTE:
The customer can view electronic invoices on FEITH the first morning following a financial cycle. (This only applies to business days.)

6.1 MANUAL PAYMENTS

A manual payment is usually requested if a provider was underpaid or the provider submitted claims and received no payment. The provider contacts the Agency and the Agency informs Financial Services. The Agency provides the provider number, provider name, and the amount to be paid. The Cash Financial Clerk submits an invoice to the Agency with the preceding information and the fund code. The Agency will contact the Cash Financial Clerk when the funds are available to pay the provider.

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7 INDIVIDUAL CLAIM AND MASS ADJUSTMENTS

Through review of their RA, providers may find a payment error caused by a billing error in their office or an error made during claims processing. Should this occur, the provider may perform an adjustment through the Medicaid's Interactive Web Portal. This allows the adjustment to be submitted in an on line in a real time environment. The Provider Electronic Solutions (PES) software allows providers to submit adjustments on-line in batch mode.

For a single claim adjustment request by the Agency or Contractor staff, the adjustment specialist enters the adjustment into the Claim Adjustment Entry Panel by entering the Internal Claim Number (ICN) number or selecting a valid number from the search panel. The adjustment specialist modifies the data to correct the billing error. Every claim adjustment request form is scanned on the day of receipt. It receives an adjustment ICN and is also filed for historical audit trail purposes.

The Mass Adjustment transaction process is used when the same change or correction can be applied to an entire set of claims. Examples of mass adjustments include situations when retroactive rate changes occur to a provider's set reimbursement rate or procedure or drug code payment amounts, or when a recipient's nursing home patient liability amount changes retroactively.

All previous claims for the specified occurrence and time period may be adjusted by submitting a single mass adjustment transaction. The system uses the transaction criteria to search claims history to identify all claims that meet the specified selection criteria and automatically create individual claim adjustments with the corrected data for processing in the claims processing cycle. The adjustments are processed to determine the net underpayment or overpayment that will then appear in the weekly provider check amount and on the affected provider RA.

The following steps indicate the process the adjustment specialist must follow to complete a claim adjustment:

1. Receive all Adjustment Request forms and related mail from the mailroom.
2. Sort all adjustment requests into appropriate adjustment region codes and bundle the adjustments into batches.
3. Review each incoming adjustment to determine if it is a claim that can be adjusted. Claims that can be adjusted are as follows:
   - Claim is in a paid status.
   - Claim is on the history file.
   - Claim has a valid reason for the adjustment.
4. Prepare a return letter and return adjustment requests to the provider (or other initiator) if the request is not valid.
5. Complete an Adjustment Batch Cover Sheet and attach it to the batch of adjustment requests.
6. Log the batches of adjustments into the Adjustment Batch Log Book to record daily counts of receipts and to track special priority batches.
7. Deliver all batched adjustment request forms to the mailroom for scanning and Internal Control Number (ICN) assignment.

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8. The mailroom scans the batches and assigns ICN numbers to the batches then returns them to the Adjustment Specialist. Once the document is returned, sign on to AMMIS and enter the adjustment transaction via the adjustment panel.
9. Enter all adjustment requests using the adjustment panel, making appropriate changes to the original paid claim information and resolving online edits that appear on the panel during data entry.
10. Obtain adjustment worksheets via the data corrections panel and perform resolutions to edits or audits that suspended during the claims processing cycle.
11. Enter data corrections into the Claims system.
12. Once each month, compile the Adjustment Statistics, using the Adjustment Batch Log Book and last month’s ending adjustments inventory count, and submit them to the Financial Services manager.

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8 NON-CLAIM EXPENDITURES AND ACCOUNT RECEIVABLES

In addition to claims payments and claims adjustments, AMMIS processes two other primary financial transactions. They are as follows:

- Non-Claim Expenditures
- Non-Claim Account Receivables

8.1 NON-CLAIM EXPENDITURES

The Agency determines when a non-claim expenditure (audit adjustment payment) should be requested and only those persons who are authorized at the Agency may submit them. After the requests are received from the Agency, the Cash Financial Clerk prepares and submits the expenditure transaction to AMMIS. An expenditure amount (lump sum payment amount) is added to the provider's check amount to satisfy this audit request. In-house expenditures (audit payment adjustments) are done to correct a refund error.

To ensure separation of duties, a different Cash Financial Clerk reviews expenditure (audit adjustment) reports to confirm that the amount paid matches the original authorized request. Every audit adjustment transaction is assigned a transaction tracking number and filed for historical audit trail purposes.

8.2 NON-CLAIM ACCOUNT RECEIVABLES

The Agency determines when a non-claim accounts receivable (audit adjustment recoupment) should be requested and only those persons who are authorized at the Agency may submit them. After the requests are received from the Agency, the Cash Financial Clerk prepares and submits the account receivable transaction to AMMIS. An account receivable amount (audit adjustment recoupment amount) is subtracted from the provider's check amount to satisfy this account receivable request. Any positive payment money for the provider in the current or subsequent financial payment cycles is applied to the open account receivable until all of the money has been recovered.

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9 PROVIDER CASH RECEIPTS

Providers who owe money to the Medicaid program may pay by writing a personal check. The check is attached to a Check Refund Request form and may be accompanied by a letter that identifies the reason for the refund and the claims that are being refunded.

A separate, interest-bearing account is maintained by HPES for handling provider refunds. To ensure separation of duties and provide adequate financial controls, multiple individuals play a part in processing refunds. Monthly, the funds deposited into this account, along with the interest earned, are turned over to the Agency.

There are two other primary cash receipt transactions. They are as follows:

- Refunds
- Voids and stale dates

The Cash Financial Clerk performs appropriate research on the money refunded and prepares financial transactions to correctly post the money to individual claims or open accounts receivable as directed by the provider.

The responsibilities of opening the mail and depositing the checks into the refund account are assigned to the staff in Financial Services. Refunds that are not accompanied by the Check Refund Request form are deposited into the Refund account. The check copy and associated documentation are returned to the provider for additional information so that accurate posting can occur.

Cash Financial Clerk 1

1. Receive mail from the mailroom that is directed to Financial Services.
2. Open the mail and sort the mail into the categories described in the table below:

Cash Unit Categories

Category	Description	Disposition
Adjustments	Checks received by Financial Services for a recoupment that was established as the result of an adjustment. The provider can send a copy of the RA Financial Item page that shows the recoupment and the Check Refund form with the check to help identify the A/R.	Checks are given to the person responsible for applying money to the open A/R during the current week.
Cashed HPES checks	The provider requests a copy of a check with a letter asking that a copy of a cashed Medicaid check be pulled and sent back to them.	A copy of the check is printed from Regions iTreasury listing all cashed checks. This copy is sent to the provider as proof of payment.

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Category	Description	Disposition
Checks received in another unit	Checks received in any unit within HPES.	When a check is received in another unit, a person from that unit brings the check and other information to the person responsible for that day's mail and the check is logged along with all other refund checks.
RA copies	Checks received with a letter requesting a copy of a RA.	Checks are forwarded to Financial Services. The Cash Financial Clerk lists these checks on the check log for RA copies. The current date is stamped on the check and the check is forwarded to the Administrative Secretary.
Return mail	Mail not delivered by the post office. The yellow sticker placed on HPES envelopes by the post office identifies these checks. The sticker indicates that either the check could not be delivered or that there is a forwarding address on file at the post office.	The copy of the check is forwarded to Provider Enrollment so that the address for the provider can be verified. The original check is forwarded to Financial Services. After the provider address has been verified and corrected on file, the Cash Financial Clerk mails the original check to the correct address.
Stop payment request	A form filled out by the PAC team member to have a payment stopped on the original check and a new check reissued.	This form goes to Financial Services for the stop payment.
Warrants (checks)	Returned HPES checks that the provider refused. These checks can be identified by a note written on the HPES envelope or on the HPES check issued to the provider stating why the check was refused.	All HPES checks that are returned because the provider refused the check are given to a Cash Financial Clerk.

3. Determine the check is for a refund. Make a copy of all checks and attach to associated documentation. The check information is then entered into the AMMIS under financial panel/cash receipt.

Refund Check Types

Refund Type	Refund Type Description
Letter	Checks that require a letter to the sender because information is needed to determine where to apply the refunded money. All checks deposited into the refund account must have an amount of refund to apply to each individual claim ICN when a provider is sending one refund check for numerous claims.
Medicare	Claims that are refunded because Medicare made payment for a service that was also paid by Medicaid.
Personal	Claims that are refunded due to duplicate claims, billing errors, payments to the wrong provider, etc.
TPL	Claims that are refunded because a third-party payer made payment for the service which was also paid by Medicaid.

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4. Enter the following information on the financial cash receipt panel:

Field	Entry Description
Payment Type	Select from drop down box, choose cash, check, EFT or money Order
Paid Amount	Enter the amount of the check.
Payment Number	Enter the check number.
Payment Date	Enter the date of the check.
Payee Type	Select Provider from drop down box.
Payee ID	Click Search and enter provider ID.
Reason/Unit	Enter 100-Medical.

6. Print a Daily Cash Receipt by Unit Log and passes the checks and associated document to Cash Financial Clerk 2.

Cash Financial Clerk 2

1. Compares the checks to the Daily Cash Receipt Log.

2. Review all checks to be deposited into the refund account for the following information:

- Reason for the refund.
- Amount applied to each ICN.
- Patient's name.
- Patient's Medicaid number.
- Dates of service so that the ICN can be identified.

> Make sure the check is made payable to HPES or Alabama Medicaid. Checks not made payable to HPES or Alabama Medicaid are returned to the check owner.

3. Stamp the back of each check that will be scanned and deposited through Regions Quick Deposit Service into the refund account with the stamp that has the following information:

**PAY TO THE ORDER
OF REGIONS
BANKFOR DEPOSIT
ONLY**

**ELECTRONIC DATA SYS
CORP/ALA TITLE XIX
AGENT FOR ALABAMA**

4. Make a copy of each check and staple with the associated documents.

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NOTE:

If a check requires additional information, make a copy of the check and send the check copy and the associated documents back to the provider with a cover letter that requests additional information. The original check is deposited with all other checks.

5. Scan the original checks through Regions Quick Deposit Service to be deposited into the refund account. Print out the deposit slip and attach to the Daily Cash Receipt Log.

6. For returned HPES checks, sort the checks by those returned for address change from those returned by the provider.

7. When a computer generated check is returned by the provider, stamp the check with the date of receipt, make a copy of the check, and deliver the original checks to Financial Services.

8. For a computer generated check returned for an address change, stamp the check with the date of receipt, make a copy of the check, and deliver the original check to Financial Services.

9. The check copies and the associated documents are delivered to Provider Enrollment for address verification. Once the provider address information has been updated on the Provider Master file, Provider Enrollment notifies Financial Services that the original check may be mailed back to the provider. Checks not mailed back within 60 days of the issue date are processed according to the Stale Date guidelines.

Cash Financial Clerk

1. Batch the check copies and associated documents.
2. Complete a batch cover sheet for each batch.

General Duties

Refund transactions are entered into the AMMIS after the checks are properly logged, deposited, and returned to the Financial Services. The Cash Financial Clerk code and enter each refund transaction in the AMMIS system.

9.1 VOIDS AND STALE DATES

A provider may return checks issued by the Medicaid program if the provider does not accept payment made for claims included in the check amount. This occurs when the claims were paid incorrectly. Checks may also be returned when they could not be delivered because the provider had an address change.

If a provider fails to cash a Medicaid HPES check within 60 days, the check becomes stale dated. Stale dated checks are turned over to the Agency once a month in a refund letter. A check from the Disbursement account is given to the Agency and identified with a description of voided and uncashed checks. The checks are not voided in the system and the claims are not affected.

Checks that are returned due to a wrong provider being paid or billed in error are voided in the system along with the associated claims with the checks. A check from the Disbursement account is given to the Agency and identified with a description of voided and uncashed checks.

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10 PROVIDER PAYMENTS

Each completed financial processing cycle establishes the total amount of money to be paid to each provider. Additionally, the AMMIS produces the following documents:

- RAs that are available for providers to download from the web portal
- Provider checks

The Agency reviews the completed reports, approves the financial amounts, and requests a draw down from the Federal government for the Federal share of benefit dollars. The Agency deposits the funds into the Depository account. These funds are then transferred to the Disbursement account as checks are presented for payment.

Blank check stock is stored in a locked safe in the Operations facility, along with printed checks that are ready to be mailed. Checks are prepared for mailing to providers and are mailed when the State has released the funds.

> Signature stamps, and access to programs with digitized signatures, are strictly controlled to ensure that the check stock and printed checks are secured.

In certain situations, checks may be set aside and withheld from distribution. Financial Services maintains a Special Pull List. The Special Pull List identifies the following types of checks that require special handling:

- Checks requested by the State.
- Checks pulled as a result of an early emergency payment.
- Checks requiring special delivery—these checks require prior approval from the Agency.
- Checks to be picked up by providers.
- Checks paid to sanctioned providers or providers who are under an IRS imposed tax levy.

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GLOSSARY

The table below defines the terms used in the Financial Services functional area:

Financial Services Functional Area Terms

Term	Definition
1099	An annual report form sent to a provider that informs the provider of the total annual amount received from the Medicaid program. An electronic reporting process to the Internal Revenue Service (IRS) and the State Department of Revenue that tells the Federal and State government agencies the amount of money paid to a Medicaid provider.
Accounts receivable (A/R)	A financial transaction that creates a record of a specified amount of money to be recovered from a provider.
Adjustment	An action to correct a claim paid in error. An adjustment transaction typically is a two-part procedure performed at one time. The two-part procedure voids the original claim and establishes an accounts receivable to recover the original claim paid amount and processes the new adjusted claim. If the adjusted claim payment is more than the original claim payment, the provider receives the net increase. If the adjusted claim payment is less than the original claim payment, the account receivable established recovers the difference from the provider's total claim payment amount.
Audit Adjustment	A transaction to provide a lump sum payment to or recoupment of provider monies. In the AMMIS, these are referred to as expenditure transactions and account receivable transactions.
Backup withholding	A process that must be in place to withhold Federal income taxes if a provider fails to submit signed *W-9* forms to declare tax reporting status.
Check	A paper instrument of payment to providers for services rendered to Medicaid recipients.
Clear	A transaction that occurs when a provider presents a check to the bank or when an EFT transaction is received at the provider's bank. When a transaction has cleared, the money is claimed and paid from the Medicaid/HPES bank account.

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Term	Definition
Cost settlement	An audit process that is part of certain provider reimbursement methods. This process allows the State to set a fixed payment amount for claim services and then performs an accounting of a provider's actual cost for rendering services compared to amounts Medicaid has paid. If the State has paid less than the provider's documented cost to perform the service, then the State "cost settles" and issues a payout transaction for the difference. If the State has paid more than the providers' documented costs to perform the service, then the provider "cost settles" and the State issues a recoupment transaction to recover the difference.
Disbursement	The act of paying money to providers.
Draw down	The act of the State claiming the Federal share of Medicaid benefit dollars from Federal bank accounts.
Electronic Funds Transfer (EFT)	The paying of providers for approved claims using electronic transfer of funds from the Medicaid/HPES disbursement account directly to the provider's bank account.
Federal Employer Identification Number (FEIN)	A number assigned by the IRS to track and report earnings.
Fiscal pend	A process to suspend and hold payment to specified providers, provider types, or all providers for all or a specified set of service dates if a State budget is under-funded and the State cannot meet its' payment obligations. This process most commonly occurs at the end of the State fiscal year. (Note: Although fiscal pend is not done in Alabama, fund groups can be held from release within each financial cycle until a specified time.)
Interest-bearing	A bank account that earns money from the bank which is paid to the State for allowing the bank to use the State's Medicaid money while it is in the bank.
Lien	A transaction to establish an amount of money to be withheld from a provider's payment to satisfy a debt owed by the provider to another entity. ***Example**:* IRS tax liens for failure of a provider to pay appropriate income taxes.
Manual check	A process to obtain a blank check from available check stock and issue it to a provider (usually as an advance payment for claims that will be paid) for a State-approved amount. This process is performed outside the system's financial cycles and requires subsequent manual entry and tracking into AMMIS.
Provider Earnings File	The file that accumulates provider payment amounts and is used to produce annual 1099 reports and documents.
Receipts	The daily accumulation of checks received from providers which are deposited in the bank.

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Term	Definition
Recoupment	A transaction to establish an account receivable in AMMIS. This occurs when a provider owes the Medicaid program money. Payment is withheld from the provider by AMMIS until all money is recovered from the provider.
Refund	A check from a provider to return money that has been overpaid by the Medicaid program as a result of a claims processing error or a check for repayment on an open account receivable.
Separation of duties	A process or series of processes which ensure one person does not handle a cash or financial transaction from receipt through disposition; follows standard cash procedures to prevent fraud or financial abuse.
Stale date	A process to cancel a check still available to be claimed for payment because it has remained uncashed for a specified period of time.
Stop Pay and Reissue	A transaction to notify the bank to stop payment of a Medicaid check which was issued (usually reported as lost or never received by a provider) and then subsequently reissue a replacement check to satisfy payment.
Void	A transaction to cancel a prior transaction. Typically used in the context of voiding a claim which in turn causes a financial transaction to be established to collect the money originally paid on the claim.
W-9	A form that must be completed by a provider to declare an official name and address to an entity reporting to the IRS. The names and numbers that appear on the W-9 must match IRS records or the IRS may assess substantial penalties against the reporting entity.
Warrant (check)	Another name for a check drawn on a State Medicaid Program’s bank account that is paid to the provider.

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