

GAO

Report to the Ranking Minority
Member, Subcommittee on Health,
Committee on Ways and Means, House
of Representatives

August 2004

MEDICARE SECONDARY PAYER

Improvements Needed to Enhance Debt Recovery Process



G A O

Accountability * Integrity * Reliability



Highlights of [GAO-04-783](#), a report to the Ranking Minority Member, Subcommittee on Health, Committee on Ways and Means, House of Representatives

MEDICARE SECONDARY PAYER

Improvements Needed to Enhance Debt Recovery Process

Why GAO Did This Study

Last year, employer-sponsored group health plans (EGHP) were responsible for most of the nearly \$183 million in outstanding Medicare secondary payer (MSP) debt. MSP debts arise when Medicare inadvertently pays for services that are subsequently determined to be the financial responsibility of another. The Centers for Medicare & Medicaid Services (CMS) administers Medicare with the assistance of about 50 contractors that, as part of their duties, are required to recover MSP debt.

GAO was asked to determine whether Medicare contractors are appropriately recovering MSP debt. GAO (1) assessed the cost-effectiveness of the current debt recovery system and (2) identified CMS's plans to enhance the recovery process. GAO analyzed workload and budget information and assessed plans to develop a new debt recovery system—the Recovery Management and Accounting System (ReMAS).

What GAO Recommends

We are recommending that the administrator of CMS (1) improve the efficiency of MSP payment recovery activities by consolidating efforts under a smaller number of contractors and ensuring that contractor budgets for EGHP recovery activities more closely reflect their actual workloads and (2) expedite implementation of the EGHP component of ReMAS. CMS agreed with our recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-04-783.

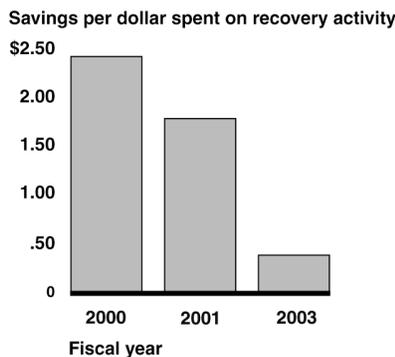
To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

What GAO Found

Medicare's system for recovering MSP debt from EGHPs is no longer cost-effective, with CMS recovering only 38 cents for every dollar it spent on recovery activities in fiscal year 2003. This is largely due to workload and budgetary factors. While the number of new debt cases referred to contractors has declined by more than 80 percent since fiscal year 2000, CMS's budget for contractor recovery activities has remained relatively unchanged. As a result, contractors were funded at a level that exceeded their workload. Almost half of the contractors that CMS funded to process the 7,634 cases associated with the fiscal year 2003 workload were assigned fewer than 50 cases—and eight were not assigned any. The current system is also constrained by procedures that prevent contractors from maximizing recoveries. For example, CMS has instructed contractors not to pursue cases in which the amount of mistaken payments made on behalf of the same beneficiary is less than \$1,000. In addition, CMS neglected to transmit more than 2,000 cases to the contractors—which depend on these transmittals to initiate recoveries—during fiscal years 2000, 2001, and 2003.

CMS is developing a new recovery system—ReMAS—to enhance the MSP recovery process. This system has the potential to help increase savings, provide CMS with greater flexibility in distributing the workload, and simplify the collection of MSP debt. ReMAS is designed to identify relevant mistaken payments and will generate a case that can be assigned to any contractor for recovery—not only the contractor that processed the mistakenly paid claims. However, ReMAS has been under development for over 6 years and is currently only being used for liability and workers' compensation recoveries by a fraction of the contractors. Pilot testing of ReMAS on EGHP cases will not begin until October 2004.

Cost-Effectiveness of MSP Debt Recovery Activities by Contractors Has Declined



Source: GAO analysis of CMS budget and workload data.

Note: Savings data for each fiscal year relate to new EGHP cases opened in that year. CMS did not assign new EGHP debt cases to contractors in fiscal year 2002 to allow them time to reduce their backlog of old cases.

Contents

Letter		1
	Results in Brief	3
	Background	5
	EGHP Debt Recovery Process No Longer Cost-Effective	8
	Contractors' Performance in Recovering EGHP Debt Is Inconclusive	15
	Efforts to Improve MSP Management Have Not Focused on EGHP Debt Cases	18
	Conclusions	20
	Recommendations for Executive Action	20
	Agency Comments	21
Appendix I	Scope and Methodology	22
Appendix II	Comparison of Current System for Recovering EGHP Debt with ReMAS	24
Appendix III	Comments from the Centers for Medicare & Medicaid Services	25
Appendix IV	GAO Contact and Staff Acknowledgments	27
	GAO Contact	27
	Acknowledgments	27
Tables		
	Table 1: Information on EGHP Debt Recoveries, Fiscal Years 2000, 2001, and 2003	10
	Table 2: EGHP Workload and Budget Information, Fiscal Year 2003	12
	Table 3: Comparison of Current Recovery System to ReMAS	24
Figure		
	Figure 1: EGHP Debt Cases, Fiscal Years 2000, 2001, and 2003	11

Abbreviations

CAFM	Contractor Administrative-Budget and Financial Management System
CMS	Centers for Medicare & Medicaid Services
COBC	Coordination of Benefits Contractor
CWF	Common Working File
EGHP	Employer-Sponsored Group Health Plan
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MPaRTS	Mistaken Payment Recovery Tracking System
MSP	Medicare Secondary Payer
ReMAS	Recovery Management and Accounting System

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

August 20, 2004

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Stark:

Medicare—the federal health insurance program that serves the nation’s elderly and disabled—paid over \$271 billion for the health care of approximately 41 million aged and disabled beneficiaries in fiscal year 2003. The Centers for Medicare & Medicaid Services (CMS)—the federal agency within the Department of Health and Human Services that administers the Medicare program—has a strong interest in protecting Medicare’s fiscal integrity. To safeguard funds, CMS must pay only for those services that are the responsibility of the Medicare program. In some instances, beneficiaries have other insurance—such as employer-sponsored group health plans,¹ automobile or other liability insurance plans, or workers’ compensation—that has the primary responsibility to pay their claims. In these cases, Medicare would be the secondary payer, responsible for meeting beneficiaries’ health care costs not covered by the primary insurer.

CMS and the contractors that assist the agency in administering the program are charged with determining whether Medicare beneficiaries have other health insurance coverage.² In fiscal year 2000, CMS estimated that about 8 percent of Medicare beneficiaries had health care claims that appeared to be the primary responsibility of another insurer. Because Medicare does not always know whether a beneficiary has other primary

¹Although persons age 65 or older are eligible for Medicare coverage, some are employed and may receive health insurance coverage for themselves and their spouses through an employer-sponsored group health plan.

²CMS and its contractors are interested in determining whether beneficiaries have other insurance coverage that is responsible for paying their claims before Medicare. This insurance differs from Medicare supplemental insurance, which typically pays for expenses that Medicare does not pay. For example, supplemental insurance may pay for routine annual check-ups, an expense that Medicare does not cover.

insurance, it may inadvertently pay for services that are subsequently determined to be the financial responsibility of another payer. These mistaken payments represent money owed to Medicare and are known as Medicare secondary payer (MSP) debt.

Employer-sponsored group health plans (EGHP) are responsible for the majority of outstanding MSP debt, accounting for about \$134 million of the almost \$183 million in outstanding MSP debt in fiscal year 2003.³ Liability insurers, workers' compensation plans, and other types of coverage accounted for the remaining \$49 million. Because of your interest in protecting the integrity of Medicare funds, you asked that we determine whether Medicare contractors are appropriately recovering payments from other health care insurers, specifically from EGHPs.

To evaluate the MSP debt recovery process, we assessed (1) the cost-effectiveness of the current system for recovering MSP debt from EGHPs, (2) the performance of CMS's contractors in recovering MSP debt from EGHPs, and (3) the agency's plans to enhance the MSP recovery process.

To perform our work, we analyzed information from two CMS databases—the Contractor Administrative-Budget and Financial Management (CAFM) System and the Mistaken Payment and Recovery Tracking System (MPaRTS)—which together contain budget, workload, and recovery data related to MSP claims. We also visited four CMS contractors that processed a high volume of MSP debt recovery cases in fiscal years 2000 and 2001 and reviewed supporting documentation for over 100 closed cases at each contractor. These cases consisted of potentially mistakenly paid claims for beneficiaries who appeared to be covered by an EGHP. Because contractors close the majority of cases without making recoveries, we specifically focused on such cases to determine whether contractors followed appropriate procedures and made sufficient efforts to recover MSP debt. We excluded cases involving liability, workers' compensation, and other forms of coverage from our review.

To further assess contractor performance, we examined whether the contractors' private health insurance businesses influenced their recovery efforts. In some EGHP debt recovery cases, the contractor's private health

³The amount of outstanding debt does not include approximately \$272 million in debt that is currently classified as "not collectible." CMS's financial reporting system does not track this debt by type of debtor—consequently, it is not possible to determine the percentage that is associated with EGHPs and other types of insurers.

insurance business sold coverage to the employer that was responsible for the MSP debt. Because this creates a potential conflict of interest requiring the contractor to collect funds from the private side of its business, our examination included an assessment of whether contractors were diligent in recovering debt in such circumstances. In addition, we reviewed CMS program guidelines and memoranda, interviewed CMS and contractor officials, and examined the results of CMS's fiscal years 2001 and 2002 Contractor Performance Evaluations pertaining to contractors' MSP operations. (See app. I for additional information on our scope and methodology and an assessment of the reliability of CMS data used in this report.) We conducted our work from December 2002 through July 2004 in accordance with generally accepted government auditing standards.

Results in Brief

The current system for recovering MSP debt from EGHPs is no longer cost-effective. Last year, Medicare recovered only 38 cents for every dollar it spent on recovery activities associated with EGHPs. This lack of cost-effectiveness is due, in part, to a decrease in the number of new debt cases, which have declined by more than 80 percent since fiscal year 2000. Despite the fact that almost half of the contractors were assigned fewer than 50 cases in fiscal year 2003, they were funded to support a much larger workload. Eight of these contractors collectively received more than \$1.8 million for their anticipated EGHP workload, but were never assigned any cases to process. Further, operational constraints also prevent contractors from maximizing their recoveries of mistaken payments. For example, CMS has instructed contractors not to pursue cases in which the amount of mistaken payments made on behalf of the same beneficiary is less than \$1,000. In addition, CMS lost an opportunity to recover debt when it neglected to transmit more than 2,000 cases to the claims administration contractors—which depend on these transmittals to initiate recoveries—during fiscal years 2000, 2001, and 2003.

Poor record keeping at three of the four contractors we visited prevented us from fully evaluating contractor effectiveness in processing MSP debt. These three contractors were unable to produce supporting documentation for some of the cases that we requested from them. The percentage of missing cases at these contractors ranged from 4 to 24 percent. For the cases that we could examine, we found that contractor decisions were supported by appropriate documentation. This held true even in those instances where the private side of a contractor's business was identified as having responsibility for MSP debt. However, because these files were not available, we were unable to fully assess whether the contractors made sufficient efforts to collect MSP debt. Without

supporting documentation, we could not conclusively determine in all cases that the contractors had followed appropriate recovery procedures, including diligently attempting to recover funds from the private side of their business. CMS's own contractor evaluations, conducted in fiscal years 2001 and 2002, identified similar problems with records and other problems related to contractors' management of MSP recovery efforts.

CMS has contracted for the development of a new recovery system—the Recovery Management and Accounting System (ReMAS)—to enhance the MSP recovery process by automating some tasks now performed manually. Because ReMAS was designed to use a national claims database to identify mistaken payments, it will be possible for CMS to assign an EGHP debt case to any contractor—not only the contractor that processed the mistaken payments, which is currently CMS's only option. These improvements have the potential to help increase savings, provide CMS with greater flexibility in distributing the workload, and simplify the collection of MSP debt. However, ReMAS has been under development for 6 years and is currently only used for liability and workers' compensation recoveries by a fraction of the contractors. While the agency indicated that it would start pilot testing ReMAS for recovering debt from EGHPs at two contractors in October 2004, it has not specified when it expects all contractors to implement ReMAS for EGHP cases.

We are recommending that the administrator of CMS (1) develop detailed plans and time frames for expanding ReMAS to include EGHP cases, and expedite implementation of the EGHP component of ReMAS; and (2) improve the efficiency of MSP payment recovery activities by consolidating MSP debt recovery efforts under a smaller number of contractors and ensuring that contractor budgets for EGHP recovery activities more closely reflect their actual workloads. CMS agreed with these recommendations and said it has begun taking action to expedite the EGHP component of ReMAS. It also said that it is considering options for consolidating EGHP recovery activities.

Background

CMS administers the Medicare program with the assistance of about 50 claims administration contractors.⁴ As part of their duties, contractors deny claims that are the responsibility of other insurers. In addition, they are required to recover mistaken payments that were made before it could be determined that the beneficiary had other insurance—such as an EGHP, an automobile or other liability insurance plan, workers’ compensation, or other types of coverage.

To ensure that contractors adequately perform these tasks, CMS periodically monitors and evaluates their performance. Contractors are required to record recovery information pertaining to EGHP debt cases in the MPaRTS database. MPaRTS tracks the status of each EGHP case and provides CMS with information on the amount of mistaken payments identified, the amount demanded to be repaid, the amount recovered, and whether the case is currently open or closed. Although CMS does not have a database for tracking liability and workers’ compensation cases that is comparable to MPaRTS, CMS requires contractors to submit quarterly accounts receivable reports for these and other types of cases. These reports show the aggregate amount of outstanding debt, but do not provide detail at the individual case level.

To prevent mistaken MSP payments, Medicare claims administration contractors match beneficiaries’ health care claims against information contained in Medicare’s Common Working File (CWF)—a repository of claims and beneficiary enrollment data—to determine whether Medicare is the primary or secondary payer. Claims are paid if the CWF indicates that Medicare is the primary payer. However, the CWF may not always contain accurate information. The MSP status of some beneficiaries is sometimes in a state of flux—for example, a retired beneficiary may return to the workforce and receive coverage under an EGHP for 6 months, and then leave that job. This information may not be recorded in a timely manner, leading to mistaken payments. In addition, the CWF can also contain inaccurate information if beneficiaries do not notify CMS of their insurance status when they become eligible for Medicare or if they provide incorrect insurance information. Furthermore, although the CWF is periodically updated with new insurance information, there is a lag

⁴The Medicare fee-for-service program is divided into two parts—A and B. The claims administration contractors that process Part A claims—those covering inpatient hospital, skilled nursing facility, hospice, and certain home health services—are known as fiscal intermediaries. Contractors processing Part B claims—covering physician services, diagnostic tests, and related services and supplies—are referred to as carriers.

between the time beneficiaries obtain coverage and when CMS learns of this coverage. In the interim, contractors may mistakenly pay beneficiaries' claims.

To identify mistaken MSP payments when an EGHP is the primary payer, claims administration contractors use information provided by CMS and the Coordination of Benefits Contractor (COBC). The COBC is a specialized contractor that does not process Medicare claims. Instead, the COBC is charged with developing information on beneficiaries who may have other primary health insurance through a process known as the data match.⁵ The purpose of the data match is to identify beneficiaries or their spouses who are employed and thus may be covered by an EGHP. To facilitate data matching, the Social Security Administration sends the Internal Revenue Service a list containing the Social Security numbers of Medicare beneficiaries. The Internal Revenue Service then matches the list against beneficiary income tax return data and sends the results to the COBC for further analysis. For example, if tax records show that an employer paid a beneficiary at least \$10,000 during the previous year, the COBC would contact the beneficiary's employer to determine whether he was covered by that employer's group health plan.

CMS compares information developed by the COBC to the national claims history file, the most comprehensive source of paid claims information. This comparison allows CMS to determine whether Medicare may have mistakenly paid claims on behalf of the beneficiary. If the mistakenly paid claims total at least \$1,000, CMS assigns the case to the claims administration contractor that processed and paid the claims.

Upon receipt of the EGHP debt case, claims administration contractors have 60 days to perform certain tasks to determine whether an attempt should be made to recover the debt. The contractor must first verify that the information being used as a basis for recovering the debt is correct and that it has not already recouped the mistaken payments. If the case passes this initial validation process, the contractor will initiate recovery by sending a demand letter to the beneficiary's employer and insurance

⁵The data match process is one of several ways that CMS, the COBC, and the claims administration contractors learn that a Medicare beneficiary has primary insurance coverage through another insurer. The processes include an initial beneficiary enrollment questionnaire, employer reports, and voluntary data-sharing agreements with some employers and insurers.

company or third-party administrator, requesting payment within 60 days.⁶ If there is no response to the demand letter within 60 days, interest begins to accrue on the debt. Contractors then send a second letter explaining that if a response or payment is not received within another 60 days, the matter will be referred to the Department of the Treasury for collection. Responses to these letters can include repayment with interest or an explanation as to why the employer and associated health insurer are not responsible for the debt. This explanation may include documentation indicating that the employee retired and thus discontinued health coverage or never obtained coverage through the employer.

The procedures followed by contractors to recover mistaken payments from liability insurers and workers' compensation plans differ from those used when the primary payer of an MSP debt is an EGHP. In a liability or workers' compensation case, mistaken payments made on behalf of a beneficiary are not related to a period of insurance coverage, but to a particular incident—for example, an automobile accident or workplace injury. The task of the contractor in such cases is to identify all paid medical claims related to the incident and to inform the beneficiary or the beneficiary's attorney of the responsibility to repay Medicare in the event that they receive an insurance settlement for their medical expenses. Because beneficiaries may require protracted medical treatment for their injuries, it may take several years before the total amount of payments related to the injury is known. In the interim, a contractor may repeatedly review the beneficiary's claims history to determine whether Medicare has paid new claims related to the injury.⁷

We previously reported that CMS maintained a substantial backlog of uncollected debt in fiscal year 2000.⁸ Although the Debt Collection Improvement Act of 1996 required that agencies refer debt delinquent for more than 180 days to the Department of the Treasury, CMS still had not

⁶In addition to the demand letter, contractors will also include the employee's name, insurer, copies of the claims, and the dates on which services were provided, to assist the responsible party in verifying its liability for the debt.

⁷Medicare may conditionally pay a beneficiary's claims if the contractor is aware that another payer may ultimately be found responsible for them. For example, Medicare may pay the claims of a beneficiary related to an incident that is the subject of a lawsuit. After a settlement or judgment is reached, it may then pursue a recovery from the liable party.

⁸GAO, *Debt Collection Improvement Act of 1996: HHS's Centers for Medicare & Medicaid Services Faces Challenges to Fully Implement Certain Key Provisions*, GAO-02-307 (Washington, D.C.: Feb. 22, 2002).

fully implemented this requirement. Prior to 2000, CMS did not instruct claims administration contractors to refer delinquent EGHP cases to the Department of the Treasury for collection. As a result, CMS maintained a substantial backlog of older cases that remained open, but inactive, for many years.

CMS's administration of the Medicare program will undergo significant changes over the next several years as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is implemented. MMA provides CMS with increased flexibility in contracting with new entities to assist it in operating the Medicare program.⁹ While CMS has relied primarily on the claims administration contractors to perform most of the key business functions¹⁰ of the program, the new law authorizes CMS to enlist a variety of contractors to perform these tasks. For example, CMS could use new contractors to process and pay claims and to perform financial management and payment safeguard activities. CMS is just beginning to develop plans to implement MMA's contracting reform provisions. Phase-in of the amendments to contracting reform takes effect on October 1, 2005. The competitive bidding of all contracts is required for contract periods that begin on or after October 1, 2011. The agency expects to issue its implementation plan for contracting by October 1, 2004.

EGHP Debt Recovery Process No Longer Cost-Effective

Since fiscal year 2000, the cost-effectiveness of EGHP recovery activities has significantly declined. The decline in cost-effectiveness occurred because the volume of EGHP debt cases significantly decreased—in fiscal year 2003, almost half of the contractors were assigned fewer than 50 cases—while, at the same time, the cost to CMS for maintaining debt collection capabilities at all claims administration contractors increased slightly. Moreover, CMS funded eight contractors who were not assigned any EGHP debt cases. The recovery process is also constrained by procedures that prevent contractors from maximizing their recoveries of mistaken payments. Because contractors have access only to claims that they have paid, they cannot identify, and thus collect, mistaken payments made by other contractors. In addition to these structural problems, we

⁹Pub. L. No. 108-173, § 911, 117 Stat. 2066, 2378-2386.

¹⁰There are nine business functions: claims processing, beneficiary and provider customer service, appeals, provider education, financial management, provider enrollment, reimbursement, payment safeguards, and information systems security.

found that in 3 of the last 4 years CMS did not transmit a substantial number of EGHP cases to the claims administration contractors, resulting in missed recoveries.

CMS Contractor Funding Has Not Decreased Despite Declining Workload

EGHP recovery activities are no longer cost-effective. To measure cost-effectiveness, we compared the amount that CMS spent on contractor recovery activities for a given fiscal year with the amount recovered from all cases that were opened during the same year—regardless of when the funds were recovered.¹¹ While Medicare recovered about \$2.49 for each dollar it spent on EGHP recovery activities in fiscal year 2000, this ratio declined to \$1.80 in 2001. Although there are no comparable data for fiscal year 2002 because CMS did not open any new EGHP cases that year, thus allowing contractors time to reduce their backlog of old cases,¹² the decline in cost-effectiveness continued in fiscal year 2003 when CMS resumed opening new EGHP cases. In that year, Medicare lost money on EGHP recovery activities, recovering only 38 cents for every dollar spent. (See table 1.)

¹¹We assigned the recovery amount to the year a case was opened because contractors perform the majority of their work shortly after they receive a case—that is, contractors must screen the case to determine whether the amount involved meets the \$1,000 threshold and send letters requesting payment to the responsible party. Although contractors may receive payments in subsequent years, these recoveries are largely the result of work performed during the year the case was opened.

¹²The contractor budget for EGHP debt recovery activities in fiscal year 2002 was \$6,237,056. Although no new EGHP debt cases were opened that year, these funds were used to close old cases, some of which had been inactive for more than 10 years.

Table 1: Information on EGHP Debt Recoveries, Fiscal Years 2000, 2001, and 2003

Fiscal year case opened	Amount of EGHP debt recoveries^a	CMS budget for EGHP debt recoveries	Savings per dollar spent on EGHP recovery activities
2000	\$21,472,071	\$8,612,677	\$2.49
2001	15,062,024	8,351,940	1.80
2003	3,719,465 ^b	9,786,510	.38

Source: GAO analysis of CMS's MPaRTS and CAFM data.

Note: CMS did not open any new EGHP cases in 2002.

^aThe recovered amount includes interest on the debt. Fiscal year recovery amounts include funds that were recovered the year the case was opened as well as any funds recovered in subsequent years.

^bBecause 28 percent of cases assigned to contractors in 2003 remain open, the recovered amount for 2003 was estimated. Using 2000 and 2001 MPaRTS data, we calculated the total amount recovered as a percentage of all EGHP debt referred to contractors—which averaged about 7 percent for these 2 years. We then applied this percentage to the total amount referred to contractors in 2003 to obtain our estimate. In fiscal year 2003, CMS referred \$51,932,106 of debt to contractors. As of March 2004, contractors had recovered \$1,094,176.

The lack of cost-effectiveness of the EGHP recovery process resulted partly from a declining workload, which limited the potential for recovery. The number of new MSP EGHP debt cases has decreased by more than 80 percent in recent years, from 49,240 cases in fiscal year 2000 to 7,634 cases in fiscal year 2003.¹³ CMS officials told us that improvements in identifying beneficiaries with other insurance before a claim is paid have reduced the number of mistakenly paid MSP claims. Consequently, according to CMS officials, this has lessened the need to recover these payments via the EGHP recoveries.¹⁴ These officials also projected that the number of EGHP cases assigned to contractors could continue to decline.

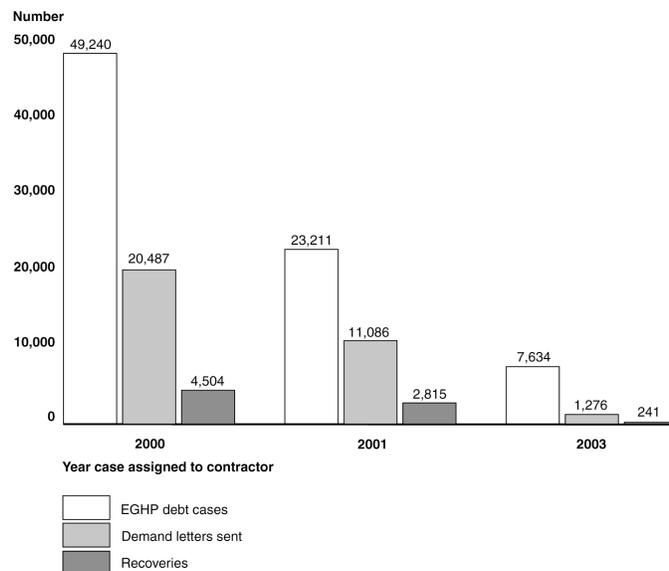
Not only have the number of EGHP cases declined since fiscal year 2000, but the complexity of these cases and the resources required to process many of them have also decreased. Since fiscal year 2000, the claims

¹³In addition to EGHP debt recoveries initiated by the data match, contractors may independently initiate recoveries. However, because CMS does not have a database comparable to MPaRTS for tracking “nondata match” recoveries, information on the number and amount recovered is not directly available.

¹⁴According to CMS officials, several recent initiatives have enhanced the ability of contractors to correctly identify Medicare beneficiaries with other coverage before paying claims. For example, CMS consolidated MSP case development activities with the COBC. CMS has also encouraged employers and insurance companies to share health insurance information on Medicare beneficiaries with CMS on an ongoing basis.

administration contractors closed more than half of the cases during their initial computer screening process. That is, they often found that the mistaken payments totaled less than \$1,000, another insurer voluntarily paid the claims, or the COBC updated the CWF to show that the beneficiary did not have other primary coverage, such as an employer-sponsored group health plan, during the time the services were delivered. In such instances, contractors are not required to correspond with employers and insurers. It is only a relatively smaller number of cases—those that pass the initial screening process—that require significant contractor resources to send demand letters, process the responses, and archive file materials. As shown in figure 1, of the 49,240 EGHP cases processed by contractors in fiscal year 2000, 20,487—about 42 percent—were resource-intensive cases that entailed sending a demand letter. In contrast, only 1,276 cases—about 17 percent—involved a demand letter in fiscal year 2003.

Figure 1: EGHP Debt Cases, Fiscal Years 2000, 2001, and 2003



Source: CMS MPaRTS database.

Note: Recovery and demand totals are based on the year the cases were assigned to contractors. CMS did not assign new EGHP cases to contractors in 2002, to allow them time to reduce their backlog of old cases. The number of recoveries for 2003 cases may increase, as the period for recovering debt is still open for about 28 percent of cases.

CMS's payments to contractors for recovery activities have not reflected the sharp decline in the number of EGHP debt cases that occurred in fiscal year 2003. For example, in fiscal year 2000, the three contractors with the

largest workloads received a combined budget of less than \$1 million and processed 7,708 EGHP cases. The workload of those three contractors was larger than the entire fiscal year 2003 workload, for which CMS spent almost \$10 million on contractors' EGHP debt recovery activities.

This disparity between workload and budget in fiscal year 2003 is even more apparent at the individual contractor level. As shown in table 2, 8 of the 51 claims administration contractors processed 400 or more EGHP cases—representing about 52 percent of the total EGHP workload of 7,634 cases.¹⁵ However, almost half of the contractors were assigned fewer than 50 cases. Despite their small combined workload—4 percent of all EGHP cases in fiscal year 2003—CMS allocated to these contractors more than a quarter of its EGHP budget, about \$2.5 million, to support EGHP and certain other recovery activities.¹⁶ Moreover, CMS funded 8 contractors that were not assigned any EGHP debt cases.

Table 2: EGHP Workload and Budget Information, Fiscal Year 2003

Number of EGHP cases assigned	Number of claims administration contractors	CMS budget for EGHP recovery activities	Percentage of total EGHP budget for recovery activities	Percentage of total EGHP cases
400 +	8	\$3,295,191	34	52
200-399	5	1,379,049	14	21
50-199	14	2,595,844	27	21
1-49	16	648,651	7	4
0	8	1,867,775	19	0
Total	51	9,786,510	100^a	100^a

Source: GAO analysis of CMS's MPARTS and CAFM data.

^aColumn percentages do not total to 100 due to rounding.

¹⁵Although these eight contractors processed significantly more EGHP cases than other contractors in fiscal year 2003, their recovery efforts were still not cost-effective—the estimated recovery amount of \$1,331,118 was significantly less than their budget of \$3,295,191.

¹⁶EGHP budgets also include funds for contractors to perform certain other tasks related to MSP debt recovery, such as responding to incoming correspondence and pursuing recoveries that they have identified independently of the data match.

CMS's budget process does not efficiently match funding for contractor recovery activities to contractors' actual workloads. CMS pays each contractor to maintain an infrastructure to support the recovery of EGHP debt, regardless of the number of cases the contractor processes during the year. In order to process EGHP cases forwarded to them by CMS, the claims administration contractors maintain an infrastructure that results in costs such as wages, equipment, and records. Typically, this includes a staff of MSP examiners who review EGHP cases, contact other potential insurers, evaluate explanations from insurers as to why the MSP debt may not be valid, make referrals to the Department of the Treasury when a debt is not paid within 180 days, and archive case files. Each contractor must also maintain screening software to identify and exclude EGHP debt cases that do not meet the \$1,000 threshold. As a result, some contractors may receive funding for their infrastructures even though they process few or no cases during the year, as occurred in fiscal year 2003.

In comparison to other MSP activities performed by contractors—such as maintaining computer programs that automatically identify and deny MSP claims—EGHP recoveries are expensive to conduct and no longer provide a return on investment. In fiscal year 2003, the return on investment for all types of MSP activities combined was 48 to 1. That is, Medicare contractors spent an estimated \$95.6 million for all MSP activities and produced identifiable savings of approximately \$4.6 billion,¹⁷ resulting in \$48 saved for every dollar spent.

Operational Constraints Reduce Potential MSP Savings

We found that several system limitations create barriers to recovering mistaken payments and reduce program savings. Some mistakenly paid claims may be missed because beneficiaries received medical services in more than one state, and thus had their claims processed by more than one contractor.¹⁸ Because contractors have access only to claims records that they process, they are unable to identify claims processed by other contractors. In addition, beneficiaries whose total MSP claims exceed \$1,000, but are split among two or more contractors, may not have all of

¹⁷There are several sources that contributed to these savings, including the amount of denied claims, recoveries (from EGHP debt, liability, and workers' compensation cases), and voluntary repayments from providers.

¹⁸The provider's geographic location determines where a beneficiary's claims are processed. For example, the claims of a beneficiary who maintains a residence in New York, but who receives medical services while vacationing in Florida, will be processed by the Florida claims administration contractor.

their mistaken payments recovered if the payments made by any single contractor total less than the \$1,000 threshold. Although CMS officials could not quantify the effect of these constraints on recoveries, they told us that they believe that these limitations have significantly reduced MSP savings.

For example, a beneficiary who lives in the Midwest but spends the winter in the South and receives health care services in both locations will have claims processed by different contractors. If mistaken payments for \$2,000 were made for services the beneficiary received during the year—for example, \$1,200 in one location and \$800 in the other—only the contractor with payments exceeding the threshold would pursue a recovery. Therefore, although the primary payer would be responsible for the entire \$2,000 in services, Medicare would attempt to recover only a portion of the amount owed.

A similar inefficiency occurs when beneficiaries receive inpatient services covered by Part A of Medicare and physician services covered by Part B. Different contractors typically process Part A and Part B claims, but they are not required to coordinate EGHP recoveries with one another. This lack of coordination also results in missed savings opportunities when neither the Part A nor Part B claims individually meet the \$1,000 threshold. Even if both the Part A and Part B claims exceed this threshold, greater administrative costs are incurred by both CMS and private employers, as two different contractors attempt to recoup payments from the same payer.

Finally, the success of the current system depends on CMS distributing EGHP cases to the claims administration contractor that processed the mistaken payments. Our review of EGHP debt cases revealed that, during fiscal years 2000, 2001, and 2003, CMS neglected to transmit 2,364 cases to the contractors, representing more than \$28 million in potential mistaken payments. CMS officials told us that the accurate referral of EGHP cases has grown more difficult in recent years as some contractors have left the Medicare program and other contractors subsequently assumed their existing workload. They explained that they suspected that these EGHP cases were overlooked when one contractor processing claims for beneficiaries in several states left the program and the related cases were never assigned to the replacement contractors. As a result, no recovery action was ever initiated for these cases. By using the percentage of potential mistaken payments that are typically recovered—7 percent—we estimate that CMS's failure to transmit these cases to contractors for potential recovery cost the Medicare program approximately \$2 million.

Contractors' Performance in Recovering EGHP Debt Is Inconclusive

We were unable to fully evaluate the effectiveness of the EGHP debt recovery efforts of the claims administration contractors we visited because three of the four contractors were unable to produce all of the case files we requested. Although the files we examined indicated that these contractors were appropriately managing their EGHP workload, the volume of unavailable files precluded us from reaching an overall conclusion on their performance. CMS's recent contractor performance evaluations found similar records management deficiencies and raised additional questions about contractors' effectiveness.

Poor Records Management Results in Inconclusive Assessment of Contractors' Performance

We found it difficult to thoroughly assess the performance of all of the contractors we visited. At each contractor, we randomly selected a sample of cases to review. The number selected varied by contractor and totaled 644 cases for all contractors combined. However, 78 case files could not be located.¹⁹ Although one contractor was able to produce the files and supporting documentation for all the cases we requested, the other three contractors poorly managed their records and were unable to provide all of the files and supporting documentation we had requested in advance of our visits.²⁰ The percentage of missing cases at these contractors ranged from 4 to 24 percent.²¹ Because these files were not available, we were unable to fully assess whether the contractors made sufficient efforts to collect MSP debt. For example, without supporting documentation for those cases, we could not conclusively determine that the contractors had followed all the appropriate recovery procedures.

Of the 566 cases available for review, we found that contractor files were complete and contained appropriate documentation to support the

¹⁹Typically, support for such cases consists of paper files that are archived in a storage facility, or computer-generated reports from the contractors' claims systems, which are stored electronically.

²⁰At each of the four contractors we visited, we reviewed from 136 to 207 EGHP cases that were assigned in 2000 and 2001.

²¹The types of missing case files varied across contractors. For example, one contractor could not produce support for almost a third of the cases that were closed during the initial screening. This contractor told us that it had changed computer systems and the electronic versions of the reports stored on the previous computer system could no longer be retrieved. Although some of these reports had apparently also been printed at one time, the contractor could not locate those documents. Another contractor was unable to produce case files for about half of the cases that involved sending a demand letter to the employer. A contractor official speculated that the records might have been lost when it assumed the Medicare contract previously held by another insurance company.

contractor's decision to close each case without making a recovery. We reviewed two types of cases: those that were closed during the initial screening process after the contractor determined that the \$1,000 threshold was not met, and those that were closed after the contractor sent a demand letter to the employer requesting payment. Together, these two types of cases constituted about 65 percent of the EGHP workload during fiscal years 2000 and 2001.²² For cases that were closed because they did not meet the \$1,000 threshold, contractors provided us with adequate supporting documentation showing that the involved claims totaled less than this amount. Other cases were properly closed because the employers provided valid reasons as to why they were not responsible for the MSP debt. For example, if a beneficiary had retired and was not covered by the employer's insurance at the time the claims were submitted, contractor case files contained correspondence from the employer documenting this fact. In about a third of the MSP cases we selected for review, the private side of the contractor's business sold insurance to the employer that was initially identified as having responsibility for MSP debt. Although this situation creates a potential conflict of interest for the contractor because it must collect funds from its private business side, we did not find evidence that contractors closed such cases inappropriately or treated them differently from others.

Our review also found that one contractor made errors entering information into CMS's MPaRTS system, which tracks the status of EGHP cases. Although such errors do not mean that the contractor had inappropriately processed cases, they make it difficult for CMS to monitor the cases' status. The tracking system uses different codes to describe the status of MSP cases. For example, there is a code to indicate that the case was closed after a demand letter was sent, and another to indicate that the case was closed because the \$1,000 recovery threshold was not met. This contractor did not correctly apply these two codes and miscoded about 18 percent of the cases we reviewed.

CMS Contractor Evaluations Highlight Other Problem Areas

CMS's recent contractor performance evaluations of MSP recovery activities support our finding of poor records management. CMS evaluated the MSP activities of 12 contractors in fiscal year 2001 and another 12 contractors in fiscal year 2002. During these evaluations, CMS reviewed

²²The bulk of the remaining cases included those which remained open, those resulting in a recovery, and those referred to the Department of the Treasury for collection.

EGHP case files from contractors. These evaluations are based on a relatively small number of case files—10 to 20—and therefore do not provide in-depth assessments of contractors' performance. However, the evaluations conducted in 2001 and 2002 highlighted contractor performance problems similar to those we identified. That is, CMS found that several contractors, which included some that were not part of our review, had missing case files and entered inaccurate information into the CMS tracking database. For example, during a review of one contractor, CMS requested 20 EGHP case files, but the contractor was able to locate only 12 files. In addition, CMS found tracking-system coding errors—in 2001, 5 of the 12 contractors reviewed did not use the correct status code when entering information into the CMS computer system that tracks the status of EGHP cases.

CMS evaluations identified additional problems in fiscal years 2001 and 2002, suggesting other weaknesses in contractors' MSP recovery activities, as illustrated by the following examples:

- **Staffing problems.** One contractor discontinued processing data match cases for 3 months when the sole staff member performing this task took an extended leave of absence. At another contractor, CMS determined that the number of staff assigned to MSP recoveries was insufficient to process the contractor's large workload. CMS also noted that a contractor had recently changed the educational requirements for MSP staff. Because most of the current staff did not possess a college degree as required by the contractor's revised standard, the contractor retained an almost entirely new MSP staff. The new staff told CMS reviewers that their training was inadequate to prepare them for processing the workload.
- **Delays in processing correspondence.** In examining documentation at one contractor, CMS reviewers identified a significant backlog of correspondence. According to CMS's estimate, there were over 2,400 pieces of mail awaiting action—including checks and correspondence from employers, insurers, and other contractors. The oldest correspondence awaiting action was more than 2 years old—well beyond CMS's requirement that contractors match incoming mail with established cases and respond to such correspondence within 45 days.
- **Failure to appropriately document case determinations.** At one contractor, CMS reviewers found several case files where the contractor did not document whether the action was necessary. For example, the contractor closed a case and indicated that a full recovery was made; however, the file did not show that a check was received from either an employer or insurer. At another contractor, CMS reviewers examined cases that were inappropriately closed without recovery because the contractor had not promptly notified the EGHP of the debt, as required. In this instance, CMS

found that once the contractor recognized its own untimeliness, it erred again by closing these cases without confirming that the health plan's time limit for accepting claims had, in fact, expired.

- Inadequate security measures. Because the recovery process partially relies on Internal Revenue Service tax information, contractors are required to take certain precautions to prevent unauthorized access. At one contractor, CMS found that the workstation of the person responsible for processing the EGHP workload was situated next to the workstations of staff who did not have authorization to access restricted tax information. Reviewers found that files were stored in unlocked file cabinets and that sensitive printed materials were left in plain view in a general work area, rendering the information easily accessible to anyone in the facility.

Efforts to Improve MSP Management Have Not Focused on EGHP Debt Cases

Recognizing the need to improve the coordination of its MSP recovery efforts, CMS contracted for the development of a new recovery system—the Recovery Management and Accounting System (ReMAS)—in 1998. The purpose of ReMAS is to improve the identification, tracking, and recovery of mistaken payments. ReMAS was designed to enhance the MSP recovery process by automating some tasks performed manually and by reducing the time required to collect MSP debt. As of May 2004, CMS has deployed the liability insurance and workers' compensation component of ReMAS to nine contractors.

Designed to Enhance MSP Recoveries, ReMAS Offers Promising Features

ReMAS is designed to receive and evaluate leads from CWF electronically, a function that is now performed in separate steps by CMS staff and individual claims administration contractors. These leads consist of information suggesting that a beneficiary has other coverage that should be primary. CMS officials claim that ReMAS will streamline other functions as well. For example, when new information on a beneficiary's MSP status is added to CWF, ReMAS is expected to determine, on a daily basis, whether mistaken payments were made on his or her behalf. Currently, the contractors review the occurrence of mistaken payments at varying intervals ranging from quarterly to semiannually. Once ReMAS determines that Medicare has paid claims that were the primary responsibility of another insurer, it will generate a case that can be assigned to any contractor for recovery. It will no longer be necessary for the contractor that processed the mistakenly paid claims to perform recovery activities.

CMS officials told us that they believe that ReMAS will have several advantages over the current process. First, efficiencies gained through ReMAS would enable contractors to pursue MSP debt that involves amounts less than the current \$1,000 threshold, resulting in additional recoveries. Second, ReMAS could facilitate the consolidation of MSP debt recovery efforts among a handful of contractors, as each contractor would have access to all paid claims. CMS officials indicated that ReMAS would enable them to reduce administrative costs, provide contractors with a more consistent and predictable workload, and simplify contractor oversight activities. (See app. II for more information comparing ReMAS to the present recovery system).

Implementation of ReMAS for EGHP Debt Cases Is Uncertain

Although CMS has spent \$7 million on the development of this system, which has now spanned 6 years, ReMAS's implementation is progressing slowly. It remains in the early implementation stages—testing on EGHP cases started in June 2004. Several critical tasks related to ReMAS's implementation have taken several years to complete. To date, only the initial software testing and validation for the liability and workers' compensation components have been completed.

CMS's initial plans for implementing ReMAS have focused on recovering liability insurance and workers' compensation debt. Thus far, 17 contractors have received training in the use of ReMAS. CMS officials told us that as of May 2004, the liability and workers' compensation components of ReMAS have been deployed to nine contractors. The remaining contractors that process MSP liability cases are scheduled to implement ReMAS by October 2004. ReMAS also has the potential to recover mistaken payments associated with EGHPs—currently handled through the data match process. CMS recently expanded the scope of ReMAS to include employer-sponsored group health plans, but details related to incorporating EGHP cases in the system are unclear. Unlike liability and workers' compensation cases, which are related to specific accidents or injuries, EGHP cases are based on a beneficiary's dates of employer-sponsored coverage. This distinction requires enhancements to the ReMAS system, to ensure that it can address and process this key difference. According to CMS's timetable, preliminary tasks such as computer testing, validation, and documentation of the EGHP component of ReMAS will be completed in September 2004. While CMS expects to pilot test the EGHP component with two contractors in October 2004, it has not specified when it will implement ReMAS for EGHP cases at all contractors.

Conclusions

As Medicare's primary steward, CMS should make a concerted effort to recoup funds owed the program. However, recovery efforts should be planned and executed with cost-effectiveness in mind. CMS's efforts to recover MSP debt from cases that involve EGHPs were cost-effective as recently as a few years ago, but CMS is now operating a recovery system that is losing money. Although funding for contractors' EGHP debt recovery activities has slightly increased since fiscal year 2000, contractor workloads have decreased by 80 percent. In addition, funding for these activities is not always related to contractors' workloads—in fiscal year 2003, almost half of the contractors received fewer than 50 cases to process while 8 of these, which had a collective budget of more than \$1.8 million, received no cases at all. As recently as fiscal year 2000, three contractors collectively processed a workload that exceeded the entire EGHP workload of all contractors in fiscal year 2003, suggesting that consolidation of debt recovery activities among a smaller number of contractors is feasible. The current system, with over 50 contractors involved in EGHP recovery activities, is cumbersome to administer, and poor record-keeping makes it difficult to determine whether contractors are doing all they can to recover debt.

One of the keys to improving the cost-effectiveness of MSP debt recoveries may rest with CMS's new ReMAS system. Plans to expand the scope of ReMAS to recover debt associated with employer-sponsored group health plans could ultimately address current operational weaknesses, such as an inefficient distribution of workload and limited coordination among contractors. Now that CMS has been given new authority to contract with a variety of entities to assist it with managing the Medicare program, it should take advantage of ReMAS's capability to consolidate debt recovery efforts with a smaller number of contractors and thereby improve the efficiency of the program.

Recommendations for Executive Action

We recommend that the administrator of CMS:

- develop detailed plans and time frames for expanding ReMAS to include EGHP cases, and expedite implementation of the EGHP component of ReMAS and
- improve the efficiency of MSP payment recovery activities by consolidating the EGHP workload under a smaller number of contractors and ensuring that contractor budgets for EGHP recovery activities more closely reflect their actual workloads.

Agency Comments

In written comments on a draft of this report, CMS agreed with our recommendations. CMS said it recognizes the importance of improving the cost-effectiveness of its debt collection process and has taken steps to expedite implementation of the EGHP component of ReMAS. CMS stated that operational efficiencies gained through the implementation of ReMAS make it feasible to consolidate recovery activities. CMS's comments are reprinted in appendix III. CMS also provided us with technical comments, which we incorporated as appropriate.

As agreed with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance. At that time, we will send copies to the Administrator of CMS and other interested parties. We will then make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff who made contributions to this report are listed in appendix IV.



Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Appendix I: Scope and Methodology

To assess the cost-effectiveness of the current system for recovering Medicare Secondary Payer (MSP) debt, we analyzed information from two CMS databases—the Contractor Administrative-Budget and Financial Management (CAFM) system and the Mistaken Payment and Recovery Tracking System (MPaRTS). CAFM provided information on CMS's budgets for contractors and MPaRTS provided information on the number of potential MSP recovery cases processed by contractors and the amount of savings from recovery activities.

To evaluate contractor performance in recovering MSP debt, we focused on cases that involved beneficiaries and their spouses who may have been employed and covered by an employer-sponsored group health plan (EGHP). These cases consisted of potentially mistakenly paid claims for services a beneficiary appeared to have received while covered by an EGHP. We selected 4 geographically dispersed contractors that processed a high volume of EGHP debt cases—all 4 were among the top 10 contractors that processed the highest number of such cases in 2000 and 2001. At each contractor, we randomly selected a sample of cases that were opened in 2000 and 2001 for review—the number of cases selected at each contractor varied, ranging from 136 to 207.¹ Of the 644 cases selected, 566 were available for review. Contractors were unable to provide documentation for 78 cases. Because contractors close the majority of cases without making recoveries, we specifically focused on such cases in order to determine whether contractors made sufficient effort to recover MSP debt and followed appropriate procedures. Our inspection of these files consisted of reviewing contractor adherence to CMS's detailed procedures for steps taken during the recovery process and the sufficiency of the contractor's documentation for closing data match cases without recovering funds or referring cases to the Department of the Treasury for collection.²

¹We excluded EGHP debt cases that resulted in a recovery, cases that were currently open, and older cases that were still considered open but, because of their age, had been referred to the Department of the Treasury for collection. We also excluded liability, workers' compensation, and other nondata match cases.

²CMS requires contractors to retain documentation supporting their case determinations including copies of mistakenly paid claims, demand letters sent to employers or other insurers requesting payment, letters informing employers or other insurers that the case will be referred to the Department of the Treasury for collection if payment is not received, contractors' reports describing the beneficiary's enrollment and payment information, a worksheet summarizing the beneficiary's insurance history, and correspondence with employers and other insurers.

All four of the Medicare contractors we examined sold private health insurance. Because of the possibility that the private side of their businesses could have been responsible for reimbursing Medicare for MSP debt, our examination included an assessment of whether this potential conflict of interest affected contractors' actions in collecting this debt. Using insurer information available from MPaRTS and contractor case files, we identified cases that involved the contractor's private health insurance business and compared them to the other cases. Our analysis found little difference between the two types of cases in terms of missing documentation—12.0 percent of cases that involved the contractor's private side health insurance business were not documented, compared with 12.1 for the other cases. To assess CMS efforts to oversee and improve MSP debt recovery, we reviewed program guidelines and memoranda and interviewed officials from CMS and Medicare contractors. To identify contractor performance problems, we also examined the results of CMS's fiscal years 2001 and 2002 contractor performance evaluations pertaining to contractors' MSP operations.

Although we did not validate CMS's CAFM and MPaRTs information, CMS has procedures in place to ensure the accuracy of these databases. The MPaRTs database, which tracks MSP debt recoveries from EGHPs, contains internal logic checks that prevent contractors from incorrectly entering certain types of information. In addition, CMS periodically reviews MPaRTs records as part of its contractor performance evaluations. CAFM is a financial management system established to enable CMS to control the national budget for the Medicare contractors. It contains a small number of system checks that ensure that expenditure information provided by contractors is totaled correctly. The reliability of the data is ensured through independent audits. In addition, CMS personnel also review the data throughout the year.

To identify the agency's efforts to enhance the MSP process, we reviewed documents and interviewed CMS officials on CMS's planned Recovery, Management and Accounting System (ReMAS), a new CMS system for MSP debt recovery activities that is under development. We conducted our work from December 2002 through July 2004 in accordance with generally accepted government auditing standards.

Appendix II: Comparison of Current System for Recovering EGHP Debt with ReMAS

The following table highlights differences between the way MSP case development, validation, and recovery are implemented under the present data match recovery system and how they will be implemented under ReMAS.

Table 3: Comparison of Current Recovery System to ReMAS

Step	Current system	ReMAS
MSP Case Development	CMS's Coordination of Benefits contractor (COBC) evaluates information provided by the Internal Revenue Service and the Social Security Administration to identify instances where beneficiaries may have primary insurance coverage through an employer. The COBC updates the Common Working File (CWF) with this information if responses to the employer data match questionnaire or other analysis confirms that Medicare is the secondary payer.	Same.
	Updated CWF information produces computer tapes that are transmitted to local contractors—usually quarterly or semiannually.	Updated CWF information produces leads daily and triggers a search for mistaken payments. Because the COBC receives tax and employer information irregularly, leads will tend to be generated in clusters, but potentially more frequent than the quarterly or semiannual basis of the current system.
Case Validation	CMS takes MSP leads from the data match. CWF updates and matches them against a national claims database to determine whether Medicare has paid claims for those individuals.	Same.
	Performed quarterly or semiannually.	Performed when new leads are generated.
	CMS must send the data match cases to the contractor that processed those claims.	CMS selects a lead recovery contractor, regardless of whether that contractor processed the mistakenly paid claims.
	Contractor validates recovery claim amounts by comparison with its internal claims history.	No manual validation is done. The recovery claim amount is identified within ReMAS.
Recovery	Recovery threshold of a minimum of \$1,000 is used by each contractor for each recovery claim.	No threshold for recovery.
	Individual contractors use standardized software to generate demand letters requesting payment from debtors.	ReMAS will interface with the CMS accounts receivable software, which will automatically generate demand letters requesting payment from debtors.
	An employer or insurer can receive several demand letters if more than one contractor processed the mistakenly paid claims or if debt involves more than one beneficiary.	One demand letter is sent. ReMAS identifies all claims for which the debtor is responsible.

Source: CMS.

Appendix III: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL 27 2004

TO: Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator *MM*

SUBJECT: General Accounting Office (GAO) Draft Report: "*MEDICARE SECONDARY PAYER: Improvements Needed to Enhance Debt Recovery Process,*"
(GAO-04-783)

Thank you for allowing the Centers for Medicare & Medicaid Services (CMS) to comment on the above GAO draft report. We concur with the recommendations contained in this report.

Like GAO, CMS has been concerned with Medicare Secondary Payer (MSP) debt that arises when the Medicare Program inadvertently makes primary payment for services that are later determined to be the financial responsibility of another payer. The CMS recognizes the necessity to streamline and otherwise bring efficiencies to its debt collection processes.

The CMS has begun taking action to expedite implementation of the Employer Group Health Plan (EGHP) function within the Recovery Management and Accounting System (ReMAS). The EGHP function within ReMAS has already been tested and will be implemented, along with the Healthcare Integrated General Ledger Accounting System (HIGLAS) functionality (debt management), at two Medicare contractor sites on October 1, 2004, and, in fiscal year 2005, at eight other contractor sites.

The CMS is confident that ReMAS will provide the efficiencies necessary to identify and recover mistaken and conditional payments in a more timely and consistent manner. Also, this new recovery system will afford CMS options for consolidation of recoveries. The CMS is considering these options in conjunction with authority contained in section 1893 (Medicare Integrity Program) of the Social Security Act, as amended.

Page 2 - Leslie G. Aronovitz

The CMS is committed in its efforts to identify and implement new and efficient processes to ensure the timely and accurate recovery of mistaken and conditional Medicare primary payments. New tools, like ReMAS, will facilitate the recovery of monies owed the Trust Funds and improve CMS' responsiveness to its business partners.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Geraldine Redican-Bigott, (312) 220-7678

Acknowledgments

Major contributors to this report were Richard M. Lipinski, Barbara Mulliken, Enchelle Bolden, Shaunessye Curry, and Kevin Milne.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Jeff Nelligan, Managing Director, NelliganJ@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548