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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Simplifying The Medicare/Medicaid Buy-in Program Would Reduce Improper State Claims Of Federal Funds

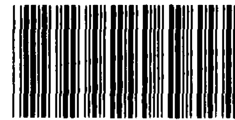
This report highlights problems in the Medicare/Medicaid buy-in program which result in improper State claims for Federal sharing. Because the program is complicated, some States

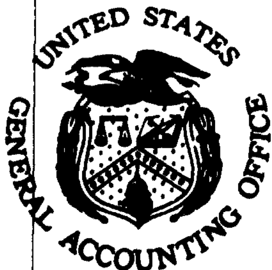
--overclaim Federal sharing for Medicare insurance premiums paid with Medicaid funds,

--overclaim for ineligible medical costs, and

--underclaim for costs eligible for Federal sharing.

The Congress should change the law to simplify program administration. Until and unless this is done, HEW should enforce the present requirements.





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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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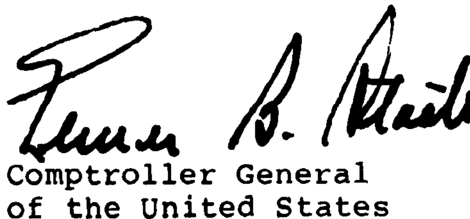
To the President of the Senate and the
Speaker of the House of Representatives

This report describes problems States have in administering their Medicare/Medicaid buy-in programs and discusses some legislative options that would simplify program administration and reduce States' improper claims of Federal funds. We recommend that the Congress amend the Social Security Act, and we believe the analysis of the effects of the alternative changes on the States, Medicaid recipients, and the Federal Government should help the Congress decide which alternative to take.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; and other interested parties.



Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

SIMPLIFYING THE MEDICARE/
MEDICAID BUY-IN PROGRAM
WOULD REDUCE IMPROPER STATE
CLAIMS OF FEDERAL FUNDS

D I G E S T

Because administering Medicaid's program to enroll its recipients in Medicare is so difficult, the Federal Government overpays some States and underpays others.

The Social Security Act authorizes Medicaid and Medicare--the Nation's two major health care programs. Medicaid is jointly funded by States and the Federal Government; it pays for certain services provided to eligible low-income people. Medicare is federally funded and pays for similar services provided to qualified aged and disabled people.

Under the act, States can enroll--"buy in"--eligible Medicaid recipients in Medicare (See pp. 1 to 7.) The buy-in provisions give States the opportunity to shift the costs of some medical services to the Federal Government.

The provisions allow States to claim Federal sharing through their Medicaid programs on premiums paid for Medicaid recipients who receive payments through one of the cash assistance programs authorized by the act. These are Supplemental Security Income and Aid to Families with Dependent Children. However, Federal sharing is generally prohibited on premiums for Medicaid recipients who do not receive cash assistance.

The buy-in provisions also prohibit States from claiming Federal sharing on medical service costs covered by Medicare but paid by Medicaid for recipients eligible for but not enrolled in Medicare. This provision was designed to encourage States to

buy in dual eligibles--individuals eligible for Medicare and Medicaid. (See ch. 2.)

States had until January 1, 1970, to decide whether to implement a buy-in program. They determine which types of dual eligibles they will buy in--aged, blind, and/or disabled recipients of Supplemental Security Income; recipients of cash through State supplementation of Supplemental Security Income; recipients of cash through the Aid to Families with Dependent Children program; and/or people who qualify for Medicaid but do not receive cash.

Currently, 5 States have no buy-in program, 21 buy in cash assistance recipients, and 27 buy in cash and noncash assistance recipients. (See app. II.) The major administrative responsibility of the 27 States that buy in all dual eligibles is to distinguish between cash and noncash recipients bought in and claim Federal sharing only on premiums for cash assistance recipients. The 5 States that have no buy-in program and the 21 States that buy in only cash recipients must segregate medical expenses for unenrolled dual eligibles and reduce their claim for Federal sharing by the amount Medicare would have paid for those people had they been enrolled.

Complying with the requirements for claiming Federal Medicaid sharing related to Medicare/ Medicaid eligibles is difficult. As a result, some States overclaim sharing and are overpaid by the Department of Health, Education, and Welfare (HEW), and others underclaim and are underpaid. Of the 10 States GAO reviewed, all except 1 improperly claimed Federal sharing, and other procedures in that State violated Federal law and regulations. Examples of improper claiming are:

--Oregon overclaimed about $745,000 in 1977 for payments for services provided to dual eligibles not enrolled in Medicare.

--Washington underclaimed about $200,000 in 1977 because it did not request sharing for all premium payments it could have.

--Colorado overclaimed about $457,000 in 1977 for payments for buy-in premiums for Medicaid recipients who did not receive cash assistance.

HEW, the department with Federal oversight responsibility, has provided little assistance to States in carrying out their buy-in programs and has inadequately monitored States to insure they comply with Federal law and regulations and properly claim sharing.

GAO believes there are a number of ways Federal law could be changed to simplify buy-in program administration and reduce States' improper claiming of Federal sharing. This report discusses the impact of several possible changes on States' costs and program administration, Medicaid recipients, and Federal Medicaid and Medicare costs. Impacts vary depending on the design of a State's Medicaid and buy-in programs. Some changes will cost particular States more and some less; some of the changes may be advantageous to the recipients and some may not; all of the changes would simplify program administration. (See ch. 3.)

RECOMMENDATION TO THE CONGRESS

Since so many States have difficulty complying with the Federal law and, as a result, have improperly claimed Federal sharing, the Congress should change the law to simplify program administration. It should consider the options discussed in chapter 3 of this report.

RECOMMENDATIONS TO HEW

Until and unless the law is changed, HEW should enforce current requirements. HEW should

--monitor more closely States' administration of the program, periodically validating claims for Federal sharing;

--collect moneys due the Federal Government from States identified as having overclaimed and pay States identified as having underclaimed; and

--provide more assistance to States in carrying out their buy-in programs.

HEW AND STATE COMMENTS

HEW agreed with GAO's findings and said the report is a sound interpretation of current buy-in policy and problems associated with interpretations of that policy. It said actions were either underway or planned to implement all the recommendations. Although HEW did not specifically comment on the chapter discussing legislation to simplify the buy-in program, it said it was analyzing legislative options for buy-in and that legislative change may be needed to rectify some of the program's major problems. (See app. III.)

All States GAO reviewed, except Alaska and Colorado, commented on the report. The States agreed with most of the information in this report. All five States that commented on GAO's legislative analysis favor legislation that would expand Federal sharing in the buy-in program. (See app. IV.)

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ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Department of Health, Education, and Welfare (HEW) is responsible for administering Federal programs that promote general welfare in the fields of health, education, and income security. Within HEW, the Health Care Financing Administration (HCFA) 1/ is responsible for Medicare and Medicaid--two major health care programs authorized by titles XVIII (42 U.S.C. 1395) and XIX (42 U.S.C. 1396), respectively, of the Social Security Act.

Medicare, a Federal program that helps pay hospital and other medical costs for eligible people 65 and older and for some disabled people under 65, serves about 25 million Social Security and railroad retirement beneficiaries. Medicaid, jointly funded by the States and the Federal Government, pays hospital and medical costs for over 21 million poor Americans who are aged, blind, disabled, or members of families with dependent children deprived of parental support. Some people are eligible for both Medicare and Medicaid and, under what is known as the buy-in program, can have their Medicare premiums paid with Medicaid funds.

MEDICARE

Medicare is health insurance that pays for certain medical services provided to individuals entitled to coverage. It is divided into two parts--part A (Hospital Insurance) and part B (Supplemental Medical Insurance).

Part A pays for medically necessary hospital services and posthospital skilled nursing facility and home health care services. Coverage is available for people 65 or over entitled to old-age or survivors benefits under title II of the Social Security Act and for people under 65 who have been entitled to disability benefits under title II for at least 24 consecutive months or have been determined to have end-stage

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1/Until March 1977, when HCFA was created, Medicaid and Medicare were administered by different organizational units within HEW.

renal disease. 1/ Premiums are not normally required for part A coverage. A deductible must be met before hospital benefits are paid, and individuals must pay coinsurance on benefits received after the 60th day in the hospital or the 20th day in a skilled nursing facility. Part A will pay, in full, up to 100 home health service visits.

Part B insurance pays certain medical costs not covered by part A for enrollees with paid-up monthly part B premiums. Anyone can enroll who is either (1) entitled to hospital insurance under part A or (2) a resident of the United States, 65 or over, and either a citizen or a legal alien who has lived in the United States for at least 5 continuous years immediately before applying for part B. Part B covers

--physician services, including those provided by chiropractors and doctors of medicine, osteopathy, dentistry or oral surgery (for surgery only), podiatry, or optometry;

--outpatient hospital services;

--home health services, up to 100 visits per year;

--outpatient physical therapy services;

--diagnostic services and diagnostic X-rays;

--X-ray, radium, and radioactive isotope therapy;

--durable medical equipment;

--ambulance services; and

--prosthetic devices (other than dental).

Part B payments do not begin until a $60 deductible is met after which, in most cases, 80 percent of the reasonable charges or costs of covered services is paid. 2/ The remaining 20 percent is coinsurance.

1/To qualify for title II benefits, a person must have sufficient quarters of employment covered under Social Security. Persons may also qualify for part A coverage if they are qualified railroad retirement beneficiaries.

2/Home health services and inpatient radiological and pathological services are covered in full.

The part B program is based on the same concept as private group insurance. It is intended to be self-supporting from enrollees' premiums and income contributed from the Government in proportion to premium payments. Although monthly premiums were originally established to equal half of program costs, beginning with fiscal year 1974 HEW could not increase the monthly premium rate by more than the percentage increases in old-age, survivors, and disability insurance benefits under title II of the act. Consequently, since that time, income from Government contributions has been greater than income from monthly premiums, and premium income has paid for an increasingly smaller percentage of program costs. The monthly premium rate for the years ended June 1977, 1978, and 1979, was $7.20, $7.70, and $8.20, respectively; it is currently $8.70.

During fiscal year 1977 Medicare paid almost $20.8 billion for services on behalf of eligible beneficiaries--$14.9 billion under part A and $5.9 billion under part B. Medicare payments for services are estimated to be about $33 billion in fiscal year 1980.

MEDICAID

Medicaid is a Federal/State program that pays for medical services provided to eligible low-income persons. States initiate, design, and operate their programs. HEW approves each State's plan, which provides the basis for claiming Federal sharing. Depending on the State's per capita income, the Federal Government pays 50 to 78 percent of Medicaid medical services costs. (See app. I.)

People who receive cash assistance under the Aid to Families with Dependent Children (AFDC) program, authorized by part A of title IV of the act, are automatically covered under Medicaid. In most States, aged, blind, and disabled people who receive cash assistance under the Supplemental Security Income (SSI) program, authorized by title XVI of the act, 1/ or under State mandatory or optional SSI

1/The federally administered SSI program replaced State-administered programs for the aged, blind, and disabled under titles I, X, XIV, and XVI of the act in the 50 States and the District of Columbia on January 1, 1974. State-administered programs under those titles are still in effect in Guam, Puerto Rico, and the Virgin Islands.

supplemental programs 1/ are also automatically covered under Medicaid. However, States can impose Medicaid eligibility requirements on SSI recipients that are more restrictive than SSI requirements, and 14 States have chosen to do so.

People qualifying for Medicaid because of eligibility for one of the cash assistance programs are considered to be categorically needy. For them, States must provide at least

--inpatient and outpatient hospital services;

--laboratory and X-ray services;

--physician services;

--home health services;

--skilled nursing facility services for people over 21;

--early and periodic screening, diagnosis, and treatment for persons under 21; and

--family planning services and supplies.

States can also cover certain people not entitled to cash assistance, including those referred to as medically needy who have income and/or resources too high to qualify for cash assistance but too low to pay their medical costs. States must provide the medically needy with either the same services listed above or some combination of services approved by HEW.

For both groups, States can cover any other medical or remedial services recognized under State law and approved in the State plan.

1/The mandatory State SSI supplementation program is required by Federal law to keep the level of assistance payments under the Federal SSI program at least the same as it was in December 1973 under each State's assistance program for persons who received assistance at that time. Optional State SSI supplementation, provided at States' discretion, raises assistance payments to a level determined by the State as necessary to meet the recipients' needs.

The District of Columbia, Guam, Puerto Rico, the Virgin Islands, and all States except Arizona have operational Medicaid programs. 1/ As of June 1, 1978, 33 States covered the medically needy and 20 served only the categorically needy. Medicaid costs in fiscal year 1977 were $17.1 billion, of which the Federal share was $9.7 billion. Total costs for fiscal year 1980 are estimated to be over $22 billion.

THE BUY-IN PROGRAM

Under the Medicaid buy-in program, States may enroll Medicaid recipients in Medicare part B and pay for their premiums. This program allows States to transfer some medical costs from their Federal/State-financed Medicaid program to the federally financed Medicare program.

States can buy in cash recipients from the month of their initial Medicaid eligibility if they were also eligible for Medicare at that time. Noncash recipients can be bought in from the second month after the month they are determined eligible for Medicaid, again if they were also eligible for Medicare.

A State's Medicaid buy-in coverage group can include any dual eligible--an individual eligible for both Medicare part B and Medicaid. Through their Medicaid programs, States are entitled to claim Federal sharing on deductible and coinsurance costs for all Medicaid recipients in their buy-in programs. However, the Federal Government only shares in premium costs for individuals receiving cash assistance or considered cash assistance recipients for buy-in purposes.

Several classes of Medicaid eligibles do not receive cash assistance but are considered cash assistance recipients for Federal sharing purposes.

--In 1972, legislation was enacted which provided a 20-percent increase in the level of benefits to retirees, survivors, and the disabled under title II of the act. Because of this increase, a number of people became ineligible for cash assistance and, thus, ineligible for automatic Medicaid coverage. Later legislation provided that people would not lose

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1/In this report, the term "States" includes Guam, Puerto Rico, the Virgin Islands, and the District of Columbia.

Medicaid eligibility solely because of the 20-percent title II increase. Anyone retaining Medicaid eligibility because of this provision would be treated as a cash assistance recipient for Federal Medicaid sharing purposes.

--In 1972, legislation was enacted which provided that AFDC recipients who lost their eligibility for cash assistance because of increased earnings would maintain Medicaid eligibility for 4 months after termination of AFDC. People receiving the additional 4 months of Medicaid eligibility are considered cash assistance recipients for Federal Medicaid sharing purposes.

--In 1976, legislation was enacted which provided that people who lost their eligibility for SSI because of a cost-of-living increase in title II benefits, or any general increase in such benefits, would remain eligible for Medicaid. Anyone retaining Medicaid eligibility because of this provision is considered a cash assistance recipient for Federal Medicaid sharing purposes.

Another requirement relating to Federal sharing for dual eligibles prohibits sharing under Medicaid for services provided to dual eligibles if they are eligible for but not enrolled in Medicare and if part B would have paid for the services had they been enrolled. States are required to fully fund Medicaid payments under these circumstances.

Procedures for claiming Federal sharing vary among States. States that participate in the buy-in program are responsible for identifying premiums on which Federal sharing is allowed and for claiming accordingly. Each State pays monthly premiums to HCFA for all persons it buys in and, in turn, claims Federal reimbursement through its Medicaid program for premiums eligible for Federal sharing. Monthly State buy-in premium bills are created from Medicare records, which are updated monthly to reflect additions or deletions to buy-in rolls.

Similarly, all States are responsible for identifying and accounting for medical expenses eligible for Federal sharing and for deducting from their Federal claims ineligible expenses. Ineligible expenses include payment for Medicare part B type medical services for Medicaid recipients qualified for part B but not entitled to benefits due to failure to enroll in Medicare.

To participate in the buy-in program, States must have requested to enter an agreement with HEW before January 1, 1970. Only Puerto Rico and four States with Medicaid programs do not participate in the buy-in program. These States cannot participate because they did not request to enter into an agreement with HEW by the deadline. Appendix II shows the scope of each State's current buy-in program.

As of December 1977, over 2.8 million persons were enrolled in Medicare through the buy-in program. Almost $250 million in buy-in premiums were paid during calendar year 1977.

SCOPE OF REVIEW

Our work relating to HEW's administration of the buy-in program was done at HCFA's Medicaid Bureau in Washington, D.C., and the Medicare Bureau in Baltimore, Maryland; 1/ HEW's regional offices in Dallas, Denver, and Seattle; and Social Security Administration (SSA) offices in various States included in our review. We reviewed 10 State agencies responsible for administering Medicaid and involved with administering the buy-in program. The States were:

--Alaska, Louisiana, Oregon, and Wyoming, which do not have buy-in programs.

--Nebraska, North Dakota, and Oklahoma, which buy in cash assistance recipients only.

--Colorado, Idaho, and Washington, which buy in cash and noncash recipients.

We reviewed pertinent Federal laws, regulations, policies, and procedures on the Medicare and Medicaid programs, with emphasis on the buy-in aspect; reviewed applicable State regulations, policies, and procedures relating to the buy-in program, with emphasis on State procedures for claiming Federal sharing; and discussed the program with Federal and State officials.

1/In a reorganization announced in April 1979, HCFA was organized on a functional basis. Most of the functions of the Medicare and Medicaid Bureau have been assumed by HCFA's Bureau of Program Operations.

We depended heavily on information provided by the States, frequently from their data processing systems, regarding Medicaid recipients' eligibility status and costs of medical services. We also relied heavily on SSA's determination of whether persons sampled in our review were eligible for and enrolled in Medicare part B, which was based on information in its computer. We did not verify the reliability of information in the States' computer systems or in SSA's system.

We requested HEW and the 10 States included in the review to comment on a draft of this report. Comments from HEW and the eight States that replied are included as appendixes III and IV, respectively.

CHAPTER 2

COMPLICATED BUY-IN PROGRAM REQUIREMENTS

RESULT IN IMPROPER FEDERAL SHARING

States are permitted to claim Federal sharing in the costs of buy-in premiums and medical services only for certain groups of Medicaid recipients. The Social Security Act and Federal regulations clearly state the persons for whom the Federal Government will share in buy-in premiums and the conditions under which States are permitted to claim Federal sharing for medical services. However, many States have found it difficult to comply with the law and regulations and have improperly claimed Federal sharing--sometimes to their advantage and sometimes to their disadvantage.

STATES IMPROPERLY CLAIM SHARING FOR BUY-IN PREMIUMS

Section 1903(a)(1) of the act provides Federal sharing in Medicare part B buy-in premium costs for people eligible for Medicaid and receiving AFDC, SSI, or State SSI supplementation cash assistance. Also, although most noncash recipients are not entitled to Federal buy-in sharing, certain groups of persons that do not receive cash are considered cash recipients for Medicaid purposes, and States are entitled to Federal sharing on their buy-in premiums. Because identifying and accounting for premiums entitled to Federal sharing can be difficult, States sometimes overclaim or underclaim for Federal sharing.

States participating in the buy-in program buy in either all Medicaid recipients eligible for part B or cash recipients only. States that buy in all eligible recipients sometimes overclaim for premiums because they claim sharing for noncash recipients, which is prohibited. Some States with buy-in programs underclaim by not requesting sharing on all eligible premiums.

Twenty-seven States buy in cash and noncash Medicaid recipients. In reviewing claiming for Federal sharing on premiums by three such States, we found they used different methods of identifying and accounting for noncash recipients. One of the States overclaimed on premiums, one underclaimed, and one may have underclaimed slightly.

Overclaiming for ineligible premiums

Since its buy-in program for noncash recipients became effective in March 1969, Colorado has overclaimed for Federal sharing by requesting Federal reimbursement on all buy-in premiums, including those paid on behalf of noncash Medicaid recipients not entitled to Federal sharing. HEW, which knew about the overclaiming for years, repeatedly recommended that the State establish procedures to properly identify ineligible premiums and adjust its Federal account accordingly. Although Colorado adjusted its claims for Federal sharing several times to compensate for overclaiming, adjustments for January 1974 through September 1978 were too small. In addition, procedures to properly identify and account for ineligible premiums have never been implemented.

Because Colorado has bought in all Medicaid eligibles since its buy-in program for noncash recipients became effective on March 1, 1969, and has claimed Federal sharing on all premiums, the State has been overpaid by the Federal Government for years. As early as February 1971, HEW noted deficiencies in Colorado's Medicaid program administration, including problems relating to identifying part B premiums ineligible for Federal sharing. Similar observations were made in later HEW reports, and the State said it made adjustments for overclaiming on premiums through 1973. After that, no additional adjustments were made to offset overclaiming until 1977, even though the State continued to claim Federal sharing on all premiums.

Since January 1974, Colorado has overclaimed almost $2.5 million for ineligible premiums. We selected a random sample of 200 persons for whom Colorado had paid buy-in premiums and claimed Federal sharing during 1977. 1/ Of the persons in our sample, 64 were noncash recipients, and 31.88 percent 2/ of the premiums paid were for noncash recipients for whom Federal sharing should not have been claimed. Projecting our figures to the State's 1977 buy-in premium universe showed

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1/The sample covered only 11 months in 1977 because names of people bought in for May were inadvertently destroyed by the State.

2/This figure is not 32 percent--the percentage of noncash recipients in the sample (64 of 200)--because of the influence of changing the premium rate from $7.20 to $7.70 per month effective July 1977.

that Colorado improperly claimed sharing on premium payments of $838,242, the Federal share of which was $456,873. In addition, using the results of a 1978 Colorado sample covering 1974, 1975, 1976, and part of 1978, with adjustments for an error we identified in the State's sampling methodology, 1/ we calculated that the State overclaimed on an additional $3,590,403 for premiums. The Federal share of this over-claimed amount was $1,996,688, bringing the total Federal overpayment since January 1974 to $2,453,561.

Reimbursements to the Federal Government for overclaiming after 1974 were too small to compensate for Federal overpayment on ineligible buy-in premiums. In 1978 HEW deferred paying Colorado $211,371 to offset overpayment for buy-in premiums during July 1977 to June 1978. In its financial reports for the quarters ended March and June 1978, the State voluntarily credited the Federal Government with $193,816 for overclaiming, in addition to a $1,424,928 adjustment in March 1977. According to our calculations, the $1,830,115 in adjustments was $623,446 too small to offset overclaiming for ineligible premiums. Colorado officials agreed with our findings and credited the Federal Government for the additional amount in its quarterly report for the period ended September 1978.

Colorado has not implemented procedures to properly identify and account for ineligible buy-in premiums even though, in response to recommendations in several critical reports, it told HEW it would do so. According to the executive officer for administration in the Department of Social Services, which administers the State's Medicaid program, these procedures were not established because of the low priority assigned to the task and the relatively small amount of money involved. In September 1978, the State told HEW that problems which precluded it from readily identifying premiums ineligible for Federal sharing were being corrected and that adequate procedures should be available by the following April. However, in April 1979, State officials told us that the new procedures, although approved, had not been implemented.

1/The Colorado sample understated the percentage of premiums paid on behalf of noncash recipients because it did not properly consider retroactive premiums. Retroactive Medicaid coverage is permitted for up to 3 months of application for Medicaid if the person was eligible for Medicaid during that period. The person can be bought in for the retroactive period.

Underclaiming for cash assistance recipients

Washington and Idaho buy in all Medicaid recipients. However, Washington underclaimed Federal sharing because it did not claim sharing on all premiums eligible for sharing, and Idaho may have underclaimed by not requesting sharing for noncash recipients for whom sharing was authorized. 1/

Washington claimed Federal sharing only on premiums it paid for aged SSI recipients. Through its computer the State calculated the amount of buy-in premiums on which it claimed Federal sharing by multiplying the number of aged SSI recipients times the applicable monthly buy-in premium rate. Consequently, the State did not request Federal sharing for premiums paid on behalf of blind and disabled SSI recipients, individuals who received State SSI supplements only, AFDC recipients, or noncash recipients considered cash recipients for Medicaid purposes. In addition, the State claimed sharing for no more than 1 month's premiums for SSI recipients even though it was entitled to sharing on retroactive premiums that may have been paid for eligible beneficiaries.

A representative of the State Department of Social and Health Services, which administers the Medicaid program, told us he did not know that the State was underclaiming. According to him, the underclaiming apparently resulted from failure to program the State's computer to identify and account for all persons eligible for sharing. Even after we brought the matter to the State's attention, it had difficulty determining the amount of Federal payments to which it was entitled. Among other problems, the State erroneously believed it was entitled to reimbursement for premiums paid on behalf of institutionalized noncash recipients. Its rationale was that, had these people not been institutionalized, they would have received cash assistance.

After being advised that premiums paid for these persons were not eligible for Federal sharing, the State calculated the amount it had been underclaiming. By comparing expenditures that were eligible for Federal sharing with the amount the State actually claimed for three sample periods, the State

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1/See p. 5 for an explanation of the classes of noncash recipients considered to be cash recipients for Federal Medicaid sharing and buy-in purposes.

estimated it may have been underclaiming about $50,000 per quarter (about $200,000 per year). The State plans to request HEW approval of the new method of determining the amount eligible for sharing. We did not verify the accuracy of the figures or credibility of the new system. However, it does not appear to take into account noncash recipients considered as cash recipients for Medicaid buy-in purposes.

Idaho may have also underclaimed, although not by as much as Washington. The State identified cash recipients it bought into the part B program by matching the list of names on SSA's buy-in premium billing tape against its own master eligibility file. The State then claimed Federal sharing on premiums paid for all identified cash assistance recipients. However, the State's system included no procedures for identifying or accounting for noncash recipients considered cash recipients for Medicaid purposes; consequently, it underclaimed by the amount of premiums paid on their behalf.

Idaho's claim for Federal sharing on cash assistance recipients appeared reasonable. According to State information, during 1977 it spent $607,033 on premiums for about 6,560 buy-in participants. The State calculated that 69.9 percent of the premium payments were for cash recipients. According to the data processing systems coordinator of the State Department of Health and Welfare, Idaho claims Federal sharing on premiums only for cash recipients. We checked the reasonableness of the State's claiming by checking the cash assistance status of 100 beneficiaries from the State's detailed buy-in lists for each of the first 6 months in 1977. Of the 600 cases we checked, the percentage of cash recipients averaged 68.7 percent.

We did not try to determine Idaho's losses resulting from its failure to claim for noncash recipients' premiums eligible for Federal sharing. However, we believe losses to Idaho, as well as to Washington and any other States not claiming Federal sharing on premiums for these people, are small because this category accounts for such a small portion of the buy-in population. None of the three groups that fall into this category are significant in number. (See p. 5 for a discussion of these groups.)

STATES CLAIM IMPROPERLY ON MEDICAL SERVICES FOR INELIGIBLE PEOPLE

Section 1903(b)(1) of the Social Security Act prohibits States from claiming Federal Medicaid sharing in health services payments for dual eligibles not enrolled in part B to

the extent that part B would have paid for them. If someone is eligible for Medicaid and part B of Medicare, but is not self-enrolled or bought into part B, any Medicaid payments on the person's behalf, which part B would have paid if the person had been enrolled, are not eligible for Federal sharing. Because States do not properly identify and account for Medicaid expenditures on recipients eligible for but not enrolled in part B, they frequently claim Federal sharing on their medical costs improperly.

According to Medicare's actuarial projections, the 1977 average monthly part B expenditure for medical services for Medicare beneficiaries, after adjustments for deductibles and coinsurance, was $20.11 for aged beneficiaries and $36.60 for disabled beneficiaries. 1/ Assuming expenditures for part B type services for Medicaid beneficiaries were the same as part B expenditures for all Medicare beneficiaries, States could have improperly claimed Federal sharing at a rate of $241.32 per year for each aged Medicaid recipient eligible for part B but not enrolled and $439.20 for each such disabled person.

We reviewed seven of the States that do not buy in all dual eligibles to determine whether they were properly claiming Federal sharing. Three of the States overclaimed because they had no procedures for identifying and accounting for ineligible expenditures. Of the four States with procedures, one overclaimed, one underclaimed on some expenses and overclaimed on others, one had highly questionable procedures that may have resulted in overclaiming, and one properly claimed but violated other Federal law and regulations.

Overclaiming by States with no procedures for identifying ineligible expenditures

Three States overclaimed for Federal sharing because they failed to implement procedures to identify and account for expenditures on Medicaid recipients not entitled to Federal sharing. Using Medicare's actuarial estimates for part B

1/Based on the average of the expenditures for benefits for the years ended June 30, 1977 and 1978. Does not include administrative expenses and other adjustments.

type expenditures for the aged and disabled in 1977 and projecting the results of samples taken in each State, we estimate that the Federal Government overpaid these three States almost $1 million for ineligible claims for 1977.

Many of Oregon's aged and disabled Medicaid recipients were eligible for but not enrolled in part B. Because the State did not reduce its claim for Federal sharing for these persons' medical costs, the Federal Government overpaid the State. We estimate Oregon improperly claimed sharing for Medicaid payments in 1977 on about $1,274,000, of which the Federal share was $745,000.

The State substantially overclaimed for aged ineligibles. Its records showed that during 1977 an average of 14,494 aged persons were eligible for Medicaid and that 23.6 percent were unenrolled in part B. Based on Medicare's cost estimates and considering that virtually all aged people are eligible for part B, Oregon improperly claimed sharing on about $826,000 1/ of Medicaid payments for the aged in 1977.

Oregon also overclaimed on medical expenditures for disabled Medicaid recipients. The State's records showed that an average of 13,792 disabled persons were eligible for Medicaid during 1977 and that 81.8 percent of its disabled population was not covered by part B. We checked with SSA to determine the status of 100 disabled Medicaid recipients in Oregon to estimate the number of disabled Medicaid people eligible for but not enrolled in part B. According to SSA records, 9 of the 100 people were eligible but not enrolled. Using Medicaid's part B cost projections, we estimate that Oregon improperly claimed sharing on about $448,000 of medical payments for the disabled during 1977.

Officials in Oregon, which does not participate in the buy-in program, told us it would be administratively unproductive to comply with Federal buy-in regulations because (1) many of the aged Medicaid eligibles were already enrolled in part B and (2) expenditures for aged people not enrolled in part B were small. They said the State's current system was not designed to identify persons eligible for but not

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1/Calculated by multiplying the percentage eligible and not enrolled times the universe and multiplying that product times the annual Medicare part B expenditures.

enrolled in part B. They added that they did not have the capability to determine which services paid with Medicaid funds would have been covered by Medicare had the recipients been enrolled in part B. To illustrate the last problem, they said they would not know how to treat ambulance services and durable medical equipment, which are covered by Medicare in some cases and not in others. According to Oregon officials, to eliminate this problem all Medicaid claims for individuals in question would have to be submitted to the Medicare part B claims processor for determination.

Like Oregon, neither Nebraska nor North Dakota had procedures to properly identify and account for expenditures on unenrolled dual eligibles. We took random samples of aged and disabled/blind persons eligible for Medicaid in each State and, through SSA's records, determined whether each person was eligible for and enrolled in part B.

Our Nebraska sample showed that 54.7 percent of the aged and 7.5 percent of the disabled/blind noncash Medicaid recipients were eligible for but not enrolled in part B. Based on the size of the universe from which the sample was taken (2,688 aged and 2,569 disabled/blind recipients) and using the 1977 national averages for part B expenditures, the State may have overclaimed sharing on about $439,000 of medical payments, of which the Federal share would have been $242,000.

In response to a February 1979 HEW letter to the State regarding problems found in our review, Nebraska informed HEW that it planned to revise its procedures for identifying unenrolled dual eligibles by using information available through HEW's Beneficiary Data Exchange system--an automated system designed to give States information on persons' Social Security entitlement. The State said it did not believe adjustments for any possible overclaiming in the past would be feasible because determining the amount overclaimed is difficult. In addition, the chief of payments and data services in Nebraska's Welfare Office informed us in April 1979 that the State discontinued implementing plans to change its procedures to use information from the automated exchange system because HEW advised it that the system was being totally revised.

In commenting on this report, Nebraska's director of public welfare reiterated the difficulty of complying with Federal buy-in requirements, especially in determining which of the recipients not bought in are or are not self-enrolled and, correspondingly, are or are not eligible for Federal

sharing. He told us the State wants to comply but feels "it would virtually be impossible to do so in a realistic and economical manner." He said that, once HEW finalizes the Beneficiary Data Exchange system, the State can resume its its efforts to change its procedures and use the information for determining individuals' eligibility.

State and Federal records indicated that, in 1977, 2 percent of the aged and 1.5 percent of the disabled/blind noncash recipients in North Dakota were eligible for but not enrolled in part B. Using the national averages for part B costs--for an aged universe of 3,820 and a disabled/blind universe of 796--the State may have overclaimed sharing on about $24,000, of which the Federal share would have been $13,000. North Dakota's director of medical services said he did not realize that certain Medicaid expenditures on persons eligible for but not enrolled in Medicare part B were not eligible for Federal sharing. Like Oregon officials, he said his staff could not reliably determine which services would be covered by Medicare if the ineligible recipients were enrolled in part B. Officials in both States also said HEW did not press them to comply with the regulations and did not question their failure to adjust the Federal account to show expenditures for ineligible people.

Claiming by States with procedures to identify ineligible expenditures

Four of the seven States we reviewed had procedures to identify and account for Medicaid expenditures ineligible for Federal sharing, but each State's procedures were deficient in some respect.

--Wyoming's procedures adequately accounted for ineligible expenditures for the aged but not the disabled.

--Alaska's procedures resulted in underclaiming on some expenditures and overclaiming on others.

--Louisiana's procedures, which became highly questionable after changing fiscal agents in 1977, may have resulted in overclaiming.

--Oklahoma's procedures appeared to result in proper claiming but violated other Federal law and regulations.

Wyoming

Wyoming, which does not have a buy-in program, had procedures to identify and account for expenditures on aged Medicaid recipients not entitled to Federal sharing. However, because its procedures had a major deficiency, the State improperly claimed Federal sharing for the disabled. When bills were received from providers, State officials checked their manual files to determine whether the recipients had part B insurance. Using this information, the State processed bills and claimed Federal sharing on Medicaid expenditures. However, procedures used to process bills for the aged were different from those used for the disabled.

Procedures for handling aged Medicaid recipient claims resulted in proper claiming. Wyoming had identified about 230 of its 1,200 aged recipients as not enrolled in part B. The State properly claimed Federal Medicaid sharing on bills paid for these people (that is, claiming for deductible, coinsurance, and other expenses eligible for Federal sharing). Bills for the remaining aged recipients, on whom the State had no information about Medicare status, were paid under the assumption that they were self-enrolled in part B. The State paid the provider 20 percent (coinsurance) of the amount considered to be an allowable charge by Medicare. This procedure was based on the assumption that the recipient had met his/her deductible for the year. If the provider later notified the State that its payment was incorrect or that the recipient did not have part B, the State made the necessary accounting adjustments and, for future reference, updated its files to show the person was not covered by Medicare. The State claimed Federal sharing on the $60 deductible, the 20-percent coinsurance, and other expenditures covered by Medicaid but not by Medicare.

Procedures for processing claims for disabled Medicaid recipients were inadequate for properly identifying expenditures eligible for Federal sharing. When Wyoming's files showed disabled recipients had Medicare part B coverage, the State paid the deductible and coinsurance with Medicaid and let Medicare pay the balance. Bills for all other disabled Medicaid recipients were paid under the assumption that the persons were not eligible for part B and Federal sharing was claimed on all Medicaid expenditures.

To determine whether Wyoming overclaimed on expenditures for the disabled, we reviewed the State's claiming for Federal sharing on a sample of disabled Medicaid recipients. Out of a random sample of 50 disabled recipients who received Medicaid services during 1977, SSA's records showed 9 were eligible for part B; all were self-enrolled. Consequently, we

identified no overclaiming for disabled people eligible for but not enrolled in part B. On the other hand, because the State had inadequate procedures for determining which disabled Medicaid recipients were enrolled in Medicare, Wyoming inappropriately paid claims which Medicare should have paid.

Of the nine disabled people SSA identified as being enrolled in part B, Wyoming's records showed only four were enrolled. Under the procedures discussed above relating to processing bills for disabled Medicaid recipients, the State incorrectly paid for part B services under Medicaid and claimed Federal sharing for five part B enrollees which the State had not identified as being enrolled in Medicare. If our sample is representative, the State may have used Medicaid funds to pay for services Medicare was liable for on 10 percent of all disabled recipients. In addition to this problem, Wyoming's procedures could result in duplicate payments for the same services. Duplicate payments could be made if providers billed Medicare at the same time they billed Medicaid and the State did not identify the recipients as being enrolled in part B.

The supervisor of claims processing said the State was unaware that these individuals had Medicare coverage. The State acknowledged that in some cases Medicaid funds were being used to pay for services provided to disabled beneficiaries when Medicare funds should have been. The problem was attributed to the difficulty of obtaining accurate information from HEW about individuals' Medicare coverage.

Alaska

Because it had ineffective procedures for identifying Medicaid expenses eligible for Federal sharing, Alaska underclaimed for some eligible expenditures. At the same time, the State may have overclaimed sharing on Medicaid expenditures for persons eligible for but not enrolled in part B. While we were unable to determine the net effect of the improper claiming without a full-scale audit, we did identify some serious problems that need correcting.

State officials responsible for claims processing designated whether Medicaid recipients were eligible and not enrolled in part B on a case-by-case basis when providers submitted bills for payment. As a result, claims were sometimes misclassified because Medicaid recipients were classified differently for different claims even though their status had not changed. The medical assistance program

officer in Alaska's Department of Social and Health Services showed us examples of this misclassification. He said the problem could have resulted from the use of inexperienced claims clerks in 1977 and 1978. These clerks, which were used to eliminate Alaska's backlog of claims, may have been given some misleading instructions on classifying recipients' part B status.

According to the program officer, the State underclaimed by not requesting sharing on some medical expenditures eligible for sharing. The State did not claim sharing on deductible or coinsurance expenditures for anyone classified by claims clerks as eligible for but not enrolled in part B. The program officer said he was unaware the State was allowed to claim sharing on deductible and coinsurance for these people. In addition, the State reduced its Federal claim for all Medicaid expenditures on these persons regardless of whether the expenditures were for part B type services. We did not determine how much the State lost through this error. However, of expenditures totaling over $213,000 for 1976 and 1977 on which the State did not claim Federal sharing, we identified $106,000 as hospital costs for which Federal sharing could have been claimed. This left only $107,000 as potential ineligible costs, part of which might have been amounts which could be properly claimed as deductible and coinsurance.

While Alaska underclaimed on some expenses, it may have overclaimed on others. The State's records showed 2,014 aged and 1,811 disabled people were eligible for Medicaid services during fiscal year 1977. We asked HEW to determine the Medicare status of 100 aged and 110 disabled persons from a random list of individuals eligible for Medicaid during fiscal year 1977. If the sample was representative, and we believe it was, 1/ 56.1 percent of the State's aged and 1.4 percent of the disabled were eligible for but not enrolled in part B. Using Medicare's actuarial projections of part B costs, we estimate Alaska may have spent about $273,000 on aged and $11,000 on disabled Medicaid recipients that was not eligible for Federal sharing. It appears the State failed to properly account for ineligible expenditures when our estimate of expenditures ineligible for Federal

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1/We believe the sample was representative because it was taken from a list of case numbers which the head of the State's data processing told us were assigned randomly, with no relation to age, date of enrollment, or anything else.

sharing for 1 year--$284,000--is compared to the expenditures for which the State did not claim sharing during a 2-year period--$213,000. Overclaiming could have been greater except for the State's inadvertent underclaiming.

Louisiana

Louisiana, which does not have a buy-in program, accumulates ineligible expenditures for persons eligible for part B but not enrolled and reduces its claim for Federal sharing for such expenditures. The State has had such procedures since 1970. However, the reliability of the adjustments since July 1977 1/ has been highly questionable and may have resulted in the State overclaiming.

Until July 1977, Louisiana contracted with the Medicare part B claims processor for the State to be its Medicaid fiscal agent for processing Medicaid claims. The fiscal agent accumulated ineligible Medicaid costs, and the State's claim for Federal sharing was adjusted accordingly. The State's claim for Federal sharing during its fiscal year ended June 1977 was reduced by $1,680,662 for ineligible expenditures.

After changing fiscal agents the State encountered some administrative problems. The new agent had difficulty establishing a system to account for ineligible expenditures. Initially, expenditures identified as not eligible for Federal sharing were too high because the new fiscal agent erroneously included some allowable expenditures for AFDC recipients. After correcting this problem, the estimated expenditures appeared too low--only $220,258 for the first 9 months of the State's fiscal year compared to $1,271,211 for the first 9 months of the previous fiscal year. 2/ The estimated ineligible expenditures would have been even lower if the new fiscal agent had not included allowable deductible and coinsurance costs. In addition, the amount was distorted because the agent did not include any allowance for ineligible expenditures in November and December 1977 that were accumulated as less than zero, which the State said might be attributed to computerized adjustments for prior periods.

1/We did not analyze the effectiveness of Louisiana's system before this time.

2/State officials said some of the difference was caused by a large backlog of claims resulting from changing fiscal agents.

Louisiana officials told us they recognized that the new fiscal agent had encountered some administrative problems and that the State had overclaimed Federal sharing during the first 9 months after the new fiscal agent assumed responsibility for claims processing. In commenting on our draft report, the director of the Department of Human Resources said many of the problems would be common to any State the size of Louisiana that changed fiscal agents. He said both State and contractor personnel made a concerted effort to correct these problems, especially during the first 6 months when the problems were greatest.

The assistant comptroller of the Office of Management and Finance in the Department of Health and Human Resources told us the State estimated that it spent $1,936,000 on part B type service for unenrolled dual eligibles during the fiscal year ended June 30, 1978, and that adjustments were made to compensate for the overclaiming. She said the adjustments, which were included as part of the State's quarterly financial reports for fiscal year 1978, were derived by applying the percentage of costs identified as ineligible for Federal sharing during fiscal year 1977 (identified by the previous fiscal agent) to payments for medical services during fiscal year 1978. State officials said the amounts were estimated because actual retrieval would have been very expensive. According to the assistant comptroller, the State would have retrieved the actual figures if HEW had not accepted the adjustments.

HEW did not question the State's quarterly financial reports for fiscal year 1978. However, HEW examined the report for the first quarter of fiscal year 1979, which was prepared using the same methodology discussed above. The examination showed Louisiana overclaimed on expenditures for unenrolled aged dual eligibles. HEW computed the amount spent for part B type services for these people to be $684,927, as opposed to $399,387 reported by the State--a difference of $285,540. HEW said Louisiana made a voluntary adjustment to correct the report.

Although HEW's computation of expenditures ineligible for Federal sharing appears more reasonable than the State's, it is still too low. The HEW estimate considered only expenditures for outpatient hospital, physician, laboratory, and X-ray services. It would have been higher if all part B type services provided by Louisiana (such as home health service and prosthetic devices) had been considered. In

addition, to be complete, any computation of ineligible expenditures must include identifying expenditures for unenrolled disabled dual eligibles. The HEW analyses of the State's December 31, 1978, financial report did not include the disabled. No similar analyses were made for other financial reports since the new fiscal agent assumed responsibility for claim processing.

In commenting on the report, Louisiana said that, by working with the HEW regional office and changing its computer logic, it believes the necessary analysis can be done for proper reporting. The State added that requiring it to do the work necessary to identify dual eligibles without HEW assistance is an unreasonable burden. We believe this further illustrates the difficulty States have complying with buy-in requirements.

Oklahoma

Oklahoma's buy-in procedures appear to have resulted in proper claiming in 1977. We found only one person eligible for part B but not enrolled out of a random sample of 65 disabled/blind and 35 aged people who were eligible for Medicaid during 1977 but not receiving cash assistance; no improper claiming was made for that person. All 35 aged Medicaid recipients were eligible and enrolled. Of the 65 disabled/blind Medicaid recipients, 48 were not eligible for part B, and 16 of the 17 eligible persons were self-enrolled. One person was eligible for part B but not enrolled because the guardian refused to buy the part B insurance. The person's medical profile showed the State paid no part B type Medicaid expenditures.

The State's administrative assistant supervisor for medical units, Department of Institutions, Social and Rehabilitation Services, told us she was not surprised with our observations. She said we should not have found any ineligible payments because the State screens all cases to make sure no payment is made for part B services provided to anyone eligible for but not enrolled in Medicare. This is relatively simple in Oklahoma because the State Medicaid agency is also the Medicare claims processor for dual eligibles who are cash recipients. She added that State procedures require bills for dual eligibles be sent to Medicare for payment before they are paid by Medicaid.

While Oklahoma's procedures for handling claims for dual eligibles appear to result in proper claiming of Federal sharing, we believe other procedures contradict the approved State plan and violate Federal law and regulations.

The State's approved Medicaid plan states, as required by Federal law and regulations, that the categorically needy are entitled to at least as many services as the medically needy. However, the State does not pay for part B type services for institutionalized categorically needy noncash recipients who are eligible for but do not self-enroll in Medicare while it does pay for part B type services for medically needy recipients not eligible for Medicare. Thus, the State provides more services to medically needy recipients than to some categorically needy recipients in violation of Federal law and regulations and the approved State Medicaid plan.

Also, the approved State Medicaid plan states that all of the services required by Federal law and regulations to be provided to categorically needy recipients are, in fact, provided. Many of these Medicaid required services, such as physician, laboratory, and X-ray services, are covered by Medicare part B. However, because the State does not pay under Medicaid for part B type services for institutionalized categorically needy noncash recipients who decline to self-enroll, these recipients are not provided some services Federal law and regulations require the States to provide.

Oklahoma's director of public welfare told us State law precludes using State funds to pay for unenrolled dual eligibles' part B type services which are ineligible for Federal Medicaid sharing. He said the Department of Public Welfare has interpreted Oklahoma's statutes that require the State to receive maximum Federal funds (such as required by 56 Oklahoma Statutes Annotated Section 198) to preclude the use of State funds unless they are matched with Federal funds.

Application of the State Medicaid agency's interpretation of State law conflicts with Federal law because it results in fewer services being provided to some categorically needy recipients than are provided to medically needy recipients and it denies some categorically needy recipients coverage of services required by Federal law. In addition, the State's interpretation contradicts its approved State Medicaid plan.

CONCLUSIONS

Because the buy-in requirements are so complicated and States have not complied with them, States often improperly claim Federal sharing. In turn, the Federal Government has overpaid some States and underpaid others based on these claims.

States that buy in all Medicaid recipients eligible for part B, such as Colorado, Washington, and Idaho, have difficulty properly accounting for expenditures on buy-in premiums. The adequacy of States' compliance with Federal requirements depends on the effectiveness of their systems for identifying and accounting for cash assistance recipients' premiums which are eligible for Federal sharing and noncash recipients' premiums which are not eligible for sharing. When States such as Colorado claim Federal sharing on premiums for ineligible people, the Federal Government overpays. On the other hand, when States such as Washington or Idaho fail to claim sharing on all eligible premiums due to ineffective identification procedures or inadequate accounting systems, they lose money because the Federal Government underpays them.

States that do not participate in the buy-in program or buy in only cash assistance recipients have even greater difficulty properly claiming Federal sharing. Not only do these States have difficulty identifying people qualified for Medicare part B but not enrolled, they also have trouble determining which services would have been covered by part B and the amount of expenditures ineligible for sharing. Of the seven such States we reviewed, only Oklahoma had a system that resulted in proper claiming and that State violated Federal law and regulations regarding coverage of Medicaid services. Oregon, Nebraska, and North Dakota ignored the requirements, and Alaska, Louisiana, and Wyoming had inadequate systems for identifying and accounting for ineligible expenditures. As a result, although there were some underpayments, the Federal Government generally overpaid States due to improper claiming.

HEW has done a poor job of monitoring States' buy-in program administration and enforcing the Federal law and regulations. It has not required States without mechanisms for identifying and accounting for expenditures ineligible for Federal sharing, such as Oregon, Nebraska, and North Dakota, to establish them, and it has not adequately verified the accuracy of claims by States that do have such mechanisms. For example, HEW did not take timely or effective action to require Colorado to repay the Federal Government or correct the deficiencies in its system. In States where quarterly financial reports indicate irregularities, such as the drastic change in Louisiana's adjustments for ineligible expenditures, HEW has taken inadequate followup action to determine the reason for the possible irregularity. This lack of adequate monitoring, coupled with States' improper claiming, has resulted in overpayment to some States and underpayment to others.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator, HCFA, to enforce the requirements of Federal law and regulations by

--monitoring more closely States' administration of the program, periodically validating claims for Federal sharing;

--collecting moneys due the Federal Government from States identified as having overclaimed and paying States identified as having underclaimed; and

--providing more assistance to States in carrying out their buy-in programs.

In addition, the Administrator should direct Oklahoma to stop discriminating between self-enrolled and unenrolled noncash institutionalized Medicaid recipients.

HEW COMMENTS

HEW agreed with our recommendations. It said the buy-in program will be among a number of operational areas that will be carefully reviewed by the HCFA financial management staff during 1979 and that our recommendations will be considered during HCFA's financial review of States' buy-in programs. HCFA will ask the HEW Audit Agency to consider increasing its coverage of the buy-in program with reference to over- and underclaiming for adjustments in the States' quarterly expenditure reports. The Department also plans to step up its assistance to States found deficient in the buy-in program during its State management assessments.

HEW said it would have the financial management staff in the regional office review our finding in Oklahoma with State agency officials and see that corrective actions are taken.

CHAPTER 3

LEGISLATIVE CHANGE NEEDED TO SIMPLIFY PROGRAM ADMINISTRATION

The legislative history of the Social Security Act clearly shows that the Congress believed the buy-in program would benefit the States and recipients and wanted States to buy in dual eligibles. However, as discussed in chapter 2, two basic legislative requirements cause States problems in identifying Medicaid expenditures on dual eligibles so Federal sharing can be properly claimed. Present law requires:

--States with buy-in programs to distinguish between cash and noncash recipients and to claim sharing only in Medicare premiums paid for cash recipients.

--States to separate medical payments made for Medicaid recipients who are eligible for but not enrolled in Medicare part B and to not claim sharing for costs Medicare would have paid if the recipients had been enrolled in Medicare.

Administrative problems and improper claiming related to the first requirement could be eliminated by changing the law to (1) permit sharing in all premium payments or (2) prohibit sharing in premiums. The problems related to the second requirement could be eliminated by changing the law to (1) permit sharing in all medical costs regardless of Medicare enrollment status or (2) require States to buy in all dual eligibles. The problems discussed above could also be eliminated by repealing the buy-in provisions and treating Medicare coverage, for persons who elect to self-enroll, as any other third-party liability, such as Blue Shield insurance or workmen's compensation. Many combinations of these possible changes would simplify administration and reduce or eliminate improper claiming of Federal sharing. Each change would affect States' costs and program administration, recipients, and Federal costs differently. Each would also have different effects in different States, depending on the design of each State's Medicaid and buy-in programs.

LEGISLATIVE HISTORY OF THE BUY-IN PROGRAM

The Medicare law as originally enacted in the Social Security Amendments of 1965 included a provision (section 1843)

permitting States to buy in cash assistance recipients eligible for Medicare. Medicaid was also added to the act by these amendments and included a provision (section 1903(a)(1)) which permitted States to claim Federal Medicaid sharing in premiums for cash recipients bought in by the State. States were permitted to buy in only dual eligibles who became eligible for part B by December 31, 1967.

The Social Security Amendments of 1967 contained provisions revising the buy-in program. This act extended until January 1, 1970, the time during which States could request to enter into a buy-in agreement with HEW. It also made the following changes in the buy-in provisions designed to make having a buy-in program more attractive to the States:

--The requirement that Medicaid recipients become eligible for part B by December 31, 1967, was repealed. Thus, States could buy in all cash assistance dual eligibles.

--States were permitted to buy in noncash recipients, but not claim Medicaid sharing in their premiums. Thus, States could buy in all dual eligibles regardless of cash assistance status.

--States could not claim Federal Medicaid sharing for services provided to unenrolled dual eligibles if part B would have paid for them. The Congress viewed this as an incentive for States to buy in dual eligibles.

--The Medicaid requirement that all recipients in a given class be provided with the same amount, duration, and scope of services was waived for States who chose to buy in dual eligibles. Thus, the States could provide the full range of part B benefits to enrolled dual eligibles without having to provide as extensive a range of services to other Medicaid eligibles.

The committee reports relating to the buy-in provisions state that the program's purpose was to have one uniform program on which the elderly could depend for payment for medical services--part B of Medicare--and clearly express congressional intent to encourage States to buy in dual eligibles.

In addition, the committee reports show that the Congress recognized the fiscal benefits derived by the States from buying in dual eligibles. For example, the House report on the 1967 amendments (No. 90-544) states:

"[The House Ways and Means Committee] believes that it is very much to the advantage of States to cover their medically needy aged under [part B], under which one-half of the cost is met from [Federal] general revenues."

As noted earlier, this fiscal benefit to the States has increased. Currently, over two-thirds of the cost is met by Federal general revenues. The report continues to give the rationale for not sharing in buy-in premiums for noncash recipients based on the belief that the fiscal benefit was sufficient to encourage States to buy in noncash recipients.

The legislative history of the buy-in program clearly shows that the Congress

--intended States to have buy-in programs and to buy in all dual eligibles;

--recognized that the buy-in program provided fiscal relief to the States;

--decided not to permit sharing in buy-in premiums for noncash recipients because it believed adequate fiscal relief was provided without permitting such sharing;

--intended to further encourage States to have buy-in programs by penalizing States without programs by not sharing in many medical payments made for unenrolled dual eligibles; and

--recognized that dual eligibles would, in many cases, benefit from having Medicare coverage.

However, because of changes to the Social Security Act since Medicaid was originally authorized in 1965, compliance with the buy-in requirements has become increasingly difficult, especially relating to proper claiming of Federal sharing.

EFFECTS OF CHANGING PROVISIONS OF THE BUY-IN LAW

We analyzed alternative ways in which the buy-in law could be changed to determine the effects each alternative would have on (1) State Medicaid costs and buy-in administration, (2) Medicaid recipients, and (3) Federal costs for the Medicaid and Medicare programs. We analyzed the status quo and options that would eliminate one or both administrative problems. The options we analyzed were:

1. Leave the buy-in provisions as they are.

2. Permit Federal sharing in all buy-in premiums regardless of recipients' cash assistance status.

3. Prohibit Federal sharing in buy-in premiums.

4. Permit Federal sharing for all Medicaid medical payments regardless of Medicare enrollment status.

5. Require States to buy in all Medicaid recipients who are eligible for Medicare while leaving the other buy-in provisions as they are.

6. Repeal the buy-in provisions and treat Medicare coverage the same as any other third-party liability.

7. Require States to buy in all dual eligibles and permit Federal sharing in all premium payments.

8. Require States to buy in all dual eligibles and prohibit Federal sharing in premium payments.

9. Require States to buy in cash recipients, prohibit buying in noncash recipients, and share in all medical payments for noncash recipients.

Options 2, 3, 6, 7, 8, and 9 would eliminate the administrative problems in claiming Federal sharing resulting from the need to distinguish between premiums paid for cash and noncash recipients. Options 4, 5, 6, 7, 8, and 9 would eliminate the administrative problems related to the need to segregate part B type medical payments for dual eligibles who are not enrolled in Medicare. Options 6, 7, 8, and 9 would eliminate the administrative problems related to both requirements.

Effects on State Medicaid costs and buy-in program administration

To determine the effects on State Medicaid costs and buy-in program administration, the following assumptions were made:

--The average dual eligible receives the same amount of part B type benefits as the average Medicare beneficiary.

--Because of the fiscal advantage of buying in dual eligibles, States would not voluntarily delete a coverage group--such as cash recipients--from its buy-in program. The fiscal advantage results from the fact that an $8.70 per month premium buys $27.22 per month in coverage for an aged person and $49.26 in coverage for a disabled person.

--The State Medicaid program covers the same medical services as does part B. If the State covers fewer services or has more restrictive service limitations than part B, the fiscal advantage to the State is less.

--A 50-percent Federal Medicaid sharing rate was used. If a State's sharing percentage is higher, and most are, the fiscal advantage to the State of shifting costs to the Federal Government is greater. (See app. I.)

--Federal sharing is properly claimed.

The following table shows the effects of options 2 through 9 versus the current situation (option 1) on State Medicaid costs and buy-in program administration for each aged dual eligible under its jurisdiction. Regarding disabled dual eligibles, the effects are the same except that changes related to medical payments are larger.

Monthly Effects on State Costs and Administration per Aged Dual Eligible (note a)

Option number	States without buy-in programs	States which buy in cash recipients only	States which buy in all recipients
2	None	None	-$4.35 per noncash recipient for premium; no longer have to distinguish between premiums paid for cash and noncash recipients.
3	None	+$4.35 per cash recipient for premium.	+$4.35 per cash recipient for premium; no longer have to distinguish between premiums paid for cash and noncash recipients.
4	-$13.61 per dual eligible who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-enrolled.	-$13.61 per noncash recipient who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-enrolled.	None
5	+$8.70 per noncash recipient for premium; $+4.35 per cash recipient for premium; -$27.22 per cash and noncash dual eligible who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-ernolled.	+$8.70 per noncash recipient for premium; -$27.22 per noncash recipient who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-enrolled.	None
6	-$13.61 per recipient who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-employed.	-$4.35 per cash recipient for premium; -$13.61 per noncash dual eligible who is not self-enrolled; +$13.61 per cash recipient who declines to self-enroll; no longer have to segregate medical payments for noncash recipients who are not self-enrolled.	-$4.35 per cash recipient for premium; -$8.70 per noncash recipient for premium; +$13.61 per cash and noncash dual eligible who does not choose to self-enroll; no longer have to distinguish between premiums paid for cash and noncash recipients.

Option number	States without buy-in programs	States which buy in cash recipients only	States which buy in all recipients
7	+$4.35 per dual eligible for premium; -$27.22 per dual eligible who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-enrolled.	+$4.35 per noncash recipient for premium; -$27.22 per noncash recipient who is not self-enrolled; no longer have to segregate medical payments for noncash recipients who are not self-enrolled.	-$4.35 per noncash recipient for premium; no longer have to distinguish between premiums paid for cash and noncash recipients.
8	+$8.70 per dual eligible for premium; -$27.22 per dual eligible who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-enrolled.	+$4.35 per cash recipient for premium; +$8.70 per noncash recipient for premium; -$27.22 per noncash recipient who is not self-enrolled; no longer have to segregate medical payments for noncash recipients who are not self-enrolled.	+$4.35 per cash recipient for premium; no longer have to distinguish between premiums paid for cash and noncash recipients.
9	+$4.35 per cash recipient for premium; -$27.22 per cash dual eligible who is not self-enrolled; -$13.61 per noncash dual eligible who is not self-enrolled; no longer have to segregate medical payments for dual eligibles who are not self-enrolled.	-$13.61 per noncash recipient who is not self-enrolled; no longer have to segregate medical payments for noncash recipients who are not self-enrolled.	-$8.70 per noncash recipient for premium; +$13.61 per noncash recipient who does not choose to self-enroll; no longer have to distinguish between premiums paid for cash and noncash recipients.

a/A plus (+) represents an increase in State costs; a minus (-) represents a decrease. The effects relate to increases or decreases for part B medical expenses unless specified as relating to premium costs.

Changing legislation to permit sharing in premiums for noncash dual eligibles has another potential impact. States which presently do not buy in noncash recipients might be encouraged to do so by the availability of sharing in such premiums. To the extent that additional States buy in noncash recipients, Federal Medicaid and Medicare expenditures would increase and State Medicaid expenditures decrease. Federal Medicaid expenditures would increase by $4.35 a month per aged noncash recipient bought in by the additional States. Federal Medicare expenditures would increase by $27.22 a month for each additional aged dual eligible who is not self-enrolled in Medicare. State Medicaid expenditures would decrease by $27.22 a month per aged recipient who is not self-enrolled because the States would not have to absorb Medicare part B type expenses for unenrolled dual eligibles.

Effect on Medicaid recipients

There are two possible effects on recipients' income. In the five States that do not buy in cash recipients, the options which would require these States to buy in these recipients (options 5, 7, 8, and 9) would increase self-enrolled cash recipients' spendable income by $8.70 per month because the State would be paying their premiums under these options. The other effect would occur if one of the options (6 or 9) which prohibit buying in recipients who are currently bought in were enacted. Such recipients who decided to self-enroll would suffer an $8.70 per month decrease in spendable income.

An indirect effect on recipients of any change which results in more dual eligibles being enrolled in part B would be the increase in services available to some newly enrolled dual eligibles. This results because part B covers more kinds of services or is less restrictive in its coverage of particular services than some State Medicaid programs. The opposite effect would result for any option which decreases the number of recipients who are enrolled in part B.

A potential effect on recipients of any change which might reduce the number of dual eligibles bought in is increased pressure to self-enroll. This could result because States would lose the fiscal benefits of Medicare coverage unless recipients self-enroll. This potential effect is very possible, considering that officials in several States included in our review--that do not buy in all dual eligibles--told us they strongly encourage these people to self-enroll. The Oklahoma Medicare coordinator told us that local case workers emphasize the importance of self-enrolling by explaining to applicants the State policy of not paying certain costs for unenrolled dual eligibles. Louisiana's medical assistance program director said the State makes a concerted effort to encourage self-enrollment. Oregon also strongly encourages self-enrollment, according to an HEW official. The spendable income of many of these people who self-enroll would decrease by $8.70 per month.

Effects on Federal Medicaid and Medicare costs

The following table gives the effects of options 2 through 9 versus the current situation (option 1) on Federal Medicaid and Medicare costs of the nine options listed on page 30. The same assumptions apply to this analysis as applied to the analysis of effects on State Medicaid costs.

Monthly Effects on Federal Government
Costs Per Aged Dual Eligible
(notes a and b)

Option number	States without buy-in programs	States which buy in cash recipients only	States which buy in all recipients
2	Medicaid: None Medicare: None	Medicaid: None Medicare: None	Medicaid: +$4.35 per noncash recipient for premium. Medicare: None
3	Medicaid: None Medicare: None	Medicaid: -$4.35 per cash recipient for premium. Medicare: None	Medicaid: -$4.35 per cash recipient for premium. Medicare: None
4	Medicaid: +$13.61 per dual eligible who does not self-enroll. Medicare: None	Medicaid: +$13.61 per noncash recipient who does not self-enroll. Medicare: None	Medicaid: None Medicare: None
5	Medicaid: +$4.35 per cash recipient for premium. Medicare: +$27.22 per dual eligible who would not have self-enrolled.	Medicaid: None Medicare: +$27.22 per noncash recipient who would not have self-enrolled.	Medicaid: None Medicare: None
6	Medicaid: +$13.61 per dual eligible who is not self-enrolled. Medicare: None	Medicaid: -$4.35 per cash recipient for premium; +$13.61 per noncash recipient who is not self-enrolled; +$13.61 per cash recipient who chooses not to self-enroll. Medicare: -$27.22 per cash recipient who chooses not to self-enroll. c/	Medicaid: -$4.35 per cash recipient for premium; +$13.61 per dual eligible who chooses not to self-enroll. Medicare: -$27.22 per dual eligible who chooses not to self-enroll. c/

Option number	States without buy-in programs	States which buy in cash recipients only	States which buy in all recipients
7	Medicaid: +$4.35 per dual eligible for premium. Medicare: +$27.22 per dual eligible who is not self-enrolled.	Medicaid: +$4.35 per noncash recipient for premium. Medicare: +$27.22 per noncash recipient who is not self-enrolled.	Medicaid: +$4.35 per noncash recipient. Medicare: None
8	Medicaid: None Medicare: +$27.22 per dual eligible who is not self-enrolled.	Medicaid: -$4.35 per cash recipient for premium. Medicare: +$27.22 per noncash recipient who is not self-enrolled.	Medicaid: -$4.35 per cash recipient for premium. Medicare: None
9	Medicaid: +$4.35 per cash recipient for premium; +$13.61 per noncash recipient who is not self-enrolled. Medicare: +$27.22 per cash recipient who is not self-enrolled.	Medicaid: +$13.61 per noncash recipient who is not self-enrolled. Medicare: None	Medicaid: +$13.61 per noncash recipient who chooses not to self-enroll. Medicare: -$27.22 per noncash recipient who chooses not to self-enroll. c/

a/A plus (+) represents an increase in Federal costs; a minus (-) represents a decrease. The effects relate to increases and decreases for part B medical expenses unless specified as relating to premiums.

b/Where Medicare payments increase by a total of $27.22, the increase is funded by an $8.70 premium and $18.52 in Federal general revenues. In those cases where the State premium payment is shared in by the Federal Government, an additional $4.35 in Federal general revenues is expended. Thus, when premiums are shared, Federal expenses increase by $22.87, and when they are not shared, by $18.52.

c/Medicare payments would decrease by a total of $27.22, which is comprised of $18.52 in Federal general revenues and the $8.70 premium which is no longer paid.

CONCLUSIONS

Because of the complex administrative requirements imposed by the law relating to claiming Federal sharing for dual eligibles and because of the problems States have in complying with these requirements, we believe the law should be amended to reduce or eliminate such administrative problems. This report discusses eight possible changes to the law which would eliminate one or both of the administrative requirements that result in improper claiming for Federal sharing for dual eligibles. The impact of these alternatives on State Medicaid expenditures, dual eligibles, and Federal Medicaid and Medicare expenditures is also outlined.

We are unable to accurately estimate the overall impact on Federal expenditures, or of expenditures by a given State, of enactment of any of the options. The basic information needed to make an accurate estimate has not been, and in some cases could not be, developed. For example, we do not know, overall, how many dual eligibles are not bought in so we cannot estimate the impact of the options which require them to be bought in. Also, we do not know, and it would be virtually impossible to determine, how many dual eligibles currently bought in would decline to self-enroll if one of the options which prohibits buying in dual eligibles were to be enacted. Many other data problems exist which would be extremely difficult to resolve. In fact, for an accurate estimate of overall costs of the options to be possible, all 53 jurisdictions with Medicaid programs would have to be reviewed in detail; even then, assumptions would still have to be made.

However, when viewed from the perspective of the Congress' intent in enacting the buy-in provisions, we believe certain options appear more attractive than others. One of the primary purposes of the Congress in authorizing the buy-in program was to enable all the aged to receive the benefits of being covered by Medicare part B and to have one uniform health program cover them. We believe that enacting option 5, 7, or 8 would best meet this intent because each would result in all dual eligibles being enrolled in Medicare part B.

The Congress' other primary purpose in authorizing the buy-in program was to provide the States with fiscal relief. Of options 5, 7, and 8, option 7 would provide the greatest fiscal relief to the States. In fact, every State would have decreased Medicaid expenditures under option 7 unless, of those dual eligibles currently not bought in, more than 84 percent of the aged and 91 percent of the disabled are self-enrolled. 1/

1/Under option 7, the State would have to pay its share of the part B premium for all dual eligibles--$4.35 per dual eligible assuming a 50-percent Federal share. For each aged dual eligible who is not currently bought in and who does not currently self-enroll, the State will save $27.22 in payments for health services. Therefore, unless more than 84 percent are currently self-enrolled ((1 - $4.35/ $27.22)(100)), State expenditures will decrease. Using the same logic and the average part B expenditure for the disabled of $49.26, State expenditures for the disabled would decrease unless more than 91 percent of them are self-enrolled ((1 - $4.35/$49.26)(100)).

Of the options which eliminate both administrative problems (options 6, 7, 8, and 9), option 8 would probably result in the smallest increase in Federal expenditures. Option 8 would result in all dual eligibles being enrolled in Medicare; therefore, the Congress' intent in enacting the buy-in provisions of having all dual eligibles in Medicare would be met. However, because options 6, 7, and 9 would provide more fiscal relief to the States, the Congress' other major intent in enacting the buy-in provisions would be less fully met by option 8 than by these other options. As noted above, option 7 would provide the most fiscal relief to the State.

HEW AND STATE COMMENTS

HEW said legislation may be necessary to rectify the major problems with the State buy-in program. It said HCFA was analyzing legislative options, including those discussed in this report, in terms of their administrability, impact on beneficiaries, and total Federal and State costs. (See app. III.)

All five of the States that commented on our analysis of legislative change favored options to expand Federal sharing. All identified option 7 as a viable alternative, although some favored options 2 and 4. Louisiana said option 7 was the most viable alternative. Washington said its needs would be best met by option 7, which avoids most of the claiming difficulties. Idaho supported option 7 or 2. Nebraska suggested combining options 2 and 4 but said option 7 would be acceptable, noting "* * * there is something distasteful about the word 'require' * * *." North Dakota said option 7 was the simplest and best but that either option 2 or 4 would eliminate its administrative headaches and costs. (See app. IV.)

Giving States an option to buy in all dual eligibles would be less effective than requiring States to buy in all dual eligibles with regard to meeting the legislative intent of the buy-in program. As discussed above, option 7 would most effectively meet the Congress' intent of enabling aged and disabled people to receive Medicare benefits and providing fiscal relief to States unless all States would decide to buy in all dual eligibles if given the opportunity.

RECOMMENDATION TO THE CONGRESS

We recommend that the Congress amend the Social Security Act to simplify buy-in program administration and improve the accuracy of States' claims for Federal Medicaid sharing. The analysis of the effects of alternative changes on the States, Medicaid recipients, and the Federal Government presented in this chapter should help the Congress decide which alternative to take.

FEDERAL MEDICAID SHARING PERCENTAGES

States	Fiscal year 1975-77	1978-79	1980-81
Alabama	73.79	72.58	71.32
Alaska	50.00	50.00	50.00
Arizona	60.48	60.81	61.47
Arkansas	74.60	72.06	72.87
California	50.00	50.00	50.00
Colorado	54.69	53.71	53.16
Connecticut	50.00	50.00	50.00
Delaware	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00
Florida	57.34	56.55	58.94
Georgia	66.10	65.82	66.76
Guam	50.00	50.00	50.00
Hawaii	50.00	50.00	50.00
Idaho	68.18	63.58	65.70
Illinois	50.00	50.00	50.00
Indiana	57.47	57.86	57.28
Iowa	57.13	51.96	56.57
Kansas	54.02	52.35	53.52
Kentucky	71.37	69.71	68.07
Louisiana	72.41	70.45	68.82
Maine	70.60	69.74	69.53
Maryland	50.00	50.00	50.00
Massachusetts	50.00	51.62	51.75
Michigan	50.00	50.00	50.00
Minnesota	56.84	55.26	55.64
Mississippi	78.28	78.09	77.55
Missouri	58.98	60.66	60.36
Montana	63.21	61.10	64.28
Nebraska	55.59	53.46	57.62
Nevada	50.00	50.00	50.00
New Hampshire	60.28	62.85	61.11
New Jersey	50.00	50.00	50.00
New Mexico	73.29	71.84	69.03
New York	50.00	50.00	50.00
North Carolina	68.03	67.81	67.64
North Dakota	57.59	50.71	61.44
Ohio	54.39	55.46	55.10
Oklahoma	67.42	65.42	63.64
Oregon	59.04	57.29	55.66
Pennsylvania	55.39	55.11	55.14

States	Fiscal year 1975-77	1978-79	1980-81
Puerto Rico	50.00	50.00	50.00
Rhode Island	56.55	57.00	57.81
South Carolina	73.58	71.93	70.97
South Dakota	67.23	63.80	68.78
Tennessee	70.43	68.88	69.43
Texas	63.59	60.66	58.35
Utah	70.04	68.98	68.07
Vermont	69.82	68.02	68.40
Virgin Islands	50.00	50.00	50.00
Virginia	58.34	57.01	56.54
Washington	53.72	51.64	50.00
West Virginia	71.90	70.16	67.35
Wisconsin	59.91	58.53	57.95
Wyoming	60.94	53.44	50.00

STATE BUY-IN COVERAGE GROUPS

	Groups bought in (note a)		
	Cash recipients only	Cash and noncash recipients	No buy-in program
Alabama		X	
Alaska			X
Arizona (note b)			
Arkansas		X	
California		X	
Colorado		X	
Connecticut	X		
Delaware	X		
District of Columbia		X	
Florida		X	
Georgia		X	
Guam		X	
Hawaii		X	
Idaho		X	
Illinois	X		
Indiana		X	
Iowa		X	
Kansas		X	
Kentucky	a/X		
Louisiana			X
Maine	X		
Maryland		X	
Massachusetts	X		
Michigan	X		
Minnesota	X		
Mississippi		X	
Missouri	X		
Montana		X	
Nebraska	X		
Nevada		X	
New Hampshire	X		
New Jersey		X	
New Mexico		X	
New York	X		
North Carolina		X	
North Dakota	X		
Ohio		X	

	Groups bought in (note a)		
	Cash recipients only	Cash and noncash recipients	No buy-in program
Oklahoma	X		
Oregon			X
Pennsylvania	X		
Puerto Rico			X
Rhode Island	X		
South Carolina		X	
South Dakota	X		
Tennessee	X		
Texas		X	
Utah		X	
Vermont	X		
Virgin Islands		X	
Virginia		X	
Washington		X	
West Virginia	X		
Wisconsin	X		
Wyoming			X
Total in each category	21	27	5

a/The "Cash recipients only" group includes people receiving aid as aged, blind and disabled, and AFDC beneficiaries (except Kentucky, which does not buy in AFDC recipients). The "Cash and noncash recipients" group includes all cash recipients plus noncash title XIX beneficiaries.

b/Has no Medicaid program.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUN 21 1979

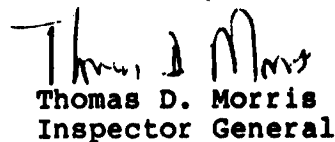
Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Simplification of the Medicare/Medicaid Buy-In Program Would Reduce States' Improper Claiming of Federal Funds." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,



Thomas D. Morris
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED, "SIMPLIFICATION OF THE MEDICARE/MEDICAID BUY-IN PROGRAM WOULD REDUCE STATES' IMPROPER CLAIMING OF FEDERAL FUNDS"

OVERVIEW

In our opinion the subject GAO Report is a sound interpretation of current policy and problems associated with the interpretation of that policy.

The creation of the Health Care Financing Administration (HCFA) provides the organizational focus to correct some of the deficiencies pointed out in the report. As a result of the recent reorganization of HCFA, the State buy-in and Federal financial participation in the Medicaid program are now functional responsibilities of the Bureau of Program Operations within HCFA. We also agree with GAO that legislation may be necessary to rectify the major problems with State buy-in.

The GAO Recommendation

The Secretary of HEW should direct the Administrator, HCFA, to enforce the requirements of Federal law and regulations by:

--Monitoring more closely States' administration of the program, periodically validating claims for Federal sharing.

--Collecting monies due to the Federal Government from States identified as having overclaimed and paying States identified as having underclaimed.

Department Comments

Concur

On March 5, 1979, HCFA Regional Letter No. 79-18 directed HCFA regional offices to carefully review a number of operational areas. Seven areas required mandatory review and nine were considered optional review areas.

The mandatory areas covered collection of overpayments from providers, abortion, cost settlement of hospitals and long term care facilities, maximum allowable cost regulations for drugs, follow-up on HEW audit or GAO reports with potential disallowances, administrative costs and payments to providers with no valid provider agreements.

The optional areas covered maintenance of effort for inpatient psychiatric care of patients under age 21, recipients with mental diseases, reimbursement of home health care, reimbursement to ICF for the mentally retarded, buy-in, fraud and abuse collections, and review of Quarterly Statement of Expenditures.

Based on the above, the buy-in program is covered under both the mandatory area and the optional area. Since this is a GAO report finding with potential money disallowance, it is covered as a mandatory item under this heading. The coverage under the optional area is self-evident.

The present GAO report will be distributed to HCFA Regional Offices with instructions that its recommendations be addressed in the course of the financial review conducted of State buy-in programs. We are also making the buy-in program a specific mandatory review area.

HCFA's Bureau of Program Operations will request the HEW Audit Agency - - in developing its annual audit plan - - to consider increasing its coverage of the State buy-in program with particular reference to determining overclaims and underclaims for adjustment in the State's quarterly expenditure reports.

GAO Recommendation

The Secretary of HEW should direct the Administrator, HCFA, to enforce the requirements of Federal law and regulation by:

--Providing more assistance to States in carrying out their buy-in programs.

Department Comments

Concur

The Department will step up the assistance offered by the Corrective Action Projects initiative to States found deficient in the buy-in program through State Management Assessments. Recently revised Quarterly Statement of Expenditure Reports also will help identify States which need assistance.

Many attempts to instruct the States in buy-in are made, including a handbook which explains the entire buy-in procedure, written instructions to supplement the handbook, telephone advice and guidance from HCFA central and regional offices, and the conduct of training sessions. Among our additional on-going activities to assist the States are several HCFA instituted systems applications that can be helpful to States in determining the amounts due them through Federal sharing.

GAO Recommendation

The Administrator should direct Oklahoma to stop discriminating between self-enrolled and unenrolled non-cash institutionalized Medicaid recipients.

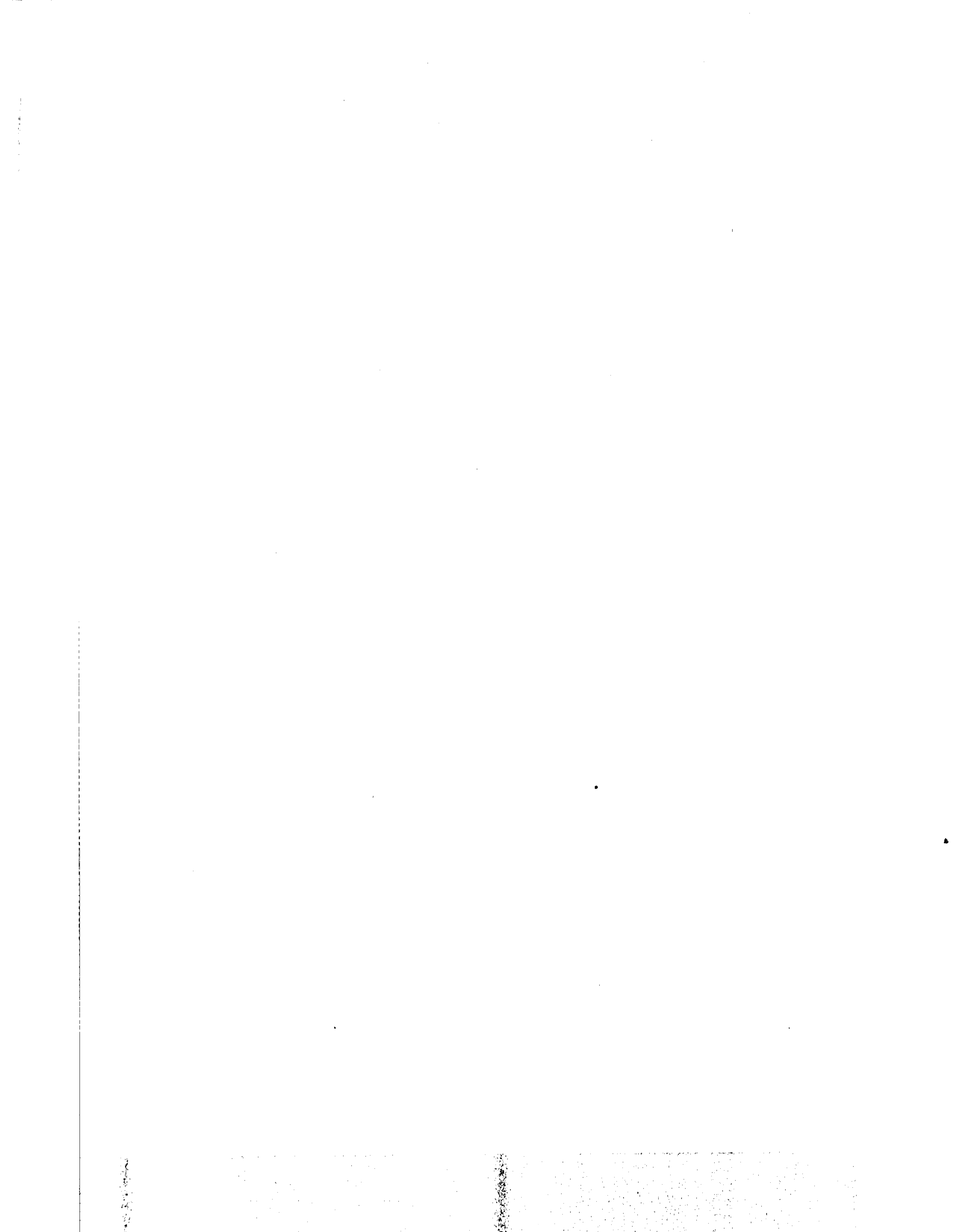
Department Comment

Concur

The Department will inform the Financial Management staff in Region VI to explore and review this finding with Oklahoma State agency officials and to ensure that corrective actions are taken.

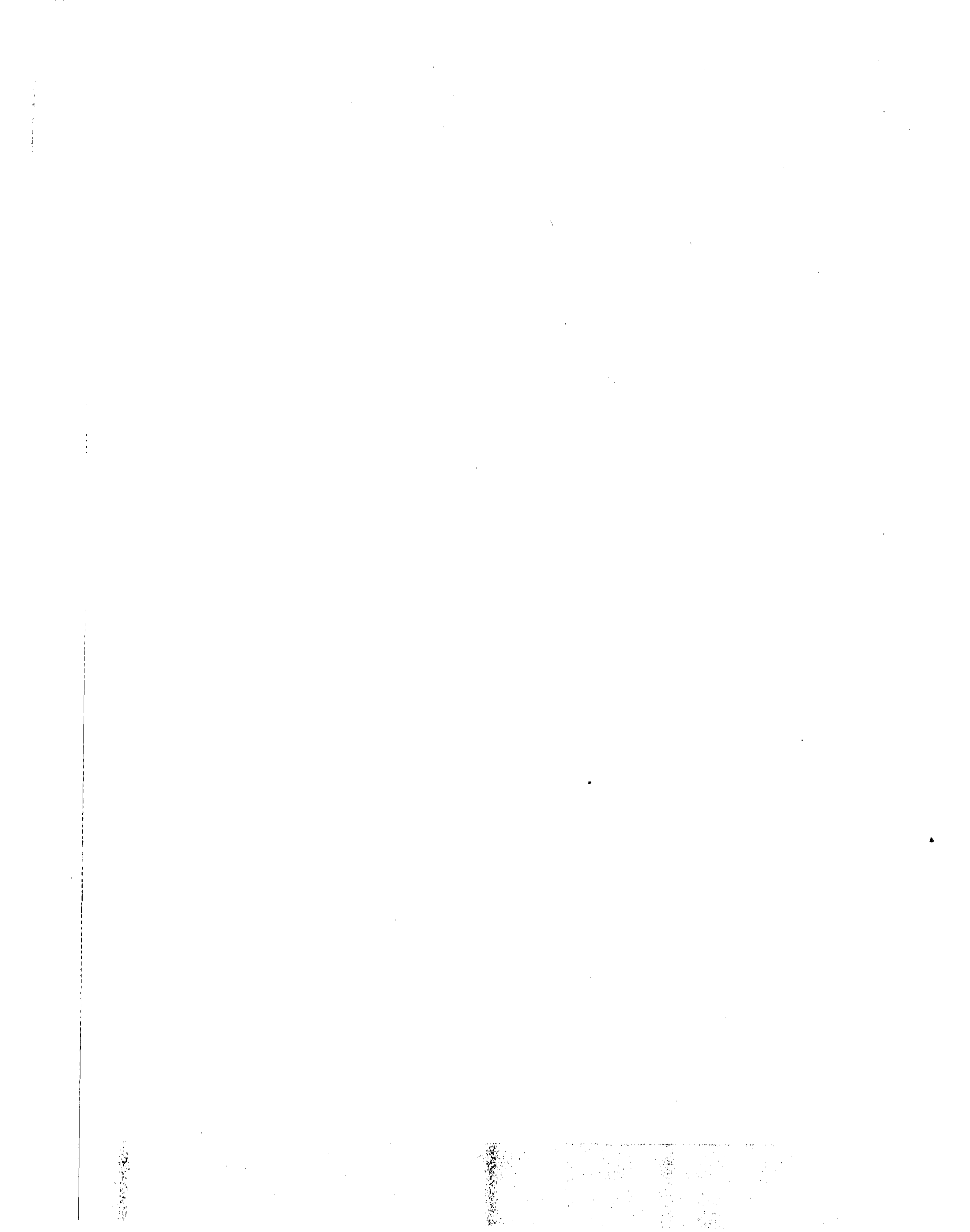
Summary of Legislative Proposals

The GAO report listed nine legislative alternatives for correcting some or all of the current statutory problems. Legislative options, including those presented in the GAO Report, are now being analyzed within HCFA as to administrability, total federal and state costs, and impact on beneficiaries.



STATES' COMMENTS ON PROPOSED BUY-IN REPORT

GAO note: Any page references in this appendix may not correspond to page numbers in the final report.



STATE OF IDAHO

DEPARTMENT OF HEALTH AND WELFARE

Statehouse, Boise, Idaho 83720

July 11, 1979

Gregory J. Ahart, Director
Human Resources Division
U. S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We thank you very much for giving my staff an opportunity to comment on this draft report in regard to the simplification of the Medicare/Medicaid Buy-in Program.

We have reviewed the section in the report related to the Idaho's buy-in. Your findings are all correct. Although the State of Idaho may have underclaimed the federal sharing on the buy-in premium, as you have concluded, we believe that the losses are small due to the small population which could be claimed as cash recipients. Nevertheless, we are anxious to correct the problem in a cost effective manner.

We have studied your proposed eight options in simplifying the buy-in program. Due to the fact that the State of Idaho is currently buy-in for all dual eligibles, therefore, we support either Option 2--"Permit federal sharing in all buy-in premiums regardless of recipients' cash assistance status" or Option 7--"Require states to buy-in all dual eligibles and permit Federal sharing in all premium payments."

Our support is based upon the following reasons:

1. The required administrative staff, as well as the necessary ADP system support, required to report the correct federal sharable premium amount under the current regulations are too expensive to be cost effective. Option 2 or 7 will allow the state to report the correct federal sharable premium without requiring any administrative or system changes.

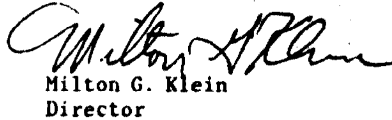
2. We feel that the current regulations are inconsistent. While the states are only allowed to claim federal shares on premium cost for individuals receiving cash assistance, the costs for coinsurance and deductible for all recipients in buy-in program are federal sharable.

EQUAL OPPORTUNITY EMPLOYER

3. The cash assistance group includes individuals receiving SSI or state supplement assistance. Due to the different state supplement standards among the different states, we feel that not all states are equally provided with fiscal relief through the federal shares of buy-in premiums.

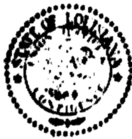
If you have any questions regarding our comments, please feel free to contact our MMIS Supervisor, Dr. Derek Wang, or myself at your convenience.

Sincerely,



Milton G. Klein
Director

MGK/dh/M3



State of Louisiana

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

EDWIN EDWARDS
GOVERNOR

OFFICE OF THE SECRETARY

WILLIAM A. CHERRY, M.D.
SECRETARY

July 9, 1979

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accountant Office
Washington, D. C. 20548

Dear Mr. Ahart:

Thank you for your letter of June 11, 1979, attaching a draft of your proposed report concerning the simplification of Medicare/Medicaid Buy In Program. We have reviewed your report and would like to offer the following comments:

1. In general, we feel that the report is quite comprehensive, consisting of all viable alteratives and presenting option number seven as the most viable alterative. We concur with this.

2. Specifically, in relation to the section (draft pages 33A-34) dealing with the State of Louisiana, we should like to offer further comments:

   A. On page 33B of the draft report, the following statement appears, "Until July, 1977, Louisiana contracted with the Medicare Part B claims processor for the State to be its Medicaid fiscal agent for processing claims," this reference and other references throughout the report ignore the fact that not only did we contract with the Medicare Part B claims processor, but we contracted with a separate entity for the payment of drug claims, a separate entity for Part A claims and did in-house payment of all other claims.

   B. The above leads us to comment on the first paragraph on page 33C. We believe that this conversion from four payment sources to one necessarly involved many administrative problems which would be common to any state operation the size of Louisiana's in such a conversion. The GAO Auditors looked primarily at the first six months of operation under

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"AN EQUAL EMPLOYMENT OPPORTUNITY AGENCY"

our new fiscal intermediary. These first six months were, administratively, a very difficult time. During this time, continual efforts were being made, both on the part of state personnel and the personnel employed by the new fiscal intermediary, to correct these problems.

C. The last sentence in paragraph 1 of page 33C, continued on page 33D, is erroneous. We utilize a computerized adjustment system which made and continues to make adjustments for prior periods. It is therefore possible and, often the case, that amounts are accumlated less than zero as debit adjusting is performed for prior periods.

D. The penultimate and last sentences of the same paragraph imply a difference between the Medicaid officials and the Assistant Comptroller for the Department of Health and Human Resources. No such contradiction exists. It is theoretically possible for the Louisiana Medical Assistance Program to retrieve the actual amounts, however, the administrative cost would be extremely high and would out weigh any money, either under or over reported. The Assistant Comptroller was aware of this fact as were the officials of the Medical Assistance Program.

E. In the paragraph beginning at the bottom of 33D and continued on page 34, we wish to point out that the Department Health Education and Welfare estimated the amount spent for Part B services. We wish to stress that DHEW estimated. They recognized that retrieval would be non-cost effective.

F. In the following paragraph on page 34, it is stated, "In addition, a comprehensive estimate of ineligible expenditure must include indentifying expenditures for unenrolled disabled dual individuals". This is true not only for disabled but for aged individuals. The State of Louisiana has continually endeavored to use the BENDEX system of the Social Security Administration to identify such individuals since its inception. Until July, 1978, however, the BENDEX system was highly unreliable. Additionally, beginning September 20, 1977, we requested the CAST/BEST report for this purpose. It was at this time that we became aware of this existance of this report. As of this writing we have not been able to obtain a CAST/BEST and, unless Social Security Administration is willing and able to help us identify dual enrolled eligibles, it is an unreasonable burden on the State for us to perform the

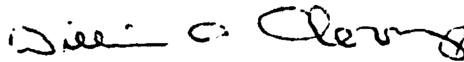
necessary investigative work to determine these.

G. In regard to the last sentence of the last paragraph on page 34 of the draft, we have worked closely with personnel in the Regional Office of the Health Care Financing Administration and instituted new changes in our computer logic. We believe that these changes have allowed us to perform the necessary analyses for financial reporting.

Again, we express our gratitude for being allowed to review and comment upon this draft. We hope that you will make available to us the final copy of the report when it is presented to the Congress.

Should you have any questions concerning our comments, please feel free to contact Mr. Alvis D. Roberts, Assistant Secretary.

Sincerely yours,



William A. Cherry, M. D.
Secretary

cc: Alvis D. Roberts
Assistant Secretary

Charles Thone
Governor

State of Nebraska
DEPARTMENT OF PUBLIC WELFARE

John E. Knight
Director

July 10, 1979

Gregory J. Ahart, Director
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

The Nebraska Department of Public Welfare appreciates your consideration and the opportunity to comment on the report which you intend to submit to the United States Congress regarding the various alternatives in attempting to simplify the Medicare/Medicaid "Buy-In" program.

In general, the report is thorough and accurate and should give those legislators who have limited knowledge in this field, a sufficient background to comprehend the program and to consider the alternatives in light of the Buy-In problem as presented. Also, when considering the time, effort and money that has gone into your research, we are really in no position to dispute the accuracy of the statistics which you have developed.

We do have some reservations about the rather negative implications of Nebraska's on-again off-again approach to using and relying on the BENDEX system. It was not until mid-1978 that the BENDEX system began furnishing the information necessary to properly identify those Medicaid non-cash Part B eligibles who were or were not enrolled in Part B, along with the associated reason for enrollment or nonenrollment. Our preliminary systems analysis work was already underway to use this new intelligence, when it was learned that it would change again in the near future and our current efforts were then aborted at that time. Without an accurate source of information, we cannot properly identify the various Part B eligibles in a manner that will allow us to separate the eligible from the non-eligible claims. Although we can identify those cash recipients that we Buy-In for, the non-cash recipients present to us virtually the same problem that you identify in the last paragraph on page 57. Without a more costly data processing system that would demand monthly caseworker review and update, we have no way of identifying those non-cash Part B eligibles who are or are not self-enrolled. We do want to comply with the law, but feel that "it would virtually be impossible" to do so in a realistic and economical manner. Once the proposed BENDEX is finalized, we may be able to resume our efforts, if the current information remains available.

As for your proposed alternatives and relying on the validity of your information and statistics, we would encourage a combination of options 2 and 4. Although there is something distasteful about the word "require", option 7 could also be an acceptable alternative, assuming that Federal sharing includes all Medicaid medical payments as well as Medicare premium payments.

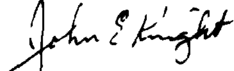
MAIL: P.O. Box 95026 / Lincoln, Nebraska • OFFICES: 301 Centennial Mall South / Fifth Floor • Telephone: 402 / 471-3121

APPENDIX IV

While it is not specifically stated, we are also assuming that any new legislation would result in the termination of our current Buy-In agreement, as we have long since elected not to Buy-In for non-cash recipients. Otherwise, we are automatically prohibited from reevaluating our current position in relation to any future alternatives.

Thank you again for the opportunity to respond to your draft report.

Respectfully,



John E. Knight
State Director

JM:al/11,12

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July 6, 1979

George J. Ahart, Director
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

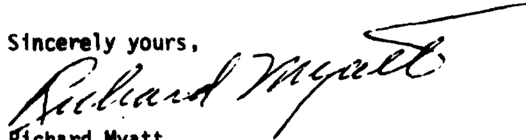
This is in response to your letter to Mr. Tangedahl dated June 11, 1979, with which was enclosed copies of excerpts from the draft of your report to Congress regarding the Buy-In Program.

I reviewed one of the five copies that were sent with your letter and only have some general comments. I would also like to identify an area not noted in your report which had a bearing on our state originally not electing to cover non-cash or medically needy individuals when the buy-in began. At the time, medically needy individuals became eligible seven days prior to date of application. Specifically, the item in question is the difference in policy which existed and continues to exist in the starting date of buy-in coverage between cash and non-cash recipients. Cash assistance recipients could be brought in as of the date of Medicaid eligibility assuming they are Medicare eligible. Non-cash eligibility "begins the first day of the second month after the month they become eligible for medical assistance only" and I am quoting from Part I, item 135A of HIM-24. The differences in potential coverage are obvious when considering the retroactive eligibility provisions in Medicaid and the fact that a good share of medical expense is generally incurred during the month of Medicaid eligibility or the months immediately preceding application. I hope this fact was taken into consideration in calcuating the amount of financial disadvantage a state incurred by not including non-cash recipients in the buy-in and related calculations as to the advantages.

As for the recommended buy-in options, the simplest alternative and best for the people involved would be to require buy-in on all "dual eligibles" providing the eligibility or coverage periods are the same for both groups and there is federal sharing in all premium payments. Otherwise, leave it as it is with elimination of the provision for no sharing by the federal government for Medicare Part B or leave it optional for non-cash recipients and include federal sharing on premiums. Any of these courses of action would eliminate a number of administrative headaches and costs of dealing with many nuisance transactions on the part of the state and federal governments.

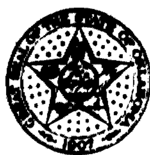
Thank you for the opportunity to comment on the draft of your proposed report to Congress.

Sincerely yours,



Richard Myatt
Director of Medical Services

cc: T.N. Tangedahl
rs



STATE OF OKLAHOMA
OKLAHOMA PUBLIC WELFARE COMMISSION

DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES
(Department of Public Welfare)

L. E. Rader
Director of Public Welfare

Mailing Address: P.O. Box 25352

Sequoyah Memorial Office Building
OKLAHOMA CITY, OKLAHOMA - 73125

July 11, 1979

Gregory J. Ahart, Director
United States General Accounting Office
Human Resources Division
Washington, D. C. 20548

Dear Mr. Ahart:

Attached are our comments regarding the GAO review of the Medicare-Medicaid Buy-In Program.

On page 36 of the draft, you state that Oklahoma pays for Part B services for medically needy. This State does not pay for Part B services for medically needy recipients who are eligible for Medicare. If they are eligible for Medicare and have not bought in, we do not make any payment for services that would have been covered by Part B, if the premium had been paid. Your review apparently overlooked the fact that one cannot pay from Title XIX for services which could be provided under Title XVIII, if the individual had paid their own Supplemental Medical Insurance premium. Our failure to pay for services from Title XIX funds which could be paid under Title XVIII is in keeping with the law.

Since we are under a legislative mandate to receive maximum Federal matching funds, we are precluded from paying for such services from State funds only. On numerous occasions, we have had discussions with the Health Care Financing Administration's Regional Office regarding modification of our buy-in contract which currently covers only those individuals receiving a money payment. We have been told that since our buy-in contract prior to January 1974 covered only those individuals receiving a State money payment, an expansion of the buy-in contract to cover other individuals is prohibited by law.

If you have any questions regarding our comments, please let us know.

Very truly yours,

L. E. Rader
Director of Public Welfare

Department of Human Resources
OFFICE OF THE DIRECTOR
318 PUBLIC SERVICE BUILDING, SALEM, OREGON 97310 PHONE 378-3033

July 17, 1979

Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

According to your request of June 11, 1979, we have reviewed the draft of "Simplification of the Medicare/Medicaid Buy-In Program Would Reduce States' Improper Claiming of Federal Funds." In your letter, you requested we comment on the portion of the report related to our state.

The report appears to adequately reflect our concerns and situations. We wish to point out, however, that there is no method available to us for verifying the accuracy of your estimates of affected population or your estimates of a total fiscal impact.

We trust that this is the information you need.

Sincerely,

Leo T. Hegstrom
Director

LTH:dms

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

July 9, 1979

Mr. Gregory Ahart, Director
Human Resources Division
U.S. General Accounting Offices
Washington D.C. 20548

Dear Mr. Ahart:

Your draft report to the United States Congress on simplification of the Medicare/Medicaid buy-in program sent to Dr. Beare has been directed to my office for review and comment.

We agree with your contention that the current regulations governing the buy-in program are needlessly complex and consequently lead to improper federal share calculations by the states. Following HEW's review of our Medicaid Part - B (SMI-B) payment system last year, we developed a computer program which identifies most, but not all, of the premiums paid on behalf of cash assistance recipients. It is quite clear that this area is in need of substantive legislative revision.

Of the nine options analyzed in your report, it is our determination that regulations permitting the buy-in of all dual eligibles and permitting the federal sharing of all premium payments would best serve the needs of this state. (option number 7, page 46) This option basically aligns with the congressional intent of the original legislation, avoids most of the claiming difficulties experienced by states and permits federal/state cost sharing for all Medicaid eligible persons.

We appreciate this opportunity to review and comment on your draft material and sincerely hope that appropriate legislative action will be taken.

Sincerely,

John E. Cordy, Director
Budget & Fiscal Services Division OB-33C

JEC:DF:dl

THE STATE OF WYOMING

ED HERSCHLER
GOVERNOR

Department of Health and Social Services

Division of Health and Medical Services

HATHAWAY BUILDING CHEYENNE, WYOMING 82002

July 12, 1979

Mr. Byron S. Galloway
Team Leader
United States Accounting Office
Washington, D.C. 20548

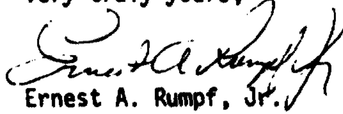
Dear Mr. Galloway:

We received a copy of the letter from Mr. Gregory J. Ahart giving us a draft of the report on the Medicare/Medicaid Buy-In Program. In the section that pertains particularly to Wyoming, on Page 28d it states that the supervisor of claims processing said "the State was unaware that these individuals had Medicare coverage. She and another State official said they knew of no way they could accurately determine whether Medicaid recipients had Part B coverage." This is not accurately stated since the problem was in identifying which of the disabled recipients had Medicaid coverage not in the fact that we did not know how it could be done. I quote from our office file of August 24, 1978 of a telephone conversation by Jacqueline Crumbliss. "On this date I received a phone call from Mr. Jerry Hunt of the Regional Office. He made a visit to Cheyenne on August 14th to try to clear up the problems we have had with the Bendex System. We attempted to accrete the SSI recipients to the Bendex on a one time accrete and it failed. Mr. Hunt came to see if it was our fault or whether it was their error. The result of that visit did reveal that it was in fact an error of the Central Office. The Bendex output tape had been destroyed so a rerun was impossible. Mr. Hunt indicated that another attempt would be made to accrete SSI recipients to the Bendex but this could not be completed until approximately the 10th of October." and further in the same memo "I have made a note of this information for purposes of GAO audit which will be held in September 1978".

Although I would not disagree with the fact that we are aware that in some instances Medicaid funds are being used where Medicare funds

could be used in the case of disabled it is not a result of the supervisor not knowing how they could be determined. The problem was within receiving this information from Central Office of SSA on the Bendex.

Very truly yours,



Ernest A. Rumpf, Jr.
Director
Medical Assistance Services

cc: Mr. W. Don Nelson

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