BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Improved Efforts Needed To Relieve Medicaid From Paying For Services Covered By Private Insurers

Medicaid, a federally aided, state-administered medical assistance program for low-income people, should be relieved of health care costs if some other party is legally responsible to pay. Nevertheless, states receive bills for Medicaid recipients who have coverage under health and liability insurance. State Medicaid administrative systems often do not identify the liable insurers or redirect these medical bills to them. As a result, the Health Care Financing Administration estimates that Medicaid pays annually from $500 million to more than $1 billion that private insurers should be paying.

GAO recommends that the Secretary of Health and Human Services adopt either of two options that would influence states to improve Medicaid practices for recovering additional health care costs from available health and liability insurance resources.

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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

Medicaid is not supposed to pay for health care costs if a private insurer is legally responsible. This report describes how state Medicaid practices for identifying and collecting private party insurance could be improved through greater oversight by the Health Care Financing Administration.

We undertook this review to assess the extent and effectiveness of state efforts to reduce Medicaid program costs by using other available health care resources. According to 1981 Bureau of the Census data, the latest available, about 18 percent of the Medicaid population have some form of private health insurance coverage. States often fail to identify or pursue these insurance resources, and Medicaid is estimated to be paying between $500 million and more than $1 billion annually for medical services that other insurers should be paying.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Health and Human Services.

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

IMPROVED EFFORTS NEEDED TO RELIEVE MEDICAID FROM PAYING FOR SERVICES COVERED BY PRIVATE INSURERS

D I G E S T

Medicaid, which provides medical assistance to about 22 million low-income people, is administered by the states in accordance with federal requirements. At the federal level, the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS) has oversight responsibility for the program. In fiscal year 1984, the federal and state shares of Medicaid costs were $21 billion and $17 billion, respectively.

By law, Medicaid is the payer of last resort; that is, all other available resources must be used before Medicaid pays claims. In this regard, the Bureau of the Census reported that in 1981, the most recent available data, about 18 percent of Medicaid recipients were covered by private health insurance. Also, in the case of accidents, liability insurers may be responsible for injured Medicaid recipients' medical bills. States are required to make reasonable efforts to identify and collect from health and liability insurers before making Medicaid responsible for paying medical bills. However, HCFA estimates that Medicaid is paying $500 million to more than $1 billion annually for medical services that insurers should be paying.

GAO undertook a review to assess the effectiveness of state practices for using available insurance resources and to determine whether federal corrective action was needed. Between November 1982 and April 1984, GAO reviewed state practices in California, Maryland, Oregon, Pennsylvania, Texas, and Washington. These states account for about 23 percent of Medicaid spending. Limited work was also done in New York.

IDENTIFICATION OF PRIVATE INSURANCE COVERAGE NEEDS IMPROVEMENT

State procedures for identifying Medicaid recipient insurance resources could be improved to better assure that insurance is used before Medicaid. Specifically:

--When determining and redetermining eligibility for Medicaid, California, Pennsylvania, and Texas asked only general questions about whether insurance resources existed. If these states expanded the questions to cover situations that can be associated with insurance coverage, such as whether any member of the family is employed or has recently been in an accident, there would be a greater probability that insurance coverage is identified. The effectiveness of asking more questions was demonstrated by Washington State. Within 6 months after adding to its Medicaid eligibility determination procedures six questions related to insurance coverage, the number of recipients with identified insurance resources increased by 12 percent.

--In California, Maryland, and Texas, when the recipient's response to questions about insurance coverage indicated it existed, caseworkers often failed to follow up and obtain the information necessary to use the insurance, such as the name of the insurer and the policy number. For example, California caseworkers failed to obtain such information for 71 percent of the recipients who said they had health insurance. (See pp. 9 to 11.)

--California, Maryland, Pennsylvania, and Texas did not have ongoing programs to identify potential insurance coverage by computer matching Medicaid files with other state data sources. Such data matching can identify insurance resources available to Medicaid recipients who (1) have an employed divorced or otherwise absent parent who has insurance covering his/her children, (2) are employed, or (3) work for the state. Some states have used matching effectively to identify insurance resources. For example, the state of Washington matched Medicaid recipient files to state data files containing the information listed above. Developing and operating this program cost about $46,000 but saved an estimated $2.5 million in Medicaid funds during its first year. (See pp. 11 to 14.)

The information GAO gathered also shows that state procedures to identify services that might be covered by liability insurers could be improved. The primary means to identify Medicaid claims where a liability insurer may be responsible for payment is to screen claims for

medical services associated with accidents, such as treatments for broken bones and for multiple lacerations. Claims for such services identified by the screening are researched to determine whether the recipient has liability insurance.

In New York, the counties were responsible for researching, but state officials said that county follow-up was rare. While Pennsylvania and Texas followed up only on claims involving $1,000 or more, California took action on claims of $50 or more. California's lower threshold, combined with a state requirement for attorneys to report when they represent Medicaid recipients in accident-related cases, contributed to the state's recovery of over 50 percent more, as a percentage of total Medicaid costs, from liability insurers than any other state reviewed. (See pp. 14 and 15.)

SSA COULD HELP STATES BETTER IDENTIFY MEDICAID RECIPIENT INSURANCE RESOURCES

While the states normally determine Medicaid eligibility, the Social Security Administration (SSA) does this for about 10 percent of the Medicaid population--Supplemental Security Income (SSI) recipients in 30 states. SSA determines their Medicaid eligibility concurrently with their SSI eligibility. However, when determining Medicaid eligibility, SSA does not obtain the name and address of the insurance carrier and policy number for those covered by health insurance. Without this information, knowledge of insurance is of little use to the states.

In 1977 GAO recommended that SSA provide the states with the insurance information they need to adequately pursue liable insurers for SSI recipients. In 1983, HCFA and SSA pilot tested a program to provide more information to the states. HCFA's report on this project states that it more than tripled the number of SSI recipients identified as having health insurance. The report estimates that net annual savings of $69.5 million could be achieved by implementing the project nationwide.

GAO proposed that SSA provide detailed insurance information on Medicaid/SSI applicants to states in which SSA now determines Medicaid eligibility. HHS commented that HCFA and SSA have agreed to offer the improved data collection services to the states that agree to pay for it, effective January 2, 1985. Providing this information to the states should help them assure that insurance companies pay before Medicaid and thereby help reduce Medicaid costs. (See ch. 4 and app. II.)

STATES NEED TO IMPROVE PRACTICES FOR APPLYING INSURANCE RESOURCES

Most states require health care providers to seek payment from identified health insurers before billing Medicaid--the "cost avoidance" method. However, 14 states pay providers and then try to recover the money from liable insurers--the "pay and chase" method. Two of the states GAO reviewed (California and Maryland) used the pay and chase method. Because this method requires considerable administrative work, these states were not seeking recovery of millions of dollars in Medicaid costs. (See pp. 16 to 18.)

In fiscal year 1983, Maryland paid $19.5 million in medical bills for Medicaid recipients whom state records showed had health insurance coverage. Because of the work involved in recovering payments from insurers, the state sought recovery only on claims of $200 or more. As a result, Maryland sought recovery for only $7.3 million, or 37 percent, of the $19.5 million.

California often did not follow up on health insurance carriers that did not respond to the state's request for reimbursement. From 1977 through 1983, insurance companies had not responded to about 87,000 claims totaling about $158 million that the state sent them. (See p. 17.)

HCFA NEEDS TO STRENGTHEN ITS OVERSIGHT OF STATE PRACTICES

HCFA focuses its oversight of state practices related to recipient insurance resources on compliance reviews. It uses these reviews to suggest improvements in identifying and applying insurance resources. These compliance reviews, however, have not identified some major weaknesses, and HCFA has not consistently gotten states to adopt suggested improvements. GAO believes this occurs because there are no specific regulatory standards on how states should identify and use Medicaid recipients' insurance resources. Without such standards, the states GAO visited generally viewed HCFA's suggestions for improving their practices as advisory and often did not adopt them.

For example, of the 10 states where HCFA conducted compliance reviews in 1983, 6 reports pointed out problems with state practices for identifying or using recipient insurance resources that had been mentioned in HCFA's previous compliance reports and had not been corrected. From 1978 through 1982, HCFA also used its Medicaid quality control program to assess state performance in the recipient insurance resources area. The quality control program is designed to use statistically projectable samples of cases to measure erroneous payments. One type of erroneous payment sampled for was uncollected insurance liabilities.

GAO reported in 1981 that this aspect of the quality control program was ineffective and recommended improvements to it. However, HCFA deleted this program aspect in 1982 and as a result has not implemented its plans to deny federal sharing in erroneous payments made because of uncollected insurance. Thus, HCFA decided not to use its quality control program to provide states with an incentive to improve practices for identifying and applying insurance resources. (See pp. 21 to 23.)

RECOMMENDATION TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO recommends that the Secretary direct the Administrator of HCFA to adopt one of two options to improve state practices for identifying and using Medicaid recipients' insurance resources.

The options involve (1) strengthening HCFA's regulatory requirements and its compliance reviews of state programs or (2) using its quality control program to determine the amount of erroneous payments attributable to unrecovered health and casualty insurance and denying federal sharing in such erroneous payments exceeding a specified level of performance.

These options and their advantages and disadvantages are discussed in detail on pages 24 to 26.

AGENCY COMMENTS

HHS stated that it was reassessing its future strategy for the Medicaid third party liability program with options ranging from continuing its compliance monitoring policy to reinstating a quality control program. HHS stated that a final decision on its strategy was expected soon and that it would select the most cost-beneficial approach.

GAO believes that any approach HHS selects should have specific criteria and result in adequate data to measure whether those criteria are met. GAO, therefore, believes that adopting one of the options presented in its recommendation is the preferable course of action. Either option should provide HHS, and the states, with information and criteria on which to base a decision about the effectiveness of state third party liability operations. Without specific criteria and measurement data, third party liability operations will continue not to realize their full potential, as they have over the years, as evidenced by the estimates of available but unused insurance coverage cited in this report and GAO's 1977 report. (See pp. 26 and 27.)

GAO also discussed its findings with officials of the states it visited and incorporated their views in appropriate sections of this report.

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ILLUSTRATIONS

ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
SSA	Social Security Administration
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Medicaid program is a federally aided, state-administered medical assistance program that serves about 22 million low-income people. Medicaid became effective on January 1, 1966, under authority of title XIX of the Social Security Act, as amended (42 U.S.C. 1396). Within broad federal limits, states set the scope and reimbursement rates for the medical services offered and make payments directly to the providers who render the services. Generally, persons receiving public assistance under the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs are eligible for Medicaid assistance. Also, at each state's option, persons who do not qualify for public assistance but cannot afford the costs of necessary health care may be entitled to Medicaid benefits.

Depending on a state's per capita income, the federal government pays from 50 to 78 percent of the Medicaid costs for health services. In addition, the federal government reimburses the states for 50 to 90 percent of their administrative costs, depending on the functions performed.

The Department of Health and Human Services (HHS) has overall responsibility at the federal level for administering Medicaid. Within HHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations.

Medicaid costs have been rising. In fiscal year 1980, state and federal Medicaid payments totaled $25.8 billion. By fiscal year 1984 these costs had risen to $38 billion; the federal and state shares were $21 billion and $17 billion, respectively.

MEDICAID IS INTENDED TO BE A SECONDARY PAYER

The Congress intended that, as a public assistance program, Medicaid would pay for health care only after Medicaid recipients had used all other health care resources. Medicaid recipients may have other health care resources through third parties, such as private health or liability insurers, that are responsible for the Medicaid recipients' medical costs.

According to 1981 Bureau of the Census[1] and 1980 HHS[2] data, between 18 and 20 percent of the Medicaid population have some form of private health insurance coverage. Normally Medicaid recipients with private health insurance obtain it through their (or their parents') full- or part-time employment, wherein employers pay for all or part of the insurance premiums. Working Medicaid recipients consist of three groups. These groups contain the working poor who have (1) incomes low enough to qualify for AFDC benefits, (2) incomes below the level needed to pay for their medical costs, or (3) lost their AFDC assistance because their income has exceeded the eligibility maximum, but because of Medicaid law, continue to be Medicaid eligible for the succeeding 4 months.

Dependent children in AFDC families qualify for Medicaid coverage. They may also be covered under insurance policies of their employed absent parents. In fact, federal child support enforcement law encourages states to assist Medicaid recipients in obtaining court orders requiring absent parents to obtain coverage for the children under employer-sponsored health insurance.

Besides private health insurers, other third parties may be responsible for the medical costs when a Medicaid recipient requires medical services because of an automobile, work, or other accident. For example:

--In states with "no fault" automobile insurance, an automobile insurance company becomes liable for a Medicaid recipient's medical costs resulting from an automobile accident.

--In a court judgment or settlement, a liability insurer may be held responsible for a Medicaid recipient's medical costs that resulted from an automobile accident or other injury.

--Workers' compensation laws operate in every state to ease personal losses that workers sustain from work-related diseases or injuries. These laws require that such workers be compensated for lost income and medical costs.

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[1]Current Population Survey, Characteristics of Households and Persons Receiving Selected Noncash Benefits, Bureau of the Census, 1981 sample data, published January 1983.

[2]National Medical Care Utilization and Expenditure Survey, conducted by HHS, on characteristics of the noninstitutionalized Medicaid population, 1980 sample data.

Medicaid regulations require that states, in administering the program, make reasonable efforts to identify and collect from liable third parties. The states then share with the federal government, in the same proportion as medical expenditures, any third party liability savings.

STUDIES INDICATE A SIGNIFICANT LOSS BECAUSE MEDICAID IS NOT USED AS A SECONDARY PAYER

Using Medicaid as a secondary payer is important because federal and state Medicaid costs are reduced without affecting Medicaid services. However, in June 1983, HCFA officials estimated that between $500 million and more than $1 billion annually in state and federal Medicaid funds are lost because responsible health and liability insurers are not paying Medicaid recipients' medical bills. More than half of this amount would be federal funds. HCFA officials told us that they based their estimate on a combination of studies concerning the states' efforts to use available health and liability insurance.[3]

HHS' National Medical Care Utilization and Expenditure Survey supports the reasonableness of HCFA's estimate of unused insurance resources. According to these 1980 data on characteristics of Medicaid eligibles with health insurance (the latest available), at least 3.3 million noninstitutionalized Medicaid eligibles were covered by both Medicaid and private health insurance. If states had used the available health insurance resources (excluding liability insurance) to pay the medical bills of these Medicaid eligibles to the same extent as the non-Medicaid public used their insurance, we estimate that $750 million annually would have been saved in state and federal Medicaid funds.[4]

Appendix I summarizes other federal and state audit reports and studies that have found weaknesses in state programs to identify and collect medical care costs from liable third parties.

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[3]Evaluation of the Cost Effectiveness of the Collection of Third Party Liability by State Medicaid Agencies, Maximus Inc. (Aug. 21, 1981), Hoffman-La Roche Company Analysis of HCFA Seattle Regional Office 1980 Study, and Final Report of Joint SSA/HCFA Task Group on Medicaid Third Party Liability Information Needs (Oct. 1981).

[4]The sources of these data are HHS' National Medical Care Utilization and Expenditure Survey (1980 data) and actual Medicaid program cost data adjusted for program cost growth to federal fiscal year 1983.

OBJECTIVES, SCOPE, AND METHODOLOGY

This review was made to assess the extent and effectiveness of state efforts to reduce Medicaid program costs by using other available health care resources. For our review, we considered nonfederal health care resources that should be used to reduce the federal portion of Medicaid program cost--primarily private health or liability insurance.

We focused on the following objectives:

--To assess the effectiveness of state practices for using available insurance resources.

--To determine to what extent HHS was influencing states to adopt the most effective practices.

--To determine, in cases in which HHS establishes Medicaid eligibility for SSI applicants, if HHS was giving the states adequate information about the Medicaid eligibles' insurance resources.

This review was performed at HCFA headquarters; at the HCFA regional offices in Seattle, San Francisco, Dallas, and Philadelphia; and at state Medicaid agencies in Washington, Oregon, California, Pennsylvania, Maryland, and Texas. We selected these states to cover a large portion of Medicaid expenditures and also to include some medium and small programs. These states account for about 23 percent of total Medicaid expenditures.

To determine the effectiveness of state practices for using available insurance resources, we did the following.

--We obtained data from the six states on the (1) number of Medicaid eligibles/recipients that the states had identified as having insurance resources and (2) amount of Medicaid funds saved by using available health and liability insurance. While we reviewed these data for comparability among the states, we did not verify the reliability of state-generated data.

--In California, Texas, Washington, and Pennsylvania, we reviewed at least 30 randomly selected Medicaid case files from each state's AFDC quality control sample to test state practices for identifying health and liability insurance. Staff limitations and the unavailability of data

because the state was converting to a computerized eligibility system prevented us from conducting the sample in Maryland. In Oregon, we obtained the results of a similar study performed by the state Medicaid agency.

--We sampled Medicaid paid claims to see whether states were using identified insurance resources to reduce Medicaid program costs.

--In the six states, we identified state practices that appeared to be contributing to a high level of savings and assessed whether other states could adopt similar practices. In Washington, data were not available on liability insurance collections, so we limited our work to practices involving health insurance.

In addition, we performed limited work at the state Medicaid agency in New York concerning its practice of requiring working Medicaid recipients to enroll themselves and their families in available employer-sponsored health insurance. A separate report was issued on this aspect of New York's third party liability program (GAO/HRD-84-86, Aug. 10, 1984, see app. I). We also obtained information on New York's practices relating to liability insurance and HCFA's evaluation of the state's third party liability program.

To determine the extent to which HHS was influencing states to adopt the most effective practices for using available insurance resources, we reviewed HCFA's evaluation of state practices generally performed during fiscal years 1980-83. In the states we visited, we assessed the completeness of these evaluations by comparing their results to our findings. We reviewed correspondence between HCFA and the states concerning the states' responsiveness in adopting HCFA recommendations, and we interviewed state and HCFA headquarters and regional office officials knowledgeable about the evaluations.

To determine if HHS was giving the states adequate information about the SSI/Medicaid eligibles' insurance resources, we

--reviewed HCFA studies and reports and talked to HCFA and state officials concerning this issue and

--evaluated the data HHS was giving the seven states we visited to determine its usefulness in identifying SSI/Medicaid recipient insurance resources.

To accomplish our objectives, we also looked at what progress HHS had made in correcting problems noted in our May 1977 report Problems in Carrying Out Medicaid Recovery Programs From

Third Parties (see app. I). We performed the review in accordance with generally accepted government auditing standards. We obtained information, where readily available, for federal fiscal years 1982 and 1983. Fieldwork was performed between November 1982 and April 1984. We discussed our findings with officials of the six states we visited and considered their views in preparing this report.

CHAPTER 2

IMPROVEMENT NEEDED IN STATE IDENTIFICATION AND APPLICATION OF INSURANCE RESOURCES

The six states we reviewed employed various practices for assuring that available health insurance resources are used to reduce Medicaid costs. We found, however, that these practices could be improved in three areas.

--Four of the six states could ask Medicaid applicants more questions about their insurance coverage or increase follow-up on the applicants' answers.

--Four states could match Medicaid eligibility files with other state data to identify additional Medicaid applicants with available insurance resources.

--Four states could screen more claims that are indicative of an accident and pursue them to determine if a liability insurer is responsible.

Further, once a state has identified an available insurance resource, it should apply the resource to reduce Medicaid costs. However, two states were paying claims and later trying to recover some of the costs from liable insurers. This practice requires more administrative cost and is less effective than the other four states' practices of avoiding costs by directing those providing Medicaid services to collect from liable insurers. The two states using the less effective method were not seeking recovery of millions of dollars in Medicaid costs.

STATES' IDENTIFICATION OF HEALTH AND LIABILITY INSURANCE NEEDS IMPROVEMENT

A state must identify insurance resources before it can apply them to pay for a Medicaid recipient's medical costs. Bureau of the Census statistics and HHS data estimate that, nationwide, about 18 percent of Medicaid eligibles have a health insurance resource available to them. However, as table 1 shows, the rate of health insurance identification reported by the seven states we reviewed ranged between 3.2 and 9.2 percent.

Table 1

Medicaid Eligibles/Recipients With Identified Health Insurance as a Percentage of Total Eligibles/Recipients[a]

State	Eligibles/recipients with insurance as a percentage of total eligibles/recipients[b]
California	3.2
Texas	4.2
Oregon	4.5
Pennsylvania	7.1
Maryland	7.8
Washington	9.2

[a]These data are for periods during federal fiscal year 1983, except for Maryland data, which are for the entire state fiscal year 1983, and Oregon data, which are HCFA data for federal fiscal year 1982.

[b]Due to differences in reporting methods among states, some data are for eligibles and some for recipients (known Medicaid users).

The wide variance among these states' rates of health insurance identification of Medicaid recipients, and the substantially lower identification rate that the Bureau of the Census and HHS data estimate, indicate that the states may not be identifying significant amounts of health insurance coverage of their Medicaid populations. Furthermore, studies by several states and HCFA, and our work, indicated that states had often not identified available insurance resources. For example:

--A 1983 Oregon review of 431 of 4,332 families in which absent parents were paying child support identified previously undetected health insurance resources in 124 cases, or 29 percent.[1]

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[1]Third Party Liability Study, Oregon Department of Human Resources, Adult and Family Services Division (June 1983).

--A 1983 New York State review of 1,390 randomly sampled Medicaid eligibles showed that 64, or 4.6 percent, had insurance the state did not know about.[2]

--A 1981 joint HCFA and Washington State Department of Social and Health Services study found that 90 of 367 randomly sampled recipients, or 24.5 percent, were covered by insurance previously unidentified by the state.[3]

--In California, Pennsylvania, Texas, and Washington, we reviewed a total of 124 randomly selected case files of AFDC families and found that overall the states failed to identify health insurance available to pay incurred medical bills for 18 of the families (15 percent).

States could detect more insurance resources by using all available techniques. Factors that could help them identify more insurance resources include (1) more effective practices for obtaining information from Medicaid applicants, (2) increased use of data matches, and (3) increased follow-up on Medicaid claims where liability insurance may be available. These factors are discussed in the following sections.

Practices for obtaining health insurance information from Medicaid applicants need to be improved

The most efficient and timely method for identifying health insurance coverage is when Medicaid eligibility is determined and redetermined. At these times, the caseworker normally asks the Medicaid applicant to provide health insurance information on the same form used to determine Medicaid eligibility. The caseworkers have primary responsibility for identifying health insurance coverage.

Oregon and Washington caseworkers asked relatively extensive questions about Medicaid applicants' health insurance resources. In our opinion, however, California, Maryland, Pennsylvania, and Texas could improve their procedures by either asking Medicaid applicants more questions or following up on the applicants' answers.

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[2]Review of random sample of Medicaid eligibles' case files in 10 New York counties, Department of Social Services, Third Party Recovery Unit (1983).

[3]Third Party Liability in the Medicaid Program: A Seattle Case Study, HCFA Region X and Washington State Department of Social and Health Services (Oct. 1, 1981).

In Texas, Pennsylvania, and California, the Medicaid application forms asked only general questions aimed at identifying insurance coverage, such as "do you or your family have any of the following insurance coverages: life; burial; medical/health or dental; or mortgage?" Answers to such questions at best provide information only on whether the applicant has some type of insurance. Asking more questions would help to pin down what type of insurance is available.

For example, Washington, which once had an application form similar to those in the states mentioned above, improved its identification rate by incorporating six questions about situations correlated with the existence of insurance. Caseworkers now ask such questions as whether any member of the recipient's family is working, is a member of a union, or has recently been in an accident for which medical services were received. These situations often indicate the presence of insurance coverage. If a question is answered affirmatively, the caseworker is instructed to follow up to determine whether insurance exists. The additional questions appear to have helped identify insurance resources. Between July and December 1983, the first 6 months after Washington revised its application form, the number of Medicaid recipients with insurance identified through the eligibility interview process increased 12.6 percent, although the total number of Medicaid recipients decreased 4.9 percent. A Washington official attributed the increase to the additional questions on the application form.

In addition to asking enough questions to detect insurance coverage, the caseworker needs to obtain information on the name of the insurance carrier, coverage dates, and the type of insurance coverage (that is, hospitalization, dental). This information is needed so that the Medicaid recipients' bills can be directed to the identified insurance carrier. In California, Maryland, and Texas, caseworkers did not obtain all of this information at the time of eligibility determination, and subsequent attempts to obtain it were either not made or unsuccessful. As a result, potential insurance resources were not identified. For example:

--In California, state records showed that in September 1983, about 164,000 Medicaid eligibles had responded affirmatively to the Medicaid application form questions on availability of insurance resources, indicating that they had insurance coverage. However, for 115,000 (71 percent) of the eligibles the caseworkers had not completed the additional form to obtain such information as the insurance carrier's name or the policy number. State officials told us that the local eligibility office was responsible for obtaining the insurance information and that the local

offices had not complied with state requests to obtain the missing information. An official at one local office told us that workload restrictions make it impractical to recontact Medicaid eligibles to obtain the missing insurance information.

--In Maryland, caseworkers often do not complete the part of the form that includes such information as the group or policy number, place of employment, or union membership information. For the year ended June 30, 1983, state records showed that 37,390 follow-up letters were sent to obtain missing information. However, 23,198 (or 62 percent) of these letters were not returned. The state Medicaid official in charge of recovering insurance, in a report to his superior, estimated that, based on the number of caseworker omissions in gathering insurance information, insurance recoveries could increase by at least 40 percent if the forms were completely filled out.

--In Texas, a state official estimated from state Medicaid applications that about 54,000 current Medicaid eligibles had told caseworkers they had health insurance, but the caseworkers did not complete the additional forms required to obtain the needed details to identify the insurance carrier or policy. According to this official, at the time of our review, procedures did not exist to recontact the Medicaid applicant to obtain the needed information. However, he informed us that after our review, the state had instituted a procedure to send questionnaires to Medicaid recipients to obtain the missing health insurance information. He told us that sufficient time had not elapsed to evaluate this procedure's effectiveness.

More computerized data matching needed

Although asking Medicaid recipients whether they have health insurance coverage can help identify insurance, used alone this interviewing technique has its limitations. A HCFA publication[4] stated that about one-third of the 1,481 families studied who reported that they had no health insurance actually did have it. Similarly, Medicaid applicants may not know that they have health insurance coverage through employed absent parents or they may not report the coverage. In these situations, the state can

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[4]Health Care Financing Review, Fall 1983, Volume 5, Number 1, "Consumers' Knowledge About Their Health Insurance Coverage."

identify insurance by matching computerized Medicaid eligibility files with state data sources, such as employees working in the state who are covered by unemployment insurance, as a supplement to the interviewing process.

Two states we visited, Washington and Oregon, had adopted data matching programs that identified recipients who had insurance coverage not found through eligibility interviews. Through data matching, these states identified three different types of individuals who may have insurance resources available that could be used to reduce Medicaid costs: (1) employed absent parents whose dependents are Medicaid recipients, (2) employed Medicaid eligibles, and (3) Medicaid recipients who are also state employees.

One-third of the Medicaid recipients that Washington identifies with health insurance are detected through a data match program initiated in February 1982. This program matches the computerized Medicaid eligibility file with other state data files. These files contain information on absent parents who are obligated to pay child support[5] and employers who pay unemployment insurance on their employees. Almost all wage and salary workers nationwide are covered by state-administered unemployment insurance. Matching these two state data files produces employment information on two groups with potential health insurance coverage: (1) employed absent parents whose dependents are Medicaid eligibles and (2) employed Medicaid eligibles. The state then follows up with employers to verify the type and extent of health insurance coverage. Although this match cost about $33,000 to develop and operate during its first year of operation, it saved an estimated $2.2 million in Medicaid costs.

In June 1982, Washington also developed a program to match computerized personnel records of state employees with Medicaid eligibility files. This match identifies full-time state employees, all of whom have employer-sponsored health insurance, that are also Medicaid eligibles. According to state records, during a 6-month period this match detected an average of 165 Medicaid recipients a month with health insurance that the state had not

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[5]The Child Support Enforcement program, authorized by section 451 of the Social Security Act, is an intergovernmental program that involves federal, state, and local governments. This program was established to enforce the support obligations owed by absent parents to their children, locate absent parents, establish paternity, and obtain child support. Accordingly, state Child Support Enforcement programs maintain data on absent parents with child support obligations.

known about. While this project cost about $13,000 to develop and operate, it saved an estimated $300,000 in its first year of operation.

As of January 1984, Oregon had completed one match between absent parent files and the Medicaid eligibility files. According to a state official, this match, now planned on a regular basis, was completed between January and September 1983 at a cost of about $16,000 and saved an estimated $459,000 in Medicaid costs.

Although these two states have been able to increase the number of Medicaid recipients identified with insurance resources through data matching techniques, four other states we visited either have not implemented these matches or have done so only on a limited basis, as shown in table 2.

Table 2

Status of State Data Matching Activities

	Matching state files to detect:		
State	Employed absent parents	Employed Medicaid recipient	Medicaid eligibles working as state employees
California	Limited	Pilot test	Not done
Maryland	Not done	Not done	Not done
Oregon	Ongoing	Ongoing	Ongoing
Pennsylvania	Pilot test	Not done	Not done
Texas	Not done	Ongoing[a]	Not done
Washington	Ongoing	Ongoing	Ongoing

[a]Texas had just started this match during our audit. Data on its cost effectiveness were unavailable.

Maryland and Texas had not started an absent parent match, and California and Pennsylvania had done so only on a limited basis. In Pennsylvania, according to a state official, about 50 of 67 counties maintain computerized child support enforcement information. We believe these counties could conduct automated matches like Washington's. As of July 1984, however, this automated match was planned to be pilot tested in one county. A California official said that the counties were providing only limited information sharing between absent parent and Medicaid files. Because counties are not reimbursed for the costs of supplying the information, two-thirds of the counties--which determine eligibility for 72 percent of the Medicaid population--have not participated in the manual matching program.

Although Bureau of the Census data show that almost half of the Medicaid recipients working full time have health insurance available through their employers, California, Maryland, and Pennsylvania had not implemented data matches of Medicaid recipients against unemployment insurance files that identify employed persons. Texas and these three states were also not performing data matches against state employee files. California had pilot tested a match with state employee files in two counties. The state estimated that if the match was implemented statewide at an estimated cost of $50,000, it could save an estimated $1.3 million annually.

Liability insurance identification practices need to be improved

In the six states[6] where information on liability insurance identification practices was available, we found wide variations in the amount of states' liability collections. Table 3 shows available data on liability recoveries for the states reviewed.

Table 3

Liability Recoveries, Federal Fiscal Year 1983

State	Liability recoveries	Liability recoveries as a percent of Medicaid costs
California	$12,777,772	0.33
Maryland[a]	1,117,103	.20
New York[a]	9,690,615	.16
Oregon	276,348	.12
Pennsylvania[a]	1,870,113	.11
Texas	355,823	.03

[a]These states have automobile no-fault insurance, whereby within prescribed limits the involved automobile insurers are automatically liable for medical expenses of the injured parties without regard to which party was responsible for the accident.

California had significantly higher liability collection rates than other states--over 50 percent more in liability recoveries as a percentage of Medicaid costs than the next highest

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[6]We did not review Washington's liability insurance collections because at the time of our review we could not obtain reliable data on the amount of collections resulting from liability insurance.

state. We found two factors that we believe contributed to these higher rates. First, California has legislation requiring that the attorney representing a Medicaid recipient in a liability-related accident notify the state. This practice resulted in 41 percent of the liability collections in California. The second factor relates to liability insurance. Accident-related claims are identified by screening claims for medical services indicative of an accident, such as fractures or internal injuries, and then following up on them to identify whether an insurer is liable. California pursues all cases when the claims total more than $500 and all cases over $50 if the provider indicates that an accident had occurred. In contrast, other states have more limited collection practices. For example:

--In Pennsylvania, follow-up on cases with potential liability collections was limited to claims over $1,000, in which case the state sent questionnaires about the claim to recipients. However, according to a state official, a review of the questionnaires mailed out and returned between March and November 1983 revealed that about half of the 3,710 recipients had not responded to the questionnaire. Nonresponses were pursued only if the claim exceeded $5,000.

--The administrator of the third party recovery unit in Texas stated that the unit also limited its follow-up on cases with potential liability collections to those over $1,000. These claims were sent to caseworkers for follow-up; however, the administrator had no direct control over follow-up on these referrals and did not have a system to monitor whether referrals were returned to the state.

--State officials in New York said that, although counties were responsible for following up on claims with potential liability collections, such follow-up was rare. For example, over a 3-month period, 48 of the 57 New York counties had no liability collections.

--In Oregon, the third party resource division supervisor said that, due to recurring problems with computer-generated reports that track liability-related Medicaid claims, the state was not pursuing potential liability cases identified by screening claims for medical services indicative of an accident.

COST AVOIDANCE NORMALLY IS BETTER THAN PAYING CLAIMS AND TRYING TO COLLECT

Once a state has identified that a health or liability insurance carrier is responsible for a Medicaid recipient's medical costs, the state needs to assure that these resources are used. Two basic methods exist: (1) "cost avoidance," under which the state avoids paying claims when insurance is available by requiring the provider of services to collect from the liable insurer, and (2) "pay and chase," under which the state uses Medicaid funds to pay the recipient's medical costs and then attempts to recover from liable health insurers. According to a 1983 HCFA survey of state practices, 14 of 50 states use the pay and chase system and the rest use cost avoidance. Of the states that we reviewed, Maryland and California use the pay and chase system when Medicaid recipients have health insurance coverage.[7]

In our May 1977 report (HRD-77-73), we questioned the wisdom of the pay and chase approach when Medicaid recipients have private health insurance. The pay and chase system has two costs not associated with cost avoidance: (1) the opportunity costs related to the funds used to pay the claims and (2) the cost of recovering payments from liable insurers. We compared the 1983 administrative cost of Washington's cost avoidance system with that of California's pay and chase system. Washington spent about $157,000 to save $7.9 million in Medicaid costs, whereas California spent about $600,000 to recover $7 million.

Because the pay and chase system requires considerable administrative work, California and Maryland did not seek recovery of millions of dollars in Medicaid costs from liable health insurance carriers. For example:

--Maryland did not try to recover payments made on pharmacy, home health, and nursing home claims and, except for one insurance carrier, did not attempt to collect any health insurance claim under $200. As a result, in fiscal year 1983, Maryland paid $19.5 million in medical bills for Medicaid recipients that state records showed had health

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[7]Some providers may prefer pay and chase systems because the Medicaid program can reimburse them sooner than the liable insurers. However, both California and Maryland have legislation that, in effect, requires providers to bill known third parties before billing Medicaid. Some providers in both states do seek payment from third parties before billing Medicaid; however, when they do not, both states pay and chase all claims even though health insurers may be liable.

insurance coverage, but sought recovery from these insurance companies for only $7.3 million.

--California often did not collect from liable health insurance companies that did not respond to the state's request for reimbursement. In our random sample of 71 paid claims for which California sought recovery from insurance companies, the state had not received responses for 32 of them. Between 1977 and 1983, insurance companies had not responded to about 87,000 medical bills totaling about $158 million that California had sent them. To encourage a greater response rate from insurers, the state audited 34 insurance carriers during the year ended June 30, 1983. These audits cost about $68,400 to review 1,700 claims and resulted in collections of about $353,000, for a benefit-to-cost ratio of more than 5 to 1. While these audits were a cost-effective method of increasing recoveries, state officials said it was not feasible to audit most carriers due to staffing limitations. Thus, many carriers continued to ignore bills.

Under a cost avoidance system, states would not experience the problems that California and Maryland did in recovering from insurance companies because providers would be responsible for collecting first from health and no-fault insurers, billing Medicaid only after these resources had been exhausted. In our 1977 report, we recommended that if the effectiveness of California's pay and chase approach (compared to cost avoidance methods) could not be demonstrated by empirical evidence, either it should be abandoned or HHS should decline federal financial participation on uncollected claims for which third parties are liable.

Proposed regulations do not assure cost avoidance when health insurance resources may be available

On June 4, 1984, HHS published proposed regulations that would implement our 1977 recommendation by requiring states to use cost avoidance techniques when the state has established the probable existence of a liable third party at the time the Medicaid claim is filed. The proposed regulations leave it up to the states to establish procedures that take into account the type of medical expenses and insurance involved for determining when health insurance probably exists.

Because of this discretion, it is questionable how effective this proposed regulation will be in assuring that states make maximum use of the cost avoidance approach in applying health insurance resources. For example, in fiscal year 1982 California

recovered $7 million by paying and chasing Medicaid claims involving private health insurance, but avoided Medicaid costs of $325 million by diverting claims to the Medicare program for persons eligible for both programs. Also, about $33 million was avoided when providers voluntarily billed liable third parties before billing the California Medicaid program. The California official in charge of recovering Medicaid funds told us that, in his opinion, the state would be in compliance with the proposed rules because it had established procedures to (1) avoid significant amounts of Medicaid costs for recipients with Medicare coverage and (2) encourage providers to bill insurance companies before Medicaid. Therefore, he said that even though California was using a pay and chase approach to recover Medicaid costs from liable insurers, this regulation did not direct the state to change its system.

The five states we visited that were using the cost avoidance approach to apply health insurance resources did not determine the probable liability of an insurer for each claim, but withheld payment if there was any indication that a liable insurer existed. States normally obtained indications of insurance resources by interviewing the Medicaid recipient at the time of application, by using data matches, or when providers indicate the availability of health insurance on the Medicaid claim. States were avoiding paying claims based on this information because it showed a possible but not necessarily probable existence of an insurance resource.

CONCLUSIONS

To maximize Medicaid's role as secondary rather than primary payer, effective state systems for both identifying and applying available insurance are necessary. Our review showed that states have opportunities to more effectively identify insurance resources by obtaining complete insurance information from Medicaid applicants, matching computerized Medicaid eligibility files with other state data, and pursuing liability insurance leads. In addition, the cost avoidance method is more efficient and effective than the pay and chase method that some states use.

The next two chapters discuss actions that HHS could take to improve the Medicaid third party liability program. Our recommendation is included in chapter 3.

CHAPTER 3

HCFA NEEDS TO STRENGTHEN ITS OVERSIGHT OF STATE PRACTICES FOR IDENTIFYING AND APPLYING INSURANCE RESOURCES

HCFA uses two approaches to oversee the administration of state Medicaid programs--quality control and compliance reviews. HCFA's quality control program is designed to identify erroneous Medicaid payments and improve state payment systems to prevent similar erroneous payments in the future. HCFA also conducts compliance reviews to determine whether states are operating in accordance with federal Medicaid requirements. HCFA relies on its compliance reviews to improve state Medicaid activities for identifying and applying insurance resources. Under this approach, HCFA attempts to identify weaknesses in state practices and suggests improvements.

HCFA's compliance reviews, however, have not identified some major weaknesses in state practices, and more importantly, HCFA frequently has not gotten states to adopt suggested improvements. In our opinion, this is attributable to the lack of specific regulatory standards for how states should identify and apply insurance resources. Consequently, states we visited viewed HCFA's suggestions for improving their practices as advisory. HCFA needs to improve its oversight in state third party liability programs to ensure that deficiencies are identified and problems corrected.

HCFA NEVER FULLY IMPLEMENTED ITS QUALITY CONTROL PROGRAM TO IMPROVE STATE PRACTICES

Although HCFA has a quality control program designed to improve state Medicaid administration, it was never fully implemented as a tool to improve state practices to identify and apply available insurance resources. The quality control program, a coordinated effort by both the state and federal governments, is designed to ensure that (1) Medicaid funds go only to beneficiaries who are eligible under federal and state law and (2) claims are paid only for covered services to eligible providers in the correct amount. To accomplish these objectives, the quality control program is designed to use statistically projectable samples to measure erroneous Medicaid payments resulting from ineligibility and claims processing errors.

States are required to correct eligibility errors found in the sample cases and to act to minimize eligibility errors in the

future. If corrective action is needed, each state is required to prepare a corrective action plan and submit it to HCFA for approval. If the corrective action does not reduce eligibility errors below the state's tolerance level, HCFA recovers from the state the federal share of the erroneous payments made to ineligible recipients that exceed that level.[1] In 1979, when HCFA published its first regulation relating to disallowing federal sharing in excessive erroneous payments due to ineligibility, it informed the states that it planned to implement a similar program to recover erroneous payments made because of uncollected third party resources, such as health and liability insurance.

Between 1979 and 1982, HCFA used the same quality control sample to calculate erroneous payments resulting from both ineligible recipients and uncollected insurance. However, the sample was not adequate to produce reliable projections of the amount of uncollected insurance. According to HCFA, sample design limitations included (1) the verification of how much liable insurers would pay was frequently not returned in time to be included in the reported data and (2) not enough paid claims were sampled to make accurate projections of erroneous payments. Hence, HCFA did not implement its plans to deny federal sharing in erroneous payments made because of uncollected insurance.

In 1981, we recommended that HCFA change its sampling procedures to improve the third party liability review process used under the quality control program to obtain better data on erroneous payments resulting from uncollected third party resources.[2] However, in 1982 HCFA discontinued the portion of the quality control program that calculated uncollected insurance because of the limitations on the data developed under it and as part of its effort to reduce state administrative burdens. HCFA decided that, rather than use the quality control program, it would rely on the compliance review process to correct weaknesses in state practices. As discussed below, HCFA needs to strengthen the compliance approach if it is to succeed in influencing states to improve their practices for identifying and applying insurance resources.

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[1]Public Law 97-248 established a standard that federal sharing would be disallowed in payments for ineligible recipients that exceed 3 percent of total payments.

[2]Medicaid Quality Control System Is Not Realizing Its Full Potential (HRD-82-6, Oct. 23, 1981).

IMPROVEMENTS NEEDED IN HCFA'S COMPLIANCE REVIEW APPROACH TO STRENGTHEN STATE PRACTICES

Since 1978, HCFA has used compliance reviews in an effort to improve state performance in identifying and applying insurance. According to HCFA, however, pre-1983 reviews of state identification and application of insurance resources represented only a limited evaluation of state efforts. HCFA officials told us that generally the reviews were cursory and, as such, were of limited value in providing guidance to correct weak state practices.

As a result, in 1983 HCFA decided to supplement its regular compliance reviews of state practices by selecting 10 states each year to receive a more comprehensive assessment. These assessments looked at more state practices than did the regular compliance reviews.

HCFA's 1983 initiative represented a significant improvement over its previous oversight efforts. However, for reasons discussed below, HCFA's compliance review process has limitations in obtaining states' commitment to improve their practices for identifying and applying insurance resources.

HCFA has not gotten states to commit to improve their practices

Medicaid regulations give states much discretion in establishing policies and procedures for identifying and using insurance. The regulations require that

- --states take reasonable measures to identify and use insurance;
- --when states are aware that insurance exists, they seek reimbursement within 30 days after the end of the month that Medicaid pays for service; and
- --states establish thresholds and time periods for recovering payments from insurance and seek reimbursements from insurance only when it is cost effective.

The regulations, while requiring that states take reasonable measures to identify and apply insurance resources, do not mandate specific state practices or a specific level of state performance. This lack of specificity has caused HCFA and states to have different perspectives on what constitutes a reasonable system for identifying and applying insurance. The states we visited believed their current techniques were reasonable when measured against the broad standards specified under the regulations.

Further, they generally viewed HCFA's assessment recommendations as advisory. For example, a HCFA regional official, in transmitting a HCFA assessment to a state, said

> "I have also included in the body of the report a number of recommendations which are being made even though HCFA has no grounds on which to base these recommendations as noncompliance with the nationally defined Medicaid program."

In examining compliance reviews conducted before 1983 in the 10 states that also received 1983 comprehensive assessments, we found that HCFA and the states did not agree on dates for completing recommendations made in the assessment reports. As a result, recommendations that HCFA made several years ago have not been implemented. In 6 of the 10 states, problems HCFA identified in previous compliance reviews were again mentioned in the 1983 assessment reports. For example:

--In California, HCFA's 1978 and 1979 reviews pointed out problems with identifying insurance during eligibility determinations and inefficiencies resulting from its pay and chase system. Since 1978, California has improved its system; however, some of the problems HCFA identified in 1978 still existed in 1983.

--In Missouri, problems with not using health insurance available through absent parents or through workers' compensation were pointed out by HCFA in its 1980 and 1983 reports.

--In Louisiana, HCFA's 1980 and 1983 assessment reports both pointed out that the state was not making timely insurance updates to the eligibility file to reflect current information.

HCFA's problems of getting states to improve their practices appeared to continue with HCFA's 1983 assessments. Four of the seven states we visited (California, New York, Oregon, and Pennsylvania) received 1983 assessments. Oregon and California, however, did not agree with key recommendations HCFA made. For example:

--HCFA's 1983 assessment report on California said that the state should implement a cost avoidance system and improve training and oversight for identifying insurance resources during Medicaid eligibility determinations. State officials told us, however, that their current system for identifying and using insurance resources was

reasonable and they intended to make only minor changes as a result of HCFA's assessment.

--HCFA's 1983 assessment report on Oregon suggested that the state's approach to identifying insurance during the eligibility determination process could be improved by adding more staff and redesigning its eligibility form. Although state officials agreed more emphasis was needed on identifying insurance during eligibility determinations, they said they did not believe the changes HCFA proposed were necessary and did not plan to make them.

While New York and Pennsylvania generally agreed with HCFA's assessment, we noted that these assessments, as well as those in California and Oregon, did not point out some important weaknesses in state practices. This problem is discussed below.

Comprehensive assessments did not identify important weaknesses in state practices

In four states we visited where the comprehensive assessments were performed, HCFA identified problems with state practices to identify and apply insurance. However, we found additional weaknesses in three of the four states' practices that HCFA did not mention in its assessment reports. For example:

--New York has a limited program (see p. 15) to recover Medicaid costs from liability insurers, but HCFA's 1983 assessment report had no findings or recommendations in this area.

--In Oregon, we identified two problems that HCFA did not address in its 1983 assessment report. We found that Oregon did not (1) review 7.4 percent of the Medicaid claims with identified medical health insurance resources for insurance coverage from July 1982 to June 1983 or (2) pursue the recovery of payment on liability claims identified through trauma code edits. HCFA's assessment did not discuss the first problem we identified, and concerning liability claims, the HCFA assessment report concluded that "State procedures in this area are sound and appear to be well-executed."

--According to the supervisor of Pennsylvania's Medicaid recovery unit, serious problems exist with the local offices' ability to identify and gather information needed on Medicaid applicants' insurance coverage. Furthermore, the state had incomplete information for about 70 percent of the claims with potential insurance coverage. We

reviewed 32 Medicaid case files in two local offices and found previously unidentified insurance resources in 5 (or 16 percent) of the cases. HCFA's 1983 assessment, however, did not cite problems with the caseworkers' obtaining health insurance information at the time of application.

CONCLUSIONS

HCFA has not fully succeeded in getting states to implement its suggestions for increasing Medicaid's use of recipients' insurance. (See ch. 2.) The two main options HCFA has to motivate states to improve their practices for identifying and applying existing insurance resources are

--using its quality control program to deny federal participation in erroneous Medicaid payments or

--strengthening its compliance reviews of state programs.

Concerning the first option, HCFA could reinstitute its quality control program for third party liability and issue regulations denying federal sharing in erroneous Medicaid payments, exceeding an established tolerance level, that result because states fail to identify liable insurance coverage. Under this option, states would maintain their flexibility to adopt whatever practices they believe would be the most effective. Also, this approach would give states a fiscal incentive to improve their practices because, if states do not take corrective action, they could lose federal sharing for erroneous payments.

The disadvantage of this approach, however, is that it would take several years to implement. Sampling procedures would need to be developed so a reliable projection of erroneous payments could be made. Further, a base error rate would have to be established so that a reasonable target error rate could be determined.

Regarding the second option, strengthening HCFA's current compliance review program, HCFA must correct shortcomings that we noted, namely:

--Obtaining states' commitment to improve their practices for third party liability identification and collecting from existing insurance.

--Conducting more thorough and comprehensive evaluations of how state practices could be improved.

To overcome the first shortcoming, HCFA would need to specify, in the regulations, the techniques states should use. If HCFA set specific standards for state practices and monitored to see whether the practices are used effectively, the problem of states' viewing HCFA's recommendations as advisory would be corrected. HCFA could overcome the second problem by making more comprehensive evaluations of state programs that focus on these specific standards.

The disadvantage of requiring states to adopt specific practices for identifying and using available health and liability resources is that it would reduce the states' flexibility in administering their Medicaid programs. States view such flexibility as important because it allows them to respond to conditions that may be unique to them. HCFA could minimize this disadvantage by waiving compliance with a specific practice if a state could show that compliance would not be cost effective or if the state could demonstrate an effective alternative practice.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to do one of the following.

(1) Use HCFA's quality control program to influence states to improve their practices for identifying and applying health and liability insurance by:

--Developing quality control program sampling procedures that would determine the amount of erroneous payments due to unrecovered health and liability insurance.

--Determining an acceptable level of performance (target error rates), after a base error rate is established, and requiring that states not meeting these performance standards lose the federal share of erroneous payments exceeding the target error rates.

(2) Strengthen HCFA's oversight of state practices for using available health and liability insurance resources by issuing regulations that require specific practices (discussed in ch. 2) including:

--Using interview forms that ask the Medicaid applicants a series of questions designed to detect available insurance resources.

--Establishing procedures for obtaining needed information about the Medicaid applicants' insurance coverage.

--Requiring states to use their available state automated data bases to identify sources of insurance available to Medicaid recipients.

--Using effective follow-up procedures to recover from insurers responsible for paying claims covering accident-related injuries.

--Using a cost avoidance system that avoids paying claims where the state has indications (from the recipient, the provider, or data matches) that health insurance resources are available to pay the claims.

Additionally, HCFA would need to improve its annual compliance reviews to focus on these specific practices, and through annual corrective action plans, HCFA should hold states accountable for implementing them.

HHS COMMENTS AND OUR EVALUATION

HHS commented (see app. II) that it was reassessing its future strategy for the Medicaid third party liability program and was considering options ranging from continuing its compliance monitoring policy to reinstituting a quality control program. HHS said that a final decision on its strategy was expected soon and that it would select the most cost-beneficial approach. HHS stated that the two options we presented are not mutually exclusive and that the quality control program approach would require regulations, while the specific practices approach, to be effective, would require new legislation authorizing fiscal sanctions against the states. HHS also listed current and planned activities directed at a more effective oversight of state third party liability operations.

In summary, HHS said it is considering changing its third party liability oversight policies in line with the options in our recommendation. Based on our work leading to this report and the work leading to our 1977 report on Medicaid third party liability operations, we believe that adopting one of our options is the preferable manner to increase the effectiveness of third party liability operations. Either option should give HHS, and the states, the information and the criteria on which to base a decision about the effectiveness of state third party liability operations. Although we agree that the two options are not mutually exclusive, we believe that any approach HHS might elect should set specific criteria and provide adequate data to measure whether those criteria are met. Otherwise, third party liability operations may continue not to realize their full potential, as

they have over the years, as evidenced by the estimates of available but unused insurance coverage cited in this report and our 1977 report, and HHS will not have the tools necessary to protect the federal government's interests.

Regarding HHS' comment that fiscal sanction legislation is necessary to make our recommended approach of requiring specific practices effective, HHS currently has the authority to deny subsequent federal sharing in a state's Medicaid expenditures if the state is found out of compliance with federal requirements. Although a less drastic form of fiscal sanction would probably be preferable because it would be more usable, we do not believe it is absolutely essential.

CHAPTER 4

SSA SHOULD GIVE STATES MORE COMPLETE INFORMATION ABOUT SSI APPLICANTS' HEALTH INSURANCE

The Social Security Administration (SSA) was not obtaining health insurance information on SSI recipients that was useful in helping states defray Medicaid costs. As a result, Medicaid is paying for medical costs that health insurers should pay. HCFA estimated that if SSA changed its procedures so that states could identify the insurers, about $101 million in federal and state Medicaid funds could be saved the first year, with recurring annual savings of about $69 million.

INSURANCE INFORMATION THAT SSA PROVIDES TO THE STATES OFTEN IS NOT USEFUL

The SSI program, which is administered by SSA, provides cash assistance to needy aged, blind, and disabled persons, most of whom are also eligible for Medicaid. While the states normally determine a person's eligibility for Medicaid, section 1634 of the Social Security Act provides that the states and SSA may agree to have SSA determine Medicaid eligibility concurrently with eligibility for SSI benefits. In the 30 states and the District of Columbia that have these agreements, SSA asks a series of standard questions to determine Medicaid eligibility for about 2 million SSI applicants (about 10 percent of all Medicaid recipients). In addition, states may pay SSA to ask SSI applicants if they have any type of health insurance available to them. Each yes/no response by the applicant was forwarded to the appropriate state, which had to follow up with the SSI applicant to obtain detailed insurance information.

The insurance information that SSA obtains is not useful to most states because it lacks the name and address of the insurer and policy number. The question that SSA asks applicants is "do you or any children in your household have any health insurance or medical coverage from the Veterans Administration, Workmen's Compensation, accident insurance or any other source?" As discussed in chapter 2, without detailed insurance information, states must follow up with applicants to obtain the carrier name and policy number, often unsuccessfully. Also, because the question SSA asked was so general, some applicants responded incorrectly, reporting life insurance or Medicare coverage as health insurance.

In five of the states we visited, SSA provides the states with responses from those SSI/Medicaid applicants who said that they had insurance coverage. State officials told us, however, that the yes or no responses about insurance coverage that SSA sends them are generally inaccurate. Three states provided us with the following examples:

--California state reports show that half of the SSI applicants fail to respond to follow-up questionnaires. California obtained usable insurance information on about 2.6 percent of its SSI/Medicaid population, substantially below HHS' estimate of the 7.2 percent of SSI eligibles that have health insurance in that state.[1]

--Texas reported to HCFA that 80 percent of the yes/no responses obtained by SSA concerning the SSI applicants' insurance availability were incorrect.

--Pennsylvania questioned the cost effectiveness of paying SSA to obtain insurance information and has advised SSA that, "The present method of [SSA's] collecting third party information is incomplete and provides a negligible benefit to Pennsylvania in its present form."

Previous studies have also documented, for example, that SSA's insurance identification among SSI/Medicaid eligibles has not met state needs. In 1977, we reported that the insurance information obtained by SSA was of limited usefulness to the states. We recommended that SSA provide states with the insurance information they need to adequately pursue insurance liabilities among SSI recipients. HHS agreed to study the matter, and in 1981 HCFA and SSA surveyed the states that received the insurance indicator from SSA. The study found that most states did not use this indicator because it was insufficient and often unreliable.

IMPROVED SSI/MEDICAID INSURANCE IDENTIFICATION TECHNIQUES COULD SAVE MILLIONS

According to HCFA, because states generally have no face-to-face contact with SSI applicants, the most effective means of obtaining health insurance information from them is through the initial eligibility interview with SSA. In 1981, a HCFA and SSA

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[1]National Medical Care Utilization and Expenditure Survey, HHS survey on characteristics of noninstitutionalized Medicaid population, 1980 sample data.

task force reported that, if SSA were to provide specific insurance information on SSI/Medicaid applicants to states, more than $100 million in annual Medicaid costs could be saved. To confirm the accuracy of this estimate, HCFA and SSA conducted a pilot project in three states during 1983 to obtain detailed information on SSI/Medicaid applicants' insurance coverage. Under this pilot project HCFA paid SSA to use a special form that asks SSI/Medicaid applicants if they or a spouse, parent, or stepparent had health insurance that pays for the cost of the applicant's medical care. The form also gathers information on the insurer's name and address, policy number, and the name of the policyholder.

According to HCFA's report on this project, by obtaining this detailed insurance information, the number of SSI recipients identified as having health insurance coverage more than tripled. HCFA estimated that if these new procedures were implemented nationwide, first-year administrative costs to gather the information would be $1.3 million, and $101.9 million in federal and state funds would be saved. In addition, Medicaid would realize savings of $70 million in federal and state funds in subsequent years, at a cost of about $500,000 per year, resulting in a recurring savings of about $69.5 million. Although SSA's pilot project costs were borne by HCFA, states would share, as they now do, in the additional administrative costs to SSA.

CONCLUSIONS

Since 1977, GAO, HCFA, SSA, and certain states have pointed out the need for SSA to obtain and provide to the states more detailed information on SSI/Medicaid recipients' insurance resources. In a draft of this report submitted to HHS for comment, we proposed that the Secretary direct the Commissioner of Social Security to provide detailed insurance information on Medicaid/SSI applicants to states with section 1634 agreements that are willing to pay for it. We proposed that states receive such data as the insurer's name and address, the policy number, and the name(s) of the insured.

In its comments HHS concurred with that proposal and stated that HCFA and SSA have agreed to offer all section 1634 states the opportunity to purchase the improved data collection services from SSA. Implementation began on January 2, 1985.

For states choosing to participate, SSA will identify and document health insurance information for eligible Medicaid recipients having such resources. SSA will provide to those states the names of the policyholders, their relationship to the applicant, the policyholders' social security numbers, the name

of their insurance companies, their policy numbers, and the relevant insurance group number or name.

Providing this information to the states should result in increased payment of health care costs by insurance companies before payment by Medicaid.

APPENDIX I

SUMMARY OF SELECTED FEDERAL AND STATE AUDIT REPORTS ON STATE SYSTEMS TO IDENTIFY AND APPLY LIABLE THIRD PARTY RESOURCES

Federal and state audit reports have shown that states have had long-standing problems in identifying and collecting from third parties. As early as 1969, HHS and consultants were reporting that states needed to better identify and use liable third parties. As of July 1976 the HHS audit agency had issued at least 37 reports pertaining to reviews of state third party programs. Since then, GAO, HHS, and state audit reports have repeatedly addressed problems with programs for identifying and using liable third parties. Several of these reports are summarized below.

GAO REPORTS

Problems in Carrying Out Medicaid Recovery Programs From Third Parties (HRD-77-73, May 2, 1977).

GAO concluded that:

--HHS guidance for regional office evaluations of state third party liability programs and for state establishment and implementation of programs was limited.

--There were variations among states in identifying insurance resources, in the methods of seeking recoveries, and in accounting for and reporting collections.

--California's pay and chase system was not properly justified as equal to or an improvement over a cost avoidance approach.

--The information SSA had gathered for identifying insurance resources was of limited use.

Improved Administration Could Reduce the Costs of Ohio's Medicaid Program (HRD-78-98, Oct. 23, 1978).

GAO concluded that improvements could increase the recovery of funds from liable third parties. Specific problems found included:

--Collection efforts lack management direction, in that written procedures and instructions to state personnel were nonexistent.

--There was unexplored collection potential, such as recovering Medicaid costs from absent parents.

--Ohio's insurance recovery efforts were hampered because of insufficient cooperation from county welfare departments and the Ohio Bureau of Workers Compensation.

Medicaid's Quality Control System Is Not Realizing Its Full Potential (HRD-82-6, Oct. 23, 1981).

GAO found that HCFA was not identifying many third party errors through its quality control program. GAO also questioned the accuracy of the quality control findings and the independence of the quality control reviews.

New York Requires Employed Medicaid Recipients to Enroll in Employer-Sponsored Health Insurance (GAO/HRD-84-86, Aug. 10, 1984).

GAO concluded that New York's practice of requiring, as a condition of Medicaid eligibility, employed Medicaid recipients to enroll themselves and their dependents in available employer-sponsored health insurance plans is not permitted by federal law, unless approved as a demonstration project. Therefore, New York should be required to discontinue the practice until it has requested and been granted a waiver to test the cost effectiveness of the practice. The practice did appear to have potential for Medicaid savings.

HHS AND HCFA REPORTS

An Effective Approach to Third Party Recovery of Title XIX Funds, HCFA, Region 10 (Jan. 28, 1980).

HCFA reviewed Medicaid cases that state quality control units had previously reviewed for third party liability and, from a 96-case sample, found 68 with third parties that the state unit had not identified.

Evaluation of the Cost Effectiveness of the Collection of Third Party Liability by State Medicaid Agencies, conducted by Maximus, contractor to HHS (Aug. 21, 1981).

Maximus estimated that in fiscal year 1980 the amount of third party liability that states should have collected nationally was between $534 million and $1,067 million, about 2 to 4 percent of the total medical vendor payments. Maximus noted several issues and problems, such as insufficient state commitment to third party liability programs and problems with third party identification and recovery procedures.

Survey of the Massachusetts Department of Public Welfare's Procedures for Identifying and Recovering Third Party Resources Under Title XIX of the Social Security Act, HHS, Office of Inspector General Report, Region I (Feb. 1983).

The Office of Inspector General stated that several weaknesses in the state's third party liability system resulted in the state paying an estimated $7.3 million during a 6-month period for Medicaid services that liable third parties should have paid. Specifically, the state was

--not reviewing several types of Medicaid claims for insurance availability and

--using, in some cases, inaccurate insurance information when reviewing Medicaid claims.

SELECTED STATE REPORTS--
CALIFORNIA AND WASHINGTON

A Management Analysis of the Third Party Liability and Other Health Coverage Programs, Office of the Auditor General of California (Mar. 1977).

The auditor general found inadequate insurance reporting and review procedures, inadequate forms, duplication of identification and recovery activity, and problems in obtaining useful insurance information from SSA.

Medicaid Program Health Insurance Coverage Pilot Project, Health and Welfare Agency, California State Department of Health Services (Aug. 1, 1978).

This agency noted problems with obtaining accurate, complete, and timely health insurance information on Medicaid recipients.

Third Party Liability in the Medicaid Program: A Seattle Case Study, joint study done by HCFA Region X and Washington Department of Social and Health Services (Oct. 1, 1981).

This case study showed that, if additional insurance resources had been identified and recovered in Seattle between October 1979 and March 1980, $1 million in Medicaid funds could have been saved.

New Statutes, Policies and Procedures Could Increase MEDICAID Recoveries by at Least $4.3 Million Annually, Office of the Auditor General of California (Feb. 1981).

The auditor general found that Medicaid's insurance identification and recovery system had the opportunity to increase recoveries by an estimated $4.3 million annually. These savings could be achieved by using workers' compensation data, implementing an estate recovery program, and revising certain statutes and regulations that restrict maximum recovery.

APPENDIX II

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

NOV 23 1984

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report "Improved Federal Efforts Needed So That Liable Insurers Pay Before Medicaid." 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,

Richard P. Kusserow
Inspector General

Enclosure

APPENDIX II

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Improved Federal Efforts Needed So That Liable Insurers Pay Before Medicaid"

Overview

GAO initiated this review to assess the effectiveness of State practices for using available insurance resources and to determine whether corrective action was needed at the Federal level. By law, Medicaid is the payer of last resort; that is, all other available resources must be used before Medicaid. The information GAO gathered on State procedures for identifying Medicaid recipient insurance resources showed that States could improve their procedures and thereby better assure that insurance is used before Medicaid. The information gathered also shows, according to GAO, that State procedures to identify services that might be covered by liability insurers could also be improved.

While the States normally determine Medicaid eligibility, the Social Security Administration (SSA) performs this task for about 10 percent of the Medicaid population (those receiving Supplemental Security Income (SSI)). However, according to GAO, when determining Medicaid eligibility, SSA does not obtain the name and address of the insurance carrier and policy number for those covered by health insurance. Without this information, knowledge of insurance is of little use to the States.

GAO noted that most States require health care providers to seek payment from identified health insurers before billing Medicaid. However, GAO reports that 14 of the 50 States pay providers and then try to recover the money from liable insurers.

GAO reports that the Health Care Financing Administration (HCFA) focuses its oversight of State practices related to recipient insurance resources on compliance reviews and uses these reviews to suggest improvements in identification and application of insurance resources. These compliance reviews, according to GAO, have not identified some major weaknesses and HCFA has been unsuccessful in consistently getting States to adopt suggested improvements.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to do one of the following.

(1) Use HCFA's quality control program to influence States to improve their practices for identifying and applying health and liability insurance by:

- Developing quality control program sampling procedures that would determine the amount of erroneous payments due to unrecovered health and liability insurance;
- Determining an acceptable level of performance (target error rates), after a base error rate is established, and requiring that States not meeting these performance standards lose the Federal share of erroneous payments.

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(2) Strengthen HCFA's oversight of State practices for using available health and liability insurance resources by issuing regulations which require specific practices including:

- Using interview forms that ask the Medicaid applicant a series of questions associated with detecting available insurance resources;
- Establishing procedures for obtaining needed information about the Medicaid applicants' insurance coverage;
- Requiring States to use their available State automated data bases to identify sources of insurance available to Medicaid recipients;
- Using effective followup procedures to recover from insurers responsible for paying claims covering accident-related injuries; and,
- Using a cost avoidance system that avoids paying claims where the State has indications (from the recipient, provider, or through data matches) that health insurance resources are available to pay the claims.

Additionally, HCFA would need to improve its annual compliance reviews to focus on these specific practices, and through the use of annual corrective action plans, HCFA should hold States accountable for implementing them.

Department Comment

HCFA's third party liability-quality control (TPL-QC) program was discontinued in favor of an operational strategy geared to improve States' TPL recovery efforts. During the past couple of years, HCFA has operated an aggressive program for encouraging States to improve TPL performance. At this point, HCFA is reassessing its future strategy for TPL. Options ranging from continuing the operational strategy approach to reinstituting a TPL-QC program are being considered. A final decision on HCFA's plans for TPL for FY 85 and 86 is expected soon. HCFA will assure that its strategy for TPL will be the most cost beneficial approach.

The options discussed above, however, are not necessarily mutually exclusive and do not represent the full range of methods for improving oversight. The recommended quality control program approach of beginning with a base error rate could not be implemented without regulations.

We also question the recommendations to issue regulations. Even if the standards suggested by the GAO were developed by HCFA, we do not believe they would be effective unless coupled with usable fiscal sanctions which would require new legislation.

In line with the concept of State administrative flexibility, HCFA has a number of current and planned activities which are directed toward a strengthened and more effective oversight of State TPL operations.

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- All State Medicaid agencies have been provided with the Third Party Resource Worksheet (Form HCFA-301C(9-80)) for use in the identification of third party resources. The form is also used by HCFA to measure State TPL identification processes while conducting TPL assessments.

- HCFA has produced a training film covering interview techniques in the identification of third party resources, and has provided it to all State agencies.

- HCFA is promoting data matches through the publication of a "Model Practices Guide" which describes exemplary State data matches that may be transferable to other States. The Guide should be ready for publication by January 1985. Besides data matches, it will itemize approximately 80 model practices that some States are using, which may be transferable to other States.

- HCFA plans to conduct formal training sessions for regional office staff on the subject of TPL identification techniques and Federal oversight of TPL operations.

- HCFA has also undertaken activities designed to promote the usage of external data sources to identify recipients having health insurance resources. HCFA initiated action with the Office of Child Support Enforcement to strengthen child support identification of health insurance held by absent parents for their Medicaid eligible children, and to require that medical support be included in any child support orders. A proposed regulation was published in August of 1983 and the final is in clearance. The regulation is projected to increase TPL savings by approximately $100 million annually.

- HCFA also has a pilot project with the Department of Defense (DoD) to test the feasibility of data matches between Medicaid and DoD files of the Civilian Health and Medical Program for the Uniformed Services.

- In order to improve State practices for applying third party resources, HCFA published proposed rules in the Federal Register on June 4, 1984 requiring States to use a "cost avoidance method" in circumstances in which the agency has established the probable existence of third party liability at the time the claim is filed.

- Finally, HCFA has implemented expanded TPL assessments to focus on State performance in the identification of third party resources. These assessments have been conducted in 20 States since October, 1982. Ten additional States will be reviewed each year until all States are assessed. Recommendations are made to the States to correct deficiencies in the TPL process; States are presented with the opportunity to concur or nonconcur with the assessment findings.

Concurrence requires the submission of a corrective action plan by the State. Nonconcurrences are resolved through negotiations with the regional office. HCFA will followup to ensure that the necessary corrective action is taken.

GAO Recommendation

That the Secretary direct the Commissioner of Social Security to provide detailed insurance information on Medicaid/SSI applicants to States with Section 1634 agreements that are willing to pay for it. States should receive insurance data, such as the insurer's name and address, policy number, and name(s) of the insured.

Department Comment

We concur. An SSA/HCFA workgroup conducted a pilot project in Arkansas, New Jersey and Wisconsin from May through November 1983 to test the feasibility and cost effectiveness of collecting detailed health insurance information by SSA field offices from SSI applicants/recipients. The pilot project proved to be very successful with 21 percent of all eligible SSI Medicaid applicants reporting a third party resource during the SSI initial intake operation. Nine percent of all Medicaid recipients reported a third party resource for SSI/Medicaid eligibility. Based on the project findings and savings projections, HCFA and SSA have agreed to offer all section 1634 States the opportunity to purchase the improved data collection services from SSA. Implementation in participating States is planned to begin by January 1, 1985.

More specifically, SSA district offices will need to identify, during application and redetermination interviews, initial SSI eligibles/SSI recipients with third party health insurance and forward that insurance data to the appropriate State Medicaid office for use in its TPL recovery or cost avoidance systems. SSI initial eligibles/SSI recipients will be asked during initial and redetermination interviews for the name of their insurance company, policy number, and the group number or group name.

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