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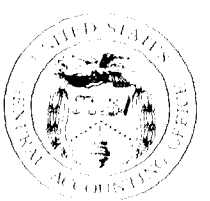
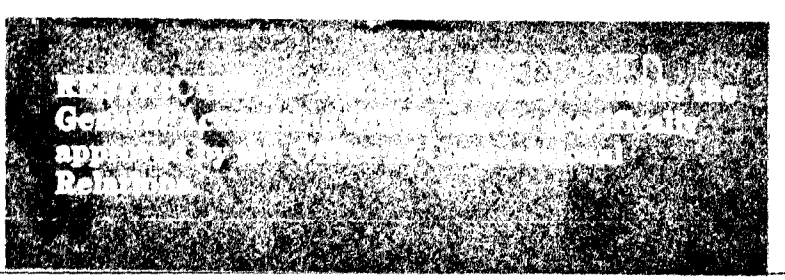
Report to the Chairman, Committee on Government Operations, House of Representatives

April 1991

MEDICAID

HCFA Needs Authority to Enforce Third-Party Requirements on States





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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-241141

April 11, 1991

The Honorable John Conyers, Jr.
Chairman, Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we review efforts by the Health Care Financing Administration (HCFA) to assure that states use Medicaid to pay for health care only after a recipient's other health care resources have been used. In 1985, we reported that Medicaid was paying an estimated $500 million to over $1 billion annually that liable third parties, such as private health insurers, should be paying. In response, the Congress amended Medicaid law in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), thereby placing additional third-party requirements on states. As agreed with your office, we sought to determine whether HCFA, by exercising its oversight responsibilities, has identified state noncompliance with federal requirements and has adequate authority to enforce compliance.

Results in Brief

HCFA has identified significant state noncompliance with federal third-party requirements. Although HCFA has not estimated Medicaid program losses resulting from this noncompliance, our work in two states identified more than $175 million in backlogged claims for which third parties may have some liability.

While imposing additional third-party requirements upon states, COBRA severely limited HCFA's enforcement authority. As a practical matter, HCFA's authority to enforce third-party requirements with financial penalties is almost nonexistent. To encourage states to comply with these requirements and, when they do not, ensure that the federal government does not contribute to Medicaid payments, the Congress should broaden HCFA's authority to impose financial penalties.

Background

A federally aided, state-administered medical assistance program, Medicaid served about 23.5 million low-income people in fiscal year 1989. States participate in the Medicaid program at their option and must administer the program within broad federal requirements and guidelines. In fiscal year 1989, net Medicaid medical assistance expenditures totaled about $58.0 billion, of which the federal government paid $32.7 billion (56 percent) and the states $25.3 billion (44 percent). The federal

portion of a state's Medicaid payments is based on its per capita income. States with lower per capita incomes receive higher rates of federal matching.

The Congress intended that Medicaid, as a public assistance program, pay for health care only after a recipient's other health care resources have been exhausted. To the extent that other resources are used instead of Medicaid, savings can accrue to the federal and state governments.

Approximately 13.2 percent of Medicaid recipients had private or employer-provided health insurance, the Bureau of Census 1990 Current Population Survey showed. In addition, recipients' health care expenses may be paid through such third parties as liability insurers and workers' compensation plans.

By law, state Medicaid agencies must take reasonable measures to determine the legal liability of third parties to pay for services furnished under Medicaid. Such measures by regulation include specific requirements to identify and recover payments from liable third parties. For a recipient with an identified insurance resource, the state Medicaid agency should return claims unpaid so that the insurer pays first.[1] Postpayment recovery occurs when a Medicaid agency pays the provider of medical services, then bills and receives payment from the insurer. When a state recovers Medicaid expenditures from a third party, it shares the recovery with the federal government in the same proportion as the federal Medicaid match.

An agency of the Department of Health and Human Services (HHS), HCFA is responsible for developing program policy, setting standards, and overseeing state compliance with federal Medicaid legislation and regulations. HCFA officials carry out their responsibility for oversight of state third-party efforts in part by performing two types of reviews:

1. Management review. This is HCFA's most comprehensive evaluation of state compliance with federal third-party requirements. Focusing solely on third-party requirements, it tests compliance by examining state procedures and a selected sample of claims. But any noncompliance so identified cannot be corrected by imposing penalties.

[1]Except in certain cases, such as prenatal or preventive pediatric claims, as mandated by law.

2. Systems performance review (SPR). By law, HCFA can penalize a state only through this review of its Medicaid Management Information System (MMIS), an automated claims-processing and information-retrieval system. The review does not focus on third-party requirements but covers a broad range of system-related requirements.

As early as 1977, along with HHS and others we reported problems state Medicaid agencies had in ensuring that Medicaid is treated as payer of last resort. After we reported in 1985 that states could do more to identify and recover from third parties,[2] the Congress enacted COBRA, which increased states' responsibilities in this area. Before enactment, the Congressional Budget Office estimated that by increasing third-party collections, COBRA would save Medicaid more than $900 million over 6 years. The law required states to collect sufficient information to identify liable third parties and submit a plan for HHS approval for recovering payments from them. Since then, HCFA has issued regulations[3] requiring states, among other things, to gather certain health insurance information from Medicaid applicants.

Scope and Methodology

To determine HCFA's oversight of and authority to enforce federal third-party requirements, we interviewed officials from HCFA headquarters and Chicago, San Francisco, and Seattle regional offices. We discussed HCFA's authority to enforce such requirements with attorneys from HHS's Office of the General Counsel. Additionally, we obtained and reviewed relevant legislation, regulations, and legislative history.

We also examined HCFA's fiscal year 1988 and 1989 management reviews of 48 states and the District of Columbia to analyze HCFA's oversight of state compliance with third-party requirements. As agreed with your office, we did not estimate national losses accruing to the Medicaid program because of state noncompliance with federal third-party requirements.

In addition, we obtained information on state third-party efforts from California and Michigan Medicaid officials, and discussed HCFA's oversight of state programs with these as well as Maryland and Washington officials. We also obtained and reviewed relevant reports prepared by the HHS Inspector General.

[2]Improved Efforts Needed To Relieve Medicaid From Paying For Services Covered By Private Insurers (GAO/HRD-85-10, Feb. 12, 1985)

[3]42 CFR 433.138 and 433.139

We conducted our work between August and December 1990 in accordance with generally accepted government auditing standards.

State Medicaid Agencies Not Complying With Third-Party Requirements

State Medicaid agencies are significantly deficient in meeting federal third-party requirements, HCFA reviews have shown. Judging from our work in Michigan and California, such deficiencies could have a substantial effect on recoveries.

Significant State Noncompliance Found in 1988 and 1989

HCFA's management reviews in 48 states and the District of Columbia[4] in fiscal years 1988 and 1989 found significant noncompliance with federal third-party requirements (see table 1). Almost all (45 of 49) states were failing to comply with at least one of nine requirements[5] addressed by HCFA in its annual reports of overall state compliance. Over half (28 of 49) of the states were not complying with four or more requirements.

[4]Hereafter referred to as a state.

[5]HCFA did not address a tenth requirement—that states assure that recipients assign their rights to medical payments to the state—because all states met this requirement.

Table 1: HCFA Management Review Findings on States' Noncompliance With Third-Party Requirements (FY 1988 and 1989)

Federal requirement that states must meet	Noncomplying states	
	No.	Percent
Edit paid claims to identify potential accident-related cases where a third party (such as a casualty or liability insurer) may be liable	34	69
Assure that third-party information is obtained at the time Medicaid eligibility is determined or redetermined	33	67
Seek payment recovery within 60 days after the end of the month in which payment was made or the liable third party identified	23	47
Attempt to establish an agreement to conduct state motor vehicle accident data matches to obtain information about Medicaid recipients involved in accidents	23	47
Attempt to establish an agreement to conduct data matches with state workers' compensation or industrial commission accident files	22	45
Conduct data exchanges with state wage information collection agencies and Social Security Administration wage and earnings files	22	45
Implement a cost-avoidance claim-payment system to reject claims to the provider when there is evidence of a liable third party	20	41
Establish a claim-recovery system based on cost effectiveness and stipulate in the state Medicaid plan either a dollar threshold of claims the state will pursue or other guidelines to determine cost effectiveness	10	20
Establish agreements with agencies that determine Medicaid eligibility to assure they collect third-party information	7	14

HCFA did not estimate losses accruing to the Medicaid program from state noncompliance, a HCFA official told us. But examination of just one requirement—to seek payment recovery from the liable third party within 60 days[6]—indicates possible losses. Because claim-filing limitations imposed by insurer contracts may decrease the likelihood of recovery over time, prompt recovery is important. However, HCFA found that 23 (47 percent) of 49 states were not adequately seeking recovery of payments. Specifically, of the 23 states, 12 attempted recoveries but not in what HCFA considered a timely manner, 9 attempted no recoveries,[7] and 2 attempted recoveries for only certain types of claims.[8] Had these latter 11 states been recovering proportionate to the other states,

[6]Specifically, states are required to seek recovery of payments within 60 days after the end of the month in which the state identified the liability or paid the claim.

[7]Arkansas, Delaware, District of Columbia, Louisiana, Maine, Oklahoma, Rhode Island, Vermont, and West Virginia.

[8]Massachusetts sought recovery mainly for prescription drug claims and Pennsylvania, for hospital claims.

we estimate the federal share of their fiscal year 1988 recoveries would have amounted to over $9 million.[9]

Problems Continuing in 1990

Problems still are occurring, our work in Michigan and California shows, and federal requirements for third-party recoveries are not being met. The Michigan Medicaid agency has recovered on no medical claim submitted to Blue Cross/Blue Shield since 1988, and California has implemented only partially a system to avoid paying claims for recipients with other insurance. Thus in these two states alone, backlogged claims for which third parties may have some liability totaled more than $175 million.

Michigan

As we reported in November 1990, the state Medicaid agency's recoveries from Blue Cross/Blue Shield of Michigan over the past 18 years were considerably less than they should have been.[10] In 1985, after suing Blue Cross/Blue Shield for payment of unpaid claims, the state negotiated a settlement. The state sought the settlement because, without substantial changes to its computer system, it could not abide by an earlier agreement. This was to give Blue Cross/Blue Shield certain information that it maintained it needed to properly process claims. In total, Blue Cross/Blue Shield paid about $18.5 million on about 5 years of claims of $90.7 million. The state has continued to have problems and since 1988, has made no recoveries on medical claims submitted to Blue Cross/Blue Shield.

Despite considerable problems with Blue Cross/Blue Shield, the state had not taken all the actions that it could. For example, it did not involve the insurance commissioner in recovering its monies. Between August 1988 and April 1990, the state had accumulated a $59 million backlog of claims for which Blue Cross/Blue Shield may have some liability.[11] Because Blue Cross/Blue Shield generally requires that claims be

[9]This estimate probably is conservative; the other states are likely not recovering to the extent they should, as the following examples of Michigan and California suggest. Further, such problems could grow in the future, as recent federal regulations require states to seek recovery for certain claims they previously did not have to pay. As of February 1990, states must pay certain claims, for example, prenatal and preventive pediatric claims, even if a third party is liable. The states then must seek payment from the third party.

[10]Medicaid: Millions of Dollars Not Recovered From Michigan Blue Cross/Blue Shield (GAO/HRD-91-12, Nov. 30, 1990).

[11]It is unlikely Blue Cross/Blue Shield is liable for the full amount because the state does not screen for Blue Cross/Blue Shield policy limitations, excluded services, deductibles, or copayment provisions.

submitted within 12-18 months, the state Medicaid agency's delay in recovering may further complicate recovery efforts.

California

For more than a quarter of its insured Medicaid recipients, California is paying providers and then seeking recovery from the liable insurers. This "paying and chasing" approach is less effective than a cost-avoidance system that does not pay claims for recipients with other insurance.[12] Also, the state is having trouble collecting from one of its largest insurers. Like Michigan, the problems have been longstanding.

In November 1985, HCFA finalized regulations requiring states to adopt cost-avoidance systems. Although California started to install such a system in 1986, as of October 1990 it was not yet fully in place. In its partially implemented form, it does not meet federal requirements, according to HCFA. For 26 percent of insured recipients, the state is making Medicaid payments and then seeking recovery from insurers—many of whom do not respond. As of September 1990, California had outstanding claims totaling $118 million for 3 years (ending April 1989) of billings. The state was writing off as uncollectable millions of dollars in aged claims that insurers had not processed.[13]

The state also has had continuing problems collecting from Blue Cross/Blue Shield, one of its largest insurers. In the mid-1970s, after threatening to sue some insurers for failure to pay third-party claims, the state settled with several, including Blue Cross/Blue Shield, a state attorney told us. In some cases, the parties agreed on a portion of the amounts claimed and arrangements for paying claims. Nevertheless, the state still was experiencing problems recovering from Blue Cross/Blue Shield, according to a January 1990 state memorandum to HCFA. As of September 30, 1990, Blue Cross/Blue Shield had unprocessed Medicaid claims from October 1987 to January 1990 of about $18 million.

Federal regulations require states to pursue recoveries when cost effective. California no longer audits insurers to recover these unprocessed claims, although this method has proven cost effective in the past. In our 1985 report, we noted that California audited 34 insurers during the year ended June 30, 1983, resulting in collections with a benefit-to-cost

[12]GAO/HRD-85-10. We reported that California, using this "paying and chasing" approach, often did not follow up with liable health insurers that had not responded to its request for payment.

[13]State third-party officials were unable to document exact amounts they had written off because they were changing their accounting system and system documentation had been discarded. Using available reports, however, it appeared the writeoffs averaged at least $11.4 million per quarter.

ratio of more than 5 to 1. However, California abandoned its audit efforts in 1986 due to staff limitations, state Medicaid officials told us.

HCFA Lacks Effective Enforcement Authority

While adding new requirements for third-party recovery, COBRA significantly limited HCFA's authority to impose financial penalties on states that do not meet third-party requirements. Prior to COBRA, HCFA had planned to implement a program to withhold federal matching funds based on unrecovered claims. COBRA, however, limited HCFA to imposing financial penalties only through its reviews of state MMISs. For several reasons, however, these reviews are ineffective as an enforcement mechanism.

Enforcement Authority Limited by COBRA

By exclusively relying on SPRs of states' automated claims-processing and information-retrieval systems to ensure compliance with third-party requirements, COBRA limited HCFA's authority to enforce these requirements. Before COBRA, HCFA could enforce third-party requirements by withholding federal matching funds when states failed to comply. Under that authority,[14] HCFA had developed a program called Third Party Recovery Audit Coordinated Effort (TRACE) to disallow certain federal matching funds. The disallowance was to be based on a projection of identified claims for which third parties were liable. Although pilot TRACE reviews were implemented in only a few states prior to COBRA, the program appeared successful. For example, in one state the TRACE reviewer estimated potential annual payment errors totaling $422,112 for certain types of claims. In light of the pilot program's results, HCFA had planned to implement the program nationally—until COBRA limited HCFA's enforcement authority.

Why, in enacting COBRA the Congress limited HCFA's penalty authority, at the same time imposing more rigorous requirements on states, is unclear. In hearings preceding legislation, however, a state official indicated that third-party penalties no longer would be justified if the Congress required states to follow specific third-party procedures. In our view, the penalty authority that remains after COBRA is of little use in gaining states' cooperation in implementing Medicaid third-party procedures.

[14]HCFA cited several authorities for withholding federal matching funds, including sections 1903(d)(2) and (p)(42 USC 1396 b(d)(2) and (p)) of the Social Security Act. Broad authority is also found at section 1904 of the act (42 USC 1396c). At the time of our review, federal regulations (42 CFR 433.140) suggested that HCFA could withhold federal matching funds if an agency failed to comply with third-party requirements. However, HHS attorneys and HCFA officials told us that this regulation, written prior to COBRA, had not been revised due to an oversight. They said HCFA was revising the regulation.

SPR Inadequate as Exclusive Third-Party Enforcement Mechanism

While COBRA requires that any penalties for noncompliance with third-party requirements be based exclusively on the SPR, the review gives states no strong incentive to comply. HCFA officials have struggled to develop an adequate third-party review that uses the SPR. They find, however, that its emphasis on third-party requirements, penalties for noncompliance, and value in reviewing nonautomated procedures all are too limited. The latter remain an important part of third-party recovery efforts.

Emphasis on Third-Party Requirements Limited

Compliance with third-party requirements has little influence on whether a state passes or fails the SPR. The SPR is HCFA's primary means of ensuring that a state's MMIS accurately processes claims and prevents fraud, waste, and abuse by providing, for example, the capability to detect duplicate payments or payments to ineligible providers. While third-party procedures are only one (12.5 percent) of eight reviewed, HCFA has assigned them a weight of about 14 percent of the scoring system.

Given the current emphasis, a state cannot fail the SPR and experience financial penalties even if third-party problems are identified. In fiscal year 1990, the first year the SPR included third-party processes for assessing penalties and 1 or 2 years after HCFA management reviews detected extensive noncompliance, all 19 states reviewed passed the SPR. However, in six states, although HCFA reviewers had identified third-party problems that should be corrected, the problems did not result in a failing score.

Financial Penalties Too Low

Potential SPR penalties are significantly lower than the federal matching funds at risk. Such penalties are limited to a portion of a state's MMIS administrative costs. The administrative costs against which penalties are assessed represent little more than 1 percent of the federal share of Medicaid payments. Because of this and an overall cap on the penalty,[15] the resulting penalties are limited to about 1/8 of 1 percent of the federal share of Medicaid payments.

Two other factors also limit the effectiveness of penalties. If a state corrects the problem in its payment system, HCFA subsequently may restore

[15]For Medicaid program administrative costs, states receive 50-percent federal matching funds. However, the Congress allows a 75-percent MMIS match to encourage efficiently operated systems. SPR penalties can be assessed only against the 25 percent that states receive above the base MMIS administrative costs, and the penalty cannot exceed 10 percent of the federal administrative match in a single year.

the amount assessed in administrative penalties. Also, a state can correct system deficiencies without recovering erroneously paid claims and yet regain the amount it was penalized by HCFA. This is because the SPR focuses on procedures rather than a review of specific claims. It may be impossible to change state behavior, HCFA officials agreed, given the limited penalties.

Focus Is on Automated Procedures

By design, the SPR generally does not include a review of nonautomated procedures, an important and necessary part of third-party identification and recovery efforts. As the SPR is the only basis for penalizing states for third-party deficiencies, this exclusion in effect places nonautomated procedures beyond enforcement.

The SPR does not, for example, test for inadequacies in a state's intake procedures for identifying available third-party resources. There is no statutory prohibition against including manual procedures in the SPR. But HCFA officials feel that a review of nonautomated procedures is inconsistent with the SPR's purpose: to evaluate automated procedures against standards for receiving federal funds earmarked for claims-processing and information-retrieval systems.

Absence of Penalties Gives HCFA Little Leverage

Given the SPR's limited value for review and enforcement, it appears that HCFA's primary recourse to correct problems with third-party requirements is to convince states that changes are needed. But states view federal management review recommendations as largely advisory. For example, Washington and California officials saw compliance with HCFA recommendations as optional. In some cases, the states openly disagreed with federal recommendations.

State legislatures or decisionmakers also may contribute to the problems. In times of constrained state budgets, they may not allocate resources to federal third-party efforts unless federal matching is at risk. HCFA reports that state third-party efforts save over $21 for every $1 in administrative costs. But state agencies often have difficulty convincing state decisionmakers to invest in a third-party recovery program, HCFA documents indicate.

Staffing shortages constitute one reason the states are not meeting third-party requirements, HCFA reviews for 10 states showed.[16] For

[16]Arkansas, Connecticut, Delaware, Louisiana, Maine, Massachusetts, Montana, Oklahoma, Pennsylvania, and Vermont.

example, for state fiscal years 1987-89 the Pennsylvania Department of Public Welfare's requests for additional positions for third-party liability activities were denied, state officials told HCFA. Similarly, Maryland and California decisionmakers were reluctant to devote additional administrative monies to any program, state officials said, especially if federal matching was not at risk.

Conclusions

In limiting HCFA's authority for enforcing compliance with third-party requirements, the Congress may have underestimated the extent to which states would fail to comply. Under current enforcement authorities, HCFA may not realize the 6-year savings of over $900 million that were to result from the COBRA changes. HCFA has modified its systems performance review to encourage state compliance and protect federal interests, but the SPR is an ineffective enforcement mechanism. States failing to meet significant third-party requirements still can pass the SPR, and potential financial penalties appear too low to influence state behavior. Finally, nonautomated third-party procedures generally are not included and thus not subject to penalty.

Without the ability to withhold federal matching funds, the federal government cannot adequately protect its financial interests when states fail to comply with third-party requirements. To strengthen HCFA's enforcement of state third-party identification and recovery efforts, the Congress should authorize HCFA to withhold federal matching funds as a financial penalty for state noncompliance with third-party requirements.

Recommendations

We recommend that the Congress amend the law to authorize HCFA to withhold federal matching funds when states do not comply with federal third-party requirements. To do so, current restrictions in the law should be removed. Our suggested legislative language appears in appendix I.

As you requested, we did not obtain written comments on this report but did discuss its contents with HCFA officials. Where appropriate, we have incorporated their comments.

As agreed, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human

Services and other interested parties and make it available to others on request. Please call me on (202) 275-5451 if you or your staff have any questions about this report. Other major contributors are listed in appendix II.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Contents

Abbreviations

COBRA	Consolidated Ominibus Budget Reconciliation Act of 1985
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MMIS	Medicaid Management Information System
SPR	Systems Performance Review
TRACE	Third Party Recovery Audit Coordinated Effort

Suggested Legislative Language

We recommend that the Congress amend section 1902(a)(25)(A)(ii)(II) of the Social Security Act (42 USC 1396 a(a) 25(A)(ii)(II)) to strike current restrictions on HCFA's authority and read as follows:

"(II) be subject to the provisions of section 1903(r)(4) relating to reductions in Federal payments for failure to meet conditions of approval;"

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