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Report to Congressional Requesters

May 1994

MEDICARE/ MEDICAID

Data Bank Unlikely to Increase Collections From Other Insurers

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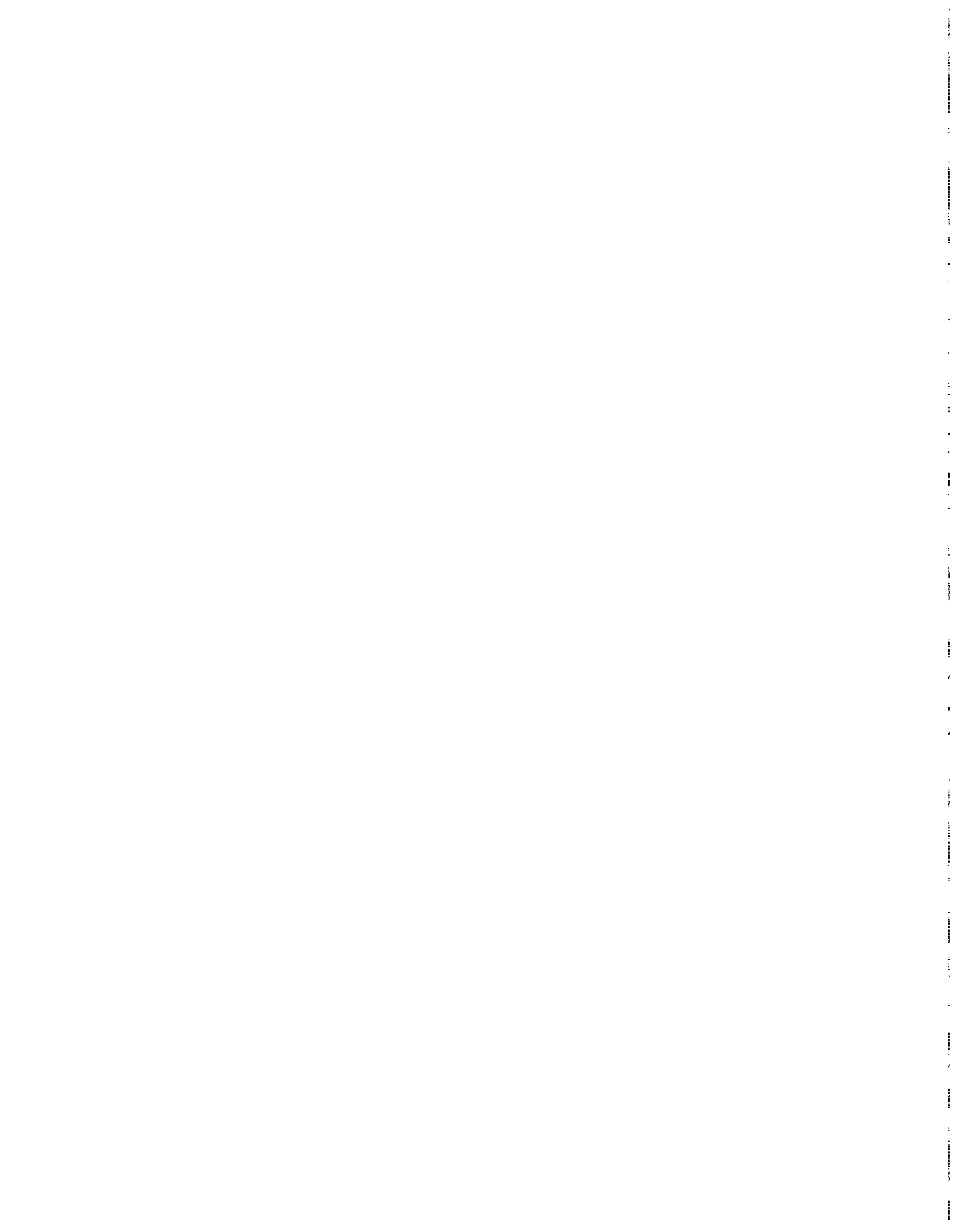


United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-255760

May 6, 1994

The Honorable Joseph I. Lieberman
Chairman
The Honorable Thad Cochran
Ranking Minority Member
Subcommittee on Regulation and
Government Information
Committee on Governmental Affairs
United States Senate

The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) directed the Secretary of Health and Human Services (HHS) to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents that are covered by employer group health plans. The purpose of creating such a data bank is to help (1) identify Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills ahead of the Medicare and Medicaid programs and (2) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs.

In November 1993, we reported our preliminary observations on why the data bank may not contribute to more effective recovery of Medicare funds.[1] As subsequently agreed with your offices, we further reviewed whether the data bank would improve existing processes for recovering Medicare and Medicaid funds, including whether it would realize additional savings beyond what existing recovery programs achieve. Appendix I presents our methodology.

Results in Brief

As the plans for implementing the data bank have progressed, our work showed that the data bank may not measurably strengthen the existing processes for ensuring that beneficiaries' health insurers pay ahead of Medicare or Medicaid. As envisioned, the data bank would have certain inherent problems and likely achieve little or no additional savings to the Medicare and Medicaid programs.

First, the data bank would add significantly to record keeping for both HHS and the nation's employers. It would require employers to report, and HHS to accumulate, health insurance coverage information on about 160 million employees and their dependents, even though only about

[1] Medicare/Medicaid Data Bank Issues (GAO/HRD-94-63R, Nov. 15, 1993).

7 million are enrolled in Medicare or Medicaid and are also covered by employer group health insurance.

Second, there is no assurance that the increased record-keeping requirements would provide additional or needed information on Medicare and Medicaid beneficiaries' health insurance coverage. For Medicare, the data bank would not add significantly to information that is already being developed in other recent cost-saving initiatives, and therefore would not enhance recoveries. For Medicaid, in most cases the data bank would not produce information quickly enough to be useful to states that administer the program.

The Health Care Financing Administration (HCFA), an agency within HHS that administers Medicare, already has processes that attempt to apply a beneficiary's private health insurance coverage to a Medicare or Medicaid claim, but these processes are also not without problems. HCFA's initial attempt to recover payments from insurers under a data match program using data from federal agencies and employers had mixed results. However, improvements to the data match program are being made for the next cycle of recoveries. In our view, the limitations of the data bank appear to make it a less effective approach than the existing data match program. We therefore believe that the Congress needs to delay its implementation until the data bank's potential cost-effectiveness and other benefits can be clearly demonstrated.

Background

Medicare is a federal program that helps pay health care costs for about 37 million people, most of whom are age 65 or older. Medicaid covers about 31 million people of all ages who have limited financial resources. HCFA administers Medicare through its contractors and also oversees the administration of Medicaid by the states.

Some persons who are eligible for Medicare or Medicaid may in fact have other health insurance. For example, 1990 census data showed that about 13 percent of Medicaid recipients have employer group health insurance coverage. Similarly, some persons eligible for Medicare have employer group health insurance through either their own place of work or a spouse's employer. Both Medicare and Medicaid have provisions requiring that such insurance be tapped for its share of medical costs.

Beginning in 1981, the Congress enacted a series of amendments calling for Medicare to act as the secondary, rather than the primary, payer for

certain beneficiaries covered under employer group health plans. These provisions are referred to as the "Medicare secondary payer provisions." Generally, when Medicare beneficiaries have such insurance, the providers of services (such as hospitals and physicians) are required to bill primary insurers first. Medicare is to act as the secondary payer in such situations, covering the remaining amount after the other insurer has paid up to the limits of the coverage under the plan. Contractors administering the payment of Medicare claims for HCFA reported that, by properly billing or recovering prior payments from other insurers, Medicare saved over $3 billion in fiscal year 1993. HCFA paid the contractors $95 million in fiscal year 1993 to administer the Medicare secondary payer provisions.

As a public assistance program, Medicaid is intended as the payer of last resort. Federal Medicaid regulations specify actions that state Medicaid agencies must take to identify and recover payments from insurers for services furnished under Medicaid. These are referred to as Medicaid third-party liability activities.

For the past 10 years, reports issued by HHS's Inspector General and by us have shown problems with efforts to identify insurers that are responsible for paying ahead of Medicare and Medicaid. As a result, more effective efforts to identify and recover from insurers that should pay before Medicare/Medicaid carry the promise of considerable cost savings to the federal government. OBRA-93, signed into law on August 10, 1993, included two provisions designed to improve both the Medicare Secondary Payer (MSP) and Medicaid Third-Party Liability programs. The two provisions, referred to as data match and data bank, are discussed in the next section.

Data Match

The data match provision, originally authorized under the Omnibus Budget Reconciliation Act of 1989, allows HHS to match data contained in several federal information systems—including the Social Security Administration (SSA) and Internal Revenue Service (IRS) files—to identify beneficiaries that have potential for health insurance coverage through their or a spouse's employer. Section 13561 of OBRA-93 extended HHS's authority to conduct data match activities until September 30, 1998.

Data Bank

Section 13581 of OBRA-93, established the Medicare and Medicaid data bank to assist in identifying, and collecting from, other insurers responsible for

Medicare and Medicaid claims.[2] The law requires employers to report annually to the Secretary of HHS specific information on individuals who elect coverage under an employer's group health plan, including (1) descriptive data on the employees and their dependents (names and social security numbers); (2) type of coverage (single or family); (3) name, address, and identifying number of the group health plan; (4) period during which coverage was elected; and (5) the name, address, and tax identification number of the employer. Once the information is reported, HHS (or its contractor) would establish and maintain the data bank and make the data available to the Medicare and state Medicaid programs. Employers must begin filing calendar year 1994 information with HCFA by February 28, 1995. In September 1993, HCFA was assigned responsibility for implementing the data bank, and as of April 1994, was developing plans for implementation.

Data Bank Would Add Significantly to HCFA and Employer Record Keeping

Both for HCFA and for employers, the proposed data bank represents a significant increase in record keeping. Employers would be required to report, and HCFA would have to maintain, health insurance information on all employees and covered dependents to identify the relatively few with Medicare or Medicaid eligibility and private health insurance coverage. HCFA estimates information would be reported for as many as 160 million people. However, the estimated number of such persons with health insurance coverage that is primary to Medicare coverage is no more than 3 million, and for Medicaid, the estimate is 4 million.[3]

Employers we spoke with consistently raised other matters in addition to the volume of records they would need to maintain: the uncertainty, potential cost, and difficulty involved in obtaining sufficient information to meet data bank requirements.

Record-Keeping Requirements Still Uncertain, Potentially Difficult, and Costly

Employers are unsure of HCFA's specific data reporting requirements for the data bank. As of April 20, 1994, HCFA had not finalized its guidance—which is to be published as a general notice in the Federal Register. While HCFA develops this guidance, some employers said that it is already too late for them to use it to reprogram their systems to capture

[2]In August 1993, just prior to the passage of OBRA-93, the Congressional Budget Office estimated that an effective data bank could save about $950 million during fiscal years 1994 through 1998—about two-thirds of it in Medicare, and the rest in Medicaid.

[3]The Medicare estimate is based on our discussions with HCFA officials, while the Medicaid estimate is based on our previous Medicaid report, Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (GAO/HRD-91-60, Apr. 11, 1991).

data needed to meet the law's calendar year 1994 reporting requirement of February 28, 1995.

Employers and employer groups said that in the past, they generally have not collected some of the information the law requires them to report, such as tax identification numbers of spouses or dependents. In many cases, employers keep very little health insurance information because it is maintained by a union or an insurance company. Some employers are understandably concerned because the data bank statute holds them accountable for reporting information that they may be unable to readily obtain from their employees, insurers, or unions[4].

Finally, employers said they would likely face significant costs to redesign their payroll or personnel systems once specific record-keeping requirements were made known. These costs would likely vary greatly depending on the size of the employer, the additional information they would need to collect, and the degree to which their systems would need reprogramming. For example, one company with 44,000 employees estimated its costs for reprogramming its system and collecting and reporting the data at $52,000, while another company with 4,000 employees estimated its costs at $12,000. Given the wide variances in the factors involved, a reliable nationwide estimate of the costs involved is not possible.

Implementation Plans Raise Concerns About Usefulness of Data Bank Approach

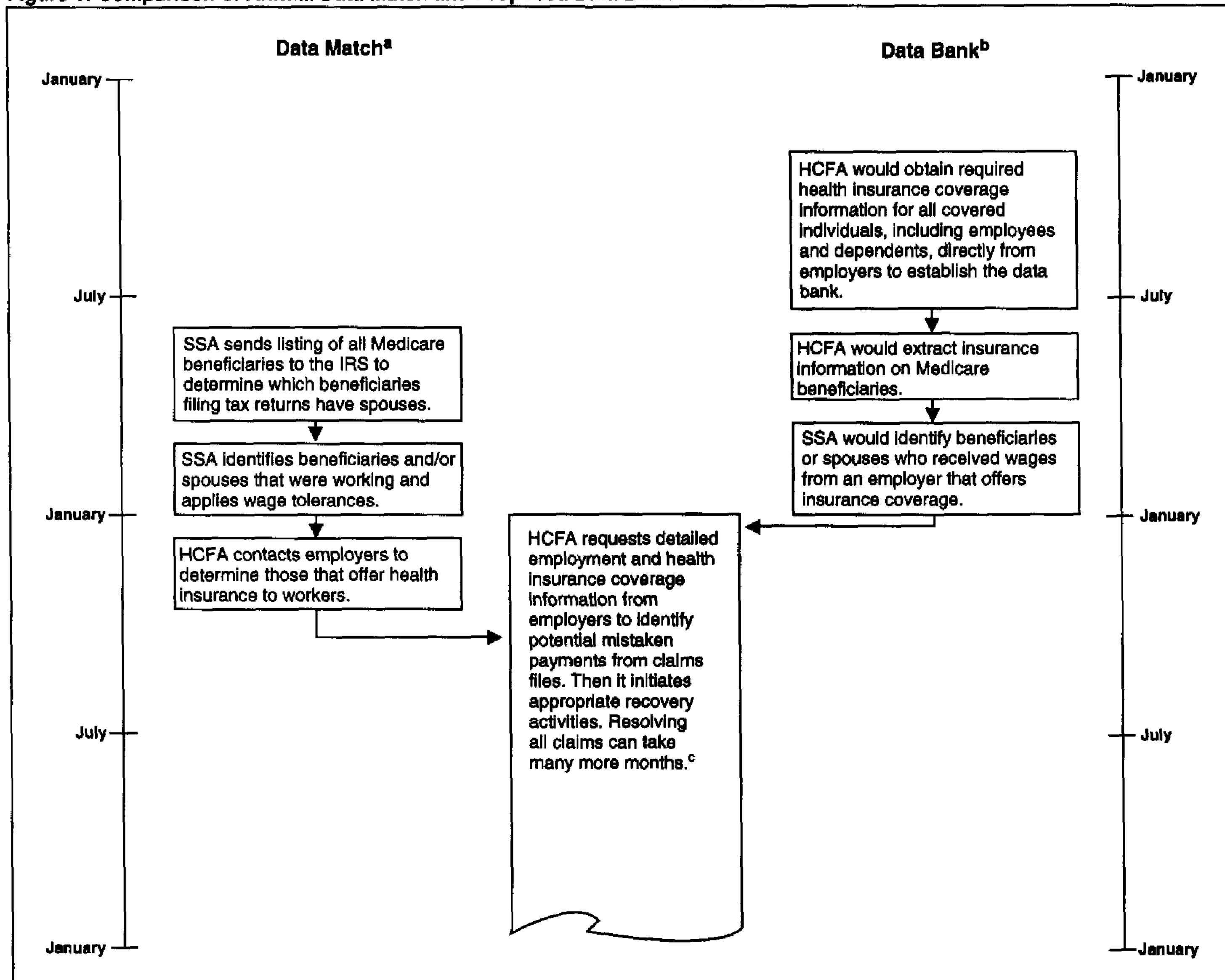
The additional information gathering and record keeping required by the data bank appears to provide little benefit to Medicare or Medicaid in recovering mistaken payments. In regard to Medicare, our review of HCFA's plans for the data bank raised concerns about whether it would provide any useful information beyond what is being collected under HCFA's ongoing data match process. In fact, HCFA anticipates using an employer questionnaire similar to that used by the data match to fill information gaps in the data bank. In regard to Medicaid, our work suggests that the data bank information would not be timely enough for use by states in their third-party liability activities.

[4]OBRA-93 subjects employers who do not meet the reporting requirements of the data bank to potential penalties of $50 for each instance in which a return is not filed or contains incorrect information, up to a maximum of $250,000 per year, or higher if nonreporting is found to be deliberate.

Data Bank Appears to Add Little to Medicare's Data Match Process

A complete comparison of the data match program with the proposed data bank process is difficult because data match activities are currently being refined and HCFA's data bank processes are still in the planning stages. However, to illustrate the similarities and differences between the two approaches, figure 1 compares the flow of information under an annual data match process versus the data bank approach as envisioned by HCFA at the time of our review. As the figure shows, the two approaches start with different data sources but arrive at the same end point—seeking recovery from insurers.

Figure 1: Comparison of Annual Data Match and Proposed Data Bank Processes



Note: Assumes that agencies' files are 95 percent complete when needed.

[a]Data match depicts GAO's estimate of the earliest an annual date match process could be accomplished, based on information from HCFA, IRS, and SSA.

[b]Data bank time frames are HCFA's preliminary planning estimates.

[c]Under data match, employers may be penalized for not responding to HCFA's requests for detailed information. Under data bank, no similar penalties apply for follow-up questionnaires.

The data match process currently under way by HCFA matches Medicare recipients against IRS and SSA files to identify instances in which a working Medicare beneficiary (or working spouse) may have employer-sponsored health insurance coverage. For those instances in which the potential for insurance is identified, HCFA must send questionnaires to employers, first to determine which employers offer health insurance, and then to confirm the insurance status of specific beneficiaries. HCFA has authority to assess penalties of up to $1,000 per employee on employers who do not respond. Medicare contractors then (1) search previous Medicare payments to determine whether Medicare paid claims that should have been paid by other insurers and (2) execute recovery actions. (See app. II for a full description of the process.)

Under the data bank program, employers would report to HCFA health insurance coverage on all workers and dependents. HCFA would then extract the health insurance information for those beneficiaries covered by Medicare. According to HCFA officials, however, the data bank provisions do not require employers to report enough specific information about beneficiaries' health insurance to pursue recovery from insurers.[5] As a result, HCFA's plan, at the time of our review, was to obtain this additional information through both matching with SSA files and separate follow-up questionnaires sent to employers—much like those required under the data match program.[6] One important difference, however, is that under this follow-up questionnaire, employers' responses would essentially be voluntary; that is, they would not be subject to penalties as they are for not responding to data match questionnaires. This enforcement weakness could seriously compromise the data bank's effectiveness in obtaining accurate and complete information from employers.

Data Bank May Be of Little Use to State Administration of Medicaid Recoveries

HCFA intends to make data bank information available to states to carry out their own matching programs for Medicaid. However, state officials have pointed out to us and to HCFA that data bank information may be too old to enhance Medicaid recoveries.

[5]For HCFA to pursue Medicare secondary payer cases, more information is needed, at the least, on period of employment and basis of coverage (i.e., current employee, retiree, or other relationship with the employer).

[6]More specifically, after SSA earnings files are matched with data bank information to determine which beneficiaries had earnings during the period, detailed questionnaires will have to be mailed to employers that have Medicare workers or dependents to determine period of employment and basis of health insurance coverage. Then Medicare claims will be reviewed to detect instances in which Medicare may have paid mistakenly as primary payer.

The reason that data may be of little use is that unlike Medicare, which has authority to recover from insurers regardless of the health insurers' claims filing deadlines, Medicaid programs are generally subject to such claims filing deadlines.[7] HCFA and state officials told us that insurance companies generally require that claims be filed within 12 months of the date of service. HCFA officials told us that they anticipate having the data bank information available for use by state Medicaid programs, at the earliest, about 6 months after the calendar year ends. In turn, the states may need several more months to match information in the data bank with their Medicaid files.

The lack of timely information to the states would also appear to restrict the Medicaid program's ability to use the data bank information to identify a beneficiary's insurance coverage before Medicaid pays future bills. HCFA data shows that 44 percent of all Medicaid recipients are on Medicaid for less than a year. Thus, by the time the states use the data bank to identify the insurance for these beneficiaries, their Medicaid eligibility may have already ended.

Improving Existing Mechanisms May Offer Better Ways to Obtain the Same Information

The overlap between the proposed data bank and HCFA's existing data match process, as well as the potential record-keeping problems that were surfacing as HCFA's plans for the data bank were taking shape, raised this question: does continued development of HCFA's existing processes offer a better alternative than establishing the proposed data bank? We believe the answer is yes, with qualification. The data match not only can provide the same information without raising the potential problems described above, but it can do so at less cost. HCFA also has other alternatives for providing information soon enough for states to enhance Medicaid recoveries.

But HCFA's existing processes still rely too much on a recovery approach. Enhancing up-front identification of other insurance and avoiding mistaken payments is much preferable to relying on after-the-fact recovery, such as the data match and data bank. HCFA has recognized this and has recently initiated a number of programs to get insurance information into their systems early, updating it with each transaction, and thereby avoiding mistaken payments.

[7]Federal regulations provide that Medicare can recover without regard to insurers' claim filing requirements, but that Medicare will not seek recovery after the end of the year following the year that Medicare discovers such claim was mistakenly paid in error (42 C.F.R. 411.24(f)).

Data Match Less Costly Than Data Bank but Also Needs Improvement

The data match program is less costly than the data bank program. For fiscal years 1995 and 1996, HCFA is budgeting $20 million and $18 million, respectively, for data match operation. By comparison, HCFA expects the data bank to cost about $15 million in start-up costs in fiscal years 1994 and 1995 and an additional $25 million to $30 million in annual operating costs for fiscal year 1995 and beyond.

Funding restrictions may place HHS in the position of choosing between the data match or the data bank. In September 1993, HHS informed the Office of Management and Budget that it was unlikely that the data bank could be established without additional administrative funding. HHS requested $15 million in supplemental funding from Congress in fiscal year 1994 for design and implementation activities, but as of April 20, 1994, no additional funding had been approved. HHS officials indicated that without such funding, reprogramming of existing funds may be necessary. While HHS had not yet identified a source for these funds, other Medicare secondary payer activities could be considered a potential source from which to draw.[8]

Development of the data match, however, has not been without its problems. Efforts have so far met with mixed results. On the positive side, under the first data match, HCFA received a high response rate on questionnaires sent to employers. Beginning in December 1992, HCFA sent notices to insurers to collect about $1.5 billion in potential overpayments. HCFA contractors were still receiving responses from insurers as of March 1994, and at that time, had resolved about $263 million of this amount, collecting about $120 million from insurers in the process. On the negative side, this first data match was marked by several problems that limited its effectiveness. Some examples follow:

- The claims for which Medicare was seeking recovery were up to 10 years old. Several insurers told us that they did not keep records that were old enough to verify coverage or payments on a large portion of these claims. As we were completing our work, HCFA was in the process of discussing with insurers approaches for lump sum settlements for these claims.
- About 40 percent of the questionnaires HCFA sent out to employers were for employees that had reported low earnings and, as such, were in a pay status or job position that had a low potential for employer-provided health insurance. Also, because no dollar tolerances were applied to

[8]Implementation of the data bank has already impacted the matching program. A number of HCFA staff who have been assigned data bank responsibilities are the same people responsible for other Medicare secondary payer programs.

recoveries, insurers were asked to refund even very small amounts—sometimes less than $1.

HCFA has made changes to address such problems. For example, it plans to use progressively more current Medicare claims information as data match becomes an ongoing process, which could eventually reduce the age of the claims being recovered to 2 to 3 years. In addition, HCFA has established tolerances for employee income and claim amounts that should substantially reduce the inquiries to employers and insurers.

According to HCFA officials, the data match may also be creating a way to overcome a persistent problem in third-party insurance recovery: the lack of an incentive for primary insurers to pay ahead of Medicare. We have reported in the past that significant Medicare secondary payer savings were not realized because insurers lacked incentives to pay ahead of Medicare.[9] As the data match becomes a systematic recovery activity, insurers should realize that by paying claims immediately, they can avoid the inevitable recovery process. Recovery is more cumbersome and costly to insurers due in large part to the need for researching claims several years later to determine the insurer's liability.[10]

Opportunities Also Available for Strengthening Earlier Identification of Medicare Beneficiaries' Insurance

Efforts such as the proposed data bank and the data match processes focus primarily on recovery of amounts paid in error. This "pay and chase" approach is widely recognized as more costly and less effective than a cost avoidance approach. The more efficient cost avoidance approach seeks to identify the other insurance, bill the insurer, and receive payment prior to billing Medicare as secondary payer. Thus, attention to any improvements that can be made with regard to these cost avoidance activities is important. HCFA has two initiatives in process that are designed to improve its ability in this regard.

- The first initiative involves increased access to Medicare information on beneficiaries that have been identified as having other primary insurance. HCFA has set up procedures to allow hospitals to have electronic access to Medicare's data on beneficiaries' primary health insurance information so that beneficiaries' insurance status can be confirmed at the point of

[9] Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

[10] Insurers told us it is time-consuming and costly to research past claims. Records must often be manually retrieved or reconstructed, and HCFA assesses interest on recovery claims not resolved within 60 days of notification.

service. Hospitals can use this information to more efficiently and correctly bill the primary payer rather than Medicare. HCFA is also studying the possibility of allowing doctors and outpatient providers similar electronic access to patients' insurance information.

- HCFA also has completed plans for a fiscal year 1995 initiative to send a health insurance questionnaire to beneficiaries as they enroll in the Medicare program. This would provide HCFA contractors a more systematic way of identifying whether a beneficiary had primary health insurance before they pay the beneficiary's first claim.

State Medicaid Systems Also Capable of Providing Health Insurance Information

Because Medicaid recoveries from other insurers must generally take place within 1 year, timely up-front identification of Medicaid recipients' insurance coverage is particularly important. Federal regulations prescribe specific cost-effective activities that state Medicaid programs are required to adopt in order to identify and recover from other insurers. These requirements include identifying a recipient's health insurance information at the time Medicaid eligibility is determined and using this information to avoid Medicaid payments when other insurance is available.

Thus far, states have made only limited progress in developing systems that effectively identify other insurance when Medicaid eligibility is determined. In 1991, we reported a significant level of state noncompliance with the regulation calling for development of such systems.[11] HCFA's latest review of state programs, which covered state activities in fiscal year 1992, concluded that despite general improvement, areas remained in which states persistently had not complied with existing federal requirements.

In our 1991 report, we concluded that one reason states had not complied with existing federal requirements to identify mistaken payments and recover from private insurers was that they faced no significant penalty for not doing so. We noted that congressional approval would be needed to broaden HCFA's authority to impose financial penalties. To date, no such action has been taken.

States are also developing the ability to perform data matches that hold potential for improving savings. According to HCFA officials, 25 states are developing the ability to obtain current data through matching activities with insurance companies within their states. For example, New York's Medicaid program has established arrangements with 15 insurance

[11] GAO\HRD-91-60, Apr.11, 1991.

companies to share, through electronic matching, its coverage eligibility information with Medicaid. The state performs these matches quarterly so that a Medicaid recipient's insurance coverage can be kept current. According to state officials, this data match costs about $40,000 but yields savings of about $20 million annually because it enhances Medicaid's ability to avoid paying claims where other insurance is available.

Conclusions

Although reports have shown that the Medicare and Medicaid programs could realize more savings if they had better information on their beneficiaries' employer group health insurance coverage, establishing the OBRA-93 health insurance coverage data bank for this purpose does not appear to be the answer. Existing procedures, with planned improvements and continuing developments, appear to be capable of providing equally useful information at less cost and effort. Over the next 5 years, the data bank would likely require more than $100 million in federal spending to administer and, at least initially, would substantially increase record keeping on the part of both HCFA and the nation's employers. These additional costs could add to the nation's administrative costs for health care without creating significant benefits.

It is also clear, however, that if existing alternatives are to be used in place of the data bank, HCFA must continue to improve them. Medicare's efforts to improve identification and data match recovery efforts are still under development, and state development of Medicaid third-party liability programs has been uneven despite federal requirements to establish such programs. If the Congress decides that implementation of the data bank should be stopped, HCFA needs to ensure that these alternatives are pursued as vigorously as possible. For Medicaid programs, this may require additional authority to impose penalties on states that do not comply.

Recommendation to the Congress

We recommend that the Congress delay the implementation of the Medicare/Medicaid data bank until its potential cost-effectiveness and other benefits to Medicare and Medicaid programs can be clearly shown. The Congress also should

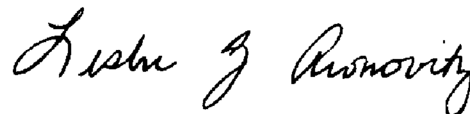
- require the Secretary of HHS to report annually on the status of HCFA's ongoing and planned efforts to improve identification and recovery of claims from other insurers and

- amend Medicaid law by authorizing HCFA to withhold federal matching funds when states do not comply with federal requirements for identification and recovery of claims from other insurers.

As you requested, we did not obtain written comments from HHS on our draft. We did, however, discuss the issues raised in this report with HCFA and HHS management officials and incorporated their comments where appropriate.

We are sending copies of this report to interested congressional committees, the Secretary of Health and Human Services, and other interested parties. We will also make copies available to others on request.

Please call me on (202) 512-7119 if you or your staff have any questions concerning this report. Major contributors to this report are listed in appendix III.



Leslie G. Aronovitz
Associate Director,
Health Care Financing Issues

Scope and Methodology

To determine whether the planned implementation of the data bank strengthens existing Medicare and Medicaid activities for identifying and recovering from other insurers, we did the following:

- We reviewed the requirements of the data bank legislation and its legislative history, including estimates on its anticipated savings. We also interviewed officials at the Office of Management and Budget and at the Congressional Budget Office who were knowledgeable about the origins and eventual passage of the data bank legislation.
- We interviewed HCFA officials responsible for implementing the data bank as well as those responsible for administering the current secondary payer programs for Medicare and Medicaid. We reviewed HHS reports and correspondence on its current and planned MSP activities, including its current resource plan for implementing the data bank. We attended HCFA's two data bank conferences held in January 1994 with employers, insurers, and others interested that discussed data bank's requirements and implementation issues.
- We interviewed Medicaid managers responsible for third-party liability activities in Texas, Washington, New York, and Connecticut, which account for about 25 percent of Medicaid expenditures. We reviewed a HCFA survey that asked 15 states' Medicaid programs to comment on the usefulness of the data bank. We also reviewed previous GAO reports on problems states were having in identifying Medicaid beneficiaries who had other health insurance and on HCFA's ability to enforce federal requirements on state Medicaid programs. We reviewed HCFA most recent review of state third-party liability programs.
- We interviewed representatives of employer associations, including the American Payroll Association, the American Trucking Association, and the ERISA Industry Committee. We also interviewed payroll/benefits managers for 6 employers with from 500 to 44,000 employees about the concerns we heard from employers at the HCFA meetings and from the employer groups. We did not verify their estimates of additional costs of complying with the data collection and record keeping burden imposed by the data bank provision. We also interviewed a number of representatives of insurance industry associations and individual insurers.

We did our work from November 1993 to April 1994 in accordance with generally accepted government auditing standards.

Health Care Financing Administration's IRS/SSA Data Match Process

Step	Description
1	SSA sends listing of all Medicare beneficiaries to the IRS.
2	IRS links together the name and social security number (SSN) of each individual who filed a joint or married filing separate tax return. The file is then returned to SSA.
3	SSA searches by SSN the Master Earnings File to identify either beneficiaries or spouses of beneficiaries that are employed by employers who filed 20 or more W-2 forms. The file is then sent to HCFA.
4	A HCFA contractor sends a "qualifying" mailer to all the identified employers. The mailer is designed to eliminate those employers who have fewer than 20 employees and those who no not offer health plans. At the same time, "larger" employers are sent Electronic Media Questionnaire election forms. This questionnaire is an electronic method of reporting information.
5	A detailed questionnaire is sent to all "qualified" employers. This questionnaire contains the name and SSN of all employees for whom HCFA is requesting information concerning dates of employment and coverage under a group health plan. Each questionnaire is "customized" to reflect the specific situation of each employer and each identified employee.
6	The questionnaire is returned to the data match contractor, who loads the data into the data match system. A Common Working File Medicare Secondary Payer update is created for each period of MSP identified. The employment and group health plan information is loaded into the Common Working File.
7	The confirmed MSP situations are forwarded to the Bureau of Data Management and Strategy. The Bureau searches the claim history database with the Medicare Automated Data Retrieval System (MADRS) to identify potential mistaken payments during periods of MSP.
8	The Bureau sends a mistaken payment report to each contractor who has mistakenly paid, identified from the MADRS search. This information, contained on the mistaken payment report, is loaded onto a tracking system called the Mistaken Payment Recovery Tracking System (MPaRTS).
9	Contractors use the mistaken payment report to search their internal paid claims history files. A total of the mistaken payments, identified from their internal files, is loaded into MPaRTS.
10	Contractors seek to recover mistaken payments from the identified third-party payer.
11	Contractors update MPaRTS to reflect the total amount recovered for each identified MSP case.

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