S. HRG. 99-32

MEDICAID THIRD-PARTY LIABILITY COLLECTIONS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

MARCH 25, 1985

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CONTENTS

ADMINISTRATION WITNESSES

PUBLIC WITNESSES

ADDITIONAL INFORMATION

MEDICAID THIRD PARTY LIABILITY COLLECTIONS

MONDAY, MARCH 25, 1985

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, the Honorable Bob Packwood (chairman) presiding.

Present: Senators Packwood, Durenberger, and Baucus.

[The press release announcing the hearing and the opening statement of Senator Durenberger follows:]

[Press Release No. 85-005]

SENATE COMMITTEE ON FINANCE SCHEDULES HEARING ON THIRD PARTY LIABILITY COLLECTIONS ON MEDICAID

Senator Bob Packwood (R-Oregon), Chairman of the Senate Committee on Finance, announced today the scheduling of a full committee hearing Monday, March 25, 1985, on Medicaid third party liability collections.

The hearing will review the General Accounting Office's February 12, 1985, report "Improved Efficiency Needed to Relieve Medicaid from Paying for Services Covered by Private Insurers."

In addition to GAO officials, testimony will be received from representatives of the Health Care Financing Administration in response to the report.

The hearing is scheduled to begin at 9:30 a.m., Monday March 25, in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman: I congratulate you for calling this hearing to review the GAO's findings on the payment by Medicaid for services covered by private health insurance. This is an appropriate time for examining the GAOs conclusions and other proposals to improve the cost-effectiveness of the Medicaid program. When there are serious proposals to cap the federal contributions to Medicaid, it is vital we find other avenues for constraining Medicaid costs—alternatives which help us reform the program and spend dollars smarter for the poor, rather than simply cut costs to meet budget reduction goals.

The evidence is mounting that the poor are getting sicker. They are becoming a greater burden for health services on state and local governments. I learned in Health Subcommittee hearings last year that judicial precedents are being set which give local governments the ultimate responsibility for the health care of the indigent. Yet local governments are less able to pay for care.

Enhanced competition in the health care marketplace is making hospitals more cost conscious and efficient. But, competition also means that hospitals have less incentive to subsidize the care for the poor in charges to patients who can pay. I feel strongly that such cross subsidies should be ended. However, the poor must still be cared for. We must recognize that the federal government has a responsibility to provide leadership as well as a portion of the resources to assure that quality care for the poor remains available.

The provision of services for the poor must be left to those who can best meet this responsibility—the state and local governments. However, "new federalism" by budget devolution will not enable them to meet their legal and moral responsibilities. We need to encourage them to experiment with Medicaid and care for the poor—to explore better, more cost-effective means to deliver health services for those who cannot pay. However, giving states and local governments freedom to experiment while cutting the funds available to them will not promote program reform or improvement. Instead, it will encourage states to reduce commitments.

The National Conference of State Legislatures reports that five states are considering the establishment of medically needy programs, while seven are considering expanding Medicaid eligibility. In all, fourteen states are considering bills to expand Medicaid eligibility. Medicaid can help close the gap between those in dire poverty and those who cannot afford health insurance coverage. But, capping Medicaid would end this positive movement.

Also, the Medicaid program can effectively respond to new needs. Diminishing gains in the fight against infant mortality cry out for congressional action. Better health prevention can save us dollars but we must invest them up front. I have introduced a bill with my colleague Senator Bentsen to enable states to broaden prenatal benefits to pregnant women. Such reform is critical. We can only reduce infant death by moving kids back from the expensive incubators in neonatal intensive care to the best incubator of all, the mother's womb. Even if this bill passed, capping Medicaid would remove the incentives states might have to offer better benefits to pregnant women.

Medicaid needs further review into its mission. On the one hand it is a medical care program for the poor. On the other, it is a long term care program to the middle class who spend down their resources and the disabled. The program costs of long term care every year eat up more of Medicaid's resources. Between 1973 and 1982 the portion of the Medicaid budget attributed to nursing home care rose from 34% to 43%, while residents of homes represent only seven percent of Medicaid enrollees.

Both the povertized elderly and the disabled deserve appropriate care. The question is, however, is Medicaid the best way to finance the long term care system? Should we drive people to the dole to afford the long term care they need? Should we force the eligibile disabled and the mentally retarded into a welfare program? I think not and I feel strongly that the Finance Committee should take it upon itself to focus on these issues. And, to develop alternative means for the middle class to finance its long term care needs, as well as rationalize what our society does for those disabled who are unable to fend for themselves.

These two points go beyond our task today. But, I, for one, am committed to these issues and am using this as an opportunity to start discussion as we look at Medicaid in the 99th Congress.

The CHAIRMAN. The hearing will come to order, please. We are starting the first of a series of health hearings today with a hearing on third-party liability under Medicaid and, as many in the audience may be aware, there has been an extensive and excellent GAO report. HCFA has views on this subject and will be testifying today, and we have witnesses from different States who have had extensive experience in this subject. It is our hope, as we are looking at different areas of budget cutting, that we can save in the area of Medicaid and perhaps in the area of Medicare without harm to the beneficiaries by tighter enforcement of third-party liability, and it is my hope that, by the time we are done with the hearing today and further hearings on this subject, if necessary, that we may be able to take some action. We will start today with Mr. Michael Zimmerman, who is the Associate Director of the United States GAO, and he will be accompanied by Mr. Thomas Dowdal. Are you ready, Mr. Zimmerman? I would encourage the witnesses to abbreviate their testimony. Fortunately, you were kind enough to have it in so that I could read it over the weekend, and I have read all of your statements in full, and they will be in the record in full, and you do not need to read them verbatim. You

will be limited in your presentation to 5 minutes and the yellow light will go on when you have about a minute left. I would say I have had some experience with Mr. Zimmerman before.

Years ago, he did the first GAO report for me involving a dam in Oregon, slightly different from the subject upon which he has done the report today, but it was an excellent report and provided the information that we wanted to know then. We wanted to know if the dam was worthwhile, and he concluded it wasn't, and we didn't build it.

Mr. Zimmerman?

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. ZIMMERMAN. Thank you, Mr. Chairman. Let me begin first by introducing the people that are here with me today. To my immediate left is Mr. Thomas Dowdal, and to his left is Mr. Frank Pasquier. Mr. Pasquier was in charge of the audit that is the subject of our hearing today. We are pleased to be here today to discuss our February 12, 1985 report entitled "Improved Efforts Needed to Relieve Medicaid from Paying for Services Covered by Private Insurers." By using private insurance resources, Federal and State Medicaid costs can be decreased without reducing Medicaid services. The six States we reviewed were taking some actions to identify liable insurers and to avoid paying claims or collect after paying them. However, while some States were using cost-effective techniques, others were not. Overall, the situation was similar to that existing when we reported on this issue in May 1977. This lack of improvement, combined with HCFA's estimate of $0.5 to $1 billion in Medicaid funds expended annually because insurers do not pay recipient bills leads us to conclude that HCFA needs to take more action in this area.

By law, Medicaid is the payer of last resort. That is, Medicaid is to pay for health care costs only after recipients have used all other health care resources, including available private health or liability insurance. Normally, Medicaid recipients with private health insurance obtain it through their own or their parents' full- or part-time employment. Also, children and families that qualify for AFDC may also be covered under insurance policies of their employed absent parents and liability insurers may be responsible when a Medicaid recipient requires medical services because of an automobile, work or other accident. Medicaid regulations require that States, in administering the program, make all reasonable efforts to identify and collect from liable insurance companies. Because of the large reductions to Medicaid expenditures that could result from better use of recipient insurance coverage, we believe that it is incumbent upon HCFA to assure that States make maximum use of these resources. HCFA has used two different approaches to oversee the States' administration of this aspect of Medicaid—the quality control program and compliance reviews. Neither of these approaches has been very effective in the past. In our 1981 report on the Medicaid Quality Control Program, we recommended that HCFA change its procedures to obtain better data

on erroneous payments resulting from uncollected third-party resources. However, in 1982 HCFA discontinued the portion of the quality control program that calculated uncollected insurance.

Instead, HCFA decided it would rely on the compliance review process to correct weaknesses in State practices. In 1983, HCFA supplemented 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 the regular compliance reviews and represented an improvement over its previous oversight efforts. However, HCFA has not been consistently able to get States to adopt suggested improvements. We believe this occurs because there are no specific regulatory requirements that link Federal financial participation to required State practices for identifying and using Medicaid recipient insurance resources. Without such requirements, the States we visited generally viewed HCFA's suggestions for improving their practices as advisory and often did not adopt them. Our February 12 report recommended that HCFA adopt——

The CHAIRMAN. Let me ask you something there if I can. Why? Why do they regard them as advisory and not adopt them? The suggestions seem to have some merit.

Mr. ZIMMERMAN. Simply because it appears that the States are more apt to react to requirements that are placed in the regulations than something that is not a specific requirement. It has to do with the resources that are available to them; they try to meet the requirements that are set forth first. So, when something is put in an advisory capacity, short of being a specific requirement, there appears to be a tendency on the part of the States not to follow through and implement so-called advisory procedures.

Continuing on. Our February 12 report recommended that HCFA adopt one of two options to improve State practices for identifying and using Medicaid recipient insurance resources. The options involve either strengthening HCFA's regulatory requirements in its compliance review of State programs or using its quality control program to determine the amount of erroneous payments attributable to unrelated health and casualty insurance and denying Federal sharing in such payments exceeding a specific level of performance. Either option should provide HCFA 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 evidenced by the estimates of available but unused insurance, cited in our 1977 and 1985 reports. If HHS implements our recommendation, we believe there are cost effective techniques available to the States to meet the new requirements without resulting in a loss of Federal funding or disruption of the Medicaid program.

The remainder of my statement addresses methods that States can use to improve their collection practices, and rather than getting into them, I would just as soon terminate my statement now and respond to questions you and the other members may have.

[Mr. Zimmerman's prepared written statement follows:]

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

FOR RELEASE ON DELIVERY
EXPECTED AT 9:30 A.M. EST
MONDAY, MARCH 25, 1985

STATEMENT OF MICHAEL ZIMMERMAN

ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON

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

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss efforts to reduce Medicaid costs by identifying and collecting from private health and liability insurance companies when they are legally liable to pay for services received by Medicaid recipients. On February 12, 1985, we issued a report entitled Improved Efforts Needed to Relieve Medicaid from Paying for Services Covered by Private Insurers (GAO/HRD-85-10). To assess state effectiveness in identifying and using available insurance resources, we reviewed state practices in California, Maryland, Oregon, Pennsylvania, Texas, and Washington. These states account for about 23 percent of Medicaid spending. We also did limited work on recovery from liability insurance companies in New York. We discussed the results of our audit work with officials of these states and incorporated their views in our report.

By using third party insurance resources, federal and state Medicaid costs can be decreased without reducing Medicaid services. In June 1983 Health Care Financing Administration (HCFA) officials estimated that between $500 million and more than $1 billion in state and federal Medicaid funds are spent annually because responsible health and liability insurers do not pay Medicaid recipients' medical bills. More than half of this amount would be federal funds. Also, our analysis of Department of Health and Human Services (HHS) survey data on the Medicaid population is consistent with the HCFA estimate. If states had used the available health insurance resources (excluding liability insurance) to pay the medical bills of Medicaid eligibles to the same extent as the non-Medicaid public used their insurance, we estimated that $750 million annually would have been saved in state and federal Medicaid funds.

The states we reviewed were taking some actions to identify liable insurers and to avoid paying claims and/or collect after paying them. However, while some states were using cost effective techniques for identifying or collecting from liable insurers, others were not. Overall the situation was similar to that existing when we reported on this issue in 1977 (see Problems in Carrying Out Medicaid Recovery Programs from Third Parties, HRD-77-73, May 2, 1977). This lack of improvement, combined with HCFA's estimate of unnecessary Medicaid expenditures for which insurers are liable, lead us to conclude that HCFA needs to take more action in this area.

My statement addresses why we believe HCFA should act to assure Medicaid recipients' insurance resources are used before Medicaid. I will also discuss techniques that the states could employ to more effectively use these insurance resources.

THE MEDICAID PROGRAM

The Medicaid program is a federally aided, state-administered medical assistance program that serves about 22 million low-income people. Within broad federal limits, states set the scope of and reimbursement rates for covered medical services and make payments directly to the providers who render the services. Depending on a state's per capita income, the federal government pays from 50 to 78 percent of the state's Medicaid costs. In fiscal year 1984, Medicaid costs totaled $38 billion; with the federal and state shares equally $21 billion and $17 billion, respectively.

By law, Medicaid is the payer of last resort; that is, Medicaid is to pay for health care only after Medicaid recipients have used all other health care resources, including available private health or liability insurance. 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.

Normally, Medicaid recipients with private health insurance obtain it though their own or their parents' full- or part-time employment. Working Medicaid recipients consist of three

groups. These groups contain the working poor who have (1) incomes low enough to qualify for Aid to Families with Dependent Children (AFDC) benefits, (2) incomes below the level needed to pay for their medical costs, or (3) lost their AFDC assistance because the income used to compute their eligibility increased above the maximum but they continue to be Medicaid eligible for the succeeding 4 to 15 months.

Also, children in families that qualify for AFDC may also be covered under insurance policies of their employed absent parents, and liability insurers may be responsible for the medical costs when a Medicaid recipient requires medical services because of an automobile, work, or other accident. Medicaid regulations require that states, in administering the program, take all reasonable efforts to identify and collect from liable insurance companies.

HCFA NEEDS TO STRENGTHEN ITS OVERSIGHT OF STATE PRACTICES

Because of the large reductions to Medicaid expenditures that could result from better use of recipients' insurance coverage, we believe it is incumbent upon HCFA to assure that the states make maximum use of these resources. HCFA's role consists of assuring that states have effective programs for identifying and using available insurance resources. HCFA has used two different approaches to oversee the states' administration of Medicaid--a quality control program and compliance reviews. Neither of these programs has been very effective.

HCFA's quality control program is a coordinated effort by both the state and federal governments to ensure that Medicaid funds go only to recipients who are eligible under federal and state law and claims are paid only for covered services to eligible providers in the correct amount. The program is designed to use statistically projectable samples to measure erroneous Medicaid payments resulting from ineligibility.

States are required to correct past eligibility errors and 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 a 3-percent tolerance level, HCFA recovers from the state the federal share of the erroneous payments for ineligible recipients that exceed that level.

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 process used was not adequate to produce reliable projections of the amount uncollected from insurance.

In a 1981 report on the Medicaid quality control program (GAO/HRD-82-6), we recommended that HCFA change its 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.

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 using the quality control program, it would rely on the compliance review process to correct weaknesses in state practices.

HCFA has used compliance reviews in an effort to improve state performance in identifying and applying insurance resources. According to HCFA, 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.

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 and represented an improvement over its previous oversight efforts. However, HCFA has not consistently been able to get states to adopt suggested improvements. We believe this occurs because there are no specific regulatory requirements that link federal financial participation to required state practices for identifying and using Medicaid recipients' insurance resources. Without such requirements, the states we

visited generally viewed HCFA's suggestions for improving their practices as advisory and often did not adopt them. For example, of the 10 states HCFA reviewed 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 still had not been corrected.

GAO'S RECOMMENDATION TO IMPROVE HCFA'S OVERSIGHT ACTIVITIES

Our February 12 report recommended that the Secretary of HHS 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.

In commenting on our recommendation, 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.

We believe that any approach HHS selects should have specific criteria and result in adequate data to measure whether those criteria are met. Either option we recommended 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 evidenced by the estimates of available but unused insurance coverage cited in GAO's 1977 and 1985 reports.

OPPORTUNITIES TO IMPROVE IDENTIFICATION AND USE OF RECIPIENT INSURANCE RESOURCES ARE AVAILABLE TO THE STATES

If HHS implements our recommendation, we believe that there are cost effective techniques available to the states to meet the new requirements without resulting in a loss of federal funding or disruption of the Medicaid program.

The states we reviewed used various methods for identifying health insurance resources for Medicaid recipients. While Bureau of Census statistics and HHS data estimate that nationwide, about 18 percent of all Medicaid eligibles have a health insurance resource available to them, the number of Medicaid recipients these states identified as having such resources ranged between 3.2 and 9.2 percent.

The remainder of my statement deals with the opportunities we identified for states to improve their practices for assuring that private insurers pay before Medicaid.

IMPROVING IDENTIFICATION OF INSURANCE RESOURCES WHEN DETERMINING MEDICAID ELIGIBILITY

Some of the states we reviewed had better techniques for soliciting information from recipients about insurance coverage when the state determined, or periodically redetermined, program eligibility. These are the primary times when a state has direct contact with recipients. Therefore, they are good times for the states to get information on insurance coverage from the recipients. However, California, Pennsylvania, and Texas asked only general questions about insurance coverage such as "Do you or your family have any of the following insurance coverages: life, burial, medical/health or dental, or mortgage?" There are other questions whose answers can provide better indications that insurance coverage exits.

A case in point is Washington. It once asked recipients only questions similar to those in the states mentioned above but improved its insurance coverage identification rate by incorporating six questions indicative of the presence of insurance coverage. These questions include 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. If a question is answered affirmatively, the caseworker is instructed to follow up to determine whether insurance exists. Between July and December 1983, the first 6 months after Washington revised its eligibility determination form, the number of Medicaid recipients with insurance identified through

the interview process increased 12.6 percent even though the total number of Medicaid recipients decreased 4.9 percent.

Another problem we identified relates to the information obtained if the questions asked the recipients indicate insurance coverage. In these cases, caseworkers need to obtain information on the name of the insurance carrier, coverage dates, and the type of insurance coverage (that is, hospitalization, dental). 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. In California, for example, caseworkers failed to obtain such information for 71 percent of the recipients who said they had health insurance.

Progress has recently been made in identifying insurance coverage for some recipients. In 30 states the Social Security Administration (SSA) currently determines Medicaid eligibility for about 10 percent of the Medicaid population who are Supplemental Security Income (SSI) recipients. During that SSI eligibility process, SSA had not obtained the name and address of the insurance carrier and policy number for those covered by health insurance. Without this information, knowledge of insurance was of little use to the states.

In 1977 we 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 which showed that net annual savings of $69.5 million could be achieved by implementing the project nationwide.

We again proposed in 1984 that SSA provide detailed insurance information on Medicaid/SSI applicants to states in which SSA determines Medicaid eligibility. Effective January 2, 1985, HCFA and SSA agreed to offer the improved data collection services to the states that pay for it. Providing this information to the states should help them assure that insurance companies pay before Medicaid and thereby help reduce Medicaid costs.

MORE COMPUTERIZED DATA MATCHING NEEDED

States can cost effectively increase identification of third party resources by using computerized matching techniques. Two states we visited, Washington and Oregon, had adopted data matching programs that identified three different types of recipients who were likely to have insurance coverage not found through eligibility interviews. One data match program initiated by Washington in February 1982 matches the computerized Medicaid eligibility file with other state data files. This produces employment information on two groups with potential health insurance coverage--employed absent parents whose dependents are Medicaid eligibles and employed Medicaid eligibles. The state then follows up with employers to verify the type and extent of health insurance coverage. Although this match cost only about $33,000 to develop and operate during its first year of operation, it saved an estimated $2.2 million in Medicaid costs by identifying Medicaid recipients with health insurance coverage.

Another program developed by Washington in June 1982 matches 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 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.

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 a cost of about $50,000, it could save approximately $1.3 million annually.

NEED TO IMPROVE LIABILITY INSURANCE IDENTIFICATION

Improvements can be made in identifying liability insurance coverage. In the six reviewed states where information on liability insurance identification practices was available, we

found wide variations in the amount of states' liability collections. California had significantly higher liability collection rates than other states primarily because of two factors. 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. Secondly, 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, Pennsylvania and Texas followed up only on claims involving $1,000 or more.

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

How states elect to use identified insurance resources can also affect Medicaid costs. Most states require health care providers to seek payment from identified health insurers before billing Medicaid. This is known as "cost avoidance." However, 14 states pay providers and then try to recover the money from liable insurers, a method often referred to as "pay and chase." 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.

For example, 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 did not try to recover payments made on pharmacy, home health, and nursing home claims and generally did not seek recovery on claims under $200. 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.

Under a cost avoidance system, states would not experience such problems because providers would be responsible for collecting first from health and no-fault insurers, billing Medicaid only after these resources are exhausted. Administrative costs would also be reduced.

In our May 1977 report, we questioned the wisdom of the pay and chase approach when Medicaid recipients have private health insurance. On June 4, 1984, HHS published proposed regulations related to our 1977 recommendation. The proposed regulations would require 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

for determining when health insurance probably exists.

Because of this discretion, we question 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, 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, if made final, would not direct the state to change its system.

This concludes my prepared statement. We will be happy to answer any questions you may have.

The CHAIRMAN. Let me ask you this, Mr. Zimmerman. Did your study find specific ways to use computer data base matching or other computer-based approaches which might increase third party collections, and do you think we should mandate these approaches?

Mr. ZIMMERMAN. In fact, we did, Mr. Chairman. We focused on three types of matching. One involves matching the Medicaid roles with the child support enforcement program, the second with State unemployment insurance programs, and the third with State payrolls. And in all three cases——

The CHAIRMAN. What was the second one—State?

Mr. ZIMMERMAN. State unemployment insurance programs. In all three cases, we found that the States that were using these matches—particularly Oregon and Washington—were having great success in identifying insurance coverage for the Medicaid beneficiaries. I would have to say that, in this program like in many other welfare programs, computer matching has proven to be quite effective, and I think certain types of matching should be required.

The CHAIRMAN. Now, let me ask you this. Even if this was a recommendation, rather than a requirement, is there any reason why States wouldn't want to computer match?

Mr. ZIMMERMAN. It gets to the situation of the resources that are available to the States in carrying out the program. It would seem logical that a State would want to identify sources of third-party insurance so they could decrease their Medicaid payments, and some States on their own initiative have done it, but our studies show that other States haven't. In fact four of the six States had done very little in the way of matching. Maybe Mr. Pasquier can give us some specific reasons why some of the States have not adopted computer matching.

Mr. PASQUIER. One reason is that oftentimes within a State government the information for matches are kept by different organizations. They might involve the department of motor vehicles or another agency which is outside the control of the agency that is administering the welfare programs. So, oftentimes it is difficult to break down a lot of these intergovernmental or interagency problems within the States.

The CHAIRMAN. You mean they just don't have a big enough cross matched computer, or what?

Mr. DOWDAL. Basically, he is talking about problems between—just like we have in the Federal Government, problems between various agencies within the State. The States have the same kind of problems in getting them to work together on these things. Obviously, it is to the State's advantage from its own standpoint to save Medicaid money, too, because it is saving its own money also, but sometimes these things just happen and the cooperation doesn't occur. And for a number of other reasons—whatever they would be in a particular State—the programs that are effective just don't get implemented.

The CHAIRMAN. I can understand different branches of the State government having their own computer base and maybe even not wanting to share. I mean, that is a natural tendency. We see it at the Federal level and at the State level, but the States surely know this will save themselves money if they do it, don't they?

Mr. DOWDAL. Yes. They should know that. It has been demonstrated for many, many years under the Medicaid Program and the Department of Health and Human Services has held meetings and training sessions with the States, pointing out the advantages of doing these kinds of things, and a number of States still haven't taken the opportunity available to them to reduce Medicaid costs. Sometimes there are legal impediments. For example, although it is not covered in this report, on workmen's compensation there are States where the State agency running Medicaid by law cannot get access to the workmen's compensation files because they are kept under privacy restrictions. And that is another resource that could be used, but some States, by their own laws, are precluded from doing it.

The CHAIRMAN. Tell me what you think of the California system, either one of you who wants to respond, on lawyers handling claims for Medicaid recipients being required to file that information with the State.

Mr. PASQUIER. Out of the States that we looked at, California had the highest rate of liability insurance recoveries. The California legislation that required attorneys representing a Medicaid recipient in liability-related accidents to notify the State was a key element that contributed to this success. According to the State reports, about 41 percent of the liability insurance collections were initially identified because of this requirement. Accordingly——

The CHAIRMAN. Say that again.

Mr. PASQUIER. About 41 percent of all the liability insurance collections were——

The CHAIRMAN. Were identified through the lawyer referral?

Mr. PASQUIER. That is correct.

The CHAIRMAN. Is that simply because California is very litigious? [Laughter.]

Would you find that in any other State, because that is an amazing amount?

Mr. PASQUIER. Their State law is very specific, and the State believes that the lawyers had a high level of compliance with that law, and——

The CHAIRMAN. I can believe the compliance. It is just an amazingly high percentage, that 41 percent of all the third party liability you have discovered in California comes through——

Mr. PASQUIER. This is 41 percent of the liability portion—not the health insurance.

The CHAIRMAN. I understand—the liability. I understand that, but——

Mr. DOWDAL. One reason that may contribute to that high percentage is that California doesn't have a no-fault insurance program for automobile accidents, and therefore there would tend to be more litigation on automobile accidents than in a State that has a no-fault program, you know, where the insurance covers regardless of fault up to a specified amount.

Mr. PASQUIER. So, in summary, we believe that the California law is effective and would increase liability recoveries in other States if they would adopt a similar provision. However, we did not cite it as a practice that HCFA should require because it concerns a procedure for handling private civil actions, and these procedures

are normally legislated at the State level, and not at the Federal level.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. Following up on Bob's question I wanted to ask you what kind of profile information do you have on people with other coverage? I mean, there is quite a large population—23 million folks out there that are in this Medicaid area, and in that number is a very large and growing number of disabled persons. It has within it the ICFMR population, I take it, which obviously is one of the figures that has grown—by 700 percent in dollars. It has in it the large number of poor elderly even though, the number is getting small. They are consuming an incredible amount of resources as they, in effect, povertize themselves in order to move from one program to the other. We then have the families. We have the subjects that we have dealt with a lot in this committee—children born into the FDC homes, and the problems of the liability of the father and what the insurance status of the father or the insurance status of the mother is. It is somewhat difficult to make clear assumptions about where the problems are unless you think about it in terms of the kinds of people who fall into these other insurance categories. And that might clue us into not only where to put the pressure, but also where to insist that continuity under insurance programs be part of our legislative mandate. Mike, can you help us?

Mr. ZIMMERMAN. Senator, the working poor is a category that most likely would have a high percentage of insurance through their employment, and the SSI population, a fair number of them are apt to have some type of health insurance. And the absent parents are apt to be working, and in a number of instances they are obligated to pay the health costs of their dependent children. So, there are certain segments. I would think a person who is in a nursing home might not be—an aged person in a nursing home—might not be the category that would be one that would be most apt to have health insurance.

Senator DURENBERGER. I apologize for not having read your report. Have you profiled by specific population the people that you are telling us we are not collecting money from?

Mr. ZIMMERMAN. I think maybe Mr. Pasquier might have some specific information on that.

Mr. PASQUIER. Generally, we use two data sources, the Census information and health statistics that were compiled by HHS. And both those data show that about 18 percent of the Medicaid population have some form of health insurance resources. This is in addition to any liability insurance that may exist as a result of an accident.

Senator DURENBERGER. You didn't just take that and then reduce it to some figure, did you?

Mr. PASQUIER. No. No, we did not include in our report a break down by type of Medicaid recipient. Also, getting back to the working poor situation, under Federal law, if a person loses his AFDC eligibility, they can still remain on Medicaid for a period currently anywhere from 4 to 15 months after the person is off cash assistance. And so, these people would be likely to be working and, as such, could have insurance resources.

Mr. DOWDAL. Those provisions were put in so there wouldn't be a disincentive to obtaining work because sometimes your employer furnished insurance doesn't necessarily start the day you start working. You may have to work for several months, and that is what those continued Medicaid eligibility provisions were for.

Senator DURENBERGER. I am glad that the chairman focused this hearing around this particular subject, but I think it also would be helpful to us (if the information is available to you) if you gave us this kind of population profile because that might give us some other clues about where to put the pressure.

Mr. DOWDAL. I think that the number of people who have insurance through regular health insurance that are Medicaid eligible are primarily going to be people who are the working poor. There are not going to be very many in the other categories—single head of household without an absent spouse or aged poor are probably not going to have private health insurance. It is going to be mainly in the working AFDC families.2

Senator DURENBERGER. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Zimmerman, this problem of Medicaid overpayments is not a new problem, is it?

Mr. ZIMMERMAN. No, it isn't, sir. In fact, this particular problem goes back a while.

Senator BAUCUS. That is correct. I recall that as long ago as 1969, HCFA and other agencies were saying that this is going to be a big problem here. As I recall, too, in 1977 GAO came out with a report that had virtually the same conclusions. And my question is: What assurance do you have that this time anything is going to be different? Are we going to be back here 5 or 6 years from now with the same conclusions from GAO, a new report discussing the same problems?

Mr. ZIMMERMAN. I wish I could forecast ahead and say that that won't happen, Senator. Right now, we don't have any assurance unless HHS takes action or the Congress requires that HHS take that action. Other than that, we can't guarantee that they will do it. They have responded to our recommendations. They say they are coming up with a plan of action. It may or may not work. It remains to be seen, what they will actually come up with.

Senator BAUCUS. Based on what you have seen, do you think that their follow-up statements will be sufficient? Do you think that the actions that they say they are going to take will be sufficient?

Mr. ZIMMERMAN. I am not that sure. We have some reservations about what they are planning on doing, but let me add that anything in the way of improvement would be better than the situation that we have right now. We think more can be done. I understand HHS has a couple of proposals they are still thinking through. I think they will be an improvement over the situation that exists now. I am not sure unless I see those proposals spelled out in detail, along with just how they are going to do it, as to whether in fact they will make the total difference.

Senator BAUCUS. With the big Federal budget deficits, why do you think that they have taken so long? Why haven't they done more in the last 2 or 3 years?

Mr. ZIMMERMAN. I guess I would have to say there are a couple of reasons. Traditionally, not just this administration—others as well—have viewed the Medicaid Program as a partnership arrangement between the Federal Government and the States, and the Federal agency has relied to a large degree on the States taking the initiative. However, as you say, in the budget situation we are faced with today, it seems to me that the Federal Government has to insist on more management and oversight on its part to address these budget deficiencies.

Senator BAUCUS. You, in your report, didn't recommend any new legislation, did you?

Mr. ZIMMERMAN. No; we did not.

Senator BAUCUS. Do you still today believe that no new legislation is required?

Mr. ZIMMERMAN. We don't necessarily think it is required. Obviously, if legislation was in place that mandated certain things, that would make the job easier for HHS to get done. We viewed it more from a regulatory approach. Nevertheless, legislation would make the job easier, I am quite sure, for HHS, and I think they have indicated their preference if a regulatory approach is taken to go the legislative route.

Senator BAUCUS. Thank you very much.

The CHAIRMAN. How much do you find that the States know about each other's good practices?

Mr. ZIMMERMAN. I think, for the most part, the States that want to know what is going on are finding out. I think in this area HHS has been more effective than they were in the past. They have conducted various activities to make sure that good practices are being made available to other States, and States' experiences are being shared. So, I think in this sense, HHS has done in recent times more than they had done in the past.

The CHAIRMAN. You are very cautious in your answer, and justifiably, but I sense that you are saying that some States just don't want to know. And earlier on when I was asking about States with different computers and matching up their own computers, you said, well, those that want to do.

Mr. ZIMMERMAN. That is correct.

The CHAIRMAN. Some, for whatever reason, just don't want to, I take it?

Mr. ZIMMERMAN. That is correct. It could be problems with the provider community. It could be problems with the insurance community in the State. There are various pressures that exist at a State level that influence State decisions. That is why sometimes it is important for the Federal Government to view it from its perspective and require certain things be done, and not just rely on the States to take the initiative. And I think in this case it is a case where the Federal Government has a good opportunity to take the lead and specify what is the appropriate course of action.

The CHAIRMAN. And you actually find a rather wide variance among the States?

Mr. ZIMMERMAN. There seems to be, in the results that are being achieved and the approaches that are being used, and the commitment on the part of the State government to pursue the issues. It does seem to vary extensively, and that is the reason why we think

the Federal Government has to jump in and provide more leadership.

The CHAIRMAN. I am always ambivalent about that. I hate to think we have to jump in with more regulations, but what you are saying is cajoling and information swapping and suggestions just may not work.

Mr. ZIMMERMAN. That is about it, Senator. We have been working on the subject now for at least 8 years, and I think the time has come for some more specific actions to be taken.

The CHAIRMAN. Do you have any more questions?

Senator DURENBERGER. No, Mr. Chairman.

The CHAIRMAN. Max?

Senator BAUCUS. No further questions, Mr. Chairman.

The CHAIRMAN. Gentlemen, no more questions. Thank you very much. Now, we will take Mr. James Scott, the Acting Deputy Administrator of the Health Care Financing Administration, and accompanied by Mary S. Kenesson, the Director of the Bureau of Quality Control of HCFA. Good morning.

STATEMENT OF JAMES L. SCOTT, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. SCOTT. Good morning, Mr. Chairman.

The CHAIRMAN. Mr. Scott, your entire statement will be in the record, and if you would abbreviate it, we would appreciate it.

Mr. SCOTT. Sir, I will certainly be pleased to do that. I am here to discuss our views on third party liability collection efforts under Medicaid, and as you noted, accompanying me is Mary Kenesson, who is the Director of our Bureau of Quality Control. Since the GAO witnesses did an excellent job of outlining the background and the history on this issue, I would, in the interest of brevity, like to move directly to that portion of my testimony which relates to the current initiatives that we have under way.

The issuance of this GAO report coincides with HCFA's plans to embark upon intensified efforts to improve TPL collections. Through our past efforts, we have improved our knowledge base such that we are now proceeding to implement a program that incorporates both of the GAO recommended options, and we think in some ways goes beyond them. We have launched a three-pronged approach that includes strengthening the regulations and a targeted QC-type program. Our approach involves measures to, No. 1, continue to provide incentives and technical assistance to the States to improve their performance and, No. 2, to impose additional regulatory requirements and to take punitive measures, including financial disallowances, for deficient programs, and No. 3, to continue to strengthen Federal oversight. I would like to describe just very briefly, if I could, what we mean in each of those three general areas.

Under our technical assistance approach, we have issued to the States an updated version of the TPL successful practices guide, which was developed as a joint effort between HCFA and the States. This guide contains over 80 descriptions of successful State practices that have been used. We have developed and made avail-

able to the States this year a systems design document which offers an automated means of processing TPL claims through the Medicaid management information systems. We have also launched a project with the Social Security Administration to have SSA field offices collect more detailed information on possible alternative health insurance resources for SSI applicants. Under our approach requiring additional regulations, we have initiated a new pilot program in fiscal year 1985 to recover misspent funds through a series of TPL audits. This program will audit those States with initial poor indicators of TPL performance. The pilot audits in 1985 will produce disallowances based on actual erroneous payments. This targeted TPL audit is a more aggressive approach than we have used in the past. It is like the general quality control program, but rather than being uniform across all States, it allows us to invest our resources more prudently by concentrating on the weakest third party programs rather than on an across-the-board review. We have also moved to strengthen our TPL regulations. A notice of proposed rulemaking was published in the Federal Register on June 4, 1984, which would require a State to use the cost avoidance procedure as opposed to the pay-and-chase method. We expect the final regulations on this to be issued in the very near future. Regulations are now in the final review process within the Department which will require State agencies administering the aid to Families with Dependent Children program to work with the State Child Support Enforcement Agency to become more aggressive in requiring medical support from absent parents. Again, we expect to publish these regulations in final version this summer. And finally, on March 14 of this year, our agency in conjunction with the Department of Agriculture, which administers the Food Stamp program, and the Department of Labor published a regulation on income and eligibility that will be requiring significant data matches for persons at the time of initial eligibility determination or reverification of eligibility. Mr. Chairman, we will continue very strong oversight of the State activities in these areas to ensure that maximum savings are being achieved. In conclusion, we recognize that the potential substantial savings from a successful TPL recovery program have yet to be fully realized. Our expanded activities to increase cost effective Federal oversight, recover misspent Federal funds, and increase State accountability for more aggressive TPL management should substantially increase Medicaid savings. We thank you, Mr. Chairman, for the opportunity to present the Department's views, and we are prepared to answer your questions, sir.

[Mr. Scott's prepared written statement follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

JAMES L. SCOTT

ACTING DEPUTY ADMINISTRATOR

OF THE HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

MARCH 25, 1985

Mr. Chairman, I am pleased to be here to discuss our views on third party liability (TPL) collection efforts under Medicaid. Accompanying me today is Mary Kenesson, Director of our Bureau of Quality Control.

The law requires that Medicaid be the payer of last resort for claims of medical assistance for its recipients. Faced with a large Federal deficit, it is incumbent upon us to utilize every tool at our disposal to reduce this deficit while providing health care to Medicaid recipients. Increasing collections from third parties for medical services provided to Medicaid eligibles holds great potential for significant cost savings to both the Federal government and the States. We have been agressively pursuing improvements in TPL in the States, and we are pleased that GAO has highlighted this important issue.

BACKGROUND

Medicaid is not supposed to pay for health care costs if a private insurer or other third party is responsible for those costs. Medicaid recipients sometimes have other health care resources which may be available for paying a beneficiary's medical costs. Types of third party liability include private health insurance policies; medical support

from an absent parent; automobile insurance policies in States with "no fault" insurance; court judgements or settlements with a liability insurer; State's Workmen's Compensation; or other Federal programs.

State and local Medicaid agencies are required by both statute and regulations to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services furnished to recipients. When a third party liability is found to exist after Medicaid has paid for services, the State is required to seek reimbursement to the extent of such liability. States cannot claim Federal matching funds when they have not taken reasonable measures to identify, pursue, or recover available third party payments.

States must require Medicaid applicants to assign to the State their rights to any medical support or other payments for medical care, and to cooperate with the State in establishing paternity and obtaining third party payments as a condition of eligibility.

States use various means for identifying and pursuing TPL collections. At the time of application and redetermination of Medicaid eligibility, the caseworker asks if any other health insurance is available to the recipient. In those

States that rely on the Social Security Administration (SSA) for determining Medicaid eligibility concurrently with Supplemental Security Income (SSI) eligibility, they have the opportunity to purchase limited information from SSA on the availability of alternative health care coverage.

Another alternative for identification is data matching. A number of States utilize data matching techniques to cross reference Medicaid eligibility files with State data sources such as Child Support Enforcement programs' files; state-administered unemployment insurance data; and personnel records of state employees.

States currently use two methods to handle claims that involve third party liability. Under the cost avoidance method, States do not pay claims that are the responsibility of third parties but require providers to bill the liable third parties directly. States do not reimburse providers for claims until they are reasonably assured that the resources of the responsible third parties have been exhausted. In the pay and chase approach, States pay the entire claim for services provided to Medicaid recipients and subsequently seek reimbursement from the liable third party.

Program experience has indicated that it is more cost effective for States to use the cost avoidance approach. Using this approach results in savings from administrative costs such as personnel and other resources which are needed to administer the filing of claims with third party payers and resulting receivable systems. Currently, 37 States use the cost avoidance method of handling claims.

ONGOING ACTIVITIES

For a number of years, we have been attempting to improve State performances in identifying and applying available third party insurance. We have been committed to strengthening the States' capacity in this area and have been incrementally building an intensified effort as our experience and knowledge have grown.

The primary means of encouraging increased TPL activities had been through our annual compliance reviews. HCFA conducts annual assessments of various facets of State Medicaid program operations. Over the past two years, all but six States have been reviewed regarding their TPL recovery programs. We work with the States to correct problems uncovered during the assessments and to generally improve State Medicaid operations.

In FY 83, HCFA launched a more aggressive operational initiative to assess and encourage effective State third party liability practices. We focused intensive program assessments on 20 States with known problems in TPL. We recommended better ways to identify and use recipient insurance resources. The operational initiatives of FY 83 which were continued in FY 84 helped us assess and encourage effective State TPL practices but they lacked meaningful enforcement mechanisms to require State improvement. However, the experience and information gained from these intensive TPL assessments have provided us with important tools with which to construct current and future TPL activities.

Last month, GAO issued its study of Federal and State efforts "...To Relieve Medicaid From Paying For Services Covered By Private Insurers." The study found that:

- Identification of private insurance coverage resources of Medicaid recipients needs improvement;
- SSA could help States better identify Medicaid recipient insurance resources;
- States need to improve practices for applying insurance resources; and
- HCFA needs to strengthen its oversight of State practices.

The GAO report concluded that HCFA should 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 (QC) 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.

INTENSIFIED ACTIVITIES

The issuance of this report coincides with HCFA's plans to embark upon intensified efforts to improve TPL collections. Through our past efforts, we have so improved our knowledge base that we are now proceeding to implement a program that incorporates both of the GAO recommended options, and also goes substantially beyond them. We have launched a three-pronged approach that includes strengthened regulations and a targeted QC-type program. Our approach involves measures to:

- Provide incentives and technical assistance to the States to improve performance;
- Impose additional requirements and take punitive measures, including financial disallowances, for deficient performance; and

- Strengthen Federal oversight.

Under our technical assistance approach:

- We have issued to the States the "TPL Successful Practices Guide" which was developed as a joint effort between HCFA and the States. The guide contains descriptions of successful State practices including cost avoidance, recovery, legislation, and identification of resources, communications, and training.

- We have developed and made available to the States in FY 84 a systems design document which offers an automated means for processing TPL claims through the Medicaid MMIS system.

- We have launched a project with SSA to have SSA field offices collect more detailed information on possible alternative health insurance resources for SSI applicants. This increased information would be available to the 31 States and the District of Columbia which have agreements with the SSA to determine Medicaid eligibility of SSI applicants. Implementation of the SSA Data Collection Service will begin on April 1, 1985 in 16 States, with most of the others following soon thereafter.

Under our approach involving additional requirements and punitive measures:

- We have initiated a new pilot program in FY 85 to recover misspent funds through a series of TPL audits. The program, referred to as TRACE (Third Party Recovery Audit Coordinated Effort), will audit those States with initial indicators of poor TPL performance. TRACE will target specific areas where TPL resources are often unidentified or unused. The pilot audits in FY 85 will produce disallowances based on actual erroneous payments discovered. We will use the findings of the pilot program to establish the statistical requirements for future audits. After FY 85, we intend to develop error rates from the audit sample and project to the universe from which the sample was drawn.

  The targeted TPL audit is a more aggressive approach than we have used in the past. It is like a quality control approach but rather than being uniform across all States, it allows us to invest our resources more prudently by concentrating on the weakest third party programs rather than on an across-the-board review. We will also contract with a private firm to work along with HCFA staff in conducting a comprehensive TPL audit program.

- We have also strengthed TPL regulations
  - A notice of proposed rulemaking was published in the Federal Register on June 4, 1984 which would require a State to use cost avoidance procedures unless it is granted a waiver because it can conclusively prove that its current method of payment is as cost effective. Final regulations are currently in the Departmental clearance process.
  - Regulations are in the final review process which will require State agencies administering the Aid to Families with Dependent Children program to work with the State Child Support Enforcement agency to become more aggressive in requiring medical support from absent parents. The Secretary is personally committed to seeing this implemented.

Under our oversight role:

- We will inventory State TPL programs; and
- We will collect State data on TPL performance through a revised quarterly expenditure statement which will refine reporting of dollar savings and permit annual monitoring of third party collection activities.

As you know, as part of the President's FY 86 budget, we are proposing to limit Federal Medicaid spending. We would expect States to become more aggressive in TPL collections under such a limit.

CONCLUSION

We recognize that the potentially substantial savings from successful TPL recovery programs have yet to be fully realized. About $500 million in total program monies could be recovered. Initiatives already underway will be the foundation upon which the new efforts I have outlined will be implemented. Our expanded activities to increase cost-effective Federal oversight, recover misspent Medicaid funds, and increase State accountability for more aggressive TPL management should substantially increase Medicaid savings. Some of these activities will meet with State resistance, but the magnitude of the potential savings makes it imperative that we move quickly and efficiently to end the drain on Federal and States' budgets from Medicaid claims which are not being paid by liable third parties.

Thank you for the opportunity to share the Department's views with the Committee. I will be glad to answer any questions you may have.

The CHAIRMAN. What do you think about GAO's statement that persuasion, cajoling, information swapping just isn't going to work and you are going to have to impose more regulations?

Mr. SCOTT. Unfortunately, Senator, we would have to be inclined to agree. Our initial efforts have been very much on the supporting and providing information approach. The successful practices guide, that I mentioned earlier, the 1985 version, is the third version. We had a thin document in 1977, and a little thicker one in 1979, and have come forward with a——

The CHAIRMAN. A thicker one yet.

Mr. SCOTT. A bigger one yet. Clearly, as the GAO has indicated, some States have done a very fine job. Others have not done such a fine job. That is why at this time you have seen us move beyond the cajoling phase and have three separate pieces of regulatory activity in place.

The CHAIRMAN. Now, why do you find the wide differences in terms of acceptance of the suggestions among the States? I would assume with a very few States—that the bulk of the States have roughly the same third party liability problem in the sense of a base to work on. Why are some so much better at it than others in collecting?

Mr. SCOTT. Mr. Chairman, they may not have the same base. That could depend a lot upon how the Medicaid Program is structured in an individual State. It could depend upon the kind of industry that is there. It would be—I just don't think we can safely assume that the base is going to be exactly the same, although the disparity that we see in the numbers certainly appears to me to be greater than what you could explain away with just what differences in the kind of Medicaid programs or economies of different States have.

The CHAIRMAN. But why is this difference, in your judgment? Why are some States more willing than others to undertake voluntarily a program which would seem to be in their benefit?

Mr. SCOTT. That is a question that has perplexed us as much as it is perplexing you and has perplexed the General Accounting Office. We, I think, like the GAO have been always of the opinion that the TPL recoveries are, first of all, good for the States because they save State money. In Medicaid, we only match what the States are initially inclined to spend. Mr. Chairman, I just don't really have a good answer on why some States are not doing it as well as others.

The CHAIRMAN. What kind of third party liability procedures do you have in effect for Medicare, and is there any analogy to what you could do with Medicaid?

Mr. SCOTT. Mr. Chairman, the programs are quite different. Medicaid is, by statute, the payer of last resort. Medicare is the primary payer unless specifically exempted. And on Medicare, our primary area of third-party liability has come about through the working aged provisions that the Congress provided——

The CHAIRMAN. Through the what?

Mr. SCOTT. The working aged provisions that the Congress provided for in the TEFRA legislation. We think this is one of the most fruitful areas for Medicare cost savings that we have available. We learned a lot from the Medicaid experience, to be perfectly frank. We started off with some limited money in our 1985 con-

tractor budget, and as we get into it we are seeing rates of return of about 22 to 23 to 1 for every dollar that was invested. So, we are for the first time in many years going to be seeking money out of our Medicare contractor contingency fund for the rest of this year to beef up additional third-party liability initiatives, and, although our contractor budget for 1986 is essentially flat for third-party liability initiatives, we are asking for almost a 50-percent increase in savings. We think there is an enormous potential there and one that we are going to continue to go after very aggressively until we see those rates of return start to fall.

The CHAIRMAN. Let me ask your judgment. In your statement you estimate about $500 million in uncollected third-party liability money, of which about $270 would be a Federal match. How much of that do you think your suggestions realistically will collect?

Mr. SCOTT. We think we have a pretty good opportunity, Mr. Chairman, in 1986 to collect quite a bit of that, especially if the regulations are published on time. The actuaries have estimated that the child support enforcement regulations, which has Medicaid savings, will yield almost $100 million in savings for us. The income and eligibility regulation will have some savings with it, and the SSI project where at the time of the SSI determination, Medicaid determination of eligibility is also made, will pick up about $35 million. So, we think we can be very close to that just based on the regulatory initiatives, and that does not factor in what savings we might achieve with the actual audits. And it is hard to estimate in advance what audit savings would be.

The CHAIRMAN. David?

Senator DURENBERGER. Back to the chairman's previous question. Isn't there something in Medicare as secondary that would help us answer this question? You said they are different, and you are getting lots of success with the TEFRA provisions. But how are they so different other than that you have control down here on the Medicare side in the 50-plus people? Why couldn't you set up some regulations and tell them this is the way they have to implement them?

Mr. SCOTT. Although the programs are different, Senator Durenberger, I guess many of the techniques are the same. The data match technique that the income and eligibility regulation will speak to for the means-tested programs is something that we are very anxiously exploring with our Medicare contractors on a pilot basis. The use of the ambulance and trauma codes—which is a way to get off of the claims forms coming in, people who are likely to have no-fault auto insurance—is a technique that is equally useful for both the Medicare and Medicaid programs. So, there are many of those kinds of techniques that are useful in different programs.

Senator DURENBERGER. What about the new provisions on child support enforcement? You made some reference to the fact that you think that will pick us up—what did you say?—$100 million or so?

Mr. SCOTT. That was the estimate the actuaries gave, yes, sir.

Senator DURENBERGER. Tell us exactly how it is going to pick up that kind of money.

Mr. SCOTT. I am going to let Ms. Kenesson go into the specifics of that regulation.

Ms. KENESSON. The new child enforcement regulation would require a lot more aggressive action at the time that the absent parent is dealt with in terms of his liability to support and——

Senator DURENBERGER. We know that in general. I want you to get down to the health issue.

Ms. KENESSON. It would require that the child enforcement agency include identification of third party liability data and transmit that to the State medicaid agency, at the time the support order was initiated. It would require that there be from the child support enforcement agency a petition for health insurance support for those Medicaid-eligible dependents as well as financial support. It would require the child support enforcement agency to seek and enforce availability of health insurance at any time that the support order was changed or a new order issued.

Senator DURENBERGER. I know that personally because one of the last responses we had from GAO about why we don't pass information around. I think they indicated appropriately that there are some agencies within the State governments which by law don't have to pass information around. They cited workers' compensation as one, but I take it in just the way we set up the authorizing legislation for reimbursement under unemployment compensation or some of these other programs, we might also be able to facilitate the access to information problem that exists in some States.

Ms. KENESSON. And the new income and eligibility regulation does require States to do audited data matching of the State agencies', as well as Federal agencies' data files. The proposed regulation on that which was published on March 14.

Senator DURENBERGER. Are there regulations then, or do we have some Federal authority over the States to account for the moneys—or one State can say "you can't have our information." Are there any stumbling blocks left there?

Ms. KENESSON. I suppose that there may be in individual States with the nuances of their own particular State laws and that particular disparity is the reason for this new legislation and the new regulation about income and eligibility, to mandate data matches with at least key agencies.

Senator DURENBERGER. All right. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Scott, what assurance can you give us that we won't be back here a few years from now discussing the same subject?

Mr. SCOTT. Three States have had very definitive sets of regulations. I will admit that they are notices of proposed rulemaking, but they are in the process of being finalized. Those three sets of regulations will provide the first, I think, very significant regulatory framework within which to address this problem. As the GAO has pointed out to you, I think administrations have been reluctant to be too heavyhanded with the States. The past administrations and our early attempts were based more on the best practices through the sharing of ideas; I think it is safe to say that we have reached the point, where given the size of the Federal deficit, as you indicated earlier, that those approaches are not going to work. The mandatory data match, the tie-in with the absent fathers—I think these things in a regulatory fashion are going to give us a

much better, much stronger regulatory basis. If not, we will be back.

Senator BAUCUS. Why hasn't the Department acted sooner on this?

Mr. SCOTT. I think, again, it comes back to the basic structure of the Medicaid Program. We have tried and continue to desire to leave the basic management and the initiatives in the Medicaid Program up to the States. We match what State legislators and State governments are willing to spend. We provide some guidance to them. Unfortunately, in this area, it has not always been successful. Some States have excellent TPL Programs. Some have not, and we have just simply reached the point in which that variation across State lines is not one that we can continue to live with.

Senator BAUCUS. Have you attempted any fiscal sanctions?

Mr. SCOTT. We had in place at one time a quality control program, like our Medicaid eligibility quality control program. That program did not yield us the kind of results that we wanted. It just wasn't giving us the kind of information that would lead us to be comfortable with taking sanctions. And so, we have eliminated the administration of that and are coming back now with this Targeted Audit Program. We have been using the concept of targeted audits since 1981, where we pick areas in the Medicaid Program and through our financial management guides go after States very aggressively. And that program has yielded $1.5 million worth of disallowances or savings to the Medicaid Program. And what we would be doing in the TPL audits would be taking that one step further. We would use that same kind of expertise to do the TPL audits to take disallowances and to hopefully establish a base for fiscal year 1986 to take even larger disallowances by extrapolating from a sample.

Senator BAUCUS. But what are we going to do in those situations where a smaller State—that is a more thinly populated State—has to pay quite a bit for these SSI computer tapes that show which people may have private health or casualty insurance? For these States the tapes don't show that a large number of people have insurance and the cost of the tapes is so much more than the benefits gained.

Ms. KENESSON. We would expect each State to make a prudent decision based on the cost of analysis. If the State could show that it would not be cost effective to purchase that information from Social Security, there is currently no requirement that they do so. We are considering——

Senator BAUCUS. Are you looking at ways to get those costs down somehow?

Ms. KENESSON. The pilot project that the Health Care Financing Administration conducted indicated that, in all the States where it was tested, it was cost effective. I would expect that for all systems, particularly data-matching systems, that there may be some savings in the operating costs, but I would also expect that, except for the very smallest States or States with very limited SSI enrollment for whatever reason, that it would prove to be sufficiently cost effective.

Senator BAUCUS. When are your regulations going to be in final form? As I understand it, some of these regulations were proposed back on June 4.

Mr. SCOTT. We are hoping for two of them to be in final form, this summer. And those are the ones——

Senator BAUCUS. Summer? Why does it take so long?

Mr. SCOTT. If I had the answer to that, I wouldn't be laboring [laughter]——

Senator BAUCUS. But what is the answer?

Mr. SCOTT. The process of writing regulations, I think, takes longer than any——

Senator BAUCUS. Where is the hangup?

Mr. SCOTT. A lot of the hangup is that the issues are very complicated. They are always much more complicated than we think when we send out the notice of proposed rulemaking. Even sometimes if they aren't complicated, they are made to appear complicated because there are 2,000 trade associations in this town and many people who make livings making issues look complicated. So, by the time you take a very complicated subject and you put it out for public comment, everybody looks at the issue from a variety of different ways. The comments come back in. The trade associations—although I made a joke, I came from that business and have a great deal of respect for their contributions—many members of this body and the body just down the way have a lot of comments and viewpoints that they would like for us to consider. And the balancing act that is required to sift through all of that and come out with a final product that——

Senator BAUCUS. I understand that. My time is up. I know that simplicity and equity often are the enemies of each other. For example, because of the effort to make the Tax Code more equitable has become too complicated. There are various opinions on that, but I think most Americans think it is too complicated. And I would say that I think there is a tendency for regulatory agencies in this town to write regulations that are too complicated. And I encourage you to err more on the side of simplicity and not on the side of complicity. [Laughter.]

Mr. SCOTT. I have to read all these regulations. I would prefer that they be as simple as possible myself.

Senator BAUCUS. Thank you very much.

The CHAIRMAN. In your testimony, you indicated you intended to use disallowances if you can as part of your quality control. Do you have sufficient legislative authority now to do that?

Mr. SCOTT. We believe that we have what we need right now, Senator.

The CHAIRMAN. You also indicated in your statement that HCFA has made a system design available to the States that provides an automated means of processing third-party liability claims through the Medicaid management information system. Do you know how many States have taken advantage of that?

Mr. SCOTT. To date, four States have asked us for the 90-percent funding to do that. The estimate that we have is that the number of States that possibly will be asking will be in the 15 to 20 range. The best practices guide that Mary held up contained many items where States had put systems designs like this into place on their

own, without waiting for us, because they just found it to be cost effective.

The CHAIRMAN. How long ago did you recommend to the States this process?

Mr. SCOTT. Can you answer that question?

Ms. KENESSON. It was last year. When the general systems design was finally completed and released as a package to the States, it went to all the States. It had been under development for some time before that, and it took a while because, as with other aspects again, the development was done in conjunction with the States' technical advisory groups, making an effort to assure that they would be satisfied with the final product.

The CHAIRMAN. Now, let me ask you this in terms of mandating them. Could you mandate collections of insurance and third-party data through your current Medicaid management information system regulations, and what do you think of the approach if you are not doing it at the moment?

Mr. SCOTT. The current set of mandating——

The CHAIRMAN. I am coming back to this mandating versus suggestions, and even your comments about—you are sort of shaking your head—and we can suggest and suggest and suggest, but you can only lead the horse so far.

Mr. SCOTT. The three sets of regulations that have been published as notices and will soon be coming out in final should get us a long way toward the final goal. The answer to your question, Mr. Chairman, I think will have to wait until we see how successful we have been with these three sets of regulations. If after those are in place and States are operating within those kinds of regulatory frameworks, the GAO does additional work and then we do additional work, we will have to decide then if more regulations are needed, or if we have struck the right balance between regulations and incentives.

The CHAIRMAN. Were you going to add something to that? You started to respond.

Ms. KENESSON. I think the audits that we are going to be doing this year are going to tell us a lot about the extent to which regulations will be necessary. They will tell us about the kinds of data matches that will be effective. We will be using data matches in our audits. And if we find that the most cost-effective audit approaches are the data matches and will pay off for the Government, I think consequently they will pay off for the States.

The CHAIRMAN. What do you think of California's attorney referral approach?

Mr. SCOTT. This is an area in the TPL, Mr. Chairman—we like to look at everything. And like the GAO people, we think it has some merit. One of the things we haven't talked about today is that now that we have this best practices guide, we are going to have a major national conference with all of the States on TPL best practices in June of this year. The California approach with its lawyers referral requirement is one of the topics that we are certainly going to want to discuss. I think Iowa is doing something similar to California, and we want to hear very much what the other States have to say. I think we, like GAO, have been reluctant to step into that arena because that is an area of regulation that States have

handled and there are States that have not been involved in it. But we are looking forward to a very open discussion on that issue with all of the States at this June conference, and I think we will know better then.

The CHAIRMAN. For every $1 that Medicaid does pay, where there would be a third-party liable, that is $1 saved for the third party, I assume, if they can get Medicaid to pay it.

Mr. SCOTT. That is correct.

The CHAIRMAN. What attitude does the insurance industry take, especially at the State legislative level, toward appropriations or efforts that might be made in the legislature to get these collections?

Mr. SCOTT. I am sure there are going to be 50 answers because there are 50 State legislatures, Mr. Chairman. Our main involvement with that has been with our Medicare contractors who are health insurers as well as our contractors. They have some very real concerns about some of our initiatives in these areas, just as do many of the health insurers in the States.

The CHAIRMAN. Now, a question. Is there concern that they are not really liable and you are going to try to make them liable or that they know they are liable, but they don't want to pay?

Mr. SCOTT. That is hard to offer an opinion on from my perspective. I haven't worked that closely with the States. I haven't talked that much to the individuals who have dealt with the State legislators. I think very clearly that in the Medicare contracting community, their attitude is that if they are liable, they are willing to pay. And in all of the arguments and discussions I have been a participant in, that has been the attitude. We have never yet encountered anybody who is acting as if they do not want to live up to a contractual obligation to an insured person.

The CHAIRMAN. So, the arqument really is over whether or not they are liable, not should they pay if they are liable?

Mr. SCOTT. That is the way it would have to be articulated.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. No other questions.

The CHAIRMAN. What success are you having—I want to come back to the computers again—in the increasing role the computer plays in trying to increase our third-party collections? Or suggesting, persuading, or making the States use them?

Mr. SCOTT. I think, Mr. Chairman, the best way to deal with that is to describe in a little bit more detail the income and eligibility regulation that came about as a result of some recent actions the Congress took that involves us and food stamps and the Departments of Agriculture and Labor. Mary, why don't you go through that real quickly for us?

Ms. KENESSON. That regulation essentially would require the States to match the Medicaid enrollment files with State wage records. And to the extent that that match produces indicators of earned income, that someone is working, that is a preliminary but, if you will, to track for potential third party coverage. I think that the key incentive that HCFA is providing to the States is 90 percent Federal matching for the cost of adding on to their own MMIS system and the capability to do all types of data matching with their own eligibility files or with trauma codes or diagnosis codes, as the claims come flowing through the payment system.

The CHAIRMAN. But your regulations at the moment don't make the States do it?

Ms. KENESSON. No, the MMIS requirements do not mandate the States to do that.

The CHAIRMAN. But your proposed regulations mandate that?

Ms. KENESSON. Not any that have been drafted at this point.

The CHAIRMAN. But they are in the comment stage. None of them would even require them to use the computers for the match?

Ms. KENESSON. Not for the MMIS general systems. The income and eligibility match proposed regulation which encompasses not only Medicaid but AFDC and the Food Stamp Program, and includes the Labor Department to ensure that their information is available to the States, was published on March 14, and I think that is the major impetus for States to begin to do data matches. Admittedly, its thrust is toward income and resources for purposes of the cash assistance programs and the eligibility aspects of Medicaid, but because earned income is a good viable indicator of potential third-party liability, it should be useful to the States.

The CHAIRMAN. Senator Baucus, any others?

Senator BAUCUS. No, Mr. Chairman.

Mr. SCOTT. Mr. Chairman, could I make one final comment, sir?

The CHAIRMAN. Yes.

Mr. SCOTT. We have talked a lot about State performance. I think it is clear that many States have done an excellent job, and I certainly would not want anything I have said this morning to cast doubts on that. There has been a range of performance among the States, some we are clearly not satisfied with, and we don't think they should be satisfied, but I certainly wouldn't want to leave here today with anybody having the impression that all of the States are doing poorly. That is not the case. Many of them are very aggressive and have achieved results.

The CHAIRMAN. We have North Carolina coming on, who has been extraordinarily successful.

Mr. SCOTT. They are very good. The State of Minnesota has been good.

Senator BAUCUS. Any other States? [Laughter.]

The CHAIRMAN. Now, we will take a panel consisting of Leonard Levine, who is the commissioner of the Minnesota Department of Public Welfare, Barbara Matula, the director of medical assistance, North Carolina Department of Human Services, and Patricia Day, the director of management planning and evaluation of the Connecticut Department of Income Maintenance. Mr. Levine, do you want to start?

STATEMENT OF LEONARD LEVINE, COMMISSIONER, MINNESOTA DEPARTMENT OF PUBLIC WELFARE, ST. PAUL, MI

Mr. LEVINE. Mr. Chairman, thank you, and members of the committee, good morning. I am Leonard Levine, the commissioner of the Minnesota Department of Human Services and chairman of the health care committee of the National Council of State Human Service Administrators of the American Public Welfare Association. Our council represents the cabinet level secretaries, commissioners, and directors who are responsible for administering human

service programs, including Medicaid, at the State level. And I am here today to present the States' perspective on the identification and collection of private insurance payments for Medicaid recipients who have such coverage known as TPL. The State administrators generally agree that in the aggregate the potential for recovering funds in Medicaid for people with other insurance coverage has not been fully tapped yet. More could be done, and most State administrators have given the issue a great deal of attention. But it must also be noted that TPL is not a simple issue of the Medicaid Program. It is a complicated program. It serves some 22 million people through more than 50 different administrative entities. And while we believe that between 10 and 15 percent of the Medicaid population has some other form of health insurance, this amount varies from State to State, the number and types of such coverage bearing as well. In Minnesota, for example, it is 9 percent. So, in evaluating the States' TPL effort, policymakers must recognize the substantial complexity and deal with the significant differences among the States. The States are also generally in agreement with the GAO findings. Currently, there are some areas where States could improve their recovery effort. The central issue for TPL recovery for the States, as well as in the GAO report, is whether it is more cost effective to use the pay and chase or cost avoidance. So, we have two approaches. The majority of the States have found that when they know of third party coverage, the cost avoidance is more cost effective. Indeed, in Minnesota we have always had an effective pay and chase TPL system, and we are now moving toward such a cost avoidance system. Information will be collected at intake and electronically forwarded to the medical practitioner. Again, however, this doesn't mean that cost avoidance is the appropriate approach to use in every instance. Some States find pay and chase the more effective mechanism. Cost avoidance should not be mandated without some kind of waiver provision for the States that can show that pay and chase is preferable. The HCFA regulation should contain this waiver provision. Let me deal directly with the two GAO recommendations. The GAO report on TPL prescribes two policies which it believes are necessary to improve the States' performance. The first GAO suggestion is that HHS establish a quality control system for TPL and hold States at if they exceed a certain target error rate. The concept of imposing sanctions isn't new. However, it is surprising that they would take this tack. The GAO has produced numerous reports criticizing the use of the eligibility quality control system used by HHS in both Medicaid and AFDC programs for the purpose of imposing punitive sanctions. Quality control systems are management tools and, as GAO has pointed out, are not designed to measure errors accurately enough for the purpose of imposing sanctions. In the past, GAO has questioned the use of quality control systems for punitive purposes because it creates incentives that run counter to its mission to identify errors. We should remember that TPL was at one time included as one aspect of the Medicaid quality control system, and it was mutually agreed by the administration and by the States to drop it because it was ineffective and would not improve unless a significant amount of more money were invested in it. TPL errors are more difficult to measure than eligibility errors. Discovering every

potential source of third party coverage would generally be much more complex than accounting for income and resources. If the Federal Government is interested in establishing a TPL quality control system, the idea should be studied first. I can assure you that the States would be willing to participate in such an examination. Now, the second recommendation is HHS should require States to follow specific practices, including asking Medicaid applicants more questions, establishing procedures for obtaining information, requiring the use of cost avoidance systems where the State has indications that health insurance is available. I would like to just indicate also that it is important to recognize that there are other ways to improve TPL recovery. In our view, rather than subject States to penalties or detailed requirements, it might be more effective to enhance the level of Federal financial participation in our TPL effort.

The CHAIRMAN. Did you say cancel it? [Laughter.]

Mr. LEVINE. No. No.

The CHAIRMAN. What did you say? It might be more effective to what?

Mr. LEVINE. Enhance.

The CHAIRMAN. All right. I didn't think you said cancel. [Laughter.]

Mr. LEVINE. I have just shortened up my remarks. I wasn't aware of what that light meant. So, I thank you. I will be pleased to answer any questions.

The CHAIRMAN. I will be surprised if you don't get in everything between questions and answers among the three of us. Ms. Matula?

[Mr. Levine's prepared written statement follows:]

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FOR THE
COMMITTEE ON FINANCE
U.S. SENATE

HEARING ON THIRD PARTY LIABILITY

MARCH 25, 1985

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, GOOD MORNING. I AM LEONARD W. LEVINE, COMMISSIONER OF THE MINNESOTA DEPARTMENT OF HUMAN SERVICES AND CHAIRMAN OF THE HEALTH CARE COMMITTEE OF THE NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS OF THE AMERICAN PUBLIC WELFARE ASSOCIATION. OUR COUNCIL REPRESENTS THE CABINET LEVEL SECRETARIES, COMMISSIONERS, AND DIRECTORS WHO ARE RESPONSIBLE FOR ADMINISTERING HUMAN SERVICE PROGRAMS, INCLUDING MEDICAID, AT THE STATE LEVEL. I COME BEFORE YOU TODAY TO PRESENT THE STATES' PERSPECTIVE ON THE IDENTIFICATION AND COLLECTION OF PRIVATE INSURANCE PAYMENTS FOR MEDICAID RECIPIENTS WHO HAVE SUCH COVERAGE, BETTER KNOWN AS THIRD PARTY LIABILITY (TPL).

THE PURPOSE OF THIS HEARING IS IN LARGE PART TO CONSIDER THE OBSERVATIONS AND RECOMMENDATIONS OF THE GOVERNMENT ACCOUNTING OFFICE (GAO) REPORT ON THIRD PARTY LIABILITY COLLECTIONS (GAO/HRD-85-10). BEFORE I PROVIDE SPECIFIC COMMENTS ON THE REPORT LET ME MAKE SOME GENERAL COMMENTS REGARDING TPL.

STATE ADMINISTRATORS GENERALLY AGREE THAT, IN THE AGGREGATE, THE POTENTIAL FOR RECOVERING FUNDS IN MEDICAID FOR PEOPLE WITH OTHER COVERAGE HAS NOT BEEN FULLY TAPPED YET. MORE COULD BE DONE AND MOST STATE ADMINISTRATORS ARE GIVING THE ISSUE A GREAT DEAL OF ATTENTION. BUT IT MUST ALSO BE NOTED THAT TPL IS NOT A SIMPLE ISSUE. THE MEDICAID PROGRAM IS A VERY COMPLICATED PROGRAM. IT SERVES SOME 22 MILLION PEOPLE THROUGH MORE THAN 50 DIFFERENT ADMINISTRATIVE ENTITIES. WHILE IT IS BELIEVED THAT BETWEEN 10 AND 15 PERCENT OF THE MEDICAID POPULATION HAS SOME OTHER FORM OF HEALTH INSURANCE, THIS AMOUNT VARIES FROM STATE TO STATE, WITH THE NUMBER AND TYPES OF SOURCES OF SUCH COVERAGE VARYING AS WELL. SO, IN EVALUATING THE STATES' TPL EFFORTS POLICY MAKERS MUST RECOGNIZE THE

SUBSTANTIAL COMPLEXITY AND DEAL WITH AND THE SIGNIFICANT DIFFERENCES AMONG THE STATES.

I WOULD ALSO LIKE TO RESPOND TO COMMENTS THAT HAVE BEEN MADE BY MEMBERS OF THE ADMINISTRATION TO THE EFFECT THAT STATES CAN ABSORB THE IMPACT OF A CAP ON THE MEDICAID PROGRAM BY COLLECTING THE ESTIMATED $500 MILLION TO $1 BILLION IN TPL NOW GOING UNCOLLECTED. ASSUMING THE ESTIMATE OF UNCOLLECTED DOLLARS IS CORRECT, AND ASSUMING THAT STATES UNDER THE BEST OF CIRCUMSTANCES COULD RETRIEVE $1 BILLION IN TOTAL FEDERAL AND STATE FUNDS, THESE TPL COLLECTIONS WOULD NOT EVEN OFFSET THE CUTS MADE BY THE PROPOSED CAP IN THE FIRST YEAR. BY 1988 IT IS ESTIMATED THAT THE CAP WILL HAVE COST THE STATES BETWEEN $6 AND $9 BILLION IN FUNDS, AN AMOUNT FAR GREATER THAN COULD EVER BE RECOVERED THROUGH TPL EFFORTS.

IT IS IMPORTANT TO STRESS THAT THE INTEREST OF BOTH THE STATE FEDERAL GOVERNMENTS COINCIDE CLOSELY ON THE TPL ISSUE. I HAVE MET WITH MANY STATE AGENCY ADMINISTRATORS AND EVERYONE IS CONCERNED ABOUT INCREASING THEIR THIRD PARTY COLLECTIONS. REVENUE GENERATION IS A MAJOR ISSUE AT THE STATE LEVEL. IN MINNESOTA, AS IN MANY STATES, WE ARE IN THE MIDDLE OF OUR LEGISLATIVE SESSION AND ARE WORKING ON PREPARATION OF A BIENNIAL BUDGET. RECENTLY I HAVE APPEARED BEFORE A NUMBER OF APPROPRIATION AND FINANCE COMMITTEES IN MINNESOTA. ONE OF THE THEMES I HAVE STRESSED REPEATEDLY IS REVENUE ENHANCEMENT, INCLUDING THIRD PARTY COLLECTIONS. REVENUE GENERATION IS A MAJOR ISSUE AT THE STATE LEVEL.

MANY OTHER STATES ARE MOVING VERY AGGRESSIVELY IN THE AREA AS WELL. IT IS

SIMPLY GOOD MANAGEMENT PRACTICE, AND PUBLIC ACCOUNTABILITY DEMANDS IT. SO OUR INTERESTS ARE THE SAME HERE.

WITH REGARD TO THE GAO REPORT, WE WOULD AGREE GENERALLY WITH ITS FINDINGS THAT CURRENTLY THERE ARE SOME AREAS WHERE STATES COULD IMPROVE THEIR RECOVERY EFFORTS. FOR EXAMPLE, ASKING MEDICAID APPLICANTS A FEW SPECIFIC QUESTIONS REGARDING SOURCES OF HEALTH CARE COVERAGE CAN HELP IN THE IDENTIFICATION OF SUCH SOURCES. IT SHOULD BE REMEMBERED, HOWEVER, THAT OUR ELIGIBILITY WORKERS ARE ALSO RESPONSIBLE FOR DETERMINING APPLICANT ELIGIBILITY, IN A LIMITED PERIOD OF TIME, FOR A NUMBER OF COMPLICATED PROGRAMS, INCLUDING FOOD STAMPS AND AFDC, EACH OF WHICH HAS DIFFERENT ELIGIBILITY REQUIREMENTS.

THE REPORT ALSO ACCURATELY POINTS OUT THAT THE USE OF COMPUTER MATCHING HAS PROVEN TO BE A USEFUL TOOL IN IDENTIFYING SOURCES OF TPL. THE STATES HAVE MADE A GREAT DEAL OF PROGRESS IN THIS AREA, DUE TO THE SUCCESSFUL PERFORMANCE OF THEIR MEDICAID MANAGEMENT INFORMATION SYSTEMS (MMIS). STATES ARE PUTTING MORE EFFORT INTO MATCHING THEIR FILES AGAINST MAJOR EMPLOYERS AND INSURANCE COMPANIES TO PINPOINT PRIVATE INSURANCE COVERAGE. ALTHOUGH TAPE MATCHING CAN BE USEFUL, IT IS NOT A PANACEA. IN A STATE WITH A FEW MAJOR EMPLOYERS, A COMPUTER MATCH MAKES SENSE AND CAN BE WORTHWHILE. BUT IF A STATE HAS A LARGE NUMBER OF EMPLOYERS, COMPUTER MATCHING MAY PROVIDE LITTLE RETURN FOR THE COST INVOLVED. THE SAME HOLDS TRUE REGARDING THE NUMBER OF INSURANCE COMPANIES WITH WHICH A STATE MIGHT MATCH INFORMATION. I MENTION THIS ONLY TO POINT OUT ONCE AGAIN THAT THERE IS NOT A SINGLE BEST METHOD FOR PURSUING TPL IN EVERY CIRCUMSTANCE.

A CENTRAL ISSUE FOR TPL RECOVERY FOR THE STATES IS WHETHER IT IS MORE COST-EFFECTIVE TO PAY FOR SERVICES PROVIDED AND THEN SEEK REIMBURSEMENT FROM LIABLE THIRD PARTIES (KNOWN AS PAY-AND-CHASE) OR IF THE AMOUNT OF THIRD PARTY LIABILITY HAS BEEN ESTABLISHED, TO PAY THROUGH MEDICAID ONLY TO THE EXTENT A STATE AGENCY'S FEE SCHEDULE EXCEEDS THE THIRD PARTY COVERAGE (KNOWN AS COST AVOIDANCE). SO WE HAVE TWO APPROACHES. THE MAJORITY OF STATES HAVE FOUND THAT WHEN THEY KNOW OF THIRD PARTY COVERAGE, THE COST-AVOIDANCE METHOD IS MORE COST-EFFECTIVE. INDEED IN MINNESOTA, WHERE WE HAVE ALWAYS HAD AN EFFECTIVE PAY-AND-CHASE TPL SYSTEM, WE ARE NOW MOVING TOWARDS SUCH A COST-AVOIDANCE SYSTEM. AGAIN, HOWEVER, THIS DOES NOT MEAN THAT COST-AVOIDANCE IS THE APPROPRIATE APPROACH TO USE IN EVERY INSTANCE. SOME STATES FIND PAY-AND-CHASE A MORE EFFECTIVE MECHANISM. COST-AVOIDANCE SHOULD NOT BE MANDATED, WITHOUT SOME KIND OF WAIVER PROVISION FOR STATES THAT CAN SHOW THAT PAY-AND-CHASE IS PREFERABLE. THE HCFA REGULATION WHICH MANDATES COST-AVOIDANCE SHOULD CONTAIN SUCH A WAIVER PROVISION.

THE GAO REPORT POINTS OUT A PROBLEM STATES HAVE WITH THE TPL INFORMATION THEY OBTAIN FROM THE SOCIAL SECURITY ADMINISTRATION (SSA) FOR SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS. AS YOU KNOW, A STATE MAY CHOOSE TO ENTER INTO A SECTION 1634 AGREEMENT WITH SSA, IN WHICH CASE SSA DETERMINES MEDICAID ELIGIBILITY FOR AN APPLICANT CONCURRENTLY WITH ELIGIBILITY FOR SSI BENEFITS. SSA DOES THIS FOR ABOUT 10 PERCENT OF THE TOTAL MEDICAID POPULATION AND THESE RECIPIENTS ENTAIL A MUCH HIGHER AVERAGE MEDICAID COST THAN OTHER GROUPS COVERED BY THE PROGRAM. CURRENTLY, A STATE PAYS SSA TO ASK SSI APPLICANTS IF ANY THIRD PARTY COVERAGE IS AVAILABLE TO THEM, WITH THE YES/NO RESPONSE BEING REFERRED TO THE STATE AGENCY. THIS INFORMATION IS OF ALMOST NO VALUE BECAUSE

THE NAME AND ADDRESS OF THE INSURER, AS WELL AS THE POLICY NUMBER, HAVE NOT BEEN OBTAINED. FOLLOWING UP TO OBTAIN THIS INFORMATION CAN BE COSTLY AND UNPRODUCTIVE BECAUSE OF THE ADDITIONAL EFFORT NEEDED TO CONTACT THE CLIENTS AND IT IS DIFFICULT TO GET RESPONSES FROM CLIENTS AT TIMES OTHER THAN THEIR APPLICATION OR REAPPLICATION. WE AGREE WITH THE GAO REPORT'S CONCLUSION THAT SSA SHOULD BE ASKING MORE DETAILED INFORMATION AND REPORTING IT TO THE STATES. SOME OF THIS HAS ALREADY STARTED.

AN ADDITIONAL IMPEDIMENT TO THIRD PARTY COLLECTION, WAS NOT ADDRESSED BY THIS GAO REPORT, BUT WAS IN AN EARLIER GAO LETTER TO CONGRESS (GAO/HRD-85-9). THIS IS THE EXEMPTION THAT SELF-INSURED BUSINESSES HAVE FROM PAYING MEDICAID CLAIMS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA). ERISA SPECIFICALLY PRECLUDES STATE REGULATIONS FROM SUPERCEDING FEDERAL LAW, SO, ALTHOUGH MEDICAID IS INTENDED TO BE THE PAYOR OF LAST RESORT IT CAN NEVERTHELESS NOT REQUIRE COLLECTIONS FROM SELF-INSURED BUSINESSESS. THE STATES AGREE WITH GAO THAT CHANGES IN ERISA ARE NEEDED TO ALLOW FOR THESE COLLECTIONS. AS YOU KNOW, SELF-INSURED BUSINESSES PRESENTLY PROVIDE A SIGNIFICANT PERCENTAGE OF THE HEALTH COVERAGE IN THE COUNTRY AND THEIR NUMBERS ARE INCREASING. IT SHOULD ALSO BE NOTED THAT ERISA'S STATUS ALSO PRESENTS SOME PROBLEMS FOR STATES TRYING TO DEAL WITH THE INDIGENT CARE PROBLEM.

IN ITS RECOMMENDATIONS TO HHS, THE GAO REPORT ON TPL PRESCRIBES TWO POLICIES WHICH IT BELIEVES ARE NECESSARY TO IMPROVE THE STATES' PERFORMANCE. THE FIRST SUGGESTION IS THAT HHS ESTABLISH A QUALITY CONTROL SYSTEM FOR TPL AND HOLD STATES AT RISK IF THEY EXCEED A CERTAIN TARGET ERROR RATE. WHILE THE CONCEPT OF IMPOSING SANCTIONS IS NOT NEW, THE SOURCE OF THIS PROPOSAL IS SURPRISING.

THE GAO HAS PRODUCED NUMEROUS REPORTS CRITICIZING THE USE OF THE ELIGIBILITY QUALITY CONTROL SYSTEM USED BY HHS IN BOTH MEDICAID AND AFDC PROGRAMS FOR THE PURPOSE OF IMPOSING PUNITIVE SANCTIONS. QUALITY CONTROL SYSTEMS ARE MANAGEMENT TOOLS AND, AS GAO HAS POINTED OUT, ARE NOT DESIGNED TO MEASURE ERRORS ACCURATELY ENOUGH FOR THE PURPOSE OF IMPOSING SANCTIONS. GAO HAS IN THE PAST ALSO QUESTIONED THE USE OF QUALITY CONTROL SYSTEMS FOR PUNITIVE PURPOSES BECAUSE IT CREATES INCENTIVES THAT RUN COUNTER TO ITS MISSION TO IDENTIFY ERRORS.

TPL WAS AT ONE TIME INCLUDED AS ONE ASPECT OF THE MEDICAID QUALITY CONTROL SYSTEM BUT IT WAS MUTUALLY AGREED BY THE ADMINISTRATION AND THE STATES TO DROP IT BECAUSE IT WAS INEFFECTIVE AND WOULD NOT IMPROVE UNLESS A SIGNIFICANT AMOUNT OF ADDITIONAL MONEY WERE INVESTED IN IT. TPL ERRORS ARE MORE DIFFICULT TO MEASURE THAN ELIGIBILITY ERRORS. DISCOVERING EVERY POTENTIAL SOURCE OF THIRD PARTY COVERAGE WOULD GENERALLY BE MUCH MORE COMPLEX THAN ACCOUNTING FOR INCOME AND RESOURCES. IF THE FEDERAL GOVERNMENT IS INTERESTED IN ESTABLISHING A TPL QUALITY CONTROL SYSTEM, THE IDEA SHOULD BE STUDIED FIRST. I CAN ASSURE YOU THAT THE STATES WOULD BE VERY WILLING TO PARTICIPATE IN SUCH AN EXAMINATION. THERE IS VERY LITTLE KNOWN ABOUT HOW TO ESTABLISH OR MONITOR A TPL QUALITY CONTROL SYSTEM, AND MANDATING A CHANGE OF SUCH A MAGNITUDE AT THIS TIME, WITH SO LITTLE KNOWLEDGE, WOULD NOT WORK WELL.

THE GAO HAS A SECOND RECOMMENDATION. THEY SUGGEST HHS SHOULD REQUIRE STATES TO FOLLOW SPECIFIC PRACTICES INCLUDING: (1) ASKING MEDICAID APPLICANTS MORE QUESTIONS ON HEALTH INSURANCE AVAILABLE TO THEM; (2) ESTABLISHING PROCEDURES FOR OBTAINING INFORMATION ABOUT AN APPLICANT'S INSURANCE COVERAGE; AND (3)

REQUIRING THE USE OF COST-AVOIDANCE SYSTEMS WHERE THE STATE HAS INDICATIONS THAT HEALTH INSURANCE IS AVAILABLE. THE STATES HAVE NO OBJECTION TO SOME GENERAL REQUIREMENTS, HOWEVER, I MUST EMPHASIZE, ONCE AGAIN, THAT PRESCRIBING THE SAME SPECIFIC PROCEDURES FOR EACH STATE IS UNLIKELY TO BE AN EFFICIENT AND EFFECTIVE WAY OF PURSUING TPL. WE SHOULDN'T PRETEND IT IS A CURE ALL. OVER THE LAST FOUR YEARS STATES HAVE BEEN RUNNING MORE COST-EFFECTIVE MEDICAID PROGRAMS THAN IN PREVIOUS YEARS, IN LARGE PART OWING TO THE ADDITIONAL FLEXIBILITY AVAILABLE TO THE STATES UNDER FEDERAL LAW. RATHER THAN PRESCRIBE TPL PROCEDURES IN MINUTE DETAIL, IT IS MORE PRODUCTIVE TO MEASURE THE OUTCOME OF EACH STATE'S CURRENT PROCEDURES. IF A STATE HAS A COST-EFFECTIVE TPL SYSTEM, WHY MAKE IT CHANGE? THE FOCUS SHOULD BE ON OUTCOMES.

LAST YEAR, HCFA ISSUED A PROPOSED RULE FOR TPL (JUNE 4, 1984) WHICH THE STATES GENERALLY AGREED WITH BECAUSE IT WOULD PROVIDE BROADER AUTHORITY IN RECOVERY FUNDS FROM THIRD PARTY PAYORS. THE ONE PROBLEM WITH THE PROPOSAL, AS I'VE ALREADY NOTED, IS THE REQUIREMENT MANDATING COST-AVOIDANCE SYSTEMS. WE BELIEVE THE FINAL RULE SHOULD ALLOW STATES TO SEEK A WAIVER OF THIS REQUIREMENT AND HAVE SUGGESTED AS MUCH TO HCFA.

ALSO, IN THE ADMINISTRATION'S FY 86 BUDGET, NEW REGULATIONS ARE PROPOSED TO PROVIDE STATES WITH GREATER ACCESS TO HEALTH INSURANCE COVERAGE IN CHILD SUPPORT CASES, A CHANGE THAT WOULD SAVE THE FEDERAL GOVERNMENT $112 MILLION NEXT YEAR. OBVIOUSLY, THE STATES SUPPORT ANY LEGISLATIVE, REGULATORY OR OTHER ADMINISTRATIVE ACTIONS THAT WOULD PROVIDE US WITH GREATER ACCESS TO HEALTH INSURANCE COVERAGE FOR THE MEDICAID POPULATION AND THAT WOULD EMPHASIZE MEDICAID AS THE PAYOR OF LAST RESORT. BOTH LEVELS OF GOVERNMENT WOULD BENEFIT

FROM THIS.

FINALLY, ITS IMPORTANT TO RECOGNIZE THAT THERE ARE OTHER WAYS TO IMPROVE TPL RECOVERY. IN OUR VIEW, RATHER THAN SUBJECT STATES TO PENALTIES OR DETAILED REQUIREMENTS, IT MIGHT BE MORE EFFECTIVE TO ENHANCE THE LEVEL OF FEDERAL FINANCIAL PARTICIPATION IN OUR TPL EFFORTS. THIS IS A PROPOSAL WE HAVE MADE BEFORE. I REALIZE SUCH A NOTION DOES NOT SIT WELL AT A TIME OF BUDGET STRINGENCY, BUT WE THINK THERE ARE SOUND REASONS FOR GIVING IT SERIOUS CONSIDERATION. IT IS DIFFICULT FOR STATES TO FINANCE THE LARGE START-UP AND OPERATING COSTS FOR THE ADDITIONAL PERSONNEL AND INFORMATION SYSTEMS TECHNOLOGY WHICH TPL TECHNIQUES OFTEN REQUIRE. THESE EFFORTS INCLUDE INCREASED INFORMATION SYSTEM COSTS FOR COMPUTER MATCHING EFFORTS, AS WELL AS INCREASED PERSONNEL AT ALL LEVELS, PARTICULARLY FOR ELIGIBILITY WORKERS. CONGRESS FACILITATED THE ESTABLISHMENT OF AND CONTINUES TO SUPPORT THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) BY PROVIDING ENHANCED FUNDING. LIKEWISE, FRAUD AND ABUSE ACTIVITIES ARE ENCOURAGED WITH A 75 PERCENT MATCH. IN BOTH CASES, CONGRESS HAS RECOGNIZED THE HIGH EXPENSE OF SUCH ADMINISTRATIVE IMPROVEMENTS. TPL EFFORTS CAN BE COST-EFFECTIVE, BUT THE HEAVY COSTS OF STARTING UP AND CONTINUING THE OPERATION OF THESE EFFORTS ARE A DETERRENT TO STATES. ADDITIONAL FEDERAL FUNDS WOULD HELP STATES ESTABLISH AND MAINTAIN SOUND TPL SYSTEMS THAT WOULD IN A LITTLE TIME MORE THAN PAY FOR THEMSELVES. THIS IS A PROPOSAL HCFA HAS CONSIDERED, BUT HAS NEVER FORMALLY INTRODUCED. I HOPE THE COMMITTEE WILL BE ABLE TO GIVE IT SOME ATTENTION.

THANK YOU FOR ALLOWING ME TO TESTIFY TODAY. I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

STATEMENT OF BARBARA D. MATULA, DIRECTOR, DIVISION OF MEDICAL ASSISTANCE, NORTH CAROLINA DEPARTMENT OF HUMAN SERVICES, RALEIGH, NC

Ms. MATULA. I am Barbara Matula, with the North Carolina Medicaid Program, and I am happy to say that we are one of the States that neither needed to be cajoled nor mandated to pursue third party resources. We have been very aggressive in TPL for about 8 years now. Last year we recovered 2 percent of our Medicaid expenditures, or some $11 million. We did this at a cost to our program of $200,000 for a benefit cost ratio of 54 to 1.

The CHAIRMAN. Say that again because that is such a stunning figure.

Ms. MATULA. We recovered $11.2 million——

The CHAIRMAN. At a cost of?

Ms. MATULA. $205,000. The average for recovery, my TPL supervisor tells me, in this area is about 20- or 30-to-1 nationwide. Our supervisor, in fact, has been one of those folks who has been leading the HCFA best practices panels across the country. He is an insurance person. He has been so incredibly helpful to us and the fact that he has stayed with us all these years, I think, attests to his interest in the area. It is a small staff—nine people only. And two-thirds of those recoveries represent the cost avoidance method, as opposed to pay and chase, but we feel of course there is a legitimate role for both. We outlined for you, I think in the summary, what we consider to be the basic components of a good TPL program, which include strong State subrogation law, a marketing approach——

The CHAIRMAN. Strong State what?

Ms. MATULA. Subrogation law, which underlines the requirement that Medicaid will be the payer of last resort. Marketing the program not only with the health care providers, particularly the hospital industry, but marketing it with our insurance folks and with our attorneys back in 1977 and 1978 when we began has certainly paid off manyfold because these are the folks what are most frustrated if they file for Medicaid payment and are denied payment and have to go through a paper chase. If you lose their attention and their cooperation early in TPR systems, you have lost the battle. But if you work with them to make it easier to help them identify probable cases where TPR would come in before they file with us, help them to correct our information when it is in error so that they don't keep making the same mistakes, if you get their cooperation early in the game, 90 percent of the battle in fact is won. We also feel that the up-front efforts have to be top priority. Here is where we have people dealing with people, and it can't be 100 percent foolproof, but our eligibility specialists are trained and manual material is distributed to them that requires them to ask a series of very probing questions. And we have a QC effort of our own not mandated, but one which we have taken on that we call a corrective action program for the counties so that our eligibility staff is viewed and reviewed on how well they have handled the TPL informating gathering aspects. And then we prepare corrective action reports for those areas where they seem to be weak. And this is helping us. Of course, the information that we gather is

entered into our eligibility system and comes up in code on that Medicaid ID card so that a provider—the billing office in the provider's area can identify what kind of insurance, who it is for, and knows what kinds of claims are likely to pick out. And I can go into that in a little bit more detail. I would caution you, however, about the rather expansive estimates of savings that we are reading about. The $0.5 to $1 billion would equate to almost 4 percent of Medicaid recoveries, and I just don't think you can take one figure and apply it across the country because so many factors enter into whether a State can be successful or not. Besides having the automated system and the good eligibility up-front approach, in many States the less industrialized, less unionized States simply will not have that kind of access to health insurance and to some of the benefits that some of our neighboring States will. I do have some more remarks which I will be happy to discuss, including perhaps an incentive to get some of the States who have been slow in moving on this a financial incentive other than 75 percent.

The CHAIRMAN. I want to ask you about those, but I will get back to that in questions. Ms. Day?

[Ms. Matula's prepared written statement follows:]

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TESTIMONY OF

BARBARA D. MATULA

DIRECTOR, NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

FOR THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

HEARING ON THIRD PARTY LIABILITY

MARCH 25, 1985

Thank you for the opportunity to discuss North Carolina's experience in Third Party Recovery with you today. This is an area where the states and the Federal Government share a strong common interest; reducing Medicaid costs. Most states recognize the cost-saving potential of a strong TPR program and are pursuing measures to increase recoveries.

In North Carolina, we have conducted an aggressive and effective Third Party Recovery Program for over eight years. Last year we recovered $11.2 million dollars from private insurance companies at a cost of $205,000. This is a benefit/cost ratio of 54:1. The $11.2 million recovered represents about 2% of our provider payments. Our TPR supervisor frequently has been asked by HCFA to explain our program to other states in nationally sponsored workshops. We believe our experience enables us to identify the practices that can make a TPR program successful. I would like to comment briefly on those practices.

A successful TPR program requires five essential ingredients:

1. A firm legal base,
2. "Marketing" the program with the health care and insurance industry,
3. Careful identification of recipient insurance,
4. Automated systems controls,
5. A well-trained staff.

1. The firm legal base for the TPR program comes from a state "subrogation" law and an assignment of rights statute. This requires all other payors to exhaust their liability for the health care of Medicaid recipients before Medicaid pays.

2. The mere existence of these laws does not guarantee results, however. The concept must be publicized and explained to all the groups that participate in the health care billing and payment process. Health care providers need to be instructed on how to identify insurance potential and how to

collect it. Hospitals are an especially important target in this effort because hospital bills are the largest component of health care costs where Third Party resources are available. In the early years of our program, our staff made frequent visits to hospitals to explain, cajole and encourage their staff to cooperate. The results were very favorable. Not only did third party recoveries increase but our overall relationships with hospital staff improved. We also marketed the TPR story with our state's attorneys and insurance adjustors. Our staff made numerous presentations at conferences and meetings of these groups. Their heightened awareness has been especially helpful in obtaining our share of settlements from accident liability cases.

3. Identifying those Medicaid recipients who have health insurance coverage for some or all of their health care bills obviously is a top priority. Our intake workers ask the applicants a number of probing questions to find if insurance of any type might be available. We then record the name of the company and type of coverage in our eligibility file and print that information on the eligibility card so that providers will know whom to bill and what services to file for. Recipients are also required to report changes in their insurance status promptly to their eligibility specialists.

   Our quality control staff conducts special follow-up reviews of the county eligibility workers' efforts in TPL and reports their findings for necessary corrective action.

4. Our claims processing system is programmed to refuse payments on any claims for recipients where the eligibility file shows that insurance is available for that type of service.

5. A good TPR program must have a strong stable staff dedicated totally to TPR. The staff need not be large - ours in North Carolina has nine employees, including a supervisor who is highly experienced in the insurance business. Three people handle casualty cases and the remaining five are support staff. Their sole focus on TPR enables them to become experts at recovery.

This approach to TPR, known as the cost avoidance method of recovery is very efficient. Two-thirds of the $11.2 million we recovered last year was obtained through this "cost-avoidance" method. Once established, it requires little staff time. The cost avoidance method is not effective in all cases, however, so systems and procedures must also be developed to recover funds that have already been paid out. This is called the "pay and chase" method of recovery.

We use the pay and chase method principally to recover the proceeds of accident liability settlements from automobile insurance, malpractice cases, homeowner insurance and school accident insurance. Our claims processing system identifies each claim with a value exceeding $50 that appears, because of the diagnosis or services provided, to have stemmed from an accident. Our staff follows up on these cases by contacting recipients, county social workers, local clerks of court, attorneys and insurance adjustors to make them aware of Medicaid's rights to recovery of medical costs from any settlement awarded the recipient. Frequently, negotiations are required because North Carolina tort law does not subdivide a settlement into medical and non-medical portions. Our TPR staff spends over half of its effort on this class of recovery. Here, especially, is where we see the benefit of our TPR marketing efforts, because we are frequently contacted by providers, attorneys, or insurance companies to discuss an accident even before our staff has identified the case.

Even though we have an effective TPR program, we are eager to improve our system where practical. To that end, North Carolina is interested in performing computer matches with other data bases, such as employment security records, to identify health insurance available from employers of absent parents or recipients.

Before I close, I would like to raise a few words of caution. First, no program of TPR can be completely accurate. The availab lity of insurance to recipients can change from month to month but eligibility is determined usually twice a year. It is difficult to monitor these changes, especially if the insurance is available from an absent parent who does not keep the recipient informed about changes in coverage. The eligibility determination process involves people getting information from people. Honest mistakes and oversights will occur. A rigid system that tries to achieve 100% identification and recovery of third party resources will never be cost effective.

Second, you should regard with healthy skepticism the rather expansive estimates of TPR potential that have been surfacing lately. I have heard of estimates of $500 million to $1 billion. This would mean a recovery of about 3 to 4 percent of Medicaid payment nationwide. Our experience in North Carolina suggests that a 2% recovery rate may be a much more realistic goal.

Third, comparing states on the basis of their recovery rates should be approached with caution. Many factors affect the rate of recovery, for example:

(1) In highly industrialized states a larger percentage of the adult population tends to be covered under some group insurance policy than in the less industralized states. Where strong unions, exist, health care benefits of employees are often more extensive than in non-union settings. Consequently, the potential for recovery is greater in the industralized and highly unionized states.

(2) A high rate of unemployment might also reduce the recovery potential.

(3) Where medicaid payment rates are very low, providers may file their claims directly with insurance companies and never submit a claim to Medicaid. In such cases Medicaid is unable to count the costs avoided, thus reducing the amount of TPR that can be verified.

Finally, I would like to suggest a change in funding for TPR activities that would create a greater incentive to improve TPR in those states with a higher than 50% program payments match, such as North Carolina. The cost of our TPR staff and other expenses is treated as an administrative cost and is supported by 50% federal funds. But the dollars we recover are program dollars. North Carolina returns about $.70 on each program dollar recovered to the Federal Government. The benefit/cost ratio at the state level is thus reduced while that of the Federal is improved substantially. I would propose, as an alternative, that HCFA would allow TPR activities to be financed from their recoveries. This would mean that the cost of recovering funds would be shared in equal proportions to the benefits of recovery.

This concludes my formal comments on the TPR issue. I will be happy to try to answer any questions that you may have on the topic.

STATEMENT OF PATRICIA DAY, DIRECTOR, MANAGEMENT PLANNING AND EVALUATION, CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE, HARTFORD, CT

Ms. DAY. Thank you. I am Patty Day from Connecticut's Department of Income Maintenance. Connecticut is one of the States that has just seen the light. Just last month we implemented a new TPL system very similar to North Carolina's and it reflects our commitment to cost containment through exploring all third-party resources. I think we share the goals that are expressed in the GAO report in Connecticut, but we have a different approach in terms of how to reach those goals. We are, of course, committed to quality control in the sense that we want to control our product and our programs, but we are very concerned about the third-party liability quality control system that seems to be envisioned by GAO because it seems to bear some resemblance to the TPL QC system we had from 1979 to 1982. I was part of the State technical advisory group that worked with HCFA in evaluating in 1982 options for TPL QC. We were doing that because the old system was ineffective. We looked at a variety of approaches, turned them upside down and backward, and we were unable to find one that would support both fiscal sanctions and corrective action. GAO's 1981 report underlined the problems with time fiscal sanction threats to a quality control system that is meant to create corrective action. We think it ignores the State's incentive to save Medicaid dollars. It results in the States looking for errors in a manner which we are trying to defend against errors being found. When one single case can be extrapolated up in the statistical sampling to cause a saction of hundreds of thousands of dollars, the States are looking to defend against errors. In a corrective action setting, on the other hand, the States would be trying to weed out every possible kind of error in order to improve the program. With fiscal sanctions, the Federal people spend their time policing the States and worrying about error rates and statistical precision. It creates a whole arena, a battleground of the error rates, which removes us into a tangent away from what the real problem is and our real goal that both sides share. Some of the specifics that we run into with TPL is sample design. It is just really impossible to get a design for the sample that tracks an individual case all the way down the line within a timeframe that is reasonable to make any corrective action sense. It also is very costly to try to make a sample large enough for precision for the sanctions to become defensible in court. There are technical difficulties in establishing an error in TPL related to deductibles, coverage limits, placing a dollar value on a hypothetical suit that never took place, or a negotiated settlement that never took place. We also have a problem with target error rates. What is the target error rate? I think people here have alluded to the fact that States have different levels of pools—underlying pools—of third-party resources that are out there. So, what kind of an error rate do we set across the country? If you try to back up the rate of cost avoidance and say let's compare the percent of cost avoidance, that is not a good standard either because States, like North Carolina, that are going out very aggressively working with their provider community are going to be cutting

those claims off at the pass, so they never come to begin with. So, North Carolina wouldn't look very good on cost avoidance.

The CHAIRMAN. What you mean is that they would never even get to the State of North Carolina? They would simply be paid by the provider and never counted in the statistic or known in the statistics.

Ms. DAY. That is right. So, we had a real problem establishing what kind of error rates are we talking about. In summary, there just isn't a good way to combine those two functions—corrective action and fiscal sanctions—in one system. I think it is important in the whole area of TPL that we look for only broad mandates because the States are so different. There are different legal structures and insurance laws, governing organizations, the industrial versus rural aspect affects the underlying pool. The state of automation among the States. Some States are in the 1960's, some in the 1970's, and some in the 1980's. So, talking about automating data matches makes it very difficult across State lines. We would be very comfortable with some very broad mandates that each State could adapt within. There is a claims processing assessment system [CPAS], a model that we could follow, which is a broad guideline that allows States to work within, and this is a model that is also being used by the administration of the AFDC work programs, realizing State differences, giving us broad outlines to work within.

[Ms. Day's prepared written statement follows:]

STATE OF CONNECTICUT

DEPARTMENT OF INCOME MAINTENANCE

TESTIMONY OF

PATRICIA DAY

DIRECTOR OF MANAGEMENT, PLANNING AND EVALUATION

CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE

before the

Committee on Finance

U.S. Senate

Hearing on Third Party Liability

3/25/85

Mr. Chairman, members of the committee, good morning. Thank you for this opportunity to testify. I am Patricia Day, Director of Management Planning and Evaluation with Connecticut's Department of Income Maintenance. I am speaking on behalf of my department regarding the options which the General Accounting Office (GAO) has proposed in the area of Third Party Liability (TPL).

This past month Connecticut implemented a TPL system which is very similar to the one in North Carolina which was just described. Our new system reflects our strong commitment to containing Medicaid costs by utilizing all available third party resources. In fact, we share the same overall goals expressed in the GAO report. Where we differ is in the approach to those goals.

GAO'S TWO RECOMMENDATIONS SHOULD BE MUTUALLY EXCLUSIVE

GAO has recommended that either specific practices be mandated or that a Quality Control (QC) system with fiscal penalties be instituted. The HCFA response suggests that the two may not be mutually exclusive. We think they are, or at least should be. Mandating that all states operate with specific practices and techniques, regardless of their individual situations, and then holding them accountable for whether those techniques work or not is unfair. We agree that states should be accountable, but they should not be penalized for the outcomes

if they have no control over the means. (Complying with mandated practices often precludes or leaves few resources for a state's exploring more appropriate approaches for its specific situation.) Hold us to the means or the ends, but not both.

DEVELOPING A TPL-QC SYSTEM (AS ENVISIONED BY GAO) WHICH CAN ADEQUATELY SUPPORT BOTH FISCAL SANCTIONS AND CORRECTIVE ACTION IS VIRTUALLY IMPOSSIBLE

We are concerned with the TPL-QC option because of the problems we have encountered with QC in the past.

In 1982 I participated with several other states' representatives on the Medicaid QC State Technical Advisory Group in evaluating TPL-QC options with HCFA. We were exploring new approaches because the TPL-QC system then in effect was inadequate in a number of respects. In this joint state-federal effort we developed a number of options and analysed them from a variety of perspectives: state and federal staffing/burden, state flexibility, provision of a basis for fiscal sanctions, QC costs, data for management and corrective action, magnitude of implementation effort, effect on Medicaid QC's integration and coordination with AFDC and Food Stamp QC systems. Although our group felt comfortable supporting certain approaches which would produce very effective performance feedback for monitoring and corrective action, we were not successful in arriving at a system which could fully support both corrective action and fiscal sanctions.

These two functions do not coexist well in any federal-state QC system we have experienced in any program. As GAO pointed out in their 1981 report, the old TPL-QC was hindered by the punitive focus and threat of fiscal sanctions. The two functions are not only incompatible in a system, they undermine each other to the point where the entire effort is so distorted that neither need is adequately met. As the 1981 GAO report put it, "GAO believes that the threat of large fiscal penalties has hindered quality control from reaching its full potential because it has focused state and HFCA attentions on the error rates instead of on corrective action. States resist citing errors because they view them as potential sources of penalties rather than as indications of administrative weaknesses, the corrections of which would reduce erroneous payments. Because the error rates are tied to the penalties, HCFA has placed its emphasis on developing quality control processes and policies which will provide statistically defensible error rates which can withstand challenge if penalties are assessed. The penalties have led to a somewhat adversary relationship between the states and HCFA, and corrective action has assumed a secondary role in the quality control process."

The sample design required to support statistically defensible penalties which will stand up in court calls for a nationwide, standardized, broad approach which is inflexible, long and drawn out. Such a system is not responsive to corrective action needs in terms of timeliness, pinpointing of problems, and targeting review resources to problem or error-prone areas.

The threat of sanctions encourages "gameplaying" and distorts management's normal cost-benefit decisions by inserting an artifical factor into the cost-benefit equation.

There are a number of technical difficulties involved in establishing error dollar rates: treatment of deductible, coverage limitations, recoveries on hypothetical suits and negotiated settlements, etc.

There are even more difficulties in establishing base or target error rates. The proportion of program costs recovered is not appropriate since the underlying pool of available resources varies from state to state. Moreover, a state with good front-end cost avoidance would have a poor showing on such a measure, while a state with no screening at all could come out with high marks. Just looking at cost-avoidance through screened and denied claims is not a good standard either. A state which has done an excellent job in working to educate its providers and supplying them with full TPL data will successfully reduce the number of TPL claims it receives to begin with, thus having a low rate of cost avoidance denials.

For a system to support fiscal sanctions there must be not only an enormous state resource investment, but also a significant federal staffing effort. To assure the integrity of state findings, federal rereviews must be performed. Use of resources in this way would not be necessary under a corrective action

approach. Federal resources could be used to complement and add to findings from state efforts rather than just to police and validate them.

In summary, the development of a system to meet both sanction and management needs is virtually impossible. If the TPL-QC system is to be primarily a sanction tool we should question whether it is a cost-effective approach for encouraging state efforts in the TPL area.

If we already know that significant resources are available and not being tapped because states are not performing one of the broad TPL functions, does it make sense to set up and institutionalize a huge, inflexible, very costly, national system to tell us that? If we know that some states are making tremendous strides and doing everything possible on TPL while other states are doing less, do we need the huge nationwide system to tell us? Are we trying to use a shotgun to get at the big picture which we already know about instead of a rifle to hone in on those trouble spots HCFA is well aware of? The use of a massive national system is not appropriate either for the current state of progress in TPL across the country. The unevenness in development among the different states undercuts the value of the information that could be gained and used in a timely manner, especially since a lengthy implementation phase would precede any data at all.

The national QC system with fiscal sanctions is clearly an inappropriate route. This is not to say, however, that quality control in the broad sense is not a vital element of any approach to be adopted. There are a number of techniques and systems which could provide performance feedback and support corrective action efforts: targeted reviews, procedural reviews, automated edits and audits, in-depth adhoc reviews, etc.

OPERATIONAL MANDATES SHOULD BE LIMITED TO BROAD FUNCTIONAL AREAS

Although the mandate of very specific practices is inappropriate, regulations requiring states to perform very broad functions in TPL seem acceptable. Avoiding specifics is important for a number of reasons.

Mandatory techniques tie up resources, and management's hands, so that states are precluded from developing systems that fit their unique environments. They are hindered in trying new and innovative approaches which could potentially advance the state of the art as a whole. They may also be hampered in taking advantages of opportunities unique to their state: say, a state where the fiscal intermediary is also the primary insurance carrier in the state.

Specific mandated techniques do not make sense because of the differences among states which affect the way an effective TPL program should be designed. States have different legal systems and insurance laws. State government agencies are

organized in a variety of ways which are more or less amenable to cross program interfaces. Some states have MMIS and some do not. Industrial urbanized states have a much larger underlying pool of TPL than rural states and the two types may require a different focus for identification and recovery.

States are in very different stages of development. States who have made really significant investments in their TPL programs are already on the path they think is best for them. Should they be required to stop and retool at extra expense to meet some specific operational mandate? What about states in the middle of contracts with their TPL development in process?

In order to accommodate states' varying needs and situations, only very broad requirements should be considered. We would urge that HCFA develop these with state input in a joint effort.

MONITORING MANDATES SHOULD BE LIMITED TO BROAD REQUIREMENTS REFLECTING OPERATIONAL PRACTICES

If states are allowed to develop their TPL programs within broad functional mandates, it is reasonable to expect them to incorporate some method of assuring themselves and HCFA that their approaches are effective. Any such monitoring requirement should be very broad to allow states to employ the most cost effective methods to fit their programs and their stage of development, and to change those methods when necessary to remain responsible to corrective action and evaluation needs.

GAO CONCERNS CAN BE MET BY ESTABLISHING BROAD OPERATIONAL MANDATES AND TYING THE MONITORING FUNCTION TO EXISTING OVERSIGHT MECHANISMS

If broad operational functions are mandated and state approaches are subject to HCFA approval, compliance and corrective action can be handled in a number of ways.

In depth, ad hoc system assessments could be performed as a federal effort, with states being required to develop corrective action plans for deficiencies found.

States could also monitor the different phases of the TPL process by piggy-backing on Medicaid QC (MQC) and the Claims Processing Assessment System (CPAS).

Feedback on TPL resource identification could be obtained as part of the existing MQC system. This was done in the past and did identify case error by asking TPL questions at the home visit.

Additional TPL identification and monitoring of the other TPL phases (data flow within the system, cost avoidance, recovery), could be handled with a CPAS approach. This requires a system for monitoring functions which is sufficient to alert the state to problems and support corrective aciton/evaluation efforts. The state's system must be approved by HCFA, but maximum flexibility is allowed in its design so that states can consider anything from a full-fledged traditional QC system to an annual

independent audit. They can use any combinations of techniques which fit their system and satisfy the basic federal requirements.

In summary, I feel the states share the goals outlined in the GAO report. Recovery from TPL resources presents a tremendous opportunity for reduction of Medicaid costs. Our experience with sanction-oriented QC programs and our sensitivity to differences among the states, however, give us a somewhat different perspective on the directions to be taken.

We would urge that states be given broad guidelines and the flexibility within these guidelines to fashion systems suited to the individual states. This is the approach proposed by the administration for the AFDC work programs and for the Medicaid Claims Processing Assessment System.

Systems such as these ensure adherence to broad federal goals, while at the same time respecting states' individual differences and encouraging the development of innovative technology.

In closing, I would also suggest that positive approaches be considered to help states progress faster: enhanced funding for operations, incentive payments, technical assistance, funding of technology transfers among the states, etc.

Thank you for allowing me to present these views. I would be happy to answer any questions.

The CHAIRMAN. Ms. Matula, let me ask you a question. You said you would have a wide variance of base depending upon unionization and what kind of third-party legal coverage there was. Where does North Carolina fit in the spectrum? I don't think of you as an overly unionized State.

Ms. MATULA. We are not unionized at all. Probably on the lowest end of that scale, and also we are a rural State, but there are of course the industries related to tobacco manufacturing and furniture manufacturing, textiles. Again, I don't think that the benefit packages are as broad or as sweeping as they are in perhaps the northeast and middle west end of——

The CHAIRMAN. So, you would actually have less of a base of liability than other States?

Ms. MATULA. That is right.

The CHAIRMAN. And yet you have been remarkably successful.

Ms. MATULA. Also, we cover a fewer number of the working poor. Our eligibility standards are quite low and therefore we are less apt to get those who have some working poor coverage.

The CHAIRMAN. Then, it would seem if you have done as well as you have done in your State that many other States ought to be able to do at least equally well, because they couldn't be starting with a much more rural base or not many of them with less unionization and therefore less contracts that cover medical liability.

Ms. MATULA. And I wouldn't disagree with that, but, again, our success—which you call very successful—might not be measured as successful if a factor such as 4, 5, or 6 percent of payments were counted. We would fail miserably.

The CHAIRMAN. No, but you are paying out $200,000 and collecing what—$11.5 million?

Ms. MATULA. Right.

The CHAIRMAN. With nine people?

Ms. MATULA. Yes, sir. And an eligibility system which we are unable to do any computer matches on because our system is from the 1800's. [Laughter.]

The CHAIRMAN. Would you like to move to Washington?

Ms. MATULA. No comment. [Laughter.]

The CHAIRMAN. Have you reached the limit of what you can do?

Ms. MATULA. No; we are interested in the computer matches. We are excited about that, but I think we have in terms of both the pay and chase and the cost avoidance. I believe we have, yes, sir.

The CHAIRMAN. Now, you have read the GAO report?

Ms. MATULA. Yes.

The CHAIRMAN. And you have seen the previous HCFA recommendations over the years. Why then—Most States can probably do better than they are doing. You even admit that maybe you can do better than you are doing. Why are some States so reluctant, when it is a cost saver, for them to do? I would think their legislatures would jump at the chance to mandate enforcement of this.

Ms. MATULA. You know, I have thought about that as I heard each of the folks talking today. What is it, especially since we are on the selling end—we are trying to sell other States to do it. Why does it appear States don't react so quickly? And I know this seems like a roundabout answer, but a Medicaid agency has to wear so many hats, it is often difficult to know which is the one that should

have top priority. Last week, fraud and abuse was top priority here in the Congress in terms of hearings. We have to be medical geniuses and financial wizards and computer wizards in terms of adding staff, going to legislatures for money. You also have to be a businessman to recognize this cost avoidance area. And I think that we have failed to sell the States on what a painless way it is to save money, and the failure has been ours—both other States and the Federal Government for not promoting this in a very positive way.

The CHAIRMAN. Over and over, you talk about promotion and marketing. Give me an idea of what good marketing is, especially with your providers and insurance companies, so that you make them happy, willing, and enthusiastic to participate.

Ms. MATULA. Again, rather than just mandate that they submit their bills to us and then get them the paper chase that I described, that I suspect every provider has been through, we invited ourselves to present what we were about to do to annual meetings, to training sessions, to workshops of attorneys, of hospital financial managers, of the insurance industry. And as someone pointed out earlier, where liability is established, people do not want to shirk that duty. So, we had much more cooperation because we were aiding them in how to identify claims that they should file somewhere else if they were the provider. And if they were the attorney, how to—they contact us. They initiate contacts with us, often before we know of an accident to tell us that they are representing a Medicaid client or that there is a potential Medicaid recovery. So, it is really a hands-on, face-to-face effort as you begin. It cannot just be handled with provider bulletins and letters and penalties and denials. You have to be very positive.

The CHAIRMAN. How long has North Carolina been at this effort?

Ms. MATULA. Since 1977.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Barbara, the chairman is going to find out during his chairmanship that you are here often enough to qualify for citizenship in the District of Columbia. She is very, very good at what she does, and a lot of things that she can't do that she would like to do. There are two areas I want to ask you about the very last recommendation in your statement which has to do with, if you let us keep some of that recovery money, we might all of us—50 or whatever it is—have more incentives to do a better job of recovery. Maybe you can expand on that.

Ms. MATULA. I didn't even get a chance to describe what I was going to suggest, not to necessarily enhance Federal match beyond that which they are paying out for programs, but particularly in the poorer States which encompass most of the southern States. We have a higher Federal match on program expenditures than we have on administration. Therefore, for every dollar that we are recovering and returning to the Federal Government we are returning more than we are allowed to keep for our administrative expenses. I was proposing only that we finance our recovery activities out of the recoveries themselves in the same proportion so that a dollar collected in North Carolina, 70 cents goes back to the Federal Government, but it costs the State 50 cents to administer that program.

Senator DURENBERGER. All right. The second question, maybe each of you can respond to a little bit. I asked earlier the question about the different kinds of population that are involved. It strikes me that as the population mix changes a little bit, that you may see changes in the way to approach certain populations of people And I wondered if you were all here for that little interchange. I think I went over it with the GAO. Is there a response that you can give us? I will start with you, Barbara, what populations might we concentrate certain kinds of efforts on.

Ms. MATULA. I would like to think about that and give the others a chance to answer.

Senator DURENBERGER. All right.

Ms. DAY. I would say that obviously the populations may change, but what is more important to me is that they are different right now from State to State. And perhaps the one that is the most obvious is the absent parent who may be working and have insurance for the dependent children. I think the fact that you recognize the need for change in flexibility, our view is for having broad mandates rather than very specific ones so that States are able to look at their own specific situations and tailor their approach to go after that population for them now and for them next year.

Senator DURENBERGER. All right.

Ms. MATULA. That population, the absent parent population, really worries me. We have parents, of course, those who bothered marrying—marrying many times and who is covered is a good question. Really. Most coverage for children, because that is what we are seeking here—the spouse is really covered—doesn't cover the kinds of expenses we incur for these kids, which are routine, primary care, and are found——

Senator DURENBERGER. But the benefits question at least is a part——

Ms. MATULA. That is right.

Senator DURENBERGER. It isn't just have you got coverage but what kind of coverage.

Ms. MATULA. Those whose families are intact have very little insurance for other than trauma for our children, so I think we ought not get too excited about what is out there in some of these data matches because I think we can identify the insurance and have very little coverage, except for accident cases for hospitalization.

Senator DURENBERGER. All right. Mr. Levine?

Mr. LEVINE. I look forward, Mr. Chairman, to the HHS regulations in the area of child support. I think in the area of child support—and AFDC——

Senator DURENBERGER. All right. Thank you.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. I just have one question for Ms. Matula. We seem to be stressing carrots—the States will want to cooperate if they see the benefit in it in a positive way, but if you hammer on them they won't cooperate as much.

Ms. MATULA. That is right. That is because that has been our experience. No one has forced us to do what we have done.

Senator BAUCUS. Oh, I think that is generally true in human nature, too, isn't it?

Ms. MATULA. Right.

Senator BAUCUS. Should the carrots be bigger and more juicy?

Ms. MATULA. No, I just think that in terms of setting priorities, as I said, States have competing priorities, that perhaps we have not a good enough job of informing States of how easy this is to accomplish and how much the reward can be.

Senator BAUCUS. You don't think that it is necessary to change the Federal match? That is, as I understand it, some States get, let's say, a third or 25 percent of what they recover and other States get much more.

Ms. MATULA. Oh, I do encourage that, yes, but I mean, if we are talking about an approach——

Senator BAUCUS. Should the States' share be increased?

Ms. MATULA. My suggestion was that the cost to the State ought to be the same proportioned to that which it recovers. So, for those States that are returning a higher percentage of dollars to the Federal Government, the cost of administration should be shared the same way.

Senator BAUCUS. Do you think any sticks should be used at all?

Ms. MATULA. Yes. I think that now the way to get that mule's attention, of course, is with a 2 by 4, but give them the time to put it ahead, to put the sanctions ahead. Give all States a time period now with which they have to be onboard and things running rather smoothly, as opposed to immediate mandates. I just think we have failed in informing States better. The way that the best practices works is an invitation is extended saying if you would like to come and hear how to do it, you know, we are meeting in such and such a city. But if you don't know why you should be there, you probably won't go. So, those that are already interested will be there, and those that don't know enough about it won't.

Senator BAUCUS. But would a pending 2 by 4 help them realize why they should be there?

Ms. MATULA. A pending 2 by 4 will usually get you there. Yes, sir.

Senator BAUCUS. Thank you very much.

The CHAIRMAN. By pending, do you mean that it is going to be used if they don't—you call that a carrot?

Senator BAUCUS. I call it a stick. [Laughter.]

Ms. MATULA. I call the pending the carrot.

The CHAIRMAN. That is what I mean. Mr. Levine, let me ask you a question. You mentioned the possibility of recovery from ERISA, and you are one of the few people that has brought the subject up. I wonder if you would expand on it a bit. From the employee retirement security. At the moment, you prevent it from collecting out of the ERISA funds even though in some cases you have got medical coverage under them.

Mr. LEVINE. Mr. Chairman, I have to consult on that.

The CHAIRMAN. All right. [Pause.]

Mr. LEVINE. Mr. Chairman, we should allow the States to collect so that Medicaid is the payer of last resort.

The CHAIRMAN. All you need there is for the Federal Government to change the law, which at the moment prohibits you from collecting there, and then you can pursue it as you do your other normal third party liability recoveries.

Mr. LEVINE. Yes.

The CHAIRMAN. Do all of you want to comment on California's lawyer referral approach?

Ms. MATULA. Would you describe it in your words? From what I have heard, I was a little curious about it, and litigation is the key in California.

The CHAIRMAN. All I know is what I have heard today, that apparently any California lawyer that takes a Medicaid client reports it to the State. I don't know if you actually have to go to law suit or whether you settle or have to file a case—I am not sure what their requirements are—before you report it to the State, but at least as far as California is concerned, they think it works.

Ms. MATULA. I don't know how it differs from simple subrogation, which requires that collections be returned to the State.

The CHAIRMAN. I don't think it differs in terms of subrogation. I just think California is further behind than you are, and for you this may not be a necessity at all. What I sensed is that it is a reporting mechanism that was finding parties—liable parties—that the States were not—that California at least was not otherwise finding. I doubt if we have much to suggest for you in terms of enforcement. Ms. Day, what do you think?

Ms. DAY. I am not that familiar with it.

The CHAIRMAN. Mr. Levine, let me come back to you then. None of you have actually said today that you need more money from the Government—from the Federal Government. Ms. Day?

Ms. DAY. We think that incentives always help. Some enhanced funding for operations would be an incentive.

The CHAIRMAN. Mr. Levine?

Mr. LEVINE. Mr. Chairman, it is difficult to finance a large startup in operating costs for the additional personnel and for information systems; the technology which TPL techniques often require. So, we think that an additional financing would be important. The Congress facilitated the establishment of and continues to support the Medicaid management information system and likewise fraud and abuse. Activities are encouraged with 75 percent—so, in both cases, Congress has recognized the high expenses of these administrative costs, and the States in our discussions, the administrators feel that TPL efforts can be cost effective, but we do need help with the heavy startup costs in continuing the operations of the program. It would help us to establish and maintain sound systems and it was our feeling in our last discussion that in a reasonably short period of time we would be able to demonstrate some cost saving results.

The CHAIRMAN. I am so impressed with North Carolina's figures. I am even intrigued that you would need much in the way of startup costs if the return is any place close to what North Carolina is talking about. Unless you have reached such a high level of collection in Minnesota that there is literally nothing left to collect, short of extraordinary upfront money.

Mr. LEVINE. Mr. Chairman, the general feeling is that because of the competing interests and difficulty with State budgets, that there are heavy costs to be incurred at the startup time and that by doing it this way, it can prove to be cost effective.

The CHAIRMAN. Let me ask about HCFA's dissemination activities and whether you would like to see them step them up and, if so, in what areas. And we will start with Mr. Levine and just go across.

Mr. LEVINE. Mr. Chairman, HCFA hasn't done a lot of information in the past, but I understand that they are having a conference coming up this June. And so, that would be helpful and the States would participate.

The CHAIRMAN. Are you saying basically that you are not satisfied at the moment with what you are getting from HCFA? Or at least the good things that they are finding they are not passing on to you in a timely fashion?

Mr. LEVINE. Mr. Chairman, the information that we are getting could be improved, and it would be helpful.

The CHAIRMAN. Ms. Matula.

Ms. MATULA. Sometimes when HCFA writes to us, it is like singing to the choir, and other times there is an empty church. This is one of those cases, I think. In North Carolina in 1981, when we had a 5-percent across the board in all State employees, regardless of source of funding even if they were 100 percent Federal funding, 5 percent of the employees were cut. We were able to be the one exception to the rule, and we added three people to this unit, based on the cost benefit analysis that we could show them, which was relatively impressive to them. Perhaps what HCFA is failing to do is going over the heads of those Medicaid directors in the States where little action has taken place and instead writing to their Governors and to their legislative leaders and saying, "Look, you are passing up a golden opportunity and is it because you are stalling this at the lowest level or are you just not aware of it?" Perhaps that is a way to get at it.

The CHAIRMAN. What you are saying is that HCFA is following too much a normal bureaucratic tendency. They are looking for medical cost recovery so they talk to the people who are in charge of medical cost recovery, and if that happens to be a stumbling block, it never gets to the North Carolina speaker of the house.

Ms. MATULA. That is right.

The CHAIRMAN. Who would be very interested in picking up just $3 or $4 million, let alone $8 or $10 million.

Ms. MATULA. Uh-huh. And it only need occur in isolated cases where efforts to interest the agency have failed. I am sure my other State counterparts are fainting as I say this, but you know, it is one way to look at it.

The CHAIRMAN. Ms. Day?

Ms. DAY. I don't think I could add to that. I would agree.

The CHAIRMAN. What do you do—and I will go back the other way this time—what are you doing in your respective States with computer matching?

Ms. DAY. Our system on TPL is very similar to Barbara's, and we have some difficulties, for example, with the child support agency which used to be part of our agency in an umbrella and is no longer a part of our agency. So, it is not as easy to set up matches, and besides that, they don't carry health insurance on the file. So, it really would make sense. So, without this new legislation, we have a problem on that kind of data match.

The CHAIRMAN. Did you have access to that kind of information when they were part of your organization?

Ms. DAY. We didn't have the access of the health insurance on the data elements.

The CHAIRMAN. It wasn't there anyway?

Ms. DAY. Right.

Ms. MATULA. And our problem, as I said, is we have been trying to bring our own eligibility system into the 20th century, and I am very nervous that any mandates before our system is ready to accept a match could put us behind the eight ball and into the penalty box very quickly. So, we are very cautious about that. We are eager to do computer matches, but I can't ascertain for certain that our system will be a valid enough system to take——

The CHAIRMAN. You mean the computer system?

Ms. MATULA. My in-house eligibility computer system.

The CHAIRMAN. The computer system, yes.

Ms. MATULA. We are struggling with——

The CHAIRMAN. You are doing as well as you are doing, and you still haven't got an adequate computer system.

Ms. MATULA. We have an excellent computer system for claims processing, but that is because it is not State-run. Our eligibility system is State-run, and anyone who has tried to hire or fire a computer programmer that is on a State payroll knows what I am dealing with. [Laughter.]

Ms. MATULA. So, our eligibility redesign has had top priority for about 7 years now, and it could have been done in probably a 2-year span outside the State.

The CHAIRMAN. I sense even in testifying before the State Legislature that timidity is not one of your qualities. [Laughter.]

Ms. MATULA. No, sir.

The CHAIRMAN. Mr. Levine?

Mr. LEVINE. Mr. Chairman, we are matching with State employees and also with major employee groups to determine if they are covered. And in addition, we are now discussing with a large company for the design and implementation of an eligibility verification system which would be automated and work electronically where we would have immediate access to that information. We see that as quite a cost savings to both the public and private sectors. We have several things we have to work out yet, but we hope to have that up and running in a couple of months, if everything goes well.

The CHAIRMAN. My last question, and let me start again with you, Ms. Day. Tell me what problems you see with the quality control approach that HCFA outlined today, and for the moment we are not talking about mandating it, just what problems you see with the suggestions they have.

Ms. DAY. Do you mean the trace system?

The CHAIRMAN. Yes.

Ms. DAY. The audits?

The CHAIRMAN. Both. Yes.

Ms. DAY. I can see that the design approach avoids some of the problems we have had with quality control in the past because in the past we were having the initial reviews done by State reviewers and then seconded by Federal reviewers. We had a problem of

difficulties in determining those judgment calls. So, there is a solution to that by just having one party do those reviews. I also like the fact that it targets resources. I think it is a great waste of money to have a national institution collecting data all the time that doesn't really tell us anything we don't already know. So, targeting those resources to places where we know that there are problems I think is a very good step. I also think that it is a good idea that the initial disallowances are planned for just the actual discoveries, rather than any extrapolation. Some of the problems I see is that it isn't flushed out enough—at least what we have heard today. And I would urge that HCFA work with the States—the State technical advisory groups—to try to work out something and address the myriad of problems that are going to come up. For example, the ones that we mentioned before about error rates. They are talking about establishing a rate to use for extrapolation in the future. What kind of rate? Is it going to be the rate of proportion of program costs? Is it going to be based on cost avoidance dollars, which is the problem we went over before? How are they going to handle all of the hypothetical dollar-rising, that sort of thing? How far are they going to go, to the ends of the Earth, to find a dollar which might be reasonable if you are doing a one-shot audit, but may not be reasonable in ongoing operations. So, there are all those kinds of questions that are similar to those that we experience in QC today but really will need to be looked at. I think that it is also important, as Barbara said, that we don't crack down the following year with extrapolated sanctions. States have to be given a chance to see what the story is all about. This can be a real eye-opener for some of those States who haven't noticed yet that this is something important, and going in with an audit and coming up with, say, $90,000.00 of actual recoveries and presenting that to the Governor and saying look what are you going to do about it and so forth—I think this is one way that it could really have good impact. They certainly will sit up and listen, but coming in with an extrapolated sanction the next year is really not going to be fair. I think if we are going to go target our resources on this individual basis, we have to look at what we find on an individual basis. What kind of underlying pool does that State have? And what is the cost benefit? How far do you want a State to go? A certain procedure may cost $50 in Montana. It may cost $1,000 to go all the way through in New York. So, we need some reason with HCFA in dealing with what they come up with. I really agree with targeting and going at it like this if they can be reasonable, and I would suggest working with HCFA. And one other thing is I think that in terms of error rates, when we have Federal-State partnerships, I do think the Federal Government needs to take their responsibility—take their share of the error rate because there is not any kind of human endeavor where there is not an error. When the States have done all they can, to expect them to take the whole burden, I don't think is reasonable. And I am not saying that the Feds should take it all, but I think we should share in that, too, once we agree what is a reasonable base level.

The CHAIRMAN. Ms. Matula.

Ms. MATULA. I don't pretend to understand half of what I hear about quality control efforts. My quality control director is the

chairman and works closely with Ms. Day for the National Association of Quality Control Directors, and I do know that when I suggested to her broadly that they were going to reimpose QC for TPL, she swooned and hit the floor. [Laughter.]

So, I know it is bad.

The CHAIRMAN. So, on that, you will take your lead from her.

Ms. MATULA. I would hope that we would look at this in an individual way, and that we would first go after the States that appear not to be making the effort, and then that we come up with some more—well, some better measures of how effective we are individually as States, and that could be tailored to their individual situations. In that sense then, of course, it isn't so much quality control as it is just a measure of effectiveness. And I would like to see that.

The CHAIRMAN. You are literally just talking about a common sense approach.

Ms. MATULA. That is right.

The CHAIRMAN. Look at the worst State first and, obviously, some things could almost be mandated to them in the bottom pits of the States—I am not sure where the bottom line would be—and gradually change it as you bring the worst ones up.

Ms. MATULA. And some States may be able to garner a larger share of their expenditures, but their cost of doing so may be out of sight. Bring down their cost and work on it that way.

The CHAIRMAN. Mr. Levine.

Mr. LEVINE. Mr. Chairman, we certainly agree with what was said here by the two previous speakers. In the time that I have been in this position, I have looked with a great deal of respect and have followed the professional advice of Barbara Matula in the technical areas where she has demonstrated on several occasions. I would just like to make a couple of points. In the area of quality control, we should not go down the same route that we have on eligibility. And HCFA indicated here today that they would not be pursuing this route, and we would support that. In addition, the point made earlier, and I might just indicate again that HCFA should consult with the States more in the development of quality control efforts.

The CHAIRMAN. Thank you. I have no more questions. This is a most informative panel. It is another good example of a proof of the talent that we have in State governments. I appreciate your coming. Thank you. We are adjourned.

[Whereupon, at 11:13 a.m., the hearing was adjourned.]

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