

**Memorandum**Date *RK* APR 14 1992From Richard P. Kusserow
Inspector GeneralSubject Review of Selected Part B Medicare Secondary Payer
Activities at Blue Shield of Florida (A-04-91-02004)To J. Michael Hudson
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on April 17, 1992, of our final audit report. A copy is attached.

The report discloses that the Medicare Part B carrier, Blue Shield of Florida (BSF), made improper primary payments for medical claims totaling \$26.9 million. The claims were paid on behalf of beneficiaries who had other primary insurance coverage. Our review indicated that reduced funding for Medicare secondary payer (MSP) activities resulted in BSF not pursuing, for recovery, previously identified MSP cases. We also noted that due to an increase in the Medicare Part B claims threshold, potential MSP cases are not being identified. We are recommending that the Health Care Financing Administration (HCFA) pursue alternative funding strategies to provide the needed resources to identify and recover the improper payments.

The purpose of our review was to determine the impact of reduced funding on MSP identification and recovery activities in Florida. The review showed that the budget reductions contributed to procedures that increased backlogs of undeveloped MSP claims. Specifically, prepayment development thresholds were increased which subjected fewer claims to reviews prior to payment. Also, post-payment development activities for suspected MSP claims were substantially curtailed.

Our review identified claims totaling \$24.3 million that were paid for beneficiaries who, according to BSF records, were known to have other insurance coverage. We also identified an estimated \$2.6 million of improper primary payments for which BSF was notified by providers, insurers, and beneficiaries that improper payments were made.

The report recommends that HCFA consider alternate funding strategies such as contingency contracts with collection agencies which would allow BSF to help defray the cost of collections with amounts recovered.

The HCFA's regional officials contend that the backlogged improper payments will be recovered through a joint Internal Revenue Service/Social Security Administration/Health Care Financing Administration Data Match Project required by the Omnibus Budget Reconciliation Act of 1989, section 6202, adding section 1862(b)(5) to the Social Security Act. Accordingly, they believe that a separate recovery project for the improper payments in our review would not be cost-effective. Moreover, they contend that they do not have the authority to award contracts to collection agencies or compensate carriers based on recoveries.

The development of MSP cases identified in our review is not a separate recovery project, but rather, potential overpayments that should be recovered by the Medicare program. We do not believe that it is cost-effective to delay development of these claims until another data match can be completed. Further, HCFA has already awarded a contract, as a pilot review, to a firm to identify and collect overpayments as part of an MSP recovery effort. We recommend that the unrecovered improper payments in Florida, a State which is a part of this effort, should be provided to this contractor for collection actions.

The timely recovery of improper payments is particularly important in view of the recovery regulations implemented in November 1989 which required that Medicare advise insurers of mistaken payments within 2 years. The BSF has identified about \$4 million of mistaken payments for which notices were sent on December 30 and 31, 1991.

For further information, contact:

Emil A. Trefzger, Jr.
Regional Inspector General
for Audit Services, Region IV
FTS: 841-6229

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF SELECTED PART B
MEDICARE SECONDARY PAYER
ACTIVITIES AT BLUE SHIELD OF
FLORIDA**



**Richard P. Kusserow
INSPECTOR GENERAL**

A-04-91-02004

**Memorandum**

Date

From Regional Inspector General
for Audit Services, Region IVSubject Review of Selected Part B Medicare Secondary Payer
Activities at Blue Shield of Florida (A-04-91-02004)To George R. Holland
Regional Administrator, Region IV
Health Care Financing Administration

This report presents the results of our Review of Selected Part B Medicare Secondary Payer (MSP) Activities at Blue Shield of Florida (BSF). The objective of our review was to determine the effect of a Health Care Financing Administration (HCFA) funding cut in Fiscal Year (FY) 1990 for MSP activities at BSF. We found that reduced funding for MSP activities contributed to improper primary payments for Medicare claims totaling \$24.3 million. These improper payments were caused by a combination of a HCFA directive to increase prepayment development thresholds, a BSF systems limitation, and BSF not retroactively recovering payments subsequent to the identification of other insurance coverage for a beneficiary.

In a related matter, we found that due to funding limitations, the carrier was not performing MSP post-payment activities. Specifically, we identified an estimated \$2.6 million of improper primary payments representing post-payment correspondence cases that were not developed by BSF. The correspondence cases represent notification to Medicare by providers, insurers, and beneficiaries that improper payments had been made.

The Medicare program was responsible for secondary payments on some of the claims; however, BSF estimates that as much as 70 percent (\$18.8 million) of the \$26.9 million (\$24.3 + \$2.6 million) should have been paid by another insurer, not the Medicare program. Further, the November 1989 MSP recovery regulations requiring the carrier to notify other insurers of their liability may limit recovery of some of these claims if action is not implemented immediately. The BSF has identified about \$4 million of improper primary payments for which notices were sent on December 30 and 31, 1991.

We recommend that HCFA instruct BSF to develop and recover the overpayments related to the \$26.9 million of improper primary payments disclosed in our report. In view of the limited funding for such activities, we suggest that alternative strategies to additional funding be considered. Such strategies might include contracting with a collection agency to pursue the recoveries or establishing an amount that BSF can retain from recoveries to compensate for the recovery activity. We suggest that HCFA monitor BSF's progress in its recovery activities. We also recommend that HCFA require BSF to notify other insurers of improper payments within the time frames of the recovery regulation. Further, HCFA should consider extending the period of the MSP recovery regulation to notify insurers of an improper payment. We will pursue this issue with HCFA's central office staff to determine any plans they have to change the applicable regulation. Finally, we recommend that HCFA require BSF to provide assurance that the MSP claims processing system is operational in accordance with program requirements.

We requested and received written comments from HCFA that addressed our findings and recommendations. The HCFA assured that the BSF's MSP claims processing system was operational in accordance with program requirements and that notification actions would be initiated for claims subject to the MSP recovery regulation deadline. The HCFA stated that BSF will be developing and recovering overpayments related to the improper primary claims identified in our report through the Internal Revenue Service/Social Security Administration/HCFA (IRS/SSA/HCFA) Data Match Project. The HCFA's comments are included in its entirety as Appendix I.

BACKGROUND

The Medicare program provides for a hospital insurance program (Part A) and a voluntary supplementary medical insurance program (Part B) for eligible beneficiaries. The Medicare program is administered by HCFA which contracts with intermediaries and carriers to assist in the administration of Part A and Part B services. The HCFA provides direction to the contractors on payment matters and is responsible for assuring that contractors are adhering to applicable policies and procedures governing such payments. The contractors process and pay claims in a geographical area.

The MSP program refers to situations where Medicare does not have primary responsibility for paying the medical expenses of a beneficiary. In these cases, Medicare claims processing contractors have two interrelated

responsibilities: (1) to identify other insurers and, thus, prevent inappropriate Medicare payments; and (2) to identify and recover mistaken payments that were made prior to determining that the beneficiary had other insurance coverage.

Effective January 1, 1983, the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, amended the Social Security Act to make Medicare a secondary payer to Employer Group Health Plans (EGHP) in those instances where medical services were rendered to Medicare entitled employees or to their Medicare entitled spouses. The amendment is limited to employed individuals or their spouses who elected to be covered by the EGHP and whose employers have 20 or more employed individuals.

Medicare is also the secondary payer in situations involving coverage under: workers' compensation; black lung benefits; automobile, no-fault or liability insurance; Veterans Administration; and end stage renal disease and disabled beneficiary provisions.

Due to budgetary constraints on administrative funding for contractors in FY 1990, HCFA increased the dollar thresholds for developing potential MSP claims and put less emphasis on post-payment recovery activities. The threshold for developing EGHP claims increased from \$50 to \$250; the threshold for developing workers' compensation and liability claims increased from \$400 to \$1,000. As a result of budget cuts, the BSF budget package for FY 1990 did not include post-payment recovery as a required task.

In February 1991, the House Subcommittee on Oversight held a hearing on the MSP provisions, including the backlogs of mistakenly paid claims that contractors had not attempted to recover. Testimony at the hearing was provided by representatives of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), the General Accounting Office (GAO), HCFA, and Blue Cross and Blue Shield of Maryland. The GAO testimony disclosed that contractors were not recovering identified overpayments resulting from the FY 1990 funding cutbacks and that future overpayments would go unrecovered depending on HCFA's funding actions. Estimates of recoverable overpayments were in the hundreds of millions of dollars; however, it was pointed out that HCFA had no reliable information on the size or amount of the backlog. The GAO has performed some reviews to determine the extent of improper Medicare payments as a result of the funding cutback. Also, HCFA officials testified that they requested all contractors, in September 1990, to estimate the extent of their MSP backlog cases.

A potential encumbrance to contractors in recovering improper payments is a recent HHS MSP recovery regulation (42 CFR 411.24 (f)(2)). The regulation, effective November 13, 1989, states that contractors must initiate recovery action within 15 to 27 months after identifying another insurer as being primary or the insurer will no longer be liable for the amount mistakenly paid by Medicare. As a result, the time limit for recovery of many FY 1990 (those identified since the effective date of the regulation) backlogged claims expired December 31, 1991.

SCOPE

The purpose of our review was to estimate improper Medicare payments that were not recovered due to MSP budget cuts. Specific areas reviewed were the effect of raising the prepayment development threshold; the effect of budget cuts on post-payment development activities; and the effect of the recent MSP recovery requirement on the contractor in its efforts to recover mistaken payments.

We examined the effect of the FY 1990 funding cutbacks on HCFA's and BSF's policies and procedures. We discussed various aspects of the policies with representatives from HCFA's central and regional offices, GAO and BSF. Also, we reviewed on-line computer data as well as microfiche history records.

We obtained computer extracted data from General Telephone and Electronics (GTE), the data processing services subcontractor for BSF. The GTE performed a computer match of the Part B paid claims history file, for the period October 1, 1989 through December 31, 1990, with the MSP beneficiary eligibility data. We extended the period of coverage for our data match to include 3 months of FY 1991 because the records were readily available. The purpose of the match was to determine the amount of improper Medicare payments for confirmed MSP beneficiaries.

The GTE also provided an extract listing the correspondence cases that were not developed and closed out on the BSF accounting system in FY 1990. The correspondence did not have an associated dollar value. Therefore, we selected a random statistical sample of correspondence cases in order to determine the Medicare dollars represented by the correspondence. We selected 200 cases to review with each case representing a sampling unit. The correspondence was reviewed to determine whether Medicare made an improper payment and the amount of that payment. We projected the results of the sample to estimate the total amount of the improper primary Medicare payments represented in the

correspondence. The projection was reported at the point estimate. The point estimate was calculated using a standard statistical formula.

We did not perform a study and evaluation of the carrier's internal control system applicable to MSP. Through substantive audit tests, we did consider the potential for weaknesses in internal controls. Our review, however, would not necessarily disclose all material weaknesses. We, therefore, do not express an opinion on the internal controls of the carrier.

The review was conducted in accordance with generally accepted Government Auditing Standards. Our site work was performed at BSF offices in Jacksonville, Florida during FY 1991.

RESULTS OF REVIEW

Our review showed that BSF improperly paid as the primary insurer on claims under Part B of the Medicare program totaling \$24.3 million during the period October 1, 1989 through December 31, 1990. The payments were made for services to Medicare beneficiaries who were covered by other primary insurance. Our review also identified a backlog of MSP correspondence files representing claims improperly paid totaling an estimated \$2.6 million. We concluded that reduced funding by HCFA for MSP activities and a BSF systems weakness contributed to making the improper payments. We recommend that HCFA develop financial incentives for BSF to seek recovery of the improper payments (about \$18.8 million, based on estimates of BSF officials) due to the Medicare program. We also recommend that HCFA take measures to ensure that BSF notifies the other insurers within the time frames of expiration contained in the November 1989 MSP recovery regulation.

The HCFA requires Medicare contractors such as BSF to take certain actions after determining that a beneficiary has other EGHP coverage. First, they identify or "flag" the beneficiary's record so that future claims will be denied. Second, they are required to research claims history to determine if Medicare has paid claims after the effective date of other EGHP coverage. Such payments should be adjudicated and overpayments recovered.

Overpayments occur in two ways: (1) BSF pays primary and the EGHP pays primary and (2) BSF pays primary and the EGHP pays secondary or not at all. In the first instance, the provider is overpaid and BSF must recover the money from the provider. In the second instance, the EGHP has

underpaid and BSF must recover from the EGHP. The BSF officials estimate that about 70 percent of improperly paid MSP claims represent overpayments by the Medicare program.

Since 1986, HCFA has required all contractors to implement three standardized computer modules to identify and process MSP claims (MSPPRIM, MSPSEC, MSPPAY). The modules identify records of other insurance coverage and locate claims that should not be processed as primary. Section 4306 of the Medicare Carriers Manual describes the functions of the required modules. The MSPPRIM is an edit module that examines all primary claims against beneficiary historical data searching for evidence of other insurance coverage. The MSPPRIM interfaces with an MSP control file, which contains previously processed MSP data by beneficiary. If this interface results in a code indicating another insurer, the claim is suspended and developed for MSP. If no evidence is indicated, the claim is processed as primary. The MSPSEC is an MSP edit module that reviews claim data for a valid MSP situation. If a valid situation is identified, the MSP control file is updated and the claim is processed accordingly. The MSP payment calculation is performed by the MSPPAY module. The module computes the secondary payment, applicable deductible, and coinsurance amounts.

In 1986, HCFA waived the requirement for two of the three modules (MSPPRIM and MSPSEC) for BSF. According to the Carriers Manual, a waiver can be granted when the contractor has a system in place which performs the same edits on all claims on a prepayment basis and uses the same data element as MSPPRIM and MSPSEC. However, according to BSF officials, their system did not properly utilize information regarding other insurance coverage until October 1990. In lieu of the module edits, BSF developed all EGHP claims over \$50 for MSP and all claims over \$400 for liability claims (automobile, workers' compensation, etc.). Those not meeting the threshold were processed and paid as primary regardless of indication or confirmation of other primary insurance coverage. Their system did not deny claims for confirmed MSP beneficiaries as required by the Carriers Manual.

In FY 1990, HCFA reduced administrative funds available to BSF to carry out MSP activities for Part B claims. Accordingly, BSF curtailed MSP activity. Also, in accordance with HCFA's instructions, BSF raised the threshold for developing MSP claims. Specifically, the threshold for liability claims was raised to \$1,000 and the threshold for EGHP claims was raised to \$250. Further, BSF discontinued post-payment recovery activity.

The threshold increase, the BSF systems limitation, and the absence of post-payment recovery activity caused a large number of primary payments to be made by BSF for Medicare beneficiaries that should have been paid by other primary insurers. First, because of the systems limitation, claims under \$250 (for EGHP) and \$1,000 (for liability) were not routinely denied even if the beneficiary had previously been confirmed as having other primary coverage. Second, BSF was not required to develop claims under the new threshold amounts that would otherwise have been developed prior to the funding cuts. Third, due to reduced funding, BSF did not recover primary payments retroactively after they determined the periods of primary coverage or after they received correspondence acknowledging other primary coverage.

In October 1990, incidental to implementing the Common Working File (a computerized prepayment authorization system), BSF maintained an MSP control file. The MSP control file identified beneficiaries who had confirmed periods of other primary insurance coverage, beneficiaries who were potentially covered by other primary insurance, and beneficiaries who were definitely not covered by other insurance. We used this file to determine the amount of improper payments by matching the control file (as of April 1991) to the paid claims file for the period October 1, 1989 through December 31, 1990. We identified payments for claims totaling \$24,296,093 that were made for beneficiaries who were known to have other insurance coverage.

We also identified a large inventory of correspondence that pertained to potential improper Medicare payments that were not developed for recovery. We estimated that about \$2.6 million of improper primary payments were related to correspondence for which no action was taken to adjudicate the MSP claim. The BSF had notified HCFA regarding the MSP tasks they could perform based on their FY 1990 funding. Post-payment development recovery activity was not included as a task. As a result, correspondence received from insurance companies, providers, and beneficiaries that notified Medicare of improper payments, was set-aside without response.

The unworked correspondence set-aside in FY 1990 was categorized as "closed" or "pending." The closed correspondence consisted of information received in the last 4 months of FY 1989 and the first quarter of FY 1990. The closed correspondence represents claims that were paid prior to FY 1990. At that time, the MSP unit was reorganized and these cases were closed to an accounting classification "cases not developed due to lack of

funding." The pending correspondence consisted of information received the last three quarters of FY 1990. At the time of our review (FY 1991), the MSP unit had begun development of the pending cases. Our review focused on the backlog area that was not being pursued by the carrier, the closed correspondence.

We obtained a listing of 13,964 closed correspondence case numbers from GTE. We validated the listing to ensure that these were the cases that were assigned the closed classification. A "case" consisted of correspondence from an insurer, provider, or beneficiary that pertained to one or more Medicare claims. Based on a statistical sample, we randomly selected 200 of the 13,964 cases for review to determine whether the correspondence pertained to improper Medicare payments. We reviewed the correspondence and the related paid claims history and determined the amount of potential improper amounts in each case. We then projected the results of our sample review to the universe of closed correspondence.

We estimate that \$2,560,239 of improper primary payments are directly represented by the closed correspondence cases. The amount represents the point estimate at the 90 percent confidence level. The lower limit projection is \$1,639,337 and the upper limit projection is \$3,481,140. Furthermore, we believe this is a conservative estimate of potential recoveries. Normal HCFA procedures would be to research a claims history related to the correspondence for additional overpayments retroactively for a 27-month period. Considering these additional overpayments, the potential post-payment recoveries for FY 1990 could be much greater than the \$2.6 million estimate.

During the time of our site work, HCFA provided additional funding nationwide that was earmarked for developing backlogged cases. The HCFA's instructions required contractors to develop the oldest cases first. Therefore, BSF will be developing the closed correspondence cases that we reviewed.

Recent changes in the HCFA's MSP recovery regulations may prevent the recovery of many improper Medicare payments, resulting in a significant loss of Medicare funds. Mistaken payments identified prior to November 13, 1989, were subject to the 6-year recovery period for filing suit for recovery. However, effective November 13, 1989, HHS regulations (42 CFR 411.24(f)(2)) limited the time for initiating recovery of mistaken payments. These regulations stated that contractors must initiate recovery action within 15 to 27 months after identifying another insurer as being primary or the insurer will no longer be

held liable for the amount mistakenly paid by Medicare. Therefore, claims identified as having another insurer between November 13, 1989 and September 30, 1990 would not be recoverable after December 31, 1991 unless the contractor notified the other insurer of the improper payment.

In FY 1991, HCFA provided supplemental funding to develop the backlog recovery cases and provided instructions to the carriers for use of the funds. The instructions were to work the oldest backlogged cases first. However, these instructions may not have been in the best interests of the Medicare program. These instructions resulted in BSF concentrating resources on closed cases that have a 6-year recovery limitation as opposed to working subsequent backlog cases whose recovery limitation expired at the end of Calendar Year 1991.

In April 1991, HCFA sent instructions to contractors for the purpose of tracking cases as they became subject to the MSP recovery limitations. Each contractor was required to report this information to HCFA on a quarterly basis. In its initial report, dated June 3, 1991, BSF reported that it had identified about \$4 million in improper payments that had a notification deadline of December 31, 1991. Therefore, HCFA needed to be aware of the impending claims that would become unrecoverable as the time period expired. We so notified HCFA as part of our draft report, and HCFA sent the notices on December 30 and 31, 1991.

We believe the current recovery regulation limitation could have a significant adverse effect on the recovery of Medicare funds. The shorter time frame for making recoveries comes at a time when contractors are already unable to manage their MSP work load. Unless the recovery limitation is lengthened or contractors devote additional resources to backlogged claims, we believe a significant amount of Medicare recoveries could be lost due to a lack of follow-up.

CONCLUSION AND RECOMMENDATIONS

We have identified \$26.9 million of Medicare payments that represent improper primary payments by the Medicare program. The BSF estimates that about 70 percent of the improper payments represent overpayments by the Medicare program. Therefore, the recoverable overpayments total about \$18.8 million. The questionable primary payments were the result of several factors:

- o A limitation in the BSF's claims processing system, coupled with a HCFA's systems implementation waiver and an increase in the prepayment development threshold
- o Funding cutbacks in FY 1990 that resulted in BSF not developing post-payment cases even after BSF was notified by external correspondence that an improper payment was made
- o The absence of action by BSF to retroactively recover payments subsequent to BSF's identification of other insurance for a beneficiary

Two factors influence the recovery of these improper payments:

- o The effect of the MSP recovery regulation on the recovery period
- o The availability of contractor resources to pursue recoveries

The HCFA has provided some supplemental funding to recover these improper payments. However, the funding may not be adequate to allow for the recovery of all identified overpayments. Further, HCFA's regional officials have indicated that future funding to BSF, as well as the other carriers, for MSP activities will be tight.

RECOMMENDATIONS

Based on our review and in the light of future anticipated funding considerations, we recommend that HCFA:

1. Instruct BSF to develop and recover the improper primary payments identified in our review. In lieu of additional funding, we suggest that HCFA consider alternative strategies, such as, contracting with a collection agency to pursue the recoveries or establishing an amount that BSF can retain from recoveries to compensate for the administrative costs of the recovery activity. We realize that these alternative approaches would require departmental involvement. We believe that the successful implementation of an alternate approach could have a positive future impact on Medicare contractor recovery activities nationwide. The BSF should also track recoveries of the improper payments we have identified and periodically report on this activity. The BSF estimates that 70 percent or \$18.8 million could be recovered. In this

regard, we will provide to the carrier, under separate cover, a list of our computer match results which identify the payments in question.

2. Ensure that BSF notify other insurers of improper payments within the time frames of the recovery regulation. Also, HCFA should determine the feasibility of lengthening the period for the current recovery regulation. We believe that easing the time restraints will benefit recovery activities by BSF as well as all contractors.
3. Require that BSF provide assurance that the MSP claims processing system is operational in accordance with program requirements.

AUDITEE'S COMMENTS AND OIG'S RESPONSE

The Region IV HCFA officials responded to our findings and recommendations in a memorandum (included as an Appendix to this report). The HCFA's comments and our responses are summarized below.

The HCFA stated that the MSP claims processing system at BSF is now operational in accordance with program requirements. Further, HCFA expects that BSF will meet the deadline provisions of the MSP recovery regulation. In this regard, HCFA's regional officials stated that there are no plans to lengthen the recovery period of the regulation.

The HCFA's statements regarding proper MSP claims processing at BSF and HCFA's expectation that BSF will meet the recovery regulation deadline are in consonance with our recommendations. Further, if HCFA's prediction that contractors will meet the recovery regulation deadlines are accurate, we would concur with HCFA that the regulation may not require revision. Nevertheless, we believe that HCFA should establish a contingency plan to assure that no claims are lost to the recovery deadline. We will pursue, with HCFA's central office staff, the potential for revising this regulation.

The HCFA stated that the development and recovery of the \$26.9 million of improper primary payments identified in our audit would be accomplished through the IRS/SSA/HCFA Data Match Project required by the Omnibus Budget Reconciliation Act of 1989, Section 6202, adding Section 1862(b)(5) to the Social Security Act. They stated that it would not be cost-effective to require BSF to implement a separate recovery project for the same beneficiaries and insurers that will be identified in the Data Match Project.

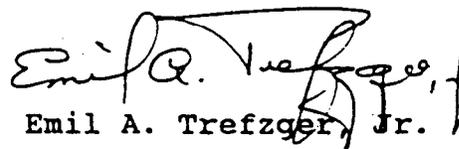
HCFA also commented that they did not have the authority to contract with a collection agency or to allow contractors to fund collection activities from the proceeds of collected overpayments.

We are not recommending that BSF implement a separate recovery project. We are recommending that HCFA explore alternative strategies to fund the adjudication and recovery of amounts due to the Medicare program as a result of improper primary payments that we identified in our review. The measures would be cost-effective because the cost to recover improper payments as part of the alternative strategies would offset the cost of recovering those identified in the HCFA data match. Furthermore, implementing recovery action currently would reduce the risks associated with collection of accounts receivable as they grow older. Moreover, we have already conducted a match and will provide the carrier, under separate cover, with a list of highly probable or known improper primary payments. The HCFA match has not yet been completed and thus there is no assurance that it will effectively and efficiently identify improper payments. The improper payments identified in our review and adjudicated by the carrier will not result in extra cost; they will serve as a verification of the HCFA data match, and will provide for timely adjudication of the improper payments. We do not concur that it would be more cost-effective to delay adjudication of improper payments until the HCFA match can be completed.

We recognize that the regulations do not specifically authorize HCFA to enter into contingency contracts, but HCFA's central office has a pilot MSP recovery project already underway which includes the State of Florida. We believe that the collection of the identified overpayments referenced in our report should be included in this pilot review.

The findings and recommendations in this report represent the opinions of the OIG Office of Audit Services. We would appreciate your views, and the status of any further action taken or contemplated on our recommendations within the next 60 days. Any questions or further comments on any aspect of the report are welcome.

To facilitate identification, please refer to the common identification number (A-04-91-02004) in all correspondence relating to this report.


Emil A. Trefzger, Jr.

**Memorandum**

Date **October 28, 1991**
From **George R. Holland**
George R. Holland
Regional Administrator
Health Care Financing Administration, Atlanta

Refer to: MCR-1-22
DMCR:MOB:LJ

Subject **Comments Regarding Draft Audit Report of Blue Shield of Florida
(BSF) Medicare Secondary Payer (MSP) Activities**

To **Emil A. Trefzger, Jr.**
Regional Inspector General
For Audit Services, Region IV

Following are our comments on your draft report.

The OIG recommends that HCFA instruct BSF to develop and recover overpayments of \$26.9 million and suggests that alternative methods of funding the recovery effort be considered. Suggested alternatives include paying a collection agency or the carrier a percentage of the amount recovered.

Blue Shield of Florida, as well as all other Medicare contractors, will implement the IRS/SSA/HCFA Data Match Project during FY 1992. This project is required by the Omnibus Budget Reconciliation Act of 1989. The law requires HCFA, SSA, and the IRS to match information each agency has within its records and then query identified employers to determine if a Medicare beneficiary or the spouse of a Medicare beneficiary has/had coverage through the group health plan of an employer. The purpose of this program is to identify situations in which Medicare is the secondary payer and recover any incorrect primary payments by Medicare.

The first year of this project will cover Federal tax years 1987-1989. HCFA is required to implement a match each year through 1994. It is estimated that HCFA will recover between \$600 million to \$1 billion dollars from third party payers as a result of the Data Match. We estimate that Blue Shield of Florida will incur a Data Match recovery workload of 35,265 cases in FY 1992. To require the carrier to implement a separate recovery project as you suggest for the same beneficiaries and insurers that have been or will be identified through the Data Match Project would not be cost effective.

We do not have the regulatory authority to contract with a collection agency or compensate the carrier for the administrative cost of recovering MSP overpayments based on a percentage of the benefits recouped. However, HCFA currently has a pilot recovery project with Health Management Systems, Inc. of New York to determine the feasibility of contractor specialization for certain MSP recovery activities. This contract is for a one-year period and will be operational in several states, including Florida and Georgia.

-OIG also recommended that HCFA require BSF to notify other insurers of improper payments within the timeframe specified in the regulations on MSP recovery.

In April and October of this year, we instructed all contractors that had identified MSP overpayments situations between November 13, 1989 through September 30, 1990 to notify primary insurers by December 31, 1991 in order to preserve Medicare's right of recovery. All contractors are still expected to meet this deadline.

The OIG suggests that HCFA consider extending the time limit for notifying insurers of incorrect primary payments.

The time limits for notifying insurers of MSP overpayments were published in section 411.24(f)(1) of the Federal Register, Volume 54, No. 195, dated October 11, 1989. Any change in these limits would require a change in the regulation. The majority of contractors are currently meeting the deadline outlined in the regulation. At present, HCFA has no plans to change the current regulation.

Finally, OIG recommends that HCFA require BSF to provide assurance that the MSP claims processing system is operational in accordance with program requirements.

The system problem which prevented the BSF from retaining "y" trailer codes was corrected when the carrier went online with the Common Working File (CWF) in March of 1990. During the Regional Office annual review in July 1991, we verified that the contractor's system retains "y" trailers and that the contractor is in compliance with MSP development threshold of \$250 for group health plans and \$1000 for liability cases. We will continue monitoring the performance of this contractor.

Thank you for giving us the opportunity to comment on this audit.