

ELIGIBILITY ERRORS RESULTING
IN MISSPENT FUNDS
IN THE MEDICAID PROGRAM



OFFICE OF INSPECTOR GENERAL
OFFICE OF ANALYSIS AND INSPECTIONS

MAY 1988

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This inspection, entitled "Eligibility Errors Resulting in Misspent Funds in the Medicaid Program," was conducted to identify the reasons some States are more successful than others in reducing Medicaid payment errors and to attempt to determine those factors which prevent some States from meeting their Medicaid error rate reduction goals.

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FUNDS IN THE MEDICAID PROGRAM**

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May 1988

Control No. OAI-04-87-00014 -

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EXECUTIVE SUMMARY

PURPOSE: The purpose of this inspection was to:

- o identify the reasons some States are more successful than others in reducing and maintaining a low rate of Medicaid eligibility errors which result in misspent funds; and
- o highlight the best practices of States that have successfully reduced Medicaid error rates as practices that other States should adopt.

BACKGROUND: Medicaid is a Federally aided, State-administered program providing health care to the poor. Generally, local welfare agencies process applications for aid, and eligibility is based on need. State Medicaid agencies make direct payments to health care providers for medical services rendered to eligible recipients.

The costs of the Medicaid program to Federal and State Governments are growing dramatically. In Fiscal Year 1966, the first-year benefit costs were \$1.5 billion. In Fiscal Year 1986, the benefit costs rose to \$42.3 billion. Costs are projected to rise to \$50 billion in Fiscal Year 1988.

The Medicaid eligibility quality control (MEQC) program reviews eligibility determinations from a statistically valid random sample of cases. Payments made to medical providers for ineligible recipients and overpayments for eligible recipients who had not properly met beneficiary liability prior to receiving Medicaid services are used to determine a State's payment error rate.

By law, States with Medicaid payment error rates exceeding 3 percent are subject to lose a portion of the Federal share of Medicaid dollars. Although most States have been successful in reducing their errors below 3 percent, Medicaid errors are costly. The national 2.6 percent error rate in Fiscal Year 1986 cost Federal and State Governments approximately \$1.1 billion in misspent funds.

METHODOLOGY: This program inspection is based on qualitative information gathered from discussions with 151 managers and staff in 3 Department of Health and Human Services (HHS) regional offices, 9 State agencies, and 12 local welfare offices. The inspection team also reviewed existing records, pertinent quantitative data, and applicable Federal and State statutes, regulations, and policies pertaining to Medicaid eligibility.

FINDINGS:

- o Effective State management is the primary reason for success in error reduction. Successful agencies have a high level of awareness and commitment to corrective action by managers and staff, State Medicaid quality control staff visibility and input into Medicaid policy decisions, advance preparation for anticipated changes, systems for

communication between State and local offices, effective training for local staff, local office input on policies and procedures, and effective monitoring of local offices. Although this kind of expertise exists in the States, no formal network exists for States to share information on ways to improve Medicaid eligibility determinations.

- o A major purpose of the Medicaid eligibility quality control system is to measure misspent Medicaid funds in each State. Although it accomplishes its goal, it is not always a useful management tool to States for corrective action purposes.
- o While the threat of Federal disallowances puts a sharp focus on Medicaid error reduction, the Medicaid program has a lower priority in error reduction activities when compared to the Aid to Families with Dependent Children (AFDC) and Food Stamp programs. A major reason is that many States (all but 12 in Fiscal Year 1985) meet their Medicaid error rate goals, while most do not meet their AFDC error rate goals (47 in Fiscal Year 1985). Yet, in Fiscal Year 1985, misspent funds in the Medicaid program cost Federal and State Governments a combined \$1.01 billion, while misspent funds in the AFDC program amounted to \$918 million.
- o Several States either have difficulty achieving the 3 percent national standard or have had volatility in their error rates over the past few years. Yet, there is no national system to provide special assistance to those States in identifying specific causes of errors and designing corrective action measures.
- o While punitive measures exist by law for States exceeding the 3 percent error rate, there are no rewards or incentives for States below 3 percent. Some States have been consistently below 3 percent for many years. Yet, little recognition or incentives are available to States and individuals in those States for outstanding performance.
- o New sampling techniques, like Nebraska's retrospective sampling technique described in appendix A, may help improve precision of the error rate and also provide additional data to assist in corrective action. Yet, States are unwilling to adopt retrospective sampling for reasons outlined in this report.
- o States report they often have to implement Medicaid program changes prior to the promulgation of Federal regulations or policy, and, when the Federal guidelines are finally received, the language is sometimes confusing and lends itself to various interpretations. Further, States are concerned about eligibility requirements that are incompatible with medical needs and about Health Care Financing Administration (HCFA) proposals to redefine "technical errors," which may raise error rates. States feel achievability of error rate goals depends on program stability.

RECOMMENDATIONS: A .5 percent decrease in the Medicaid eligibility error rate nationally, based on Fiscal Year 1988 Medicaid benefit cost projections, would result in a savings to Federal and State Governments of \$250 million. The HCFA needs to take a more active role in partnership with States to reduce and contain Medicaid eligibility errors which result in misspent funds. The following recommendations are addressed to HCFA:

- o The HCFA should publish a compendium or catalog of error reduction techniques on a periodic basis. States should submit specific successful practices found to be helpful in reducing or maintaining low errors, and a contact person should be listed for further information.
- o The HCFA should develop strategies to distinguish areas where one State can help another and coordinate this effort both regionally and nationally.
- o The HCFA should hold regular meetings, both in regions and nationally, that focus on Medicaid eligibility and related corrective action. Attendees should include State and Federal Medicaid quality control and program policy staff.
- o The HCFA should publish case error rate data annually by element and by State to assist in tracking the progress of States in error reduction efforts. The information can be used in addition to payment error data to determine areas of weakness which corrective action can address.
- o The HCFA should alert State officials annually to the actual costs associated with misspent Medicaid funds--not only the Federal portion exceeding 3 percent but also the total Federal and State dollars misspent in each State.
- o The HCFA should identify States having difficulty reducing errors to a consistently low rate and provide special assistance through the HCFA regional offices. This could consist of determining the specific causes of errors and assisting in the design of corrective action measures.
- o The HCFA should establish annual awards to recognize States which have error rates below the 3 percent national standard. Another method to recognize successful States would be to seek legislation to allow credits for States with error rates below 3 percent. A successful State that might rise above the rate during one quality control sample period could use accumulated credits to offset disallowances.
- o The HCFA should offer incentives for States to demonstrate sampling techniques. One incentive would be to waive disallowances for a period of time and allow a State the option of returning to its previous sampling system.
- o The HCFA should issue Medicaid policy in a timely manner to provide States with the lead time to properly implement changes. Policies should be written clearly to lessen the likelihood of different error-causing interpretations.

COMMENTS FROM HCFA: The HCFA believes "that many of the report's recommendations fail to take into account the congressional role in the existing MEQC program." Due to this congressional interest, HCFA believes it does not have a completely free hand to manage MEQC.

We do not believe that congressional interest precludes implementing the recommendations outlined in this report. Although some of the findings of the inspection illustrate limitations of the current MEQC system, the majority of the recommendations address actions HCFA should take to assist States in reducing eligibility errors, regardless of the way the errors are counted for disallowance purposes. Because eligibility errors are costly to Federal and State Governments, we believe it to be a critical responsibility of HCFA in its role as technical advisor to State agencies to facilitate the initiation of successful corrective action measures.

INTRODUCTION

BACKGROUND

Medicaid Program

The Medicaid program is a Federally aided, State-administered program under which the Federal Government pays from 50 to 78 percent (depending on a State's per capita income) of the cost of providing health services to the poor. Medicaid was authorized by title XIX of the Social Security Act (42 U.S.C. 1396) and became effective on January 1, 1966.

The individual States are responsible for designing, establishing, and operating their Medicaid programs under the provisions of title XIX and the Department of Health and Human Services (HHS) regulations. Within broad Federal limits, States set their own reimbursement rates for covered health services, and they normally make payments directly to providers who render the services to eligible individuals. Generally, eligibility for Medicaid can cover two groups of people. The first group is the "categorically needy," which includes persons receiving public assistance under the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. The second group is referred to as "medically needy." At the option of each State, persons who do not meet the "categorically needy" requirements because of excess income or resources, but cannot afford to pay for necessary health care, can be made eligible for Medicaid. The following table lists national estimated Medicaid recipients for Fiscal Year 1987 according to HHS statistics:

MEDICAID RECIPIENTS FISCAL YEAR 1987

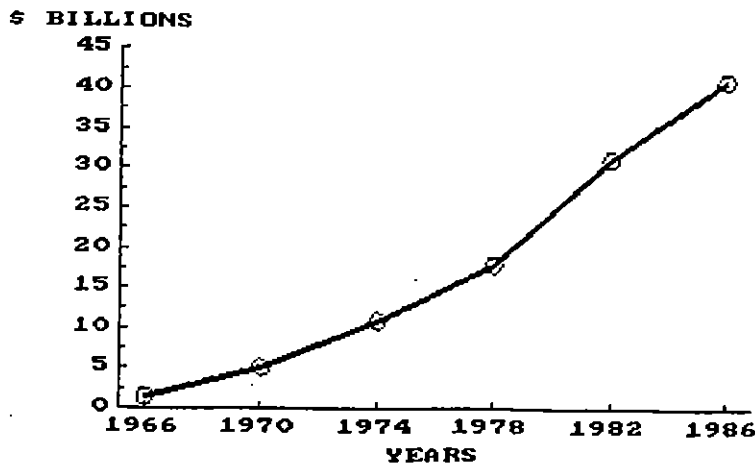
Aged 65 and over	3.3 million
Blind and Disabled	3.2 million
Adults in AFDC Families	5.9 million
Children under 21	10.3 million
Other	1.4 million
 Unduplicated Medicaid Beneficiaries	 23.3 million

Medicaid programs differ greatly from State to State because of variations such as benefits offered, groups covered, income and resource standards, and levels of reimbursement.

The Medicaid "State plans" required for each State list the eligibility criteria for Medicaid, the scope of services covered, and the method the State will use to administer the program. The Health Care Financing Administration (HCFA) then monitors State Medicaid operations to ensure that they conform to Federal requirements and the approved State plans.

According to HCFA statistics, the costs of the Medicaid program to Federal and State Governments have grown dramatically since its beginning. In Fiscal Year 1966, the first-year benefit costs were \$1.5 billion. In Fiscal Year 1980, the benefit costs rose to \$25.2 billion and in Fiscal Year 1986 increased to \$42.3 billion. The following table illustrates the rise in total State and Federal Medicaid benefit costs since the program's inception:

TRENDS OF MEDICAID PROGRAM BENEFIT PAYMENTS
COMBINED FEDERAL AND STATE EXPENDITURES



According to a 1986 HCFA projection, benefit costs will rise to \$50 billion in Fiscal Year 1988.

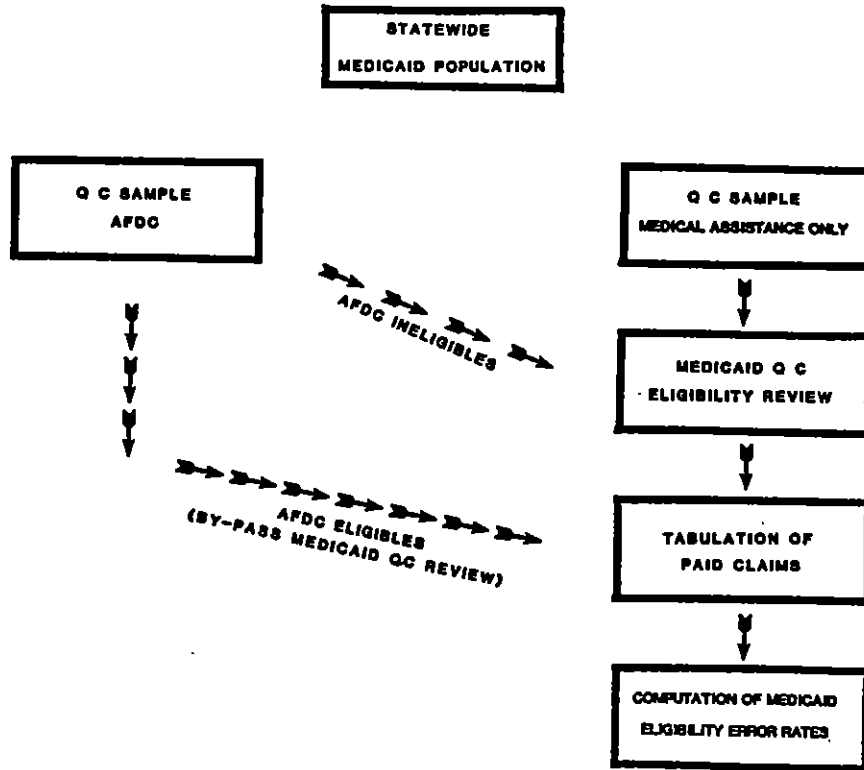
Medicaid Eligibility Quality Control System

Since the early 1970s, HHS, States, and the Congress have been concerned with the high incidence of erroneous Medicaid payments. In 1975, HHS issued regulations requiring States to initiate a Medicaid quality control system. Since that time, there have been revisions to the system. Currently, erroneous medical assistance payments due to eligibility and beneficiary liability errors are detected through the State and Federal Medicaid Eligibility Quality Control System (MEQC).

For quality control purposes, the Medicaid population is stratified by the State into AFDC and Medical Assistance Only (MAO) cases. The AFDC stratum normally includes the same cases included in the quality control sample for the AFDC program. The MEQC accepts the eligibility determination decision of the AFDC quality control program. Those cases found eligible under the AFDC quality control system are considered eligible for Medicaid. However, if the sample case is found ineligible in the AFDC quality control review, Medicaid quality control staff review the case to determine if it meets eligibility criteria for Medicaid under another coverage code. The MAO stratum includes all other

Medicaid cases where eligibility is the responsibility of the State. In each stratum, the MEQC operation draws a representative sample of cases from the eligibility file and reviews eligibility determinations for a specific month. Then, paid claims of the sampled cases are identified for the month being reviewed. A payment error rate is determined for each sample period by computing the ratio of erroneous payments for medical assistance to the total payments for medical assistance. The following flow chart diagrams the State MEQC process:

MEDICAID ELIGIBILITY QUALITY CONTROL PROCESS



After completion of the State's review, HCFA regional office quality control staff conduct a re-review to validate the accuracy of the State's findings. To do this, a subsample is extracted from the State's sample. Differences between the Federal and State MEQC reviews are then reconciled to produce an official State error rate for the period. There are two sampling periods per year for the MEQC review: October through March and April through September.

Disallowances for Payment Errors

States were required by the "Michel Amendment" (section 201 of the Labor-HEW Appropriations Bill for Fiscal Year 1980) regulations to set a series of payment error rate goals beginning in Fiscal Year 1981 to reduce their payment error rate in one-third increments to reach a 4 percent payment error rate by September 30, 1982. The 4 percent error rate for Medicaid was to be a national standard for all fiscal years thereafter. In 1982, section 133 of the Tax Equity and Fiscal Responsibility Act (TEFRA) authorized a 3 percent payment error standard beginning in the April through September 1983 sample period.

Those States which fail to meet the established standard during each sample period are subject to lose a portion of the Federal share of Medicaid benefit costs. The amount, referred to as a disallowance, is based on the difference between the State's official payment error rate and the applicable standard for each fiscal year. Beginning April 1983 a prospective quarterly withholding based on a State's estimated error rate was mandated by section 1903(u)(1)(C) of the Social Security Act; i.e., funds are withheld in advance for each calendar quarter a State's error rate is expected to continue above the imposed error rate standard. The withholdings are reconciled with the actual error rate (when available) and disallowance amounts. States that have error rates above the national standard can administratively appeal the final disallowance to HCFA. If the error rate exceeds the national standard, then a State is given the opportunity to demonstrate that the disallowance should not be imposed because the State made a good faith effort to meet the national standard. From Fiscal Years 1981 through 1985, a total of \$155.6 million of prewaiver disallowances have been levied. The number of States that did not meet their error rate standard ranged from 12 to 17 per year during this 5-year period.

Study of Quality Control Systems

Section 12301 of the 1986 Consolidated Omnibus Budget Reconciliation Act included a requirement for studies to be conducted of the quality control systems of the Aid to Families with Dependent Children (AFDC) and Medicaid programs. Independent studies are to be conducted by HHS and the National Academy of Sciences. Both studies are to examine "...how best to operate such systems in order to obtain information which will allow program managers to improve the quality of administration, and provide reasonable data on the basis of which Federal funding may be withheld for States with excessive levels of erroneous payments."

Costs of Medicaid Payment Errors

Not all Medicaid overpayments based on eligibility are subject to a Federal disallowance. Only the Federal share of Medicaid erroneous payments which exceed the national standard (currently 3 percent) can be withheld. For example, in Fiscal Year 1985, approximately \$584.8 million of Federal Medicaid benefits were misspent due to eligibility errors; of that amount only \$32.2 million is recoverable in prewaiver disallowances (i.e., the Federal share that exceeded 3 percent). Yet, the States' share of these misspent funds, combined with the nonrecoverable Federal share, amounts to more than \$1 billion in Medicaid misspent dollars due to eligibility errors in Fiscal Year 1985 alone.

PURPOSE OF INSPECTION

This program inspection report identifies the reasons some States are more successful than others in reducing and maintaining low Medicaid eligibility payment errors. The best practices used in States which have successfully reduced Medicaid eligibility error rates are highlighted as practices which other States should adopt. The following issues are addressed in this program inspection:

- o Has the threat of Federal disallowances affected States in their mission to reduce Medicaid eligibility payment errors?
- o What priority do the State and local welfare agencies place on Medicaid eligibility error reduction activities?
- o Are there common problems which States are encountering in attempting to reduce and maintain low Medicaid error rates?
- o Are quality control findings useful as a management tool to State program managers and staff in developing corrective action plans to reduce Medicaid eligibility payment errors?
- o Why are some States more successful than others in reducing and maintaining low Medicaid error rates and what could States with higher rates learn from the successful States?
- o What measures are currently being taken by States to reduce Medicaid eligibility payment errors?
- o How and to what extent have Medicaid corrective action activities been used effectively in error rate reduction?
- o What type of Federal assistance, if any, is needed to help States reduce eligibility payment errors in the Medicaid program?

METHODOLOGY

This program inspection is not designed to be a statistically valid research study, compliance review, audit, or program monitoring activity. Rather, this program inspection uses qualitative information gathered from the people most directly involved in Medicaid eligibility payment error reduction activities. Existing records and quantitative data are used as appropriate to the inspection, e.g., copies of State and local corrective action plans which include QC types and frequency of errors; special studies conducted in error reduction by the agency itself or in conjunction with a contractor; materials on practices and techniques States and local welfare agencies are using to effectively reduce and maintain low Medicaid eligibility payment error rates.

The data collection and analysis plan included mainly on-site personal discussions and the review of applicable Federal and State statutes, regulations, and policies. Discussions were held with 151 respondents in 3 Department of Health and Human Services (HHS) regional offices, 9 State agencies, and 12 local welfare offices. Respondents were in the following categories:

<u>Number of Respondents</u>	<u>Category</u>
32	Federal Regional Health Care Financing Administration (HCFA) Program and Quality Control Managers and Staff
83	State Agency Administrators and Medicaid Program Policy, Corrective Action, and Quality Control Managers and Staff
<u>36</u>	Local Welfare Office Managers and Staff
151	Total All Respondents

FINDINGS

CAUSES OF MEDICAID ELIGIBILITY ERRORS

Respondents at all levels report the highest dollar errors, those with the most significant impact on the error rate, generally occur in cases where the client is in a medical care facility. This care is expensive, and, according to those interviewed, eligibility determinations for clients needing this type of care are the most susceptible to high-dollar errors caused by unreported or inaccurately reported resources, primarily property and bank accounts. State and local respondents attribute this to several factors:

- o Clients in medical care facilities often have difficulty handling their own affairs, and the information used to determine eligibility must be obtained from a responsible relative. Errors may occur because the relative is either not knowledgeable about a resource, does not monitor the increasing value of a resource (for example, interest payments to a bank account nearing the resource limit), or hides the resource in order to make the client appear to be eligible.
- o Some banking institutions are not cooperative in searching for or verifying clients' accounts. A verification procedure used by many States is to check with local banks to determine if accounts exist for the clients. The search is time consuming and costly to banks. For this reason, they are reluctant to respond to the requests since State agencies are unable to pay for the banks' services.
- o It is often difficult to determine if property is legally available to the client. This is particularly true when the property is jointly owned, in trust, or willed.

THREAT OF DISALLOWANCES

The threat of Federal disallowances has aided most States in their efforts to reduce Medicaid eligibility payment errors by keeping the issue before top management in the State. The threat of disallowances for Medicaid, AFDC, and Food Stamp programs has the attention of upper level management. Imposing Federal disallowances on States that exceed the 3 percent national standard has helped to put a sharp focus on error reduction. States are spending time and resources to improve accuracy in eligibility determinations, not only for Medicaid, but also for the AFDC and Food Stamp programs. State agency staff and managers who are responsible for Medicaid error reduction are continually working to either reduce errors or keep errors low. However, high-dollar cases found in error in the MEQC sample can drive the error rate up. Many State respondents whose States have error rates below 3 percent do not feel secure because of

the threat of high-dollar cases in error being included in the sample. "We can never relax," was how one State official put it.

There are no rewards or incentives for States below 3 percent. Some States have been consistently below 3 percent for many years. Yet, little recognition or incentives are available to States and individuals in those States for outstanding performance.

While admitting that the threat of disallowances has helped bring attention to error reduction, many State respondents did not like the concept of disallowances by the Federal Government. They reported that the integrity of the program has always been a major concern of States, even prior to disallowances.

LOWER PRIORITY PLACED ON MEDICAID ERROR REDUCTION

While the threat of disallowances puts a focus on error reduction, the Medicaid program in many States has a lower priority in error reduction activities when compared with the AFDC and Food Stamp programs. The main reasons are:

- o Most States are currently below 3 percent in the Medicaid program and not subject to a Federal disallowance, while most States are above the national standard in the AFDC and Food Stamp programs and, therefore, subject to a disallowance. Consequently, more attention is given to the programs with higher error rates.
- o In States where the Medicaid agency is separate from or independent of the agency or organizational unit that administers the AFDC and Food Stamp programs, the Medicaid agency usually contracts with the other agency or unit to determine eligibility. In the contract agency, AFDC and Food Stamps come first because the agency is totally responsible for those programs. In the Medicaid agency, eligibility is a small part of the operation. Most activity is concentrated on services provided after the client is certified; e.g., claims and payments to providers. Medicaid's access to the local welfare offices, where eligibility is determined, is usually through the State agency that administers the AFDC program.

At the local offices, Medicaid is considered important, but the main focus for corrective action is on AFDC and Food Stamps. To overcome this attitude, many States have caseworkers who specialize in MAO cases, as opposed to having generic caseworkers who determine eligibility for many programs. These cases generally involve elderly or disabled persons receiving institutional care and are the more costly cases. As one State Medicaid corrective action officer said, "Since we specialize MAO adult cases, we create our own priority at the local offices."

ACHIEVABILITY OF ERROR GOALS

The 3 percent national standard for the Medicaid program is achievable. All but 11 States are below 3 percent in Fiscal Year 1986. Many States have been for several years. The national average in Fiscal Year 1986 (latest available data) is 2.6 percent. However, most respondents believe that States have "bottomed out" or are beginning to "bottom out" in achieving the lowest error rates possible. They reason that the Medicaid program is very complex and that new factors can cause the error rate to increase. For example, there is widespread concern that the proposed rules in the Federal Register (Vol. 52, No. 16, January 26, 1987) regarding the definition of technical errors can raise the Medicaid error rate. Technical errors are defined as errors in eligibility conditions that, if corrected, would not result in a difference in the amount of medical assistance paid. By law, these errors are not counted when determining the error rate in Medicaid. The HCFA has proposed to exclude from the definition of a technical error those errors resulting from a failure to obtain Social Security numbers and the failure to assign to the Medicaid program the rights to such third-party benefits as insurance payments. Therefore, these errors would then be counted when computing the error rate. It should be noted that the AFDC program counts technical errors for disallowance purposes. Technical errors account for approximately 15 percent of all AFDC errors, or 1 percent to 1.5 percent of the national payment error rate. It remains to be seen what impact the exclusions mentioned above will have on the Medicaid program with regard to eligibility payment errors.

AFDC VERSUS MEDICAID ELIGIBILITY PAYMENT ERROR RATE

Both the AFDC and Medicaid programs are based on a recipient's needs. Both programs are administered by State agencies, and, in most States, they are located in the same agency. Eligibility for both programs is determined at the same local welfare offices. A family eligible for AFDC is also eligible for Medicaid. In fact, more than two-thirds of the Medicaid recipients nationally are comprised of the AFDC population. Both the AFDC and Medicaid quality control systems that determine the extent of errors in each State have similar review processes. Medicaid accepts the AFDC quality control findings for the AFDC stratum in the Medicaid quality control sample. Most of the cases in the Medicaid quality control sample are from the AFDC quality control sample. Therefore, at least on the surface, it stands to reason that the Medicaid eligibility payment error rate should ride on the success or failure of the AFDC payment error rate--the more AFDC eligibility payment errors, the more Medicaid eligibility payment errors. Yet, the AFDC national payment error rate for Fiscal Year 1985 is 6.15 percent, with 47 States not meeting their error reduction goals. In Medicaid, the national payment error rate for the same year was 2.7 percent, with only 12 States not meeting their error reduction goals. With few exceptions, no distinct differences exist in the States'

commitment to error reduction. In fact, as previously noted, the priority to reduce errors is higher in AFDC. Yet, AFDC continues to have a much higher error rate. The following are reasons, based on discussions with local, State, and Federal staff and inspection team observations, as to why Medicaid has a lower payment error rate:

- o Many of the quality control cases determined to be AFDC ineligible for payment purposes are determined to be Medicaid eligible. The following are situations where this can happen:
 - Technical errors currently do not count in Medicaid as they do in AFDC. An AFDC case found to be ineligible in the quality control review due to a technical error still may be considered eligible for Medicaid.
 - Many of the AFDC cases determined to be ineligible in the AFDC quality control review can be eligible for Medicaid under a different coverage code.
- o The majority of Medicaid dollars are spent by the elderly population whose circumstances are less likely to change. They generally have a fixed income and have fewer changes in lifestyles. Therefore, if the correct eligibility determination is made initially, the case is less subject to errors. Local offices that conduct thorough front-end eligibility reviews and periodic redeterminations usually keep their Medicaid eligibility errors in check.
- o In cases with erroneous payments due to excess resources, the amount of the error is the lesser of:
 - the amount of the medical payments made on behalf of the family or individual for the review month, or
 - the difference between the actual amount of countable resources of the family or individual for the review month and the State's applicable resources standard.

For example, if a case has erroneous medical payments of \$1,000 in the review month and the actual amount of resources exceeded the State's standard by \$400 then the lesser of the two, the \$400, would be the erroneous payment, not the \$1,000 in medical claims. In AFDC, excess resources would result in erroneous payments of the entire benefit amount. This Medicaid quality control policy is allowed by legislation, and State respondents feel strongly that this is the correct way to count errors: only count the portion of the error that makes the recipient ineligible, not the entire amount.

COMMON PROBLEMS STATES ENCOUNTER

Although most States are under the targeted error rate, they continually grapple with policy issues that make the containment of errors difficult. The difficulty is largely due to the increase of coverage groups, untimely and unclear Federal policy, and eligibility requirements that are incompatible with medical needs. Although the national error rate has steadily declined from 3.8 percent in Fiscal Year 1981 to 2.6 percent in Fiscal Year 1986 (see appendix B), States are concerned that if program changes continue they will not be able to keep the error rate under 3 percent.

Increase Of Coverage Groups

With regard to eligibility, there is no single Medicaid program per se; it is a patchwork of spin-offs from the AFDC and SSI programs. There are in excess of 15 mandatory coverage groups and another 20 or so optional groups that a State can choose to include. The criteria used for determining eligibility for each group, or category, may be similar; however, each group has a unique qualifier. For example, an employed mother who loses AFDC eligibility due to an increase in earnings can be eligible for an additional 4 months of Medicaid, while an employed mother who loses AFDC eligibility due to the loss of AFDC earned income disregards can be eligible for Medicaid for 9 months.

To further complicate eligibility determinations, in the last few years, Congress has made the criteria for cash assistance programs more restrictive but has not imposed the same regulations on the Medicaid program. Consequently, the eligibility requirements for Medicaid often are qualified by such statements as "would be eligible for AFDC except...." In addition, Congress has created new coverage groups to compensate for reductions in the cash programs. One such example is the previously mentioned group eligible for 9 months of Medicaid if AFDC benefits are terminated due to the loss of earned income disregards.

A program with so many sets of eligibility criteria makes it difficult for States to put together a package for local welfare offices to use in determining eligibility. The criteria, although similar, have significant differences which make the program prone to errors.

Federal Policy

States report a problem receiving timely, comprehensive Federal policy. To comply with effective dates set by Congress, States often have to implement changes prior to the promulgation of Federal regulations or policy, and when Federal guidelines are finally issued, the language often is confusing and lends itself to various interpretations. This lack of clear policy means that States must take the risk that their interpretation will not match that of the Federal quality control reviewer. To address

this problem, some States write to HCFA with their interpretation and request that HCFA respond if the interpretation does not comply with Federal intent. The States which use this practice feel this provides them some protection against errors caused by a conflicting interpretation.

States also encounter problems keeping abreast of all the changes for the various categories of assistance. Since the methodology for determining Medicaid eligibility is tied to cash assistance programs, the laws and regulations may be found in various sources; e.g., title XIX (Medicaid), title IV-A (AFDC), title IV-D (child support enforcement), and title IV-E (foster care and adoption). To keep up with the changes, States must subscribe to clearinghouses that review and sort all the laws.

With such a complicated program to administer, States need timely and clear interpretations of the Federal statutes to ensure accuracy in determinations of eligibility.

Effects Of Applying Cash Assistance Methodology

Although the purpose of the Medicaid program is to provide medical services to the poor, States often find it difficult to make eligibility requirements associated with cash assistance programs compatible with the need for medical care. Therefore, to meet a client's immediate medical need, a State may fail to apply a cash assistance policy that would prevent the client from being eligible for Medicaid. To illustrate, according to SSI regulations, a client whose resources exceed the allowable State standards as of 12:01 a.m. on the first day of the month must be considered ineligible for the entire month. Applying this policy to the Medicaid program places an undue hardship on the client. For example, an applicant who needs nursing home care but is \$100 over the resource limit is ineligible for the entire month, although the nursing home charge for that month would far exceed the client's resources. Two States report that to provide assistance to clients in need they sometimes deliberately ignore a regulation and just take the error should the case be in a quality control sample.

Another problem in applying cash assistance methodology is that cash assistance regulations sometimes conflict with Medicaid regulations or are not applicable to the Medicaid program. When the policy reads "use SSI methodology," States must determine which parts of the methodology can be used and which parts cannot. A wrong decision could result in an error.

QUALITY CONTROL AS A MANAGEMENT TOOL

There is a link between the Medicaid quality control sampling system and corrective action to reduce errors. The better the quality control data, the more the information can be used to establish reliable trends for corrective action. Some State respondents believe that it is difficult to have the quality

control function serve as a disallowance tool and a management tool. Because disallowances are tied to MEQC, it is difficult to make the best use of payment error data for identifying problems. The following are reasons why the payment error data are not always a useful management tool:

- o The number of cases in the quality control sample is not sufficient to do trend analysis by geographic area within a State and by error element. The MEQC system will identify the trends statewide, but the data are not sufficient to focus on a given local office. To illustrate, one State with 159 county welfare offices has 275 MAO cases for each quality control sample period. In addition, as stated previously, Medicaid serves many categories of assistance. Therefore, MEQC data, while statistically valid for disallowance purposes, do not reflect error trends for geographic areas within a State or for each category of assistance. Many States address this by conducting enhanced, or targeted, quality control reviews as a management tool. For example, if certain geographic areas of the State or certain program elements are more prone to errors, additional sampling (not part of the official MEQC review) is conducted to determine the extent of the problem and help design corrective action measures to reduce those errors.
- o Cases identified in the quality control sample as ineligible are not counted as errors when there are no paid claims for the review month. These cases are ineligible but there is no payment error. However, these cases have the potential to have a payment error. "Luck of the draw" in the quality control sample plays an important part of whether or not cases found to be ineligible also have medical claims for that review month. Because payment error rate data do not reflect all errors, States use case error data as a management tool to supplement the payment error rate data. A case error rate is the estimated percent of cases in a universe that had errors regardless of dollars associated with the cases. The MAO case error rate for Fiscal Year 1985 was approximately 8.5 percent nationally. Reducing case errors through corrective action reduces the potential for payment errors. States with consistently low payment error rates also have low case error rates.
- o The payment error rate for Medicaid eligibility can fluctuate from sample period to sample period and not give a true picture of that State's performance. The volatility is due to utilization by Medicaid recipients in the sample; i.e., high versus low or no medical claims in the review month. For example, in one State visited, the error rates in the last four quality control sample periods showed extreme fluctuation. The error rates were 2.4, 6.0, 1.9, and 7.5 percent, respectively. One \$6,000 case found to be ineligible raised the error rate 2.4 percent. In another State, five ineligible cases accounted for 82 percent of the

payment errors. Even more dramatic, one State (not in the inspection sample) recently went from 2.4 percent (April through September 1985 sample period) to 12.5 percent (October through March 1986 sample period). It was reported that a single case was primarily responsible for the increase. The payment error rate is not just based on eligibility; it is also based on how sick a person is in the review month. As one State corrective action official put it, "It can work for you, or it can work against you."

Respondents in States that have had a consistently low error rate also voiced concern about the effect high-dollar cases found to be erroneous can have on the error rate. One State quality control director stated:

"I'll tell you one thing, if a majority of the States were above 3 percent, you would hear a lot more complaining about the sampling methods regarding high-dollar cases. Since most States are currently below the 3 percent tolerance, the issue is left alone. What it comes down to is, basically, why change to another system of counting errors and take a chance on the error rate going up? So States do the best they can to avoid disallowances in Medicaid."

Nebraska's Medicaid program has an innovative quality control sampling system that began in Fiscal Year 1984 as a demonstration project. It is called retrospective sampling. The advantages of such a system are that it helps avoid volatility of the error rate caused by high-dollar cases, and it produces data that are helpful in identifying error trends for corrective action. This system stratifies cases into high, medium, and low or no-paid claims. The error rate is determined for each stratum and then weighted to determine the overall error rate. This method of stratifying and focusing on paid claims helps avoid fluctuation of the error rate. Since there are more cases in the sample with paid claims, especially high-dollar claims, there are more dollars to divide into when computing the error rate. This helps avoid the "luck of the draw" with regard to high-dollar cases. Retrospective sampling also helps in corrective action because enough cases are sampled in the medium and high-dollar strata to enable reliable error trends to be established. It is a good management tool because it helps identify errors where there are dollars.

Respondents in other States either were not familiar with retrospective sampling or voiced several concerns as follows:

- o There are too many unknowns in retrospective sampling to take a chance, especially in predominately urban States. A new way of counting errors may penalize a State currently under 3 percent. Also, start-up costs and implementation problems are unknown.

- o The current system of including error cases with no claims helps keep the error rate from rising.
- o States which have integrated quality control sampling (Medicaid combined with AFDC and/or Food Stamps) cannot convert to retrospective sampling without additional costs.

In recent proposed rules, HCFA is allowing retrospective sampling as an option and is considering mandating it in the future. The HCFA believes that this sampling technique improves the precision of the Medicaid eligibility payment error rate by stratifying Medicaid cases according to their dollar value. Appendix A gives a further description of Nebraska's retrospective sampling.

ENVIRONMENT FOR SUCCESS

Local welfare offices determine eligibility for AFDC, Food Stamps, and Medicaid. The staff is required to know and apply different sets of criteria, standards, and definitions. This built-in complexity sets the climate for misinterpretation and misapplication of policy. The potential is there for making errors. States having success in error reduction have created systems in their operations to improve the accuracy of eligibility determinations statewide. These systems help reduce errors and improve services to clients. States do this by effectively managing the Medicaid program. They maintain control of the program and create accountabilities throughout the statewide network. The State agencies have a presence in local offices and create credibility by keeping local offices involved. States with good management systems have the ability to maintain low errors. Isolated problems or breakdowns are quickly identified, and proper corrective action is initiated to remedy the situation. Successful States adhere to the following practices in their day-to-day operations:

- o There is a high level of awareness and commitment to corrective action in every part of the operation. That awareness and commitment are generated from the top down.
- o Medicaid quality control staff have high visibility and input on Medicaid policy decisions.
- o There is a system in place to provide easy communication between State and local offices.
- o Staff at the State and local levels are well-trained on policies and procedures.
- o State agencies use local input to develop, write, and implement policies and procedures. They are responsive to the needs of local offices.

- o There is effective monitoring of local offices to improve accuracy.
- o Policy changes are kept to a minimum.
- o State staff plan for impending congressional policy changes. They start planning early to get local offices' input and prepare material and training on the changes in order to prevent tight time frames to implement policy.

Early planning also gives States time to think through policies to avoid distributing one policy interpretation to the local offices and then having to change it shortly thereafter.

Staff in successful States do not rely on one particular activity to reduce or maintain low error rates. They understand the system in which their State operates and learn how to achieve goals within that system.

SUCCESSFUL ACTIVITIES

The following is a brief summary of activities States have found successful to reduce and maintain low error rates. However, these activities are most effective in States that have established the environment for success.

- o Specialization of MAO caseloads--particularly institutional care cases.
- o Revised State policy manuals--designed with input from caseworkers, easy to understand, and kept current.
- o Consistent, regular training--preferably designed with input from quality control staff and conducted statewide by the same trainer(s) so that all staff members get identical information.
- o Targeted corrective action--strategies designed to reduce errors in a specific locality or error element.
- o Supplemental quality control reviews--concentrated record reviews to correct potential quality control errors and identify error trends.
- o Supervisory or second-party review--case record reviews of a percentage of the caseload with an increased number of cases read for error-prone workers. The reviews may cover all points of eligibility or only an error-prone element, such as resources.

- o Corrective action panels or committees--to develop, approve, and evaluate corrective action measures that target the causes of errors. The panels are most effective when quality control managers and decision makers serve on them.
- o Front-end verification--intensive investigation, including up-to-date, on-line computer matches, prior to case approval.
- o Performance appraisal reviews--specific, quantifiable performance standards for workers, supervisors, and offices. Quality work is recognized in an identifiable manner, such as an award or a luncheon.
- o Timely redeterminations--to avoid the continuation of erroneous benefits.

Appendix A lists effective practices and techniques States in the inspection sample are using to successfully reduce errors.

EFFECTIVENESS OF CORRECTIVE ACTION PLANNING

Corrective action planning is effective in error reduction. Since the AFDC agency or organizational unit in each State is responsible for errors related to AFDC cash assistance, Medicaid corrective action usually concentrates on the MAO stratum. The effectiveness of corrective action planning seems to be dependent on three factors: commitment, continuity, and monitoring. Successful plans are developed with input from all staff involved with Medicaid eligibility, including Medicaid quality control staff. Top-level managers are involved in developing the plans, and their commitment is conveyed to all levels of staff. The corrective action plan sent to HCFA integrates these activities and strategies. Successful corrective action planning is an ongoing process with frequent monitoring of the quality control findings to identify problems and move to correct them as quickly as possible. Regularly scheduled communication occurs among quality control, program, and local staff. This provides a forum for potential problems to be identified and resolved before they become errors.

The close working relationship between the State Medicaid quality control, corrective action, and program policy staff is a key to successful error reduction. This helps facilitate better communication about the identification and causes of eligibility errors and ways to remedy the situation through corrective action. In many States, Medicaid quality control is a driving force behind corrective action and has a direct input into the corrective action process. Although there is a fine line between identifying errors for disallowance purposes and helping to correct them, States have maintained the integrity of both functions. The Medicaid quality control assistance is beneficial to local offices. The State Medicaid quality control reviewers help local eligibility staffs improve their accuracy in

eligibility determinations by meeting with them to explain how a review is conducted and the types of things that they look for in determining whether a case is eligible. Many States are emulating the Medicaid quality control reviewer's process at the local offices by having caseworkers conduct the same types of verification checks that the Medicaid quality control reviewer does.

CURRENT FEDERAL ROLE IN CORRECTIVE ACTION

State agencies see themselves as a support to local offices to provide them with the tools needed to do accurate work in eligibility determinations. By the same token, States view the Federal agencies as a support to State operations; i.e., to provide States with the information necessary to administer programs efficiently and effectively. Based on our findings, HCFA does not view itself as that support in regard to corrective action. It appears HCFA's role, aside from review and comment on required annual State corrective action plans, is to use the MEQC system as a disallowance tool to recoup Federal Medicaid dollars that exceed the 3 percent national standard.

The following are quotes from HCFA staff:

- o "One way to get the States to lower their error rate is not through corrective action but, rather, to lower the tolerance level from 3 percent to zero. On everything over zero, the Feds get their share back, so nothing is lost."
- o "Recovering money from States is a high priority. When a State is over 3 percent and money is withheld, it makes our office look good. Of course it makes the State look bad, but it shows we are doing a good job."
- o "Corrective action is less than 1 percent of our workload."

It is the opinion of some State and HCFA regional office respondents that HCFA's main focus is Medicare, not Medicaid. Outside of the quality control function, Medicaid does not get the attention it should. While respondents recognize that the Medicaid program is a State responsibility, they point out that eligibility regulations and policy emanate from the Federal level.

It should be pointed out that the MEQC system at the State and Federal level is visible, with clearly defined structures and functions. While State and Federal quality control staff may from time to time disagree on issues, at least there is a forum to discuss issues relating to quality control matters. For example, there is presently a Medicaid Quality Control Technical Advisory Group (TAG) composed of representatives of States which meet periodically with HCFA representatives. Another example is the National Association of Public Welfare QC Directors. This is a very active and effective organization which not only includes

Medicaid but also the AFDC and Food Stamp programs. This organization has meetings and newsletters to keep States informed on quality control matters. Participants also include Federal representatives. No such entity exists for corrective action. While the National Association of Public Welfare QC Directors does include items on its agenda for corrective action, it is essentially a quality control organization.

There is no national forum for corrective action. With national direction lacking, each State is left to its own devices. This finding is not new. A 1981 General Accounting Office (GAO) report, entitled Medicaid Quality Control Is Not Realizing Its Full Potential (HRD-82-6), states:

"HCFA central office has depended heavily on the regional offices to provide leadership to the States for corrective action programs. Yet, the regions were doing little to aid the States with their problems."

The GAO report concludes that HCFA has not provided effective leadership or clear direction for the Medicaid corrective action program. This inspection found that to still be true.

CONCLUSION

The Medicaid program is complex and in constant flux; thus, it has a high susceptibility to payment errors. States are organized differently with not only State-administered and county-administered programs but also varying degrees of organizational structures and functions within these frameworks. Added to these differences are variations in socioeconomic characteristics, program options, automated systems, caseload size, and the qualifications of caseworkers. In addition to these complexities, there exists the dichotomy between the basic needs of the client and the problems of local and State staff grappling with intricate, ever-changing policies. Yet, under these circumstances, State and local agencies are performing well but always feel the constant pressure to improve.

It can be reasoned that misspent funds due to Medicaid eligibility errors are not a major problem nationally compared with the AFDC program. All but 11 States were below the 3 percent national standard in Fiscal Year 1986 (latest available data), and the national payment error rate was 2.6 percent. The AFDC program, on the other hand, was at 6.15 percent in Fiscal Year 1985 (latest available data), with 47 States above the 3 percent national standard. However, the Medicaid program is nearly three times larger than the AFDC program in terms of dollars spent on recipients. Using Fiscal Year 1985 data to compare the two programs, misspent funds based on quality control eligibility errors in Medicaid cost Federal and State Governments a combined \$1.01 billion (2.7 percent error rate x \$37.5 billion in benefit costs) compared to \$918 million in AFDC (6.15 percent error rate x \$14.93 billion in payments to clients). Since most of the States are below 3 percent in Medicaid, only a small percentage of the Federal share of misspent funds is recoverable. Even those dollars that are recoverable by HHS/HCFR are passed on as costs to the States. Thus, there are no savings to the taxpayer as a result of disallowances.

As health care costs in Medicaid continue to rise each year by several billions of dollars, misspent funds will rise proportionately if the Medicaid payment error rate remains at the current 2.6 percent. To illustrate, in Fiscal Year 1988, Medicaid costs to Federal and State Governments are projected to reach \$50 billion. Therefore, a 2.6 percent error rate will cost Federal and State Governments about \$1.3 billion in misspent funds. These misspent funds in Medicaid only address errors related to eligibility. They do not include misspent funds due to third-party liability errors or claims processing errors.

In addition, the proposed regulations regarding the definition of technical errors can raise the Medicaid error rate as noted in the findings of this report. It is unknown what impact these errors will have on the error rate. Using Fiscal Year 1988 Medicaid cost projections, a .5 percent rise in the Medicaid eligibility error rate nationally will cost Federal and State Governments an additional \$250 million in misspent funds

annually. Likewise, a .5 percent decrease in the national error rate from 2.6 to 2.1 percent would save \$250 million annually.

This study found that the success of the program to date has been the States' role in providing local offices with the tools necessary to do accurate work. However, while some States are struggling to reach a 3 percent error rate, many States below 3 percent report that they have gone as far as they can. The best that they can hope for, given the complexities of the program and the quality control "luck of the draw," is to maintain the rate that they have.

While HCFA has provided leadership and direction at the national level for Medicaid quality control in terms of counting eligibility and beneficiary liability errors, HCFA's role to date in corrective action for eligibility errors has been minimal. Although HCFA reviews and comments on corrective action plans, it needs to be more involved in working as a partner with the States to identify areas that have a potential for errors and explore cost effective ways to help reduce those errors. Corrective action on a national scale can help address Federal and State misspent funds while continuing to provide health care to those in need.

RECOMMENDATIONS

A .5 percent decrease in the Medicaid eligibility error rate nationally, based on Fiscal Year 1988 Medicaid benefit cost projections, would result in a savings to Federal and State Governments of \$250 million. Although HCFA supports the efforts of and meets with the Medicaid TAGs, it needs to take a more active role in promoting corrective action to remedy Medicaid eligibility errors. The HCFA staff should work with States in a partnership role to assist them in their continuing efforts to reduce and contain errors. The following recommendations, based on findings, are addressed to HCFA:

IDENTIFY AND COMMUNICATE EFFECTIVE MANAGEMENT PRACTICES

Finding

Effective State management is the primary reason for success in error reduction. Successful programs adhere to the following practices in day-to-day operations:

- o Managers and staff have a high level of awareness and commitment to corrective action.
- o State Medicaid quality control staff is highly visible and has input into Medicaid policy decisions.
- o The State agency maintains management control over the program and prepares for anticipated changes.
- o The State agency is cognizant of local office needs by having systems to provide easy communication between State and local offices, effective training for local staff, local office input on policies and procedures, and effective monitoring of local offices.
- o The State has specialized staff to deal with Medicaid cases, rather than generic workers who deal with eligibility for many programs.

However, no formal network exists for States to share information on ways to improve Medicaid eligibility determinations. Many respondents believe that the expertise already exists in the States, but it needs to be coordinated so that States can learn from each other. In fact, the HCFA region V office, when informed of this inspection, sent reports completed in 1982 and 1984 showing outstanding corrective action initiatives and proposals in the region. This type of format, updated annually, could be useful to States on a national basis.

Recommendations

- o The HCFA should publish a compendium or catalog of error reduction techniques on a periodic basis. States should submit specific successful practices found to be helpful in

reducing or maintaining low errors, and a contact person should be listed for further information.

- o The HCFA should develop strategies to distinguish areas where one State can help another. Staff in one State can share its expertise with staff from another State. The HCFA could help coordinate this effort both regionally and nationally.
- o The HCFA should organize regularly scheduled meetings, both in regions and nationally, that focus on Medicaid eligibility and related corrective action. Attendees should include Medicaid quality control and program policy staff at the State and Federal levels.

PROVIDE DATA TO ENHANCE CORRECTIVE ACTION INITIATIVES

Finding

A major purpose of the Medicaid eligibility quality control system is to measure misspent Medicaid funds in each State. Although it accomplishes its goal, it is not always a useful management tool to States for corrective action purposes.

Case error rate data are a useful management tool to supplement payment error data. Case errors identify the causes of the errors upon which corrective action is established. By reducing case errors through corrective action, States reduce the potential for payment errors.

Recommendation

The HCFA should publish case error rate data annually by element and by State to assist in tracking the progress of States in error-reduction efforts. The information can be used in addition to payment error data to determine areas of weakness which corrective action can address.

NOTIFY STATES OF POTENTIAL SAVINGS

Finding

Although there is great concern in the Medicaid program about the loss of Federal dollars due to disallowances for eligibility errors, there is little emphasis on the loss of the State dollars and other Federal dollars associated with misspent Medicaid funds.

While the threat of Federal disallowances puts a sharp focus on Medicaid error reduction, the Medicaid program has a lower priority in error reduction activities than the AFDC and Food Stamp programs. A major reason is that many States meet their Medicaid error rate goals, while most do not meet their AFDC and Food Stamp error rate goals. In Fiscal Year 1985, for example,

Medicaid had a 2.7 percent error rate nationally with only 12 States not meeting their goals, and AFDC had a 6.15 percent error rate nationally with 47 States not reaching their goals.

Naturally, people will tend to give priority to reducing high error rates. In Fiscal Year 1985, however, misspent funds in the Medicaid program cost Federal and State Governments a combined \$1.01 billion, while misspent funds in the AFDC program amounted to \$918 million.

Recommendation

The HCFA should alert State officials annually to the actual costs associated with misspent Medicaid funds--not only the Federal portion exceeding 3 percent, but also the total Federal and State dollars misspent in each State.

PROVIDE SPECIAL ASSISTANCE

Finding

Several States either have difficulty achieving the 3 percent national standard or have had high volatility in their error rates over the past few years. Yet, there is no national system to assist States in identifying causes of error and taking appropriate corrective action measures.

Recommendation

The HCFA should identify States which have difficulty reducing their errors to a consistently low rate and provide special assistance through the HCFA regional offices. This could consist of determining the specific causes of the errors and assisting in the design of corrective action measures to address the problem.

ESTABLISH INCENTIVES FOR SUCCESSFUL EFFORTS

Finding

While punitive measures exist by law for States exceeding the 3 percent error rate, there are no rewards or incentives for States below 3 percent. Most States have been successful in reducing errors below the Federally mandated 3 percent. Some States have been consistently below 3 percent for many years. Yet, little recognition or incentives are available to States and individuals in those States for outstanding performance.

Further, a State can be consistently below 3 percent for years, only to find a sample period where one or a few high-dollar cases are in error. This can raise the error rate above 3 percent and subject the State to a disallowance.

Recommendation

The HCFA should establish an annual awards procedure to recognize States which have error rates below the 3 percent national standard. Another method to recognize successful States would be to seek legislation to allow credits for States with error rates below 3 percent. A successful State that might rise above the rate during one quality control sample period could use accumulated credits to offset disallowances.

EXPERIMENT WITH NEW SAMPLING TECHNIQUES

Finding

New sampling techniques, like Nebraska's retrospective sampling technique described in appendix A, may help improve precision of the error rate and also provide additional data to assist in corrective action. Yet, States are unwilling to adopt retrospective sampling for several reasons outlined in this report.

Recommendation

The HCFA should offer incentives for States to demonstrate new sampling techniques. One incentive would be to waive disallowances for a period of time and allow a State the option of returning to its previous sampling system.

PROVIDE TIMELY AND CLEAR POLICY

Finding

States report they often have to implement Medicaid program changes prior to the promulgation of Federal regulations or policy, and when the guidelines are finally received, the language is sometimes confusing and lends itself to various interpretations.

Recommendation

The HCFA should issue Medicaid policy in a timely manner to provide States with sufficient lead time to properly implement changes. Policies should be written clearly to lessen the likelihood of different interpretations that could cause eligibility errors. States could implement changes in a manner similar to Virginia's practice described in appendix A.

APPENDIX A

EFFECTIVE TECHNIQUES AND PRACTICES

This section highlights some practices and programs which States consider to be effective and/or innovative. The practices may not be exclusive to the State identified, nor does this section list all the practices employed by the particular State.

NEW JERSEY

To improve program administration, all eligibility functions have recently been brought under the Division of Medical Assistance and Health Services within the Department of Human Services. This gives a single agency control of the program and prevents fragmentation of responsibilities. The Medicaid quality control staff plays a significant role in the management of New Jersey's Medicaid program and is consulted in all decisions affecting eligibility. Through a number of management strategies, New Jersey has been able to maintain a low Medicaid error rate.

Monitoring of Quality Control Errors

A summary report of each quality control error is sent to the county that committed the error, and that county has 3 weeks to respond to the notice. If the county agrees with the finding, staff must notify quality control of the action taken to correct the problem and prevent further occurrences. State program staff gets copies of the initial reports; however, it is the Medicaid quality control staff that monitors the counties' responses. If the corrective action is not acceptable, the counties are contacted for additional information.

The quality control unit uses the error reports to evaluate corrective action activities in place and to develop new strategies. Errors are analyzed by county, region, and type of problem. The collective findings are reviewed quarterly and are discussed with field service supervisors who monitor work in the counties.

County Management Reports

County welfare agencies are evaluated annually by performance standards set by the Department of Human Services. The guidelines of the review are very specific as to the subjects to be examined and the methods used for evaluating the elements. The review is thorough, and the results are provided to each county agency and county executive officer who supervises the county director. The State feels that publication of these management reviews has a major impact on error reduction.

Communication

Realizing the importance of communication among all the eligibility functions (and particularly between the State and local offices), New Jersey has established avenues that facilitate contact between the "players."

New Jersey has a comprehensive regional network of Medicaid staff which allows each county to have at least one regional representative exclusively. With this ratio, regional staffs are able to spend most of their time in county offices providing technical assistance and monitoring local activities.

The State office staff (program, quality control, and corrective action) meet with the regional directors and field service supervisors once a month and with the county Medicaid supervisors bimonthly. These meetings serve as a forum to discuss problems, corrective action, and impending policy changes.

The Medicaid Corrective Action Panel meets quarterly and is chaired by the Medical Assistance Division Director. All areas of eligibility responsibility are represented, and membership is comprised of high-level managers who have the authority to see that activities approved by the panel are implemented.

Policy Development

To minimize the negative effect of implementing program changes, New Jersey starts planning for the changes well in advance of implementation dates. Designated staff members monitor all proposed Federal regulations and policy changes. Managers are assigned to respond to the proposals, follow the proposals' progress, and lead the planning for possible implementation. When the policy is received from HCFA, the State's preparation for implementation is well underway. The lead time gained by planning early gives the State time to take the actions needed for a smooth implementation.

GEORGIA

Georgia's Medicaid error rate has fluctuated over the last few sample periods. In an attempt to reduce and stabilize the rate to avoid disallowances, the State has implemented a number of practices.

Specialization

There are specialized SSI-related Medicaid eligibility staff at the local level. These positions are on the highest caseworker pay grade. Specialization means that fewer people are involved with the program, and these caseworkers are required to know only one program thoroughly. Since the Medicaid staff number so few,

caseworkers are able to receive more direct support from the State office, providing more consistent application of policy throughout the State. Examples of this direct support are:

- o Caseworkers are assigned to regions (as opposed to county offices) with one front-line supervisor per region. These supervisors get policy clarifications directly from the State office and do not have to go through several layers of the organization.
- o State office staff conduct quarterly training sessions for front-line Medicaid supervisors and visit each region at least once a quarter. The topics for training may be new policy or a review of current policy in which errors are occurring.
- o The State office staff provides programmatic training for new caseworkers once a quarter and provides refresher training as needed.

Supervisory Reviews

A random sample of MAO cases is reviewed each month for areas that are prone to errors. The review criteria for SSI-related Medicaid cases requires that caseworkers do extensive research, verification, and documentation of resources, which is the State's major error element. The review process is as follows:

- o Front-line supervisors review a specified number of cases each month.
- o In urban counties, administrative supervisors review a sample of those cases to check the supervisors' reviews.
- o State office staff review a sample of cases that have been reviewed by local offices.

Computer programs are used to compile the findings so errors can be identified by worker, unit, county, region, or error element.

Decision Tree

A program for use with a personal computer has been written to assist caseworkers in screening an applicant's eligibility for AFDC-related Medicaid. After the caseworker answers a series of questions, the computer determines the appropriate category of assistance and potential eligibility. The information is available both on-line and printed. This procedure does not replace the application process; however, it helps the worker identify which set of eligibility criteria is to be used in processing the application.

MICHIGAN

In Michigan, there is evidence of commitment from the top, starting at the Governor's office. To maintain a low error rate, Michigan uses a number of targeted strategies.

Corrective Action Specialization

Specialization of the corrective action function exemplifies the commitment to error-reduction by making corrective action a priority.

The highly visible Office of Quality Improvement has been established at the direction of the Governor and reports to the Director of Social Services. The Office of Quality Improvement is responsible for reducing errors in the Medicaid, AFDC, and Food Stamp programs. The function is accomplished by identifying causes of errors, initiating remedies, and coordinating with county offices for implementation.

Fifty-five quality assurance specialists have been located in county offices to coordinate corrective action at the local level. These specialists analyze local findings, develop local strategies, and provide local managers with timely and relevant information on the status of errors. The quality assurance specialists have evolved from a reduction of quality control staff, and its expertise is now utilized in a related function. The State places emphasis on the coordination of information among the quality assurance specialists, county managers, and State managers to share problems and remedies.

Local Office Automation

Budget computations are made by caseworkers on personal computers located in each local office. After eligibility is established, pertinent information is transmitted to the statewide system for the issuance of benefits. Michigan finds this type of system, as opposed to an integrated statewide system, easy to update and useful in monitoring activity on a case.

Case Reviews

Supervisors review a percentage of cases to identify problem areas or workers that need special training. This practice is considered essential to error reduction.

Kent County (Grand Rapids) Department of Social Services

This county might well be used as a model in dealing with the containment of errors in an urban county, and the office has hosted many observers from other States. County staff attributes its low error rates to:

- o use of local office automation to compute eligibility budgets and track caseload activity;
- o case reviews of all points of eligibility and targeted reviews of specific error-prone elements;
- o structuring of the eligibility worker's time to ensure maximum efficiency;
- o clearly defined performance standards for timeliness and accuracy (agreed upon by both management and workers);
- o consistent, regular monitoring of worker and management performance;
- o worker and management involvement in quality circles; and
- o procedure and policy interpretations formalized in writing to ensure uniform application.

NORTH CAROLINA

Although North Carolina's county offices are locally administered, the Division of Medical Assistance works in close cooperation with them. Some of the many practices the State employs to maintain consistently low error rates follow:

Medicaid Error Reduction Committee (MERC)

This committee meets quarterly and is a key to communications between the State and local offices. Counties that have errors are directly involved in the corrective action process by participating on this committee. In the meetings, county staff learn the severity of the potential Federal disallowances and the potential loss of dollars to their counties due to incorrect eligibility determinations. County staff is involved in the development of strategies, such as the revision of manual material, forms, and training procedures. The MERC is also designed to motivate county supervisors to focus their attention on error reduction in the county offices. The MERC meetings are also used as a vehicle for sharing successful administrative practices.

"QC Flash"

This is an on-line message sent monthly by the State Medicaid Quality Control Section to county offices via the State computer system. It provides local staff with error-reduction tips and verification techniques. It also identifies problems and methods to prevent future occurrence. The "QC Flash" is not a policy directive, but rather a means to transmit information quickly to address error reduction.

Corrective Action Record Review (CARR)

This is a review that can be used as a corrective action management tool to identify error trends in all the counties. This enhanced, or supplemental, sample is outside the Federal quality control sample required for disallowance purposes but uses the same standards. The quality control analysts review approximately 25 records per county. A detailed report of each case is shared with appropriate county staff, and the State monitors their corrective action. The CARR has helped in the reduction of agency-caused errors in institutional care cases and has helped reduce the State's case error rate.

Administrative Letters

At the end of each 6-month sample period, the State Division of Medical Assistance sends to county directors and Medicaid supervisors a compilation of the errors found by quality control staff. This administrative letter analyzes each error by type, cause, and county. It also suggests corrective action methods for the prevention of errors. This letter is used as a training tool to help prevent similar errors from occurring in future samples.

Recognition

Certificates are awarded to counties that have no Medicaid errors in any given sample period. A star on the certificate indicates one consecutive error-free sample period, two stars indicate two consecutive periods, etc. Counties which earn recognition often receive publicity through their local newspapers. This recognition is an effective and low-cost incentive for counties to maintain low error rates.

NEBRASKA

Nebraska received approval of a waiver to implement retrospective sampling in Fiscal Year 1984. Nebraska felt that, by reviewing only cases with claims, they could pinpoint areas where large amounts of money are likely to be misspent.

The following is a brief description of how Nebraska's sampling system works:

- o The month reviewed is 4 months prior to the month the sample is pulled; therefore, claims for the review month have been paid. (For example, a case selected in November is reviewed for July eligibility.)
- o A large number of cases are selected (in November) and claims (from July) are identified.

- o The claims are sorted by dollar value into three strata: low, medium, and high. Then, some cases with no claims are added to the low stratum.
- o Samples are selected from each stratum and quality control reviews are performed on the related eligibility cases.
- o Since eligibility is determined retrospectively (July), Medicaid claims have been processed (by November), and an error rate can be determined immediately upon completion of the quality control review.

Nebraska sees the following as advantages of this system:

- o It offers a more precise picture of errors because rates are not determined by the "luck of the draw."
- o By reviewing an increased number of cases with paid claims, the State is able to identify the most costly types of errors.
- o Enough cases are sampled in the high and medium-dollar strata to establish more reliable error trends that are used to develop corrective action measures.
- o The system requires no significant increase (or decrease) in staff or administrative costs.

Nebraska's major fear when requesting the demonstration project was that the State error rate would increase due to the concentration of cases with paid claims, especially since some of those claims were very high. However, this did not occur; since retrospective sampling was implemented in 1984, the State's error rate has been in the 1 percent range.

VIRGINIA

This State has consistently maintained a low error rate by emphasizing a close working relationship among quality control, policy, corrective action, and local offices. To complement this management, Virginia employs a number of corrective action measures.

New Worker Training

The State has provided each region with a video training package to be used for new workers. The package is divided into modules which can be updated easily. The training itself is provided by regional program specialists and is offered in at least one region every month. The purpose of this training is to bring all staff to the same level of understanding and ensure that policy instruction is consistent.

Special Corrective Action (SCA)

If a local agency's quality control error rate exceeds a specified tolerance level set by the State, that agency is classified as an SCA agency. State managers meet with the SCA agency staff members and provide them with analysis data and impact projections. The agency then develops a corrective action plan that must include specific activities depending on whether the concentration of errors is caused by the agency or clients. The plan must be approved by the State, which monitors the agency's activities on a weekly basis.

Development of the special corrective action program is a joint effort between the State and local agency, and the monitoring is maintained for at least 6 months (through the next quality control sample period). The State makes available to the SCA agency the support needed to carry out the plan and, when needed, assists with funding projects, such as a computer-generated questionnaire sent to clients.

Issuance of Policy

Virginia limits the issuance of new policy to once a quarter in an attempt to prevent errors caused by constant changes. In addition, this systematic method of policy release gives local agencies better control over their own workloads. They know when to expect and plan for changes. The quarterly issuances are also accompanied by training. The only exceptions to this plan are made to meet Federally mandated or court-ordered implementation dates.

When policies change, Virginia starts planning early for implementation. State staff keep abreast of statutory changes and begin formulating State policy and procedures as soon as a change is passed by Congress. From reading the law itself, State officials usually can determine the intent, and they immediately start drafting manual material and developing training. When Federal guidelines (or interpretations) are finally received, minor changes to the material might need to be made, but most of the work has already been done. By starting early, the agency has time to solicit county input and think the policy through, which decreases the need for having to make changes once the policy has been issued. In other words, they start early to allow themselves enough time to do it right the first time.

To prevent the misinterpretation of information that can cause errors in eligibility determinations, policy questions and answers are put in writing. This procedure is handled speedily through the use of a turnaround form that is initiated by the local office. It is routed to the regional specialist and is forwarded to the State office if the question cannot be answered at the regional level. The turnaround form is completed by hand

(to eliminate time needed for typing), and a time limit for responding is imposed. The form also can be used by local offices to comment on policies or procedures. Thus, this form helps prevent the misapplication of policy and facilitates communication between the State and local offices.

Regional Attorneys General

Seven regional offices serve as links between the State and local agencies. Assistant Attorneys General are located in each region to assist local agencies in legal matters. These attorneys serve the Medicaid program by reviewing legal documents such as deeds, trusts, and wills to determine the availability of a resource to the client.

OKLAHOMA

The following is a brief description of some of the activities the Oklahoma Department of Human Services is undertaking to reduce Medicaid errors.

State and Regional Corrective Action Committees

Each of the five regions has a corrective action committee comprised of county and regional staff. In addition to recommending new corrective action strategies, this committee reviews eligibility determination cases from the region to identify error-prone areas and training needs. The reading of cases by a group of peers from another county is reported to be an excellent error deterrent.

The State Corrective Action Committee meets bimonthly and reviews every error case to identify error types and causes. The activities of the regional committees are also discussed, and their recommendations are considered by the State committee for implementation.

Case Reviews

In addition to the case readings done by the regional corrective action committees, Oklahoma conducts ongoing and targeted case reviews. Each supervisor is required to read a fixed percentage of cases from each caseworker, depending on the worker's level of experience. The results are used to identify causes of errors and need for training. Twice a year, all institutional care cases are reviewed by regional field representatives, since errors in these cases have substantially contributed to previous error rates.

Weekly Corrective Action Memos

The Corrective Action Unit compiles a weekly error report which is sent to counties to be used as a training tool. The report is

a detailed summary of each error type and cause. It also gives the review month and the date of the onset of the error.

SOUTH CAROLINA

South Carolina, through the following strategies, has reduced its error rate in Fiscal Year 1986 to 2.7 percent.

Medicaid Quality Control Targeted Sample (MQCTS)

This is a statistically valid sample drawn from specific error-prone counties or error-prone eligibility categories. This supplemental sample is over and above the official quality control sample which is used to determine Federal disallowances. The review uses quality control standards, and an error rate is established for a given county or eligibility category. Findings are used to identify weaknesses so that measures can be taken to eliminate problems. The MQCTS is used solely as a management tool for corrective action and is among the State's most effective practices.

Training

Regional training is conducted for county staff on a quarterly basis. Long-term care cases are specialized in the county offices, and those workers and supervisors are trained to enhance their case-processing skills. The same people conduct the training in each region so all staff receive the same information. New and revised policies and procedures are also an integral part of the training sessions.

Medicaid Planning Task Force

This task force has been formed to evaluate current corrective action initiatives and to assist in the development of Medicaid training. The committee is comprised of 12 county supervisors, with representation from large, medium, and small counties. The quality control staff attend the meetings to offer assistance and expertise. The task force is divided into three subcommittees that are given the responsibility for developing recommendations in the following areas:

- o development of a supervisory review system;
- o revisions needed to all forms and computer reports; and
- o statewide or county-specific corrective action measures.

Special Reviews

A printout of institutional care cases is sent to each county office. Workers complete desk reviews of cases that have resources near the resource limit (in excess of \$1,499) to ensure that the resources have not exceeded the limit.

Comprehensive Medicaid Program Review (CMPR)

This review is a managerial tool that can be adapted to assess a specific county's performance or any program component in Medicaid. The object of CMPR is to:

- o provide assistance in error detection and correction;
- o identify weaknesses in program administration; and
- o provide technical assistance for the operation of the Medicaid program.

The CMPR is comprised of five parts:

- o general program knowledge assessment;
- o corrective action assessment;
- o eligibility case record review;
- o Early Periodic Screening, Diagnostic, Testing case record review; and
- o follow-up training.

This initiative assists program staff in identifying weaknesses of individuals, counties, or programs. It also establishes a framework within which State program staff can provide follow-up monitoring and training for county staff.

Targeted Corrective Action

In Fiscal Year 1985, approximately 48 percent of the agency-caused errors occurred in 13 percent of the State's counties. For this reason, South Carolina has targeted corrective action strategies to those counties. The initiatives may include specific technical assistance, county visits, CMPR, or MQCTS.

MARYLAND

Prior to the April through September 1985 sample period, Maryland's error rate had been under the Federal tolerance. State officials attribute the recent error rate increase to a particular State policy they are now changing. In addition, they are stepping up corrective action in the Medicaid program. Specific practices include:

- o direct training of local staff by the State office;
- o policy clearances provided directly by the State office to local offices;

- o development of a second party, or supervisory, review of a percentage of Medicaid cases; and
- o development of a case management system to ensure that case records and case processing are uniform across the State.

APPENDIX B

**STATE BY STATE MEDICAID PAYMENT
ERROR RATES**

The following table is a State by State Medicaid payment error rate by year from Fiscal Year 1981 through Fiscal Year 1986.

The two pages of charts following the table show the Medicaid payment error rates, by fiscal year, for States in the inspection sample.

MEDICAID ELIGIBILITY PAYMENT ERROR RATES

	FY 1981	FY 1982	Apr.-Sep. 1983	FY 1984	FY 1985	FY 1986
NATIONAL AVERAGE	3.8	3.8	2.9	2.7	2.7	2.6
REGION I						
Connecticut	5.1	2.1	1.6	2.7	2.4	3.16
Maine	7.5	7.7	3.1	1.8	3.6	1.96
Massachusetts	8.3	7.8	3.8	2.7	2.5	2.08
New Hampshire	3.5	4.1	2.4	2.6	0.2	0.32
Rhode Island	5.5	2.0	3.9	1.2	2.5	3.36
Vermont	5.0	4.2	3.2	4.3	2.9	0.75
REGION II						
New Jersey	3.0	2.5	2.8	1.1	1.2	1.38
New York	2.4	1.9	2.8	2.3	2.8	1.57
REGION III						
Delaware	9.4	4.4	1.9	0.9	0.4	0.14
Dist. of Col.	2.6	10.8	1.1	1.6	4.8	2.05
Maryland	5.3	4.0	3.0	2.2	3.3	4.41
Pennsylvania	3.7	5.5	3.6	3.8	4.1	2.85
Virginia	2.1	3.2	2.0	1.5	1.3*	1.08
West Virginia	10.2	5.5	0.1	1.6	1.8	1.85
REGION IV						
Alabama	3.0	2.9	1.9	3.0	1.6	0.96
Florida	5.3	4.3	1.4	2.4	1.4	3.12
Georgia	6.8	5.6	2.9	6.4	4.3	4.84
Kentucky	4.4	2.8	2.1	1.6	1.5	0.95
Mississippi	3.0	5.7	3.3	1.1	2.4	0.77
North Carolina	3.7	2.1	1.4	0.7	2.3	1.17
South Carolina	2.3	5.8	2.2	3.6	3.0	2.70
Tennessee	3.6	4.5	2.9	1.7	2.6	1.95

*VIRGINIA'S ERROR RATE IS BASED ON OCT. - MAR. 1985 DATA SINCE APR. - SEP. 1985 PERIOD IS INCOMPLETE.

MEDICAID ELIGIBILITY PAYMENT ERROR RATES

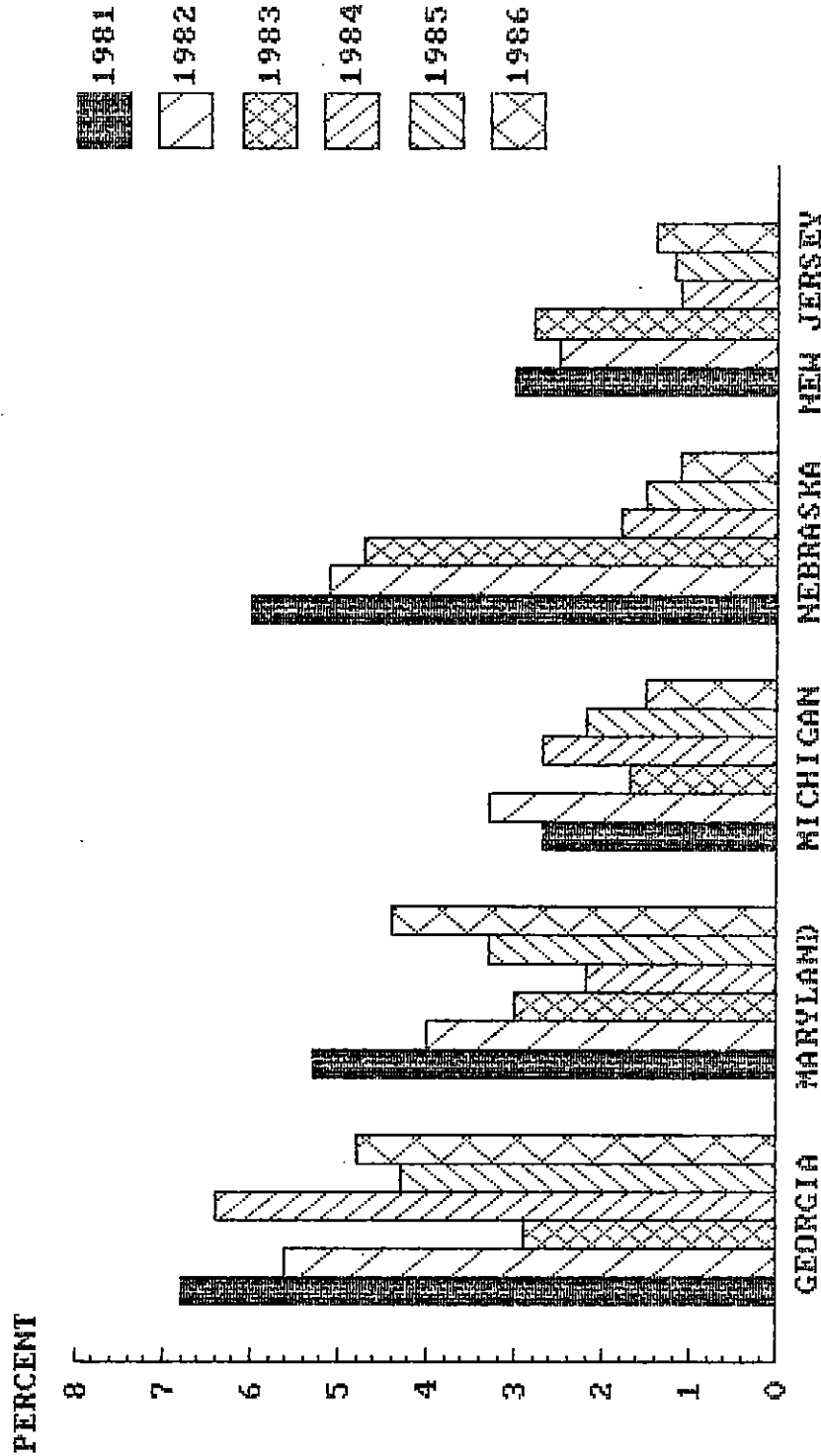
	<u>FY</u> <u>1981</u>	<u>FY</u> <u>1982</u>	<u>Apr.-Sep.</u> <u>1983</u>	<u>FY</u> <u>1984</u>	<u>FY</u> <u>1985</u>	<u>FY</u> <u>1986</u>
REGION V						
Illinois	4.9	2.0	2.5	2.4	1.9	1.94
Indiana	1.1	7.4	2.9	4.8	3.6	3.01
Michigan	2.7	3.3	1.7	2.7	2.2	1.52
Minnesota	0.5	0.5	2.0	1.3	3.4	4.31
Ohio	2.2	4.5	2.6	2.7	3.5	2.05
Wisconsin	3.1	3.9	3.6	3.3	2.2	4.56
REGION VI						
Arkansas	3.1	3.5	6.1	3.5	1.7	1.36
Louisiana	3.2	3.1	3.0	2.0	2.9	6.96
New Mexico	3.9	8.4	4.5	3.7	4.4	1.75
Oklahoma	5.7	3.0	2.6	5.5	5.0	1.85
Texas	3.4	5.4	2.7	2.8	1.8	2.99
REGION VII						
Iowa	3.0	4.7	2.5	2.0	2.1	2.04
Kansas	3.1	3.0	2.1	3.1	1.1	1.31
Missouri	0.5	3.4	6.9	1.4	2.7	2.41
Nebraska	6.0	5.1	4.7	1.8	1.5	1.06
REGION VIII						
Colorado	4.1	5.5	2.4	2.6	4.1	1.52
Montana	14.7	8.5	1.2	1.0	2.2	1.22
North Dakota	3.6	2.3	1.3	1.0	1.1	1.25
South Dakota	3.7	3.5	2.1	1.0	1.4	1.40
Utah	4.9	3.7	1.4	3.2	1.1	0.93
Wyoming	3.9	3.6	3.5	1.4	2.3	2.61
REGION IX						
Arizona	---	---	5.2	7.3	6.2	4.60
California	5.8	5.5	4.4	4.2	2.8	5.16
Hawaii	8.4	6.8	1.3	1.5	1.9	0.71
Nevada	1.8	2.1	1.2	0.5	0.1	0.32

MEDICAID ELIGIBILITY PAYMENT ERROR RATES

REGION X	FY 1981	FY 1982	Apr.-Sep. 1983	FY 1984	FY 1985	FY 1986
Alaska	12.7	2.6	6.8	2.6	2.0	0.64
Idaho	4.6	2.4	0.4	1.8	0.7	0.40
Oregon	3.4	3.5	2.9	2.1	1.7	1.25
Washington	6.8	6.7	4.1	2.2	2.0	1.82

SOURCE OF INFORMATION: HHS/HCFA

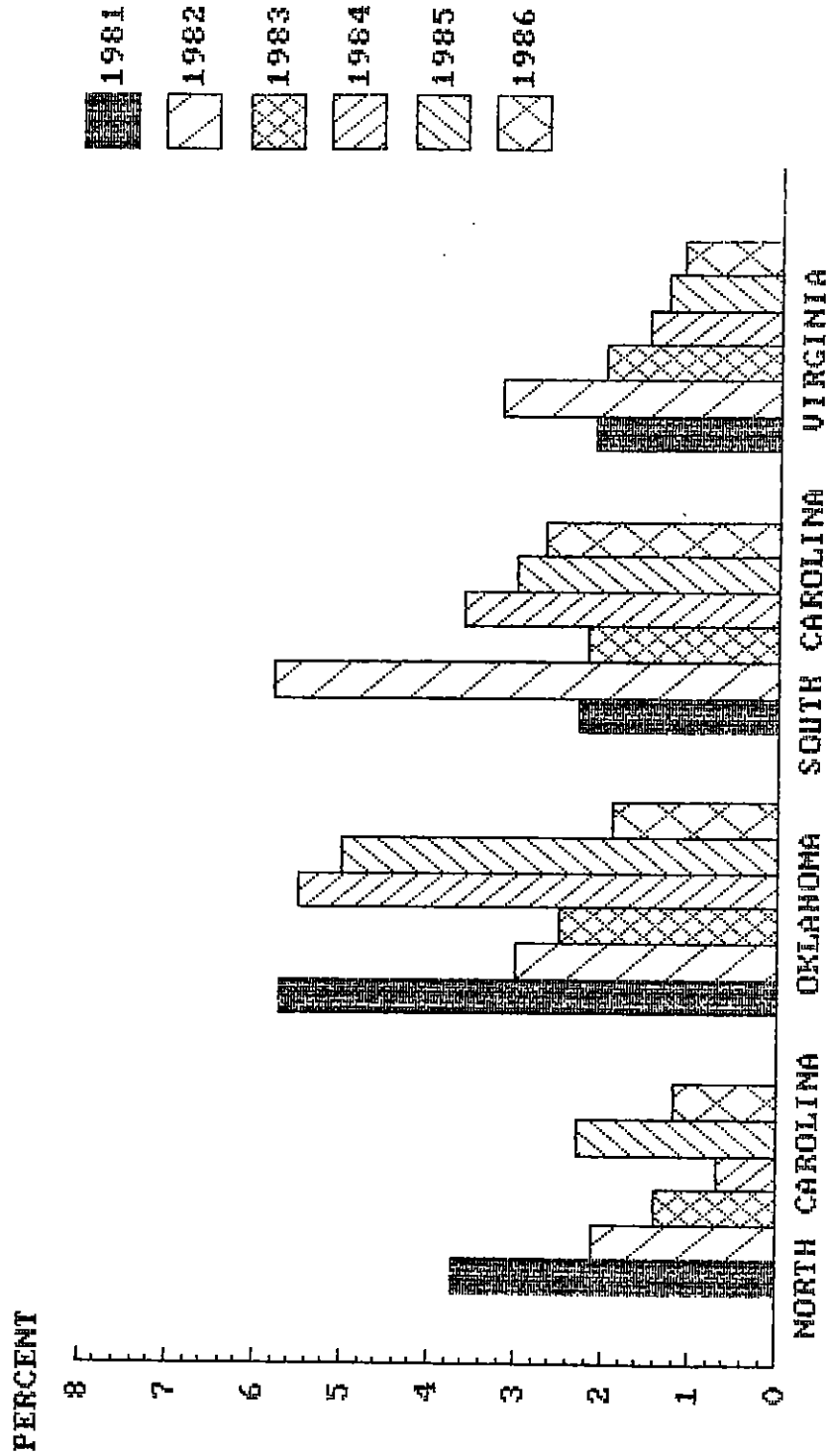
MEDICAID ELIGIBILITY PAYMENT ERROR RATES
 FROM QUALITY CONTROL ERROR RATE DATA
 FY 1981 THROUGH FY 1986



STATES BY YEAR FY 1981-1986

STATES IN INSPECTION

MEDICAID ELIGIBILITY PAYMENT ERROR RATES
 FROM QUALITY CONTROL ERROR RATE DATA
 FY 1981 THROUGH FY 1986



STATES BY YEAR FY 1981-1986

STATES IN INSPECTION

APPENDIX C

HEALTH CARE FINANCING ADMINISTRATION'S COMMENTS

The comments on the following pages are from HCFA in response to our draft report. We have incorporated many of the editorial comments into this final report.

The HCFA believes "that many of the report's recommendations fail to take into account the congressional role in the existing MEQC program." Due to this congressional interest, HCFA believes it does not have a completely free hand to manage MEQC.

We do not believe that congressional interest precludes implementing the recommendations outlined in this report. Although some of the findings of the inspection illustrate limitations of the current MEQC system, the majority of the recommendations address actions HCFA should take to assist States in reducing eligibility errors, regardless of the way the errors are counted for disallowance purposes. Because eligibility errors are costly to Federal and State Governments, we believe it to be a critical responsibility of HCFA in its role as technical advisor to State agencies to facilitate the initiation of successful corrective action measures.

Memorandum

DEC 22 1987

William L. Roper, M.D. *WR*
Administrator

Draft Report - Eligibility Errors Resulting in Misspent Funds in the
Aid Program (OAI-04-87-00014)

Inspector General
Office of the Secretary

I have reviewed with interest the OIG report on the Medicaid Eligibility
Control (MEQC) program.

and that many of the report's recommendations fail to take into
account the congressional role in the existing MEQC program. In order to
be properly balanced, it is important that the report include a discussion
of the congressional role. Specifically, the report should describe some
of the conflicting congressional actions related to quality control over
the past several years. The report states that in 1980 the appropriations
act established the 4 percent tolerance level and that in 1982 the Tax
and Fiscal Responsibility Act of 1982 (TEFRA) lowered the tolerance
to 3 percent. However, what has been left out of the report is the
continued congressional concern with the Federal government taking
allowances based on the quality control systems. For example, in 1984
section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA) established a
moratorium on MEQC penalties for a certain category of errors. This
moratorium was recently clarified (or strengthened) in section 9 of the
Omnibus Budget Reconciliation Act and Medicaid Patient and Program Protection Act of 1987 (P.L.
100-33). Section 12301 of the Consolidated Omnibus Budget Reconciliation
Act (COBRA) in 1986 included a requirement for comprehensive studies of
quality control in both the Aid to Families with Dependent Children (AFDC)
and the Medicaid programs. The reports are currently due in December and
require final clearance by Executive OMB. (A similar requirement was
established for the Food Stamp program.) Finally, included in the current
version of the 1987 reconciliation legislation is a continuation
through 1988 of a broad moratorium, established in COBRA, applied to both
Medicaid and AFDC. (The moratorium originally applied only to AFDC).

A summary of Congressional actions is provided to show (1) that
Congress is acutely interested in MEQC, (2) that HCFA does not have a
completely free hand to run the MEQC program, and (3) that Congress is
entirely not sure what the correct policy should be towards the
recovery of misspent monies identified through the MEQC program. The
report does not address these concerns and implies that HCFA has
complete discretion on how it might proceed in this area. This is not the
intention.

Further, any actions taken before the COBRA required reports are
completed and Congress, HCFA, and the Family Support Administration have

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Page 2

There can be no argument that policies should be written clearly and issued in a timely fashion. It is HCFA's goal to do just that and we have done so in many instances in the past. It is not always possible, however, to control legislative or court-imposed deadlines for policy changes. Those deadlines often do not permit sufficient lead time for policy changes to be implemented, however HCFA has no choice but to abide by those mandates. We will continue to work diligently to ensure that as much lead time for implementation as is possible and reasonable is given, and that our policies are expressed in as clear and concise a way as possible.

Page 15, Paragraph 3 - HCFA had an integral part in the retrospective sampling process, and continues to strongly urge its adoption by any State. The reasons listed by the States for not adopting it center around relatively minor start-up costs or the desire not to have a more accurate error rate.

Page 22, Paragraph 2 - The report says, "many States below 3 percent have gone as far as they can." Nothing in the report supports this conclusion.

Page 22, Paragraph 3 - We disagree that HCFA offers minimal corrective action assistance to the States. Among other things, HCFA requires each State to report annually on its corrective actions and our regional offices review and provide technical assistance on these plans.

Page 23, Paragraph 1 - During the past annual conference of the State Medicaid Directors' Association, jointly sponsored by HCFA and the American Public Welfare Association, we announced our decision to centralize funding for Technical Advisory Group (TAG) travel, and to develop a consistent policy for utilizing TAGs. Comprised of technicians and specialists in particular fields, TAGs meet with HCFA policymakers and program specialists to resolve policy and implementation problems. This decision was made in direct response to State Medicaid Directors' calls for more interaction with HCFA policymakers. We believe that this effort will resolve many issues that are inherent in a program as complex as Medicaid.

Page 26, Paragraph 2 - The normal Medicaid match rate system gives States considerable incentive to avoid making erroneous payments. On average the States pay 45 percent of the costs of the Medicaid program. Therefore the States save a significant amount, along with the Federal government, when they avoid payment errors. In addition, establishing an incentive program could be quite costly to the Federal government if it rewarded those States that had already implemented appropriate management controls to avoid errors. Also, such an incentive program would be judged unfair if it did not reward past State performance. Finally, congressional action would be necessary to establish such a program, and until the COBRA reports have been completed Congress is unlikely to make any changes to the current MEQC program.