OFFICE OF INSPECTOR GENERAL

CMS Oversight of Cost-Avoidance Waivers

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EXECUTIVE SUMMARY

OBJECTIVE

This inspection reviewed the Centers for Medicare & Medicaid Services's (CMS's) oversight of the cost-avoidance waiver process.

BACKGROUND

Millions of Medicaid beneficiaries have additional health insurance through third-party sources such as Medicare or private health insurance. Because Medicaid is the payer of last resort, these third parties are liable for many claims submitted to Medicaid. When they receive claims that have a liable third-party payer, State Medicaid agencies can: (1) cost avoid, i.e., return the claim to the provider so that the provider can bill the liable third party, or (2) pay and chase, i.e., pay the provider's claim and then seek recovery from the liable third party. States report cost-avoidance and pay-and-chase data to CMS as part of their CMS-64 report.

States are required to use cost avoidance for most services unless the State has a waiver allowing it to pay and chase. According to 42 CFR § 433.138, CMS regional offices may grant these waivers when States demonstrate that pay and chase is as cost-effective as cost avoidance. The *State Medicaid Manual* requires States to renew their cost-avoidance waivers every 3 years. The manual does not have any requirements addressing the retention of waiver documentation by the CMS regional offices.

We reviewed the waiver process at all 10 CMS regional offices. We requested information from the regional staff about their offices' policies and procedures regarding the waiver review process, the steps they take when reviewing waiver requests, and the criteria they use to examine cost-effectiveness. We collected information and documentation from the regional offices about waivers currently held by States as well as waiver requests that had been denied. In addition, we surveyed Medicaid agencies in 50 States and the District of Columbia on their third-party liability processes and policies. We requested financial data, cost-avoidance waiver information, and a description of any problems States encounter when attempting to recover money from third parties. Forty-eight States responded to our survey.

FINDINGS

CMS and States disagreed about whether certain States were operating under approved waivers

Fourteen States and their respective CMS regional offices provided contradictory responses as to whether these States had been approved for cost-avoidance waivers. Four States reported that they had cost-avoidance waivers for certain services, but their regional offices indicated that they did not. In addition, 10 States reported that they did not have waivers for specific service types, yet the CMS regional office reported they did. Some of the inconsistencies over cost-avoidance waivers may stem from the lack of documentation maintained by certain States and CMS regional offices.

CMS approved cost-avoidance waiver requests that did not address the criteria for proving cost-effectiveness

Federal regulations require that for a waiver request to be approved, States must show that the pay-and-chase method is as cost-effective as the cost-avoidance method. The *State Medicaid Manual* provides several examples of factors that may be used to determine cost-effectiveness, including average-cost-per- claim, denial rates of claims, administrative costs, and equipment/computer costs. However, our review of 51 recent waiver requests (submitted by 18 States from 7 regions) found that 6 of the 7 CMS regional offices approved waivers that did not address this criteria. In all, CMS approved 46 of the 51 waiver requests that we reviewed. For 20 of these requests, States did not compare the cost-effectiveness of pay and chase to that of cost avoidance. CMS denied 5 of the 51 waiver requests, and 1 of the denials was due to a failure to prove cost-effectiveness. In addition, unlike other regional offices, one CMS regional office is not requiring States to renew cost-avoidance waivers every 3 years as required by the *State Medicaid Manual*. Therefore, the data used to justify cost-avoidance waivers in this region could potentially be years out-of-date.

CMS does not require States to report the data necessary to determine the cost-effectiveness of cost-avoidance waivers

While CMS requires the reporting of actual recovery amounts on the CMS-64, it does not require States to track the amounts they attempted to recover or the amounts validly denied by third parties. Keeping an accurate account of this information is necessary in order to evaluate the cost-effectiveness of both pay-and-chase and cost-avoidance efforts. We asked States to identify the amount they attempted to recover, the amount actually recovered, and the amount validly denied by third parties in 2000. Of the 34 States that had cost-avoidance waivers (according to CMS), 17 did not report attempted recoveries or validly denied figures to us. Without this data, we believe it would be difficult for CMS to make informed decisions concerning the cost-effectiveness of waivers.

Another 17 States, however, did provide the requested data to us. Figures reported by 14 of the 17 States that provided data showed $307 million in outstanding payments

potentially owed by liable third parties in Federal fiscal year 2000. This money has been paid out by the Medicaid program, yet the dollars associated with these claims have not been returned to the Federal government and the States.

RECOMMENDATIONS

Our findings show that CMS is not exercising effective oversight of the cost-avoidance waiver process. Because of the significant program dollars potentially at risk, we believe that proper oversight is critical.

We understand that waivers provide Medicaid agencies with the flexibility to design effective programs for their individual States. We also recognize that CMS has taken steps to review their guidance of the waiver process. However, based on our findings, we believe that CMS needs to provide more effective oversight of the cost-avoidance waiver process.

We recommend that:

CMS improve its oversight of the cost-avoidance waiver process by:

- Approving only waivers that meet the criteria for cost-effectiveness set forth by Federal regulation
- Ensuring that States abide by the *State Medicaid Manual*'s requirement that waivers be renewed every 3 years
- Requiring regional offices to retain proper documentation for all waivers

CMS require States to track the amount of money they attempt to recover from third parties and the amount that is validly denied to assist in evaluating the cost-effectiveness of both pay-and-chase and cost-avoidance efforts

Agency Comments

CMS concurs with our recommendation that they should improve its oversight of the cost-avoidance waiver process. CMS also concurs with our recommendation that States should track the amount they attempt to recover from third parties and the amount that is validly denied. However, CMS added that requiring States to track these amounts would produce little additional information of value, while at the same time taking away needed resources regarding the implementation of Health Insurance Portability and Accounting Act (HIPAA) requirements. With the implementation of HIPAA electronic billing standards, CMS believes providers will be able to bill liable third parties more easily, thereby reducing Medicaid third-party recovery activities. CMS says that they will reassess the need to track the amount States attempt to recover from third parties and the amount that is validly denied within a few years of HIPAA implementation.

In addition, CMS believes that our potential outstanding debt calculation may be significantly less than what is stated in our report. CMS noted that it is difficult to actually quantify the dollars at risk since there are many factors that affect this calculation. For instance, States "cast a wide net when seeking recoveries" because they do not always know if individuals have third-party insurance coverage nor do they know the extent of coverage. As a result, some third parties are not liable for the claims or liable for only a portion of the claim. In addition, States often do not receive responses from third parties regarding pursued claims.

OIG Response

In terms of our potential outstanding debt calculation, we simply based our calculation on figures reported to us by States. We recognize the fact that States may be pursuing dollars that in the end are not owed by third parties. For this reason, we use the phrase "as much as" when referring to the potential outstanding debt estimate. Both the States and CMS would have a more accurate picture of the amount owed to the States if CMS were to implement our recommendation that States track the amount they attempt to recover from third parties and the amount that is validly denied. These data would assist CMS in determining the cost-effectiveness of cost-avoidance waivers. Furthermore, we believe that non-responses from third parties should not be a factor when calculating how much money is owed to the State. The State's entitlement to recovery does not change if a liable third party has not responded to the State's request for recovery.

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INTRODUCTION

OBJECTIVE

This inspection reviewed the Centers for Medicare & Medicaid Services's (CMS's) oversight of the cost-avoidance waiver process.

BACKGROUND

The Medicaid Program

Medicaid is a jointly-funded Federal-State health insurance program for certain low income and medically needy individuals and families. Individual States establish eligibility requirements, benefits packages, and payment rates for Medicaid under broad Federal standards set by CMS. In 2001, the Medicaid program served 42 million beneficiaries at a cost of $217 billion.

Beneficiaries with Third-Party Insurance

Millions of Medicaid beneficiaries have additional health insurance through third-party sources such as Medicare, State worker's compensation, or private health insurance. When a beneficiary has coverage under a third party, the Medicaid program is required by law to be the payer of last resort. Federal regulations (42 CFR § 433.145) state that if Medicaid paid for a service that is covered by a third party, Medicaid has a right to recover the payment from the third party.

According to 42 CFR § 433.138, State Medicaid agencies must take reasonable measures to determine the liability of third-party payers in order to avoid paying claims inappropriately. Reasonable measures include: (1) collecting insurance information from prospective Medicaid beneficiaries; (2) conducting data exchanges with Social Security Administration wage and earnings files; and (3) conducting data exchanges with State files that contain information on wages, welfare enrollment, motor vehicle accidents, and workers' compensation. Any of these sources may indicate the existence of other health insurances.

Processing Claims with a Liable Third-Party Payer

When State Medicaid agencies receive claims that may have a liable third-party payer, States can either: (1) cost avoid, i.e., return the claim to the provider so that the provider can bill the liable third party, or (2) pay and chase, i.e., pay the provider's claim and then seek recovery from the liable third party. According to CMS data, Medicaid avoided paying almost $21 billion in claims in Federal fiscal year 2000, and collected another $683 million from liable third parties after originally paying the claims.

States are required to use the cost-avoidance method unless the claim received is for preventive pediatric services, prenatal care, or services provided through a parent's court-ordered child support obligation. However, States may apply to CMS for a waiver if they wish to pay and chase other types of claims. According to 42 CFR § 433.139(c), Medicaid agencies may sometimes pay and chase claims without a waiver if they cannot determine the existence of third-party coverage at the time the claim was received.

Granting of Cost-Avoidance Waivers by CMS

States request cost-avoidance waivers from the CMS regional office serving their geographic area. According to 42 CFR § 433.138, a CMS regional office may approve a State's waiver request if the State demonstrates that the pay-and-chase method is as cost-effective as the cost-avoidance method. The *State Medicaid Manual* provides several examples of factors that may be used to determine cost-effectiveness, including average-cost-per- claim, denial rates of claims, administrative costs, and equipment/computer costs. Usually, a separate waiver request is submitted for each specific service type (e.g., pharmacy services). According to the *State Medicaid Manual*, States are required to renew their cost-avoidance waivers every 3 years. The manual does not have any requirements addressing the retention of waiver documentation by the CMS regional offices.

Reporting of Third-Party Liability Data

States report third-party liability data to CMS as part of their Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The CMS-64 report for each State is recorded in CMS's Medicaid Budget and Expenditure System. States are required to provide both the total amount that was cost avoided and the total amount collected through pay and chase on their CMS-64 report. These amounts are reported as overall totals and are not subdivided by service type. States are not required to report the amount of money they attempted to recover or the amount that was validly denied by third parties on the CMS-64. "Validly denied" refers to claims where the third party was found not to be liable for the amounts that the State attempted to recover. According to CMS, the data from the CMS-64 report is used to monitor and evaluate the effectiveness of States' third-party liability activity.

Previous OIG Work

A previous study conducted by the Office of Inspector General (OIG), *Medicaid Recovery of Pharmacy Payments from Liable Third Parties* (OEI-03-00-00030, August 2001), found that Medicaid was at risk of losing over 80 percent of the dollars it paid and chased for pharmacy claims. We recommended that CMS: (1) review States cost-avoidance waivers for pharmacy claims; (2) require States to track the amount they pay and chase for pharmacy claims; and (3) determine whether legislation is needed to assist States in recovering payments from liable third parties. CMS concurred with all but one of our recommendations. Specifically, in response to our recommendation on tracking pay-and-chase amounts, CMS concurred in theory, but wrote that, in the interest of State flexibility, it was reluctant to require States to collect this data.

Recent CMS Efforts to Review Waivers

CMS has recently made a concerted effort to track States' pay-and-chase activities. Specifically, on February 7, 2002, CMS central office sent a memorandum to all the regional offices on the subject of cost-avoidance waivers. The memorandum asked the regional offices to contact each State in their respective regions in order to identify: (1) any waivers that have been granted; (2) any pending waiver requests; and (3) situations where a State is using pay and chase without an approved waiver. According to the memorandum, once CMS central office obtains all the information requested from the regions, CMS will issue a follow-up memorandum that provides guidance on the waiver process. CMS has also conducted conference calls with third-party liability coordinators in some regions in an effort to develop potential guidelines and criteria for the review of waiver requests.

METHODOLOGY

State Medicaid Agency Data

We sent a written request to the Medicaid directors at 51 State Medicaid agencies, including the District of Columbia, in November 2001. We asked the directors to distribute the survey to the staff best able to answer our questions. Representatives from 48 States responded to our request. The three States that did not respond were Michigan, New Jersey, and Rhode Island. In this report, we use the word "State" as a synonym for "State Medicaid agency."

We asked States to identify the cost-avoidance waivers they had been granted by CMS, to list any waivers that had been denied in the past 5 years, and to assess the cost-avoidance waiver review process. We requested that States provide documentation verifying the cost-avoidance waiver information reported to us. This documentation included waiver requests from States, approval and denial letters from CMS regional offices, and any additional correspondence between the States and CMS regional offices regarding cost-avoidance waivers. In addition, we requested that States identify any problems they encounter when trying to recover money from liable third parties.

We also asked States to verify the accuracy of third-party liability data reported in the Medicaid Budget and Expenditure System. In November 2001, we accessed this system in order to obtain the amount each State cost-avoided and the amount each State recovered from third parties in Federal fiscal year 2000. If a State said that the amount originally reported in the Medicaid Budget and Expenditure System was not accurate, we asked them to provide a revised figure. We also asked States to report the amount they attempted to recover, the amount validly denied by third parties, and the amount unrecovered for Federal fiscal year 2000.

For any State with waivers that reported each of these figures, we calculated the amount of money that was outstanding by adding the amount recovered to the amount validly

denied, and then subtracting the total from the amount the State attempted to recover. For States that indicated the recovery amount originally reported on the CMS-64 was incorrect, we used revised figures for this calculation.

CMS Regional Office Data

We reviewed the waiver process with staff from all 10 CMS regional offices. We requested information from regional staff about their offices' policies and procedures regarding the waiver review process, the steps they take when reviewing waiver requests, and the criteria they use when determining cost-effectiveness. We also asked staff from CMS regional offices to assess the waiver review process. We collected information about the waivers currently held by States in each region, and about any cost-avoidance waiver requests that had been denied. A chart listing cost-avoidance waivers for each State is presented in Appendix A.

Staff from OIG visited all but one CMS regional office to collect documentation verifying the cost-avoidance waiver information. This documentation consisted of waiver requests from States, approval and denial letters from CMS regional offices, and any additional correspondence between the States and CMS regional offices regarding cost-avoidance waivers. One CMS regional office mailed us documentation because we were unable to visit the office. Some regional offices were unable to provide documentation supporting the existence of all cost-avoidance waivers held by States in their region. We reviewed all recent State waiver requests (51) that were provided to us in order to determine if they met the criteria for approval described by Federal regulation. Neither the regulation nor the *State Medicaid Manual* provides specific instructions as to how States must meet the criteria, only that they must show that the pay-and-chase method is as cost-effective as the cost-avoidance method. Therefore, we considered any request that compared the cost of performing pay and chase to the cost of performing cost avoidance to have met the criteria.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

CMS and States disagreed about whether certain States were operating under approved waivers

The regional offices identified 73 waivers currently held by 34 States. For 21 of the 34 States, the only waiver in place was for pharmacy services. Appendix A lists the waivers that were approved according to CMS regional offices.

Four States reported having cost-avoidance waivers when their respective CMS regional offices indicated they did not

Four States reported that they had cost-avoidance waivers for certain services, but their CMS regional offices indicated that these States did not. One of these States reported having a waiver for dental claims while its regional office indicated it did not. Another reported having a waiver for pharmacy claims and long-term care/home and community- based services for the disabled and elderly, while the regional office said it did not. Neither State provided any documentation supporting their position. However, documentation from the regional offices showed that the waivers claimed by these States had expired. For the other two States, one said it had a cost-avoidance waiver for mental health evaluations, and the second reported it had waivers for their "birth-to-three" program and their school disability program. In both instances, the respective regional offices said that they were not aware of these waivers. Neither the State nor the CMS regional offices were able to provide documentation supporting their positions.

Ten States reported not having waivers cited by their regional offices

Ten States reported that they did not have waivers for the service types reported by their CMS regional office. For example, CMS said one State was operating under an approved waiver for pharmacy claims, but the State said that it did not have a pharmacy waiver. The 10 States were represented by 6 different regional offices. Out of the six regional offices, only one regional office was able to provide any documentation supporting the presence of cost-avoidance waivers. Table 1 below shows the cases where CMS regional offices and States differed as to the number of waivers held by the States.

Table 1: Discrepancies in the Number of Waivers Reported by States and CMS

State	Number of Waivers Reported by State	Number of Waivers Reported by CMS Regional Office
AK	7	6
GA	0	1
ID	0	2
IL	0	1
KS	0	4
MN	0	1
MO	7	6
OH	0	1
OR	1	6
TN	0	1
TX	1	2
WI	3	1
WV	0	1
WY	4	2

Source: OIG Survey of State Medicaid Agencies and OIG Interviews with CMS Regional Offices

Inconsistencies concerning the presence of cost-avoidance waivers may stem from insufficient documentation

Some of the inconsistencies concerning cost-avoidance waivers may stem from the lack of documentation maintained by certain States and CMS regional offices. Eight regional offices reported that at least one State in their region had a waiver. However, only three of the eight regions had a comprehensive set of documentation that supported the existence of the waivers. These three offices were able to provide both the waiver requests and the regional response for the 36 different waivers currently in place in their regions. The other 5 regions reported that they had approved a total of 37 cost-avoidance waivers. For two-thirds (25) of the 37 waivers, these 5 regional offices were unable to provide documentation supporting their existence. For only 4 of the 37 waivers were the regional offices able to provide documentation showing that the waiver had actually been approved. For five waivers, the only documentation on file was the waiver request letter from the State. In another three instances, the regional office had documentation faxed in from the State prior to our interview.

CMS approved cost-avoidance waiver requests that did not address the criteria for proving cost-effectiveness

Federal regulations (42 CFR § 433.138*)* require that for a waiver request to be approved by CMS, a State must show that the pay-and-chase method is as cost-effective as the cost-avoidance method. The *State Medicaid Manual* provides several examples of factors that may be used to determine cost-effectiveness, including average-cost-per-claim, denial rates of claims, administrative costs, and equipment/computer costs. We requested that CMS regional offices provide the documentation for any current waivers. As previously mentioned, some CMS regional offices were unable to provide any documentation for a number of the waivers. We reviewed all of the recent waiver requests provided to us. There were 51 waiver requests submitted by 18 States from 7 different regions. If a State provided any comparison of the costs of performing pay and chase to the costs of performing cost avoidance, we considered that request to have addressed the approval criteria. However, our review found that six of the seven CMS regional offices approved waivers that did not address this criteria.

CMS approved 46 of the 51 cost-avoidance waiver requests that we reviewed. For 20 of these requests, States did not, as required, compare the cost-effectiveness of pay and chase to that of cost avoidance. In some of these cases, States provided data, such as the costs associated with performing pay and chase or the amount recovered through pay-and-chase efforts, but did not show how this data compared with any costs associated with performing cost avoidance. In other cases, States did not provide any financial data at all on pay and chase or cost avoidance, yet their waiver requests were still approved by CMS. Requests sometimes focused on provider issues (e.g., cost avoidance would drive providers out of business) and beneficiary issues (e.g., cost avoidance may reduce beneficiary access to care) instead of cost-effectiveness.

Of the five waiver requests that were denied by CMS, only one was due to a failure to prove cost-effectiveness. Three of the requests were denied because the services were not generally covered by third parties; a fourth request was denied because beneficiaries eligible for the services had typically exhausted any third-party coverage. In these cases, CMS stated that waivers would create an unnecessary administrative burden for both the State and CMS.

In addition, unlike other regional offices, one CMS regional office is not requiring States to renew cost-avoidance waivers every 3 years as required by the *State Medicaid Manual*. The eight States in this region are not required to submit updated data supporting the cost-effectiveness of a waiver. Therefore, the data used to justify cost-avoidance waivers for States in this region could potentially be years out-of-date.

CMS does not require States to report the data necessary to determine the cost-effectiveness of cost-avoidance waivers

While CMS requires the reporting of actual recovery amounts on the CMS-64, it does not require States to track the amounts they attempted to recover or the amounts validly denied by third parties. "Validly denied" refers to claims where the third party was found not to be liable for the amounts that the State attempted to recover. Keeping an accurate account of this type of financial information is necessary in order to evaluate the cost-effectiveness of both pay-and-chase and cost-avoidance efforts. This is especially true for States with cost-avoidance waivers, where tracking the recovery rate of outstanding payments from third parties is of primary importance in determining the cost-effectiveness of the waivers.

As part of our survey, we asked States to identify the amount they attempted to recover, the amount actually recovered, and the amount validly denied by third parties in 2000. Of the 34 States that had cost-avoidance waivers (according to CMS), 17 did not report attempted recoveries or validly denied figures to us. Several of these States indicated that they were unable to determine these amounts, while other States simply provided no response. Without this data, we believe it would be difficult for CMS to make informed decisions concerning the cost-effectiveness of waivers.

Another 17 States with cost-avoidance waivers did report attempted recovery, actual recovery, and validly denied amounts to us. Figures reported by three of the 17 States indicated no outstanding debts owed by liable third parties. However, 14 of the 17 States had $307 million in outstanding payments potentially owed by liable third parties in Federal fiscal year 2000. These 14 States identified $1.33 billion in potential recoveries from liable third parties. According to these States, $262 million of the $1.33 billion was actually recovered, and another $761 million was validly denied by third parties. The remaining $307 million is considered to be a potential outstanding debt because the money was neither recovered by the State nor validly denied by the third party.[1] This money has been paid out by the Medicaid program, yet the dollars associated with these claims have not been returned to the Federal government and the States.

[1]It is important to note that all of the outstanding debt may not be attributable to services covered by a cost-avoidance waiver. Because States are statutorily required to pay and chase for certain types of services (e.g., preventive pediatric care), it is possible that portions of the outstanding debt stem from these services.

RECOMMENDATIONS

Our findings show that CMS is not exercising effective oversight of the cost-avoidance waiver process. Because of the significant program dollars potentially at risk, we believe that proper oversight is critical.

CMS and the States were not in agreement as to whether certain States were operating under approved waivers. The inconsistent responses may stem from the lack of documentation maintained by certain States and CMS regional offices. If regional offices are unsure of which States in their area even have cost-avoidance waivers, proper oversight would be difficult. In addition, many waivers were granted by CMS despite the fact that cost-effectiveness was not sufficiently addressed. According to Federal regulation, cost-effectiveness is the sole criteria for a regional office to use when evaluating a waiver request.

Furthermore, while CMS requires the reporting of actual recovery amounts on the CMS-64, it does not require States to track the amounts they attempted to recover or the amounts validly denied by third parties. We believe that keeping an accurate account of this information is necessary in order to evaluate the cost-effectiveness of both pay-and-chase and cost-avoidance efforts. This is especially true for States with cost-avoidance waivers, where tracking the recovery rate of outstanding payments from third parties is of primary importance in determining the cost-effectiveness of the waivers. The fact that 14 States with waivers are potentially owed as much as $307 million by liable third parties leads us to question whether their waivers are truly cost-effective.

We understand that waivers provide Medicaid agencies with the flexibility to design effective programs for their individual States. We also recognize that CMS has taken steps to review their guidance of the waiver process. However, based on our findings, we believe that CMS needs to provide more effective oversight of the cost-avoidance waiver process.

We recommend that:

CMS improve its oversight of the cost-avoidance waiver process by:

- Approving only waivers that meet the criteria for cost-effectiveness set forth by Federal regulation

- Ensuring that States abide by the *State Medicaid Manual*'s requirement that waivers be renewed every 3 years

- Requiring regional offices to retain proper documentation for all waivers

CMS require States to track the amount of money they attempt to recover from third parties and the amount that is validly denied to assist in evaluating the cost-effectiveness of both pay-and-chase and cost-avoidance efforts

Agency Comments

CMS concurs with our recommendation that the agency should improve its oversight of the cost-avoidance waiver process. CMS also concurs with our recommendation that States should track the amount they attempt to recover from third parties and the amount that is validly denied. However, CMS added that requiring States to track these amounts would produce little additional information of value, while at the same time taking away needed resources regarding the implementation of Health Insurance Portability and Accounting Act (HIPAA) requirements. With the implementation of HIPAA electronic billing standards, CMS believes providers will be able to bill liable third parties more easily, thereby reducing Medicaid third-party recovery activities. CMS says that they will reassess the need to track the amount States attempt to recover from third parties and the amount that is validly denied within a few years of HIPAA implementation.

In addition, CMS believes that our potential outstanding debt calculation may be significantly less than what is stated in our report. CMS noted that it is difficult to actually quantify the dollars at risk since there are many factors that affect this calculation. For instance, States "cast a wide net when seeking recoveries" because they do not always know if individuals have third-party insurance coverage nor do they know the extent of coverage. As a result, some third parties are not liable for the claims or liable for only a portion of the claim. In addition, States often do not receive responses from third parties regarding pursued claims.

The full text of CMS's comments is presented in Appendix B.

OIG Response

In terms of our potential outstanding debt calculation, we simply based our calculation on figures reported to us by States. We recognize the fact that States may be pursuing dollars that in the end are not owed by third parties. For this reason, we use the phrase "as much as" when referring to the potential outstanding debt estimate. Both the States and CMS would have a more accurate picture of the amount owed to the States if CMS were to implement our recommendation that States track the amount they attempt to recover from third parties and the amount that is validly denied. These data would assist CMS in determining the cost-effectiveness of cost-avoidance waivers. Furthermore, we believe that non-responses from third parties should not be a factor when calculating how much money is owed to the State. The State's entitlement to recovery does not change if a liable third party has not responded to the State's request for recovery.

APPENDIX A

States with Cost-Avoidance Waivers as of December 2001

The table below presents the cost-avoidance waivers approved for States based on information from CMS regional offices.

Region	State	Type of Service
II	NJ	Intermediate Care Facilities for the Mentally Retarded Part B Services at State and County Hospitals
III	DC	Pharmacy
	DE	Pharmacy
	MD	Pharmacy
	VA	Pharmacy
	WV	Pharmacy [a]
IV	AL	Pharmacy
	FL	Pharmacy
	GA	Pharmacy [a]
	KY	Pharmacy
	MS	Pharmacy
	NC	Pharmacy
	SC	Part B Physician Crossovers Pharmacy
	TN	Pharmacy [a]
V	IL	Pharmacy [a]
	IN	Pharmacy
	MN	Pharmacy [a]
	OH	Pharmacy [a]
	WI	Pharmacy [b]
VI	LA	Pharmacy
	OK	Pharmacy
	TX	Pharmacy Long-term Care [a]
VII	IA	Pharmacy
	KS	Community Mental Health [a] Long-term Care [a] Personal Care [a] Pharmacy [a]
	MO	Adult Day Health Care [c] Care for Mentally Retarded/Developmentally Disabled Non-Emergency Transportation Personal Care
	NE	Pharmacy Respite Care Long-term Care Pharmacy Private Duty Nursing

Region	State	Type of Service
VIII	MT	Audiology Dental Home and Community-Based Waiver Services Non-Emergency Transportation Nursing Homes Oxygen and Oxygen-related Services in Nursing Homes Optometry Personal Care Pharmacy
	ND	Pharmacy Claims under $100
	SD	Dental Optometry Pharmacy
	UT	Home and Community-Based Waiver Services Long-term Care Non-emergency Transport Pharmacy Tort
	WY	Care for Adults with Developmental Disabilities [d] Care for Children with Developmental Disabilities
X	AK	Accommodations [e] Eyewear Home and Community-Based Waiver Services Personal Care
	ID	Pharmacy Transportation Nursing Homes [a] Pharmacy [a]
	OR	Intermediate Care Facilities for the Mentally Retarded [a] Institutes for the Mentally Diseased [a] Pharmacy School-based Rehabilitation Services [a]
		Targeted Case Management for Children in Foster Care [a] Targeted Case Management for the Developmentally Disabled [a]

Source: CMS Regional Offices

[a] While CMS reports the State has a waiver for this service type, the State reports it does not.

[b] State reports it also has a waiver for its birth-to-three program and school disability program.

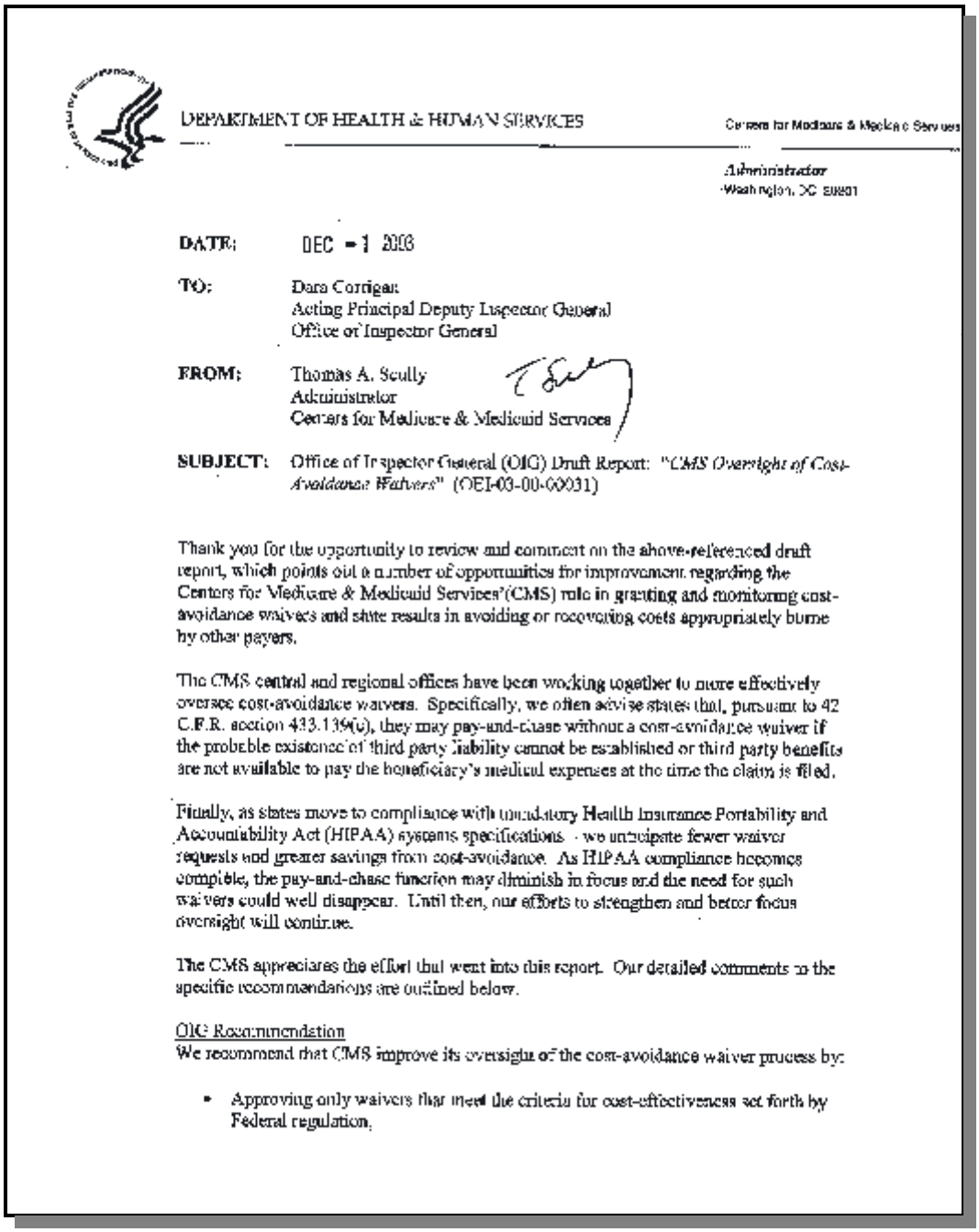
[c] State reports it also has a waiver for Department of Mental Health annual evaluation.

[d] State reports it also has a waiver for pharmacy claims and a waiver for long-term care/home and community-based services for the disabled and elderly. Documentation from CMS shows that these waivers have expired.

[e] State reports it also has a waiver for dental claims. Documentation from CMS shows that the dental waiver request had expired.

APPENDIX B

Centers for Medicare & Medicaid Services's Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC - 1 2000

TO: Dara Corrigan
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *"CMS Oversight of Cost-Avoidance Waivers"* (OEI-03-00-00031)

Thank you for the opportunity to review and comment on the above-referenced draft report, which points out a number of opportunities for improvement regarding the Centers for Medicare & Medicaid Services'(CMS) role in granting and monitoring cost-avoidance waivers and state results in avoiding or recovering costs appropriately borne by other payers.

The CMS central and regional offices have been working together to more effectively oversee cost-avoidance waivers. Specifically, we often advise states that, pursuant to 42 C.F.R. section 433.139(c), they may pay-and-chase without a cost-avoidance waiver if the probable existence of third party liability cannot be established or third party benefits are not available to pay the beneficiary's medical expenses at the time the claim is filed.

Finally, as states move to compliance with mandatory Health Insurance Portability and Accountability Act (HIPAA) systems specifications, we anticipate fewer waiver requests and greater savings from cost-avoidance. As HIPAA compliance becomes complete, the pay-and-chase function may diminish in focus and the need for such waivers could well disappear. Until then, our efforts to strengthen and better focus oversight will continue.

The CMS appreciates the effort that went into this report. Our detailed comments to the specific recommendations are outlined below.

OIG Recommendation

We recommend that CMS improve its oversight of the cost-avoidance waiver process by:

- Approving only waivers that meet the criteria for cost-effectiveness set forth by Federal regulation;

- Ensuring that States abide by the *State Medicaid Manual's* requirement that waivers be renewed every 3 years,

- Requiring regional offices to retain proper documentation for all waivers.

CMS Response
We concur.

OIG Recommendation
CMS require States to track the amount of money they attempt to recover from third parties and the amount that is validly denied to assist in evaluating the cost-effectiveness of both pay-and-chase and cost-avoidance efforts.

CMS Response
We concur. It would be possible to meet this recommendation by having states simply track and report aggregate data. While this would represent little additional administrative burden, it is likely to produce little additional information of value. Alternatively, requiring states to track data in a more detailed way, service by service, would impose significant systems and cost burdens at the time when states are trying to comply with HIPAA requirements (and state budgets are already stretched thinly). Meeting the new HIPAA standards for electronic billing should enable providers to more easily bill other responsible parties before Medicaid. This, in turn, should generally reduce the number of cases where states must either cost-avoid or pay-and-chase. However, it is likely to produce unpredictable changes in which states need additional attention to help them achieve better results. It seems prudent, given the significant changes likely to occur with HIPAA, to reassess the situation after we have a few years of experience. In the meantime, if more data were considered necessary to monitor the situation, then perhaps a sampling approach would be more appropriate and cost effective.

Finally, we believe that the amount potentially owed to the 14 states identified in the report is significantly less than $307 million. The question is, how much less? It is difficult to quantify the actual dollars at risk since there are myriad factors that would affect the answer.

For instance, states generally cast a wide net of claims when seeking recoveries. This is necessary because the state does not always know if the individual is eligible under the private health insurance plan, nor does the state always know the extent of the coverage. Often, it turns out that the third party is *appropriately not liable* and it was correct that Medicaid paid. In addition, it is common that states often do not receive any response to claims they aggressively pursue with potentially liable third parties. Furthermore, states often receive only a partial payment from a liable third party because the state is

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appropriately liable for only a deductible and/or co-payment. Therefore, it is misleading to suggest that "*as much as $307 million*" may be considered as potential outstanding debt.

Attachment

ACKNOWLEDGMENTS

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