Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

States Face Ongoing Challenges in Meeting Third-Party Liability Requirements for Ensuring That Medicaid Functions as the Payer of Last Resort

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Report in Brief

Date: October 2023
Report No. A-05-21-00013

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Audit

Medicaid is generally the payer of last resort. This means that if a Medicaid enrollee has another source of health care coverage, that source should pay its share before Medicaid pays. Federal regulations refer to amounts owed by non-Medicaid payers as third-party liability (TPL). Prior OIG and Government Accountability Office reports identified several challenges State Medicaid agencies have encountered in their efforts to meet TPL requirements to help ensure that Medicaid functions as the payer of last resort. Some of the more recent reports suggest that many of these challenges are ongoing and that billions of dollars are at risk.

The objectives of our audit were to identify challenges States have experienced in their efforts to meet TPL requirements and actions they have taken to address those challenges. In addition, we were to determine whether States reported Medicaid TPL amounts on the CMS-64 statement according to Federal requirements.

How OIG Did This Audit

We sent questionnaires to State agency officials from all 50 States and the District of Columbia (collectively referred to as States) to inquire about TPL challenges each State has incurred and to gather information on how they responded to those challenges. We also reviewed States' TPL reporting during Federal FYs 2019 and 2020.

States Face Ongoing Challenges in Meeting Third-Party Liability Requirements for Ensuring That Medicaid Functions as the Payer of Last Resort

What OIG Found

States reported that they continue to experience several challenges in their efforts to meet TPL requirements, including: difficulties obtaining complete, accurate, and up-to-date coverage information from Medicaid enrollees and providers; difficulties obtaining timely and reliable coverage information from third parties; difficulties coordinating TPL with out-of-State third parties; technical issues related to third-party coverage information received and electronic billing of Medicaid claims with third parties; a lack of Federal prompt payment requirements and penalties for third parties that do not cooperate with States' efforts to meet TPL requirements; difficulties coordinating TPL with TRICARE, which is the U.S. military's health care program; and difficulties coordinating TPL with Medicare. While surveying the States, we found that some did not have in effect laws addressing all Deficit Reduction Act of 2005 provisions, as required. These provisions were meant to enhance States' ability to meet TPL requirements.

States did not always report TPL amounts according to Federal requirements. Specifically, 27 States either did not report or did not correctly report TPL amounts during at least one fiscal quarter of our audit period.

What OIG Recommends and CMS Comments

Our primary recommendation is for CMS to develop an action plan that addresses States' ongoing TPL challenges. We made six additional procedural recommendations and one recommendation involving $1.25 million in questioned costs. A complete list of our recommendations is included in the body of the report.

In its comments on our draft report, CMS concurred with all our recommendations and described actions that it has taken or plans to take to address them. Among other things, CMS stated that it will provide updated guidance to States on effective practices for addressing challenges the States continue to encounter related to identifying liable third parties and recovering Medicaid payments.

The full report can be found at https://oig.hhs.gov/oas/reports/region5/52100013.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicaid is generally the payer of last resort. This means that if a Medicaid enrollee has another source of health care coverage, that source should pay, to the extent of its liability, before Medicaid pays. Federal regulation refers to amounts owed by non-Medicaid payers as third-party liability (TPL).[1] Office of Inspector General (OIG) and Government Accountability Office (GAO) reviews conducted over the past two decades have identified several challenges State Medicaid agencies have encountered in their efforts to meet TPL requirements and to help ensure that Medicaid functions as the payer of last resort.[2] Although these prior reports indicate that changes to Federal and State TPL requirements have improved States' ability to avoid paying for services that third parties should have paid (known as "cost avoidance") and to recover costs Medicaid paid before other coverage was identified (known as "cost recovery"), some of the more recent reports suggest that many of the challenges States have faced are ongoing and that billions of dollars are at risk.

Because of this history and the amount of Federal and State Medicaid funding at stake, we conducted this audit to determine which challenges continue to affect the States' and the District of Columbia's efforts to comply with TPL requirements and to determine whether they have identified ways to address those challenges.[3] In addition, because the previous reviews did not assess whether States complied with TPL reporting requirements, we wanted to determine in this audit whether States correctly reported to the Centers for Medicare & Medicaid Services (CMS) Medicaid TPL amounts that were avoided or recovered.

OBJECTIVES

Our objectives were to: (1) identify challenges States have experienced in their efforts to meet TPL requirements and actions they have taken to address those challenges and (2) determine whether States reported Medicaid TPL amounts on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64) according to Federal requirements.

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[1] 42 CFR part 433, subpart D.

[2] OIG, *Medicaid Recovery of Pharmacy Payments from Liable Third Parties* (OEI-03-00-00030), issued August 2001; GAO, *Medicaid Third-Party Liability, Federal Guidance Needed to Help States Address Continuing Problems* (GAO-06-862), issued September 2006; OIG, *Medicaid Third-Party Liability Savings Increased, But Challenges Remain* (OEI-05-11-00130), issued January 2013; GAO, *Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts* (GAO-15-208), issued January 2015.

[3] In this report, we refer to the 50 States and the District of Columbia as "States."

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program according to a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Federal Government pays its share of a State's medical assistance costs (referred to as Federal financial participation (FFP) or Federal share) under the Medicaid program on the basis of the Federal medical assistance percentage (FMAP), which generally changes each Federal fiscal year (FY) and varies by State based on the State's relative per capita income. The State Medicaid agency (State agency) is responsible for computing and reporting the Federal share, which is based on the total computable amount multiplied by the FMAP. The total computable amount and the Federal share of Medicaid expenditures are both reported on each State's CMS-64 (42 CFR § 430.30).

Medicaid Third-Party Liability

Federal law and regulations require States to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid State plan. Specifically, States are required to: (1) identify Medicaid enrollees' third-party health coverage, (2) determine TPL for services, (3) avoid payment for services in most circumstances in which the State believes that a third party is liable (known as cost avoidance),[4] and (4) recover reimbursement from liable third parties after Medicaid payment if the State can reasonably expect to recover more than it paid to seek reimbursement (known as cost recovery) (section 1902(a)(25) of the Act and 42 CFR §§ 433.137 through 433.139).

Cost avoidance of a Medicaid payment occurs under two scenarios. In the first scenario, a provider submits a claim to a State agency and the State agency rejects the claim, sending it back to the provider for the provider to submit the claim to the liable third party. In the second scenario, a provider first bills a liable third party (i.e., bills before submitting a claim to Medicaid).[5] Third parties include health insurers such as private commercial insurers and

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[4] According to 42 CFR § 433.139(b)(3), cost avoidance exceptions include claims for preventive pediatric services or when coverage is through a parent whose obligation to pay for medical support is enforced by the State's child enforcement agency.

[5] CMS, *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3901.

Government-sponsored health insurers such as Medicare and TRICARE;[6] self-insured plans; group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (ERISA)); service benefit plans; managed care organizations (MCOs); pharmacy benefit managers (PBMs); and other parties that by statute, contract, or agreement are legally responsible for payment of a claim for a health care item or service.[7]

Section 1903(d)(2) of the Act requires the Secretary of Health and Human Services to recover Medicaid overpayments, including Medicaid payments for which the State has been reimbursed directly by a third party; payments to providers that received third-party payments for the same services; and estate recoveries.[8] If a State receives FFP in Medicaid payments for which it receives third-party reimbursement, the State must pay the Federal Government a portion of the reimbursement determined according to the FMAP for the State (42 CFR 433.140(c)). States report the Federal share of overpayment collections and receive a reduced amount of Federal funding for the quarter. States generally must report TPL activity related to fee-for-service (FFS) claims on the form 64.9A of the CMS-64, entitled Third-Party Liability Collections and Cost Avoidance.[9] Section A of the form 64.9A is used for reporting TPL collections, and section B is used for reporting TPL cost avoidance. However, depending on how a State's Medicaid program is set up and approved by CMS, TPL collections could be reported as adjustments that reduce expenditures on other parts of a CMS-64 rather than the form 64.9A. Without obtaining and reviewing a State's supporting documentation of these adjustments reported on other parts of the CMS-64, there is no way to determine which portion of those adjustments relate to TPL collections.

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[6] TRICARE is the uniformed services health care program for active duty service members, active duty family members, National Guard and Reserve members and their family members, retirees and their family members, survivors, and certain former spouses.

[7] The Act § 1902(a)(25).

[8] A State Medicaid agency may seek recovery of Medicaid claims for payment from the estate of a Medicaid enrollee.

[9] States may offer Medicaid benefits on an FFS basis, through MCOs, or both. Under the FFS model, States directly pay providers for each covered service received by a Medicaid enrollee. Managed care-related claim data are reported based on individual contractual requirements under the managed care plans (on other parts of the CMS-64).

The Deficit Reduction Act of 2005 Amended the Social Security Act's Third-Party Liability Provisions

The Deficit Reduction Act of 2005 (DRA) (P.L. No. 109-171) was signed into law on February 8, 2006.[10] Section 6035 of the DRA amended TPL provisions in section 1902(a)(25) of the Act to enhance the ability of each State to: (1) identify third parties that are legally responsible to pay claims primary to Medicaid and (2) avoid payments to and seek recoveries from liable third parties. Specifically, it clarifies which entities are considered "third parties" and "health insurers" that may be liable for paying a claim prior to Medicaid and prohibits those entities from discriminating against individuals on the basis of Medicaid eligibility. CMS issued guidance to States explaining that DRA language stating that "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim" includes prepaid inpatient health plans, prepaid ambulatory health plans, third-party administrators (TPAs), fiscal intermediaries, and managed care contractors.[11] CMS further explained that PBMs, TPAs, and similar entities may not have financial liability for claims, depending on the nature and extent of services to be performed for the health insurer as specified by a contract. However, if a PBM or a TPA performs claim review and payment authorization for another third party, the PBM or TPA is expected to provide information to the Medicaid program for determining who is the primary payer.

The DRA also requires States to have in effect laws that require third parties to:

- provide the State with coverage and eligibility data needed to identify potentially liable third parties;
- accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
- respond to State inquiries regarding claims for payment for any health care item or service that is submitted to a third party not later than 3 years after the date of the provision of such health care item or service; and

[10] Section 6035 of the DRA was effective on Jan. 1, 2006. States that needed to amend legislation to comply with the DRA's TPL provisions were given until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after Feb. 8, 2006, the date of enactment (State Medicaid Director Letter #10-011, issued June 21, 2010, which corrected an error in State Medicaid Director Letter #06-026, issued Dec. 15, 2006).

[11] CMS, "Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid." Originally issued Sept. 4, 2014, and updated Sept. 11, 2014. Accessed on Apr. 19, 2023.

- agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim if the State:
    - submits the claim within the 3-year period from the date of service and
    - takes action to enforce its rights with respect to such claim within 6 years of the State's submission of such claim.[12]

In this report, we refer to these requirements as the DRA provisions.

Previous Federal Reviews Identified Challenges to Ensuring Medicaid's Payer of Last Resort Status

Previous Federal reviews recognized the significant impact of TPL on Medicaid expenditures as well as the challenges that come with each State's responsibilities as the payer of last resort. Following is a summary of key findings from those reviews. Appendix B includes a table that shows the frequency with which specific TPL-related challenges were identified in the previous reviews.

- In 2001, OIG reported that 32 States were at risk of losing more than 80 percent ($367 million) of the Medicaid pharmacy payments they tried to recover from liable third parties. States had challenges with identifying liable third parties and recovering amounts that they should have paid, and those challenges were made more difficult in situations involving PBMs. However, using the cost avoidance approach 17 States prevented $185 million in improper payments. (We refer to this OIG report in Appendix B as OIG 2001.)[13]

- In 2006, a GAO report that referenced information from the Census Bureau's annual Current Population Surveys covering 2002 through 2004 said an average 13 percent of respondents who reported having Medicaid coverage for the entire year also reported having private health coverage at some time during the same year. This coverage most often was obtained through an employer. States reported challenges in identifying or verifying third-party coverage and in recovering from liable third parties after Medicaid paid. GAO reported that it was too soon to assess the extent to which the DRA provisions would help States address challenges but recommended that CMS issue

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[12] For purposes of our report, we will refer to these reasons for denying claims as "procedural reasons."

[13] OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties* (OEI-03-00-00030), issued August 2001.

guidance to clarify for States issues related to the DRA requirements. (We refer to this GAO report in Appendix B as GAO 2006.)[14]

- In 2013, OIG reported that Medicaid TPL savings increased 114 percent between 2001 and 2011 but that an estimated $4 billion remained at risk of not being recovered in 44 States due to longstanding challenges associated with State efforts to identify third-party coverage and recover payments.[15] States reported that improvements to their processes facilitated savings. (We refer to this OIG report in Appendix B as OIG 2013.)[16]

- In 2015, GAO estimated that 7.6 million Medicaid enrollees (13.4 percent of all Medicaid enrollees) had private health insurance in 2012.[17] Selected States reported taking various steps to address challenges to ensuring that Medicaid was the payer of last resort. In addition, CMS issued guidance and shared information on effective State practices. However, States suggested additional Federal actions. (We refer to this GAO report in Appendix B as GAO 2015.)[18]

Although State and Federal actions (such as the implementation of the DRA provisions) led to improvements in States' abilities to identify and verify third-party coverage and recover from liable third parties, the 2013 OIG and 2015 GAO reports identified a variety of challenges States continued to face. In response to the 2013 OIG and 2015 GAO reports, CMS issued TPL-related guidance and documents describing effective State practices that have helped some States meet TPL requirements.[19]

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[14] GAO, *Medicaid Third-Party Liability, Federal Guidance Needed to Help States Address Continuing Problems* (GAO-06-862), issued September 2006.

[15] The remaining seven States did not provide this information.

[16] OIG, *Medicaid Third-Party Liability Savings Increased, but Challenges Remain* (OEI-05-11-00130), issued January 2013.

[17] Estimate was based on responses to the Census Bureau's 2012 American Community Survey. The report focused on private sources of health care coverage rather than public sources such as Medicare and TRICARE.

[18] GAO, *Medicaid, Additional Federal Action Needed to Further Improve Third-Party Liability Efforts* (GAO-15-208), issued January 2015.

[19] See CMS, "Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid," updated Sept. 11, 2014; CMS, "Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program, A Guide to Effective State Agency Practices," issued July 2014; and CMS, "Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program, A Guide to Effective and Innovative State Agency Practices," update issued December 2015. Each accessed on Apr. 19, 2023.

HOW WE CONDUCTED THIS AUDIT

We sent questionnaires to State agency officials to determine how each State: (1) collects Medicaid enrollees' other insurance information, (2) conducts data matches to identify third-party coverage information, (3) processes Medicaid claims when a third party has been identified, (4) recovers costs when TPL is identified after a Medicaid payment was made, and (5) reports TPL cost recoveries and cost avoidance on the form 64.9A. Additionally, we inquired about challenges each State faced in trying to meet its TPL responsibilities and gathered information on how States responded to those challenges.[20] We received responses from all 50 States and the District of Columbia. Unless otherwise indicated, we did not independently verify the information States reported to us.

We also reviewed States' TPL reporting for FFS claims on their forms 64.9A for FYs 2019 and 2020 (October 1, 2018, through September 30, 2020) and asked States about any irregularities or significant changes in the amounts reported.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

States reported that they continue to experience several challenges in their efforts to meet TPL requirements. These challenges relate to:

- difficulties obtaining complete, accurate, and up-to-date coverage information from Medicaid enrollees and providers (10 States);

- difficulties obtaining timely and reliable coverage information from third parties (37 States);

- difficulties coordinating TPL with out-of-State third parties (16 States);

- technical issues related to third-party coverage information received and electronic billing of Medicaid claims with third parties (33 States);

[20] The question we posed to the States about their TPL-related challenges was open-ended. As a result, States may not have enumerated all the challenges they were encountering. The frequency of challenges mentioned in the *Findings* section of the report may be understated compared to what might have been reported had we given States a predefined list of challenges.

- a lack of Federal prompt payment requirements and penalties for third parties that do not cooperate with States' efforts to meet TPL requirements (28 States);

- difficulties with third parties that deny Medicaid claims for procedural reasons (32 States);

- difficulties coordinating TPL with TRICARE (34 States); and

- difficulties coordinating TPL with Medicare (12 States).

Despite Federal legislative changes and CMS guidance intended to improve each State's ability to meet TPL responsibilities, many of the challenges noted above are the same challenges that States have reported to OIG and to GAO over the past 20 years in connection with previous TPL reviews. Some States reported that they have taken actions that have helped address some of these challenges. Many of those actions are described below. However, based on consistencies among the States' responses to our inquiries and the longstanding nature of many of the challenges the States reported to us, this report includes recommendations for additional CMS action. In addition, Appendix C includes States' suggestions for actions that might be taken at the Federal level to further assist them in meeting TPL requirements.[21]

While surveying the States to determine which TPL-related challenges they are experiencing, we found that some States did not have in effect laws addressing all DRA provisions as required. These DRA provisions were intended to assist States in meeting their TPL responsibilities.

The 50 States and the District of Columbia did not always report amounts that payers other than Medicaid were responsible for paying (referred to as TPL amounts) on the form 64.9A according to Federal requirements. Specifically, during our audit period 24 States reported TPL amounts correctly on the form 64.9A. However, 27 States either did not report or did not correctly report TPL amounts on the form 64.9A during at least one fiscal quarter of our audit period. We identified more than one type of reporting error and noted that some States made the same type of error in more than one fiscal quarter. Repeated and undetected reporting errors increase the risk of improper State Medicaid reimbursement. In addition, incomplete and inaccurate TPL information in the CMS-64 is not useful to CMS for monitoring how well States are meeting TPL requirements.

[21] We provide the information in Appendix C for Federal stakeholders' consideration in determining steps that might be taken to assist States in addressing TPL-related challenges. We did not evaluate the merits or costs of the States' ideas for Federal assistance. Therefore, the information we report in Appendix C should not be considered an OIG endorsement of the States' suggestions.

STATES FACE CHALLENGES IN THEIR EFFORTS TO MEET THIRD-PARTY LIABILITY REQUIREMENTS AND SOME HAVE TAKEN ACTIONS TO ADDRESS THOSE CHALLENGES

To meet TPL requirements, States must: (1) identify Medicaid enrollees' third-party health coverage, (2) determine the TPL for services, (3) avoid payment for services in most circumstances in which a State believes that a third party is liable (known as cost avoidance), and (4) recover a reimbursement from a liable third party after a Medicaid payment if a State can reasonably expect to recover more than it paid to seek reimbursement (known as cost recovery).[22]

States reported several challenges in their efforts to meet TPL requirements. Many of these challenges were also identified in OIG and GAO reviews conducted over the past two decades. States reported that they have taken some actions to address these challenges. We believe additional CMS actions could further help address them.

Difficulties Obtaining Complete, Accurate, and Up-to-Date Coverage Information From Medicaid Enrollees and Providers

Ten States reported longstanding challenges with obtaining from Medicaid enrollees and providers complete, accurate, and up-to-date coverage information, including information about coverage changes and coverage related to casualty and other tort cases.[23] Specifically, States reported that the coverage information received from Medicaid enrollees and providers is sometimes incomplete or inaccurate. Some States reported that Medicaid enrollees fail to provide coverage information at enrollment, when there is a change in coverage, or when the claims relate to a casualty case.

Two States reported that they took actions to improve the collection and reliability of coverage information. Specifically:

- One State reported that it created a secure, online web form that end users (such as enrollees and providers) may use to submit third-party information. End users were required to include certain information when submitting the web form. In addition, the web form was designed so that the number of ways to report third-party coverage was reduced from 14 to 1. According to State officials, as a result of the web form the quality of information the State has received has been extraordinarily high, and end-user feedback has been positive.

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[22] Section 1902(a)(25) of the Act and 42 CFR §§ 433.137 through 433.139.

[23] We use the terms "longstanding challenge" and "ongoing challenge" for a challenge that a State identified and was reported in a prior OIG report(s), GAO report(s), or both. The OIG reports and GAO reports are referenced in footnote 2.

- One State passed a law in 2017 implementing a new State reporting requirement to help identify employer-sponsored insurance.[24] To comply with this requirement, employers must report to the State the insurance provided to employees. The State then uses the information collected and performs data matching to identify Medicaid enrollees who work for employers that offer insurance to their employees.

Difficulties Obtaining Timely and Reliable Coverage Information From Third Parties

Thirty-seven States reported longstanding challenges with obtaining timely and reliable coverage information from third parties.

Twenty-six States reported that some third parties refused to provide coverage data or did not provide timely access to coverage data. States reported that third parties have provided States or their MCOs with a variety of reasons for denying or not providing timely access to the data.[25] The reasons third parties provided include:

- concerns about Health Insurance Portability and Accountability Act (HIPAA) compliance;
- the fact that States are not providers with National Provider Identifiers (NPIs) and, therefore, are not set up to access coverage data available in third parties' systems;
- third parties insisting on performing their own data match to identify enrollees who also have Medicaid rather than allowing States to perform the match using third-party data files;
- a lack of legal authority to require third parties to share coverage data (e.g., PBMs that say they are not authorized by their clients to provide data to States or their MCO(s), out-of-State third parties that say they are exempt from State laws because they are licensed or "doing business" in a different State, and plans subject to ERISA that say Federal requirements exempt them from State requirements); and
- third parties' unwillingness to participate in the Payer Initiated Eligibility/Benefit (PIE) Transaction suggested by CMS (which allows States to obtain third-party coverage information from third parties in a single, unsolicited transaction).[26]

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[24] M.G.L. Chapter 118E, Section 78: Employer healthcare coverage form.

[25] Most States contract with MCOs to provide health care to at least some Medicaid enrollees and delegate some or all TPL responsibilities to those MCOs.

[26] CMS recommended that States use the PIE Transaction as the transmission format for eligibility and benefit information between a State or its agent, and health plans or their agent. The PIE Transaction is not an adopted HIPAA standard (State Medicaid Director Letter #10-011, issued June 21, 2010).

In addition, 13 States gave specific examples of challenges they have encountered with receiving reliable (i.e., complete, accurate, and up-to-date) coverage information from third parties.[27] For example, one State reported that some third parties complete the State's TPL verification form but black out information that identifies an enrollee. This same State reported that some third parties create their own TPL verification form rather than complete the State's form. The third parties' TPL verification forms often do not include information that the State needs to verify TPL. Other States reported that they receive third-party coverage information with inaccurate coverage dates or no coverage-end dates. For example, some States reported that third parties' policies for Medicaid enrollees appeared active because the coverage end dates were either future dates or were left blank; however, the enrollees' third-party coverage had already ended.

To address the timeliness issue for receiving coverage information, one State included in its DRA-required State laws provisions that require third parties to respond to coverage data requests within 30 days. A third party that fails to respond within 30 days could be subject to penalties for noncompliance. The State reported that this provision has been effective and that the State has not needed to impose any penalties for noncompliance with the 30-day requirement.

Difficulties Coordinating Third-Party Liability With Out-of-State Third Parties

The DRA mandated that each State have in effect laws requiring third parties, as a condition of doing business in the State, to provide coverage information to the State and respond to State Medicaid claims for third-party payments.[28] While States reported that these State laws have generally helped them meet TPL requirements, 16 States reported ongoing challenges with coordinating TPL benefits with out-of-State third parties. Specifically, States told us that some third parties located outside the State deny TPL claims, arguing that they are "not doing business" in the State. Additionally, States reported difficulty identifying where to send claims when the third party has multiple plans and the Medicaid enrollee's third-party plan is based in a different State than the enrollee's Medicaid eligibility. In those instances, the States reported sending claims to both the home plan (the plan associated with the State in which the policy was purchased) and the local plan (the plan associated with the State in which services were provided) and having both claims rejected. Furthermore, some States reported difficulty in obtaining coverage information from out-of-State third parties when enrollees work in one State but live in another, or when children receive insurance coverage through an out-of-State parent's plan.

According to States, COVID-19 has led to a significant rise in interstate health care, further necessitating Federal TPL laws that strengthen States' authority to ensure cooperation from

[27] The total number of States exceeds 37 because some States reported challenges with both timely access to coverage information and receiving reliable coverage information.

[28] Section 6035(b) of the DRA (P.L. No. 109-171) revised section 1902(a)(25) of the Act.

third parties. In 2014, CMS issued a Medicaid and Children's Health Insurance Program FAQ that included guidance to States regarding Medicaid TPL.[29] This FAQ said that while State Medicaid agencies have a need for and can request coverage information from third parties licensed in a different State, State law cannot reach beyond the entities that are "doing business" in their States. In response to this challenge, some States have revised their DRA-required laws to clarify that the law applies to all third parties that provide coverage to residents of the State, even if the third party is located in a different State.

Technical Issues Related to Third-Party Coverage Information Received and Electronic Billing of Medicaid Claims With Third Parties

Thirty-three States reported technical issues in coordinating with third parties to identify or verify coverage for Medicaid enrollees, recover amounts Medicaid paid when a third party was liable, or both. For example, some States reported challenges with the format of coverage data files that third parties provided to States. Under HIPAA, the Department of Health and Human Services adopted certain standard transactions for the electronic exchange of health care data. CMS is responsible for enforcing compliance with these adopted standards. These standard transactions occur between two parties to carry out financial or administrative activities including, but not limited to: a health care claim; eligibility, coverage, or benefit information; and remittance advice. However, there is no national standard for the enrollee coverage data files that third parties send to States. In the absence of a standard file format, States reported struggling to integrate multiple file formats into their systems.

Other States cited as challenges issues with States' systems electronically interfacing with third-parties' systems, and limitations within those systems that prevent States from identifying and verifying Medicaid enrollee coverage and from billing and receiving third-party reimbursements for Medicaid claims. Some States reported that third parties are generally set up to pay providers rather than States or their MCOs. As a result, for some third parties processing claims submitted by States requires either manual interventions or new or modified claim processing procedures. Additionally, third parties have unique requirements that States or their MCOs must meet when billing Medicaid claims. For example, States reported that they sometimes have to convert a billed claim file to a specific file format (i.e., a file with a specific file extension) requested by the third party. Some third parties request that claims be billed in a way that is set up specifically for Medicaid TPL claims. For example, some third parties require States to set up additional data fields or change data fields included in the Medicaid claim before billing the third party. In addition, some third parties have told States that they are only set up to pay providers that have NPIs.[30] Some States reported that they bill some or all third parties through paper billings because of State system limitations.

[29] CMS, "Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid," updated Sept. 11, 2014. Accessed on Apr. 19, 2023.

[30] States typically do not meet the definition of a covered health care provider and therefore are not eligible to receive an NPI.

To address the standardization of coverage data files challenges, two States reported that they submitted their own proprietary data file formats to the Accredited Standards Committee X12 (ASC X12) for review with the aim of establishing a new standard that can be used by all State Medicaid agencies and third parties in sharing enrollee coverage data files with each other.[31] However, as of January 2023, ASC X12 had not provided an update since early 2021 regarding the status of its review of the States' proprietary data file format.

To address issues of system compatibility between States and third parties, one State's laws require that third parties accept claims submitted in an electronic format. This State reported that, to comply with the law, third parties have had to modify their systems to allow for electronic processing of Medicaid claims.

Lack of Federal Prompt Payment Requirements and Penalties for Noncompliance

Twenty-eight States reported challenges associated with third parties that are resistant to States' efforts to recover when Medicaid paid before identifying other coverage for a Medicaid enrollee. Although the DRA included a provision that States must have in effect laws that require third parties to respond to any State inquiry regarding reimbursement of Medicaid claims for payment, there was no time period stipulated in the DRA for a third party's response.[32] The Consolidated Appropriations Act, 2022 (CAA of 2022) changed the DRA provisions of the Act by requiring States to have in effect laws for a third party to respond to a State Medicaid claim for payment within 60 days.[33] However, prior to the CAA of 2022, 16 States reported that they or their MCOs were experiencing challenges with third parties paying in a timely manner due to a lack of Federal prompt payment requirements and penalties for third parties that do not cooperate with State or MCO efforts to meet TPL requirements. Some States reported that it often took more than 120 days for third parties to process or respond to claims for payment. These States also reported that some third parties did not process or respond to claims. States gave the following reasons for third parties failing to process claims in a timely way:

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[31] ASC X12 is a group from the American National Standards Institute responsible for developing and maintaining X12 standards for the electronic exchange of business documents, often called "transaction sets." A transaction set is a single business document such as a health care claim. The X12 standards were developed to support companies in business-to-business operations. For more information, see https://www.edi2xml.com/blog/ansi-asc-x12-standards-overview/. Accessed on Apr. 19, 2023.

[32] Section 6035(b)(3) of the DRA, section 1902(a)(25)(I)(iii) of the Act.

[33] The Consolidated Appropriations Act, 2022, Division P, Title II, section 202, is effective Jan. 1, 2024, and amends section 1902(a)(25)(I)(iii) of the Act. States that cannot meet the Jan. 1, 2024, effective date because legislation is required will have until the beginning of the first calendar quarter following the end of the regular legislative session that begins after Mar. 15, 2022. For States that have 2-year legislative sessions, each year of such session will be considered to be a separate, regular legislative session. This legislative change to the Act should address the States' request for a timeframe for third parties to respond to State Medicaid claims for payment. CMS issued guidance to States regarding the change in TPL requirements in March 2023 (State Medicaid Director Letter #23-002, issued Mar. 8, 2023).

- third parties are set up to pay providers only, and Medicaid is not considered to be a provider,
- some third parties do not understand or do not acknowledge Medicaid's assignment of rights or right to recover from third parties, and
- there is a lack of standardization of claim forms and responses.[34]

Some States reported significant resistance to their TPL recovery efforts from third parties such as PBMs and TPAs. According to the States, the reason given by these third parties for the resistance is that their clients have not contractually authorized them to process Medicaid claims for reimbursement.[35] In these instances, States reported they must pursue reimbursement from the client rather than from a PBM or TPA that otherwise has contractual responsibility for paying claims on the client's behalf.

To address this issue, some States have revised their DRA-required statutory provisions to require third parties to respond in a set amount of time. For example, several States established a 90-day deadline. Some State laws stipulate that a failure to pay or deny a claim after a certain amount of time creates an uncontestable obligation to pay the claim. Some State laws also established monetary penalties that can be imposed for noncompliance, although none of the States indicated that they had imposed penalties.

To address challenges MCOs face in recovering TPL, several States have implemented "come-behind" processes for recovering third-party payments that MCOs are not able to recover within a specified period.

Difficulties With Third Parties That Deny Medicaid Claims for Procedural Reasons

Thirty-two States reported longstanding challenges with third parties denying Medicaid claims for procedural reasons. For example, third parties denied claims because: (1) enrollees or providers had not obtained prior authorizations from the third parties, (2) States did not comply with third-party-imposed timely filing limits that conflict with Federal and State laws, and

[34] As mentioned in the previous section, States reported that third parties have unique requirements that States must meet when billing Medicaid claims. States or their contractors must work with a third party to set up the billing and payment processes. This sometimes requires a manual intervention, which can result in a long recovery process. Additionally, States reported that third parties may require data fields to process a claim that the State does not require on the Medicaid claim that providers submit. This requires a State to use additional resources to obtain the information necessary to bill third parties.

[35] Examples of PBM or TPA clients include insurers, employers, and unions.

(3) States did not include nonstandard data elements on claims that third parties require for processing.[36]

The CAA of 2022 requires States to have in effect laws prohibiting a third party, except for Medicare plans, from denying a State's Medicaid claim for payment for failure to obtain a prior authorization from the third party for the item or service. Rather, the third party must accept the State's authorization as its own.[37] Prior to the CAA of 2022, some States addressed denials for lack of prior authorization by including language in their State statutes that either prohibits third parties from denying claims based on a lack of prior authorization or explicitly requires third parties to accept Medicaid's payment as authorization for services. Some States reported that they require Medicaid enrollees and providers to follow third-party coverage requirements for Medicaid to pay. Among other things, this places the responsibility on the provider to seek prior authorization from the third party, which may reduce instances in which third parties would reject the Medicaid claim for procedural reasons.

Difficulties Coordinating Third-Party Liability With TRICARE

In June 2020, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that approximately 867,000 Medicaid enrollees had primary coverage through TRICARE.[38] Thirty-four States reported various challenges associated with coordinating third-party liability with TRICARE. These challenges are described below.

Before 2017 and according to an agreement with CMS, the Department of Defense (DOD) conducted an annual data match with States to identify enrollees who had coverage through both Medicaid and TRICARE. According to CMS officials, DOD in 2017 stopped the data matching process with States after CMS determined that, because it did not own and was not involved in sending and receiving the data, it could not guarantee States' compliance with DOD's security and privacy provisions.

In addition to no longer being able to rely on the annual DOD data match to obtain TRICARE coverage information, 38 States reported that they no longer had access to DOD's eligibility system (known as the Defense Enrollment Eligibility Reporting System, or DEERS), which could be used to determine whether a Medicaid enrollee had TRICARE coverage. Some States reported losing access to DEERS because: (1) State employees with access to DEERS left the

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[36] State Medicaid agencies or their contractors (such as State-contracted MCOs) make prior authorization decisions for certain services. When Medicaid authorizes a service that is also covered by third-party insurance, some States consider its prior authorization and payment for services as valid with respect to establishing a third party's liability for that service.

[37] The Consolidated Appropriations Act, 2022, Division P, Title II, section 202, made changes to section 1902(a)(25)(I)(ii) and (iv) of the Act.

[38] MACPAC, *Report to Congress on Medicaid and CHIP*, June 2020, estimated the number of Medicaid enrollees with primary coverage through TRICARE based on the results of the Census Bureau's 2017 American Community Survey.

State Medicaid agency and (2) DOD stopped allowing access to new users and began terminating access among current users. States including those retaining access to DEERS reported that the process is an inefficient, time-consuming method for identifying TRICARE coverage information because it requires looking up Medicaid enrollees one at a time.

States reported that one challenge with the DOD TRICARE data matching process that ended in 2017 was that the process occurred only once per year. For other types of third-party sources, States or their TPL contractors reported performing data matches at least monthly to identify Medicaid enrollees with third-party coverage. The once-per-year frequency of the TRICARE data matches made it difficult for States to identify in a timely way enrollees who were new to TRICARE or whose TRICARE coverage changed during the year. States reported more frequent TRICARE data matches would be needed if the process is restarted.

Another longstanding challenge States reported is that TRICARE has a 1-year timely filing requirement that limits the period for States to recover Medicaid payments. The DRA required States to have in effect laws requiring third parties to respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the service. However, Congress passed a law that predates the DRA and explicitly exempts TRICARE from State and local laws related to health insurance or other health care financing mechanisms.[39] Therefore, TRICARE does not follow the DRA's requirement that all third parties accept TPL claims from Medicaid for at least 3 years.[40] Instead, TRICARE requires claims to be filed within 1 year of either the date of service or the date of the last data match with a State.[41] If CMS and DOD agree to restart the TRICARE data matching process, States reported that they would need an extension of the timely filing requirement. Such an extension would allow States time to recover amounts that Medicaid paid but that TRICARE was responsible to pay during the years since data matching stopped in 2017.[42] HMS, a TPL contractor that works with more than half the States, estimated that Medicaid pays about $20 million each year in FFS payments that TRICARE should pay.[43]

An additional challenge that States reported is that DOD, despite previously sharing TRICARE eligibility information with States through the data matching process, has been unwilling to share that information with State-contracted MCOs. States reported a need for MCO access to TRICARE data and have also encountered resistance from TRICARE in processing claims. HMS

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[39] 10 U.S.C. § 1103.

[40] 32 CFR 199.7(d).

[41] 10 USC § 1106, CMS Manual, *Coordination of Benefits and Third-Party Liability in Medicaid 2020.*

[42] The Director of the Defense Health Agency may grant exceptions to the claim filing deadline requirements (32 CFR § 199.7(d)). The Defense Health Agency manages TRICARE for the Department of Defense.

[43] HMS published this estimate in a 2020 report *Coordination Between Medicaid and TRICARE*. Multiple States referenced the HMS estimate in their responses to our questionnaire. We did not verify the accuracy of HMS's estimate.

estimated that Medicaid pays $63 million annually in managed care payments that TRICARE should pay.[44]

The June 2020 MACPAC report made two recommendations related to the States' difficulties with coordinating Medicaid benefits with TRICARE: (1) CMS should facilitate States' coordination of benefits with TRICARE by working with DOD to develop a mechanism for DOD to routinely share eligibility and coverage data with States and (2) Congress should direct DOD to require its carriers to implement the same third-party liability policies as other health insurers (as defined in 1902(a)(25) of the Act). In early 2022, CMS officials reported that it continues to actively work on finding a solution to allow States access to TRICARE data.

Difficulties Coordinating Third-Party Liability With Medicare

CMS does not allow State agencies to submit Medicaid claims directly to Medicare because States are not direct providers or suppliers of services and, therefore, are not eligible to obtain an NPI that would enable them to bill Medicare.[45] Because States cannot bill Medicare directly, they must notify providers to bill Medicare and adjust Medicaid claims accordingly. Under provisions of the Patient Protection and Affordable Care Act (ACA), an FFS provider has 1 year after the date of service to submit Medicare claims.[46] However, the Secretary may specify exceptions to the 1-year timely filing requirement. One exception that allows providers to submit claims after the 1-year timely filing requirement is when CMS awards an enrollee retroactive Medicare coverage on or before the date of the Medicare-covered service being provided to the enrollee.[47] However, the provider must know about the retroactive eligibility to file for an exception to the timely filing requirement. Twelve States reported that the 1-year timely filing requirement, coupled with the requirement that only providers can submit claims to Medicare directly, have been longstanding challenges that have not been addressed.

SOME STATES DID NOT HAVE IN EFFECT LAWS ADDRESSING ALL DEFICIT REDUCTION ACT PROVISIONS INTENDED TO ASSIST STATES IN MEETING THEIR THIRD-PARTY LIABILITY RESPONSIBILITIES

Section 6035 of the DRA amended section 1902(a)(25)(I) of the Act requiring States to have in effect laws requiring third parties as a condition of doing business in a State to: (1) provide coverage information to the State upon request; (2) accept the State's right of recovery; (3) respond to claims inquiries submitted by the State up to 3 years after the date that a health

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[44] HMS published this estimate in its report *Coordination Between Medicaid and TRICARE*. We did not verify the accuracy of HMS's estimate.

[45] CMS, "Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid," updated Sept. 11, 2014. Accessed on Apr. 19, 2023.

[46] ACA, P.L. No. 111-148 § 6404, amending SSA §§ 1814(a)(1), 1835 (a)(1), and 1842(b)(3)(B), 42 U.S.C. §§ 1395f(a)(1), 1395u(b)(3)(B), and 1395 n(a).

[47] 42 CFR 424.44(b).

care item or service is provided; and (4) agree not to deny a claim submitted by the State solely on the basis of the date of a claim's submission, the type or format of the claim form, or failure to present proper documentation at the point of sale that is the basis of the claim if: (a) the claim was submitted by the State within the 3-year period after the date of service and (b) any action by the State to enforce its rights with respect to such claim commences within 6 years of the State's submission of the claim.

In performing audit work to address our first objective, we found that four States did not have in effect laws that addressed all four DRA-required provisions. Specifically, these four States did not have in effect laws prohibiting third parties from using procedural reasons to deny or refuse to pay claims. In addition, three of these same four States did not have in effect laws requiring third parties to respond to claim inquiries submitted within 3 years after the date of service. CMS officials told us CMS verified that States had in effect the laws that the DRA required; however, because of staff transitions, CMS could not provide supporting information that indicated what had been verified or when the verifications occurred.

TWENTY-SEVEN STATES DID NOT ACCURATELY REPORT MEDICAID THIRD-PARTY LIABILITY AMOUNTS

If a State receives FFP in Medicaid payments for which it receives third-party reimbursement, the State must pay the Federal Government a portion of the reimbursement determined according to the FMAP for the State (42 CFR 433.140(c)). On the form 64.9A of the CMS-64, States report a source and an amount for: (1) reimbursements received from liable third parties such as Medicare and other insurers (these reimbursements are referred to as TPL collections) and (2) payments made by liable third parties before Medicaid paid its share (these third-party payments are referred to as TPL cost avoidance) (CMS *State Medicaid Manual*, section 2500.3(C)).

The amounts entered on the line for total TPL collections on the form 64.9A automatically filter into line 9A of the CMS-64 Summary Sheet. The amount reported on line 9A is an offset to the total amount of Medicaid expenditures that the State reports.

Because the TPL cost avoidance amounts reported on the form 64.9A represent Medicaid savings rather than expenditures, these amounts are considered informational only. This means that these amounts do not affect the reimbursement the State receives from the Federal Government. The instructions for the form 64.9A that CMS had in place during our audit period require all cost avoidance to be reported on either the Medicare Cost Avoidance line or the Health Insurance Cost Avoidance line. These instructions required States to leave the Other

Cost Avoidance line blank.[48] Instructions in place well before our audit period allowed States to report on the Other Cost Avoidance line.[49]

Twenty-seven States did not report Medicaid TPL amounts on the form 64.9A according to Federal requirements. Specifically, for at least one fiscal quarter of our audit period, we identified: (1) 12 States that did not report TPL collection amounts, cost avoidance amounts, or both on the form 64.9A and (2) 21 States that did not correctly report TPL amounts on the form 64.9A.[50] See Appendix D for additional details on the types of errors in State reporting.[51]

Twelve States Did Not Report Third-Party Liability Collection Amounts, Cost Avoidance Amounts, or Both

Twelve States did not report TPL collection amounts, cost avoidance amounts, or both, for at least one fiscal quarter of our audit period.[52] State officials attributed these reporting errors to data entry errors and staff turnover. Of the 12 States that did not report all TPL amounts, 2 States did not identify the omissions before we sent the States questions regarding their TPL reporting. The remaining 10 States identified the errors before we sent our questions to the States. However, one State that identified that it had not reported cost avoidance amounts chose not to correct that reporting error in a subsequent fiscal quarter because cost avoidance amounts are informational only, and two States that indicated they planned to correct their reporting errors did not do so before we sent the States our questions. Five of the twelve States failed to report TPL amounts in more than one fiscal quarter of the audit period. Repeated and undetected errors increase the risk of improper State Medicaid reimbursement.

Twenty-One States Did Not Correctly Report Third-Party Liability Amounts

Twenty-one States did not correctly report TPL amounts for at least one fiscal quarter of our audit period. State officials attributed these reporting errors to data entry errors and staff turnover. Two of these twenty-one States reported incorrect amounts, 14 States did not report using the correct lines, and 10 States incorrectly reported Other Cost Avoidance amounts on

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[48] As of the end of our audit period, CMS had not removed the Other Cost Avoidance line from the form 64.9A.

[49] CMS officials were unable to provide the exact date that CMS changed the instructions but stated that they believed the change occurred in the early 2000s.

[50] The total number of errors exceeds 27 because 6 States had both types of errors.

[51] According to CMS officials, based on information we provided during our audit, CMS has contacted States to confirm the reporting errors and to begin working with States to ensure that the errors were corrected.

[52] We included in this category only States that had a history of reporting TPL amounts but failed to report those amounts for any fiscal quarter. We excluded the States that did not routinely report a particular line on the form 64.9A.

the form 64.9A during the audit period.[53] Some of the 10 States that incorrectly reported Other Cost Avoidance amounts indicated they were not aware that CMS had instructed States to leave the Other Cost Avoidance line on the form 64.9A blank and had repeatedly reported on this line.

Among these 21 States, 18 did not identify or did not correct or otherwise address the cause of the errors before we sent the States our questions regarding their TPL reporting. Fourteen of the twenty-one States did not correctly report in more than one fiscal quarter of the audit period. As noted above, repeated and undetected errors increase the risk of improper State Medicaid reimbursement. Some of these States indicated challenges with ensuring accurate TPL reporting after staff members responsible for reporting amounts on the form 64.9A left the State agency or assumed new roles. Some of these States told us that, after realizing reporting errors were made, they implemented new processes or provided training to new staff members to ensure accurate TPL reporting.

Limitations in CMS's Analysis of Third-Party Liability Reporting and a Lack of Communication About Reporting Requirements Likely Contributed to Inaccurate State Reporting of Medicaid Third-Party Liability

For the States that did not identify or correct the TPL reporting errors we identified, CMS either did not identify the errors during its quarterly or annual reviews or, if it did identify them, the errors were not corrected, and States continued to make the same types of errors in subsequent fiscal quarters.[54] According to CMS officials, CMS may not have identified and ensured that States corrected TPL reporting errors for the following reasons: (1) CMS-64 reviews are more limited for States not in the top 20 for highest dollar amount of expenditures than for States with higher expenditures, (2) CMS focuses on higher priority areas of the Medicaid program (i.e., areas that have the greatest impact on Federal funds), and (3) CMS performs variance analyses on total TPL collections rather than on each line of a form 64.9A.[55] (Such variance analyses would not have identified States that reported TPL amounts on the wrong lines.) Other than the variance analyses performed on total TPL collections, CMS does not perform any other State or nationwide analyses of the TPL amounts reported on the form 64.9A.

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[53] The total number of States that did not correctly report TPL amounts exceeds 21 because 5 States had more than 1 type of error.

[54] CMS conducts quarterly reviews of the CMS-64 for States that are among the top 20 for the highest dollar amount of expenditures. It conducts annual reviews of the CMS-64 for the remaining States.

[55] CMS analysts generate reports that compare a State's current-quarter expenditures to the preceding quarter's expenditures and review the variance between those amounts. The analyst then determines the level of risk associated with the variance for each category of services. If the variance exceeds established thresholds, the analyst documents the reason for the variance.

CMS officials could not locate documentation notifying States of the change to reporting instructions which required States to leave the Other Cost Avoidance line blank. CMS officials stated that possibly some States were never notified of the change. Three of the ten States said they did not know about the change, but they contacted CMS and were instructed to stop reporting on this line after we informed them of the change.

Financial and Program Integrity Consequences of Undetected Medicaid Third-Party Liability Reporting Errors

The effects of TPL reporting errors are sometimes, but not always, financial. During our audit period one State (Virginia) underreported TPL collections for two fiscal quarters, and these errors resulted in a $2.5 million ($1.25 million Federal share) improper reimbursement of Medicaid expenditures. Although the remaining 26 States' reporting errors did not affect Medicaid reimbursements, some errors were repeated for other fiscal quarters.[56]

In determining whether States correctly reported TPL, we noticed that the total TPL amounts that States reported varied significantly from State to State. Although some differences among the TPL amounts that States reported likely resulted from reporting errors, other differences related to the way a State's Medicaid program was set up. For instance, CMS has approved some States to report TPL associated with waiver programs as an offset to waiver program expenditures rather than on the form 64.9A. Similarly, any TPL associated with managed care expenditures (a large part of total Medicaid expenditures in many States) is not reported as a separate line item. Instead, it is reported as an offset to managed care expenditures. As a result, TPL associated with waiver program and managed care expenditures is not apparent on the CMS-64. Without obtaining and reviewing a State's supporting documentation of TPL amounts reported as offsets to expenditures on other parts of the CMS-64 than the form 64.9A, CMS is not able to determine whether those amounts reflect TPL collections and, if they do, by how much.

Because (1) States' reporting of TPL on the form 64.9A was not always accurate, (2) some States report TPL in different places on the CMS-64, and (3) CMS did not have effective procedures in place for detecting TPL reporting errors on the form 64.9A when they occurred, we believe the information available on the CMS-64 is not useful for monitoring how well States are meeting TPL requirements.

[56] These States' errors were corrected prior to our audit, or the errors were related to incorrect reporting of a collection type (although the total reported in TPL collections amount was correct) or to incorrect reporting of cost avoidance. Because cost avoidance represents savings rather than expenditures, these types of reporting errors do not have a financial effect on the CMS-64.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- use the information we obtained from States about the challenges they are still encountering and develop an action plan for helping States more easily identify liable third parties and recover Medicaid payments;

- work with States, as appropriate, to encourage better cooperation from third parties that routinely resist States' TPL identification and recovery efforts;

- for the four States we identified as not having fully complied with the DRA's TPL provisions: (1) verify whether the States have since come into compliance and (2) pursue corrective actions for States that have not fully complied;

- verify whether Virginia has refunded the $1.25 million Federal share of the Medicaid TPL collections underreported during two fiscal quarters and, if not, require Virginia to refund any remaining amount owed;

- provide guidance to States to assist them with developing processes that improve the reporting of Medicaid TPL amounts on the form 64.9A;

- ensure that States have current instructions on completing the form 64.9A;

- ensure that States correctly report TPL amounts on the form 64.9A; and

- remove or disable lines from the form 64.9A that States are supposed to leave blank.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, CMS concurred with all our recommendations and described actions that it has taken or plans to take to address them.

- Regarding our first and second recommendations, CMS stated that it will provide updated guidance to States on effective practices for addressing the challenges the States continue to encounter related to identifying liable third parties and recovering

Medicaid payments. CMS also said that it will continue to provide individual technical assistance to States as needed and participate in the Technical Advisory Group (TAG).[57]

- Regarding our third recommendation, CMS stated that it will work with the four States we identified as not having complied with the DRA's TPL provisions to verify their current compliance status and "identify next steps as appropriate."

- Regarding our fourth recommendation, CMS stated that it is working closely with Virginia to ensure that the Federal share of the Medicaid TPL collections the State underreported is refunded.

- Regarding our fifth recommendation, CMS stated that it will remind States that they should have standardized processes in place to properly report TPL amounts on the form 64.9A, and that these processes should account for staff transitions.

- Regarding our sixth recommendation, CMS stated that it will provide States with updated instructions on completing the form 64.9A.

- Regarding our seventh recommendation, CMS stated that it will evaluate its current review procedures and determine whether any changes related to its review of the form 64.9A should be made. CMS also stated that its quarterly reviews are prioritized based on areas that have the largest impact on Federal funds. CMS concluded that, because the majority of the TPL amounts reported on the form 64.9A are "purely informational," the current review procedures are likely appropriate given the corresponding risk.

- Regarding our eighth recommendation, CMS stated that it will evaluate whether to remove or disable the Other Cost Avoidance line from the form 64.9A and will take action accordingly.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix E.

We thank CMS for its cooperation throughout our audit and for the actions it has taken and plans to take to address our recommendations. Regarding our eighth recommendation, if CMS should elect not to disable the Other Cost Avoidance line of the form 64.9A, we encourage CMS to consider alternative ways of helping to ensure that States do not erroneously report amounts on that line.

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[57] In its comments on our draft report, CMS explained that TAG is a forum for States to discuss technical and operational issues and share best practices with CMS related to TPL policy issues. CMS stated that TAG also enables CMS to apprise State Medicaid agencies of current and planned initiatives related to TPL.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We sent State agency officials questionnaires and reviewed States' TPL reporting for FFS claims on their forms 64.9A for FYs 2019 and 2020 (October 1, 2018, through September 30, 2020). We received responses from all 50 States and the District of Columbia. Unless otherwise indicated, we did not independently verify the information States reported to us.

We interviewed CMS regarding its internal controls for verifying the completeness and accuracy of States' TPL reporting. We also obtained information from States about their procedures for meeting TPL requirements and reporting TPL.

We conducted our audit from January 2021 to May 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed the Act, other applicable Federal requirements, and CMS guidance;
- interviewed CMS officials to obtain an understanding of their oversight of States' TPL reporting and compliance;
- reviewed the CMS instructions to States for completing the form 64.9A of the CMS-64;
- sent State agency officials in each State questionnaires to inquire about challenges faced, to gather information on practices that have helped States mitigate challenges, and to determine how each State:
    - collects Medicaid enrollees' other insurance information,
    - conducts data matches to identify third-party coverage information,
    - processes Medicaid claims when a third party has been identified,
    - collects cost recoveries when TPL is identified after a Medicaid payment was made, and
    - reports TPL cost recoveries and cost avoidance on the form 64.9A;
- reviewed States' TPL reporting for FFS claims on their forms 64.9A for FYs 2019 and 2020 and asked States about any irregularities, significant changes in the amounts reported, and explanations for not reporting TPL amounts;

- sent followup questions to CMS to inquire about challenges States reported and States' TPL reporting errors;

- sent all States additional questions based on initial responses to our questionnaire and followup questions for clarifications of responses (when needed); and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: THIRD-PARTY LIABILITY-RELATED CHALLENGES IDENTIFIED IN PREVIOUS REVIEWS

Challenge	OIG 2001	GAO 2006	OIG 2013	GAO 2015
Difficulties Affecting Third-Party Identification				
Obtaining complete, accurate, and up-to-date coverage information	X		X	X
Third-party resistance to providing information (e.g., because of HIPAA compliance concerns)		X	X	
Third-party unwillingness to share coverage files electronically with States or insistence on performing data matches themselves		X		X
Difficulties Affecting Third-Party Liability Recovery				
Incompatible claim formats (e.g., system limitations or different field requirements)	X	X		
Unprocessed claims with no explanation	X	X	X	
Denials for procedural reasons (e.g., failure to obtain third-party prior authorization or to file third-party claim in a timely manner)	X	X	X	X
Vague claim denials or incomplete information	X		X	
Resistance to reimbursing States (e.g., not recognizing a State's right to collect, or the third-party system is set up to pay providers or enrollees only)		X	X	
Difficulties Affecting Both Identification and Recovery				
Coordinating TPL with out-of-State third parties			X	X
Resistance from PBMs to provide coverage information and reimburse Medicaid claims	X	X	X	
TRICARE's infrequent data-match process and 1-year timely filing requirement	X		X	
Medicare's 1-year timely filing requirement, restrictions preventing a State from billing directly, and issues that arise when Medicare enrollees are granted retroactive coverage			X	

APPENDIX C: STATE REQUESTS FOR ADDITIONAL FEDERAL ACTION

In responding to our inquiries about challenges they face in meeting their TPL responsibilities, some States requested additional Federal assistance. We provide the following information for stakeholders to consider in determining steps that might be taken to help States in addressing TPL-related challenges. We did not evaluate the feasibility of the States' ideas for Federal action. Therefore, OIG does not endorse the States' suggestions.

- To address difficulties associated with obtaining complete, accurate, and up-to-date coverage information:
    - One State requested that Federal law mandate the establishment of a national database of insurance coverage information that States could perform data matches against.
    - One State requested that CMS share the information Medicare receives on casualty or workers' compensation insurance claims or ask its Medicare administrative contractors to share with States the claims information it sends to Medicare.[58]
- To address difficulties associated with coordinating TPL with out-of-State third parties, States reported that Federal clarification of the definition of "doing business" in a State would strengthen their ability to ensure that third parties pay before Medicaid pays. Specifically, States suggested that either:
    - CMS issue guidance that clarifies for third parties that the DRA-required State laws that apply to third parties "doing business in the State" include third parties providing coverage to residents of the State; or
    - Federal legislation be enacted to modify DRA requirements regarding State laws for third parties "doing business in the State" to include third parties providing coverage to residents of the State.
- To address technical issues affecting the way TPL coverage information is shared between third parties and States, States requested a federally mandated data file standard to meet States' needs for matching Medicaid enrollee information with third parties' enrollment data files.
- To address difficulties associated with third parties that are resistant to States' efforts to recover when Medicaid paid before identifying other coverage for a Medicaid enrollee,

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[58] A Medicare administrative contractor is a private health insurer to which CMS has awarded a geographic jurisdiction for processing Medicare FFS claims. Medicare becomes a secondary payer for an enrollee in certain situations when the enrollee is covered by: (1) a group health plan, (2) no-fault or liability insurance, or (3) workers' compensation insurance.

some States requested legislative changes that would establish Federal prompt payment requirements and strengthen the States' ability to assess penalties for noncompliance with those requirements.[59]

- To address difficulties States face with third parties that deny Medicaid claims for procedural reasons, States requested that:
  - CMS issue guidance to clarify that a lack of a prior authorization is not an acceptable reason for a third party to deny a Medicaid claim; or
  - Federal legislation be enacted to either require third parties to accept State agency claims for payment as their own authorization for services or prohibit third parties from denying Medicaid claims due to a lack of prior authorization.[60]
- To address difficulties States face in coordinating TPL with TRICARE, States requested:
  - that CMS work with DOD to re-establish a coordination-of-benefits process with States at a frequency that meets States' needs for ensuring that Medicaid is the payer of last resort; and
  - an exception to the 1-year timely filing requirement on Medicaid claims to help States recover costs when TRICARE was liable during the lapse in the data matching process.
- To address difficulties States face in coordinating TPL with Medicare, States requested:
  - an exception to the 1-year timely filing requirement on claims associated with Medicare enrollees who also have Medicaid coverage and
  - the authority to bill Medicare directly in instances when Medicare is liable.

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[59] Subsequent to States reporting the need for Federal prompt payment requirements, the Consolidated Appropriations Act, 2022, Division P, Title II, section 202, changed section 1902(a)(25)(I)(iii) of the Act by requiring States to have in effect laws for a third party to respond to a State Medicaid claim for payment within 60 days. This legislative change to the Act should address the States' request for a timeframe for third parties to respond to State Medicaid claims for payment.

[60] Subsequent to States reporting the need for Federal legislation affecting prior authorization, the Consolidated Appropriations Act, 2022, Division P, Title II, section 202, made changes to section 1902(a)(25)(I)(ii) and (iv) of the Act by requiring States to have in effect laws prohibiting a third party, except for Medicare plans, from denying a State's Medicaid claim for payment for failure to obtain a prior authorization from the third party for the item or service. This legislative change to the Act should address the States' request for third parties to be prohibited from denying State Medicaid claims for payment due to a lack of prior authorization.

APPENDIX D: TWENTY-SEVEN STATES DID NOT REPORT MEDICAID THIRD-PARTY LIABILITY AMOUNTS ACCORDING TO FEDERAL REQUIREMENTS

	2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Alabama	2c	2c	2c	2c	2c	2c	2c	2c
Colorado	2c	2c	2b, 2c	2c	2c	2c	1b	1b
Connecticut		1b	2b					
Delaware			1b	1b	1b	1b	1b	
Florida	2c	2c	2c	2c	2c	2b, 2c	2b, 2c	2b, 2c
Indiana							2b	
Iowa				2b				
Kentucky			2b					
Louisiana	2c	2c	2c	1b, 2c	2c	2c	2c	
Maryland					1c			
Massachusetts					1b	2b	2b	2b
Michigan		1b	1b	1b	1b			
Minnesota	2c	2c	2c	2a, 2c	2c	2c	2c	2c
Mississippi	2c	2c	2c	2c	2c	2b, 2c	2b, 2c	2c
Missouri	2c	2c	2c	2c	2c	2c	2c	2c
Nebraska	2c	2c	2c	2c	2c	2c		2c
New Hampshire				1b				
New York				1b				
North Carolina						2b	2b	
North Dakota	1a	1a	1a	1a	1a	1a	1a	1a
Ohio	2b	2b	2b					
South Dakota						2b		
Tennessee							2b	
Texas	2b	2b		1b				
Virginia	2a, 2b	2a						
Washington	2c	1b	1b	1b	1b	1b	1b	1b
Wyoming	2c	2c	2c	2c	2c	2c	2c	2c

1- 12 States did not report TPL collection amounts, cost avoidance amounts, or both.
   - 1a- Did not report TPL collection amounts (1 State).
   - 1b- Did not report cost avoidance amounts (10 States).
   - 1c- Did not report either amount (1 State).

2- 21 States did not correctly report TPL amounts for at least one fiscal quarter of our audit period.[61]
   - 2a- Reported incorrect amounts (2 States).
   - 2b- Did not report amounts on the correct lines (14 States).
   - 2c- Incorrectly reported other cost avoidance amounts (10 States).

[61] The total number of States exceeds 21 because some States had more than 1 type of reporting error.

APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 7, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: States Face Ongoing Challenges in Meeting Medicaid Third-Party Liability Requirements (A-05-21-00013)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of the Medicaid program. Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities.

Individuals with Medicaid can have one or more additional sources of coverage for health care services. For example, an individual may have health care coverage through their employer as well as coverage through Medicaid. However, Medicaid is generally the "payer of last resort," meaning that Medicaid only pays claims for covered items and services if there are no other liable third-party payers for the same items and services. Section 1902(a)(25)(A) of the Social Security Act (the Act) defines third-party payers as health insurers, managed care organizations, and group health plans, among others. Third Party Liability (TPL) refers to the legal obligation of third parties to pay part, or all, of the expenditures for medical assistance furnished to individuals with Medicaid.

As noted in the OIG's report, in 2005 the Deficit Reduction Act (DRA) (P.L.109-171) made a number of changes to title XIX of the Act that were intended to strengthen state Medicaid programs' ability to identify and collect from third-party payers that are legally responsible to pay claims primary to Medicaid. For example, the DRA clarified that Pharmacy Benefits Managers (PBMs) are considered to be liable third parties by amending Section 1902(a)(25)(A) of the Act. More recently, the Consolidated Appropriations Act, 2022 (CAA) (P.L. 117-103) further increased state flexibility by requiring states to have laws in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules.

In order to support states in meeting their TPL obligations CMS has issued FAQs,[1] a handbook,[2] two guides for effective state practices,[3,4] as well as guidance regarding legislative changes to TPL requirements that have occurred over the years.[5,6] Additionally, CMS provides regular technical assistance to states when requested and participates in a Technical Advisory Group (TAG). The TAG is comprised of a Chairperson and 10 State Representatives, one for each of the 10 CMS regions. CMS participates in the monthly meetings, however, the TAG Chairperson is responsible for the overall management of the meetings. Each State Representative is responsible for soliciting subjects for discussion from the states in their region, and then subsequently shares TAG meeting summaries and other communications back with the states. The TAG is a forum for states discuss technical and operational issues and share best practices with CMS relating to TPL policy issues. The TAG also enables CMS to apprise state Medicaid agencies of current and planned initiatives related to TPL.

In addition to the activities described above, CMS ensures that quarterly TPL collections are reported by states on the Form CMS-64.9A timely, correctly, and properly supported by state documentation. CMS has provided instructions for states on how TPL information should be reported, and also has an internal review guide used by CMS staff when reviewing state submissions. The quarterly reviews are prioritized based on areas that have the largest impact on federal funds, and certain components of the review must be completed every quarter for the 20 states with the highest expenditures in the previous federal fiscal year. For states that do not fall into this category, certain components of the review can be performed annually. If issues are identified during the quarterly reviews, CMS works collaboratively with the state to resolve any issues to reach reporting compliance. The results of a quarterly review could also lead to the performance of a focused financial management review (FMR) if significant or persistent issues are identified.

States, as the direct administrators of their programs, are responsible for ensuring that Medicaid is the payer of last resort. CMS remains committed to supporting states in meeting their TPL obligations, and appreciates the information in the OIG's report on challenges states are continuing to face in this area.

OIG's recommendations and CMS's responses are below.

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[1] CMS, Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid. 2014. Accessed at:https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/FAQ-09-04-2014.pdf

[2] CMS, Coordination of Benefits and Third Party Liability (COB/TPL) In Medicaid. 2020. Accessed at: https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf

[3] CMS, Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program A Guide to Effective State Agency Practices. 2014. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/effective-state-practices-all-states.pdf

[4] CMS, Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program A Guide to Effective and Innovative State Agency Practices. Update Issued 2015. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/effective-and-innovative-state-practices.pdf

[5] CMS, Third Party Liability in Medicaid: State Compliance with Changes Required in Bipartisan Budget Act of 2018 and Medicaid Services Investment and Accountability Act of 2019. 2021. Accessed at: https://www.medicaid.gov/sites/default/files/2021-08/cib082721.pdf

[6] CMS, Third-Party Liability in Medicaid: State Compliance with Changes Required in Law and Court Rulings. 2023. Accessed at: https://www.medicaid.gov/sites/default/files/2023-03/smd23002.pdf

OIG Recommendation 1

Use the information we obtained from States about the challenges they are still encountering and develop an action plan for helping States more easily identify liable third parties and recover Medicaid payments.

CMS Response 1

CMS concurs with this recommendation. CMS will provide updated guidance on effective practices to states to assist them in addressing the challenges they are still encountering related to identifying liable third parties and recovering Medicaid payments. CMS will also continue to provide individual technical assistance to states as needed, as well as participate in the Technical Advisory Group (TAG).

OIG Recommendation 2

Work with States, as appropriate, to encourage better cooperation from third parties that routinely resist States' TPL identification and recovery efforts.

CMS Response 2

CMS concurs with this recommendation. CMS will provide updated guidance to states to assist them in addressing the challenges they are still encountering related to third parties that routinely resist TPL identification and recovery efforts. CMS will also continue to provide individual technical assistance to states as needed, as well as participate in the Technical Advisory Group (TAG).

OIG Recommendation 3

For the four States we identified as not having fully complied with the DRA's TPL provisions: (1) verify whether the States have since come into compliance and (2) pursue corrective actions for States that have not fully complied.

CMS Response 3

CMS concurs with this recommendation. CMS will work with the four states OIG identified as not having fully complied with the Deficit Reduction Act's (DRA) TPL provisions to verify their current compliance status and identify next steps as appropriate.

OIG Recommendation 4

Verify whether Virginia has refunded the $1.25 million Federal share of the Medicaid TPL collections underreported during two fiscal quarters and, if not, require Virginia to refund any remaining amount owed.

CMS Response 4

CMS concurs with this recommendation. CMS is working closely with the state to ensure that the Federal share of the Medicaid TPL collections the state underreported are refunded.

OIG Recommendation 5

Provide guidance to States to assist them with developing processes that improve the reporting of Medicaid TPL amounts on the form 64.9A.

CMS Response 5

CMS concurs with this recommendation. CMS will remind states that they should have standardized processes in place to properly report TPL amounts on the Form 64.9A, and that these processes should account for staff transitions. States, as the direct administrators of their programs, are responsible for ensuring that any standardized processed are followed and that the TPL amounts report on the Form 64.9A are correct.

OIG Recommendation 6

Ensure that States have current instructions on completing the form 64.9A.

CMS Response 6

CMS concurs with this recommendation. CMS will provide states with updated instructions on completing the Form CMS 64.9A.

OIG Recommendation 7

Ensure that States correctly report TPL amounts on the form 64.9A.

CMS Response 7

CMS concurs with this recommendation. CMS will evaluate its current review procedures and determine whether any changes should be made as it relates to the review of the Form 64.9A. As described above, CMS's quarterly reviews are prioritized based on areas that have the largest impact on federal funds. Because the majority of the TPL amounts reported on each state's 64.9A are purely informational, CMS feels that the current review procedures are likely appropriate given the corresponding risk.

OIG Recommendation 8

Remove or disable lines from the form 64.9A that States are supposed to leave blank.

CMS Response 8

CMS concurs with this recommendation. CMS will evaluate whether to either remove or disable line B3 from the Form 64.9A, which states have been previously instructed to leave blank, and will take action accordingly.