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MEDICAID THIRD-PARTY LIABILITY SAVINGS INCREASED, BUT CHALLENGES REMAIN

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EXECUTIVE SUMMARY: MEDICAID THIRD-PARTY LIABILITY SAVINGS INCREASED, BUT CHALLENGES REMAIN
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WHY WE DID THIS STUDY

Millions of Medicaid beneficiaries have additional health insurance through third-party sources. If beneficiaries have another source of payment, that source should pay before Medicaid does, up to the extent of its liability. Prior studies from the Office of Inspector General and the Government Accountability Office reported that State Medicaid agencies (States) encountered challenges getting third parties to pay when they are responsible, leading to hundreds of millions of dollars in potential losses each year. To address these challenges, the Deficit Reduction Act of 2005 contained provisions designed to enhance States' ability to identify and recover payments from liable third parties.

HOW WE DID THIS STUDY

We determined trends in Medicaid third-party liability (TPL) savings from 2001 to 2011 by analyzing data that States reported to the Centers for Medicare & Medicaid Services (CMS). We also collected data from States on the amount of money at risk of not being recovered. Finally, we surveyed States regarding factors that (1) helped them save money that third parties should pay and (2) made saving money challenging.

WHAT WE FOUND

Medicaid TPL savings increased; however, $4 billion remains at risk of not being recovered. States' reported savings from cost avoidance drove the growth in TPL savings, although savings from recoveries also contributed. States reported that improvements to their processes facilitated savings. Despite these improvements, States reported longstanding challenges with third parties when trying to identify insurance coverage and recover payments. In addition, States reported challenges—caused, they say, by laws and regulations—that hinder the recovery of payments.

WHAT WE RECOMMEND

Since 2001, States have made sizable gains in TPL savings. Improved State processes and congressional action seem to have had some effect. However, a significant amount of money remains at risk of not being recovered. On the basis of the amount of money that is at risk and the longstanding challenges that States continue to face, we recommend that CMS: (1) work with States to address longstanding challenges related to identification of insurance coverage and recovery of payments, (2) address States' challenges with 1-year timely filing limits for Medicare and TRICARE, and (3) work to strengthen enforcement mechanisms designed to deal with uncooperative third parties. CMS concurred with our recommendations.

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OBJECTIVES

1. To determine trends in State Medicaid agencies' cost-avoided amounts and amounts recovered through pay and chase from 2001 to 2011.
2. To describe factors that influenced State Medicaid agencies' ability to maximize cost avoidance.
3. To describe factors that influenced State Medicaid agencies' ability to maximize payments recovered through pay and chase and to estimate the amount of money that remains at risk of not being recovered.

BACKGROUND

Millions of Medicaid beneficiaries have additional health insurance through third-party sources. For example, from 2008 to 2010, an estimated 15 percent (approximately 6.8 million) of Medicaid beneficiaries had employer-sponsored health insurance annually.[1] During this same period, an estimated 14 percent (approximately 6.3 million) of beneficiaries had Medicare.[2] Prior studies by OIG and the Government Accountability Office (GAO) reported that States encountered challenges to identifying and recovering payments from third parties, leading to hundreds of millions of dollars in potential losses each year.[3, 4] To address these challenges, the Deficit Reduction Act of 2005 (DRA) contained provisions designed to enhance State Medicaid agencies' (States) ability to identify and obtain payments from liable third parties.

Medicaid Third-Party Liability

Medicaid is intended to be the payer of last resort.[5, 6] If Medicaid beneficiaries have another source of payment for health services or items covered by Medicaid, that source should pay before Medicaid does, up to

[1] Office of Inspector General (OIG) analysis of U.S. Census Bureau Current Population Survey (CPS) 2008, 2009, and 2010 data (collected in 2009, 2010, and 2011). The CPS is a household survey on employment and unemployment. It also collects data on health insurance coverage.

[2] Ibid.

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

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

[5] Centers for Medicare & Medicaid Services (CMS), *State Medicaid Manual*, Pub. No. 45, ch. 3, § 3900.1.

[6] In a few limited circumstances, Medicaid is not the payer of last resort. For example, Ryan White programs are the payer of last resort, even with respect to Medicaid. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, P.L. 101-381, § 2615; 42 U.S.C. 300ff-25.

the extent of its liability. These other sources of payment are referred to as third parties.

Third parties include health insurers; self-insured plans; group health plans; Government-sponsored health insurance, such as Medicare and TRICARE; service benefit plans; managed care organizations; pharmacy benefit managers; and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.[7] CMS interprets other parties to include third-party administrators, fiscal intermediaries, and managed care contractors that administer benefits on behalf of the risk-bearing plan sponsor.[8] Further, CMS includes medical support from absent parents, automobile insurance, workers' compensation, and probate-estate recoveries as third parties.[9]

To ensure that Medicaid does not pay for services for which third parties are liable, States conduct a number of coordination of benefits activities. They include identifying liable third parties, preventing payment on claims for which third parties are liable, and recovering reimbursements from liable third parties.

Identifying Third Parties

Identifying third parties is the first step to ensuring that they pay claims for which they are liable. Federal law requires States to take reasonable measures to identify liable third parties that are responsible for payment of claims for health care items or services.[10] Part of identifying potentially liable third parties is verifying coverage. States must ask beneficiaries at the time of their initial applications for and redeterminations of Medicaid eligibility whether they have other sources of health coverage. In addition, States must independently identify health coverage of Medicaid beneficiaries by matching States' coverage files with those of third parties. States must also conduct diagnosis and trauma edits on Medicaid claims to identify potential casualty and liability coverage.[11]

States' identification systems require continual updates of beneficiary information and potential third-party liability (TPL) information to accurately identify liable third parties. Regular updates allow States to make new matches, but also to update information from previous matches because beneficiary coverage status can change over time.

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[7] Social Security Act § 1902(a)(25), 42 U.S.C. § 1396a(a)(25).

[8] CMS, *State Medicaid Director Letter*, December 15, 2006 (SMD #06-026), Questions and Answers. Accessed at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121506QandA.pdf on August 29, 2012.

[9] CMS, *State Medicaid Manual*, Pub. No. 45, ch. 3, § 3901.

[10] Social Security Act § 1902(a)(25), 42 U.S.C. § 1396a(a)(25).

[11] 42 CFR § 433.138; CMS, *State Medicaid Manual*, Pub. No. 45, §§ 3902 and 3903.

Third-Party Payment

When States identify probable TPL, they, or a contractor operating on their behalf, use two methods to ensure that Medicaid is the payer of last resort: cost avoidance and pay and chase.

Cost Avoidance. Cost avoidance is the method that States use to avoid payment when other insurance resources are available to the beneficiary. When States recognize claims as belonging to beneficiaries who have other insurance, they will deny payment and return the claims to providers, who are then required to bill and collect payment from any liable third parties. If States have electronic claims processing systems, they can automatically deny payment when claims enter their systems. Federal regulations generally require States to use cost avoidance when probable TPL is established.[12]

Cost avoidance is the most cost-effective way to ensure that Medicaid is the payer of last resort. When States avoid costs, they do not pay money upfront or spend resources on recovery. Once States deny payment and notify providers of a liable third party, providers should bill future claims to the third party first, rather than the States.

Pay and chase. In contrast, the pay-and-chase method occurs when States pay providers for submitted claims and then attempt to recover payments from liable third parties. States may pay and chase claims for two primary reasons: postpayment identification of TPL and Social Security Act exceptions to cost avoidance. First, if States identify probable TPL after payment, Medicaid will have to pay and chase claims. If a third party, such as Medicare, awards retroactive eligibility to a beneficiary, Medicaid will also have to pay and chase claims.[13] Second, the Social Security Act requires that States pay and chase claims instead of using cost avoidance when (1) the service is prenatal care, (2) the service is preventive pediatric care, or (3) coverage is through a parent whose obligation to pay support is enforced by the States' child enforcement agency.[14] However, the

[12] 42 CFR § 433.139(b).

[13] Because Medicaid beneficiaries assign to the States any rights they may have to support or payment from a liable third party, States are able to pay and chase claims if a third party awards retroactive coverage. Instances in which Medicaid beneficiaries may obtain retroactive health coverage from a liable third party include court-ordered health coverage and Medicare retroactive eligibility.

[14] Social Security Act §§ 1902(a)(25)(E) and (F), 42 U.S.C. §§ 1396a(a)(25)(E) and (F). See also 42 CFR § 433.139(b)(3).

President's fiscal year (FY) 2013 budget contained a provision to remove these Social Security Act exceptions to cost avoidance to strengthen TPL.[15]

In general, States obtain recoveries by billing third parties directly and receiving reimbursements from them. For instance, States commonly use this process when trying to obtain recoveries from third-party health insurance.

Some types of third parties require specialized pay-and-chase recovery processes. Specifically, States engage in specialized recovery processes when seeking reimbursements from Medicare and settlements involving either casualty insurance or probated estates.

When seeking reimbursements from Medicare, States may not bill Medicare directly. Instead, they can direct providers to bill Medicare for claims for which States have already paid providers. States must decide whether to take this step and, if so, how they should obtain reimbursement from providers. Some States choose to immediately recover money from providers for Medicare-related claims and do not wait for providers to be reimbursed by Medicare. Some States give providers a defined period (e.g., 60 days) to receive reimbursement from Medicare before they recover money or disallow future payments. These States may not recover money during this period, or afterward, if providers can prove that they did not receive reimbursement from Medicare. Other States do not attempt to recover payments for Medicare-related claims for which they have paid providers.

In casualty insurance and probated estates, States may have to negotiate or wait for a settlement or court decision before they can recover money for billed claims. Casualty recoveries will be limited to the amount of the settlement that is designated for reimbursement of medical costs.[16] States' ability to recover money from probated estates depends on the value of the estates and whether other creditors are also making claims against them.

[15] Office of Management and Budget, *Fiscal Year 2013 Budget of the U.S. Government: Cuts, Consolidations, and Savings*. Accessed at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/ccs.pdf on August 29, 2012.

[16] Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. 268 (2006).

To obtain pay-and-chase recoveries from absent parents, States enter into cooperative agreements with State-run child support enforcement agencies.[17]

During the pay-and-chase process, States may not recover all amounts billed to third parties for several reasons. States may bill third parties for claims for which they are not liable. This may occur when a service for which Medicaid paid is not covered by the third party or the third party did not cover the beneficiary on the date of service. Alternatively, third parties may be liable for a claim but be uncooperative, refusing to pay or to process a claim. In these cases, the third party may refuse to pay the entire claim or try to pay a lesser amount. States may contest the denial and resubmit the claim to the third party. Finally, States may determine that it is no longer cost-effective to try to recover a reimbursement on a claim. Based on Federal regulations and State Medicaid plans, each State sets a dollar threshold or other guidelines for following up on claims owed to them by liable third parties.[18] Using the threshold or guidelines amount, States determine whether it is cost-effective to devote resources to following up on an unpaid claim.[19]

Hiring TPL Contractors

States may choose to conduct all benefits coordination activities themselves or hire a contractor to conduct some or all of these activities. The range of responsibilities that States delegate to contractors varies. For instance, some States delegate all coordination of benefits to contractors. Other States conduct most coordination of benefits activities themselves but have agreements with contractors to perform certain limited functions.

TPL Reporting

States submit a Quarterly Expense Report (CMS-64) to CMS. The CMS-64 is a statement of expenditures for which States are entitled to Federal reimbursement.[20] The CMS-64 also includes information on recoveries, including TPL-related recoveries.

The CMS-64.9A, an attachment to the CMS-64, describes TPL activity. On the CMS-64.9A, States must report the amounts they avoided paying to third parties and the amounts they recovered from third parties. Some

[17] 42 CFR § 433.151. Pursuant to 42 CFR § 433.151, States must enter into written cooperative agreements for enforcement of rights to and collection of third-party benefits with at least one of the following entities: State child support enforcement agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. Collections through cooperative agreements are a specific line item on the CMS-64.9A.

[18] 42 CFR § 433.13 (f)(2).

[19] Ibid.

[20] 42 CFR § 430.30(c); CMS, *State Medicaid Manual*, Pub. No. 45, § 2500(A)(1).

types of third parties, such as Medicare, are specific line items on this attachment. However, not all types of third parties are listed separately.

The CMS-64.9A does not include certain types of information. First, regarding pay and chase, CMS does not require States to report the amount of money they attempted to recover or the amount denied by third parties. Second, regarding cost avoidance, States do not report how they calculated cost avoidance. CMS does not have a standard formula for calculating cost avoidance, and States' methods for calculating it vary. For instance, some States calculate the amount Medicaid avoided paying as the difference between the amount that Medicaid would have paid and the amount that Medicaid actually paid. By contrast, other States report the total amount of a claim as savings, regardless of what Medicaid would have covered.

States submit the CMS-64 and its attachments through the Medicaid Budget and Expenditure System (MBES) and certify that the dollars reported are correct.

CMS uses the reported recovery information, including TPL-related recoveries, to compute the Federal financial participation (FFP) amount for the States' Medicaid program costs. However, CMS does not factor reported cost avoidance into the FFP amount because it does not involve dollars returned to States by third parties.

TPL Provisions of the DRA

The DRA contained provisions that were designed to enhance States' ability to identify and recover payment from liable third parties. The law clarified the list of entities considered third parties by including specific entities that were previously not listed, such as pharmacy benefit managers.[21] In addition, the DRA required that States have laws requiring specified health insurers and certain other third parties to (1) provide States with information on health insurance coverage, (2) accept the State's right of recovery, (3) allow States 3 years after the date of service to submit claims, and (4) not deny or refuse to pay claims for procedural reasons.[22] These provisions took effect on January 1, 2006.[23] According to CMS staff, as of April 2012, all States except Florida and the District of Columbia had the necessary laws in place.

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[21] DRA, P.L. 109-171 § 6035(a), amending Social Security Act § 1902(a)(25), 42 U.S.C. § 1396a(a)(25).

[22] DRA, P.L. 109-171 § 6035(b)(3), amending Social Security Act § 1902(a)(25), 42 U.S.C. § 1396a(a)(25). See also CMS, State Medicaid Director Letter, December 15, 2006 (SMD #06-026), Questions and Answers. Accessed at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121506QandA.pdf on August 29, 2012.

[23] DRA, P.L. 109-171, § 6035(c), 42 U.S.C. § 1396a note.

There are some exceptions to the 3-year timely filing rule under the DRA. For instance, when Medicare is the liable third-party payer, fee-for-service providers have only 1 year after the date of service to submit claims under provisions of the Patient Protection and Affordable Care Act (ACA).[24] If Medicare awards a Medicaid beneficiary retroactive eligibility, the 1-year timely filing requirement may be waived.[25] In addition, TRICARE claims filing regulations, issued before enactment of the DRA, also require that claims be submitted no later than 1 year after the date of service.[26]

Related Work

OIG has reported problems with TPL. In 2001, OIG found that Medicaid was at risk of losing over 80 percent of the dollars it paid and chased for pharmacy claims in 32 States.[27] It also found that almost three-quarters of States reported that third parties refused to process or pay pharmacy claims.[28]

GAO has also reported problems with TPL. A 2006 GAO report found that States encountered problems verifying which Medicaid beneficiaries had private insurance and recovering payments from third parties.[29] Not all third parties were willing to provide access to their coverage files, and some third parties imposed barriers to coverage identification. For example, some pharmacy benefit managers ignored or denied States' requests for verification information, citing privacy provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or claiming that they were not liable parties. Other third parties and contractors would not participate in data-matching agreements. Fourteen States estimated their combined losses because of problems recovering payments from third parties to be between $184 million and $196 million per year.[30]

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[24] ACA, P.L. 111-148 § 6404, amending Social Security Act §§ 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B), 42 U.S.C. §§ 1395f(a)(1), 1395u(b)(3)(B), and 1395n(a). The Secretary may specify exceptions to the 1 calendar year period under each provision.

[25] If the Medicare contractor determines that CMS's conditions for the exception are met, it may allow the provider a filing extension from the end of the sixth calendar month from the month in which States recovered their money. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.1, § 70.7.3.

[26] 32 CFR § 199.7(d). TRICARE was formerly known as the Civilian Health and Medical Program of the Uniformed Services and is still referred to as such in some regulations.

[27] OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties*.

[28] Ibid.

[29] GAO, *Medicaid Third-Party Liability: Federal Guidance Needed to Help States Address Continuing Problems.* The data in the report were collected prior to the DRA's effective date, although the report was published after the effective date.

[30] Ibid.

METHODOLOGY

To determine trends that influenced State savings from liable third parties, we analyzed data on savings from cost avoidance and pay and chase, and on money at risk of not being recovered. We also surveyed States regarding factors that (1) helped them save money that third parties should pay and (2) made saving money more challenging.

Scope

This study covered all 50 States and the District of Columbia.

The focus was on savings from fee-for-service claims and, to the extent that they are included in States' reports to CMS, managed care claims. Approximately one-third of States included some information from managed care claims in their CMS-64 reports.

We analyzed trends in State savings from 2001 to 2011, the period since the last OIG study. Our assessment of factors that influenced State savings was focused on more recent periods. We realized through extensive conversations with States that collecting data on the factors that influenced State savings for 11 years would be intensely burdensome to them. We also realized that in some cases data were not available. Instead, we collected data on these factors for as much of that time as was reasonable (e.g., point-in-time, or FYs 2010 and 2011). These periods are described in more detail below.

Data Sources and Data Collection

Annual TPL Data. We obtained State-reported CMS-64 and CMS-64.9A data from MBES for each State for FYs 2001 through 2011. We used these data to determine States' total Medicaid expenditures and their savings from, and trends in, cost avoidance and pay-and-chase over the 11-year period. The data collected are totals, reflecting the Federal and State shares.

Data Collection From States. In November 2011, we sent a data collection instrument to each State's TPL coordinator. The instrument had two sections—a data request and a survey. We obtained a 100-percent response rate to the data collection instrument, although some States could not provide portions of the requested data. Where appropriate, item response rates are included below.

We asked States to provide data on their recovery rate for pay-and-chase claims and on the amount of money they believed was owed to them by third parties.[31] We collected these data separately for Medicare, health insurance, casualty insurance, and probated estates. The response rate for

[31] All data collected directly from States also reflect both the Federal and State share.

items in the data request section of the collection instrument ranged from 88 to 98 percent.

We collected data on States' recovery rates in two ways. First, for Medicare and health insurance, we asked States for the total amount that they billed for FYs 2010 and 2011 and, of that, the total amount collected for each year. We requested these data for only 2 years to reduce the burden on States. Second, for casualty insurance and probated estates, we asked States to report their rate of return for closed cases. We did not specify a time period for the self-reported rates.

We also asked States to provide data on the amount of money that they considered to be at risk of not being recovered. To do so, we asked States to provide their best estimate of money that they believed was owed to them from third parties. To reduce the likelihood that claims still in the process of being paid would be reported as dollars at risk of not being recovered, we instructed States to include only dollars they had considered to be at risk 6 months before the survey was due.

The survey section of the collection instrument focused on factors that might influence States' savings from third parties. We asked States which activities were most useful for identification of third parties. We also asked which factors had improved their ability to avoid costs or recover payments since 2006. Similarly, we asked about challenges related to coordination of benefits activities. Finally, we asked States about their CMS-64 reporting activities, about their use of TPL contractors, and for basic program information. The response rate for items in the survey section ranged from 96 to 100 percent.

Data Analysis

TPL Trends and Total Savings. We analyzed the data that States reported to CMS to identify the percentage change in total savings from cost avoidance and pay and chase between 2001 and 2011, the percentage change in the total amount of money that States expended over these 11 years, and the cumulative amount that States saved over this period.[32] We compared the percentage change in States' savings to the percentage change in total Medicaid expenditures. We then calculated the percentage change in savings related to cost avoidance, pay and chase, probated estates, and subgroups of these categories that States report to CMS. To obtain the cumulative amount in total savings, we summed all States' cost avoidance and pay-and-chase savings for all 11 years.

[32] To account for inflation, we used the Consumer Price Index conversion factor to convert to 2011 dollars.

We analyzed differences among States; however, this information is not included in this report. While we found differences among States, we did not have contextual data on State demographics and other factors. Without this contextual information, our analysis of State comparisons was largely inconclusive.

Rates of Recovery. We calculated recovery rates both for Medicare and for health insurance pay-and-chase claims. To calculate the recovery rate for Medicare, we divided the amount of money each State collected from Medicare in 2011 by the total amount that State billed to Medicare for pay-and-chase claims. We also performed this calculation for health insurance recoveries.

Money at Risk of Not Being Collected. To calculate the money at risk of not being collected, we added up the money that States reported for Medicare, health insurance, casualty insurance, and probated estates. For Medicare and health insurance, we reported the dollars at risk exactly as States reported them. For casualty insurance and probated estates, we adjusted the amounts that States reported to provide a more accurate account of the money that States are likely to recover.[33]

Factors That Influence State Savings. We analyzed States' responses to survey questions about factors that influenced savings to determine those that were most influential. We also reviewed States' open-ended responses to provide context for factors that States identified as "very challenging."

Limitations

All data are State reported. We did not independently verify the accuracy of data that States reported to CMS or to OIG.

Some portion of cost-avoided dollars cannot, by definition, be quantified. For example, States cannot identify savings from cost avoidance that occurs when a provider correctly submits a claim for reimbursement to a third party rather than to Medicaid.

States' calculations of cost avoidance may be affected by variations in tracking methods. For example, some States track the entire amount that was billed for a cost-avoided claim as savings, while others track only the amount that Medicaid would have paid for that claim as savings. However, these data are sufficient to represent broad trends in savings over time. It is likely that States reported data in the same way in 2011 as in 2001.

[33] To calculate a reasonable estimate of the amount that States might be able to recover from casualty insurance and probated estates, we adjusted the raw numbers provided by States by the rates of return for closed cases (data also provided by States).

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Medicaid TPL savings increased, but 44 States reported $4 billion is at risk of not being recovered

Overall, States reported increased savings from both cost avoidance and pay and chase between 2001 and 2011. Specifically, savings increased from nearly $34 billion in 2001 to slightly more than $72 billion in 2011, representing a 114-percent increase. However, because States generally were not able to recover all of the money they went after, a significant amount remains at risk of not being recovered. Cumulatively, 44 States reported $4 billion is at risk.[34]

States' reported growth in cost-avoidance and pay-and-chase savings does not appear to be tied to growth in Medicaid expenditures or in the percentage of Medicaid beneficiaries with another source of insurance. For example, reported expenditures increased 47 percent from 2001 to 2011, compared to TPL's 114-percent growth. Such growth suggests that TPL savings outpaced growth in Medicaid expenditures. Further, the percentage of beneficiaries with another source of health insurance generally remained stable between 2002 and 2010.[35]

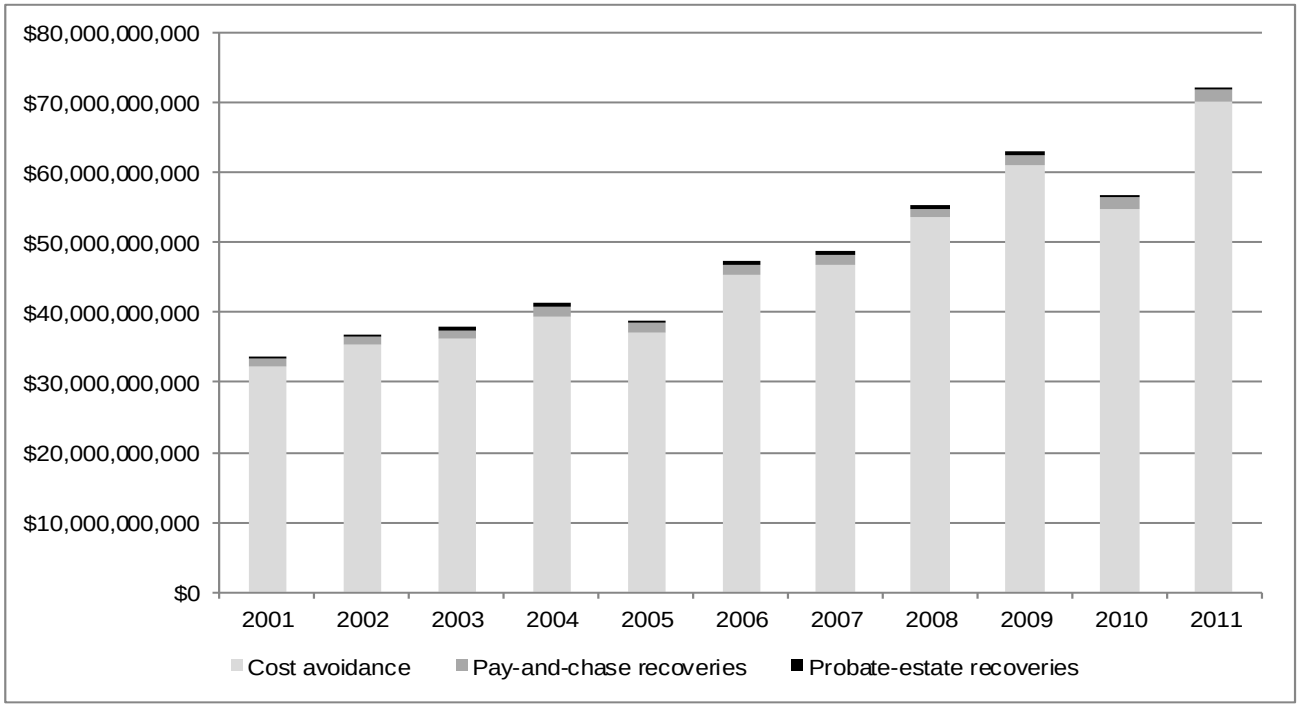
States' reported savings from cost avoidance drove growth in TPL savings

States' reported cost-avoidance savings accounted for most TPL growth and total savings between 2001 and 2011. States' reported savings from cost avoidance grew 117 percent, from $33 billion to $70 billion, between 2001 and 2011. Cumulatively, States reported that they avoided paying $512 billion from 2001 to 2011. Had States paid for these services, reported Medicaid expenditures could have been 13 percent greater. See Chart 1 for TPL savings trends from 2001–2011 by cost avoidance, pay and chase, and probated estates.

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

[35] OIG analysis of U.S. Census Bureau CPS 2008, 2009, and 2010 data (collected in 2009, 2010, and 2011).

Chart 1: TPL Savings From 2001 to 2011

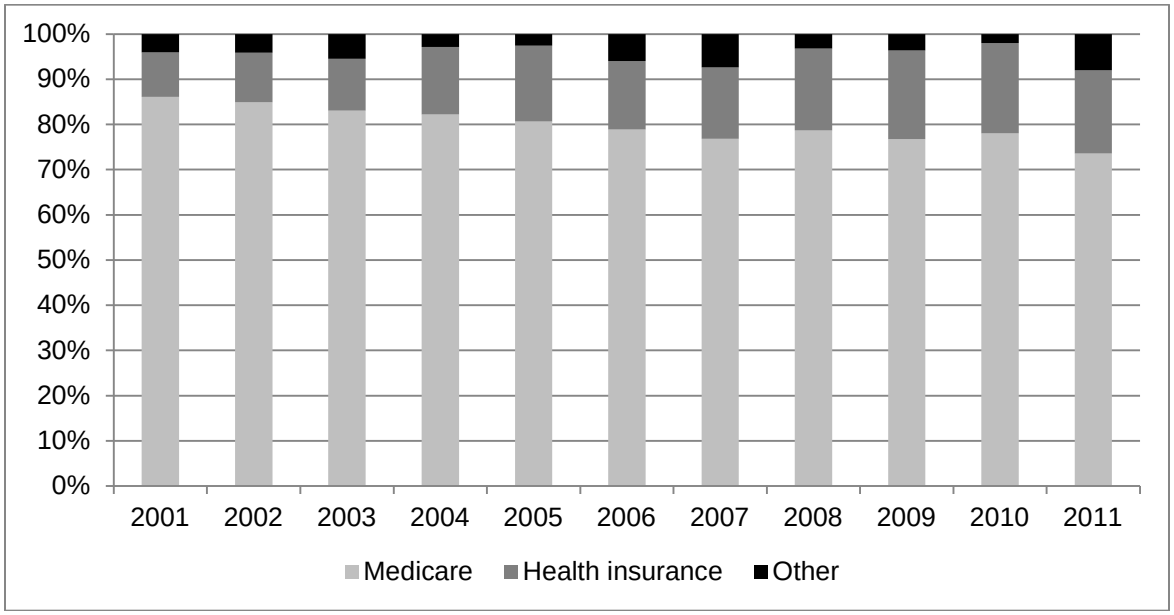


Source: OIG analysis of CMS-64.9A reports, 2012.

Although similar proportions of Medicaid beneficiaries have Medicare or health insurance as third-party payers nationally, Medicare makes up about 80 percent of total costs avoided. A variety of factors contributes to this, including that cost avoidance is generally easier for Medicare claims than for other types of third parties. Because Medicare beneficiaries tend to keep Medicare after they become eligible, once States have third-party coverage information they can avoid payment for all future claims. In contrast, other forms of third-party coverage, such as health insurance obtained through an employer, are more likely to fluctuate and result in multiple updates to State systems.

Although Medicare traditionally has been the largest driver of cost avoidance since 2001, States reported some recent gains in cost avoidance from third-party health insurance. For example, in 2001, health insurance made up 10 percent of total costs avoided; by 2011, it had grown to 18 percent. These gains suggest that the DRA had some effect on States' ability to avoid costs, likely through improvements in States' identification of third parties. See Chart 2 for more detail.

Chart 2: Cost-Avoidance Percentages Over Time, by Type of Third-Party Insurance



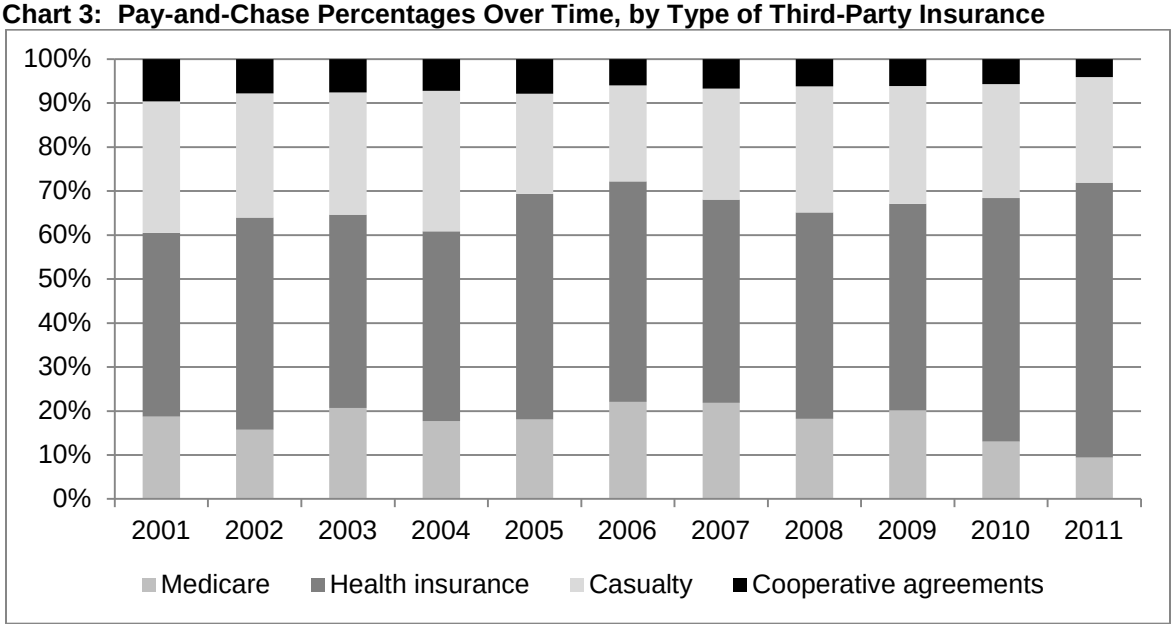
Source: OIG analysis of CMS-64.9A reports, 2012.

Increases in State recoveries also contributed to TPL savings

Although State recoveries through pay and chase make up only about 3 percent of total TPL savings, these recoveries are increasing. States' pay-and-chase recoveries from health insurance, Medicare, casualty settlements, and cooperative agreements increased by 61 percent, from $1 billion to $1.6 billion, between 2001 and 2011. Cumulative pay-and-chase recoveries over this period resulted in $14.7 billion in savings for States.

As with cost avoidance, the proportion of pay-and-chase recoveries varies by type of third-party. Specifically, pay-and-chase recoveries from health insurance accounted for 50 percent of cumulative pay-and-chase recoveries between 2001 and 2011, while Medicare accounted for 18 percent of such recoveries. See Chart 3 for more detail.

Chart 3: Pay-and-Chase Percentages Over Time, by Type of Third-Party Insurance



Note: Casualty insurance and cooperative agreements are other sources through which States may recover funds from third parties. Casualty coverage may be a source of TPL if Medicaid paid for medical expenses resulting from accidental injury that should have been covered by casualty insurance. Cooperative agreements assist States in pursuing a liable third party, for example, to identify parents who are obligated to pay for the health care of Medicaid recipients.
Source: OIG analysis of CMS-64.9A reports, 2012.

Moreover, the percentage of recoveries from health insurance is growing. In 2001, health insurance accounted for 42 percent of recoveries from pay and chase, compared to 62 percent of total dollars recovered in 2011. Similar to cost avoidance, these gains suggest that the DRA had some effect on States' ability to recover money, possibly because of an increased ability to identify claims that need to be recovered or to the DRA's expansion of the timely filing limit to 3 years.

Despite increased savings, States reported potential recoveries at risk

As of June 30, 2011, 44 States cumulatively reported $4.1 billion that they believe is owed by third parties and is at risk of not being recovered.[36] This sum includes Federal and State dollars. The term "dollars at risk" refers only to claims that States pay and chase; cost-avoided dollars are never at risk because they are never expended by States. Table 1 shows the money that States report being owed by third parties.

[36] Each State determined what dollars were at risk of not being recovered using its own methodology. As a result, this amount represents varying time periods.

Table 1: Dollars at Risk of Not Being Recovered

Type	Dollars at Risk	Percentage of Dollars at Risk
Health insurance	$2,356,853,103	57%
Probated estates*	$931,268,692	22%
Casualty*	$744,684,814	18%
Medicare	$110,868,962	3%
Total	**$4,143,675,571**	**100%**

*The dollars for probated estates and casualty reflect the average amount States expect to recover and consider to be owed to them, not the entire amount of the probated estate or casualty claim.
Source: OIG analysis of data collection instrument responses, 2012.

The disparity between the amount that States tried to recover from third-party health insurance and the amount actually collected may contribute to high amounts of dollars at risk. On average, 45 States reported recovering 18 percent of what they billed to third-party health insurance in 2011. These low recovery rates may be due in part to States' challenges to reimbursement, which are discussed in more detail later in the report.

States experience higher recovery rates from Medicare than from third-party health insurance, contributing to fewer dollars at risk. The average recovery rate in 2011 for Medicare was 69 percent among the 32 States that were able to provide data. It is unclear why Medicare recovery rates are higher, but one explanation could be that some States automatically recover money from providers when Medicare is the third party. By contrast, when a health insurance carrier is the third party, States generally submit bills directly to the carrier and must wait for its response.

States reported that improvements to their processes facilitated TPL savings, but challenges remain

States identified several factors that facilitated improvements in cost avoidance and pay and chase, despite also reporting some longstanding challenges. In general, process improvements, such as information technology and use of contractors, facilitated these improvements, which led to greater savings. At the same time, States reported continued challenges with third parties when trying to identify insurance coverage and recover payments similar to those identified by States in previous OIG and GAO studies. In addition, States reported challenges—caused, they say, by laws and regulations—that hinder the recovery of payments.

States reported that their use of electronic systems and contractors facilitated improved savings

Forty-Five States Reported That Their Electronic Systems Facilitated Improvements in Their Identification, Cost Avoidance, and Recovery Efforts. States indicated that electronic systems improved the efficiency with which they were able to identify beneficiaries with third-party insurance. This improved efficiency resulted from: (1) conducting online verification of coverage and (2) having electronic data-matching agreements with third parties. Forty-two States reported that at least one of these systems was "very useful" for identifying third parties. See Table 2 for a breakdown of the number of States that reported that each system was very useful for identifying third parties.

Table 2: Electronic Systems That States Reported as Very Useful for Identifying Third Parties

Electronic System	Reported as Very Useful	Percentage of States
Online verification	37	73%
Via third-party Web site	36	71%
Via TPL clearinghouse vendor	20	39%
Having electronic data matching agreements with third parties	34	68%

Source: OIG analysis of State data collection instrument responses, 2012.

Electronic systems helped States identify third parties more efficiently, which helped States save money. For instance, verifying coverage online through a third-party Web site is quicker than phoning or faxing a third party. In addition, States reported that using TPL clearinghouses—vendors with electronic agreements with many insurance companies—was helpful. States pay clearinghouses to match coverage information for beneficiaries against a clearinghouse's collection of data. Lastly, data-matching agreements increase efficiency because they allow States to check for third-party insurance for many beneficiaries at one time. In these cases, States share their Medicaid enrollment with third parties, which then compare States' lists to their covered individuals and produce a report of all matches for States.

Similarly, using electronic systems increased States' efficiency in avoiding costs and recovering payments. Thirty-six States reported that increases in electronic claims or electronic billing significantly improved their ability to save money. Electronic claims occur when providers submit claims electronically for services provided to Medicaid beneficiaries to States for payment. Electronic billing occurs when States send their invoices for reimbursement to third parties via electronic means. Both of these systems

may help States save money because automated processes replace manual processes. For example, because electronic claims from providers are transmitted directly to States' claim management processing systems, claim reviews, TPL checks, and cost-avoidance activities happen automatically, rather than manually.

In addition, States' ability to receive payments electronically from third parties appears to have had some positive effect on savings. As of December 2011, 32 States reported accepting electronic payments. These States demonstrated a 78-percent increase in recoveries between 2001 and 2011. On the other hand, the 18 States that did not accept electronic payments had an 18-percent increase in recoveries over the same period.

States Reported That Assistance From Contractors Facilitated Improvements in Their Identification and Recovery Efforts. Forty-seven States used a contractor for at least one TPL activity, and all but two of these States indicated that contractor assistance was either useful for identifying third parties or improved States' ability to collect pay-and-chase claims.

States reported that the most helpful functions contractors provide are identification and verification. Overall, 29 States that have contractors indicated that such assistance was very useful in identifying third-party insurance. States indicated that contractors' data-matching agreements with out-of-state third parties helped them identify third-party insurance. Because contractors were more likely to have relationships with a wider array of third parties, they could more easily develop data-matching agreements than States could.

States reported that the second-most helpful contractor-assisted function was conducting collections. Overall, 27 States that used contractors indicated that such collection assistance with pay-and-chase claims from third parties significantly improved States' ability to recover money. For example, some States indicated that contractors may be useful in doing followup work on claims that are hard to recover.

States reported longstanding challenges with third parties when trying to identify insurance coverage and recover payments

Although States' TPL savings improved, they continue to face challenges in maximizing savings from third parties. States reported challenges in identifying third parties and recovering payments through pay and chase. In fact, 49 States identified at least one part of these activities as "very challenging." However, data are inconclusive as to whether States that identified more challenges than others have less in TPL savings.

In passing the DRA, Congress attempted to mitigate challenges in identifying third parties and recovering payments.[37] However, we found that many of the challenges that States reported are similar to those reported in 2001 and 2006.[38, 39]

States Continue To Face Challenges Identifying Beneficiaries With Third-Party Insurance Because Third Parties Do Not Always Provide Complete Coverage Information. All States reported that identifying third parties was challenging. Identification of third-party insurance is the first, and key, step in saving money through TPL. Without the appropriate information, States cannot avoid costs or recover payments.

Although the details may have changed for certain challenges, identification has historically been challenging for States. In 2001, States reported concerns about inaccurate or incomplete information in coverage files and difficulty identifying claims processing entities.[40] In 2006, States noted problems with third parties' ignoring their requests for coverage information and being unwilling to share data electronically.[41] In 2011, States reported challenges with third parties' submitting explanation of benefit (EOB) forms that were confusing or incomplete. See Table 3 for a complete list of challenges related to identification of third parties that States identified in 2011.[42]

Table 3: Challenges That States Reported Related to Identification

Specific Challenge With Identification	Percentage of States That Reported the Challenge in 2011
Third-party concerns about HIPAA and releasing insurance coverage information to States	90%
EOB forms from third parties that are confusing or incomplete	86%
Cooperation from pharmacy benefit managers	84%
Obtaining data about beneficiaries' third-party insurance from State or Federal entities	78%
Obtaining data from TRICARE on Medicaid beneficiaries with potential TRICARE coverage	74%

Source: OIG analysis of State data collection instrument responses, 2012.

The most frequently cited challenge to identification was third-party concern about HIPAA and whether third parties can release information to

[37] DRA, P.L. 109-171 § 6035, Social Security Act § 1902(a)(25), 42 U.S.C. § 1396a.

[38] OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties*.

[39] GAO, *Medicaid Third-Party Liability: Federal Guidance Needed to Help States Address Continuing Problems.*

[40] OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties*.

[41] GAO, *Medicaid Third-Party Liability: Federal Guidance Needed to Help States Address Continuing Problems.*

[42] See Table A-1 in Appendix A for a list of these challenges by State.

States. States are exempt from HIPAA under the privacy rule's exception for the use and disclosure of protected health information for treatment, payment, and health care operations.[43] CMS has also issued guidance on this issue.[44] However, States indicated that third parties continue to use HIPAA as an excuse to not provide information. For example, one State reported:

> Many commercial carriers frequently quote HIPAA and then refuse to verify coverage when our State agency contacts them. We frequently must go through their compliance office in an attempt to get clearance. Once we obtain clearance it does not always help us the next time we need to verify coverage. Carriers feel it is a violation of HIPAA to confirm the existence of coverage and the lives covered.

The next most frequently cited challenge to identification was that EOB forms States receive from third parties are either difficult to interpret or incomplete. Inaccurate and incomplete information on EOB forms hinders States' attempts to determine whether they correctly identified the liable third party. When a third party refuses liability, it denies the claim via an EOB form. The EOB form should indicate the reason for denying a claim (i.e., that the third party refuses its coverage liability). However, there is no standard format for the EOB form. States indicated that, even across national plans, EOB forms are inconsistent and that data may not be easily identifiable or be in the same spot on the form. This is problematic for States because "it can be very difficult … to understand them and key it correctly." In addition, States reported that third parties did not always submit all information on the EOB form denying States' requests for payment. One State provided this example: "There are some companies that do not provide a complete EOB the first time around. Claims are corrected and resubmitted based on the first EOB, only to receive a second EOB with new items that need to be resolved."

Another challenge that States reported was lack of cooperation from pharmacy benefit managers. States have reported this challenge since 2001. In fact, in 2001, OIG found that more States had problems with pharmacy benefit managers than with all other third parties combined.[45] The DRA attempted to increase cooperation from pharmacy benefit managers by clarifying that they are third parties, and as such must accept

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[43] 45 CFR § 164.506.

[44] CMS, *State Medicaid Director Letter*, June 21, 2010 (SMDL #10-011), Questions and Answers. Accessed at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10011.pdf on August 29, 2012.

[45] OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties*.

States' right of recovery. CMS has also issued guidance to this effect.[46] Yet in 2011, States again reported that pharmacy benefit managers were uncooperative. One State provided this example: "They make you guess a date [of coverage eligibility] and then will tell you yes or no." States indicated that pharmacy benefit managers will not provide eligibility dates for covered beneficiaries, will not verify coverage unless a State has the policy number, and may be unwilling to speak to States' representatives.

Finally, States reported challenges obtaining data about third-party coverage from State and Federal entities. Some States cited problems getting workers' compensation or child support claims needed to identify additional sources of third-party insurance. States also reported that some entities cite Internal Revenue Service or Social Security Administration security requirements that prevent them from disclosing Social Security numbers and other personal identifiers required for data matching. In addition, States reported that TRICARE is challenging, mostly because it will conduct only one data match per year with each State.

States Continue To Face Challenges Recovering Payments Because Third Parties Refuse To Process or Pay Claims. All but one State reported continuing challenges with third parties refusing to process or pay claims, despite State laws requiring third-party cooperation that were enacted pursuant to the DRA. Generally, States have reported these challenges since 2001. In 2001, States reported that claims were not processed or were returned with vague denial codes, and that some pharmacy benefit managers would not process claims because their clients had not authorized them to do so.[47] In 2006, States reported that third parties refused to respond to or cooperate on claims filed for payment by States.[48] In 2011, States reported similar challenges, such as third parties' issuing denials for procedural reasons. See Table 4 for a complete list of the challenges related to third-party refusal to pay or process claims, whether States reported the challenges in the past, and whether the DRA sought to address them.[49]

[46] CMS, *State Medicaid Director Letter*, December 15, 2006 (SMD #06-026), Questions and Answers. Accessed at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121506QandA.pdf on August 29, 2012.

[47] OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties*.

[48] GAO, *Medicaid Third-Party Liability: Federal Guidance Needed to Help States Address Continuing Problems.*

[49] See Table A-2 in Appendix A for a list of these challenges by State.

Table 4: Challenges States Reported About Third-Party Refusal To Process or Pay Claims

Challenge	Identified in 2001 OIG Report	Identified in 2006 GAO Report	DRA Attempted To Address	Identified in 2011 (This Study)	Percentage of States That Reported Challenge in 2011
Denial by third parties	X			X	98%
For procedural reasons	X	X	X	X	96%
No explanation	X			X	88%
Third parties not responding when State submits bills	X	X	X	X	92%
Third parties not abiding by 3-year timely filing rules				X	88%
Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed				X	88%
Third parties not accepting States' right to collect	X	X	X	X	82%
Pharmacy benefit managers claim they do not have the authority to reimburse States directly	X	X	X	X	82%

Source: OIG analysis of State data collection instrument responses, 2012.

The most frequently cited longstanding challenge to recovering payments is denial from third parties for procedural reasons or with no explanation. In 2011, 42 States reported that $3.4 billion of the $7 billion that they billed to third-party health insurance was denied. Although third parties may legitimately deny claims (e.g., if the insurer did not cover the Medicaid beneficiary), denials for procedural reasons or with no explanation are not considered legitimate. In fact, the DRA specifically required States to pass laws prohibiting third parties from refusing to reimburse States for procedural reasons. It is unclear what portion of the $3.4 billion in denied claims was inappropriately denied by third parties and still eligible for collection. However, some portion of that money may contribute to the amount that States reported as at risk.

An additional longstanding reported challenge is third parties' failing to respond to States' claims. For instance, in 2011, 41 States reported that third parties did not respond to $2 billion of the $7 billion billed to third-party health insurance. When this happens, States may lose money.

Another challenge that States have reported since 2001 is that third parties do not accept States' right to collect reimbursements. One State indicated that this was a particular problem with out-of-State third-party insurers. Another State indicated that there still appeared to be some confusion about Medicaid being the payer of last resort.

A final challenge States have reported since 2001 is that pharmacy benefit managers claim they do not have the authority to reimburse States directly.

Despite State laws requiring third-party cooperation that were enacted pursuant to the DRA, in 2011, half of States reported this issue as "very challenging." Several States reported that pharmacy benefit managers claim they can reimburse States only when beneficiaries' employers have authorized them to do so. In refusing to reimburse States, pharmacy benefit managers have contended that the Employee Retirement Income Security Act of 1974 (ERISA) prevents reimbursement to States by pharmacy benefit managers for employer-governed health benefit plans.[50] Pharmacy benefit managers have also argued that they must refuse reimbursement to States according to procedural restrictions chosen by plan sponsors.[51] These arguments have proved unsuccessful for pharmacy benefit managers in recent litigation.[52]

States reported that certain laws and regulations created challenges to recovering payments

In addition to longstanding challenges from third parties, all States reported that particular laws and regulations, or the lack thereof, are challenging to recovery efforts. Specifically, the Medicare and TRICARE 1-year timely filing limits were most frequently reported to be "very challenging." See Table 5 for a list of specific challenges related to current laws and regulations.[53]

Table 5: Challenges That States Reported With Current Laws and Regulations

Challenge	Percentage of States That Reported Challenge in 2011
Medicare 1-year timely filing limit	98%
TRICARE 1-year timely filing limit	92%
Lack of enforceable penalties for third parties that refuse to reimburse States	90%
Inability to bill Medicare directly	88%
Lack of rules requiring third parties to reimburse in a timely manner	82%

Source: OIG analysis of State data collection instrument responses, 2012.

Medicare Timely Filing Limit Is Challenging. States reported that the Medicare 1-year timely filing limit creates barriers to recovery. Because States cannot bill Medicare directly, they must decide whether and how to recover money from providers. Some States direct providers to first bill Medicare and then forward payment to States once it is received. If States

[50] See, e.g., Caremark, Inc. v. Goetz, 480 F.3d 779 (6th Cir. 2007).
[51] Ibid.
[52] Ibid.
[53] See Table A-3 in Appendix A for a list of these challenges by State.

do not discover the third-party insurance in time for providers to meet the 1-year timely filing deadline, States lose that money. Some States may not attempt to recover Medicare claims because it is not cost effective.

States may remedy the problem by recovering money from providers, regardless of whether providers are paid by Medicare. In this case, States recover their payments, but providers may not complete their recovery from Medicare in time to get paid. However, States expressed concern about the consequences of taking money back from providers when they do not expect the providers to recover the money from Medicare. Multiple States indicated that providers may choose not to participate in Medicaid because of this challenge and are concerned that this may limit beneficiary access. Some States are so concerned that they do not attempt to recover money from providers for Medicare claims.

Medicare regulations allow providers an exception to the 1-year timely filing limit, but States expressed concern that the exception is of limited use to providers in getting their money back.[54] If CMS, or one of its contractors, determines that beneficiaries were retroactively awarded Medicare coverage and States have recovered their money from providers, providers will be granted additional time to file claims with Medicare. However, States reported that the requirements for meeting the conditions for exception to the timely filing limit are challenging. At the time of our data collection, providers had to produce the letter notifying the beneficiary of retroactive Medicare entitlement to qualify for the exception. States reported that providers often do not have, and cannot get, this letter. CMS changed this requirement after we completed our data collection. As of August 27, 2012, if providers do not have access to this letter, Medicare contractors can use Medicare databases to verify retroactive eligibility.[55]

TRICARE's 1-Year Timely Filing Limit Is Challenging. States reported that TRICARE's 1-year timely filing limit is also challenging, primarily because TRICARE allows each State one data match per year. States may find claims that were already paid and potentially should have been paid by TRICARE, but are for dates of service more than 1 year previous and are past the 1-year window.

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[54] 42 CFR 424.44(b)(2).

[55] CMS, *Modifying Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies, Medicare Claims Processing Manual (CMS Pub. 100-04), Transmittal 2477, Change Request 7834* (May 25, 2012; effective August 27, 2012). Accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2477CP.pdf on August 29, 2012.

The high percentage of States reporting that TRICARE's 1-year timely filing limit is challenging may be due to lack of clarity about TRICARE's policy. Specifically, States may have a different interpretation of the start date of the 1-year window, depending on which source of TRICARE guidance they consult. TRICARE regulations indicate that States have 1 year from the date of service to file a claim.[56] The *TRICARE Reimbursement Manual* extends that window by allowing States 1 year from the date of the annual data match. According to the *TRICARE Reimbursement Manual*, States may file claims no later than 1 year after the: (1) date of service, (2) date the prescription was filled, (3) date of discharge if the services were rendered during an inpatient admission, or (4) the date a State received the results of the annual data match.[57] However, the sample billing agreement that States sign to claim reimbursement from TRICARE does not mention the four options and indicates only that claims must be filed "no later than one year following the date of service or the date of discharge for inpatient services."[58] Although the billing agreement indicates that TRICARE contractors can grant waivers to the claims filing deadline, the requirements for obtaining a waiver are not listed.

Some States and CMS staff have indicated that they were not aware of alternatives to using the date of service for the start of the 1-year timely filing deadline.

States Lack an Enforcement Mechanism for Uncooperative Third Parties. States indicated that the lack of penalties for refusal to reimburse and lack of rules for timely reimbursement were challenges to achieving TPL savings. Without a mechanism to enforce penalties, States have no influence over third parties and few resources to compel payment. Although States' Attorneys General may seek legal action against third parties, States indicated that these efforts are resource intensive and the outcomes are uncertain and may not be cost effective. In addition, there are no rules for how long third parties have to reimburse States once States have submitted a bill. Lacking rules requiring third parties to reimburse States in a timely manner, States bill third parties multiple times and have outstanding balances in their fiscal systems for indefinite periods.

[56] 32 CFR § 199.7(d).

[57] TRICARE, *TRICARE Reimbursement Manual 6010.58-M*, ch. 1, § 20, para. 2.1.2 (Feb. 1, 2008).

[58] TRICARE, *TRICARE Reimbursement Manual 6010.58-M*, ch. 1, add. A (Feb. 1, 2008).

CONCLUSION AND RECOMMENDATIONS

Since 2001, States have made sizable gains in TPL savings. Improvements in States' processes and changes enacted by the DRA appear to have had a positive effect. However, States reported that $4 billion remains at risk of not being recovered, so further efforts to improve TPL savings are warranted.

Longstanding challenges persist in recovering payments from third parties. In particular, States reported challenges in getting third parties to provide complete insurance coverage information and to process or pay claims. States have been reporting these challenges since 2001. States also indicated that challenges involving current laws and regulations limited their ability to recover payments.

Based on the amount of money at risk of not being recovered and the longstanding challenges that States continue to face, we make three recommendations to CMS to strengthen Medicaid TPL outcomes.

CMS should:

Work With States To Address Longstanding Challenges Working With Third Parties To Identify Insurance Coverage and Recover Payments

CMS should work with States, and potentially with third parties, to address challenges related to identification and recovery of payments. Because States face similar TPL challenges, CMS could help coordinate their efforts. In addition, many of the third parties have coverage across the country, so a broad plan, rather than individual State negotiations, would be appropriate.

At a minimum, CMS should address the challenges with identifying third parties and recovering payments that were identified in this report. This could include collecting and disseminating examples of State best practices for working with third parties or methods to educate third parties on particular topics (e.g., HIPAA, obligation to respond to States, or not denying claims with no explanation).

CMS could also explore ways to take an active role in facilitating States' coordination of benefits activities. This could include (1) acting as a liaison for data-sharing agreements, (2) coordinating with TRICARE, and (3) working with States to determine whether CMS has a role to play in working with third parties that are consistently uncooperative across a number of States.

CMS's actions to address State challenges should pay particular attention to pharmacy benefit managers. Since OIG's 2001 study, States have

consistently reported that pharmacy benefit managers are uncooperative. CMS could facilitate efforts to better understand and mitigate pharmacy benefit managers' concerns.

CMS could use the TPL Technical Assistance Group (TAG) to develop solutions to address States' challenges. Or, it could create a task force that includes States and third parties, including key pharmacy benefit managers, to work toward feasible solutions.

Address States' Challenges With 1-Year Timely Filing Limits for Medicare and TRICARE

Medicare's and TRICARE's filing limits were the two items that had the most "very challenging" responses from States. States may be unable to bill for and recover claims within the 1-year limit, resulting in losses for the States.

To address the Medicare concerns, CMS should ensure that States and providers are aware of and understand the August 2012 change to the policy for requesting an exception to the 1-year timely filing limit for retroactive Medicare eligibility. CMS could issue a State Medicaid Director Letter explaining this change.

To address the TRICARE concerns, CMS could engage in conversations with TRICARE to clarify the policies for the 1-year timely filing limit. CMS could clarify the start date of the timely filing limit. CMS could also ask TRICARE to clarify how its claims processing contractors apply the *TRICARE Reimbursement Manual*'s start date policies when reviewing claims submitted by State Medicaid agencies. They could also discuss the procedures and circumstances, if any, under which States should request waivers. CMS and TRICARE could also discuss whether any changes should be made to the State Agency Billing Agreement to further incorporate the *Reimbursement Manual* guidelines. CMS could then issue guidance to States on TRICARE policies and procedures.

Work To Strengthen Enforcement Mechanisms Designed To Deal With Uncooperative Third Parties

The DRA enacted solutions for many of the challenges that OIG and GAO found related to working with third parties to identify insurance coverage and recover payments, but States reported that working with third parties remains challenging. The law does not include any enforcement authority to penalize third parties for violations. Enforcement mechanisms would allow States and the Federal Government to send a strong message that third parties must comply with the law, and ultimately help States and the Federal Government recover some of the $4 billion that States report as being at risk.

Enforcement could take many forms. For example, penalties could be assessed if third parties are uncooperative when States attempt to identify or verify coverage. On the recovery end, enforcement could include interest, or a fine, for claims that are not responded to in a given period.

Because different organizations govern different aspects of health insurance, CMS should work with the appropriate Federal and State entities to determine whether these suggestions are feasible enforcement options or whether others exist. For example, to explore possibilities for enforcement related to employer-sponsored health plans subject to ERISA, CMS could work with the Department of Labor. The appropriate divisions within CMS could explore enforcement options for pharmacy benefit managers that contract to provide Medicare services. CMS should also work with States to explore options to strengthen State enforcement mechanisms under State laws and regulations governing insurance. Finally, CMS could consider whether additional congressional action would be helpful.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations. For the first recommendation, CMS stated that it will work with States and third parties to address the problems with identifying insurance coverage and recovering payments that are identified in this report. CMS will consult with its TPL TAG to identify what guidance is needed from CMS and will work with States to identify best practices. For the second recommendation, CMS indicated that it would inform States and Medicare providers about the recent change in Medicare's requirements for an exception to the Medicare 1-year timely filing limit. CMS also stated that it would talk with the Department of Defense and States to understand and to clarify policies for the TRICARE 1-year timely filing limit. For the third recommendation, CMS indicated that it would work with States to explore options to strengthen enforcement mechanisms under State laws. CMS also stated that it would review its own existing enforcement authorities. OIG encourages CMS to think broadly about this third recommendation, as we believe that CMS can play a role in facilitating the conversation about additional enforcement authority.

CMS noted that OIG did not adjust States' estimates of dollars at risk for Medicare or health insurance and therefore the overall dollars at risk may be less than reported. CMS asserted that States usually submit claims to health insurance carriers for more than the amount that the carrier is legally liable to pay. OIG acknowledges that actual health insurance liability may reduce the dollars at risk that States are legally entitled to recover from

health insurers. However, no reliable estimate of how often States bill above the health insurers' liability cap or the rate of liability reduction is available. Further, OIG does not think it is instructive to look to the average rate of return of 18 percent on health insurance as a proxy measure for reduced liability. The average rate of return reflects reduced liability along with a variety of other factors, chiefly the challenges identified in this report, including payment denials for procedural reasons and nonresponsive third parties.

We did not make any changes to the report based on CMS's comments. For the full text of CMS's comments, see Appendix B.

APPENDIX A

Challenges by State

Table A-1: Challenges That States Reported to Identification and Verification, by State

	Third-party concerns about the Health Insurance Portability and Accountability Act of 1996 and releasing insurance coverage information to States		Confusing or incomplete Explanation of Benefit forms from third parties		Cooperation from pharmacy benefit managers		Obtaining data from State or Federal entities that may have data about beneficiaries' third-party insurance		Obtaining data from TRICARE on Medicaid beneficiaries with potential TRICARE coverage	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Alabama		X		X		X	X			X
Alaska		X				X				
Arizona		X				X	X		X	
Arkansas		X		X		X		X		X
California					X					
Colorado		X		X		X	X			X
Connecticut		X		X				X		
Delaware		X		X		X			X	
District of Columbia										X
Florida		X				X	X			X

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Table A-1: Challenges That States Reported to Identification and Verification, by State (Continued)

	Third-party concerns about the Health Insurance Portability and Accountability Act of 1996 and releasing insurance coverage information to States		Confusing or incomplete Explanation of Benefit forms from third parties		Cooperation from pharmacy benefit managers		Obtaining data from State or Federal entities that may have data about beneficiaries' third-party insurance		Obtaining data from TRICARE on Medicaid beneficiaries with potential TRICARE coverage	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Georgia		X		X		X		X		X
Hawaii		X		X		X		X		X
Idaho		X		X		X	X			X
Illinois		X		X		X				
Indiana				X			X			X
Iowa				X		X	X			
Kansas	X			X		X		X		X
Kentucky		X		X		X	X			X
Louisiana		X	X				X			X
Maine		X		X		X		X		X
Maryland		X	X							X
Massachusetts		X	X			X		X		X
Michigan	X		X		X		X			X

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Table A-1: Challenges That States Reported to Identification and Verification, by State (Continued)

	Third-party concerns about the Health Insurance Portability and Accountability Act of 1996 and releasing insurance coverage information to States		Confusing or incomplete Explanation of Benefit forms from third parties		Cooperation from pharmacy benefit managers		Obtaining data from State or Federal entities that may have data about beneficiaries' third-party insurance		Obtaining data from TRICARE on Medicaid beneficiaries with potential TRICARE coverage	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Minnesota	X			X	X			X		
Mississippi		X		X		X		X		X
Missouri		X	X			X		X		X
Montana		X	X			X				X
Nebraska		X		X		X		X		X
Nevada		X		X		X	X			X
New Hampshire		X	X			X				
New Jersey		X		X		X	X			X
New Mexico		X				X				X
New York		X		X		X	X			X
North Carolina		X		X		X	X			X
North Dakota		X		X		X	X		X	

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Table A-1: Challenges That States Reported to Identification and Verification, by State (Continued)

	Third-party concerns about the Health Insurance Portability and Accountability Act of 1996 and releasing insurance coverage information to States		Confusing or incomplete Explanation of Benefit forms from third parties		Cooperation from pharmacy benefit managers		Obtaining data from State or Federal entities that may have data about beneficiaries' third-party insurance		Obtaining data from TRICARE on Medicaid beneficiaries with potential TRICARE coverage	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Ohio	X			X						
Oklahoma	X			X	X		X		X	
Oregon	X			X	X			X		X
Pennsylvania	X		X					X		
Rhode Island		X		X				X		X
South Carolina		X			X		X			
South Dakota	X		X		X		X			
Tennessee		X		X		X	X			
Texas	X			X		X		X	X	
Utah		X		X		X		X		X
Vermont		X		X		X		X		
Virginia		X		X		X	X			X
Washington		X		X	X					

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Table A-1: Challenges That States Reported to Identification and Verification, by State (Continued)

	Third-party concerns about the Health Insurance Portability and Accountability Act of 1996 and releasing insurance coverage information to States		Confusing or incomplete Explanation of Benefit forms from third parties		Cooperation from pharmacy benefit managers		Obtaining data from State or Federal entities that may have data about beneficiaries' third-party insurance		Obtaining data from TRICARE on Medicaid beneficiaries with potential TRICARE coverage	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
West Virginia	X			X		X		X		X
Wisconsin			X			X		X		X
Wyoming	X		X		X			X		X

Source: Office of Inspector General (OIG) analysis of State data collection instrument responses, 2012.

Table A-2: Challenges That States Reported With Third-Party Refusal To Process or Pay Claims, by State

	Denials from third parties for procedural reasons		Denials from third parties with no explanation		Third parties not responding when State submits bills		Third parties not abiding by 3-year timely filing rules		Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed		Third parties not accepting States' right to collect		Pharmacy benefit managers claim they do not have the authority to reimburse States directly	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Alabama	X			X	X			X	X			X	X	
Alaska		X	X			X	X		X			X		
Arizona		X		X						X			X	
Arkansas		X		X		X	X			X		X		X
California		X		X		X		X				X		X
Colorado		X		X		X		X		X		X	X	
Connecticut		X		X		X		X		X		X		X
Delaware		X		X		X		X		X		X	X	
District of Columbia		X		X		X		X		X				X
Florida		X		X		X		X		X		X	X	
Georgia		X		X		X		X		X		X		X
Hawaii		X		X	X			X		X		X		X

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Table A-2: Challenges That States Reported With Third-Party Refusal To Process or Pay Claims, by State (Continued)

	Denials from third parties for procedural reasons		Denials from third parties with no explanation		Third parties not responding when State submits bills		Third parties not abiding by 3-year timely filing rules		Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed		Third parties not accepting States' right to collect		Pharmacy benefit managers claim they do not have the authority to reimburse States directly	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Idaho		X		X		X		X		X		X	X	
Illinois		X				X		X		X				X
Indiana		X		X		X		X		X			X	
Iowa		X		X		X		X		X		X	X	
Kansas		X		X		X		X		X		X	X	
Kentucky		X		X		X		X		X		X	X	
Louisiana		X		X		X		X		X		X		X
Maine		X		X		X		X		X		X	X	
Maryland										X				
Massachusetts				X		X		X				X		X
Michigan		X		X		X		X		X		X		
Minnesota		X		X		X		X		X		X		X

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Table A-2: Challenges That States Reported With Third-Party Refusal To Process or Pay Claims, by State (Continued)

	Denials from third parties for procedural reasons		Denials from third parties with no explanation		Third parties not responding when State submits bills		Third parties not abiding by 3-year timely filing rules		Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed		Third parties not accepting States' right to collect		Pharmacy benefit managers claim they do not have the authority to reimburse States directly	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Mississippi	X		X		X		X		X		X		X	
Missouri		X		X		X		X		X		X	X	
Montana		X		X	X			X		X		X		
Nebraska		X		X		X			X			X		
Nevada		X		X		X		X		X		X	X	
New Hampshire	X					X		X		X		X	X	
New Jersey		X		X		X		X		X		X	X	
New Mexico		X		X				X		X				X
New York		X		X		X		X		X		X	X	
North Carolina		X		X		X		X		X		X	X	
North Dakota		X		X		X		X		X		X		X
Ohio		X												
Oklahoma		X		X		X		X		X		X		X

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Table A-2: Challenges That States Reported With Third-Party Refusal To Process or Pay Claims, by State (Continued)

	Denials from third parties for procedural reasons		Denials from third parties with no explanation		Third parties not responding when State submits bills		Third parties not abiding by 3-year timely filing rules		Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed		Third parties not accepting States' right to collect		Pharmacy benefit managers claim they do not have the authority to reimburse States directly	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Oregon	X		X		X		X		X		X			X
Pennsylvania	X			X		X	X				X		X	
Rhode Island		X		X		X		X		X		X		X
South Carolina		X		X	X		X				X		X	
South Dakota		X	X		X		X		X		X			
Tennessee		X		X		X		X		X		X	X	
Texas		X		X		X	X			X		X	X	
Utah	X			X	X			X		X		X	X	
Vermont	X					X			X			X		X
Virginia		X		X		X		X		X		X	X	
Washington		X				X				X				
West Virginia		X		X		X		X		X		X	X	
Wisconsin		X		X		X		X				X		

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Table A-2: Challenges That States Reported With Third-Party Refusal To Process or Pay Claims, by State (Continued)

	Denials from third parties for procedural reasons		Denials from third parties with no explanation		Third parties not responding when State submits bills		Third parties not abiding by 3-year timely filing rules		Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed		Third parties not accepting States' right to collect		Pharmacy benefit managers claim they do not have the authority to reimburse States directly	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Wyoming		X	X		X		X		X		X		X	

Source: OIG analysis of State data collection instrument responses, 2012.

Table A-3: Challenges States Reported With Current Laws and Regulations, by State

	Medicare 1-year timely filing limit		TRICARE 1-year timely filing limit		Lack of enforceable penalties for third parties that refuse to reimburse States		Inability to bill Medicare directly		Lack of rules requiring third parties to reimburse in a timely manner	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Alabama	X		X			X		X		X
Alaska	X			X	X		X			X
Arizona	X		X			X		X		X
Arkansas		X		X	X			X		X
California	X		X		X		X			
Colorado	X		X		X			X		X
Connecticut	X			X		X	X			X
Delaware	X		X			X	X			X
District of Columbia		X		X		X		X		X
Florida	X		X			X	X			X
Georgia		X		X		X	X			X
Hawaii		X		X	X			X		X
Idaho	X		X			X		X		X

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Table A-3: Challenges States Reported With Current Laws and Regulations, by State (Continued)

	Medicare 1-year timely filing limit		TRICARE 1-year timely filing limit		Lack of enforceable penalties for third parties that refuse to reimburse States		Inability to bill Medicare directly		Lack of rules requiring third parties to reimburse in a timely manner	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Illinois	X			X				X		X
Indiana	X		X			X	X			X
Iowa	X		X			X		X		X
Kansas	X		X			X		X		X
Kentucky	X		X			X		X		X
Louisiana		X	X				X			
Maine	X		X			X		X		X
Maryland		X								
Massachusetts	X		X			X	X			X
Michigan		X		X	X			X	X	
Minnesota		X		X	X					X
Mississippi	X		X		X			X	X	
Missouri	X		X			X		X		X

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Table A-3: Challenges States Reported With Current Laws and Regulations, by State (Continued)

	Medicare 1-year timely filing limit		TRICARE 1-year timely filing limit		Lack of enforceable penalties for third parties that refuse to reimburse States		Inability to bill Medicare directly		Lack of rules requiring third parties to reimburse in a timely manner	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Montana		X	X			X				
Nebraska		X				X		X		X
Nevada	X		X			X		X		X
New Hampshire	X		X		X		X			
New Jersey	X		X			X		X		X
New Mexico		X		X		X				X
New York	X		X			X		X		X
North Carolina	X		X					X		X
North Dakota		X		X		X		X		X
Ohio		X					X			X
Oklahoma		X		X		X		X		X
Oregon	X		X		X		X			X
Pennsylvania	X		X			X	X			X

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Table A-3: Challenges States Reported With Current Laws and Regulations, by State (Continued)

	Medicare 1-year timely filing limit		TRICARE 1-year timely filing limit		Lack of enforceable penalties for third parties that refuse to reimburse States		Inability to bill Medicare directly		Lack of rules requiring third parties to reimburse in a timely manner	
State	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**	**Very Challenging**	**Somewhat Challenging**
Rhode Island		X		X		X		X		X
South Carolina	X		X		X					
South Dakota	X		X		X		X		X	
Tennessee	X		X			X		X		X
Texas	X		X			X	X			
Utah		X		X	X					X
Vermont	X		X				X			
Virginia	X		X			X		X		X
Washington		X			X			X		
West Virginia	X		X			X		X		X
Wisconsin					X		X			X
Wyoming	X		X		X		X		X	

Source: OIG analysis of State data collection instrument responses, 2012.

APPENDIX B
Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 18 2012

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Third-Party Liability Savings Increased But Challenges Remain" (OEI-05-11-00130)

Thank you for the opportunity to review and comment on the OIG draft report entitled "Medicaid Third-Party Liability Savings Increased But Challenges Remain" (OEI-05-11-00130). The purpose of this report was to determine trends in state Medicaid agencies' cost-avoided and recovered amounts from 2001 through 2011, to describe factors that influenced the states' ability to cost avoid or recover funds, and to estimate the amount of money that remains at risk of not being recovered.

The Deficit Reduction Act of 2005 (DRA), enacted in the middle of the review period for this report, contained provisions to enhance the states' ability to identify and recover payment from liable third parties of Medicaid beneficiaries. The law clarified the existing list of liable third parties to include entities such as pharmacy benefit managers. The DRA also required states to have laws requiring health insurers to provide coverage information to state Medicaid programs, accept the state Medicaid programs' right of recovery, not deny or refuse to pay claims for procedural reasons, and allow states to submit claims for a minimum of three years from the date of service. Since the passage of the DRA, the Centers for Medicare & Medicaid Services (CMS) has taken many steps to assist states and health insurers to meet these requirements.

The OIG found that Medicaid third party liability (TPL) savings totaled $529 billion from 2001 to 2011. Savings grew 114 percent during the period, while Medicaid expenditures increased by 47 percent. For the majority of the period (2002 – 2010), there was no significant change in the number of Medicaid beneficiaries with third party resources.

Most of the growth in TPL savings came from cost avoidance: $512 billion for the review period, with Medicare accounting for 80 percent of these savings. Cost avoidance from third party health insurers increased from 10 percent in 2001 to 18 percent in 2011, which can most likely be attributed to the DRA's effect on states' ability to identify third party coverage.

Pay and chase recoveries from 2001 to 2011 totaled $15 billion, an increase of 61 percent. Recoveries from health insurers accounted for 50 percent of pay and chase recoveries for the period, with recoveries from Medicare accounting for 18 percent.

States' implementation of DRA requirements likely had a positive effect on recoveries through increased identification of Medicaid-paid claims subject to recovery and the lengthened timely filing period. Most states reported that use of electronic systems helped improve third party identification, cost avoidance, and recovery efforts. States also cited use of contractors as aiding states in performing some or all of those tasks, and noted that creating the capacity to receive payments electronically from third parties also contributed to the increased cost avoidance savings and third party recoveries during the review period.

Despite the overall improvement in cost avoidance and recovery during the review period, states (44 reporting) believe that $4.1 billion in claims that states have paid and are seeking recovery are at risk of not being recovered. The $4.1 billion at risk includes $2.3 billion in health insurance claims, $931 million in probated estates, $745 million in casualty claims, and $111 million in Medicare claims.

The OIG describes the casualty and probated estate claims amounts above as "the average amount states expect to recover and consider to be owed to them, not the entire amount of the probated estate or casualty claim." (Draft report, page 15, note to Table 1). However, OIG does not indicate an adjustment of health insurance or Medicare amounts at risk to reflect the amount states expect to recover. CMS notes that state Medicaid programs usually submit claims to insurance carriers for 100 percent of Medicaid's payment for services that may be covered by insurance. Carriers then determine the extent of their legal liability to pay for the service. The rate of recovery is affected by the carriers' actual liability for payment for each Medicaid claim. Actual carrier liability may reduce the amount of Medicaid payments at risk of not being recovered. For example, OIG reported that the average recovery rate for claims billed to health insurers in 2011 was 18 percent (45 states reporting), and the recovery rate for Medicare claims was 69 percent (32 states reporting).

States reported that challenges remain to increasing TPL savings. Some of these challenges are similar to those reported in previous OIG and Government Accountability Office studies, but states also reported challenges caused by current laws and regulations.

Despite state laws prohibiting third parties from refusing to process claims or denying claims for procedural reasons, states still encounter these situations. It is not known what portion of the $4.1 billion identified by states as being at risk is due to improper refusal to process, or improper denial of claims.

States also cited the lack of enforcement penalties for third parties that refuse to reimburse states and lack of rules regarding reimbursement in a timely manner, as additional challenges to recovery from third parties.

OIG Recommendation

The CMS should work with states to address longstanding challenges working with third parties to identify insurance coverage and recover payments.

The CMS should work with states, and potentially with third parties, to address challenges related to identification and recovery of payments. Because states face similar TPL challenges, CMS could help coordinate their efforts. In addition, many of the third parties have coverage across the country, so a broad plan, rather than individual state negotiations, seems appropriate.

At a minimum, CMS should address the challenges with identifying third parties and recovering payment that were identified in this report. This could include collecting and disseminating examples of state best practices for working with third parties or methods to educate third parties on particular topics (e.g., Health Insurance Portability and Accountability Act (HIPAA), obligation to respond to states, or not denying claims with no explanation).

The CMS could also explore ways to take an active role in facilitating states' coordination of benefits activities. This could include (1) acting as a liaison for data-sharing agreements, (2) coordinating with TRICARE, and (3) working with states to determine whether CMS has a role to play in working with third parties that are consistently uncooperative across a number of States.

The CMS's actions to address state challenges should pay particular attention to pharmacy benefit managers. Since OIG's 2001 study, states have consistently reported that pharmacy benefit managers are uncooperative. CMS could facilitate efforts to better understand and mitigate pharmacy benefit managers' concerns.

The CMS could use the existing TPL Technical Assistance Group to develop solutions to address states' challenges. Or, it could create a task force that includes states and third parties, including key pharmacy benefit managers, to work toward feasible solutions.

CMS Response

The CMS concurs with the recommendation. CMS has worked, and will continue to work, with the states, and third parties as appropriate, to address problems identified by states with identification and collection from liable third parties of Medicaid beneficiaries. Initially, we will approach the Coordination of Benefits/Third Party Liability Technical Advisory Group (COB/TPL TAG) to help us further define the challenges identified in this review and the type of technical assistance or policy guidance CMS can provide that would have a cost-effective impact, with emphasis on enhancing the states' cost avoidance efforts. CMS will solicit input from states to identify best practices for third party identification and utilization, focusing on the

areas identified as challenges by the states. As appropriate, CMS will issue new guidance, or reissue previously issued guidance, on specific topics such as implementation of cooperative agreements with third parties to identify coverage, clarification of the relationship between HIPAA and state Medicaid programs' information requests to third parties, and the status of pharmacy benefits managers as third party resources. CMS will continue to provide technical assistance to states upon request.

OIG Recommendation

The CMS should address states' challenge with 1-year timely filing limits for Medicare and TRICARE.

Medicare's and TRICARE's filing limits were the two items that had the most "very challenging" responses from States. States may be unable to bill for and recover claims within the 1-year limit, resulting in losses for the States.

To address the Medicare concerns, CMS should ensure that states and providers are aware of and understand the August 2012 change to the policy for requesting an exception to the 1-year timely filing limit for retroactive Medicare eligibility. CMS could issue a State Medicaid Director Letter explaining this change.

To address the TRICARE concerns, CMS could engage in conversations with TRICARE to clarify the policies for the 1-year timely filing limit. CMS could also ask TRICARE to clarify how its claims processing contractors apply the TRICARE Reimbursement Manual's start date policies when reviewing claims submitted by State Medicaid agencies. As part of this, they could discuss the procedures and circumstances, if any, under which states should request waivers. CMS and TRICARE could also discuss whether any changes should be made to the State Agency Billing Agreement to further incorporate the Reimbursement Manual guidelines. CMS could then issue guidance to states on TRICARE policies and procedures.

CMS Response

The CMS concurs with the recommendation. CMS will pursue options for informing Medicaid programs and Medicare providers of the recent modification of Medicare's requirements for claims submitted for beneficiaries retroactively entitled to Medicare coverage.

The CMS will also continue discussions with the Department of Defense (DOD) about TRICARE limitations and requirements, including clarifying the start date of the timely filing limit, TRICARE's Reimbursement Manual's start date policies, and any circumstances under which states should request waivers. CMS will share information with the states about the exemption of TRICARE from governance under state insurance laws, including the DRA timely filing period. CMS will confer with the COB/TPL TAG members and, if necessary, other state Medicaid TPL directors, to determine concerns with the operation of the State Agency Billing Agreement, and determine whether we should enter into discussions about possible adjustments

of the agreements with the DOD. As appropriate, CMS will issue new guidance, or reissue previously issued guidance. CMS will continue to provide technical assistance to states upon request.

OIG Recommendation

The CMS should work to strengthen enforcement mechanisms for uncooperative third parties.

The DRA enacted solutions to many of the challenges that OIG and GAO found related to working with third parties to identify insurance coverage and recover payments, but states reported that working with third parties remains challenging. The law does not include any enforcement authority to penalize third parties for violations. Enforcement mechanisms would allow states and the federal government to send a strong message that third parties must comply with the law, and ultimately help states and the federal government recover some of the $4 billion that states report at risk.

Enforcement could take many forms. For example, penalties could be assessed if third parties are uncooperative when states attempt to identify or verify coverage. On the recovery end, enforcement could include interest, or a fine, for claims that are not responded to in a given period.

Because different entities govern different aspects of health insurance, CMS should work with the appropriate federal and state entities to determine whether these suggestions are feasible enforcement options or whether others exist. For example, to explore possibilities for enforcement related to employer-sponsored health plans subject to ERISA, CMS could work with the Department of Labor. The appropriate divisions within CMS could explore enforcement options for pharmacy benefit managers that contract to provide Medicare services. CMS should also work with states to explore options to strengthen state enforcement mechanisms under state laws and regulations governing insurance. Finally, CMS could also consider whether additional congressional action would be helpful.

CMS Response

The CMS concurs with the recommendation that we should work with states to explore options to strengthen State enforcement mechanisms under state laws and regulations governing insurance. The DRA requires that state law apply to "health insurers, including self-insured plans, group health plans (as defined in section 607(l) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, managed care organizations, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for the healthcare item or service, as a condition of doing business in the State". . . . Further, the DRA does not prohibit a state from including enforcement provisions, such as penalties or even revocation of the third party's right to offer coverage in the state, in the state law.

The CMS will review existing authorities for enforcement authority for entities not in the list of third parties included in the DRA, such as TRICARE.

The CMS would again like to thank OIG for their efforts in reviewing Medicaid third party liability savings from 2001 to 2011.

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office; Thomas F. Komaniecki, Deputy Regional Inspector General; and Laura Kordish, Deputy Regional Inspector General.

Nicole Hrycyk served as the team leader for this study, and Mara Werner served as the lead analyst. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Jonathan Jones and Margarita Rodriguez. Central office staff who provided support include Heather Barton, Kevin Farber, and Debra Roush.

Office of Inspector General

http://oig.hhs.gov

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