Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program
A Guide to Effective and Innovative State Agency Practices
Update Issued August 2025

INTRODUCTION

A Guide to Effective and Innovative State Agency Practices is intended to provide state Medicaid agencies with recent information on practices that may assist states in improving their identification and successful pursuit of legally liable third party resources. Each practice included in the guide has proven to be effective for the submitting state. State agencies that consider adopting any of these practices should assess whether the practice is transferable to their own state operations. A contact person is listed for each practice and will be available to discuss the practice in greater detail with a state that considers adopting the practice.

A *Guide to Effective State Agency Practices* was originally published in 2014 and developed in response to a recommendation by the U.S. Department of Health and Human Services' Office of the Inspector General (HHS OIG), following a study of Medicaid COB/TPL savings from 2001 to 2011 ("Medicaid Third-Party Liability Savings Increased, but Challenges Remain," OEI-05-11-00130, issued January 2013). The study determined trends in Medicaid TPL savings during that period and gathered information from states regarding challenges and issues the states faced in identifying third party coverage and recovering payments from liable third parties.

A 2015 update renamed the publication to *A Guide to Effective and Innovative State Agency Practices* to acknowledge the inclusion of innovative state practices and came in response to a new recommendation by the U.S. Government Accountability Office (GAO), following a study of Medicaid COB/TPL ("Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts," GAO-15-208, issued January 2015). The study recommended that CMS provide information to ensure all states are aware of key TPL efforts and challenges. CMS agreed to continue looking at ways to provide guidance to states to allow for sharing of effective practices and to increase awareness of initiatives under development in states.

A Guide to Effective and Innovative State Agency Practices has been updated for 2025 in response to a recommendation by the HHS OIG, following a study of Medicaid COB/TPL ("States Face Ongoing Challenges in Meeting Third Party Liability Requirements for Ensuring That Medicaid Functions as the Payer of Last Resort," A-05-21-00013, issued October 2023). The study recommended that CMS use information obtained from states to address challenges states face when trying to meet third party liability requirements. CMS utilized the COB/TPL Technical Advisory Group (TAG) and its TAG State Representatives to solicit information from all states and territories on their effective and innovative COB/TPL practices. States and territories were asked to submit best practices that address any of the challenges identified in the 2023 OIG report, and were also encouraged to submit any best practices that address other challenging COB/TPL issues. The information included below reflects each state's submission.

This version of the guide continues to provide an opportunity for peer assistance among the state Medicaid programs through sharing of practices that are in place and working, and to address some of the challenges and issues identified in the various OIG and GAO studies, as well as other challenges to maximize third party identification and recovery.

ACKNOWLEDGMENT

CMS extends its appreciation to the Directors and staff members of the state COB/TPL units that shared their effective and innovative practices for inclusion in this update to the September 2014 and December 2015 publications. CMS also acknowledges the significant and continuing support and assistance of the Chairman and State Representatives of the COB/TPL TAG in contributing effective and innovative practices from their states and soliciting such practices from other states for this update.

EFFECTIVE AND INNOVATIVE STATE PRACTICES, BY TOPIC AND SUBMITTING STATES[i]

1. Difficulties obtaining complete, accurate, and up-to-date coverage information from Medicaid enrollees and providers: Alabama, Idaho
2. Difficulties obtaining timely and reliable coverage information from third parties: Alabama, Georgia, Idaho, Texas
3. Difficulties coordinating TPL with out-of-state third parties: Idaho
4. Difficulties with lack of Federal prompt payment requirements and penalties for third parties that do not cooperate with states' efforts to meet TPL requirements: Idaho
5. Difficulties with third parties that deny Medicaid claims for procedural reasons: Alabama, Idaho, Michigan, Texas
6. Difficulties coordinating TPL with Medicare: Idaho, Nebraska
7. Third Parties insist on performing their own data match to identify enrollees who also have Medicaid rather than allowing states to perform the match using third party data files: Michigan
8. Attorney not disclosing primary insurance to a provider for tort case: Ohio
9. Disproportionate impact on historically marginalized populations caused by the Estate Recovery Program policies: North Carolina
10. Incorrectly reported other cost avoidance amounts (Form CMS-64 during OIG audit period): Alabama

Effective and innovative practices follow, in topic order.

CATEGORY:

Documenting and Sharing Effective State COB/TPL Practices

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties obtaining complete, accurate, and up-to-date coverage information from Medicaid enrollees and providers

STATE RESPONDING:

Alabama

IN THE RESPONDING STATE, THIS ISSUE:

_X_ Currently Occurs or Has Occurred:

____Very Frequently
_X_ Often Enough to Require Correction
____Infrequently
____Doesn't Occur or Hasn't Occurred

EFFECT OF THE PRACTICE:

____Resolved the Issue Fully
_X_ Resolved the Issue Partially (*Indicate what was resolved and what remains in the Summary below*)
____Resolved Temporarily With a Workaround Process

WHY DOES THIS ISSUE OCCUR?

Recipient and provider noncompliance and a limited understanding of Medicaid Third Party requirements.

SUMMARY OF EFFECTIVE PRACTICE:

Alabama Medicaid Agency (Agency) created a form available on the Agency's website that allows recipients and providers the opportunity to submit Third Party insurance information. This form is fillable and can be emailed, faxed, or mailed. The Agency has created a secure group email address, handled by the Third Party Division/Resource Identification Unit, that receives these forms on a daily basis for insurance policy adds and updates.

Information regarding the Resource Identification Unit and form are available at this link: Alabama Medicaid.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Fillable form made available on the Alabama Medicaid Agency's website. This form is available for Medicaid recipients and providers.

Deficit Reduction Act of 2005 (DRA) (P.L. No. 109-171) - Section 6035 of the DRA amended TPL provisions in section 1902(a)(25) of the Act to enhance the ability of each state to: (1) identify third parties that are legally responsible to pay claims primary to Medicaid, and (2) seek recoveries from liable third parties.

FOR MORE INFORMATION, CONTACT:

Codie Rowland, TPL Director, 334-242-5248

Codie.Rowland@Medicaid.Alabama.Gov

CATEGORY:

Challenges That States Reported in Meeting TPL Requirements

(Source: OIG TPL Report—October 2023)

ISSUE:

Difficulties obtaining complete, accurate, and up-to-date coverage information from Medicaid enrollees and providers.

STATE RESPONDING:

Idaho

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
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WHY DOES THIS ISSUE OCCUR?

Members and providers may not be aware of other coverage.

SUMMARY OF EFFECTIVE PRACTICE:

Multiple factors contribute to the challenge of obtaining and subsequently validating other coverage information from Medicaid members and providers. Members may be unaware of other coverage they've elected or have been signed up for by a spouse or parent/guardian. As the Medicaid enrollment process has modernized, the opportunity to explain to a potential new member in detail how they might have other coverage that's primary to Medicaid and collect policy information through the interview process has diminished. Additionally, providers are either not aware of other coverage if a patient only presents their Medicaid card or are only aware of the coverage impacting their services rendered at a given point in time. This leads to an incomplete coverage profile for a member that may only include medical coverage information and leave minor or benefit manager-supported coverage, such as pharmacy, dental, vision, or behavioral health, unknown and lacking a complete coverage span timeframe.

Managing the ingestion, investigation, and validation of other coverage information on behalf of our Medicaid enrollees is both taxing on our staff and costly in the form of employee time allocation to this task. As a solution to this, we leverage a vendor and their nationwide repository of other coverage within their National Eligibility Data Platform (NEDP). NEDP is one of the largest commercial datasets in the United States for identifying other health coverage for Medicaid and Medicare members, housing more than 2.2 billion insurance carrier eligibility records from 1,600 payers that is updated daily with the most current coverage information.

Through the NEDP, the vendor receives "raw" eligibility information from the "raw" data sent from third party administrators (TPAs), insurance carriers, and benefit managers. Though the information received from these third parties is accurate information as of the date it is obtained, it does not always reflect the very latest developments impacting members' access to supplemental benefits. To overcome these challenges, the vendor takes the TPL policy leads from a match with a Medicaid enrollee and a coverage segment within the NEDP and validates

the information directly with payers through 270/271 transactions, portal and web lookups, or manual call center inquiries. The vendor's TPL verification process reduces the potential for match errors and inaccurate information.

The vendor also continually monitors the other coverage information that's maintained and identifies changes to the information that have been provided already. All new coverage segments and updates to existing known coverage are provided to us in a weekly deliverable that's loaded into our system for cost avoidance and/or post-payment recovery efforts.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

None.

FOR MORE INFORMATION, CONTACT:

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OR

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CATEGORY:

Documenting and Sharing Effective State COB/TPL Practices

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties obtaining timely and reliable coverage information from third parties

STATE RESPONDING:

Alabama

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WHY DOES THIS ISSUE OCCUR?

States have issues with establishing direct data matches with Third Party companies because States are not set up to access cover data available in Third Party systems.

SUMMARY OF EFFECTIVE PRACTICE:

Alabama Medicaid Agency (Agency) was able to establish a monthly data match with Blue Cross Blue Shield of Alabama (BCBS-AL).

BCBS-AL is the leading provider of insurance in the state. By obtaining information directly through data match, the Agency no longer needs to obtain this insurance policy information from the recipients or providers.

Over the last 10 years, the Agency has worked with BCBS-AL to improve this match. Recently, the Agency has begun work to obtain a weekly match rather than a monthly match. This will enable the Agency to cost avoid more effectively, receiving additions and updates more frequently.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Data Exchange Agreement between Alabama Medicaid Agency and Blue Cross Blue Shield of Alabama.

Deficit Reduction Act of 2005 (DRA) (P.L. No. 109-171) - Section 6035 of the DRA amended TPL provisions in section 1902(a)(25) of the Act to enhance the ability of each state to: (1) identify third parties that are legally responsible to pay claims primary to Medicaid and (2) seek recoveries from liable third parties.

FOR MORE INFORMATION, CONTACT:

Codie Rowland, TPL Director, 334-242-5248

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CATEGORY:

Documenting and Sharing Effective State COB/TPL Practices

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Obtaining Timely and Reliable Coverage Information from Third Parties

STATE RESPONDING:

Georgia

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WHY DOES THIS ISSUE OCCUR?

Trustees and Legal Representatives may be unaware of Special Needs Trust (SNT) are subject to Medicaid approval and payback.

SUMMARY OF EFFECTIVE PRACTICE:

- Allowed by federal law for Medicaid eligibility purposes since 1993
- ODIS: DFCS Medicaid Policy and Manual: MAN3480, Section 2346 Special Needs Trust
- Review and approval of SNTs has been required since April 1, 2005
- The Georgia Trust Unit started operations as of January 2, 2009, with a trust attorney and Certified Public Accountant to oversee the daily operations
- The Georgia Trust Unit reviews trusts as well as the annual accountings filed by the SNT trustees
- Benefit: An approved SNT is not included when determining resource eligibility
- The Georgia Trust Unit frequently reviews and approves SNTs and SNTs drafts prior to the filing of a Medicaid application
- Allows for recovery of Medicaid expenditures. First upon settlement of Casualty tort case and second payback upon dissolution of trust or upon death of the Medicaid beneficiary
- SNT recoveries are at $38.6 million as of March 31, 2024, since go-live in 2009

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Omnibus Reconciliation Act of 1993 (OBRA 93) (P.L. No. 103-66)

Social Security Act §1917(d)(4)

FOR MORE INFORMATION, CONTACT:

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CATEGORY:

Challenges That States Reported in Meeting TPL Requirements

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties obtaining timely and reliable coverage information from third parties.

STATE RESPONDING:

Idaho

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WHY DOES THIS ISSUE OCCUR?

No universal standard exists for the purpose of TPL data sharing.

SUMMARY OF EFFECTIVE PRACTICE:

Managing both the setup and ongoing maintenance of third party engagement for the purpose of data sharing can be a substantial task. In addition to examples of third party refusal or reluctance to provide timely and reliable coverage reported in the 2023 TPL OIG report, many carriers, benefit managers, and TPAs desire interfaces and data exchange coordination to be customized to their requirements and platforms. As no universal standard exists for the purpose of TPL data sharing, the infrastructure and management of hundreds of interfaces with all liable third parties within a State Medicaid program's geographic location can be herculean.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

None.

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

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CATEGORY:

Difficulties Obtaining Timely and Reliable Coverage Information from Third Parties

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties obtaining timely and reliable coverage information from third parties.

STATE RESPONDING:

Texas

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WHY DOES THIS ISSUE OCCUR?

There is no timely and reliable reporting solution for pharmacy insurance identification.

States still rely on Pharmacy Benefit Manager (PBM) eligibility rosters to identify other pharmacy insurance coverage. These eligibility rosters have complexities and delays in reporting new coverage and essential updates, such as terminations. Some of the major PBMs also act as Medicaid PBMs. It is important to know how to identify these lines of business to be able to distinguish between commercial and Medicaid coverage. This is critical to effectively use the data in Point-of-Sale activities. This is one key example of the complexities in the process.

While the EDI National Standard 270/271 verification will, in some cases, report when a policy includes pharmacy coverage, it is not reported consistently and when it is reported, it does not include essential pharmacy policy attributes such as Bank Identification Number (BIN) or Processor Control Number (PCN).

SUMMARY OF EFFECTIVE PRACTICE:

For medical other insurance coverage discovery, the data match used by most states is outdated and provides significant challenges. This process is burdensome and requires data exchanges which creates security risks, especially considering the recent ransomware attack that affected most states.

Texas has worked with their vendor to implement a solution that offers more accurate coverage information than matching only with carrier eligibility rosters.

In addition to using carrier eligibility rosters, Texas uses a data lake of insurance leads made up of employer, plan and claim data. These leads are used to determine which third party carrier might cover the Medicaid member. An eligibility request is then performed with the third-party carrier using Electronic Data Interchange (EDI) National Standard 270/271 transactions. This results in more timely identification of other insurance thereby strengthening upfront cost avoidance and reduces state payments from going out the door, which have their own challenges.

This comprehensive solution also solves the Tricare data match challenges other states, who rely on the DEERS data match, face.

The state of Texas can timely and effectively identify TPL coverage for the Tricare population and share the information with providers to coordinate benefits upfront, thereby increasing savings through cost avoidance.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Texas has worked with their contractor to find more TPL coverage and has implemented a solution that offers more accurate coverage information than matching only with carrier eligibility rosters.

FOR MORE INFORMATION, CONTACT:

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CATEGORY:

Challenges That States Reported in Meeting TPL Requirements

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties coordinating TPL with out-of-State third parties.

STATE RESPONDING:

Idaho

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WHY DOES THIS ISSUE OCCUR?

Different interpretations of legal requirements.

SUMMARY OF EFFECTIVE PRACTICE:

Occasionally, an insurance carrier may interpret legal requirements to share data with Medicaid agencies differently. For example, some assert that they are not legally required to comply with statutes of a state where they are not headquartered or licensed to do business. Others have argued that they are not subject to the DRA requirements. This can be particularly challenging for a State Medicaid agency with multiple adjacent states, or which has a major employer headquartered in a different part of the country.

Steps to remediate and ensure compliance include:

- Use of in-house counsel to enforce compliance
- Leveraging the use of a national vendor with the expertise and resources to obtain data

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Idaho Statute 41-318 *Cooperation with the Department of Health and Welfare*

FOR MORE INFORMATION, CONTACT:

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CATEGORY:

Challenges That States Reported in Meeting TPL Requirements

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties with lack of Federal prompt payment requirements and penalties for third parties that do not cooperate with States' efforts to meet TPL requirements.

STATE RESPONDING:

Idaho

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
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WHY DOES THIS ISSUE OCCUR?

Federal requirements do not match State's efforts to meet TPL requirements.

SUMMARY OF EFFECTIVE PRACTICE:

Idaho has State Statute 41-318 *Cooperation with the Department of Health and Welfare* to hold health insurers responsible to comply with the State's effort to meet TPL requirements.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Idaho Statute 41-318 *Cooperation with the Department of Health and Welfare*

FOR MORE INFORMATION, CONTACT:

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Rebekah Spencer, TPL Contract Monitor 208-287-1160
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CATEGORY:

Documenting and Sharing Effective State COB/TPL Practices

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties with third parties that deny Medicaid claims for procedural reasons

STATE RESPONDING:

Alabama

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WHY DOES THIS ISSUE OCCUR?

Pharmacy Benefit Managers (PBM) were refusing to reimburse State Medicaid Agencies promptly, or at all, for the lack of prior authorizations.

SUMMARY OF EFFECTIVE PRACTICE:

Alabama Medicaid Agency (Agency) worked with its TPL Contractor to establish a TPL Follow Up Unit for Carrier Engagement. This allowed the Agency to identify and track direct billing issues with carriers monthly. In doing so, the Agency became aware of the prompt payment issues that were occurring.

The Agency then worked with the Alabama Department of Insurance on an amendment to their rules for Coordination of Benefits citing section 202 of Division P, Title II of the Consolidated Appropriations Act, 2022 (P.L. No. 117-103).

The Agency has also updated its State Plan Amendment effective January 1, 2024.

The updated State Plan Amendment can be viewed at**:** 9.8_A4.22-B_Third_Party_Collection_Procedures_Cost_Effective_2-20-24.pdf (alabama.gov)

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Alabama Department of Insurance: *Ala. Admin. Code r. 482-1-128-.06*

Alabama Medicaid Agency: *AL-21-0009 Attachment 4.22-B*

FOR MORE INFORMATION, CONTACT:

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CATEGORY:

Challenges That States Reported in Meeting TPL Requirements

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties with third parties that deny Medicaid claims for procedural reasons.

STATE RESPONDING:

Idaho

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WHY DOES THIS ISSUE OCCUR?

Liable third-party payers refuse payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules.

SUMMARY OF EFFECTIVE PRACTICE:

Idaho will be initiating new legislation for the 2025 legislative session to bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Section 202 of Division P, Title II of the Consolidated Appropriations Act, 2022 (P.L. No. 117-103)

FOR MORE INFORMATION, CONTACT:

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OR

Rebekah Spencer, TPL Contract Monitor 208-287-1160

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CATEGORY:

Difficulties With Third Parties That Deny Medicaid Claims for Procedural Reasons

ISSUE:

States did not include non-standard data elements on claims that third parties require for processing

STATE RESPONDING:

Michigan

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
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WHY DOES THIS ISSUE OCCUR?

States often do not include non-standard data elements on claims to third parties, because states may not have access to the required data.

SUMMARY OF EFFECTIVE PRACTICE:

Section 3 of Michigan Public Act 593 requires entities (health insurers) to provide the State of Michigan with health coverage data directly. This allows the State of Michigan to receive non-standard data elements required by the entity for subrogation billing activities. Michigan's health insurer onboarding process requires entities to disclose and provide in the format determined by the state, all data elements (standard or non-standard) to ensure successful claims processing.

The State of Michigan has found specific data elements are required when performing Pharmacy subrogation billing activities, such as NCPDP Processor ID (BIN), Processor Control Number (PCN) and Pharmacy group number (Rx Group). In addition, Michigan has found that other data elements are required to ensure successful billing. For example, 'Quantity Prescribed for Controlled Substance' may or may not need to be populated in field 460-ET on the NCPDP D.0 Subrogation B1 Request file.

SHARING HEALTH CARE INFORMATION ACT

Act 593 of 2006

AN ACT to provide for the sharing of certain health care coverage information; to provide for the powers and duties of certain departments and agencies; and to provide penalties and fines.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

Sec. 3.

(1) An entity shall provide on a monthly basis to the department, in a format determined by the department, information necessary to enable the department or entity to determine whether a health coverage recipient of the entity is also a medical assistance recipient.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

State Law

Michigan Health Insurer Onboarding Business Process Check List - Pharmacy Subrogation

FOR MORE INFORMATION, CONTACT:

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Director of Third Party Liability
517-335-8760

***CATEGORY**:*

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

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Technical issues related to billing of Medicaid claims with third parties.

STATE RESPONDING:

Texas

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WHY DOES THIS ISSUE OCCUR?

Texas experiences challenges billing some Medicaid claims to third parties due to carrier claims engines generally being configured for provider claims and not Medicaid reclamation. For this reason, some claims may be rejected or denied for missing information, such as medical records or other supporting documentation that may be required from the provider of service. In some cases, claims may be paid by commercial or other third-party insurers to the provider instead of the State Medicaid agency (SMA).

SUMMARY OF EFFECTIVE PRACTICE:

Texas applies data analytics to identify:

1. Claims that may have been denied or rejected for erroneous reasons, identified by specific Claim Adjustment Reason Codes (CARC)
2. Payments that may have been paid to the provider instead of the SMA.

Close communication and collaboration with carriers is essential to identify solutions to resubmit impacted claims so that they are adjudicated according to Medicaid reclamation requirements.

For payments that may have been made to providers instead of the SMA, Texas communicates with providers to confirm payment and agree on a recoupment process.

Strong relationships with third parties and providers are essential to reach mutual agreement on Medicaid reclamation specific processes and to ensure payment is sent to the SMA instead of the providers.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

None

FOR MORE INFORMATION, CONTACT:

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CATEGORY:

Challenges That States Reported in Meeting TPL Requirements

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Difficulties coordinating TPL with Medicare.

STATE RESPONDING:

Idaho

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WHY DOES THIS ISSUE OCCUR?

States are unable to submit Medicaid claims directly to Medicare because state Medicaid agencies (SMA) are unable to obtain a National Provider Identifier (NPI) because SMAs are not "health care providers" as defined in 45 CFR § 160.103. FFS providers have 1 year after the date of service to submit Medicare claims.

SUMMARY OF EFFECTIVE PRACTICE:

Idaho is contracted with a vendor to conduct recovery of Medicare claims through provider disallowance billing whereby the provider is given the third-party information and instructed to bill the primary carrier. The vendor then coordinates with the provider to adjust the provider's Medicaid claim. Direct payments are not received from providers.

For retroactively enrolled Medicare beneficiaries, CMS allows an exception to the normal 12-month timely filing limit. Idaho is contracted with a vendor who identifies claims for participants with retroactive Medicare coverage and includes them in recoupment cycles.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

None

FOR MORE INFORMATION, CONTACT:

KayLee Leavitt, TPL Contract
Manager 208-287-1175
kaylee.leavitt@dhw.idaho.gov

OR

Rebekah Spencer, TPL Contract
Monitor 208-287-1160
Rebekah.Spencer@dhw.idaho.gov

CATEGORY:

Verifying Medicare Primacy Coverage

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Unknown Medicare coverage

STATE RESPONDING:

Nebraska

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
_X_ Currently Occurs or Has Occurred: ____Very Frequently ____Often Enough to Require Correction ____Infrequently ____Doesn't Occur or Hasn't Occurred	_X_ Resolved the Issue Fully ___ Resolved the Issue Partially (*Indicate what was resolved and what remains in the Summary below.*) ____Resolved Temporarily With a Workaround Process

WHY DOES THIS ISSUE OCCUR?

Medicare coverage is unknown for current members. The time for verifying other coverage through data files is time consuming and potentially outdated.

SUMMARY OF EFFECTIVE PRACTICE:

Added capability to use the Responsible Reporting Entity Interactive Voice Recognition line (RRE IVR) to confirm Medicare entitlement and enrollment for Marketplace and Medicaid members. The RRE number assists with achieving correct coordination of benefits in Cost Avoidance and Post Pay recoveries by obtaining current Medicare entitlement and enrollment information by using the CMS Interactive Voice Recognition (IVR) line. Previously, data analysis had been used to confirm Medicare eligibility. With the use of the RRE IVR, we have real-time verifications and can receive verifications much faster than working with data.

Responsible Reporting Entity is the party that is responsible for funding a claim payment to an individual who is eligible for Medicare benefits and considered the Responsible Reporting Entity under the provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. No. 110-173). The RRE must register with the Centers for Medicare & Medicaid Services (CMS) and report electronically all claims and claim payments related to any workers' compensation, general liability, or automobile no-fault claim where the claimant is also entitled to Medicare benefits.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Responsible Reporting Entity number is required from CMS.

FOR MORE INFORMATION, CONTACT:

Aimee Reis, Manager of Claims Administration, 531-329-8569

CATEGORY:
Difficulties Obtaining Timely and Reliable Coverage Information From Third Parties

ISSUE:
Third Parties insist on performing their own data match to identify enrollees who also have Medicaid rather than allowing States to perform the match using third party data files

STATE RESPONDING:
Michigan

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
____Currently Occurs or Has Occurred: ____Very Frequently ____Often Enough to Require Correction _X_ Infrequently ____Doesn't Occur or Hasn't Occurred	_X_ Resolved the Issue Fully ____Resolved the Issue Partially (*Indicate what was resolved and what remains in the Summary below.*) ____Resolved Temporarily With a Workaround Process

WHY DOES THIS ISSUE OCCUR?

Third Parties are somewhat reluctant to share HIPAA data with State entities as they typically work directly with national vendor(s) to perform the data match.

SUMMARY OF EFFECTIVE PRACTICE:

Section 3 of Michigan Public Act 593 requires entities (health insurers) to provide the State of Michigan with health coverage data directly. This allows the State of Michigan to receive third party coverage data directly in the format required by the State at a minimum monthly basis. The state is then able to perform a robust data match to identify the Medicaid recipients that have third party coverage. The Third Party Liability Division has the full support from the Office of Legal Affairs, giving the Act the legal support necessary for enforcement.

SHARING HEALTH CARE INFORMATION ACT

Act 593 of 2006

AN ACT to provide for the sharing of certain health care coverage information; to provide for the powers and duties of certain departments and agencies; and to provide penalties and fines.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

Sec. 3.

(1) An entity shall provide on a monthly basis to the department, in a format determined by the department, information necessary to enable the department or entity to determine whether a health coverage recipient of the entity is also a medical assistance recipient.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

State Law

FOR MORE INFORMATION, CONTACT:

Keelie Honsowitz, Director of Third Party Liability
517-335-8760

CATEGORY:

Tort

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Attorney not disclosing primary insurance to a provider for tort case

STATE RESPONDING:

Ohio

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
_X_ Currently Occurs or Has Occurred: ____Very Frequently ____Often Enough to Require Correction _X_ Infrequently ____Doesn't Occur or Hasn't Occurred	_X_ Resolved the Issue Fully ____Resolved the Issue Partially (*Indicate what was resolved and what remains in the Summary below.*) ____Resolved Temporarily With a Workaround Process

WHY DOES THIS ISSUE OCCUR?

Attorney may not want to disclose primary insurance to a provider because attorney may not want to share settlement with more payers.

SUMMARY OF EFFECTIVE PRACTICE:

Ohio passed specific legislation in 2013 to clearly specify attorneys must disclose third party insurance information to a provider if asked.

The current law in Ohio is- Section 5160.371 - Ohio Revised Code | Ohio Laws

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

Ohio Revised Code Section 5160.371 Disclosure of third-party payer information. Effective: September 29, 2013 Legislation: House Bill 59 - 130th General Assembly

In addition to the requirement of division (C) of section 5160.37 of the Revised Code to cooperate with the department of Medicaid and county department of job and family services, a medical assistance recipient and the recipient's attorney, if any, shall cooperate with each medical provider of the recipient. Cooperation with a medical provider shall consist of disclosing to the provider all information the recipient and attorney, if any, possess that would assist the provider in determining each third party that is responsible for the payment or processing of a claim for medical assistance provided to the recipient. If disclosure is not made in accordance with this section, the recipient and the recipient's attorney, if any, are liable to reimburse the department or county department for the amount that would have been paid by a third party had the third party been disclosed to the provider by the recipient or the recipient's attorney.

FOR MORE INFORMATION, CONTACT:

Patrick A. Tighe 614-752-3635 Patrick.Tighe@medicaid.ohio.gov

CATEGORY:

Equity

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Disproportionate impact on historically marginalized populations caused by the Estate Recovery Program policies.

STATE RESPONDING:

North Carolina

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
_X_ Currently Occurs or Has Occurred: ____Very Frequently ____Often Enough to Require Correction ____Infrequently ____Doesn't Occur or Hasn't Occurred	_X_ Resolved the Issue Fully ____Resolved the Issue Partially (*Indicate what was resolved and what remains in the Summary below.*) ____Resolved Temporarily With a Workaround Process

WHY DOES THIS ISSUE OCCUR?

The Estate Recovery program policies has impacted historically marginalized populations by pursuing recovery from people of color or individuals with modest means. The thresholds for the Estate Recovery program directly impacted these populations.

SUMMARY OF EFFECTIVE PRACTICE:

To address the issue, we revised the Estate Recovery policies to increase the threshold. Recovery was waived for Hardship waivers and where the gross assets were below $5,000 or when the amount of Medicaid expenditures subject to recovery were less than $3,000. Last year we changed the existing policy to not recover from homes of modest value, increasing the minimum from $5,000 to $50,000. We increased the threshold for a member expenditure subjected to recovery from $3,000 to $5,000. We also increase the asset value for members from $12,000 to $25,000 to allow more hardship waivers. The policy changes increase the amount of flexibility for North Carolina Estate Recovery program and reduces burden on members and their families.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

State Plan Amendment Attachment 4-17-A Pages 3,4 and 6

FOR MORE INFORMATION, CONTACT:

Pratrice Partee, Third-Party Recovery, Associate Director

Phone: 984-888-3134 Email: pratrice.partee@dhhs.nc.gov

CATEGORY:

Documenting and Sharing Effective State COB/TPL Practices

(Source: OIG TPL Report—October 2023*)*

ISSUE:

Incorrectly reported other cost avoidance amounts (Form CMS-64 during OIG audit period)

STATE RESPONDING:

Alabama

IN THE RESPONDING STATE, THIS ISSUE:	***EFFECT OF THE PRACTICE:***
_X_ Currently Occurs or Has Occurred: ____Very Frequently _X_ Often Enough to Require Correction ____Infrequently ____Doesn't Occur or Hasn't Occurred	_X_ Resolved the Issue Fully ___ Resolved the Issue Partially (*Indicate what was resolved and what remains in the Summary below.*) ____Resolved Temporarily With a Workaround Process

WHY DOES THIS ISSUE OCCUR?

During the OIG audit period, some states had incorrectly reported Other Cost Avoidance amounts on line B3 of the form 64.9A. These states indicated they were not aware that CMS had instructed them to leave this line blank and had repeatedly reported on this line.

SUMMARY OF EFFECTIVE PRACTICE:

The Third Party Division was submitting Liens/Estate Recovery information on its CMS-64 memo to the Agency's Finance Division as Other Cost Avoidance. This amount was keyed on Form 64.9A line B3 – Other Cost Avoidance. CMS concurred with the recommendation of OIG to remove or disable lines from the form 64.9A that States are supposed to leave blank.

Third Party's memos no longer have this Liens/Estate Recovery line. The Cost Avoidance section on the 64.9A is now considered to be for informational purposes only, so no correction has been made to the OIG audit periods.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

States Face Ongoing Challenges in Meeting Third-Party Liability Requirements for Ensuring That Medicaid Functions As The Payer of Last Resort (OIG Audit A-05-21-00013; October 2023)

FOR MORE INFORMATION, CONTACT:

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[i] Several submitting states identified particular vendors with whom they work, that, for the purposes of this guide have been identified as "vendor."