United States Government Accountability Office

Report to Congressional Committees

August 2019

MEDICAID PAYMENT

CMS Has Not Overseen States' Implementation of Changes to Third-Party Liability

GAO-19-601

August 2019

MEDICAID PAYMENT

CMS Has Not Overseen States' Implementation of Changes to Third-Party Liability

GAO Highlights

Highlights of GAO-19-601, a report to congressional committees

Why GAO Did This Study

The Medicaid program is typically the payer of last resort. The Bipartisan Budget Act of 2018 changed the Medicaid third-party liability payment requirements for prenatal care services, pediatric preventive services, and services provided to CSE beneficiaries. Before the act, in the case of these three services, states were generally required to pay providers for services delivered to Medicaid beneficiaries and then obtain any payments from liable third parties.

The Bipartisan Budget Act of 2018 also included a provision for GAO to study the potential effects of these changes. In this report, GAO (1) describes the status of selected states' implementation of Medicaid third-party liability changes; (2) evaluates CMS's implementation and oversight of the Medicaid third-party liability changes; and (3) describes stakeholders' views of the possible effects of these changes on providers and beneficiaries. GAO conducted interviews with state Medicaid agencies and provider associations in nine selected states, which were selected by taking into consideration Medicaid spending and stakeholder recommendations, among other factors. GAO also conducted interviews with national experts in Medicaid, national organizations representing beneficiaries and providers, and officials from CMS.

What GAO Recommends

GAO is recommending that CMS (1) ensure that its guidance to states on third-party liability requirements reflects current law, and (2) determine the extent to which state Medicaid programs are meeting federal third-party liability requirements. The Department of Health and Human Services concurred with these recommendations.

View GAO-19-601. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Medicaid officials in the nine selected states GAO reviewed described being in various stages of implementing third-party liability changes as required by law. These changes affect whether health care providers must seek payment from a liable third party, such as private insurance, before the state Medicaid agency pays for services. The changes apply to prenatal care services, pediatric preventive services, and services for children subject to child support enforcement (CSE beneficiaries). At the time of GAO's review,

- Officials from four of the nine selected states reported having fully implemented the changes for prenatal care services, which were required to be implemented starting in February 2018. Officials from the remaining five states were discussing the changes internally, researching how to implement the changes in their Medicaid payment systems, or waiting for additional guidance from the Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for overseeing states' Medicaid programs.

- None of the nine states had implemented the changes to pediatric preventive services and services for CSE beneficiaries, which must be implemented starting in October 2019. Officials from six states told GAO that they were in the early stages of exploring how they would make the changes, while the remaining three states had not developed such plans.

GAO found that guidance issued by CMS in June 2018 to assist states in implementing the third-party liability changes contains information inconsistent with the law. For example, CMS's guidance incorrectly informs states that providers do not need to seek third-party payments before the state pays for some prenatal services. In addition, CMS has not determined the extent to which states are meeting third-party liability requirements. CMS officials stated that they expect states to comply with current law for Medicaid third-party liability and that they do not verify whether states have implemented the required third-party liability changes unless the agency is made aware of non-compliance. However, this approach is inconsistent with CMS's Medicaid oversight responsibilities, including its responsibility to ensure federal funds are appropriately spent.

Medicaid experts and other stakeholders told GAO that the third-party liability changes could affect some health care providers in ways that could result in decreased beneficiary access to care, because some providers might be less willing to see Medicaid patients. According to stakeholders, this could occur for two primary reasons.

1. The changes may increase administrative requirements for providers by requiring them to identify sources of coverage, obtain insurance information, and submit claims to third-party insurers before submitting them to Medicaid.

2. The changes may result in providers waiting longer to receive Medicaid payment for certain services to the extent that states require providers to seek third-party payments before paying the providers' claims.

Contents

Abbreviations

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSE	child support enforcement
HHS	Department of Health and Human Services
MCO	managed care organization
MMIS	Medicaid Management Information System

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 9, 2019

The Honorable Chuck Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Frank Pallone
Chairman
The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
House of Representatives

With few exceptions, Medicaid is considered the payer of last resort, meaning that when beneficiaries have another source of health care coverage—such as private health insurance provided through an employer—that source, to the extent of its liability, should generally pay for services before Medicaid does. This concept is referred to as "third-party liability." When a third party pays for its share of an individual's Medicaid costs, savings can accrue to the federal government and the states.

The Bipartisan Budget Act of 2018 made changes to the procedures state Medicaid agencies must follow when they receive certain claims for which a third party might be liable, among other things.[1] Specifically, the act changed states' responsibilities for processing claims for three types of services: prenatal care services, pediatric preventive services, and services for children for whom child support enforcement (CSE) is being

[1]See Pub. L. No. 115-123, § 53102, 132 Stat. 64 (codified as amended at 42 U.S.C. § 1396a(a)(25)).

carried out by the state (also known as CSE beneficiaries).[2] The changes pertaining to prenatal care services went into effect in February 2018; the changes related to pediatric services and services for CSE beneficiaries go into effect in October 2019. Before the act, in the case of these three services, states were generally required to pay providers for services delivered to Medicaid beneficiaries and then obtain any payments from liable third parties—a process known as "pay and chase." The Congressional Budget Office estimated that the Bipartisan Budget Act of 2018 third-party liability changes would result in approximately $4 billion in federal savings from 2018 through 2027.

The Bipartisan Budget Act of 2018 includes a provision for GAO to study the impact or potential future impact of these third-party liability changes on both Medicaid beneficiaries and providers. In this report we

1. describe the status of selected states' implementation of third-party liability changes for state Medicaid programs;
2. evaluate CMS's implementation and oversight of third-party liability changes for state Medicaid programs; and
3. describe stakeholders' views on the possible effects of third-party liability changes and the methods state Medicaid program officials could use to monitor these changes.

To describe the status of states' implementation of third-party liability changes, we judgmentally selected nine states: Connecticut, Florida, Illinois, Kentucky, Nevada, New Jersey, Tennessee, Texas, and Utah. We selected these states to include a range of characteristics such as the delivery systems of their Medicaid programs (e.g., fee-for-service verses managed care), Medicaid spending, percentage of births financed by Medicaid, and third-party liability collections, and while also taking into consideration recommendations from background experts and national

[2]In this report, we refer to these statutory changes as the "third-party liability changes," although the Bipartisan Budget Act of 2018 made other changes to the Medicaid third-party liability statute that are not the focus of this report. CMS defines "pediatric preventive services" to include all services covered under the Medicaid early and periodic screening, diagnosis and treatment benefit. 42 C.F.R § 433.139(b)(3)(i) (2018). CMS provides definitions of prenatal care services, which it defines to include, at state option, pregnancy-related services (i.e., labor, delivery, and postpartum care services) in section 3904.4 of the State Medicaid Manual, but indicates that states have the option to define these terms more broadly, such as to include preexisting conditions that are likely to affect the pregnancy. In this report, we use the term "CSE beneficiary" to refer to a Medicaid beneficiary on whose behalf child support enforcement is being carried out by the state.

provider associations.[3] We conducted semi-structured interviews with relevant officials from each state's Medicaid agency between November 2018 and March 2019. We also conducted interviews with stakeholders from state chapters of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, with two providers, with Medicaid managed care organizations (MCO) in three of our selected states, and with three groups advocating for the needs of Medicaid beneficiaries.[4] Throughout this report, we use the term "stakeholders" to refer collectively to officials from state Medicaid agencies and Medicaid MCOs, background experts, beneficiary advocates, provider associations, and providers.

To evaluate CMS's implementation and oversight of third-party liability changes for state Medicaid programs, we reviewed relevant laws and available guidance, including relevant regulations, CMS's Coordination of Benefits and Third-Party Liability (COB/TPL) in Medicaid handbook, and an informational bulletin released on June 1, 2018, concerning CMS's implementation of federal third-party liability requirements and agency oversight responsibilities regarding Medicaid state plans and state plan amendments. We also conducted interviews with officials from CMS and obtained written responses from CMS officials.

To describe stakeholders' views on the possible effects of the third-party liability changes and the methods state Medicaid officials could use to monitor the potential effects on providers and beneficiaries, we conducted interviews with state Medicaid agency officials in the nine selected states. During these interviews, we asked officials about what potential effects they anticipated these changes having on beneficiaries and providers and

[3]During the course of interviews with background experts and national provider associations, we asked which states they recommended we review regarding this topic. Background experts we interviewed included two individuals with experience in Medicaid policy, as well as officials from the National Health Law Program, the Medicaid and CHIP Payment and Access Commission, the Center on Budget and Policy Priorities, the National Association of Medicaid Directors, and Medicaid Health Plans of America. The national provider associations we interviewed included the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Some of these stakeholders suggested states based on factors such as the number of children and women served by a state's Medicaid program and the perceived effectiveness of the Medicaid agency within a state, among other things.

[4]Medicaid managed care organizations (MCO) are organizations with which states may contract to provide a specific set of Medicaid-covered services to beneficiaries. States pay MCOs a set amount per beneficiary to provide these services, typically per month.

how states could monitor the effects of the third-party liability changes. We also conducted interviews with other relevant stakeholders—including individuals and organizations with expertise in Medicaid (identified through interviews), national provider associations (e.g., the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists), state chapters for provider associations, and organizations representing beneficiaries—during which we asked about the potential effects the third-party liability changes would have on affected beneficiaries and providers.[5]

We conducted this performance audit from April 2018 to August 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Overview of Medicaid Expenditures and Oversight

Medicaid expenditures are financed jointly by the federal government and the states. In order to receive federal matching funds for Medicaid expenditures, states must adhere to a broad set of federal requirements and administer their programs consistent with individual state plans approved by CMS. These plans are agreements between a state and the federal government that describe how states will administer their Medicaid programs, including how the state will administer Medicaid third-party liability procedures. When states make changes to their Medicaid programs or policies, including when necessary to comply with a change in federal law, they must submit a state plan amendment to CMS. CMS reviews and approves state Medicaid plans and state plan amendments.

The federal government matches each state's Medicaid expenditures for services according to a statutory formula called the Federal Medical Assistance Percentage. This formula provides for a match that is no lower

[5]We interviewed officials from organizations that have expertise in Medicaid, including the National Association of Medicaid Directors, the Center on Budget and Policy Priorities, the Medicaid and CHIP Payment and Access Commission, and the National Health Law Program.

than 50 percent of a state's Medicaid expenditures and no higher than 83 percent.[6] States can receive a 90 percent federal match for the costs associated with the development of each state's Medicaid Management Information System (MMIS), a claims processing and retrieval system supporting the administration of the state's Medicaid program.[7] States also receive a 75 percent match for the costs associated with ongoing MMIS maintenance and operations.[8] States use their MMIS systems to process provider claims, including claims for prenatal care services, pediatric preventive services, and services provided to CSE beneficiaries.

The Medicaid program is administered at the state level and overseen at the federal level by CMS, which, among other things, ensures that funds are used appropriately and beneficiaries have access to covered services. Medicaid allows significant flexibility for states to design and implement their programs. Within broad federal parameters, states have discretion in, among other things, setting Medicaid eligibility standards and provider payment rates; determining the amount, scope, and duration of covered benefits; and developing their own administrative structures.

States may also decide how Medicaid-covered services provided to beneficiaries will be delivered. For example, states may pay health care providers for each service they provide—fee-for-service—or contract with MCOs to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary, typically per month. While most states use both delivery systems, the percentage of beneficiaries served through MCOs has grown in recent years, and represented nearly 70 percent of all Medicaid beneficiaries in 2016.[9]

Federal Third-Party Liability Requirements

Medicaid beneficiaries across various eligibility categories may have access to private health insurance or other sources of third-party

[6]Adjustments may apply to certain populations or services, however. For example, for certain Medicaid enrollees, states receive a higher federal match based on whether the state expanded Medicaid, as provided for under the Patient Protection and Affordable Care Act. See Pub. L. No. 111-148, § 2001(a)(3), 124 Stat. 119, 272 (2010) (codified as amended at 42 U.S.C. § 1396d(y)).

[7]See 42 C.F.R. § 433.111(b) (2018).

[8]See 42 U.S.C. §§ 1396b(a)(3)(A)(i), (B).

[9]See Centers for Medicare & Medicaid Services, Medicaid Managed Care Enrollment and Program Characteristics, 2016 (Spring 2018).

coverage. For example, some adult beneficiaries may be covered by employer-sponsored private health insurance even though they also qualify for Medicaid. Children, similarly, may be eligible for Medicaid, while also being covered as a dependent on a parent's private health plan.[10] As such, federal law requires states to perform various activities to ensure that Medicaid is the payer of last resort, including taking all reasonable measures to identify Medicaid beneficiaries' other potential sources of health coverage and their legal liability.[11] Specifically, states must ensure that the following steps, among others, are taken.

1. **Coverage identification.** To identify beneficiaries with third-party health coverage, states are required to request coverage information from potential Medicaid beneficiaries at the time the agency makes any determination or redetermination of eligibility. States are also required to obtain and use information pertaining to third-party liability, for example, by conducting data matches with state wage information agencies, Social Security Administration wage and earning files, state motor vehicle accident report files, or state workers' compensation files.
2. **Coverage verification.** When other health coverage is identified, states often verify the information, including the services covered through the other insurance and the dates of eligibility.
3. **Cost avoidance payment procedures.** As a general rule, federal law requires states to apply cost avoidance payment procedures to claims for most Medicaid items and services. Under cost avoidance

[10]Third parties are not limited to health insurers. Rather, they include any individual, program, or entity legally responsible—liable—for payment for all or part of a claim for a health care item or service. Such third parties may include private health insurance, medical support from non-custodial parents, automobile insurance, workers' compensation, probate-estate recoveries, and public programs, among others—unless excluded by federal statute. See 42 U.S.C. § 1396a(a)(25)(A); 42 C.F.R. § 433.136 (2018) (definition of a third party); CMS, State Medicaid Director Letter #06-026 (Dec. 15, 2006).

Because children are generally not permitted to enroll in a State Children's Health Insurance Program (CHIP) if they have another source of health care coverage, the existence of third-party liability in CHIP is rare. However, if a child enrolled in CHIP were to obtain private health insurance or another source of coverage (such as court-ordered medical support from a non-custodial parent) during the course of an eligibility period, third-party liability requirements would apply.

[11]See 42 U.S.C. § 1396a(a)(25)(A). CMS requires such activities to include the measures specified in sections (b) through (k) of 42 C.F.R. § 433.138 unless waived. See 42 C.F.R. § 433.138(a) (2018). States may delegate these responsibilities to entities such as a contractor or managed care organization.

procedures, the state must reject claims for which a third party is or is probably liable, and the agency instructs the provider to collect from the third party.[12] Once the provider determines the amount of the third party's liability, the provider submits a claim to the state Medicaid agency for any remaining balance, up to the maximum amount allowed under the state's payment schedule.[13] States are then required to make timely payment to the provider, generally within 30 days from the date the claim for the balance is filed.[14]

4. **Pay-and-chase payment procedures.** The Consolidated Omnibus Budget Reconciliation Act of 1985 made an exception to cost avoidance procedures for three types of services: prenatal care services, pediatric preventive services, and services provided to CSE beneficiaries.[15] It required states to pay such claims without regard to the liability of the third party, a procedure CMS calls "pay and chase." Under the pay-and-chase payment procedure, the state Medicaid agency is generally required to make a timely payment to the provider within 30 days, and then the state, instead of the provider, will seek to recover payment from any potentially liable third parties within 60 days.[16] According to CMS, cost avoidance does not apply to these claims because there is a risk some providers might not participate in

[12]See 42 C.F.R. § 433.139(b)(1) (2018) (requiring states to reject, but not deny, such claims under cost avoidance procedures). See also, CMS, State Medicaid Manual, § 3904.1.

[13]Once the amount for which a third party is liable is known, the state Medicaid agency must then pay the claim to the extent, and in the amount, that Medicaid payment for the particular claim exceeds the amount of the third party's payment. See 42 C.F.R § 433.139(b)(1) (2018).

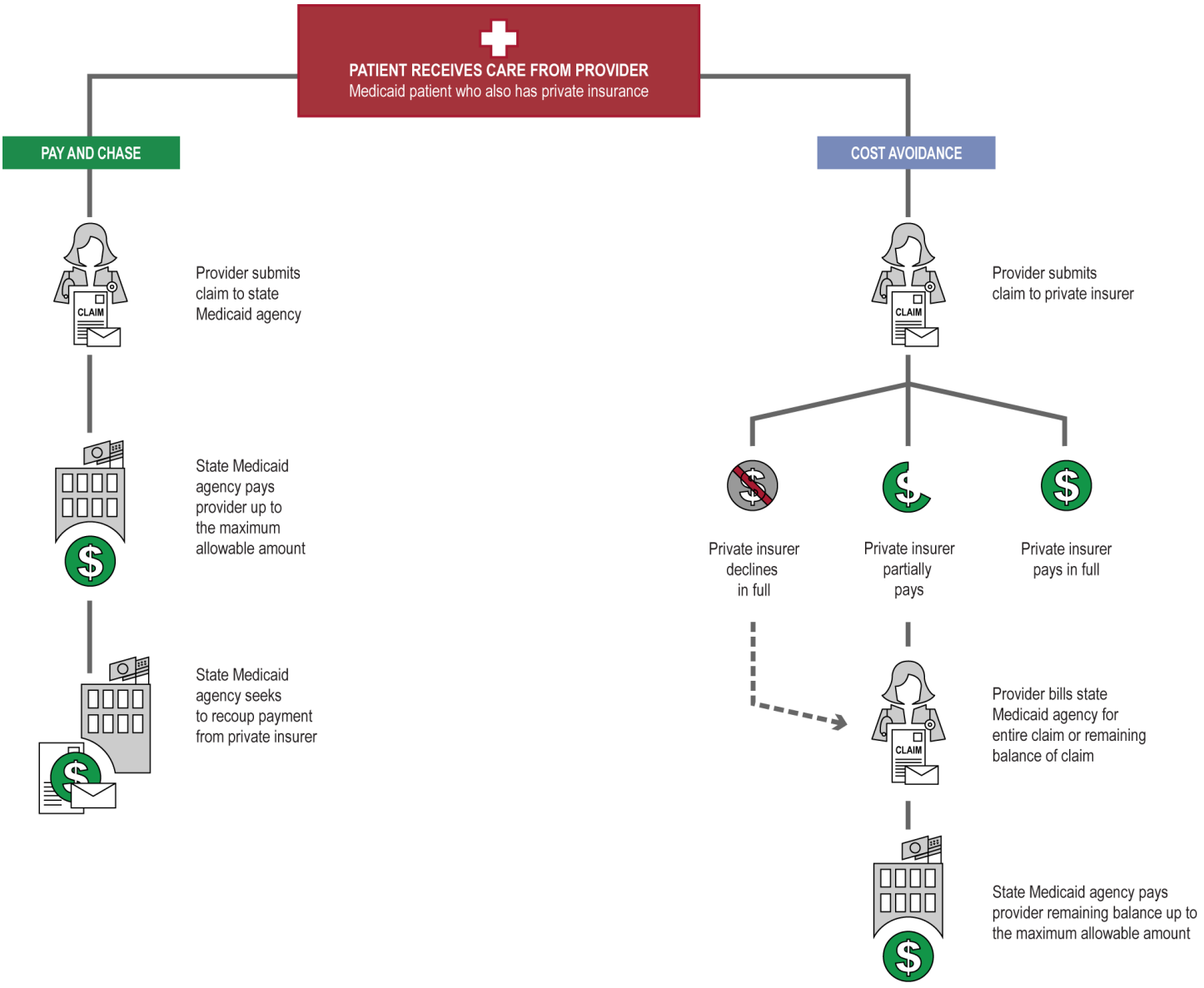
[14]Specifically, states are required to make timely payments within 30 days for 90 percent of clean claims—those for which no additional information from the provider or a third party is necessary to process the claim. See 42 C.F.R. §§ 447.45(b), (d) (2018).

[15]See Pub. L. No. 99-272, § 9503, 100 Stat. 82, 205 (1986). The conference report accompanying the act notes that prenatal care and preventive pediatric services were excepted from the application of cost avoidance procedures so that third-party collections would be pursued by the state, not by the provider. The conferees expressed a concern that the administrative burdens associated with third-party collection efforts should not discourage provider participation in Medicaid. The conference report also notes that the intent of the conferees in excepting services provided to CSE beneficiaries was to protect the custodial parent from pursuing collections from the non-custodial parent's employer, insurer, or other funding sources. See H.R. Rep. No. 99-453, at 544 (1985) (Conf. Rep.).

[16]States may request initial and continuing waiver of the requirement to recover payments, and may suspend or terminate such recovery efforts, if the state determines it would not be cost-effective to pursue recovery. See 42 C.F.R. §§ 433.139(e), (f) (2018).

Medicaid to avoid dealing with the administrative burden of cost avoidance.[17] (See fig. 1.)

Figure 1: Third-Party Liability Payment Processes for Medicaid Claims with Probable Private Insurer Liability



Source: GAO analysis. | GAO-19-601

[17]Center for Medicaid and CHIP Services Informational Bulletin (June 1, 2018), p. 1.

Note: With few exceptions, Medicaid is considered the payer of last resort, meaning that when beneficiaries have another source of health care coverage—such as private health insurance provided through an employer—that source, to the extent of its liability, should pay for services before Medicaid does. This concept is referred to as "third-party liability."

The Bipartisan Budget Act of 2018 amended various sections of the Medicaid third-party liability statute, including the required processes states must follow when paying claims with probable third-party liability for the following three types of services:

- **Prenatal care services.** The Bipartisan Budget Act of 2018 eliminated, effective February 2018, the statutory exception for prenatal care services that had required states to apply pay-and-chase procedures to such claims.[18] Thus, under the amended statute, states must apply cost avoidance procedures to claims for prenatal care services when it is apparent that a third party is or may be liable at the time the claim is filed.[19] Additionally, to the extent states had opted under CMS regulations to apply pay-and-chase procedures to claims for labor, delivery, or postpartum care services—which CMS calls "pregnancy-related services"—states must now apply cost avoidance procedures to those as well.[20]
- **Pediatric preventive services.** Beginning in October 2019, under federal law as amended by the Bipartisan Budget Act of 2018, states are no longer required to pay claims for pediatric preventive services immediately.[21] While states will still have the option to apply pay-and-chase procedures to these claims, a state may instead choose—if it determines doing so is cost-effective and will not adversely affect access to care—to require the provider to first submit the claim to the third party and wait 90 days for payment by the third party before

[18]See Pub. L. No. 115-123, § 53102(a)(1) (codified at 42 U.S.C. § 1396a(a)(25)(E)).

[19]See 42 U.S.C. § 1396a(a)(25)(A).

[20]CMS regulations issued in 1985 permitted states to apply either cost avoidance or pay-and-chase procedures to claims for labor, delivery, and postpartum care services, excluding any costs associated with an inpatient hospital stay. See 42 C.F.R. § 433.139(b)(2) (2018). In section 3904.4 of the State Medicaid Manual, CMS explained its view that the statutory prenatal care services exception permitted states to apply pay-and-chase procedures broadly to "pregnancy-related services," reasoning that obstetricians frequently bundled these claims with prenatal care services.

[21]These statutory requirements initially appeared in the Bipartisan Budget Act of 2013, but the effective date was delayed by subsequent legislation, most recently by the Bipartisan Budget Act of 2018. See Pub. L. No. 113-67, § 202, 127 Stat. 1165, 1177 (2013) and Pub. L. No. 115-123, § 53102(b)(2), 132 Stat. 64, 298 (2018), codified as amended at 42 U.S.C. § 1396a note.

seeking Medicaid payment. For purposes of this report, we refer to such a 90-day period as a "wait-and-see period."

- **Services provided to CSE beneficiaries.** Beginning in October 2019, states must make payment for a CSE beneficiary's claim if the third party has not paid the provider's claim within a 100-day wait-and-see period.[22] However, the state may instead choose—if the state determines doing so is cost-effective and necessary to ensure access to care—to make payment within 30 days.[23] (See table 1.)

Table 1: Pre- and Post-Bipartisan Budget Act of 2018 Requirements for State Medicaid Payment of Certain Claims with Probable Third-Party Liability

Type of claim	Pre-Bipartisan Budget Act of 2018	Post-Bipartisan Budget Act of 2018	Effective date
Prenatal care services (including pregnancy-related services)[a]	**Pay-and-chase**. State must make timely payment to provider and then seek payment from third party.[b]	**Cost-avoidance.** State must reject claim until the provider bills the third party. If balance remains after provider bills third party or if third party denies claim, provider can submit claim to state for balance.	Feb. 2018
Pediatric preventive services	**Pay-and-chase.** State must make timely payment to provider and then seek payment from third party.	**State option.** State must pay-and-chase or, upon determination of cost-effectiveness and access, reject claim for up to 90 days before making timely payment.	Oct. 2019
Services for children subject to child support enforcement	**State option.** State must pay-and-chase or reject a claim for up to 30 days before making timely payment.	**State option.** State must reject claim for up to 100 days or, upon determination of cost-effectiveness and access, make payment within 30 days.	Oct. 2019

Source: GAO analysis of the Bipartisan Budget Act of 2018 and related legislation. | GAO-19-601

Note: See Pub. L. No. 115-123, § 53102, 132 Stat. 64, 298 (codified as amended by the Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, § 7, 133 Stat. 852, at 42 U.S.C. §§ 1396a(a)(25), note).

[22]The Bipartisan Budget Act of 2018 provided for a 90-day wait-and-see period for claims for CSE beneficiaries with probable third-party liability; however, subsequently enacted legislation extended it to 100 days. See Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, § 7, 133 Stat. 852. The Congressional Budget Office estimates that the additional 10 days of the wait-and-see period, which is optional for states, would save $60 million over 10 years. See Congressional Budget Office, *Cost Estimate: H.R. 1839, Medicaid Services Investment and Accountability Act of 2019,* (Washington, D.C.: Mar. 22, 2019), accessed July 3, 2019, https://www.cbo.gov/system/files/2019-03/hr1839_0.pdf.)

[23]CMS has not announced whether a state that chooses to make payment within 30 days will continue to have the option of requiring providers to certify that they have waited 30 days for third-party payment before filing the claim with the state or whether the state will be required to pay right away under pay-and-chase procedures. Under current regulations, states have both options and must specify the state's procedures in their state Medicaid plans. See 42 C.F.R. § 433.139(b)(3)(ii) (2018).

[a]We use the term "pregnancy-related services" to refer to labor, delivery, and postpartum care services, excluding any costs associated with an inpatient hospital stay. Under Centers for Medicare & Medicaid Services (CMS) regulations, states had the option to treat these services the same as prenatal care services. See 42 C.F.R. § 433.139(b)(2) (2018). Under current law as amended by the Bipartisan Budget Act of 2018, states must apply cost avoidance to all prenatal care and pregnancy-related services. See 42 U.S.C. § 1396a(a)(25)(A).

[b]We use the term "timely payment" to refer to a payment made within the timeframe required by CMS under its prompt payment regulation, 42 C.F.R. § 447.45(d) (2018), which requires states to pay 90 percent of clean claims—those for which no additional third party information is necessary—within 30 days of the date such claims are filed with the state agency and to pay 99 percent of clean claims within 90 days of that date. See 42 C.F.R. § 447.45(b) (2018) (definition of a clean claim).

Once the third-party liability changes in the Bipartisan Budget Act of 2018 are fully implemented, states will have authority to require providers to wait longer to receive Medicaid payments in certain circumstances.[24] For example,

- **Prenatal care services claims,** which were previously paid within 30 days under pay-and-chase procedures, are now subject to cost avoidance. This could potentially result in providers waiting indefinitely to receive payment, depending on whether the provider is able to resolve the third-party liability (i.e., submit a claim for payment to the third party and determine the amount of the third-party liability), which must occur before the state may make payment under cost avoidance.
- **Pediatric preventive services claims,** which are generally paid within 30 days under pay-and-chase procedures, could be subject to a 90-day wait-and-see period beginning in October 2019 if a state decides to implement one. This could result in providers waiting 120 days to receive payment (90 days to wait and see if the liable third party pays, and then another 30 days for the state to make timely payment on any remaining balance).
- **Claims for services for CSE beneficiaries,** which are currently subject to pay-and-chase procedures or a 30-day wait-and-see period at state option, may be subject to either a 30-day or 100-day wait-and-see period beginning in October 2019, depending on which option the state chooses. This could result in providers waiting 130 days to receive payment (up to 100 days to wait and see if the liable third party pays, and then another 30 days for the state to make timely payment on any remaining balance).

[24]Although states are required to implement some of the third-party liability changes, such as the requirement to apply cost-avoidance procedures to prenatal care services, the changes applicable to pediatric preventive services claims and claims for services for CSE beneficiaries provide the state with options.

Some Selected States Have Implemented Third-Party Liability Changes for Prenatal Care Services; Most of the States Were in the Early Stages of Planning for Other Changes

Officials from four of the nine selected states we reviewed reported having implemented the required third-party liability changes for prenatal care services. The changes were required to be implemented in February 2018. For the third-party liability changes affecting pediatric preventive services and services provided to CSE beneficiaries, which are due to take effect October 2019, Medicaid officials from six of the nine selected states noted that they were in the very early stages of planning how they might implement the changes.

Four of Nine Selected States Have Implemented Required Third-Party Liability Changes for Prenatal Care Services

Officials from four of the nine selected states we reviewed stated that their state Medicaid agency had implemented the mandated third-party liability changes for prenatal care services, which required states to implement cost avoidance payment procedures for claims for these services beginning in February 2018.[25] Officials from three of the four states that have implemented the third-party liability changes for prenatal care services told us that changing from pay-and-chase to cost avoidance procedures involved identifying all the applicable service codes for prenatal care and making the necessary changes in their systems to ensure that any new claims were subject to cost avoidance procedures. They said it also involved communicating the need for such changes to the MCOs in their state.[26]

State Medicaid officials from the remaining five states generally noted that they were discussing the changes internally, researching how to implement the changes in their MMIS, assessing the likely impact of

[25]Under the new law, the state must reject any provider's claim for prenatal care services when it is apparent that a third party may be liable for those services. Once the provider determines the amount of the third party's liability, the state Medicaid agency may pay any remaining balance up to the maximum allowed under the state's payment schedule.

[26]Officials from two states said that they had already been applying cost avoidance procedures to claims for prenatal care services, even though the law in effect prior to the Bipartisan Budget Act of 2018 required states to apply pay-and-chase payment procedures to these claims.

these changes on MMIS, or waiting for additional guidance from CMS.[27] For example:

- Officials from several states noted that they were undertaking activities, such as identifying the prenatal care codes in their data systems that would need to be switched to cost avoidance payment procedures, or researching the best way to implement these changes.
- Officials from one state said they were in the process of assessing what the likely impact of these changes on beneficiaries and providers would be, and would only subject claims for prenatal care services to cost avoidance if they determined that doing so was the best course of action.[28]
- Officials from one state indicated that they were waiting to determine whether it was more cost effective to implement these changes in their legacy MMIS, or wait and implement the changes in the new MMIS they are planning to roll out in the future.

State Medicaid officials also described other efforts that they would need to undertake as they implemented these changes to third-party liability. These included staff retraining and communicating the changes to providers in their states.

Beyond state Medicaid programs, officials from the five Medicaid MCOs we interviewed all stated that their organizations had not yet implemented the prenatal care third-party liability changes. The MCO officials stated that they were waiting for additional instructions on how to implement the third-party liability changes or for revised contract language from their state Medicaid agencies. Officials from one of the MCOs noted they were not aware of the third-party liability changes until we reached out to them for an interview. Officials from two MCOs we interviewed generally agreed that the third-party liability changes for prenatal care services would require changes to claims processing systems and internal processes, but would not be significant. Several MCO officials noted that

[27]Although CMS issued initial guidance to states regarding the third-party liability changes on June 1, 2018, the statutory requirement applicable to prenatal care services went into effect in February 2018. See Center for Medicaid and CHIP Services, Informational Bulletin (June 1, 2018).

[28]While federal law allows states certain options in processing claims for pediatric preventive services and services provided to CSE beneficiaries, it does not allow states to apply any procedures other than cost avoidance for prenatal care claims.

these changes would likely result in some cost-savings to MCOs in the future.

Most Selected States Were in Early Stages of Planning Implementation of Third-Party Liability Payment Changes for Pediatric Preventive Services and Services to CSE Beneficiaries

Medicaid officials from six of the nine selected states noted that they were in the very early stages of planning whether—or how—they would implement the wait-and-see periods for pediatric preventive services and services to CSE beneficiaries.[29] For example, some Medicaid officials from these six states described how they were assessing what changes would need to be made to their MMIS, deciding whether to implement the wait-and-see periods, or exploring how to assess the potential impact of these changes. Some Medicaid officials also expressed uncertainty regarding how such changes would affect Medicaid beneficiaries or the amount of effort required by their agency to implement the third-party liability changes. Officials from one state noted that they had begun discussions about implementing the third-party liability changes for both pediatric preventive services and services for CSE beneficiaries in June 2018, and were in the process of identifying the necessary system changes needed to implement third-party liability changes by the October 2019 effective date. Officials from two of these states stated that they do not believe their state will implement the wait-and-see periods for pediatric preventive services or CSE beneficiaries when the changes go into effect. Officials from the remaining three states noted at the time of our interviews they had not yet developed plans for assessing implementation of these changes. Table 2 summarizes the status of selected states' implementation of the third-party liability changes.

[29]During a wait-and-see period, the state must reject a claim with probable third-party liability while the provider attempts to collect payment from the third party. The Bipartisan Budget Act of 2018 gives states the option of implementing a 90-day wait-and-see period for pediatric preventive services if states determine that implementing a wait-and-see period would be cost-effective and would not adversely affect beneficiaries' access to care. In addition, the Bipartisan Budget Act of 2018 gives states the option of not extending the wait-and-see period for child support enforcement beneficiaries to 100 days if the state determines that not extending the wait-and-see period would be cost-effective and necessary to ensure access to care. See Pub. L. No. 115-123, § 53102(b)(2), 132 Stat. 64, 298 (2018), as amended by Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, § 7, 133 Stat. 852 (codified as amended at 42 U.S.C. § 1396a note).

Table 2: Status of Selected States' Implementation of Bipartisan Budget Act of 2018 Medicaid Third-Party Liability Changes

State	Prenatal care changes (effective February 2018)	Pediatric preventive and child support enforcement beneficiaries' changes (effective October 2019)
#1	Not implemented	No plans developed
#2	Not implemented	Has plans to implement (will implement if they determine it is the best course of action)
#3	Not implemented	No plans developed
#4	Not implemented	Has plans to implement
#5	Implemented	In discussions on the advantages and disadvantages and exploring wait-and-see periods
#6	Not implemented	No plans developed at this time
#7	Implemented	Evaluating the changes and the approach they might take for implementing these changes
#8	Implemented	Has plans to implement. In process of identifying what system and process changes are needed
#9	Implemented	Has plans to implement

Source: GAO interviews with officials from nine selected state Medicaid agencies. | GAO-19-601

Note: Under the Bipartisan Budget Act of 2018 and subsequently-enacted legislation, state Medicaid programs were required to use cost avoidance, as opposed to pay and chase, payment procedures when processing claims for prenatal care and pregnancy-related services for which a third party may be liable beginning in February 2018. This law also gives states the option to establish 90-day and 100-day wait-and-see periods for claims for pediatric preventive services and services for CSE beneficiaries. During a wait-and-see period, the state must reject a claim with potential third party liability while the provider attempts to collect payment from the third party. These pediatric changes will go into effect in October 2019. See Pub. L. No. 115-123, § 53102(a)-(b), 132 Stat. 64, 298 (2018), as amended by Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, § 7, 133 Stat. 852 (codified as amended at 42 U.S.C. §§ 1396a(a)(25), note).

For pediatric preventive services, state Medicaid officials generally noted that the third-party liability changes would involve identifying the relevant codes and making changes to their MMIS to ensure those claims were subject to a wait-and-see period, if implemented. Several state Medicaid officials characterized this effort as "significant" or "difficult." For services delivered to CSE beneficiaries, officials from several state Medicaid agencies speculated that making the third-party liability changes to their MMIS would necessitate having some sort of indicator in their system to identify which claims were for the CSE beneficiaries and, therefore, should be subject to a wait-and-see period, if implemented. Some state Medicaid agency officials said that this would require obtaining the information from another state agency responsible for administering CSE agreements.

Several of the state Medicaid officials we interviewed expressed concerns regarding how to implement the wait-and-see periods for pediatric preventive services and services for CSE beneficiaries. Specifically, these officials noted that—within their MMIS—it is not possible to capture on a

Medicaid claim when a provider has billed a third party, waited a specified amount of time, and not received payment. As a result, officials from one state noted that additional guidance from CMS on how to implement and track provider billing of third parties—including wait-and-see periods and providers' collection of payment—would be necessary before moving forward with implementing the third-party liability changes. Officials from two states said that the administrative burden associated with these changes would possibly make them not cost-effective to implement. However, MCO officials we interviewed generally acknowledged that while these changes would require changes to their claims processing systems and internal processes, they were not significant and could potentially result in some cost-savings to their MCO in the future.

The third-party liability change affecting all Medicaid services provided to CSE beneficiaries was a particular concern for officials from three state Medicaid agencies and three MCOs. Specifically, these officials said there is currently no way to identify CSE beneficiaries in their MMIS or claims processing systems, which could potentially make this change difficult, if not impossible, to implement. Officials from one state described how setting up a system to receive this information would involve a significant effort, potentially necessitating new hardware and system modifications, as well as a data sharing agreement with the state entity maintaining the CSE information. Officials from one MCO noted that the third-party liability changes affecting CSE beneficiaries was a particular concern, because those changes would potentially require additional administrative work and changes to their processes in order for providers in their network to track down insurance information from a non-custodial parent.

CMS Has Issued Implementing Guidance with Information Inconsistent with Federal Law and Has Not Overseen States' Implementation of Third-Party Liability Changes

CMS's Implementing Guidance Contains Information Inconsistent with Provisions of Federal Law Related to Medicaid Third-Party Liability

After enactment of the Bipartisan Budget Act of 2018 in February 2018, CMS issued guidance in the form of an informational bulletin to states on June 1, 2018, to facilitate states' implementation of the key provisions of the Bipartisan Budget Act of 2018 related to third-party liability in Medicaid. However, CMS's June informational bulletin is missing some key information and contains information that is inconsistent with the federal law. This is inconsistent with CMS's responsibility for ensuring states' compliance with federal requirements. In particular,

- **Pregnancy-related claims.** Under federal law, states must apply standard cost avoidance procedures to all non-pediatric claims, including claims for prenatal services beginning in February 2018.[30] However, CMS guidance indicates that a state need not apply cost avoidance procedures to claims for labor and delivery services if those claims can be differentiated from prenatal services.[31] The guidance also provides that, effective October 1, 2019, states will have 90 days to pay claims related to labor, delivery, and postpartum care claims. As a result, CMS's guidance is inconsistent with federal law, which requires states to reject any such claim under cost

[30]See 42 U.S.C. § 1396a(a)(25)(A) (requiring standard cost avoidance procedures for all Medicaid claims with probable third-party liability under subsection (A) except for certain pediatric claims identified in subsections (E) and (F)).

[31]See Center for Medicaid and CHIP Services, Informational Bulletin (June 1, 2018), p. 2.

avoidance procedures until the third-party liability is resolved, regardless of how many days that might take.[32]

- **Pediatric preventive claims.** Under federal law, states must generally apply pay-and-chase procedures to pediatric preventive services. However, beginning in October 2019, states are permitted to implement a 90-day wait-and-see period before making payment for these services if the state determines that it would be cost-effective and would not adversely affect access to care to do so.[33] However, CMS guidance simply provides that states will have 90 days to pay such claims, suggesting that states need not make the cost-effectiveness or access determinations required by statute.[34]
- **CSE beneficiary claims.** Under federal law, beginning in October 2019, for claims for services to CSE beneficiaries, states may choose to make payment within 30 days (as opposed to implementing a 100-day wait-and-see period), if the state determines doing so is cost-effective and necessary to ensure access to care.[35] If the state does not make such a determination, the statute would require the state to avoid making payment for such services for up to 100 days to allow third parties to make payment first. However, CMS guidance does not identify this as an option for states. Instead, CMS guidance simply provides states with the option of implementing the wait-and-see period, omitting the option for states to make payment within 30 days.

CMS officials told us that the Bipartisan Budget Act of 2018 did not change state responsibilities related to cost-effectiveness and access to care, and CMS does not intend to issue additional guidance on this issue. However, prior to enactment of the Bipartisan Budget Act of 2018 in February 2018, federal third-party liability law did not authorize states to

[32]See 42 U.S.C. § 1396a(a)(25)(A).

[33]See 42 U.S.C. § 1396a note.

[34]See Center for Medicaid and CHIP Services, Informational Bulletin (June 1, 2018), p. 2.

[35]See 42 U.S.C. § 1396a note.

apply cost avoidance procedures to preventive pediatric claims or pediatric services provided to CSE beneficiaries.[36]

Furthermore, other CMS guidance documents, such as the third-party liability handbook and CMS regulations on third-party liability, are out of date and not a reliable source of information for states to use in implementing the new federal third-party liability requirements. In particular, the third-party liability handbook was last revised in 2016 and does not reflect the Bipartisan Budget Act of 2018 changes. Additionally, CMS regulations implementing federal requirements for state payment of claims for prenatal care, labor and delivery services, postpartum care, preventive pediatric services, and services to CSE beneficiaries were last amended in 1997 and, accordingly, do not reflect current statutory requirements, including the Bipartisan Budget Act of 2018 requirement to cost avoid prenatal and other non-pediatric claims beginning February 2018.[37]

CMS officials told us the agency is in the process of updating its third-party liability handbook and anticipates issuing the updated document in September 2019. Agency officials also told us they plan to revise the agency's regulations regarding pay-and-chase and release the revised regulations in early 2020. However, federal law requires state Medicaid plans to provide for proper third-party liability procedures, which states often carry out through references to federal regulation, according to CMS officials. Without updated third-party liability guidance that is timely, complete, and consistent with federal law, states may lack the necessary information to update their state Medicaid plans so that they comply with these requirements.

[36]Under CMS regulations, states are permitted to request a waiver of cost avoidance or recovery of reimbursement requirements if the state determines that such a requirement is not cost-effective. See 42 C.F.R. § 133.139(e) (2018). However, this cost-effectiveness determination for purposes of the waiver does not involve a determination of access to care or permit a state to waive pay-and-chase requirements. According to CMS officials, no waivers are currently in effect.

[37]Compare 42 C.F.R. § 433.139 (2018) with 42 U.S.C. §§ 1396a(a)(25)(A), (E), (F), note.

CMS Has Not Overseen States' Implementation of Third-Party Liability Changes

CMS has not taken steps to determine the extent to which state Medicaid agencies are meeting the third-party liability requirements, and therefore CMS officials were unaware of whether states were meeting the new requirements. In particular, CMS officials did not know the extent to which the selected states in our review had implemented the required third-party liability changes. In our interviews with nine selected state Medicaid agencies conducted between November 2018 and March 2019, we learned that five states continued to apply pay-and-chase procedures to prenatal care claims, despite the federal requirement to implement cost avoidance since February 2018.[38]

During our interviews, we also learned that CMS had not monitored state Medicaid agencies' third-party liability approaches prior to the Bipartisan Budget Act of 2018. For example, officials from one of the selected states told us that they had been using cost avoidance for most claims for pediatric preventive care, rather than applying pay-and-chase procedures, as required by law.[39] We also learned from an official from another selected state that the state had been applying cost avoidance procedures to claims for prenatal care services well in advance of the enactment of the Bipartisan Budget Act of 2018, despite the federal requirement to apply pay-and-chase procedures to such claims from 1986 to 2018.

CMS's failure to monitor the implementation of the third-party liability changes in the Bipartisan Budget Act of 2018 is inconsistent with the agency's responsibilities for oversight of the Medicaid program, including ensuring that federal funds are appropriately spent. We have previously recommended that, given the significant federal Medicaid outlays, the federal government has a vested financial interest in further increasing states' third-party liability cost savings, and that CMS should play a more active leadership role in monitoring, understanding, supporting, and promoting state third-party liability efforts.[40]

[38]Federal law requires Medicaid state plans to provide for the cost avoidance of prenatal care claims effective February 9, 2018. See 42 U.S.C. § 1396a(a)(25)(A) (as amended by the Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 53102(a), 132 Stat. 64, 298).

[39]Officials from the state noted that they apply pay-and-chase procedures to claims for pediatric immunizations and apply cost avoidance procedures to all other pediatric services.

[40]See GAO, *Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts*, GAO-15-208 (Washington, D.C.: Jan. 28, 2015).

However, CMS officials stated that they expect states to comply with current law for Medicaid third-party liability, and that they do not verify whether states have implemented the required third-party liability changes unless the agency is made aware of non-compliance. When asked how CMS ensures that states apply pay-and-chase procedures required under federal law, such as for pediatric preventive claims, CMS officials stated that it is the agency's expectation that states comply with current law. According to agency officials, if a state has difficulty complying and reaches out to CMS for technical assistance, the agency will work with that state to come into compliance. CMS officials told us that CMS plans to review all state Medicaid plans and provide technical assistance for any necessary action only after the agency has updated its regulations related to third-party liability.[41] As of May 2019, CMS anticipated that it would release updated regulations in early 2020.

Because CMS has not monitored states' compliance with federal third-party liability requirements, the agency does not know whether states have applied the federally required third-party liability procedures to certain Medicaid claims as required by federal law. In the case of prenatal care services claims, the failure to implement cost avoidance payment procedures could result in unnecessary Medicaid expenditures, to the extent that Medicaid pays providers for services for which a third party is liable. To the extent that states are not properly applying pay-and-chase procedures to pediatric preventive service claims, children's access to such services could be impacted.

[41]However, CMS officials noted in response to our identification of specific state compliance concerns that the agency would follow up with the identified states directly.

Stakeholders Anticipate Third-Party Liability Changes Could Affect Beneficiary Access to Care; Selected States Discussed Using Existing Methods to Assess Effects of Changes

Most Stakeholders Anticipate Increased Administrative Requirements for Providers and a Possible Decrease in Beneficiary Access to Care

According to most of the stakeholders we interviewed, Medicaid providers—especially prenatal care and rural providers—could face increased administrative requirements or delays in payments for services as a result of the third-party liability payment changes to the three service categories in the Bipartisan Budget Act of 2018. Several stakeholders agreed that the tasks associated with identifying sources of third-party liability and attempting to collect from third parties would shift from state Medicaid agencies to providers as a result of the payment changes, although opinions differed on the extent to which this shift would affect providers.

- Several stakeholders said that the third-party liability changes could increase administrative requirements for providers, because obtaining accurate information on third-party liability sources for Medicaid beneficiaries and resubmitting claims that result from incorrect or outdated third-party liability information can be resource intensive and time consuming. One provider and officials from one state Medicaid agency noted that providers may lack the administrative resources or claims-processing expertise to deal with these changes. Officials from one state Medicaid agency, two state provider associations, and an organization advocating for Medicaid beneficiaries also noted that providers may encounter Medicaid beneficiaries who may be unaware or may not disclose that they have other insurance policies; for example, children who are covered under multiple insurance policies by custodial and non-custodial parents or experience insurance transitions following birth. These issues may increase the amount of

time and resources providers spend on processing and resubmitting claims.

- Other stakeholders were less certain that the added requirements would cause difficulties for providers. Officials from one state Medicaid agency and one MCO said that the payment changes would not be difficult to implement, because providers were familiar with billing third parties for medical services for other beneficiaries. Officials from four state Medicaid agencies and two MCOs noted that providers may prefer to submit claims to commercial insurers, because these insurers pay at a higher rate compared with state Medicaid programs.

Several stakeholders we interviewed agreed that providers could wait longer periods of time for payment as they track down third-party insurers or wait up to 100 days for potential payment from these insurers before seeking payment from the state Medicaid agency. According to one provider and officials from two provider associations and one MCO, these delays could put providers at risk of not receiving payments for services or not having enough cash on hand to sustain operations. Additionally, officials from three provider associations noted that payment delays would affect pediatric providers in particular, because the majority of the services that pediatricians provide are preventive care—which would be affected by the third-party liability changes.

According to several stakeholders we interviewed, smaller or independent providers and those located in rural areas could be more affected by the third-party liability changes compared with providers affiliated with managed care systems or those located in urban areas. Officials from one state Medicaid agency, two provider associations, and one MCO noted that smaller or rural-based providers generally have fewer staff and resources to deal with the larger volume of administrative paperwork and delays in payment for services that could result from the payment changes.

Most of the stakeholders we interviewed said that providers might be less willing to serve Medicaid beneficiaries due to the administrative and payment issues, potentially reducing access to care or delaying services for children and pregnant women.[42] However, some other stakeholders

[42]Providers may not refuse to see a Medicaid beneficiary on the basis of their potential third-party liability, although a provider may reduce or stop their participation in the Medicaid program. 42 U.S.C. § 1396a(a)(25)(D).

said that the third-party liability changes would have little to no effect on Medicaid beneficiaries. Officials from one state Medicaid agency and one MCO noted that third-party liability payment practices for other Medicaid populations and services have been in place for many years, and providers would already be familiar with processing claims with third-party liability.

Several stakeholders said that providers may opt to reduce or eliminate the number of Medicaid beneficiaries they serve, because of actual or perceived increase in administrative requirements or payment delays. Officials from three state provider associations speculated that the potential for additional delays in payment for services could be the "final straw" in providers' decision to stop serving Medicaid beneficiaries. Other stakeholders, including a Medicaid expert, one provider, and officials from one state provider association noted that providers may decide to see fewer Medicaid beneficiaries, but are unlikely to stop seeing them entirely, because some providers are reluctant to deny care to these beneficiaries.

Payment delays could also lead to delays in beneficiaries receiving time-sensitive services, such as immunizations, as well as reduced access to specialists, such as midwives or mental health professionals, according to several stakeholders. Officials from one national provider association and an organization advocating for Medicaid beneficiaries noted that providers may seek to identify sources of third-party liability before providing services to beneficiaries. In addition, officials from one state Medicaid agency, a state provider association, and an organization advocating for Medicaid beneficiaries expressed concern that the third-party liability changes had the potential to reduce access to care for populations, such as children and pregnant women, that already faced challenges in accessing adequate, timely, or quality health care.

Selected States Discussed Using Existing Methods for Assessing Provider Availability and Beneficiary Access to Care Once Payment Changes Are Implemented

Medicaid officials we interviewed from seven of the nine selected states said that their agencies will—or could—use existing methods to assess the effects of the third-party liability changes on provider availability and beneficiary access to prenatal care services, pediatric preventive services, and services for CSE beneficiaries. Officials from the remaining two states did not discuss or provide information on how they could assess the effects of the changes.

Medicaid officials provided examples of existing methods that could be used to assess the effects of payment changes:

- Tracking beneficiary access by comparing a set of access-to-care measures for a state's Medicaid population with its non-Medicaid, commercially insured population, as well as carrying out customer satisfaction surveys with Medicaid beneficiaries,
- Using a third-party liability hotline to track patient issues and conducting secret shopper calls to monitor if providers are accepting new patients,
- Contracting with a state university to evaluate Medicaid beneficiary access for prenatal and pediatric services.

In addition, one state has an independent health advocacy agency that monitors and seeks to resolve provider availability and beneficiary access issues on behalf of the state's Medicaid population.

However, one state Medicaid official and a Medicaid expert agreed that measuring any possible effects of the third-party liability changes—such as a decline in provider availability or beneficiary access—would be difficult without baseline data. According to officials from two state Medicaid agencies and a Medicaid expert, many other factors could potentially affect provider availability and beneficiary access, making it difficult or impossible to pinpoint if a decline in provider availability or beneficiary utilization of services was the result of the third-party liability changes or something else—such as changes in the managed care market or levels of private coverage among beneficiaries.

We found other evidence suggesting that it might be challenging for some states to assess the effects of the third-party liability changes. Specifically, Medicaid officials from eight of the nine selected states did not readily identify the number of beneficiaries in their state that had third-party liability and would be affected by the changes. Moreover, officials from two states noted that obtaining this data would require a "significant" effort.

- Officials from five states shared information on the number of children, pregnant women, or births covered by Medicaid in their state, but did not specify how many of these beneficiaries had other insurance coverage.
- Seven of the nine selected states had no data readily available on CSE beneficiaries who were also covered by Medicaid. In several cases, officials noted that their MMIS or other data systems had no way to track whether a child was a CSE beneficiary.

Conclusions

Omissions and inaccuracies in CMS's guidance to states on third-party liability changes from the Bipartisan Budget Act of 2018 have the potential to adversely affect the extent to which Medicaid expenditures are being used to pay for services for which a third party is liable, as well as states' compliance with federal requirements. Furthermore, CMS has not assessed whether state Medicaid agencies are complying with federal third-party liability requirements, under which states must change how they pay claims for certain services as a result of the Bipartisan Budget Act of 2018 and subsequently enacted legislation. In the absence of CMS overseeing states' compliance, the agency cannot ensure that federal funds are being spent properly and that states are complying with current federal statute.

Recommendations

We are making the following two recommendations to CMS:

- The Administrator of CMS should ensure the agency's Medicaid third-party liability guidance is consistent with federal law related to
  - the requirement for states to apply cost avoidance procedures to claims for labor, delivery, and postpartum care services,
  - the requirement for states to make payments without regard to potential third-party liability for pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days, and
  - state flexibility to make payments without regard to potential third-party liability for pediatric services provided to child support enforcement beneficiaries. (Recommendation 1)
- The Administrator of CMS should determine the extent to which state Medicaid programs are meeting federal third-party liability requirements and take actions to ensure compliance as appropriate. Such actions can include ensuring that state plans reflect the law. (Recommendation 2)

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for comment. In its written comments, which are reprinted in appendix I, HHS concurred with our recommendations and indicated a commitment to providing states with accurate guidance on the third-party liability changes in the Bipartisan Budget Act of 2018. The agency noted that it is in the process of updating its guidance and third-party liability handbook to reflect the changes and ensure that such guidance is

consistent with federal law. The agency also noted that it will determine the extent to which state Medicaid programs are meeting federal third-party liability requirements and will take actions to ensure compliance.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. Major contributors to this report are listed in appendix II.

Carolyn L. Yocom
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 3 0 2019

Carolyn Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid Payment: CMS Has Not Overseen States' Implementation of Changes to Third-Party Liability*" (GAO-19-601).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

for

Sarah Arbes
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - MEDICAID PAYMENT: CMS HAS NOT OVERSEEN STATES' IMPLEMENTATION OF CHANGES TO THIRD-PARTY LIABILITY (GAO-19-601)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to working with states to ensure compliance with all Medicaid statutory and regulatory requirements.

Third Party Liability refers to the legal obligation of third parties (for example, certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan.

There are certain circumstances under which a State Medicaid Agency may pay a claim and then seek to recover payment from the liable third party. This is required when there is a risk that if the State Medicaid Agency were to cost avoid claims, or not pay until a liable third party had paid, providers might choose not to participate in the Medicaid program in order to avoid dealing with the administrative burden associated with Medicaid cost-avoidance claims processing requirements. Previously, the law provided third party liability exceptions for prenatal services, pediatric preventive services, and pediatric services for children subject to child support enforcement. These exceptions permitted states to make payments for these services, and if a third party was found to be liable and it was cost-effective to recover payment, seek reimbursement after payment was made.

However, the Bipartisan Budget Act of 2018 included several provisions, which modify third party liability rules related to the special treatment of these services and payment.[1] Specifically, it removed the third party liability exception for prenatal services effective upon enactment. In addition, it amended the third party liability exception for pediatric preventive services and pediatric services of children subject to child support enforcement effective October 1, 2019. States are now generally required to pay and seek reimbursement from a third party after payment is made unless they make a determination relating to cost-effectiveness and access to care, in which case they would delay payments for 90 days before making payment.

HHS is committed to providing accurate guidance to states on the Third Party Liability changes from the Bipartisan Budget Act of 2018 and is in the process of updating its guidance and Third Party Liability Handbook to reflect the changes. HHS will continue to provide technical assistance on third party liability via monthly calls with states and will also monitor states' implementation of the Third Party Liability requirements to ensure compliance.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

GAO's recommendations and HHS' responses are below.

[1] https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892eas2.pdf

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - MEDICAID PAYMENT: CMS HAS NOT OVERSEEN STATES' IMPLEMENTATION OF CHANGES TO THIRD-PARTY LIABILITY (GAO-19-601)

GAO Recommendation 1

The Administrator of CMS should ensure the agency's Medicaid third party liability guidance is consistent with federal law related to the requirement for states to apply cost avoidance procedures to claims for labor, delivery, and postpartum care services, the requirement for states to make payments without regard to potential third party liability for pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days, and state flexibility to make payments without regard to potential third party liability for pediatric services provided to child support enforcement beneficiaries.

HHS Response

HHS concurs with GAO's recommendation. HHS will update the third party liability guidance to be consistent with federal law.

GAO Recommendation 2

The Administrator of CMS should determine the extent to which state Medicaid programs are meeting federal third-party liability requirements and take actions to ensure compliance as appropriate. Such actions can include ensuring that state plans reflect the law.

HHS Response

HHS concurs with GAO's recommendation. HHS will determine the extent to which state Medicaid programs are meeting federal third party liability requirements and take actions to ensure compliance.

Page **2** of **2**

Appendix II: GAO Contacts and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tom Conahan (Assistant Director), Andrea E. Richardson (Analyst-in-Charge), Marybeth Acac, Drew Long, Corinne Quinones, Jennifer Rudisill, and Ethiene Salgado-Rodriguez made key contributions to this report.