MEDICAID
Determining Third Party Liability (TPL)
State Plan Preprint and Supporting Regulations
in 42 CFR 433.138
CMS-R-0107

A. BACKGROUND

Medicaid beneficiaries frequently have third party resources which are legally obligated to pay medical claims before Medicaid pays. Some examples of third party resources are: private or employment-related health insurance, workers compensation, Medicare, medical support from non-custodial parents, and automobile insurance.

Section 42 CFR 433.138 requires State Medicaid agencies to take specific steps to identify third party resources and determine their legal liability to pay for services under the plan. Specifically, State Medicaid agencies are required to:

- obtain third party information for Medicaid applicants during the initial application and redetermination processes;

- conduct, or in some cases attempt to secure agreements to conduct, certain types of data exchanges with specific State agencies, or in some cases alternate sources, to identify legally liable third parties;

- conduct diagnosis and trauma code edits to identify third party resources; and

- follow other specified procedures regarding frequency of conducting the above activities, follow-up, safeguarding information obtained and exchanged, and reporting and reimbursement requirements.

The State plan preprint essentially repeats the requirements in the regulations and is the instrument that is used by States to describe how certain provisions contained in the regulations will be implemented. The preprint also serves as the instrument that revises the State plan. The State plan is a contract between Federal and State governments, in which the State agrees to operate in accordance with guidelines set forth by Federal statute and regulation. The State plan is a written agreement that specifies eligibility criteria for Medicaid and administrative responsibilities of the Medicaid agency. Section 1902(a) of the Social Security Act requires all Medicaid agencies to submit State plans in order to receive Federal matching funds.

B. JUSTIFICATION

1. Need and Legal Basis

In the past, many third party resources had not been diligently pursued by State governments. In an effort to improve program efficiencies and reduce Medicaid expenditures through increased utilization of Third Party Liability (TPL) procedures, it is necessary to collect the information described in 42 CFR 433.138.

The collection of TPL information results in significant program savings to the extent that liable third parties can be identified and payments can be made for services that would otherwise be paid for by the Medicaid program.

The legal authorities which give rise to the information collection requirements are Sections 1902(a)(25), 1903(o) and 1137 of the Social Security Act (the Act), as well as regulations at 42 CFR 433.138

Section 1902(a)(25) of the Act requires that State or local Medicaid agencies take all reasonable measures to ascertain the legal liability of third parties to pay for care and services furnished to Medicaid beneficiaries. States are required to collect sufficient information at the time of Medicaid determination or redetermination to enable the State to pursue claims against third parties. States also are required to seek reimbursement from a third party to the extent that the party is legally liable for the cost of any medical assistance furnished to a beneficiary under the approved State Plan.

Section 1903(o) of the Act prohibits Federal matching of State Medicaid payments if a private insurer would have been liable to pay for the medical care, except that the insurance contract limits or excludes liability when the individual is eligible for Medicaid.

Section 1137 of the Act requires State Medicaid agencies administering certain assistance programs to have in effect an Income and Eligibility Verification System (IEVS) under which certain income and other information would be exchanged and used for the purpose of verifying eligibility and benefits under these programs. We interpret the language of section 1137 of the Act to mean that State Medicaid agencies must use relevant information available under this section to the extent it is useful in the identification and pursuit of legally liable third party payers of medical expenses since this affects the correct amount of payments under Medicaid.

2. Information Users

The State Medicaid agencies are the primary users of the collected data. Whenever States identify third party resources, pertinent information is input into the State's Medicaid Management Information System (MMIS). Whenever claims are processed, the MMIS flags the claims for which there is a third party resource available to make payment. This enables the State to send the claim back to the provider with information advising the provider to bill the third party. The third party information is also used by States to seek reimbursement in situations where Medicaid has paid claims for which a third party is liable.

3. Improved Information Technology

Federal financial participation (FFP) is available to States at 90 percent of expenditures for the design, development, installation or improvement to compensate for necessary changes to upgrade data identification/collection/transmittal systems. FFP is available at 75 percent of expenditures for operation of such a system (automated or manual). For the most part, such systems changes help to facilitate TPL activities and reduce the burden on States.

Generally a new, separate system was not needed to carry out the provisions of the information collection. Rather, State Medicaid agencies carried out the provisions of the information collection within already existing information systems (e.g., MMIS or manual), making modifications only as necessary to meet the new requirements.

4. Duplication Information

There is no duplicate collection of information. However, some States already gathered similar information on available third party resources through a variety of optional methods. Nonetheless, without this collection of information there would be no mandated requirement or methodology for the comprehensive identification and collection of third party information.

5. Small Business

This information collection does not directly impose burden on small businesses but rather, for the most part, on Statewide large scale private insurance operations.

6. Less Frequent Collection

If this information were collected less frequently, it could result in delays in the detection and pursuit of third party resources. It could preclude the effective identification of third party resources resulting in increased Medicaid outlays.

7. Special Circumstances

There are no special circumstances connected with these information collection requirements.

8. Federal Register Notice/Outside Consultation

CMS published a 60-day Federal Register notice on November 14, 2008, attached.

9. Payments or Gifts

There are no payments or gifts associated with these information collection requirements.

10. Confidentiality

These regulations require that State Medicaid agencies safeguard the data received in the exchange against unauthorized disclosure.

11. Sensitive Questions

This collection of information does not ask questions of a sensitive nature. Also, Privacy Act requirements are not applicable since the information will not be retrieved by CMS using unique identifiers.

12. Estimates of Burden and Costs to Respondents

The total burden imposed by the information collection requirement is 510,968 hours. The specific information collection requirements submitted for OMB approval are as follows:

a. **Release of Information** - Section 431.306(h)

This section is included only because of its cross-reference to section 433.138(d)(1) which requires the agencies to execute data exchange agreements. The burden associated with this requirement is captured in section 433.138(d) (1).

b. **Collection of Third Party Information by SSA** - Section 433.138(b) (2)

Some States have an agreement (section 1634 agreement) whereby SSA makes Medicaid eligibility determinations concurrently with supplemental security insurance (SSI) eligibility determinations. There are currently 33 States which have such agreements with SSA.

Section 433.138(b) (2) requires 1634 States to have an agreement to provide for the collection of third party information by SSA during the SSI/Medicaid application and redetermination processes. SSA offices capture third party information for all applicants. In addition to health insurance information, SSA also collects information on potential casualty settlements when applicable. This information is currently recorded on a form SSA-8019 and sent to the State Medicaid agency.

States are required to reimburse SSA for the collection of third party data. SSA has

conducted time measurement studies to determine the average amount of time expended on collecting the data. SSA also tracks the number of 8019s which are filled out and sent to the State. Although SSA collects information for all applicants, the States are only charged for those individuals which are determined to be Medicaid eligibles. Applicants which are denied eligibility are not tracked, therefore, we are not including the burden for those individuals.

SSA tracks the number of "yes" and "no" responses for Medicaid eligibles during initial eligibility determinations and redeterminations. The "yes" responses indicate that the applicant has a third party resource available to them and the "no" indicates that no third party resource exist.

Since CMS is considered to be the "sponsor" of this information collection, the burden associated with SSA collection of third party information from applicants during intake and redetermination is charged to CMS. The burden calculation which follows is based on actual data provided by SSA.

1) Initial Eligibility Determination Burden - Section 433.138(b) (1)

For FY 2008, 460,920 new applicants were determined eligible for Medicaid. Out of the 460,920 new eligibles, there were 38,085 "yes" responses. The amount of time attributed to "yes" responses is 6.18 minutes.

There were 422,835 "no" responses. It takes 2.37 minutes to ask the pertinent questions and determine that no third party resource exists.

"Yes" responses

38,085 x 6.18 minutes = 3,923 hours

"No" responses

422,835 x 2.37 minutes = 16,702 hours

The total hours for collecting TPL information during the initial eligibility determination burden is 20,625 hours.

2) Redetermination Burden - Section 433.138(b) (1)

For FY 2008, there were 841,880 redeterminations, which resulted in continuing eligibility. Out of the 841,880 redeterminations, there were 24,836 "yes" responses. The amount of time attributed to "yes" responses during redetermination is 8.15 minutes.

There were 817,044 "no" responses. It takes 1.78 minutes to ask the pertinent questions and determine that no third party exists.

"Yes" responses
24,836 x 8.15minutes = 3,374 hours

"No" responses

817,044 x 1.78 minutes = 24,239 hours

The total hours for collecting TPL information during the redetermination process is 27,613 hours.

3) Executing the Agreement - Section 433.138(b) (2)

The CMS/State agreements are prepared by CMS with standard language tailored for all section 1634 States. To execute the agreement, a State simply signs the agreement. We consider the signing of the document by State and Federal officials to be essentially a "certification" type activity. The signing of the agreements was completed when SSA began collecting the TPL information. Therefore, there is no additional burden.

The total hours assessed for SSA's collection of third party information is 48,238 hours.

c. **Collection of Third Party Information by Medicaid Agency and/or Any Other State Agency** - Section 433.138(b) (1) and (3)

This section requires the Medicaid agency and/or any other State agency which has responsibility for making Medicaid eligibility determinations to capture third party information (e.g., name of company, policy number) at the time of application and redetermination for all Medicaid beneficiaries.

There are different processes used by States in taking applications and making Medicaid eligibility determinations. Some States utilize title IV-A intake eligibility workers to process applications for all types of State public assistance programs (e.g., Temporary Assistance for Needy Families (TANF), Food Stamps, Child Support and Medicaid). Individuals who are found eligible for TANF are also generally determined to be eligible for Medicaid. In other instances the Medicaid agency itself makes some or all of the eligibility determinations.

For FY 2005 (latest data), there were approximately 20.73 million cases of Medicaid eligibles (cases signify family units) where States attempted to collect third party information. (The 20.73 million excludes the cases where SSA collects the

information.) We are using cases since generally third party information can be obtained for an entire family at the same time through one applicant. Most Medicaid eligibility intake workers collected some type of third party information routinely during the application process prior to the existence of the regulatory requirement. On the whole, however, most States had to ask a few additional questions in order to comply with this requirement.

We estimate that about 13 percent (2.9 million cases) of the applicants have third party resources available and that it takes an average of 3 additional minutes beyond the time previously devoted by the States to gather more comprehensive data during the application process. We estimate that it takes less than 1 additional minute to query and confirm that the remaining 86 percent (17.82 million cases) of the applicants do not have third party resources available.

1) Burden Estimate:

2.9 million (applicants with a third party resource) x 3 minutes = 145,000 hours

17.82 million (applicants without a third party resource) x 1 minute = 297,000 hours

Total burden = 145,000 + 297,000 = 442,000 hours

2) Executing the Agreement - Section 433.138(b)(3)

The burden associated with modifying the State agreement was minimal. All that was required to amend the agreement was for title IV-A agencies to include stock language to expand their responsibilities to include collection of third party information. This activity was completed at the time the data collection went into effect. Therefore, there is no additional burden.

Total burden for collection of TPL information by Medicaid and/or other State agencies is 442,000 hours.

d. **Information on Custodial/Noncustodial Parents** - Section 433.138(c)

State title IV-A and IV-D agencies are required to provide the names and SSNs of custodial/noncustodial parents to Medicaid State agencies for inclusion into the eligibility case file whenever this information is available. This is not a CMS requirement but rather a requirement imposed by the Office of Child Support Enforcement as set forth in 45 CFR 303.30.

1) Burden Estimate:

We estimate that the names and SSNs of noncustodial parents will be available for about 6 percent of the 20.73 million cases or 1,243,800 cases. The burden is computed as follows:

We estimate that it takes approximately one minute to enter the name and SSN for each case with a non-custodial parent.

1,243,800 cases with noncustodial parents divided by 60 cases per hour = 20,730 hours

Total burden for collection of custodial/noncustodial parents is 20,730 hours.

e. **Data Exchanges and Agreements** - Section 433.138(d)

This section requires the State Medicaid agency to conduct data exchanges with (1) State wage information collection agencies (SWICA), (2) SSA wage and earnings files, (3) State workers' compensation or industrial accident commission files, and (4) State motor vehicle accident report files.

In the case of SWICA and the SSA wage and earnings files, the agency may use an alternate source of obtaining this data, if it can demonstrate that the information obtained from the alternate source will be timely and complete. In the case of the Workers' Compensation Commission and the State Motor Vehicle Administration, the State Medicaid agency is required to attempt to secure an agreement to exchange information.

1) **Data Exchanges with SWICA and SSA Data Exchanges** - Section 433.138(d)(1)

As mentioned in the "Background" section, the primary purpose of conducting these data exchanges is to verify income and eligibility. The regulations governing the matches for Medicaid is found at 42 CFR 935.94 thru 435.964. A separate burden package was completed and approved (see OMB control number 0938-0467,) CMS - R-74, title: Income and Eligibility Verification System. All of the information must be followed up on to determine if there is employment-related insurance in force to cover medical costs. Follow-up generally requires contact with the employer to determine if health insurance is available.

We believe that the above information collection requirement (ICR) is exempt from the Act in accordance with 5 CFR 1320.4(a)(2) since this activity is conducted during an administrative action against specific individuals or entities.

2) **Workers Compensation Commission (WCC) Data Exchange** - Section 433.138(d)(4)(i)

Data is matched to identify Medicaid beneficiaries that have sustained employment-related injuries. The matches may be conducted by the Workers' Compensation commission or the State Medicaid agency. This is generally done by using computer tapes. The information that is used is routine information that is maintained by the State (e.g., name, SSN).

We estimate 400,000 "hits" resulting from annual WCC matches. The "hits" are screened to determine if the State already has information relating to a workers' compensation injury or illness in the file. These types of cases are often discovered through the trauma code editing activity.

In addition, States use various thresholds in determining when it is cost effective to pursue claims for potential TPL. Most States do not followup on small dollar claims. Follow up based on a match involving a Medicaid beneficiary may

involve contacting the workers' compensation agency.

We believe that the above information collection requirement (ICR) is exempt from the Act in accordance with 5 CFR 1320.4(a)(2) since this activity is conducted during and administrative action against specific individuals or entities.

3) Motor Vehicle Administration (MVA) Data Exchange - Section 433.138(d)(4)(ii)

MVA conducts data matches with information provided by the State Medicaid agency (name, SSN of Medicaid applicants/beneficiaries) with the MVA accident data in order to identify beneficiaries that have sustained injuries resulting from automobile accidents. Any match indicates a potential TPL situation. These matches are usually performed manually.

We estimate a total of 2,700,000 "hits" resulting from annual MVA matches. The "hits" are screened to determine if the State already has information relating to an automobile related injury in the file. These types of cases are often discovered through the trauma code edits.

In addition, States use various thresholds in determining when it is cost effective to pursue claims for potential TPL. Most States do not follow up on small dollar claims. Follow up may include, but is not limited to, obtaining and reviewing police reports and interviewing witnesses to establish legal liability.

We believe that the above information collection requirement (ICR) is exempt from the Act in accordance with 5 CFR 1320.4(a)(2) since this activity is conducted during an administrative action against specific individuals or entities.

4) Execution of Agreements - Section 433.138(d)(4)(i) and (ii)

There was a one-time burden associated with development of State agreements for conducting data matches; therefore, this requirement does not impose any additional burden.

5) Alternative Methods - Section 433.138(d)(2)

There are no States which use alternatives methods to obtain SWICA and SSA data, therefore, we are not accessing any burden for this requirement.

f. **Diagnosis and Trauma Code Edits** - Section 433.138(e)(1)

This section requires the State Medicaid agency to identify paid claims for Medicaid beneficiaries with certain diagnosis codes for processing through the TPL payment procedures. The edits are performed retroactively after a claim has been paid in order for States to identify those claims associated with trauma codes 800 to 999. For any "hits", the State Medicaid TPL unit is to follow up for purposes of identifying liable third parties. Follow up may involve contacting the beneficiary by phone or

questionnaire to determine the nature of the trauma and then follow up with insurance companies, attorneys, witnesses, etc., to establish liability. The burden imposed on the States to identify trauma codes is nominal. Previously existing automated systems with edit programs were used to identify the trauma codes. Any systems changes that were necessary have already been made by States.

We believe that the above information collection requirement (ICR) is exempt from the Act in accordance with 5 CFR 1320.4(a)(2) since this activity is conducted during an administrative action against specific individuals or entities.

g. **Follow up on Information Obtained at Time of Application and Redetermination** - Section 433.138(g)(2)

States must follow up on the information provided by applicants to identify potentially liable third parties and incorporate the information into the eligibility case file and third party data base. Follow up may involve contacting employers, attorneys and/or insurance companies to get additional information. In some cases, follow up may not be necessary since the applicant may supply complete identifying information during the eligibility determination or redetermination processes.

We believe that the above information collection requirement (ICR) is exempt from the Act in accordance with 5 CFR 1320.4(a)(2) since this activity is conducted during an administrative action against specific individuals or entities.

h. **Safeguarding information** - Section 433.138(h)

This section requires the State Medicaid agency to enter into agreements with other agencies in which information will be exchanged for the purpose of safeguarding this information. The content of the agreement is detailed in 42 CFR 433.138(h). We have included burden associated with the development of the agreements under section 433.138(d)(4)(i) and (ii).

i. **Reports** - Section 433.138(j)

This section requires that the agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraph (d)(1) through (d)(4) and paragraph (e) section 433.138, as the Secretary prescribes, for the purpose of determining compliance under section 433.138 and evaluating the effectiveness of third party liability identification system.

We believe that the burden is exempt from the Act in accordance with 5 CFR 1320.4(a)(2) since this activity is conducted during an administrative action against specific individuals or entities.

The total burden for all of the above information collection requirements (ICR's) is 510,968 hours.

The costs of implementation and operation of a revised TPL identification program will vary

from State to State. We recognize that in some States the costs will be high. However, it is these States that we believe will benefit the most from the requirements. The States that already have effective TPL identification and collection procedures will not benefit as much. On the other hand, implementation costs for them will be relatively small.

13. Total Capital Costs as a Result of Data Collection

There are no capital costs.

14. Costs

The total estimated cost is $13,841,745. This is based on 80 percent of a Federal GS-12/1 salary which is $34.54 times the total number of hours.

34.54 x 80% =27.63 x 452,730 =13,841,745.

15. Changes in Burden

There is an increase in burden of 38,709 hours due to the additional increase of Medicaid applicants and recipients.

16. Publication

The results of this information collection will not be published for statistical use.

17. Display of Expiration Date

These ICR do not lend themselves to an expiration date.

18. Exception to Certification Statement

There are no exceptions to the certification statement.

C. Statistical Methods

These ICR's do not employ statistical methods.