Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification

SMDL # 10-011

June 21, 2010

Re: Third Party Liability

Dear State Medicaid Director:

This letter is to provide additional guidance to State Medicaid agencies on the implementation of section 6035 of the Deficit Reduction Act (DRA) of 2005. This legislation provides tools to strengthen States' ability to identify and collect payments from liable third parties. This letter addresses the DRA requirement that the Secretary of Health and Human Services specify a manner in which State Medicaid agencies and health plans may exchange eligibility and coverage data.

Health insurers, including self-insured plans, often contract with other entities (e.g., third party administrators (TPAs) and pharmacy benefit managers (PBMs)), for the purpose of verifying plan eligibility, authorizing benefits, and paying claims. While we recognize that entities such as TPAs and PBMs do not necessarily have ultimate financial liability, to the extent that they are required -- by contract or otherwise -- to pay medical claims, these entities are included in the definition of a health insurer for purposes of complying with the DRA. For purposes of this guidance, we refer to health insurers as 'plans.' When used in the context of verifying eligibility and/or processing claims, the term 'plans' includes entities that are under contract to perform such activities.

This guidance announces recommended transmission formats for sharing eligibility and benefit information between the State, or its agent, and health plans. These recommended formats will serve as a tool to enable States to comply with the DRA data exchange requirements. The transmission formats are:

- Payer Initiated Eligibility/Benefit (PIE) Transaction
- Accredited Standards Committee (ASC) X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Standard Transactions ("270/271 Transactions")

CMS is seeking formal approval for the use of these formats through the Paperwork Reduction Act. In the meanwhile, we strongly recommend that States begin using these formats. One major concern is that plans avoid the need to provide data in a variety of different formats in order to accommodate multiple States' requirements. Use of these formats will help to ensure

standardization among plans, particularly those that operate in multiple States, as well as minimize administrative cost and burden on States and plans.
The enclosed questions and answers explain in more detail the specific DRA changes to the Medicaid statute governing third party liability. These questions and answers also supplement the guidance the Centers for Medicare & Medicaid Services provided in State Medicaid Director Letter #06-026 issued on December 15, 2006, which can be accessed at: http://www.cms.hhs.gov/SMDL/SMD/.

We hope you will find this information helpful. If you have any questions regarding this guidance, please contact Ms. Barbara C. Edwards, Director, Disabled and Elderly Health Programs Group, at 410-786-7089 or by e-mail at Barbara.Edwards@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Enclosure
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Enclosure

Third Party Liability Provisions of the Deficit Reduction Act of 2005
Questions and Answers #14 – 35
(For Qs and As #1 – 13, see SMD letter dated December 15, 2006 at:
http://www.cms.hhs.gov/smdl/downloads/SMD121506QandA.pdf)

Standards for Transmitting Eligibility and Coverage Information

Q14: What Electronic Data Interchange (EDI) transactions are being recommended by the Secretary of Health and Human Services for transmitting plan eligibility and coverage information to State Medicaid agencies?

A14: Section 1902(a)(25)(I)(i) of the Social Security Act directs States to enact laws requiring health insurers to provide the requisite information "in a manner prescribed by the Secretary." CMS collaborated with States and representatives of the health care industry to determine the most efficient way to transmit the required data elements. As a result of this collaboration, CMS is recommending the following transmission formats for exchanging eligibility and benefit information between the State, or its agent, and the health plans or their agent(s) that are under contract to maintain eligibility records and process claims.

- Payer Initiated Eligibility/Benefit (PIE) Transaction
- Accredited Standards Committee (ASC) X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Standard Transaction (herein referred to as a 270/271 Transaction or referenced separately as a 270 inquiry and a 271 response)

In the December 15, 2006, guidance, we referred to the method of transmission as the "eligibility transmission format (ETF)". We have decided not to continue to use this terminology, but instead we will refer to the specific name of the transaction as indicated above.

Q15: What is the PIE Transaction?

A15: The PIE Transaction is a cumulative listing to be used as a one-way transaction to identify plan members' eligibility for health coverage and their associated benefits. The PIE Transaction was developed to transmit benefit and membership information from the plan to the State (or a designated contractor) in one single, unsolicited transaction. It is not necessary for the State to generate an inquiry to obtain a PIE Transaction. The PIE Transaction is not an adopted Health Insurance Portability and Accountability Act (HIPAA) standard. However, it uses some of the same identifiers as the 271 Response Transaction and, therefore, mirrors the format of the 271 standard.

Prior to enactment of the DRA, Medicaid agencies had difficulty obtaining information about eligibility from plans using the 270/271 Transaction because the Medicaid agencies did not have information that plans required for eligibility inquiries. Most plans require plan identifiers (i.e., group or Member ID) be supplied on eligibility inquiries. Medicaid agencies do not often have plan identifiers. The PIE Transaction allows the Medicaid agency to match the plans' subscribers and dependents with their Medicaid database recipients, thereby capturing plan identifiers as well as coverage information. These identifiers can then be used to request subsequent updates and to submit claims when appropriate.

Q16: What is the 270/271 Transaction and how will it be used?

A16: The 270/271 Transaction is an adopted HIPAA standard that was developed by the American National Standards Institute (ANSI) ASC for use in exchanging eligibility information. The 270 is used to transmit Health Care Eligibility Benefit Inquiries from health care providers to health plans, and from one health plan to another. The 271 is a response to the 270 inquiry.

HIPAA mandates use of Version 4010/4010A1 of the 270/271 Transaction for capturing eligibility and coverage information exchanged among plans, as well as between providers and plans. Version 4010A1 represents an addendum to Version 4010. The ASC X12 Version 5010 will replace the 4010/4010A1 version. Covered entities must be in compliance with Version 5010 no later than January 1, 2012. The compliance date for small health plans is January 1, 2013.

In today's environment, Version 4010/4010A1 of the 270/271 Transaction is used among providers and plans for patient eligibility and benefit inquiries. However, much of the potential value of the 270/271 Transaction is not being utilized among plans, partially because the 271 requires only a 'yes' or 'no' response, indicating whether individuals are eligible. Although plans are not restricted from providing additional information, the Version 4010/4010A1 270/271 does not require additional benefit coverage information. Therefore, use of the 270/271 Transaction has produced different levels of information ranging from a 'yes' or 'no' response to a full explanation of coverage. While limited information is permitted under HIPAA, it often necessitates manual follow-up, using the telephone to ascertain more specific eligibility information that is needed to bill appropriately. This results in significant administrative costs to providers and plans.

In the future, because the 270/271 can supplement the PIE Transaction, Medicaid agencies will be able to use the plan identifiers provided by the PIE Transaction when sending a 270 inquiry. This will produce more successful matches and provide States with additional eligibility information. The 271 responses will still vary with respect to the types of information provided. Plans will still have the option of providing additional benefit coverage information. When the Version 5010 of the 270/271 is implemented, coverage information will no longer be optional. It will become required by the standard. The 270 standard queries can be used to support prior approval of services, request updated information prior to submitting claims, or verify non-coverage when a provider reports that a claim has been denied. The combined eligibility and coverage information

derived from the PIE Transaction and the 270/271 Transactions will be used by State Medicaid programs to determine the correct payer sequence and whether a claim submission is appropriate.

Q17: Can States use formats other than the PIE Transaction?

A17: Yes. Although we strongly recommend that States utilize the PIE Transaction, particularly with plans that operate in multiple States, States and plans may implement, or continue to use, alternate "proprietary" formats to share eligibility information.

Q18: Are there guides available to assist in implementing the PIE and the 270/271 Transactions?

A18: Yes. CMS has developed a DRA Companion Guide to assist State Medicaid agencies and plans in implementing the PIE Transaction. This will enable plans to use the same implementation to construct the PIE Transaction for each Medicaid agency. The official version of the DRA Companion Guide can be found at: www.cms.hhs.gov/ThirdPartyLiability/DRA/CompanionGuide. States may download and reproduce the Guide to use as a technical reference for plans. However, the language in the official Guide must not be altered, except to include State-specific information where permitted.

The DRA PIE Transaction Companion Guide is written to support both Version 4010/4010A1 and Version 5010 270/271 standards. The Implementation Guides for the 4010/4010A1 and 5010 are available for a fee from X12 at www.X12.org.

Q19: How were specific data elements determined for inclusion in the PIE transaction?

A19: CMS collaborated with States and industry representatives to determine what information is needed by States as well as the most effective method for transmitting the information. All of the transaction-specific information, including the data elements, can found in the Companion Guide.

In the December 15, 2006, guidance, we indicated that we would identify specific data elements and we would refer to them as the Plan Eligibility Data Elements (PEDE). Subsequently, we identified the elements and have incorporated them into the DRA PIE Companion Guide. We have determined that it is not necessary to make a specific reference to the elements. Rather, it is sufficient to simply refer to the data elements included in the PIE Companion Guide. We will no longer refer to the elements as the PEDE.

Q20: Entities that are responsible for paying pharmacy claims (e.g., pharmacy benefit managers (PBMs)), use standards developed by the National Council of Prescription Drug Programs (NCPDP) which are different from the 270/271 Transaction. How will these entities provide information to States?

A20: States may negotiate with plans to utilize an agreed upon method to acquire updates. Alternatively, PBMs and other payers of pharmacy claims may provide PIE Transactions to States as well as providing subsequent updates.

Entities that have responsibility for paying pharmacy claims generally use the 5.1 Eligibility (E1) Transaction developed by the NCPDP for transmitting eligibility information. As of January 2012, Version D.0 will replace the Version 5.1 Standard. The NCPDP standard is designed as a point of sale transaction and therefore, does not supply historical information or the date range of coverage. Since Medicaid agencies need access to historical information, the E1 Transaction is not sufficient to meet their needs.

Although there is some utilization of the 270/271 Transaction by the pharmacy industry (e.g., e-prescribing programs), it is not widely used by PBMs and other payers of pharmacy claims. In order to minimize financial burden on those payers, States should work with payers to adopt a viable method of acquiring eligibility updates. Examples of other methods could include the use of a proprietary file, through a PC-based transaction or a clearinghouse. Alternatively, payers and States may agree to adopt the 270/271 standard.

A21: How will the passage of the Affordable Care Act impact the 270/271 and the PIE Transactions?

Q21: The Affordable Care Act (ACA) includes a number of changes that will impact health information technology. For instance, the Administrative Simplification provisions of the ACA are designed to accelerate the standardization of transactions. Such standardization could necessitate revisions of existing standards such as the 270/271 Transaction. Since the PIE Transaction is built on the 271 Response Transaction, any forthcoming changes made to the 271 as a result of the ACA may necessitate changes to the PIE Transaction in the future.

Scope and Frequency of Sharing Third Party Eligibility and Coverage Information

Q22: Does a health plan's submission of information from their full eligibility file, for the purpose of matching that information to the Medicaid eligibility file, violate HIPAA privacy rules?

A22: No. The disclosure and use, pursuant to State law, of insurer eligibility files containing private health information (PHI) are permitted under the HIPAA privacy provisions. Background on this issue can be found at: www.cms.hhs.gov/ThirdPartyLiability/DRA/SharingPrivateHealthInformation.

Q23: Should States request information on subscribers and dependents covered in other States?

A23: Yes. There is a significant amount of third party coverage derived from health plans licensed in a different State than where the Medicaid beneficiaries reside. This can happen when policyholders work in one State and live in another State. For example, there may be policyholders who are enrolled in Maryland Medicaid, or have dependents that are enrolled, who work in Delaware, the District of Columbia, Pennsylvania, Virginia, or West Virginia and have coverage through their employer in that State. This points to the need for Medicaid agencies to obtain plan eligibility information from contiguous States in addition to their respective State.

Another primary example is when Medicaid-eligible children are covered through the insurance of non-custodial parents who live in a different State than their child(ren). This would not be limited to contiguous States because non-custodial parents could reside in any State in the country. Depending on the size of a plan's file, it may be beneficial for the State to obtain the plan's entire eligibility file. The specific geographical areas to be included in the data exchange should be negotiated with the plans. We recommend use of a Trading Partner Agreement in the exchange of electronic data.

Q24. How far back can States go in requesting eligibility and coverage information?

A24: The DRA requires States to have laws in effect that require health insurers to honor claims submitted by the Medicaid agency within 3 years of the date of service. Therefore, it is prudent for Medicaid agencies to request up to 3 years' worth of eligibility information in the initial PIE Transaction in order to bill for older claims.

Plans do not always maintain 3 years' worth of eligibility information in their databases. Most plans maintain one to two years' worth of data. As a practical matter, it may be more beneficial for the Medicaid agency to acquire whatever data is readily available, rather than wait for the plan to complete complex development efforts needed to access older data. Where data is available, it should be provided to the State. Medicaid agencies and plans should negotiate the most feasible approach.

Q25. After States receive an initial PIE Transaction from a plan, should subsequent PIE Transactions include only updates since the previous PIE, or should it be a full file replacement?

A25. States may require plans to provide a full file replacement or States may opt to receive updates only. The amount of file information should be negotiated between the States and the plans.

Q26: How often should a third party provide eligibility information to the State?

A26: In accordance with section 1902(a)(25) of the Act, States are required to take all reasonable measures to ascertain the legal liability of third parties. It would be reasonable for States to require health plans to share a complete record of eligibility and coverage information annually, at a minimum. States may opt to require plans to share information on a more frequent basis.

Administrative Issues

Q27: Are the DRA third party liability requirements applicable to the territories?

A27: Yes. In addition to the 50 States and the District of Columbia, the DRA also applies to Puerto Rico, the Virgin Islands, and Guam. The other two territories, American Samoa and the Northern Marianas, have received a waiver of the DRA third party liability provisions.

Q28: Are third parties allowed to charge transaction fees for electronically transmitting eligibility and coverage information?

A28: The 270/271 Transaction is a HIPAA standard and covered entities must comply with 45 CFR 162.925(a)(5). This provision requires that "a health plan that operates as a health care clearinghouse or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction, may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits or receives a standard transaction to or from a health plan."

There is no Federal law that would prohibit a third party from charging a fee for transmitting the PIE Transaction. States may have laws in effect that prohibit or limit the charging of fees to Medicaid.

Q29: Is enhanced funding available for States to upgrade their Medicaid Management Information Systems (MMIS)?

A29: Yes. States that upgrade their MMIS to accommodate the PIE Transaction will be eligible to receive enhanced Federal funding at the 90 percent match rate under an approved Advance Planning Document.

Clarifying Claims Processing Requirements

Q30: Does the 3-year claim filing period apply to Medicare?

A30: State law requiring plans to honor claims submitted within 3 years from the date on which the item or service was furnished would apply to Medicare Part C and D plans.

The State law would not apply to the traditional Medicare fee-for-service program, Medicare fiscal intermediaries and carriers, or other Medicare contractors.

Q31: Are States precluded from having laws that require third parties to accept claims beyond the 3-year filing period prescribed in the DRA?

A31: No. Section 1902(a)(25)(I)(iv) of the Act requires States to pass laws that would require health insurers to accept claims submitted by the State within the 3-year period beginning with the date on which the item or service was furnished. States are not precluded from having laws or regulations that would require insurers to accept claims for a period of time longer than 3 years.

Q32: In cases where a Medicaid individual fails to obtain a plan's required authorization prior to receiving a service for which Medicaid subsequently pays, are health plans that are regulated by the Employee Retirement Income and Security Act (ERISA) permitted to preempt Medicaid's claim for reimbursement solely on the basis that the individual failed to receive prior authorization?

A32: No. The plan is to determine if the claim would have met their authorization standards and consider the claim for Medicaid reimbursement accordingly.

On March 21, 2008, the Department of Labor (DOL) issued Advisory Opinion 2008-03A addressing the applicability of prior authorization in regard to Medicaid claims. DOL stated that "it is the Department's view that ERISA would not preempt a State cause of action to recoup Medicaid payments made for covered expenses to the extent that the private plan would have been liable for those expenses if the participant had followed the appropriate prior authorization procedures under the plan before the State made the payment for the items or services." The Advisory Opinion can be found at: http://www.dol.gov/ebsa/regs/AOs/main.html#2008.

Q33: Are plans permitted to require a National Provider Identifier (NPI) for transactions with Medicaid programs?

A33: No. States typically do not meet the definition of a covered health care provider, and therefore, are not eligible to receive an NPI. If States encounter situations where plans are requiring them to submit an NPI, they can submit a formal complaint to the Office of E-Health Standards and Services (OESS) in CMS by using the online Administrative Simplification Enforcement Tool (ASET). ASET allows individuals or organizations to electronically file a complaint against an entity whose actions they believe violate an Administrative Simplification provision of HIPAA.

States may submit a formal complaint electronically at: https://htct.hhs.gov/aset/. ASET users are required to register with OESS and create a user identification name and password. States also may submit a paper complaint. The form is available at: www.cms.hhs.gov/Enforcement/Downloads/HIPAANon-PrivacyComplaintForm.pdf.

Other Clarifications of the DRA Provisions

Q34: When are the provisions of section 6035 of the DRA effective?

A34: These provisions were effective on January 1, 2006. In Question 10 of the December 15, 2006, SMD letter, we noted that a technical error had been made in the law which cited a specific section in reference to the effective date that was non-existent. On December 20, 2006, the President signed into law the Tax Relief and Health Care Act of 2006 which included a correction to the technical error.

We are also correcting another error made in the December 15, 2006, letter. We indicated that States that need to amend their legislation to comply with the DRA provisions are given until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins "after the January 1, 2006, effective date." This should have read, "after February 8, 2006, the date of enactment."

Q35: How long should third parties be given to come into compliance with the DRA requirements?

A35: Federal law does not address how long States should allow for third parties to upgrade their systems in order to provide the State with eligibility and coverage data; therefore, it should be determined by the States. Based on discussions with industry leaders, it would not be unreasonable to allow 12 to 18 months for a plan to implement the PIE Transaction once an agreement has been negotiated with the State.