DOCUMENTATION OF CITIZENSHIP

Section 6036 of the DRA requires States to obtain satisfactory documentary evidence of an applicant's or recipient's citizenship and identity in order to receive Federal Financial Participation (FFP). Effective July 1, 2006, individuals must provide satisfactory documentary evidence of citizenship and identity when initially applying for Medicaid or upon a recipient's first Medicaid re-determination. The statute and interim final regulation provide States with guidance on acceptable documentary evidence, including alternative forms not explicitly named in statute. The statute and regulation also give States guidance on the processes that may be used to minimize the administrative burden on States, applicants, and recipients. CMS encourages States to utilize automated matching systems to verify citizenship and identity in order to satisfy these requirements.

CONSUMER DIRECTED HEALTHCARE

Health Opportunity Accounts

Section 6082 of the DRA allows for ten States to operate Medicaid demonstration programs to test alternative systems to deliver Medicaid benefits through a Health Opportunity Account (HOA) in combination with a high deductible health plan (HDHP). The demonstrations will provide States with the option of allowing individuals to assume greater responsibility for their own care by enrolling in flexible consumer-based accounts. Recipients are given the tools to take a greater role and responsibility in their health care. States can adjust contributions to the accounts based on the expected health needs of recipients, to ensure that the HOA program works well both for healthier recipients and those with chronic illnesses.

PURSUING PAYMENTS FROM THIRD PARTIES

Federal law generally requires health insurers and other third parties with payment liability for health care services received by Medicaid recipients to pay for such services primary to Medicaid. However, Medicaid agencies often pay claims for which a third party may be liable because they lack information about the existence of other coverage. Section 6035 of the DRA made several changes to the third party liability provisions of the Medicaid statute which are designed to enhance States' ability to identify, and to recover payment from, third parties that are legally required to pay primary to Medicaid. Specifically, section 6035 of the DRA (1) clarified the specific entities that are considered "third parties" and "health insurers" that may be liable for payment and cannot discriminate against individuals on the basis of Medicaid eligibility; and (2) required that States pass laws requiring health insurers (a) to provide the state with eligibility and coverage information needed by the State to identify potentially liable third parties; (b) to honor the assignment to the state of the Medicaid recipient's right to payment by such insurers for health care items or services; and (c) not to deny such assignment or refuse to pay claims by Medicaid based on procedural reasons. The third party liability provisions of the DRA were effective January 1, 2006, except where States are required to pass laws in order to comply with the DRA. Some States may already have the requisite laws. As a practical matter, legislatures in States without the necessary laws should pass legislation during the current or next legislative session.

The Deficit Reduction Act is not a government mandate for States to change their Medicaid programs

S.1932

Deficit Reduction Act of 2005 (Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 6035. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.

(a) CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE- Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (A), in the matter preceding clause (i)--

(A) by inserting `, self-insured plans' after `health insurers'; and

(B) by striking `and health maintenance organizations' and inserting `managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'; and

(2) in subparagraph (G)--

(A) by inserting `a self-insured plan,' after `1974,'; and

(B) by striking `and a health maintenance organization' and inserting `a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'.

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA- Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (G), by striking `and' at the end;

(2) in subparagraph (H), by adding `and' after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

`(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

`(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

`(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

`(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

`(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

`(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

`(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;'.

(c) EFFECTIVE DATE- Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

Guidance on Implementing the DRA
Third Party Liability Provisions

Questions and Answers (Qs & As)

Clarifying Entities Considered to be "Third Parties" and "Health Insurers"

Q1: What changes did the Deficit Reduction Act of 2005 (DRA) make to the definition of "third parties"?

A1: The DRA did not change the definition of "third parties," but rather *clarified* the entities subject to the provisions of section 1902(a)(25)(A) and (G) of the Social Security Act (the Act). Specifically, subsection 1902(a)(25)(A) already required States to take all reasonable measures to ascertain the legal liability of "third parties" for health care items and services provided to Medicaid recipients. Section 6035(a) of the DRA amended section 1902(a)(25)(A) of the Act to clarify that the "third parties" subject to the provisions of 1902(a)(25) include: (1) self-insured plans, (2) pharmacy benefits managers (PBMs), and (3) "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." The DRA also replaced reference to "a health maintenance organization" with "a managed care organization" in identifying the types of third parties to which the provisions of section 1902(a)(25) apply.

Subsection 1902(a)(25)(G) already prohibits health insurers from taking an individual's Medicaid status into account in enrollment or payment decisions. Section 6035(a) of the DRA also amended section 1902(a)(25)(G) to clarify that such health insurers include self-insured plans, managed care organizations, PBMs, and "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service."

We interpret "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim" to include such entities as third party administrators (TPAs), fiscal intermediaries, and managed care contractors, which administer benefits on behalf of the risk-bearing plan sponsor (e.g., an employer with a self-insured health plan). While we recognize that entities such as PBMs and TPAs do not necessarily have ultimate financial liability, to the extent that they are required, by contract or otherwise, to review claims and authorize payment by the plan sponsor, they are included within the definition of "third party" and "health insurer" for purposes of section 1902(a)(25) of the Act.

Nothing in section 1902(a)(25) imposes new liability to pay claims on entities that do not otherwise bear such liability. Nor does section 1902(a)(25) negate any right of indemnification against a plan sponsor or other entity with ultimate liability for health care claims by a contracting party that pays the claims.

Requiring Third Parties to Provide the State with Eligibility, Coverage and Claims Data

Q2: What new requirements does the DRA impose on health insurers to share eligibility information with State Medicaid agencies?

A2: Section 6035(b) of the DRA created a new subparagraph (I) in section 1902(a)(25) of the Act, which requires health insurers (broadly defined: see Question 5) to provide States with eligibility and coverage information that will enable State Medicaid agencies to determine the existence of third party coverage for Medicaid recipients. Section 1902(a)(25)(I) does not directly mandate that health insurers provide States with the necessary information. Rather, section 1902(a)(25)(I)(i) directs States, as a condition of receiving Federal financial participation (FFP), to have laws in effect that, in turn, require health insurers doing business in their State to provide the State with the requisite information.

Q3: What information are health insurers required to share?

A3: The laws which States are required to have in order to comply with section 1902(a)(25)(I)(i) must require health insurers (broadly defined: see Question 5) to provide, upon the request of the State, information to determine during what period Medicaid recipients may be (or may have been) covered by the health insurer and the nature of the coverage that is or was provided (including the name, address, and identifying number of the plan) "in a manner prescribed by the Secretary [of the Department of Health and Human Services]." The Centers for Medicare & Medicaid Services (CMS) has been working with States and industry representatives to determine precise data elements needed by States to effectively implement the requirements of the new law. The data elements, hereafter referred to as the "Plan Eligibility Data Elements (PEDE)," will be announced at a future date.

In the case of health insurers who contract with a PBM or other TPA to administer the plan, States also will need to require that such insurers provide the PBM or TPA with such information as may be necessary to enable that entity to furnish the State with the prescribed data.

Q4: How will health insurers provide the prescribed information?

A4: As noted above, section 1902(a)(25)(I)(i) directs States to pass laws requiring health insurers to provide the requisite information (i.e., the prescribed data elements discussed in question 3) "in a manner prescribed by the Secretary." CMS is also working with States and health insurers to determine the most efficacious manner for insurers to provide States with the specified data elements. CMS will announce the method of transmission, herein referred to as "eligibility transmission format (ETF)" along with the PEDE at a future date.

Some States have existing arrangements to acquire eligibility and coverage information with regard to third party coverage. Such matches generally prove to be highly productive in reducing State expenditures. CMS will permit States and plans to adopt, or continue to use, proprietary formats to share eligibility information provided that both parties agree to its use. In the event that either party decides to discontinue use of a proprietary format, the prescribed ETF must be used to exchange eligibility and coverage data.

Q5: What entities are included within the scope of "health insurers," and are therefore required to provide States with the prescribed eligibility and coverage information?

A5: Section 1902(a)(25)(I) defines "health insurers" to include self-insured plans, group health plans (as defined in section 607(l) of the Employee Retirement Income Security Act of 1974 (ERISA)), managed care organizations, PBMs, and "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." Workers' compensation, automobile insurance, and liability insurance plans all are included within the definition of "health insurers" for purposes of this section and the requisite State laws which must be enacted pursuant to it. Sections 1856(b)(3) and 1860D-12(g) of the Social Security Act provide for broad Federal preemption of State law in the operation of Medicare Parts C and D plans; however, we do not believe such preemption would apply in the case of State laws enacted specifically to carry out section 6035(b) of the DRA. Laws enacted pursuant to section 6035(b) would not affect the traditional Medicare fee-for-service program, Medicare fiscal intermediaries and carriers, or other Medicare contractors. Question 13 discusses the applicability of the DRA provisions to health insurers governed by ERISA.

Q6: How may States use the data obtained from the third party insurers?

A6: States would use the data obtained pursuant to the process established under section 1902(a)(25)(I) to properly coordinate payments for services covered under the State plan; to ensure that correct payment amounts under the Medicaid program are made; and to recover mistaken payments that may have been made. The data may be released to entities under contract with a State agency only for use in claims adjudication activities, or for the purpose of recovering erroneous Medicaid payments made. States must have procedures in place to ensure that the privacy of individuals is appropriately protected, and that information concerning applicants and recipients is protected in accordance with the requirements of 42 CFR Part 431 Subpart F and the Rules promulgated under sections 262 and 264(c) of the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160 and 164) relating to the privacy and security of individually identifiable health information, as applicable.

Requiring Third Parties to Honor the State's Assignment of Rights and to Reimburse Medicaid Appropriately for Claims Paid by Medicaid

Q7: Did the DRA clarify the responsibility of liable third parties in any other ways?

A7: Yes. Under section1902(a)(25)(H) of the Act, before passage of the DRA, States were required to have laws in effect that to the extent Medicaid payment was made, the State was considered to have acquired the rights of the Medicaid recipient to reimbursement by any other party that was liable for payment. However, payers sometimes deny Medicaid claims based on procedural requirements (e.g., on the grounds that the plan provides benefits only if the plan's card was used for billing at the "point of sale" (POS) or only if the claim is filed using a particular claim format). New section 1902(a)(25)(I) of the Act, added by the DRA, strengthens the statute by requiring States to enact laws that require health insurers (broadly defined: see Question 5):

- To accept the State's right of recovery and the assignment to the State of the right of a Medicaid recipient or other entity to payment from such party for an item or service for which Medicaid has made payment; and
- To process and, if appropriate, pay the claim for reimbursement from Medicaid to the same extent that the plan would have been liable had it been properly billed at the POS.

  Specifically, the State should pass laws which require an insurer to agree not to deny claims submitted by the State on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation of coverage at the POS that is the basis of the claim.

Note that nothing in the DRA negates the State's responsibility to provide proper documentation when submitting claims to the health insurer so that the insurer can determine that a covered service for which the insurer is liable was provided.

Again, the new section 1902(a)(25)(I) does not directly mandate that health insurers comply with the above requirements. Rather, section 1902(a)(25)(I) requires States to have laws in effect mandating such compliance. Question 5 discusses which entities are included within the scope of "health insurers" for purposes of section 1902(a)(25)(I).

Q8: How long do States have to submit a claim for reimbursement to health insurers?

A8: Some health insurers currently deny claims submitted by Medicaid if they are not filed within a prescribed time limit, which is applied to plan beneficiaries and providers (e.g., a plan might require beneficiaries and providers to submit claims within 30 days from date of service). If the State Medicaid agency is unable to ascertain the existence of the third party coverage and submit a claim within the time limit, the insurer may attempt to avoid liability. In adding section 1902(a)(25)(I) to the Act, the DRA strengthens States'

ability to obtain payments from health insurers by requiring States to have laws in effect that require health insurers to make payment as long as the claim is submitted by the State within 3 years from the date on which the item or service was furnished. Any action by the State to enforce its rights with respect to such claim must be commenced within 6 years of the State's submission of such claim. Health insurers also must respond to any inquiry by a State regarding claims submitted within 3 years from the date on which the item or service was furnished. Question 5 discusses which entities are included within the scope of "health insurers" for purposes of section 1902(a)(25)(I).

Q9: Did the DRA give States the right to require plans to reimburse them for items and services for which the insured would not be entitled to payment from the plan?

A9: No. The State, for example, cannot compel the plan to reimburse it for items or services which are not covered under the plan, and the amount due as reimbursement to the State is limited to what the plan would have paid if it had been a timely request for payment. The assignment of a recipient's right to third party coverage to the State occurs at the time the recipient requests an item or service. Thus, the DRA prevents third parties from using procedural barriers to defeat a State's assignment of rights. Whether a plan provision affecting payment for an item or service is solely procedural in nature or whether it defines or limits the covered benefits must be determined on a case-by-case basis.

Effective Date

Q10: When are the provisions of section 6035 of the DRA effective?

A10: The provisions of section 6035 of the DRA were effective January 1, 2006, except where States are required to pass laws in order to comply with the DRA.

A technical error was made in section 6035(c) of the DRA which states that "except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006." Section 6035(e) is nonexistent. During the legislative drafting process, the TPL provisions had been cited as section 6036 with a cross-reference to section 6035(e) which would have given States until the end of their next regularly scheduled legislative session to pass the required laws. When the TPL section was re-numbered as section 6035, the cross-reference should have been changed. The reference was clearly intended to be section 6034(e).

Therefore, 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. In the case of a State that has a 2-year legislative session, each year of the session would be deemed to be a separate regular session of the State legislature. Enactment of these laws is a State plan requirement.

Implementation Requirements for States

Q11: When are States required to have enacted the legislation required under section 6035 of the DRA?

A11: As noted above, section 6035 of the DRA requires that States have laws imposing specific requirements on third parties. Some States already may have the laws required under section 6035 of the DRA. Due to a drafting error, however, other States appear to have been given no time to enact the legislation required by the DRA, which became effective January 1, 2006; this interpretation is not correct, as is discussed in Question 10. As a practical matter, legislatures in States without the necessary laws should pass legislation during the current or next legislative session.

Q12: Are States required to amend their State plans?

A12: Yes. States must submit a State plan amendment (SPA) providing assurances that the laws required by section 6035 of the DRA are in effect in the State. States that already have the requisite laws should submit a SPA as soon as practicable. States that do not currently have the laws mandated by the DRA should submit a SPA as soon as the legislation is enacted.

Applicability of the DRA Amendments to Plans Regulated by ERISA

Q13: The DRA directs States to pass laws requiring health insurers to comply with its terms. Does the DRA and/or the State laws required by the DRA apply to health insurers regulated by ERISA?

A13: Yes. There are four distinct requirements which the DRA both expressly authorizes and directs States to impose on health insurers. Health insurers must:

(1) Share prescribed eligibility and coverage information with State Medicaid agencies, as discussed in questions 2-4;

(2) Accept the State's right of recovery and the assignment of the individual's right to recovery from the plan for items or services paid for by Medicaid, as discussed in question 7;

(3) Not deny a claim submitted by a State on procedural grounds, as discussed in question 7; and

(4) Make payment to the State Medicaid agency as long as a claim is submitted by the State within 3 years from the date on which the item or service was furnished and any action by the State to enforce its rights with respect to a claim is commenced within 6 years of the State's submission of the claim, as discussed in question 8.

States generally cannot regulate employer-sponsored group health plans governed by ERISA, and the DRA does not include provisions addressing whether ERISA-covered plans must comply with the above requirements. The Department of Labor (DOL), however, which is the Federal agency charged with administering and enforcing ERISA, has issued an advisory opinion regarding the effect of ERISA on State laws similar to most of the above requirements (Adv. Op. 2005-05A, March 23, 2005).

In the advisory opinion, a copy of which is enclosed, DOL concludes that "State law (including case law) that holds a plan liable for the reimbursement of the State under such circumstances would not be preempted by ERISA, notwithstanding the plan's procedural requirements governing participant benefit claims, including filing time limits." Moreover, DOL concludes that "ERISA does not preempt a State action for reimbursement against a plan that provides benefits only at the POS and does not recognize subsequent claims for reimbursement from plan participants. A plan that makes no provision for reimbursing a State Medicaid agency for items or services covered by the plan would not be in compliance with ERISA section 609(b)(3)."

The advisory opinion does not address whether States can require ERISA-covered health plans to share eligibility and coverage information with State Medicaid agencies. We have consulted with the Department of Labor, which has informed us that, in its view, the explicit statutory reference to group health plans in section 1902(1)(25)(j) of the Act, taken together with the requirements of ERISA section 514(d), that ERISA not be construed to impair other Federal laws, indicate Congressional intent that States have authority to require in a manner prescribed by CMS information needed to effectively implement the requirements of the law. As noted above in Question 3, CMS has been working with States and industry representatives to determine precise data elements needed by States and will be announcing "Plan Eligibility Data Elements (PEDE)" at a future date.