Champion Healthy Kids Act
Sec. 401 Medicaid Third Party Liability Offsets

Medicaid Pays Last

By law, Medicaid is required to be the payer of last resort. Meaning, if a Medicaid member has other insurance coverage, such as employer-sponsored coverage, Medicare, Tricare, and/or casualty insurance, that liable party must pay to the extent of its legal liability before Medicaid pays the claim(s).

Nationally, on average, over 10% of Medicaid members have other insurance coverage. Ensuring that Medicaid is the payer of last resort is known as Medicaid Third Party Liability (TPL) or Medicaid Coordination of Benefits (COB).

According to a 2013 Health and Human Services Office of Inspector General (HHS OIG) report, *Medicaid Third Party Liability Savings Increased, but Challenges Remain*, states achieved a record $527 billion in Medicaid TPL savings and recoveries during the study period of 2001-2011. However, the study also noted that $4 billion was at risk.

Sec. 401 of *Champion Healthy Kids Act* seeks to capture those at-risk dollars, improve savings and recoveries resulting from TPL, better ensure Medicaid pays last, and drive long-term sustainability for the Children's Health Insurance Program (CHIP) and Medicaid.

Key Provisions

- Delays from Oct. 1, 2017 until Oct. 1, 2019 changes to the Medicaid lien statute that would expand Medicaid's ability to place a lien against a member's settlement in a liability case
- Expands the definitions of health insurer and responsible third parties to capture accountable care organizations and fully-insured plans
- Eliminates the exclusion of cost avoidance for children that receive Early and Periodic Screening, Diagnostic Treatment (EPSDT) and for services provided to children on child support
- Ensures that Medicaid Managed Care Organizations (MCOs) have the same access to eligibility data, and is afforded the same claims processing and payment standards by responsible third parties as enjoyed by State Medicaid programs
- Prohibits responsible third parties from denying Medicaid TPL claims due to a member's failure to receive prior authorization from that responsible third party
- Imposes a 60-day prompt payment standard for responsible third parties
- Imposes noncompliance penalties on States who fail to comply—.1% FMAP withhold
- Requires responsible third parties to pay a claim regardless of where the Medicaid services was consumed or the responsible third party is domiciled
- Seeks to standardize Medicaid third party liability savings and recoveries reporting via the CMS 64 form, T-MSIS or other data reporting tool
- Extends payer of last resort principles to the Children's Health Insurance Program (CHIP)

Medicaid Lien Changes

Congress negated the U.S. Supreme Court's decisions in Arkansas *Department of Health and Human Services v. Ahlborn* and *Wos vs. E.M.A.* via the 2013 Bipartisan Budget Act by giving Medicaid programs the same lien authorities provided to Medicare—the ability to recover Medicaid costs from a beneficiary's entire personal injury settlement or award vs limiting the recovery rights to the portion of the settlement designated for medical care. The effective date of this change has been postponed several times via Congressional action with state implementations well underway given the last known effective date of Sept. 30, 2017.

Champion Healthy Kids Act would postpone the effective date of this Medicaid lien statute to Oct. 1, 2019. At the same time, H.R. 3922 seeks to clarify which claims/cases this new Medicaid lien standard would effect, noting "any open claims, including claims generated or filed after September 30, 2017."

Capturing a Broad Array of Responsible Third Parties

Section 1902(a)(25)(A) of the Social Security Act defines "third party" as health insurers and self-insured plans, group health plans and service benefit plans, managed care organizations, pharmacy benefit managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.

H.R. 3922 seeks to modify the definitions by creating a new definition for "responsible third party" and "health insurer." In one regard the definition of responsible third party is expanded to include rapidly emerging accountable care organizations and fully-insured plans. However, the measure also proposes changes that dramatically narrow the types of payers who would be subjected to Medicaid TPL by excluding workers' compensation, automobile insurance, and other liability policies. Furthermore, the new definition of "responsible third party" seeks to exempt pharmacy benefit managers.

Expanding TPL Prepayment Capabilities

Cost avoidance is the prepayment method Medicaid uses to avoid payment when there are known responsible third parties by returning the claim/s to the provider, who is then directed to bill and collect payment from the known responsible third party.

Federal regulations (42 CFR § 433.139(b)) generally require Medicaid to use cost avoidance when probable TPL is established with the exception of a few services which historically included labor, delivery and post-partum services until passage of the Bipartisan Budget Act of 2013 when states were granted permission to cost avoid those services, too. However, EPSDT and child support cases are precluded from cost avoidance efforts.

As the healthcare industry seeks to move more functions to a prepayment model, TPL has a long, successful history in prepayment through cost avoidance activities for countless Medicaid services and as of 2013, labor, delivery and postpartum services. Cost avoidance is the preferred mechanism to ensure Medicaid pays last because it creates savings (vs recoveries), reduces administrative re-work, ensures the rendering provider is reimbursed at the often more generous commercial rate and avoids crowd out. According to the 2013 OIG report, *Medicaid*

Third Party Liability Savings Increased, but Challenges Remain, most of the growth in TPL savings during the report period of 2001-2011 were the result of cost avoidance, totaling $512 billion.

Empowering Medicaid MCOs

Medicaid MCOs provide care to over 70% of Medicaid members nationally. In 2012, CMS clarified on their website the intent of the 2005 Deficit Reduction Act (DRA) relating to its applicability to managed care organizations, noting "when TPL responsibilities are delegated to an MCO, responsible third parties are required to treat the MCO as if it were the State Medicaid agency."

Sec 401 of the *Champion Healthy Kids Act* codifies this existing sub-regulatory guidance and ensures Medicaid pays last as more states turn towards managed care models. Several states have already adopted similar language, including Ohio.

Aligning Medicaid Payment Policies with Commercial Standards

Commercial insurers are held to various state standards dictating the maximum amount of time an insurer may have to process and pay a claim, often referred to as prompt payment standards.

While some states, including Florida, Louisiana, Maine, Michigan, Minnesota, Missouri, North Carolina, Ohio, and Tennessee, have sought to impose Medicaid TPL prompt payment standards on responsible third parties, no such federal requirement exists today. H.R. 3922 imposes a 60-day response requirement—necessitating that within such time the responsible third party must pay, deny, or suspend the Medicaid TPL claim.

Limiting Administrative Denials from Responsible Third Parties

Responsible third parties may deny Medicaid TPL claims for administrative reasons, including denying a Medicaid TPL claim because a Medicaid member or rendering provider failed to seek and receive prior authorization from the responsible third party prior to the receipt of service. Services often subjected to prior authorization are very costly, like imaging services resulting in significant cost shifting to state Medicaid programs.

It is not possible to always know at the point of service whether a member has another type of insurance for numerous reasons, including retroactive eligibility. Therefore, identification of responsible third parties may not occur until after claims payment. Responsible third parties should not be permitted to deny a Medicaid TPL claim solely based on the member or provider's failure to seek and receive prior authorization. If Medicaid deemed the service medically necessary and appropriate, the responsible third party should accept that determination and pay the claim.

Several states have adopted this language, including Colorado, Connecticut, Delaware, Georgia, Indiana, Louisiana, Missouri, and Ohio. *The Champion Healthy Kids Act* is specifically modeled after Georgia's law.

Preparing for Interstate Insurance and Capturing Out-of-State Responsible Third Parties

Often Medicaid members live in one state but work in another, or there are instances of Medicaid children who live in one state and are dually covered by that state's Medicaid program, but also have a custodial parents' out-of-state commercial insurance coverage. In these instances, when Medicaid attempts to bill the out-of-state responsible third party, often their claims are denied because the responsible third party is not licensed or domiciled in the same state as that Medicaid program.

These denials should be prohibited and several states have already done so, including Minnesota, Florida and Tennessee.

Ensuring Transparency and Consistency

Today Medicaid programs report quarterly to CMS their TPL savings and recoveries via CMS 64 form. This ensures transparency and proper return of federal match for dollars recovered from TPL activities. States must report the amounts they avoided paying to third parties and the amounts they recovered from third parties. The form does not include certain types of information. First, regarding pay and chase, CMS does not require States to report the amount of money they attempted to recover or the amount denied by third parties. Second, regarding cost avoidance, States do not report how they calculated cost avoidance. CMS does not have a standard formula for calculating cost avoidance, and States' methods for calculating it vary.

H.R. 3922 would instill consistency across state reporting by creating uniform filing standards, and also promote transparency via CMS 64 form or the T-MSIS.

Instilling Proper Incentives and Disincentives

The Champion Healthy Kids Act seeks to ensure state compliance by withholding up to .1% of the State's Medicaid matching assistance for non-compliance.

Making CHIP A Secondary Payer

According to state audit activity, 3% - 7% of Children's Health Insurance Program (CHIP) recipients have other coverage, but that coverage is not optimized due to a lack of assignment of rights. Today, under the Medicaid mandatory group for poverty-level related children under section 1902(a)(10)(A)(i)(VII), insured children must be covered in addition to uninsured children. This is different from the rules governing a separate CHIP program, which preclude coverage for insured children.

Allowing CHIP eligible children, who otherwise have other insurance, to remain on CHIP encourages the use of other health insurance, promotes continuity of care, and preserves CHIP funds for individuals and services not otherwise covered. Changing eligibility standards to permit children with other health insurance coverage to remain on CHIP also allows states to avoid churn resulting from changes to private coverage (due to parental job changes, or eligibility for private coverage) which can be administratively burdensome and costly. At the same time, children with complex medical needs or inadequate private insurance, but still eligible for CHIP, will benefit from the continuity of care and coverage provided by CHIP. In order for these benefits to be realized, members must assign their rights to the CHIP program, as is done in Medicaid today.