# DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

## FINAL

### ORDER

### DRA 2005 - Third Party Data Exchange

### Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Title XIX Medicaid State Plan to comply with the third party data exchange provision mandated by Section 6035(b) of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171). The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the May 2008 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by May 31, 2008 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

### Summary of Proposed Amendment

The proposed amends the Title XIX Medicaid State Plan to document compliance with Section 6035 of the Deficit Reduction Act of 2005 (DRA). Section 6035 requires States to have laws which mandate that third parties comply with all of the provisions of section 1902(a)(25)(I) of the Social Security Act (the Act).

**Statutory Authority**

- Deficit Reduction Act of 2005 (Public Law 109-171), enacted on February 8, 2006, Section 6035, *Enhancing Third Party Identification and Payment*
- House Bill 101, 144th General Assembly, *An Act to Amend Title 18 of the Delaware Code Relating to the Insurance Code*

**Background**

Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. The Medicaid program by law is intended to be the payer of last resort; that is, 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. Examples of third parties which may be liable to pay for services include private health insurance, Medicare, employment-related health insurance, court-ordered health insurance derived by noncustodial parents, court judgments or settlements from a liability insurer, workers' compensation, first party probate-estate recoveries, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute).

Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid agency. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan. Once States have determined that a potentially liable third party exists, the State is required to either "cost avoid" or "pay and chase" claims. Cost avoidance is where the provider of services bills and collects from liable third parties before sending the claim to Medicaid. Pay and chase is utilized when the State Medicaid agency pays the medical bills and then attempts to recover from liable third parties.

Section **6035(b)** of the Deficit Reduction Act of 2005 (DRA) created a new subsection (I) in section 1902(a)(25) of the Act. Under that new subsection, States are required to have laws that mandate health insurers or other parties that are legally responsible for payment of a claim for a health care item or service to provide the State with

information that enables State Medicaid agencies to determine the existence of third party coverage for Medicaid recipients. States must amend their State plans to include an attestation that the required State law is in place.

The provisions of section 6035 of the DRA were effective January 1, 2006, except where States must pass new laws to comply with the DRA. States that already have the requisite laws should submit an amendment to their State plan as soon as practicable. States that do not currently have the required laws in place should enact the required legislation during their next legislative session and submit a State Plan amendment as soon as the legislation has been enacted.

**Summary of Proposed Amendment**

House Bill (HB) 101 was signed into law by the Governor on February 4, 2008. HB 101 implements the requirement in the DRA mandate that states have laws in place to require that, as a condition of conducting business in the State, all health insurers provide eligibility and coverage information to the State Medicaid Agency, when the State requests such information. This information exchange will guarantee that third party insurance coverage is exhausted before Medicaid pays for a service for Medicaid recipients who also have third party coverage.

The Division of Medicaid and Medical Assistance (DMMA) will amend the Title XIX Medicaid State Plan to provide assurances, satisfactory to the Secretary, that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state:

(1) To provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid;

(2) To accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the state;

(3) To respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided; and,

(4) To agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim.

DMMA will also, amend the state plan regarding the frequency of data exchange for health insurance carriers from "biannually" to "No less than once every two (2) months, unless permission is given in advance by the agency."

**Summary of Comments Received with Agency Response**

The State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows.

As background, the Deficit Reduction Act (DRA) of 2005 requires states to have laws to facilitate Medicaid's role as the payor of last resort. Such laws must include provisions mandating that health insurers and other legally responsible parties provide the State with information to enable the State to determine the existence of third party coverage for Medicaid recipients. In February 2008, the Governor signed H.B. 101 into law. That legislation authorizes DHSS to require health insurers to provide specific information on Medicaid recipients. The information is characterized as "Plan Eligibility Data Elements". The Department can require insurers to provide data electronically in a format specified by DHSS at least every two (2) months. DMMA is now issuing proposed Medicaid Plan amendments certifying compliance with the DRA. SCPD did not identify any concerns with the technical amendment which essentially confirms the adoption of H.B. 101.

***Agency Response:*** Your participation is appreciated. Thank you for your comments.

**Findings of Fact:**

The Department finds that the proposed changes as set forth in the May 2008 *Register of Regulations* should be adopted.

**THEREFORE, IT IS ORDERED**, that the proposed regulation to amend the Title XIX Medicaid State Plan to comply with the third party data exchange provision mandated by Section 6035(b) of the Deficit Reduction Act (DRA) of 2005 is adopted and shall be final effective July 10, 2008.

**DMMA FINAL REGULATIONS #08-24**
**REVISIONS:**



**Revision: HCFA-PM-94-1 (MB)**
**FEBRUARY 1994**

**State/Territory: DELAWARE**

**Citation-**

**4.22 Third Party Liability**

**42 CFR 433.137**

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.

(2) 42 CFR 433.145 through 433.148.

(3) 42 CFR 433.151 through 433.154.

**1902(a)(25)(H) and (I) of the Act.**

(4) Sections 1902(a)(25)(H) and (I).

**Section 6035 of the DRA of 2005**

(5) Section 6035 of the Deficit Reduction Act of 2005

**42 CFR 433.138(f)**

(b) **Attachment 4.22-A**

(1) Specifies the frequency with which data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

**42 CFR 433.138(g)(1)(ii) and (2)(ii)**

(2) Describes the methods and the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

**42 CFR 433.138(g)(3)(i) and (iii)**

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and

**§433.138(g)(4)(i) through (iii)**

(4) Describes the methods the agency uses for following up on paid claims under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identified legally liable third party resources.

***(Break in Continuity of Sections)***

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State/Territory: DELAWARE**

**Requirements for Third Party Liability (TPL) –**
**Identifying Liable Resources**

1. ~~Frequency of TPL Matches~~ Data Exchange Frequency (42 CFR 433.138(f)):
   a. SSA wage – quarterly
   b. IV-A agency – in Delaware is the same as the Title XIX agency and updates are available, daily
   c. State Workmen's Compensation files – weekly
   d. Motor vehicle – not computerized – no match available
   e. SWICA – quarterly
   f. Health Insurance Carriers – ~~biannually~~ no less than once every two (2) months, unless written permission is given in advance by the agency

2. Follow-up requirements of 42 CFR 433.138 (g)(1) (i) and (g) (2) (i):

   As soon as any matches on employers are received by the Delaware Client Information System (DCIS), the system will automatically generate a letter to verify health insurance coverage. This action will be taken within 30 days of the receipt of the match data.

3. State motor vehicle match is unavailable because of the information needed for TPL is not carried in the State's motor vehicle automated system. (42 CFR 433.138(g)(3)

4. Trauma code reports are produced weekly by the fiscal agent. The TPL unit sends an accident inquiry form to the client/provider within two weeks regarding potential TPL. Positive responses result in a request for claims history and subsequent bills generated to applicable insurance company or attorney. Any information on ongoing legally liable third party resources is immediately entered into the third party database, which is part of the Medicaid Management Information System (MMIS). (42 CFR 433.138(g)(4)

***(Break in Continuity of Sections)***

**NEW:**

**SUPPLEMENT TO ATTACHMENT 4.22**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State/Territory: DELAWARE**

**STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE**
**COVERAGE ELIGIBILITY AND CLAIMS DATA**

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(A)(25)(I) of the Social Security Act.