Third Party Liability: Payment of Claims (42 CFR 433.139)

The following is a summary of the public comments we received on our proposal to revise § 433.139.

Comment: One commenter requested that CMS provide guidance to Medicaid MCOs on how they can more reliably and efficiently identify other payers through the state Medicaid agency. The commenter stated this will facilitate implementation of CMS' proposals to require states to reject claims for pregnancy-related services in cases where a third party is legally responsible for payment and to allow states a period of 100 days to pay claims related to medical support enforcement services.

Response: COB/TPL requirements apply in Medicaid MCOs, as well as Medicaid FFS programs. MCOs are required to pay certain types of claims and then seek recovery – "pay and chase"-in the same circumstances as the SMA Medicaid FFS program is required to do so. SMAs have options for ensuring that they meet the COB/TPL requirements in Medicaid MCOs. Regardless of how SMAs choose to allocate responsibility for COB/TPL activities, the contract between the SMA and the MCO must list any COB/TPL responsibilities of the SMA and the MCO must list any COB/TPL responsibilities of the plan see for example, 42 CFR 438.3(t). For more information on general COBs/TPL requirements under managed care, please see our guidance published on Medicaid.gov at https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf.

Comment: One commenter recommended that CMS should ensure that providers bear the responsibility of ensuring all third parties are notified and payments are retrieved citing their belief that the burden should be removed from the state and federal government.

Response: If there is no established liable third party, the state Medicaid agency (SMA) may pay claims to the maximum Medicaid payment amount establish for the service in the state

plan. If the SMA later establishes that a third party was liable for the claims, it must seek to recover the payment. The SMA should first seek recovery from the liable third party. If that is not feasible (for example, Medicare will not accept a claim directly from an SMA), it may be necessary to recoup the payment from the provider and ask the provider to rebill correctly. Section 433.139(d)(2) states that SMAs must seek reimbursement within sixty days from the end of the month in which it learns of the existence of the liable third party.

Comment: One commenter expressed concern that the proposed revisions to § 433.139 will not permit states to elect to cost avoid claims for pediatric services as allowed under the BBA 2018. The commenter stated the BBA allows states to pursue cost avoidance for pediatric services upon determination that cost-effectiveness and access to care "warrants cost avoidance for 90 days." The commenter recommended that CMS revise the proposed provision to allow states to pursue cost avoidance for pediatric care.

Response: The BBA 2018 did not eliminate pay and chase for pediatric preventive services; The BBA 2018 amended the statute to eliminate pay and chase for prenatal services. Therefore, this request is outside of the scope of our regulation change authority under § 433.139(b)(3)(i) and the BBA of 2018 as identified within. For additional guidance on this change in law, please see our guidance published on www.Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111419.pdf and https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf.

Comment: One commenter recommended that CMS provide states with an alternative option to the required cost avoidance determinations of cost-effectiveness and access to care. The commenter stated that current cost avoidance determination process is burdensome for states to perform and recommended that CMS allow an alternative option where state Medicaid agencies may

attest that their program is compliant, has an "exception, grievance, fairing hearing" process, and does not have known access issues for beneficiaries seeking pediatric preventive services.

Response: This request is outside of the scope of our regulation change authority under § 433. 139(b)(3)(i) and the BBA 2018 as identified within.

Comment: One commenter requested clarification from CMS on the application of the 100-day waiting period application to preventive pediatric services. The commenter indicated that the provision's reference to §433.139(b)(3)(ii)(B) appears to apply to child support enforcement services. The commenter requested CMS clarify whether the 100-day waiting period applies to both preventive pediatric services and child support enforcement services as it may impact implementation and cost-effectiveness.

Response: The 100-day waiting period only applies to medical support enforcement and not preventative pediatric services. Preventive pediatric service claims must be “paid and chased” without regard to a liable third party unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Section 53102(b)(2) of the Bipartisan Act of 2018 delayed the implementation date from October 1, 2017 to October 1, 2109 of the BBA 2013 provision, which allowed for payment up to 90 days after a claim is submitted that is associated with medical support enforcement instead of 30 days under previous law. Medical support is a form of child support that is often provided through an absent parents employers health insurance plan. Effective April 18, 2019, section 7 of the MSIAA amended section 202(a)(2) of the BBA 2013 to allow 100 days instead of 90 days to pay claims related to medical support enforcement under section 1902(a)(25)(F)(i) of the Act.

Additionally, effective October 1, 2019, section 53102(a)(1) of the BBA 2018 amended section 1902 (a)(25)(E) of the Act, to require a state to make payments without regard to TPL for

pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Comment: One commenter noted that the provisions as written will not allow a state Medicaid agency to implement a cost avoidance period of less than 90 days. The commenter noted that their state requires a 60-day timeframe after finding that a 90-day period was not cost-effective and that access to care issues may result from provider abrasion. The commenter requested clarification from CMS that state Medicaid agencies may continue to keep a shorter cost avoidance period based on cost-effectiveness and access to care evaluations.

Response: Our November 14, 2019[16] guidance clarified that a state can allow up to 100 days to pay claims related to medical support enforcement. States are permitted the flexibility to pay and chase medical support enforcement claims within that 100-day time period if they have made a determination that the full waiting period creates a cost-effectiveness or access to care issue.

As background, section 53102(b)(2) of the BBA 2018 delays the implementation date from October 1, 2017 to October 1, 2019 of the BBA 2013 provision, which allowed for payment up to 90 days after a claim is submitted that is associated to medical support enforcement instead of 30 days under the previous law. Medical support is a form of child support that is often provided through an absent parents employers health insurance plan.

Effective April 18, 2019, section 7 of the MSIAA amended section 202(a)(2) of the BBA 2013 to allow 100 days instead of 90 days to pay claims related to medical support enforcement pursuant to section 1902(a)(25)(F)(i) of the Act. We are finalizing as proposed.

[16] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111419.pdf.