



Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program
A Guide to Effective State Agency Practices
Issued July 2014

ACKNOWLEDGMENT

CMS wishes to extend its appreciation to the directors and staff members of the state COB/TPL units that shared their effective practices for inclusion in this guide.

CMS also acknowledges the significant support and assistance of the Chairman and State Representatives of the COB/TPL Technical Advisory Group (TAG) in contributing effective practices from their states and soliciting effective practices from other states.

INTRODUCTION

The intent of this Effective Practices Guide is to provide state Medicaid agencies with information on practices that could assist states in improving their identification and successful pursuit of legally liable third party resources. Each practice included in the guide has proven to be effective for the submitting state. State agencies that consider adopting any of these practices should assess whether the practice is transferable to their own state operations. A contact person is listed for each practice and will be available to discuss the practice in greater detail with a state that considers adopting the practice.

The Effective Practices Guide was developed in response to a recommendation by the Office of the Inspector General ((OIG), U.S. Department of Health and Human Services, following on a study of Medicaid COB/TPL savings from 2001 to 2011 (“Medicaid Third-Party Liability Savings Increased, but Challenges Remain”, OEI-05-11-00130, issued January 2013). The study determined trends in Medicaid TPL savings during that period and gathered information from states regarding challenges and issues the states faced in trying to identify third party coverage and recover payments from liable third parties.

The Guide provides an opportunity for peer assistance among the state Medicaid programs through sharing of practices that are in place, and working, in the states in December 2013. The Guide includes effective practices to address some of the challenges and issues identified in the OIG study, and other challenges to maximizing third party savings.

EFFECTIVE STATE PRACTICES, BY TOPIC AND SUBMITTING STATES

1. States’ Interactions with Health Insurers: Iowa, Michigan, Mississippi, New York, Ohio, Texas, Washington
2. Health Insurance Portability and Accountability Act (HIPAA): Iowa
3. States’ Interactions with Pharmacy Benefits Managers (PBMs): Iowa, Minnesota
4. Other Third Party Liability Topics: Oklahoma, Pennsylvania, Washington

Effective practices follow, listed by state.

IOWA

<p>ISSUE: Denials from third parties for procedural reasons Denials from third parties with no explanation Third parties not responding when State submits bills Third parties not abiding by 3-year timely filing rules Third-party documentation submitted with reimbursement does not indicate which claims are being reimbursed Third parties not accepting States' right to collect Pharmacy benefit managers claim they do not have the authority to reimburse States directly Third party concerns about the Health Insurance Portability and Accountability Act of 1996 and releasing insurance coverage information to states Confusing or incomplete Explanation of Benefits forms from third parties Cooperation from pharmacy benefit managers</p>	
<p>IN THE RESPONDING STATE, THIS ISSUE:</p> <p><input checked="" type="checkbox"/> CURRENTLY OCCURS OR HAS OCCURRED: _____ VERY FREQUENTLY <input checked="" type="checkbox"/> OFTEN ENOUGH TO REQUIRE CORRECTION _____ INFREQUENTLY _____ DOESN'T OCCUR OR HASN'T OCCURRED</p>	<p>EFFECT OF THE PRACTICE:</p> <p><input checked="" type="checkbox"/> RESOLVED THE ISSUE FULLY _____ RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) _____ RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS</p>
<p>WHY DOES THIS ISSUE OCCUR?</p> <p>Insurance carriers do not follow the Deficit Reduction Act or Iowa legislation 249A.37.</p>	
<p>SUMMARY OF EFFECTIVE PRACTICE:</p> <p>Some insurance carriers did not effectively adopt and implement the provisions of the Deficit Reduction Act (DRA) of 2005 - indicating that Iowa did not have specific state legislation to support the DRA. In response, Iowa passed specific legislation to support the DRA as it pertains to doing business in Iowa. This legislation is codified in the Code of Iowa at 249A.37. The legislation addresses the following;</p> <p>Service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.</p> <p>The statutory language states:</p> <p>249A.37 HEALTH CARE INFORMATION SHARING.</p> <p>1. As a condition of doing business in the state, health insurers including self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health</p>	

care item or service, shall do all of the following:

a. Provide, with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan, upon the request of the state, information to determine during what period the individual or the individual's spouse or 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 accordance with section 505.25, in a manner prescribed by the department of human services or as agreed upon by the department and the entity specified in this section.

b. 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 medical assistance state plan.

c. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of such health care item or service.

d. Agree not to deny any 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 all of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to such claim is commenced within six years of the date that the claim was submitted by the state.

2. The department of human services may adopt rules pursuant to chapter 17A as necessary to implement this section. Rules governing the exchange of information under this section shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and regulations promulgated in accordance with that Act and published in 45 C.F.R.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

The State of Iowa contracts pay and chase activities to an external vendor. This includes post pay and chase billing follow-up; we call this Local Yield Management.

Iowa has dedicated staff devoted primarily to challenging carriers for what appear to be inappropriate denials and to respond to requests for additional information. We find that one-on-one education and follow-up helps the carrier process claims correctly. More examples of yield management activities

include:

- 1) Follow-up with carriers to get a clear understanding of certain claim denials on the Explanation of Benefits (EOB's).
- 2) Review with carriers the practice of denying claims for procedural reasons.
- 3) Carriers are contacted when no response is received on a reclamation claim.
- 4) If a carrier denies a reclamation claim due to needing additional information from a provider, our Local Yield Management team get the information needed in order for the claim to process.

In State Fiscal Year 2013 Local Yield Management staff was able to recover \$8,905,715.00

Iowa will be tracking the yield management separately from pay and chase recovery work on a going basis to monitor progress in the reduction of improper Medicaid claim denials.

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Sara Schneider

Iowa Department of Human Services

Iowa Medicaid Enterprise(IME)/Bureau of Adult and Children's Medical Programs

Phone: 515-974-3281

E-mail: sschnei@dhs.state.ia.us

MICHIGAN

ISSUE: Lack of enforceable penalties for third parties that refuse to reimburse States	
IN THE RESPONDING STATE, THIS ISSUE: ___ CURRENTLY OCCURS OR HAS OCCURRED: ___ VERY FREQUENTLY ___ OFTEN ENOUGH TO REQUIRE CORRECTION ___ INFREQUENTLY ___x___ DOESN'T OCCUR OR HASN'T OCCURRED	EFFECT OF PROMISING PRACTICE: ___x___ RESOLVED THE ISSUE FULLY ___ RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) ___ RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS
WHY DOES THIS ISSUE OCCUR? Medical third party declines or delays rightful reimbursement for services that were paid by Medicaid but were services in which the medical third party was responsible as the primary payer.	
SUMMARY OF PROMISING PRACTICE: Section 7 of Act 593 allows for a punitive penalty of \$500 for every day the medical third party refuses to fulfill a recovery request from Third Party Liability. The Act gives the medical third party the right to appeal the penalty through the administrative law process in the State. The Third Party Liability Division has the full support from the Office of Legal Affairs, giving the Act the legal support necessary for enforcement. <p style="text-align: center;">SHARING HEALTH CARE INFORMATION ACT</p> Act 593 of 2006 AN ACT to provide for the sharing of certain health care coverage information; to provide for the powers and duties of certain departments and agencies; and to provide penalties and fines. History: 2006, Act 593, Imd. Eff. Jan. 3, 2007 The People of the State of Michigan enact: 550.281 Definitions. Sec. 1. As used in this act: (a) "Department" means the department of community health. (b) "Entity" means a health insurer; a health maintenance organization; a nonprofit health care corporation; a managed care corporation; a preferred provider organization; an organization operating pursuant to the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63; a self-funded health plan; a professional association, trust, pool, union, or fraternal group, offering health coverage; a system of health care delivery and financing operating pursuant to section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573; and a third party administrator.	

(c) "Medical assistance" means the medical assistance program administered by the state under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(d) "Qualified health plan" means that term as defined in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

550.283 Determination that health coverage recipient is also medical assistance recipient; information to be provided by health insurer.

Sec. 3.

(1) An entity shall provide on a monthly basis to the department, in a format determined by the department, information necessary to enable the department or entity to determine whether a health coverage recipient of the entity is also a medical assistance recipient.

(2) If a health coverage recipient of the entity is also a medical assistance recipient, the entity shall do all of the following by not later than 180 days after the department's request:

(a) Pay the department for, or assign to the department any right of recovery owed to the entity for, a covered health claim for which medical assistance payment has been made.

(b) Respond to any inquiry by the department concerning a claim for payment for any health care item or service that is submitted not later than 3 years after the date the health care item or service was provided.

(3) An entity shall not deny a claim submitted by the department 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 time the health care item or service that is the basis of the claim was provided so long as both of the following apply:

(a) The claim is submitted to the entity within 3 years of the date that the health care item or service that is the subject of the claim was provided.

(b) Any action by the state to enforce its rights under this subdivision is commenced within 6 years of the date that the health care item or service that is the subject of the claim was provided.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

550.285 Determination that health coverage recipient is also medical assistance recipient; actions by department.

Sec. 5.

If the department determines that a health coverage recipient is also a medical assistance recipient:

(a) The department may use information received under section 3 to update the medical assistance database maintained by the department.

(b) If the medical assistance recipient is covered by a qualified health plan, the department shall share with that qualified health plan all information received under this act by the department for that medical assistance recipient.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

550.287 Violation of act; administrative fine; notice; right to hearing.

Sec. 7.

An entity that violates this act is subject to an administrative fine of not more than \$500.00 for each day the entity does not comply with section 3(1) or with a request for information made pursuant to section 3(2). Upon the department's determination that a violation of this act has occurred, the entity has a right to notice of the alleged violation and an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

550.289 Rules.

Sec. 9.

The department may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, necessary to implement this act. Rules governing the exchange of information under this act shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including, but not limited to, the health insurance portability and accountability act of 1996, Public Law 104-191, and regulations promulgated under that act, 45 CFR parts 160 to 164.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007

SPECIAL FACTORS THAT SUPPORT THE PROMISING PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

State Law

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Tanya Lowers
Director of Third Party Liability
517-335-8989
lowerst@michigan.gov

MINNESOTA

ISSUE: Pharmacy Benefit Managers claim they do not have the authority to reimburse states directly.	
IN THE RESPONDING STATE, THIS ISSUE: ___ CURRENTLY OCCURS OR HAS OCCURRED: <input checked="" type="checkbox"/> VERY FREQUENTLY ___ OFTEN ENOUGH TO REQUIRE CORRECTION ___ INFREQUENTLY ___ DOESN'T OCCUR OR HASN'T OCCURRED	EFFECT OF THE PRACTICE: ___ RESOLVED THE ISSUE FULLY ___ RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) <input checked="" type="checkbox"/> RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS
WHY DOES THIS ISSUE OCCUR? The employer/insurance company has not given Permission to the PBM to pay claims directly to Medicaid.	
SUMMARY OF EFFECTIVE PRACTICE: We send a letter to the employer or insurance company asking them to contact the PBM and give them whatever authority they need in order to process the claims. The letter advises the employer/insurance company that they are ultimately responsible for payment of the covered services.	
SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE: (Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)	
FOR MORE INFORMATION, CONTACT: (Name and Title, Phone Number, Email Address) Pat Dault-Beauchane Supervisor, Health Insurance Recovery Unit Benefit Recovery Section 651-431-3138 651-431-7431 (Fax) Pat.dault-beauchane@state.mn.us Sandy Burge Manager, Benefit Recovery Section 651-431-3284 651-431-7431 (Fax) Sandy.burge@state.mn.us	

MINNESOTA

ISSUE: Pharmacy providers who submit erroneous denial/reject reason	
IN THE RESPONDING STATE, THIS ISSUE: ___ CURRENTLY OCCURS OR HAS OCCURRED: <input checked="" type="checkbox"/> VERY FREQUENTLY ___ OFTEN ENOUGH TO REQUIRE CORRECTION ___ INFREQUENTLY ___ DOESN'T OCCUR OR HASN'T OCCURRED	EFFECT OF THE PRACTICE: ___ RESOLVED THE ISSUE FULLY ___ RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) <input checked="" type="checkbox"/> RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS
WHY DOES THIS ISSUE OCCUR? Pharmacies submit claims with erroneous TPL information. In some instances the PBMs deny the claims for 1) no prior authorization, 2) brand name drug dispensed and should have used a generic ,3) drug should have been dispensed by a specialty pharmacy. In these cases, the pharmacy submits a claim with a reason code stating the drug is not covered. In Minnesota, we pay and chase all pharmacy claims for clients who have reported insurance, but do not show a payment from the TPL. It has been our experience that the PBMs deny our claims 1) without an explanation, 2) as duplicates, or 3) they don't respond at all.	
SUMMARY OF EFFECTIVE PRACTICE: We recently started auditing the claims before we submit them to the carriers. We review claims with larger dollar amounts and call the PBM for additional information. This seems to work better than sending them a claim. If the PBM gives us information that: 1) a prior authorization is needed, 2) a generic should have been dispensed, or 3) a specialty Pharmacy should have been used, we take the money back from the provider as being erroneously billed. The first week we did this, we took back in excess of \$60,000.00.	
SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE: (Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)	
FOR MORE INFORMATION, CONTACT: (Name and Title, Phone Number, Email Address) Pat Dault-Beauchane, Supervisor, Health Insurance Recovery Unit Benefit Recovery Section 651-431-3138 651-431-7431 (Fax) Pat.dault-beauchane@state.mn.us Or	

Sandy Burge
 Manager, Benefit Recovery Section
 651-431-3284
 651-431-7431 (Fax)
 Sandy.burge@state.mn.us

MISSISSIPPI

ISSUE: Accept Medicaid 's right of recovery and not deny claims submitted by the Division

IN THE RESPONDING STATE, THIS ISSUE:

CURRENTLY OCCURS OR HAS OCCURRED:
 VERY FREQUENTLY
 OFTEN ENOUGH TO REQUIRE CORRECTION
 INFREQUENTLY
 DOESN'T OCCUR OR HASN'T OCCURRED

EFFECT OF PRACTICE:

RESOLVED THE ISSUE FULLY
 RESOLVED THE ISSUE PARTIALLY (*Indicate what was resolved and what remains in the Summary below.*)
 RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS

WHY DOES THIS ISSUE OCCUR?

Third party denies claims submitted by Medicaid on the basis of certain errors as condition of doing business in Mississippi.

SUMMARY OF EFFECTIVE PRACTICE:

§ 43-13-126. Health insurers required to provide certain information to the Division of Medicaid, accept Division's right of recovery and not deny claims submitted by Division on the basis of certain errors as condition of doing business in Mississippi.

As a condition of doing business in the state, 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, are required to: (a) Provide, with respect to individuals who are eligible for, or are provided, medical assistance under the state plan, upon the request of the Division of Medicaid, information to determine during what period the individual or their dependents may be (or may have been) covered by the 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 of the Department of Health and Human Services; (b) Accept the Division of Medicaid's right of recovery and the assignment to the division 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; (c) Respond to any inquiry by the Division of Medicaid regarding a claim for payment for any health care item or service that is submitted not later than three (3) years after the date of the provision of that health care item or service; and (d) Agree not to deny a claim submitted by the Division of Medicaid 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 claim, if: (i) The claim is submitted by the division within the three-year period beginning on the date on which the item or service was furnished; and (ii) Any action by the division to enforce its rights with respect to the claim is begun within six (6) years of the division's submission of the claim.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

Laws, 2007, ch. 553, § 3, eff. from and after July1, 2007.

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Margaret Robinson, Office Director II, 601-359-6113, Margaret.robinson@medicaid.ms.gov

NEW YORK

ISSUE: Denials for Prior Authorization	
IN THE RESPONDING STATE, THIS ISSUE: <input checked="" type="checkbox"/> CURRENTLY OCCURS OR HAS OCCURRED: <input type="checkbox"/> VERY FREQUENTLY <input checked="" type="checkbox"/> OFTEN ENOUGH TO REQUIRE CORRECTION <input type="checkbox"/> INFREQUENTLY <input type="checkbox"/> DOESN'T OCCUR OR HASN'T OCCURRED	EFFECT OF THE PRACTICE: <input type="checkbox"/> RESOLVED THE ISSUE FULLY <input checked="" type="checkbox"/> RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) <input type="checkbox"/> RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS
WHY DOES THIS ISSUE OCCUR? Commercial Insurance carriers deny Medicaid Subrogation claims for not having prior authorization to receive treatment.	
SUMMARY OF EFFECTIVE PRACTICE: Referring to The Federal law (42 U.S.C. 1396a(a)(25)(A)), subsequent NY State Insurance and Social Services Law, and in partnership with our TPL vendor, the NY Office of the Medicaid Inspector General (OMIG) appeals all denials for prior authorization. The body of the letter sent with the appeal includes the following: In accordance with §3212(e)(3) (C) of New York State Insurance Law, such a denial is not permitted for Medicaid subrogation claims. §3212(e)(3) (C) reads as follows: <i>“An insurer shall not deny a claim made in conformance with paragraph (b) of subdivision two of section three hundred sixty-seven-a of the social services law 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.”</i> §367-A(2) of the New York State Social Services Law, referenced above section of the NYS Insurance Law, reads as follows: <i>“Liable third parties shall not deny a claim made by a social services official or the department in conformance with this paragraph 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.”</i> Please re-process these claims and respond promptly with either payment or a valid denial.	
SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:	

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Larry Matthews, 518-474-8347, Lawrence.Matthews@omig.ny.gov

OHIO

ISSUE: Denials from third parties for procedural reasons

IN THE RESPONDING STATE, THIS ISSUE:

CURRENTLY OCCURS OR HAS OCCURRED:
 VERY FREQUENTLY
 OFTEN ENOUGH TO REQUIRE CORRECTION
 INFREQUENTLY
 DOESN'T OCCUR OR HASN'T OCCURRED

EFFECT OF PROMISING PRACTICE:

RESOLVED THE ISSUE FULLY
 RESOLVED THE ISSUE PARTIALLY (*Indicate what was resolved and what remains in the Summary below.*)
 RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS

WHY DOES THIS ISSUE OCCUR?

Some insurance carriers are not familiar with the Deficit Reduction Act of 2005 or Ohio legislation.

SUMMARY OF PROMISING PRACTICE:

Even after the implementation of the Deficit Reduction Act language in Ohio law, some insurance carriers would deny Medicaid reclamation claims for not obtaining prior authorization. To address this issue, Ohio passed specific legislation in 2009 to specifically outline a claim could not be denied for lack of obtaining prior authorization. This legislation applies to fee for service as well as Medicare Managed Care organizations. Ohio also increased the timeframe to six years for its right of recovery. The legislation in Ohio is-

5101.573 Third-party duties - managed care organizations.

(A) Subject to divisions (B) and (C) of this section, a third party shall do all of the following:

(1) Accept the department of job and family services' right of recovery under section 5101.58 of the Revised Code and the assignment of

rights to the department that are described in section 5101.59 of the Revised Code;

(2) Respond to an inquiry by the department regarding a claim for payment of a medical item or service that was submitted to the third

party not later than six years after the date of the provision of such medical item or service;

(3) Not charge a fee to do either of the following for a claim described in division (A)(2) of this section:

(a) Determine whether the claim should be paid;

(b) Process the claim.

(4) Pay a claim described in division (A)(2) of this section;

(5) Not deny a claim submitted by the department solely on the basis of the date of submission of the claim, type or format of the claim

form, or a failure by the medical assistance recipient who is the subject of the claim to present proper documentation of coverage at the

time of service, if both of the following are true:

(a) The claim was submitted by the department not later than six years after the date of the provision of the medical item or service.

(b) An action by the department to enforce its right of recovery under section 5101.58 of the Revised Code on the claim was commenced not later than six years after the department's submission of the claim.

(6) Consider the department's payment of a claim for a medical item or service to be the equivalent of the medical assistance recipient

having obtained prior authorization for the item or service from the third party;

(7) Not deny a claim described in division (A)(6) of this section that is submitted by the department solely on the basis of the medical assistance recipient's failure to obtain prior authorization for the medical item or service.

(B) For purposes of the requirements in division (A) of this section, a third party shall treat a managed care organization as the department for a claim in which both of the following are true:

(1) The individual who is the subject of the claim received a medical item or service through a managed care organization that has entered into a contract with the department of job and family services under section 5111.17 of the Revised Code;

(2) The department has assigned its right of recovery for the claim to the managed care organization.

(C) The time limitations associated with the requirements in divisions (A)(2) and (5) of this section apply only to submissions of claims to, and payments of claims by, a health insurer to which 42 U.S.C. 1396a(a)(25)(I) applies.

Amended by 129th General Assembly File No. 28, HB 153, § 101.01, eff. 9/29/2011.

Amended by 128th General Assembly File No. 9, HB 1, § 101.01, eff. 10/16/2009.

Effective Date: 2007 HB119 09-29-2007

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<http://>

SPECIAL FACTORS THAT SUPPORT THE PROMISING PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

Ohio's TPL pay and chase vendor tracked by year the impact of the denials based on reason that claims were denied for lack of prior authorization. Note the large reduction in the denial reason in SFY 2012.

OH Denial Analysis - No Prior Authorization: Denials

Based on date of service

SFY	Total No. of Claims	Total Medicaid Paid Amounts
2000	39	\$1,249.81
2001	81	\$21,704.96
2002	1,880	\$253,110.78
2003	7,034	\$1,236,309.71
2004	9,708	\$1,329,234.24
2005	10,237	\$1,751,869.57
2006	7,224	\$1,321,521.05
2007	8,940	\$1,330,381.91
2008	9,717	\$1,308,828.46
2009	9,913	\$1,612,121.00
2010	6,402	\$1,113,844.68
2011	7,910	\$1,252,648.27
2012	2,526	\$889,697.02
2013	1,086	\$503,857.17
Total	82,697	\$13,926,378.63

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Patrick A. Tighe Patrick.Tighe@medicaid.ohio.gov 614-752-3635

OKLAHOMA

ISSUE: Not passing legislation that is not mandated, but will enhance the Medicaid program	
IN THE RESPONDING STATE, THIS ISSUE: <input checked="" type="checkbox"/> CURRENTLY OCCURS OR HAS OCCURRED: <input type="checkbox"/> VERY FREQUENTLY <input type="checkbox"/> OFTEN ENOUGH TO REQUIRE CORRECTION <input type="checkbox"/> INFREQUENTLY <input type="checkbox"/> DOESN'T OCCUR OR HASN'T OCCURRED	EFFECT OF PRACTICE: <input type="checkbox"/> RESOLVED THE ISSUE FULLY <input type="checkbox"/> RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) <input checked="" type="checkbox"/> RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS
WHY DOES THIS ISSUE OCCUR? When legislation is not mandated, it is sometimes not seen as a priority or important.	
SUMMARY OF EFFECTIVE PRACTICE: This may not happen as regularly anymore, but we have found that in our state it is fairly easy to pass legislation when things are required to be in compliance with Federal law, i.e. DRA, ACA etc. We have learned that during this time, we should take advantage of the situation and put in any language that we have been trying to pass to ride on the coattails of the "required changes". Doing this has resulted in the passing of many laws that enhanced the Medicaid program.	
SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE: (Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.) Federal Law	
FOR MORE INFORMATION, CONTACT: (Name and Title, Phone Number, Email Address) Susan Geyer Business Process Manager (405)522-7199 Susan.geyer@okhca.org	

OKLAHOMA

ISSUE: Medicaid applicants' health insurance coverage was not being captured on the online eligibility application.

IN THE RESPONDING STATE, THIS ISSUE:

CURRENTLY OCCURS OR HAS OCCURRED:
 VERY FREQUENTLY
 OFTEN ENOUGH TO REQUIRE CORRECTION
 INFREQUENTLY
 DOESN'T OCCUR OR HASN'T OCCURRED

EFFECT OF PRACTICE:

RESOLVED THE ISSUE FULLY
 RESOLVED THE ISSUE PARTIALLY (*Indicate what was resolved and what remains in the Summary below.*)
 RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS

WHY DOES THIS ISSUE OCCUR?

Because TPL was not brought to the table early in the process of establishing an on-line enrollment application.

SUMMARY OF EFFECTIVE PRACTICE:

Work with the system as you begin the process of establishing on-line enrollment to insure that TPL has a place at the table. It is imperative that you make system designers aware of TPL's needs from the beginning of the process. After it is built, it is too late. Also, I would highly recommend drop-down menus for things like carrier name, and not allowing free-form text as much as possible. That will allow for automated update if you choose that option in the future.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Susan Geyer Business Process Manager
(405)522-7199
Susan.geyer@okhca.org

PENNSYLVANIA

ISSUE: Coordination of benefits of deemed newborns, when either parent has other insurance coverage. Providing for health and welfare of newborn children and their parents by regulating certain health insurance coverage for newborn children.

IN THE RESPONDING STATE, THIS ISSUE:

- CURRENTLY OCCURS OR HAS OCCURRED:
- VERY FREQUENTLY
- OFTEN ENOUGH TO REQUIRE CORRECTION
- INFREQUENTLY
- DOESN'T OCCUR OR HASN'T OCCURRED

EFFECT OF PRACTICE:

- RESOLVED THE ISSUE FULLY
- RESOLVED THE ISSUE PARTIALLY (*Indicate what was resolved and what remains in the Summary below.*)
- RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS

WHY DOES THIS ISSUE OCCUR?

Interpretation, by insurance carriers, of federal and Pennsylvania state laws for insurance carrier liability with continued confinement of the newborn past the mandated period of 48/96 hours. The Newborns' and Mothers' Health Protection Act states that carriers pay for at least 48-hours (for vaginal delivery) or 96-hours (for cesarean section delivery).

State laws like Act 81 support the federal mandate, require carrier compliance, extend the number of covered days without actual enrollment on the policy, recognize both parents as potential subscribers for available coverage, etc.

§ 54.9811-1 Standards relating to benefits for mothers and newborns Title 26, Chapter 1, Subchapter D, Part 54, Section 54.9811-1) and

Pennsylvania Code, § 89.201, Subchapter F, Coverage for Newborn Children (PA Act 81)

SUMMARY OF EFFECTIVE PRACTICE:

The premise that there should be a uniform approach as it relates to newborns and maximizing available primary coverage; i.e. if there were to be some model DRA language that states could adopt within their own state "DRA" language. It was indicated in our vendor's opinion; PA has proper language (PA Act 81) as it relates to the project being introduced to the carrier community.

Essentially, the project was a result of learning more about the PA Act 81 language through the Pennsylvania Department of Public Welfare (DPW) inquiry to our vendor, which led to a national project approach on behalf of all vendor clients. A process was developed to identify newborns with available primary coverage through a parent subscriber policy. Once billing of claims to carriers began, leverage from both Act 81 and the Federal mandates lead to a carrier education campaign covering this "Newborn" population across the country and within the timely filing limits of the state's DRA language.

The DPW provides eligibility and paid claims files to the vendor. The process begins with the vendor identifying date of service equals date of birth, a claim has been paid by the Medicaid program, identifying other primary coverage that is available using data matching algorithms in conjunction with the National Eligibility Database. Added quality checks to confirm parent/dependent relationship are used. Once primary coverage is confirmed for one of the parents associated with the newborn, paid claims are billed to the primary carrier for reimbursement back to the Medicaid agency.

The DPW collects payments and has generated more than \$1.2 million in recoveries for PA DPW to date. There is still additional follow up and education to be performed with the carrier community. As this continued claims identification, coverage confirmation, claims billings and carrier education occur, our vendor anticipates ongoing recoveries from the \$9 million+ in PA newborn claims that have been billed to date, as well as continued recovery opportunity, as newborns with available primary coverage are identified. This project can also lead to potential HIPPA referrals for those cost-effective scenarios, since the ultimate goal should be to enroll the newborn in available commercial coverage to ensure that the Medicaid program remains the payer of last resort and cost-avoided savings are maximized.

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

Pennsylvania has a contractor perform data exchange and recovery services.

§ 54.9811-1 Standards relating to benefits for mothers and newborns Title 26, Chapter 1, Subchapter D, Part 54, Section 54.9811-1) and

Pennsylvania Code, § 89.201, Subchapter F, Coverage for Newborn Children (PA Act 81)

FOR MORE INFORMATION, CONTACT:

Carole Procope | TPL Director
(Name and Title, Phone Number, Email Address)

Department of Public Welfare | Bureau of Program Integrity
116 East Azalea Drive | Harrisburg, PA 17110-3594
Phone: 717.705.8234 | Fax: 717.772.6553
www.dpw.state.pa.us

TEXAS

ISSUE: Denials from third parties for procedural reasons																			
<p>IN THE RESPONDING STATE, THIS ISSUE:</p> <p>___ CURRENTLY OCCURS OR HAS OCCURRED: ___ VERY FREQUENTLY <input checked="" type="checkbox"/> X OFTEN ENOUGH TO REQUIRE CORRECTION ___ INFREQUENTLY ___ DOESN'T OCCUR OR HASN'T OCCURRED</p>	<p>EFFECT OF THE PRACTICE:</p> <p>___ RESOLVED THE ISSUE FULLY ___ RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) <input checked="" type="checkbox"/> X RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS</p>																		
<p>WHY DOES THIS ISSUE OCCUR?</p> <p>Texas found that payers are denying our Medicaid reclamation claims for procedural reasons. To mitigate the loss of recovery dollars, we directed our vendor to create a Denials Team to manually review these third party claim denials and determine if they could be rebilled for payment.</p>																			
<p>SUMMARY OF EFFECTIVE PRACTICE:</p> <p>Our vendor established the Denials Team in 2009 which is responsible for researching the Explanation of Benefits (EOBs) in order to identify claims denied inappropriately. Claims found to have been denied inappropriately are appealed to the carrier. Not only has this process resulted in increased recoveries from the insurance carriers it has also lead to provider recoupments in situations where we discovered that the providers received payment from Medicaid and from the insurance carrier as well.</p>																			
<p>SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE: (Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)</p> <p>Since the creation of the Denials team in May 2009 they have recovered \$39,612,696.25 in this one category alone.</p> <p>See the breakout below for all denial recoveries and recoupments by State Fiscal Year (SFY) from 2009 - present.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">SFY 2009</td> <td style="width: 10%;">\$</td> <td style="width: 75%;">458,746.00 (5 of 12 months)</td> </tr> <tr> <td>SFY 2010</td> <td>\$</td> <td>1,632,707.00</td> </tr> <tr> <td>SFY 2011</td> <td>\$</td> <td>8,977,959.00</td> </tr> <tr> <td>SFY 2012</td> <td>\$</td> <td>13,051,780.00</td> </tr> <tr> <td>SFY 2013</td> <td>\$</td> <td>13,032,474.66</td> </tr> <tr> <td>SFYTD 2014</td> <td>\$</td> <td>2,459,029.59</td> </tr> </table>		SFY 2009	\$	458,746.00 (5 of 12 months)	SFY 2010	\$	1,632,707.00	SFY 2011	\$	8,977,959.00	SFY 2012	\$	13,051,780.00	SFY 2013	\$	13,032,474.66	SFYTD 2014	\$	2,459,029.59
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<p>FOR MORE INFORMATION, CONTACT: (Name and Title, Phone Number, Email Address)</p> <p>Diane Broadhurst, TPL Manager, 512-491-5638, diane.broadhurst@hhsc.state.tx.us</p>																			

TEXAS

ISSUE: Cooperation from pharmacy benefit managers and other entities	
<p>IN THE RESPONDING STATE, THIS ISSUE:</p> <p><input checked="" type="checkbox"/> CURRENTLY OCCURS OR HAS OCCURRED: <input type="checkbox"/> VERY FREQUENTLY <input checked="" type="checkbox"/> OFTEN ENOUGH TO REQUIRE CORRECTION <input type="checkbox"/> INFREQUENTLY <input type="checkbox"/> DOESN'T OCCUR OR HASN'T OCCURRED</p>	<p>EFFECT OF THE PRACTICE:</p> <p><input checked="" type="checkbox"/> RESOLVED THE ISSUE FULLY <input type="checkbox"/> RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) <input type="checkbox"/> RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS</p>
<p>WHY DOES THIS ISSUE OCCUR?</p> <p>Some insurance carriers/pharmacy benefit managers/third party administrators operating in the State of Texas did not want to perform data matches with the State Medicaid Agency in a timely fashion.</p>	
<p>SUMMARY OF EFFECTIVE PRACTICE:</p> <p>Texas statute in place prior to 2007 only required these entities to perform data matches once every six (6) months. However, in 2007, a new statute was implemented that required entities doing business in the State of Texas to enter into an agreement with the Health and Human Services Commission (HHSC). This agreement and the associated processes are known as the Billing Coordination System (BCS).</p> <p>One of the provisions within the BCS statute requires that any entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state must allow HHSC access to databases to allow for the identification of other payers. If the other entity does not allow access, then the entity is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for a violation by the entity of a rule adopted under this section.</p> <p>The initial BCS legislation was only applicable to Fee for Service (FFS) and Primary Care Case Management (PCCM) services. In the following two legislative sessions (2009 & 2011), additional provisions were added to the BCS statute and the requirement has been expanded to include all Medicaid and non-Medicaid programs overseen by HHSC. Texas is currently working on revising the carrier agreements to include not only medical insurance carriers, but pharmacy benefit managers (PBMs), long term care (LTC) carriers, and third party administrators (TPAs).</p> <p>The BCS Carrier Agreements have resulted in HHSC's ability to match more frequently (bi-weekly/monthly/quarterly) with carriers which allows for more timely TPL identification for purposes of cost avoidance and cost recovery. In addition, with the expansion of managed care in Texas, these agreements will allow HHSC the ability to take on sole responsibility for TPL identification and share it with both our FFS Fiscal Agent and with the MCO's allowing us the ability to set performance standards and service level agreements for those vendors in order for HHSC to ensure that Texas is in compliance with federal and state TPL requirements.</p>	

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

Texas Government Code Chapter 531- Health and Human Services Commission, Section 531.02413-Billing Coordination System

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Diane Broadhurst, TPL Manager, 512-491-5638, diane.broadhurst@hhsc.state.tx.us

WASHINGTON

ISSUE: Dept. of Transportation data match																																																											
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<p>A data match between Washington State’s Department of Social and Health Services (DSHS), Coordination of Benefits Section’s, Casualty Unit and Department of Transportation was established in 2006. The purpose of the match is to compare names and dates of birth of Medicaid clients with the Washington State Patrol motor vehicle accident records. A report is produced and staff validate whether third party liability is available. Prior to this exchange we relied primarily on attorney contacts, paid claims, and diagnosis based Treatment Questionnaires as resources for case managers.</p> <p>Information on all traffic accidents in the State of Washington is uploaded to our system and matched against Medicaid clients on a weekly basis. Staff members examine claims data to determine if there is potential recovery. The purpose is to catch the Motor Vehicle Accidents (MVAs) early, before the insurance companies have a chance to settle. MVAs comprise 75% of our Casualty Unit’s caseload.</p> <p>One drawback has been that in some cases we are too early...the claims have not been submitted yet. Providers have 365 days to submit a claim and we are looking for claims data prior to then. Our Information Technology resources are limited, however, we’d like to develop an automated recheck process...60/90/120 days sometime in the future to alleviate this problem.</p>																																																											
<table border="1"> <thead> <tr> <th>DATE SPREAD</th> <th>TOTALS</th> <th>Purge Hits</th> <th>WSP SEARCHS</th> <th>PENDING CREATED</th> </tr> </thead> <tbody> <tr> <td>2/1/13-3/8/13</td> <td>320</td> <td>21</td> <td>19</td> <td>12</td> </tr> <tr> <td>2/1/13-3/15/13</td> <td>481</td> <td>21</td> <td>20</td> <td>9</td> </tr> <tr> <td>2/1/13-3/22/13</td> <td>324</td> <td>14</td> <td>10</td> <td>8</td> </tr> <tr> <td>3/1/13-3/29/13</td> <td>327</td> <td>20</td> <td>14</td> <td>7</td> </tr> <tr> <td>3/1/13-4/5/13</td> <td>302</td> <td>19</td> <td>15</td> <td>8</td> </tr> <tr> <td>3/1/13-4/12/13</td> <td>285</td> <td>8</td> <td>8</td> <td>5</td> </tr> <tr> <td>3/1/13-4/19/13</td> <td>358</td> <td>11</td> <td>8</td> <td>4</td> </tr> <tr> <td>4/1/13-4/26/13</td> <td>383</td> <td>13</td> <td>10</td> <td>7</td> </tr> <tr> <td>4/1/13-5/3/13</td> <td>512</td> <td>12</td> <td>11</td> <td>8</td> </tr> <tr> <td>4/1/13-5/10/13</td> <td>524</td> <td>16</td> <td>13</td> <td>9</td> </tr> </tbody> </table>					DATE SPREAD	TOTALS	Purge Hits	WSP SEARCHS	PENDING CREATED	2/1/13-3/8/13	320	21	19	12	2/1/13-3/15/13	481	21	20	9	2/1/13-3/22/13	324	14	10	8	3/1/13-3/29/13	327	20	14	7	3/1/13-4/5/13	302	19	15	8	3/1/13-4/12/13	285	8	8	5	3/1/13-4/19/13	358	11	8	4	4/1/13-4/26/13	383	13	10	7	4/1/13-5/3/13	512	12	11	8	4/1/13-5/10/13	524	16	13	9
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5/1/13-5/24/13	507	16	14	9
5/1/13-5/31/13	381	14	12	7
5/1/13-6/7/13	701	28	23	18
5/1/13-6/14/13	1053	17	15	7
6/1/13-6/21/13	2196	36	27	13
6/1/13-6/28/13	1027	17	12	10
6/1/13-7/5/13	122	0	0	0
6/1/13-7/12/13	1056	10	9	4

KEY:

- Date Spread:** Transaction Dates that collision reports are filed into the DMV system
- Purge Hits:** Medicaid claims occurring close to the date of the auto accident
- WSP Searches:** The Washington State Patrol Collision record searches
- Pending Created:** Identification of previously unknown cases

SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE:

(Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.)

Originally, an interagency agreement was established between the Department of Transportation and (now) Washington State Health Care Authority’s Coordination of Benefits Section to enable the transfer of a monthly disk. This process evolved into a web-based application which narrows the search to just those accidents involving Medicaid clients. This process is a requirement in our State Plan.

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Andy Renggli, Coordination of Benefits Section Manager andy.renggli@hca.wa.gov (360) 725-1207

WASHINGTON

ISSUE: <i>Payer Initiated Eligibility/Benefit (PIE) Transaction</i>	
IN THE RESPONDING STATE, THIS ISSUE: ___ CURRENTLY OCCURS OR HAS OCCURRED: ___ VERY FREQUENTLY ___ OFTEN ENOUGH TO REQUIRE CORRECTION ___ INFREQUENTLY ___ DOESN'T OCCUR OR HASN'T OCCURRED	EFFECT OF THE PRACTICE: ___ RESOLVED THE ISSUE FULLY ___ RESOLVED THE ISSUE PARTIALLY (<i>Indicate what was resolved and what remains in the Summary below.</i>) ___ RESOLVED TEMPORARILY WITH A WORKAROUND PROCESS
WHY DOES THIS ISSUE OCCUR? Efficient methods for exchanging clients' eligibility for health coverage and their associated benefits are a continuous, on-going need in Coordination of Benefits.	
SUMMARY OF EFFECTIVE PRACTICE: WA State Medicaid has recently published the Payer Initiated Eligibility (PIE) transaction guide at http://www.hca.wa.gov/medicaid/hipaa/Documents/wammis_cg_pie_271-5010_07052013_version1.pdf . The purpose of this transaction guide is to assist payers in providing health plan eligibility and coverage information to State Medicaid programs. The Centers for Medicare & Medicaid Services developed the Payer Initiated Eligibility/Benefit (PIE) Transaction which can be used to meet the DRA requirements. The Guide focuses on the exchange of data from payers to Medicaid agencies. Agreement regarding geographic areas to be covered by the transaction and the schedule and frequency of transaction delivery will be addressed in the trading partner agreement. The Washington State Medicaid Management Information System (MMIS) named ProviderOne is now ready to accept the PIE transaction.	
SPECIAL FACTORS THAT SUPPORT THE EFFECTIVE PRACTICE: (Ex: State Law, Case Law, Data Exchange Agreements, Data Systems, Contractor Use, etc.) The PIE transaction was developed to comply with both the federal Deficit Reduction Act of 2005 and Washington State Substitute House Bill 1826 (http://www.leg.wa.gov/pub/billinfo/2007-08/pdf/bills/house%20passed%20legislature/1826-s.pl.pdf) Federal law requires States to identify and obtain payment from third party entities that are legally responsible to pay claims primary to Medicaid. To enhance States' abilities to identify legally liable third parties, the Deficit Reduction Act of 2005 (DRA) required States to pass laws imposing requirements on health plans, as a condition of doing business in the State, to provide plan eligibility information to the State. The Payer Initiated Eligibility/Benefit (PIE) Transaction will be used to provide Washington State Medicaid with a listing that identifies plan members' eligibility for health coverage and their associated	

benefits. Of course the same transaction format can be used by all states and all carriers.

The PIE Transaction was developed to deliver membership and benefit information in one single, unsolicited transaction. The PIE Transaction uses the same identifiers as the ASC X12 271 response transaction and therefore mirrors the format of the 271 transaction. The purpose of the transaction guide is to provide a standardized format for the PIE Transaction information. The information supplied on the PIE Transaction is to be as comprehensive as possible, with beginning and end dates and including other coverage, if available. The provided information will be used to match to the Washington State's Provider One database. For this purpose, a required key data element is the Social Security Number. If the Social Security Number is not available, other key identifiers may be used.

FOR MORE INFORMATION, CONTACT:

(Name and Title, Phone Number, Email Address)

Andy Renggli, Coordination of Benefits Section Manager andy.renggli@hca.wa.gov (360) 725-1207