COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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July 30, 2024

MEMORANDUM

TO: The Honorable Luke Torian
Chair, House Appropriations Committee

The Honorable Louise Lucas
Chair, Senate Finance and Appropriations Committee

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report pursuant to Chapter 343 (HB 2158) of the Virginia Acts of Assembly, 2023 Session

This report is submitted in compliance with Chapter 343 (HB 2158) of the Virginia Acts of Assembly, 2023 Session, which states:

"*The Department of Medical Assistance Services (the Department) shall evaluate its ability to comply with the provisions of § 1902(a)(25)(I) of the Social Security Act by the effective compliance date of July 1, 2024. In conducting its evaluation, the Department shall convene a work group, including representatives of the State Corporation Commission, State-Based Exchange, and other stakeholders, to develop a communication plan to notify carriers of the changes required by such federal law. The Department shall report its findings and recommendations to the Chairs of the House Committee on Appropriations and Senate Committee on Finance and Appropriations by November 1, 2023.*"

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure
Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

DMAS Evaluation of Compliance with § 1902(a)(25)(I) – House Bill No. 2158

A Report to the Virginia General Assembly *July 30, 2024*

Report Mandate:

Chapter 343 (HB 2158) of the Virginia Acts of Assembly, 2023 Session, states: The Department of Medical Assistance Services (the Department) shall evaluate its ability to comply with the provisions of § 1902(a)(25)(I) of the Social Security Act by the effective compliance date of July 1, 2024. In conducting its evaluation, the Department shall convene a work group, including representatives of the State Corporation Commission, State-Based Exchange, and other stakeholders, to develop a communication plan to notify carriers of the changes required by such federal law. The Department shall report its findings and recommendations to the Chairs of the House Committee on Appropriations and Senate Committee on Finance and Appropriations by November 1, 2023.

Background

Section 1902(a)(25)(I) of the Social Security Act outlines requirements for states related to Medicaid third party liability (TPL) and the state's right of recovery and assignment of rights to payment from other health insurers for items and services for which payment is made under Medicaid. Under federal law, Medicaid is the payer of last resort, meaning other sources of health coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. States have the right to take reasonable measures to identify potentially liable third parties and process claims or recover payment accordingly. The Consolidated Appropriations Act (CAA) of 2022, enacted March 15, 2022, amended this section with new language related to TPL and prior authorization. States are required to meet the following requirements:

1. States must have laws in place barring responsible third-party payers from refusing payment to the Medicaid agency for an item or service solely because that item or service did not receive prior authorization under the third-party payer's rules. The responsible third party must accept the authorization provided by the state that the item or service is covered under the Medicaid State Plan, or waiver of such plan, for the enrolled individual, as if authorization had been made by the third party for the item or service.

2. The CAA of 2022 also modified the existing requirement for a third-party payer to respond to a state inquiry regarding a health care claim that is submitted not later than three years after the provision of such item or service to specify that the third party must respond within 60 days of receiving the inquiry.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.

Compliance Evaluation Findings

To meet the mandate in state legislation, DMAS completed an analysis of § 1902(a)(25)(I) of the Social Security Act, as amended by the Consolidated Appropriations Act of 2022, and reviewed related regulatory language in the Commonwealth's Administrative Code and the Medicaid State Plan.

States must submit a Medicaid State Plan Amendment (SPA) pursuant to the CAA of 2022 attesting that the state has laws in place barring responsible third-party payers from refusing payment to the Medicaid agency for an item or service solely because that item or service did not receive prior authorization under the third-party payer's rules. Virginia has submitted the required SPA to the Centers for Medicare and Medicaid Services (CMS). DMAS is also making regulatory changes to update the Virginia Administrative Code (VAC) to reflect the CAA of 2022's amendments to § 1902(a)(25)(I) of the Social Security Act. The regulatory changes amend 12VAC30-10-610 *Third Party Liability* and 12VAC30-20-200 *Requirements for Third Party Liability; Payment of Claims*. The SPA and regulatory changes have been initiated in consultation with the Office of the Attorney General and CMS.

In addition, the 2024 Special Session I enacted budget for FY2024-26 (Chapter 2) includes a language-only provision that formally codifies the requirements of the CAA of 2022. The budget language states: "Liable third-party payers are barred from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules."

Communication Plan

As required by House Bill 2158, the Department worked with staff from the State Corporation Commission (SCC), including the Bureau of Insurance and State-Based Exchange, to develop a communication plan to notify health insurance carriers of the new requirements under federal law. No later than October 1, 2024, DMAS will issue a Medicaid Bulletin outlining the new third party liability and prior authorization requirements of the CAA of 2022. The Bureau of Insurance will provide contact information to DMAS to enable distribution of this Medicaid Bulletin to regulated health carriers and pharmacy benefit managers doing business in the Commonwealth.

Carriers subject to the new requirements under § 1902(a)(25)(I) are defined as health insurers, including self-insured plans, group health plans, 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 health care item or service, as a condition of doing business in the Commonwealth. Medicare plans are excepted from the requirements of the CAA of 2022 concerning prior authorization and TPL.