TRICARE and Medicaid
Coordination of Benefits Issues

Medicaid: Payer of Last Resort

By law, Medicaid is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is required to pay all or part of the cost of the claim prior to Medicaid making any payment – known as third party liability (TPL) or coordination of benefits (COB). Third parties that may be liable to pay for services include private health insurance, Medicare, TRICARE, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.[1]

From 2008 to 2010, an estimated 15% (approximately 6.8 million) of Medicaid beneficiaries had employer-sponsored health insurance annually. During this same period, an estimated 14% (approximately 6.3 million) of beneficiaries had Medicare. Medicaid TPL savings are substantial; however, **$4 billion remains at risk** of not being recovered – of which **over $150 million is being shifted back to the states by TRICARE.**

TRICARE and Medicaid Data-Exchange

COB between Medicaid and TRICARE has long been plagued with issues as documented in a Health and Human Services (HHS) Inspector General (IG). The report **cited challenges with access to timely, reliable data, and the requirement that claims be filed within one-year from the date of service as significant obstacles** to maintaining Medicaid as a payer of last resort.[2]

While the data match process was flawed, disappointingly it has ceased altogether due to the expiration of an agreement between the Centers for Medicare and Medicaid Services (CMS) and Tricare.

The data match process was governed by a memorandum of understanding between the two agencies, but thus far they have been unable to reestablish terms. Not conducting the data-match or allowing for the recovery of claims that TRICARE should have paid **shifts approximately $18-$21 million annually to the states from the federal government.**

Short, Timely Filing Period

Compounding this stoppage is the one-year timely filing period TRICARE imposes upon Medicaid. Medicaid cannot bill claims to TRICARE after one-year from the date of service, starkly contrasting other liable party responsibilities to honor these claims for up to three years from the date of service. Even with the flawed match process, this one-year timely filing period was shifting on average at least **another $70 million to the states**.

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[1] 42 U.S. Code § 1396a(25) - State plans for medical assistance

[2] 2011 Human Services Office of Inspector General Report, *Medicaid Third Party Liability Savings Have Increased, But Challenges Remain*.

Failure to Recognize the TPL Authority of Medicaid Managed Care Organizations

Medicaid managed care accounts for more than 70% of the total Medicaid population and half of the total spend, yet **TRICARE does not share data with or process claims from Medicaid Managed Care Organizations** (MCOs), who are contracted by the states and delegated TPL responsibilities. As a result, conservatively states are absorbing another **$63 million that TRICARE should have paid**.

Recommendations

- **Defense Health Agency (DHA) and CMS must work together and be mutually accountable** to ensure data-match restoration occurs by end of calendar year 2017 to stop the ongoing negative impact to state budgets, Medicaid MCOs, and unjustly harm to veterans, their families, and communities that support them.
- In accordance with federal statute and U.S.C. 32 section 199.7(d)(2)(i)(D)[3], **DHA should not only waive the one-year timely filing requirement** for all claims caught in this stoppage, but adhere to section 6035 of the Deficit Reduction Act of 2005, mandating a minimum 3-year timely filing requirement.
- Establish a six-month **cross-functional workgroup** that encompasses representatives from states, DHA, CMS, TPL Technical Advisory Group (TAG), National Association of Medicaid Directors (NAMD), Medicaid Health Plans of America (MHPA), and HMS. The workgroup will develop a final report to Congress addressing key recommendations on the data match process and frequency; claims filing periods; MCO TPL rights; claims payment and processing standards; and Medicaid TPL reclamation claim refund processes.

[3] "[W]hen not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination."