Chapter 4:

Medicaid and TRICARE Third-Party Liability Coordination

Medicaid and TRICARE Third-Party Liability Coordination

Recommendations

4.1 The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

4.2 To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Key Points

- Medicaid is generally the payer of last resort. By law, most other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. This requirement is referred to as third-party liability (TPL) because payment is the responsibility of a third party other than the individual or Medicaid.
- TPL recoveries are important to Medicaid programs for two reasons. First, ensuring that the appropriate party pays for care helps preserve Medicaid funds to cover services for beneficiaries; and second, they limit cost-shifting from private insurers and other federal programs to Medicaid, which is financed in part (38 percent) by states.
- MACPAC estimates that almost 1 million Medicaid beneficiaries have primary coverage through TRICARE, the Department of Defense health benefits program for U.S. Armed Forces military personnel, military retirees, and their dependents.
- Efforts to coordinate benefits between Medicaid and TRICARE have been constrained by differences in how the two programs are administered, including different policies for sharing enrollee data, accepting claims, and coordinating with delegated entities such as managed care organizations.
- While Congress has enacted changes to the Social Security Act to protect Medicaid from improper payment of claims that are the responsibility of a third party, it is not clear whether these provisions apply to government programs such as TRICARE.
- The Commission's recommendations focus on improving coordination of benefits between Medicaid and TRICARE and preserving Medicaid's role as the payer of last resort, through both administrative and congressional action.

CHAPTER 4: Medicaid and TRICARE Third-Party Liability Coordination

Medicaid is generally the payer of last resort; by law, all other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual.[1] This requirement is referred to as third-party liability (TPL) because payment is the responsibility of a third party other than the individual or Medicaid (42 CFR 447.10). A large proportion of Medicaid beneficiaries have third-party sources of insurance coverage. The U.S. Government Accountability Office (GAO) estimates that out of the 56 million people enrolled in the Medicaid program in 2012, 7.6 million had private coverage and 10.6 million had access to other public coverage through Medicare, the Indian Health Service, the U.S. Department of Defense (DoD), and the U.S. Department of Veterans Affairs (GAO 2015) (Box 4-1).

Coordinating TPL is important for two reasons: first, ensuring that the appropriate party pays for care helps preserve Medicaid funds to cover services for beneficiaries; and second, coordination of TPL limits cost shifting from private insurers and other federal programs to states, which pay more than one-third of program costs, and the federal portion of Medicaid, which pays the remaining two-thirds. Given the large proportion of Medicaid enrollees with access to other sources of coverage, the potential savings to the program through effective prospective and retrospective TPL activities are substantial. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) estimated that state and federal Medicaid savings from TPL totaled $13.6 billion in 2011, up from $3.7 billion in 2001 (OIG 2013). GAO has also noted that although states have improved TPL efforts over time, the growing number of Medicaid enrollees with third-party coverage creates additional opportunities to avoid improper payments and recover Medicaid funds (GAO 2015).

As part of its ongoing work to strengthen Medicaid program integrity activities, MACPAC is now focusing on the interaction between Medicaid TPL policy and other insurers. After Medicare, the largest public sources of third-party coverage for Medicaid enrollees are the DoD and the U.S. Department of Veterans Affairs.[2] TRICARE is the DoD program for civilian health benefits for U.S. Armed Forces military personnel, military retirees, and their dependents. MACPAC estimates based on the 2017 American Community Survey indicate that almost 1.5 percent or approximately 867,000 Medicaid enrollees have primary coverage through TRICARE, including approximately 220,000 children. For children enrolled in Medicaid on a basis other than disability, TRICARE is the largest source of third-party public coverage. Approximately 10 percent of children of active service families covered by TRICARE also have Medicaid (TFK 2018).

Despite the fact that a large number of Medicaid enrollees also have TRICARE coverage, MACPAC has found that the two programs have not effectively coordinated benefits, resulting in a cost shift at the federal level from the DoD to HHS and from the federal government to states. Many of the barriers to effective coordination of benefits result from differences in how Medicaid and TRICARE are administered, including different policies for sharing enrollee data, accepting claims, and coordinating with delegated entities such as managed care organizations (MCOs). Although reconciling these policy differences would not result in an overall cost savings to the federal government (i.e., liability for claims costs for enrollees with both Medicaid and TRICARE would return to TRICARE), improved coordination of benefits between the two programs would better maintain the statutory requirement that Medicaid serve as the secondary payer when other coverage sources are available.

This chapter presents the Commission's findings and recommendations for improving coordination between Medicaid and TRICARE.

Specifically, the Commission recommends:

- The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.
- To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

This chapter focusing on the specific issue of coordination with the TRICARE program is the result of the Commission's ongoing examination of opportunities to improve the effectiveness and efficiency of the Medicaid program.

BOX 4-1. Medicaid and Other Public Payers

Many Medicaid beneficiaries also have health coverage from other programs, including Medicare, the U.S. Department of Defense (DoD), and the U.S. Department of Veterans Affairs.

Of the three programs mentioned, Medicare enrolls the largest number of individuals who also have Medicaid coverage, with 12.2 million dually eligible beneficiaries enrolled in fiscal year 2019 (CMS 2020). Medicare is the primary payer for acute and post-acute care services. Medicaid wraps around Medicare by providing assistance with Medicare premiums and cost sharing and by covering some services that Medicare does not cover, such as long-term services and supports (LTSS). Medicare and Medicaid deliver services under fee for service (FFS) and managed care, and many beneficiaries are covered under both arrangements. The mechanisms for coordinating eligibility and benefits among the federal government, states, and managed care plans under contract to Medicare and Medicaid have been the subject of several MACPAC studies and Commission recommendations, including those described in Chapters 1 through 3 of this report to Congress.

The DoD provides civilian health benefits for U.S. Armed Forces military personnel, military retirees, and their dependents through the TRICARE program. MACPAC estimates that approximately 867,000 Medicaid enrollees have primary coverage through TRICARE, including approximately 220,000 children. TRICARE is the largest source of third-party public coverage for children enrolled in Medicaid on a basis other than disability: approximately 10 percent of children of active service members covered by TRICARE also have Medicaid (TFK 2018). TRICARE is the primary payer for acute care and pharmacy services, which are delivered through FFS and managed care programs operated by private insurance companies under contract to DoD. Medicaid covers TRICARE cost sharing for active duty military families who qualify on the basis of income and also provides coverage for services not included in TRICARE's benefit package. For example, Medicaid wraps around TRICARE by covering certain home- and community-based LTSS, and some children of active duty military families are enrolled in Section 1915(c) waivers or other programs to obtain specialized Medicaid wraparound services that are not covered by TRICARE (Shin et al. 2005).

BOX 4-1. (continued)

The U.S. Department of Veterans Affairs operates the Veterans Health Administration (VHA), which provides health care to eligible veterans through an integrated system that includes acute, outpatient, and LTSS. MACPAC estimates that approximately 960,000 Medicaid enrollees are also receiving health care through the VHA. The VHA does not provide comprehensive health coverage to all veterans, and the availability of some services may be limited based on a prioritized ranking of need. Eligibility is based on military tenure and the degree of service-connected disability, although some veterans may become eligible in part based on financial need. Medicaid covers the costs for services delivered to eligible individuals who are not covered by the VHA when these services are not related to a service-connected condition and are provided outside of the VHA system. However, if an individual is eligible for both VHA benefits and Medicaid, the VHA does not bill Medicaid for any care it provides to treat a non-service-connected condition.

A small number of public programs have been statutorily designated as payers of last resort after Medicaid (e.g., the Ryan White HIV/AIDS Program, Title V Maternal and Child Health Block Grant Program, Indian Health Service, Individuals with Disabilities Education Act programs, and World Trade Center Health Program) or are not considered to be legally liable third parties (such as schools, public health programs, and family service and child welfare agencies carrying out their general responsibilities to ensure access to needed health care).

Medicaid Third-Party Liability Policies

Medicaid generally coordinates benefits with other insurers as a secondary payer to all other payers. This means that if an insurer and Medicaid both provide coverage of a given benefit, the other payer is liable for paying the claim and Medicaid is responsible only for any balance covered under Medicaid payment rules.

In most situations, if the state is aware that a Medicaid enrollee has potential third-party coverage when the claim is filed—for example, if the eligibility file contains information on potential TPL—the state must reject the claim and instruct the provider to submit it to the potential primary payer (42 CFR 433.139). After the potential primary payer has processed the claim, the provider can resubmit a claim to Medicaid, which will pay if the Medicaid payment amount exceeds the amount of the primary payment. GAO has noted that this type of cost avoidance accounts for most of the savings to Medicaid associated with TPL (GAO 2015).

However, if a Medicaid program is unaware that an enrollee has other coverage at the time a claim is paid, it may pay the full amount, then later seek reimbursement from the primary insurer for the amount that insurer is liable, a process known as pay and chase (42 CFR 433.139). Although Medicaid is always legally the payer of last resort, from a fiduciary standpoint it is better to avoid the cost of paying a claim when there is another liable third party than to pay and chase, because not all paid claims can be recovered.

If a state has a Medicaid managed care program, it has several options for managing third-party liability (42 CFR 438.5). States can exclude enrollees with other insurance coverage from enrollment in a Medicaid managed care plan, although few states have chosen this option. States can also choose to enroll beneficiaries with other insurance coverage into managed care plans, and either retain

responsibility for administering TPL or delegate that responsibility to the managed care plan. The contract between the state and the managed care plan must describe the terms and conditions under which the plan assumes TPL responsibility and payment rates must be adjusted to take into account TPL recoveries. Most states delegate responsibility for TPL and build into the capitation payments an assumption regarding the amount of TPL the plans should be able to avoid or collect.

Medicaid TPL policies are governed by Medicaid statute and regulation (42 CFR 433 Subpart D). Federal rules require states to take reasonable measures to identify potentially liable third parties and process claims accordingly. States have two main sources of information on whether there may be a liable third party for a particular claim: (1) Medicaid enrollees themselves and (2) data matches with other insurers or data clearinghouses. States request information about other health coverage and potentially liable third parties as part of the Medicaid enrollment and renewal process. States also conduct a variety of data matches to identify third-party resources. States can conduct these matches themselves or, because they are permitted to delegate their authority to obtain information from third parties to a contractor, they may hire contractors to complete the required matches.[3]

States are required by federal statute to have laws that compel health insurers in the state to support identification of TPL (§ 1902(a)(25) of the Social Security Act (the Act)). Health plans are required to provide these files to the state Medicaid agency for purposes of identifying potential TPL. However, states do not have the ability to require federal insurance programs (e.g., TRICARE) to cooperate in data matches.

Federal statutes also assign responsibility when both sources of coverage are public programs. Generally, Medicare and other state and federal programs, including TRICARE, can be liable third parties unless specifically excluded by federal statute. A few public programs have been statutorily designated as payers of last resort after Medicaid, including the Ryan White HIV/AIDS Program and the Title V Maternal and Child Health Block Grant Program.

Congress has made additions and clarifications to the statute over time to further protect Medicaid from improper payment of claims that are the responsibility of a third party. For example, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) added a number of provisions related to TPL and coordination of benefits for Medicaid beneficiaries (CMS 2006). This statute amended Section 1902(a)(25) of the Act to require health insurers (defined as self-insured plans, MCOs, 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) to do the following:

- provide coverage information to the state upon request;
- accept the state's right of recovery;
- respond to claims inquiries submitted by the state up to three years after the date of the provision of a health care item or service; and
- agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim or the type or format of the claim form.[4]

In 2012, the Centers for Medicare & Medicaid Services (CMS) provided a policy clarification regarding implementation of the DRA provisions, noting that "when TPL responsibilities are delegated to an MCO, third parties are required to treat the MCO as if it were the state Medicaid agency," including providing access to third-party eligibility and claims data to identify individuals with third-party coverage (CMS 2014).

Health insurance is regulated by the states, so the DRA provisions, which amend federal statute, created a federal requirement that states pass their own laws requiring health insurers doing business in their state to comply with the above provisions. However, under a wholly separate section of

law that predates the DRA, Congress explicitly exempted TRICARE from state and local laws related to health insurance (10 USC § 1103). The legislative history does not clearly indicate whether Congress intended the DRA provisions to supersede these provisions. These differences could be reconciled by HHS and DoD coming to agreement, by Congress clarifying its intent, or it could be decided by the courts.

Coordination between Medicaid and TRICARE

As noted above, there are approximately 867,000 Medicaid enrollees who have health insurance through TRICARE and, given that Medicaid is designated by statute as the payer of last resort, their TRICARE plan is the primary payer for most of their primary and acute services and prescription drugs. TRICARE offers several different levels of coverage that eligible service members can choose from, with different deductibles, copayments, and catastrophic limits. TRICARE also offers optional dental plans for family members of active service members.

Medicaid covers the cost sharing for active service military families who qualify on the basis of income and provides coverage for services not included in TRICARE. For example, TRICARE does not cover home- and community-based services to the extent that Medicaid does, and many children of active service military families are enrolled in Section 1915(c) waivers or other programs to obtain specialized Medicaid services that are not covered by TRICARE (Shin et al. 2005). TRICARE informs enrollees that if they also have Medicaid coverage it will pay first, and provides an Other Health Insurance questionnaire for enrollees to populate with information about their Medicaid coverage to support coordination of benefits. However, there is no process for the information from this questionnaire to be routinely shared with states (DHA 2019a).

Although CMS has agreements with TRICARE governing the exchange of information regarding enrollee eligibility for financial assistance for coverage through state-based or federally facilitated health insurance exchanges, there is no active agreement for the exchange of information regarding Medicaid- or Medicare-eligible beneficiaries (HHS 2019).[5] Until 2017, the DoD conducted a data match with states once a year to identify enrollees who had coverage through both Medicaid and TRICARE. This data match was governed by a memorandum of understanding (MOU) between CMS and the Defense Health Agency (DHA), which administers TRICARE. This MOU expired in 2017 and has not been renewed. As of 2020, the only source of information for state Medicaid agencies on TRICARE coverage is self-reported enrollee information.

The DRA's provisions apply to all health insurers in a state but, as noted above, Congress has exempted TRICARE from state and local laws related to health insurance. TRICARE does not follow the DRA requirement that all insurers in a state accept TPL claims from Medicaid for at least three years (32 CFR 199.7(d)). Instead, it treats TPL claims from Medicaid according to its own policies, which require claims to be filed within one year of either the date of service or the date of the last data match with the state (DHA 2019b). In addition, TRICARE only reimburses states and will not issue reimbursement or explanations of benefits directly to providers (DHA 2015). Finally, as noted above, many states with Medicaid managed care programs have delegated TPL responsibility to contracted MCOs, which must coordinate benefits with other health insurers. However, TRICARE does not share data with or process claims it receives from Medicaid MCOs, including those with delegated TPL responsibilities; it will only coordinate benefits with and accept claims from state Medicaid agencies (DHA 2015).

In 2011, the HHS OIG found that the differences in TPL policies between Medicaid and TRICARE make it challenging for state Medicaid agencies

to identify and recover third-party payments from TRICARE (OIG 2013). CMS has had discussions with DoD about TRICARE limitations and requirements and has provided technical assistance to help states coordinate with TRICARE (OIG 2013). However, there is evidence that states perceive these interagency efforts to have fallen short. For example, in an amendment to its Section 1115 demonstration waiver filed in 2019, Tennessee noted that “states' ability to seek payments from other parties that may be legally responsible for the cost of care provided to Medicaid beneficiaries is currently inhibited by inconsistent and conflicting federal policies,” and “[the 12-month claims limitation] inappropriately shifts healthcare costs that should be the responsibility of the federal government to states” (TennCare 2019).

Barriers to Effective Coordination of Benefits

Despite the coverage overlap between Medicaid and TRICARE, there are several barriers to effective coordination of benefits. As a result of these policies, states have difficulty administering their Medicaid TPL responsibilities for TRICARE members who are also enrolled in Medicaid, resulting in a cost shift from the federal government to states.

Lack of a data sharing agreement between DHA and states

States conduct a variety of data matches to identify third-party resources; for example, many states conduct data matches with large insurers and data clearinghouses on a daily, weekly, or monthly basis to identify other health coverage or changes in other coverage that may not have been reported by enrollees. To encourage insurer cooperation with these processes, states have developed standardized file layouts, contracted with national data clearinghouses and other partners, and reimbursed insurers for the costs incurred in providing the requested information. States typically ask insurers to disclose a large number of fields to support automated data matching, ensure the accuracy and reliability of the match, and limit the number of mismatches and inaccurate personal health information disclosures. States can use the standardized Payer Initiated Eligibility/Benefit (PIE) Transaction developed by CMS to accomplish this or they can use state-developed or proprietary transaction formats (CMS 2010). As noted above, improvements in state efforts to coordinate directly with insurers correlated with increases in Medicaid recoveries (GAO 2015). However, without a mechanism to conduct data matches with the DoD, state Medicaid programs cannot identify all enrollees who have primary coverage through TRICARE, which leads to Medicaid improperly paying some of those claims and shifting DoD health care costs to the states and HHS.

In 1986, the DoD established an agreement with the Health Care Financing Administration (HCFA)—the name of the agency was changed to CMS in 2001—to match records between the Defense Enrollment Eligibility Reporting System (DEERS) and state Medicaid agencies (DLA 1986). This initial system of database matches, created to identify the extent to which Medicaid enrollees were eligible for military health benefits, identified DHA as the matching agency and state Medicaid agencies as the source agencies. That is, the official data sharing agreement specified a system whereby the state Medicaid agencies would submit information on Medicaid enrollees (e.g., name, date of birth) to DHA, which would link the two files and return the state's file, with the same data elements originally provided, with an additional flag to indicate which Medicaid enrollees were also on file with the DHA. This agreement also provided assurances from HCFA regarding security of the data. Because the files returned to the states did not include information on military health coverage start and end dates, they were mainly used for state identification of enrollees for follow-up regarding potential TPL. Then, in the late 1990s, states were given access to the DEERS database, which allowed

Medicaid staff to look up eligibility and coverage periods for individual enrollees (HCFA 1998).

In 2017, as part of the periodic review and renewal of the data sharing agreement, CMS determined that it was no longer able to certify the data security provisions of the agreement. Specifically, the agreement between the DoD and CMS required CMS to ensure the security of the data provided by DHA to states. However, TRICARE's TPL data matching system uses a direct data exchange between DHA and state Medicaid agencies, and CMS never collects any DoD or state data related to the match. Because CMS does not participate in the exchange of data itself, it has not conducted a specific security assessment of state information systems that would allow it to certify to the DoD that the DHA data are secure. Therefore, beginning in 2017, CMS determined that it could not sign an agreement with DoD that requires such certification. This was not the result of a change in the data match process, but rather the result of changes in CMS's standards for data sharing and its internal process for reviewing data security agreements. Without a signed agreement, DHA stopped sharing files with state Medicaid agencies, and so those agencies are no longer able to exchange enrollment information needed to coordinate benefits with TRICARE.

Infrequent data matches and one-year timely filing window

The lack of an active data sharing agreement between CMS and DHA is the biggest roadblock to coordination of benefits between Medicaid and TRICARE, but the procedures outlined in the prior agreement and the terms of that agreement also limited the effectiveness of efforts to coordinate benefits.

For example, under the procedures outlined in the original agreement, each state would send a flat file (e.g., a spreadsheet) listing all enrollees to DHA and receive the same file back with an additional column of data that indicated whether or not DHA had identified a match in DEERS (e.g., an eligible sponsor with TRICARE coverage or an eligible dependent on a TRICARE policy). State TPL staff would then have to look up each individual in the DEERS system to get the additional information needed to coordinate benefits (e.g., the insurer identifier, coverage start and end dates as applicable, or the policy number). Because the data did not include fields such as the Social Security number, address, and other details that help identify individuals, staff sometimes made incorrect matches which then required further research or created additional delays in payment processing. Depending on the number and accuracy of the matches, this manual research process could take up to six months.

In addition, the data match provided information on TRICARE coverage only as of the time of the data match; information about changes in TRICARE coverage that could affect TPL (e.g., a child aging out of family coverage) between annual data matches would not be passed on to the states as those changes occurred. The annual manual matching procedures outlined in the 1986 data sharing agreement are no longer used by most insurers; to improve Medicaid TPL collections, most states conduct frequent (e.g., weekly or monthly) data matches with other insurers for automated verification of other health insurance coverage and use more sophisticated data matching procedures.

In addition, as noted above, in 2005, Congress took action to improve Medicaid recoveries, such as requiring insurers to provide coverage information to state Medicaid agencies and to accept TPL claims for up to three years after the date of service. However, it did not extend these provisions to government health programs, and the DHA did not voluntarily renegotiate the agreement with CMS to reflect these terms or waive the claims filing deadline to align with the DRA provision for Medicaid despite having the administrative authority to do so (32 CFR 199.7(d)). Instead, although DHA allows states access to the DEERS database to look up individual enrollees, DHA will exchange data files with states only when there is an active MOU with CMS, and will accept TPL claims for only one year

from date of service or one year from the date of the last data match (DHA 2019c).

These two operational limitations contribute to a cost shift to Medicaid. First, when there was an active MOU in place, the DHA would conduct a data match with each state only once per year on a schedule established by the DHA. Depending on when a person became eligible for Medicaid, it could be up to 11 months before the next data match, meaning that the state could potentially pay claims for almost a year before learning that the enrollee had other health coverage through TRICARE that would enable it to start the TPL process. GAO has noted that cost avoidance comprises a much greater proportion of Medicaid TPL savings than the pay and chase approach (GAO 2015). Thus, it is likely that identifying Medicaid enrollees with TRICARE coverage once per year instead of monthly or quarterly limits states' ability to avoid paying most TRICARE TPL claims and results in states improperly paying claims that are the responsibility of DoD.

Second, federal Medicaid rules require states to give providers one year from the date of service to submit a claim for payment and states then have up to 90 days to pay most claims (42 CFR 447.45). Because it may take states more than one year from the date of service to receive and review a claim within the normal course of business, Congress created the statutory provision requiring insurers to accept TPL requests from states for up to three years after the date of service. TRICARE's one-year limit on TPL claims also likely results in states improperly paying claims that are the responsibility of DoD. A 2011 survey by the OIG found that 92 percent of states reported TRICARE's one-year timely filing limit to be "very challenging" to their ability to recover payments (OIG 2013).

Finally, these two policies have compounding effects on each other. By the time a state has conducted the annual data match, researched TRICARE coverage, and identified a potential claim subject to TPL, more than a year may have passed from the date of service even if the claim was submitted and paid promptly by Medicaid. TRICARE carriers have also provided conflicting guidance to states on whether they will use the later date—one year from the date of the data match or one year from the date of service—when accepting claims (OIG 2013). In a 2011 OIG survey, 74 percent of states reported that these two factors limited states' ability to identify and recover third-party payments from TRICARE (OIG 2013).

Lack of coordination with Medicaid MCOs

A third—but growing—issue is the lack of coordination between TRICARE carriers and the Medicaid MCOs that pay claims for over half of Medicaid beneficiaries and have TPL responsibilities. When the DoD and HCFA first began coordination in 1986, fewer than 3 percent of Medicaid beneficiaries were enrolled in managed care (HCFA 1995). However, as of July 1, 2017, over 68 percent of beneficiaries were enrolled in comprehensive managed care plans, which accounted for nearly half of Medicaid benefit spending (MACPAC 2019a).

From the Medicaid perspective, MCOs are state contractors and can be delegated insurance functions, including TPL responsibilities, by the state agency. In 2012, CMS provided a policy clarification regarding implementation of the DRA provisions, noting that "when TPL responsibilities are delegated to an MCO, third parties are required to treat the MCO as if it were the state Medicaid agency," including providing access to third-party eligibility and claims data to identify individuals with third-party coverage (CMS 2014). However, these provisions do not apply to government health programs, including TRICARE. As a matter of policy, DHA does not share data with Medicaid MCOs, including those with delegated TPL responsibilities. TRICARE carriers only coordinate benefits with and accept claims from state Medicaid agencies and require a current billing agreement with the state before they will do so (DHA 2015). In the best-case

scenario, states can coordinate benefits for only the subset of Medicaid enrollees remaining in FFS.[6]

The exclusion of Medicaid MCOs from TRICARE TPL activities also complicates states' abilities to accurately set payment rates for Medicaid MCOs. States have several options for complying with federal TPL rules but many have delegated TPL responsibility to MCOs, and set payment rates accordingly. That is, the states' payment rates assume that MCOs will either cost avoid or pay and chase a reasonable proportion of third-party claims. Because TRICARE carriers will not accept claims from Medicaid MCOs without a billing agreement, MCOs cannot pay and chase any TPL claims; their only option is to cost avoid. However, because DoD will not conduct data matches with Medicaid MCOs or give them access to the DEERS database, MCOs must rely on the state agency to provide information from the annual data match to identify which enrollees have TRICARE coverage to determine which claims can be cost avoided. The result is that MCOs are likely paying claims that are the responsibility of the DoD, and the capitation rates paid to the MCOs overestimate the cost of services that are the responsibility of the MCOs (i.e., MCOs pay for services that should be paid by TRICARE as the primary insurer but cannot be proactively cost avoided) and underestimate TPL recoveries (i.e., MCOs cannot recover improperly paid amounts from TRICARE due to DHA policies).

Commission Recommendations

Recommendation 4.1

The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

Rationale

Medicaid is generally the payer of last resort: by law, all other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. To put this into practice, Medicaid attempts to coordinate benefits with other insurers as a secondary payer and will deny claims (for resubmission to the primary payer) when a Medicaid enrollee has other health insurance. However, if a Medicaid program is unaware that an enrollee has other coverage at the time a claim is paid, it may pay the full amount, then later seek reimbursement from the primary insurer for the amount that insurer is liable, a practice known as pay and chase. GAO has noted that cost avoidance accounts for most of the savings to Medicaid associated with coordination of benefits and that fewer savings result from pay and chase (GAO 2015). Therefore, it is important from a fiduciary standpoint that state agencies have information in the system about which Medicaid enrollees have other sources of health insurance before claims are paid.

There are two ways that state Medicaid agencies can learn about TRICARE coverage without a data match. First, individual Medicaid enrollees are asked about sources of other coverage at enrollment and may indicate that they have TRICARE coverage. Even so, without the data match process, states are unable to identify many cases (e.g., non-custodial children, mid-year changes) and as a result, they are paying claims that should be the responsibility of DoD. The second method is for states to access the DEERS database and look up whether Medicaid enrollees have TRICARE coverage. However, state staff can research only one case at a time in the DEERS system, a time-consuming task that cannot be scaled up to determine third-party coverage for multiple enrollees at once.

The data match system need not be reinstated under the same terms as previously. From 1987 through 2016, a data sharing agreement between the DoD and CMS allowed state agencies and the DHA to share eligibility records. However, states have noted that the information and frequency

of matches allowed by the previous data sharing agreement supported an inefficient coordination of benefits process (OIG 2013). Alternatives could include: developing a process to share data between the DoD and CMS that CMS could then share with states through an existing, secure portal; facilitating direct data sharing agreements between the DoD and state Medicaid agencies; determining whether other DoD-CMS-state data sharing mechanisms include sufficient data fields and could be adapted to support this activity; or identifying a third party to conduct data sharing and coordination of benefits between DoD and state Medicaid agencies. A working group of DHA, CMS, and state representatives could help identify the approach that best balances the requirements of data security, timeliness, and administrative efficiency.

Without a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the DHA, states cannot identify all of the nearly 1 million Medicaid enrollees who also have TRICARE coverage and are therefore paying claims that should be paid first by TRICARE. Because most of these payments cannot be recouped by Medicaid even if the TRICARE coverage is later identified, the lack of a routine, complete eligibility data match results in a cost shift from DoD to state Medicaid agencies and HHS. Reinstating the data match would help ensure that Medicaid remains the payer of last resort, as intended by Congress.

Implications

Federal spending. This recommendation would increase the integrity of the Medicaid program and reduce cost shifting to Medicaid from TRICARE, which would increase federal spending, because Medicaid is partially paid for by the states and TRICARE is a wholly federal program. However, this does not represent new federal spending, because TRICARE is already responsible for these payments. The Congressional Budget Office (CBO) typically only provides cost estimates for changes to federal spending that result from statutory changes and will not score this type of recommendation. It is worth noting that CBO looks at expenditures from the perspective of the unified federal budget (meaning that it would not provide an estimate of Medicaid savings and TRICARE costs resulting from this recommendation, only the net effects, if any, on federal spending).

States. This recommendation would change the administrative demands on states; they would have additional administrative activities associated with the data match, but improved coordination of benefits could potentially streamline benefit administration and reduce the need for repayment negotiations. At the same time, some claims costs currently borne by states would be shifted back to the DoD. Generally, improved coordination of benefits is considered a positive return on investment and it is possible that reduced claims costs for the nearly 1 million enrollees with primary TRICARE coverage would outweigh any additional administrative burdens.

Enrollees. Timely data exchange would affect enrollees by helping to support coordination of benefits. For Medicaid enrollees who have primary insurance coverage through TRICARE, improved coordination of benefits should simplify Medicaid payment of patient cost sharing.

Plans and providers. Improved coordination of benefits would also affect providers by helping to ensure that claims will be paid by the appropriate organization at first billing, improving the speed and accuracy of provider payment. Some providers could receive higher payments if TRICARE becomes the primary payer for services provided to enrollees with both Medicaid and TRICARE coverage, because TRICARE physician rates are generally based on the Medicare fee schedule, which is typically higher than the Medicaid fee schedule (MACPAC 2019b).

Recommendation 4.2

To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE,

Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Rationale

The operational limitations in how DHA coordinates benefits contribute to a cost shift to Medicaid. Because it may take states more than one year from the date of service to receive and review a claim within the normal course of business, Congress created the DRA provision requiring insurers to accept TPL requests from states for up to three years after the date of service. By limiting TRICARE TPL claims to one year, it is likely that this timely filing policy results in states improperly paying claims that are the responsibility of the DoD. In addition, the exclusion of Medicaid MCOs from TRICARE TPL activities also complicates states' abilities to accurately set payment rates for Medicaid MCOs. Requiring the TRICARE carriers to implement the same TPL policies as other health insurers (e.g., share coverage information with the states, accept claims for up to three years, and accept the right of recovery from the state and its contractors, including MCOs) should reduce the shifting of costs and improve operational efficiency.

Although statutory changes are not necessary to make some changes to improve the TPL process (e.g., the DHA has the administrative authority to waive the timely filing limit), as of 2020, the Medicaid and TRICARE programs have not been able to coordinate benefits for over three years, despite efforts to improve coordination at the agency level. From the Medicaid perspective, aligning TRICARE's requirements with the requirements of other third-party insurers would be administratively straightforward. However, because Congress has previously exempted TRICARE from state and local laws related to health insurance (10 USC § 1103), it appears that clearer direction from Congress through a statutory change or other directive is needed to apply those requirements to TRICARE. This would also be consistent with prior Commission recommendations to Congress to change the statute to avoid Medicaid making disproportionate share hospital (DSH) payments to cover costs that are the primary responsibility of other payers (MACPAC 2019c).

Implications

Federal spending. This recommendation would increase the integrity of the Medicaid program and reduce cost shifting to Medicaid from TRICARE, which would increase federal spending, because Medicaid is partially paid for by the states and TRICARE is a federal program. The total effect to both programs from implementing all components of this recommendation would likely be greater than from Recommendation 4.1, which would only reinstate the data match without necessarily changing the timely filing limit or adding managed care coordination of benefits. As with Recommendation 4.1, this does not represent new federal spending, because TRICARE is already responsible for these payments.

States. This recommendation would change the administrative demands on states. They would have additional administrative activities associated with coordination of benefits but would be able to return liability for many claims back to the primary payer, DoD. Over time, states would have more accurate data to set capitation rates. It is likely that the reduced claims costs would outweigh any additional administrative burdens.

Enrollees. As with Recommendation 4.1, timely data exchange would affect enrollees by helping to support coordination of benefits and could simplify Medicaid payment of patient cost sharing for Medicaid beneficiaries who have primary insurance through TRICARE. In addition, these changes would affect Medicaid managed care enrollees by helping to support coordination of benefits and coverage of patient cost sharing.

Plans and providers. Improved coordination of benefits would affect providers by helping to ensure that claims would be paid by the appropriate organization at first billing, improving the speed and accuracy of provider payment. Some providers,

including FFS and managed care providers, could receive higher payments if TRICARE becomes the primary payer for services provided to enrollees with both Medicaid and TRICARE coverage.

Endnotes

[1] Exceptions include a small number of programs that have been statutorily designated as payers of last resort after Medicaid (e.g., the Ryan White HIV/AIDS Program, Title V Maternal and Child Health Block Grant Program, Indian Health Service, Individuals with Disabilities Education Act programs, and World Trade Center Health Program) and programs that are not considered to be legally liable third parties, such as schools, public health programs, and family service and child welfare agencies carrying out their general responsibilities to ensure access to needed health care.

[2] CMS has regulations and guidance addressing coordination of benefits between Medicare and Medicaid, but these interactions are not the focus of this analysis. MACPAC has previously examined several of these policies, including lesser-of payment policies and Medicaid coverage of premiums and cost sharing. Similar detailed policies do not exist for interactions between Medicaid and other third-party payers.

[3] Sharing of third-party liability information between the state, its contractor, and providers or potentially liable third parties is permitted under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) but must comply with the HIPAA business associate requirements, where applicable.

[4] Section 6035 of the DRA created a new section of the Social Security Act (1902(a)(35)) that directs states to pass laws requiring health insurers to provide certain information "in a manner prescribed by the Secretary" and to comply with timely filing requirements.

[5] An important distinction exists between data exchange for purposes of supporting the health insurance exchange federal data hub and data exchange for purposes of supporting Medicaid TPL activities: CMS operates the federal data hub and each state can access the data from the hub, so only one data exchange with TRICARE is needed; but under the terms of the Medicaid TPL data sharing agreement, CMS acts as an intermediary only and TRICARE conducts data exchanges with each state Medicaid program individually (i.e., 51 separate data exchanges each year).

[6] Depending on state policy, a state may be able to recoup the amount that TRICARE is liable for from the provider if it is unable to recover it directly from TRICARE.

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Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on Medicaid and TRICARE third-party liability coordination. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 4.1 and Recommendation 4.2 on April 2, 2020.

Medicaid and TRICARE Third-Party Liability Coordination

4.1 The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
Not present:	Barker	1	Not present

4.2 To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
Not present:	Barker	1	Not present