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## **Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid**

*Updated September 11, 2014*

**Q1: What are the parameters of the Social Security Act related to the liability of health insurers and other third parties in paying for health care services provided to Medicaid beneficiaries?**

**A1:** The Social Security Act (the Act) generally requires health insurers and other third parties that are legally liable to pay for health care services received by Medicaid beneficiaries to pay for the services that are primary to Medicaid. However, state Medicaid agencies might mistakenly pay claims for which a third party may be liable, because they are not aware of the existence of other coverage.

The Deficit Reduction Act of 2005 (DRA) made a number of changes to title XIX of the Social Security Act intended to strengthen state Medicaid programs' ability to identify and collect from third party payers that are legally responsible to pay claims primary to Medicaid.

Specifically, section 6035 of the DRA amended section 1902(a) (25) of the Act:

- (1) To clarify which specific entities are considered "third parties" and "health insurers" that may be liable for payment and that cannot discriminate against individuals on the basis of Medicaid eligibility; and,
- (2) To require that states pass laws requiring health insurers:
  - (a) To provide the state with the coverage, eligibility, and claims data needed by the state to identify potentially liable third parties, including, at a minimum, name, address, and ID number;
  - (b) To honor the assignment to the state of a Medicaid beneficiary's right to payment by insurers for health care items or services; and,
  - (c) Not to deny such assignment or refuse to pay claims submitted by Medicaid based on procedural reasons (e.g., the failure of the beneficiary to present his/her insurance card at the point of sale, or the state's failure to submit an electronic, as opposed to a paper, claim).

## Clarifying Entities Considered to Be “Third Parties” and “Health Insurers”

**Q2: How are “third parties” defined in the Social Security Act (the Act) and what changes did the Deficit Reduction Act of 2005 (DRA) make to that definition?**

**A2:** Section 1902(a)(25)(A) of the Act requires states to take all reasonable measures to ascertain the legal liability of “third parties” for health care items and services provided to Medicaid beneficiaries. The DRA did not change the definition of “third parties,” but rather *clarified* the entities subject to the provisions of section 1902(a) (25) (A) and (G) of the Act. Section 6035(a) of the DRA amended section 1902(a)(25)(A) of the Act to clarify that the “third parties” subject to the provisions of 1902(a)(25) include: (1) self-insured plans, (2) pharmacy benefits managers (PBM), and (3) “other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service”, including workers’ compensation, automobile insurance, and liability insurance plans. The DRA also replaced reference to “a health maintenance organization” with “a managed care organization” (MCO) in identifying the types of third parties to which the provisions of section 1902(a) (25) apply.

Section 1902(a) (25) (G) of the Act prohibits health insurers from taking an individual’s Medicaid status into account in enrollment or payment decisions.

**Q3: How does section 1902(a) (25) of the Social Security Act (the Act) define “health insurers”?**

**A3:** Section 1902(a) (25) (I) of the Act defines “health insurers” to include self-insured plans, group health plans (as defined in section 607(I) of the Employee Retirement Income Security Act of 1974 (ERISA)), service benefit plans, managed care organizations (MCOs), pharmacy benefit managers (PBMs), and “other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.” Workers’ compensation, automobile insurance, and liability insurance plans all are included within the definition of “health insurers” for purposes of this section and the requisite state laws which must be enacted pursuant to it.

The CMS interprets “other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim” to include:

- (1) Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). For purposes of Medicaid managed care, PIHPs and PAHPs are entities that contract with the state to deliver Medicaid-covered services; in that context, they would also be considered “other parties that are, by contract, legally responsible for payment of a claim for a health care item or service;” and,

- (2) Such entities as third party administrators (TPAs), fiscal intermediaries, and managed care contractors, which administer benefits on behalf of the risk-bearing plan sponsor (e.g., an employer with a self-insured health plan). CMS recognizes that entities such as PBMs and TPAs do not necessarily have ultimate financial liability, but, to the extent that they are required, by contract or otherwise, to review claims and authorize payment by the plan sponsor, they are included within the definition of “third party” and “health insurer” for purposes of section 1902(a) (25) of the Act.

Nothing in revisions to the Social Security Act made by the Deficit Reduction Act of 2005 (DRA) imposes new liability to pay claims on entities that do not otherwise bear such liability. Nor does section 1902(a) (25) of the Act negate any right of indemnification against a plan sponsor or other entity with ultimate liability for health care claims by a contracting party that pays the claims.

**Q4: Are Pharmacy Benefits Managers (PBMs) and Third Party Administrators (TPAs) considered to be third party resources for purposes of Medicaid?**

**A4:** Yes. PBMs and TPAs are considered to be “third parties,” as clarified in section 6035(a) of the Deficit Reduction Act of 2005 (DRA)’s amendment of section 1902(a)(25)(A) of the Social Security Act.

PBMs, TPAs, and similar entities may not have financial liability for actual payment of claims, depending on the nature and extent of services to be performed for the health insurer, as specified in the contract. However, if the PBM or TPA performs claims review and payment authorization for another third party, the PBM or TPA is expected to provide information to the Medicaid program, so the program can determine which party is the primary payer, for the purpose of coordinating benefits for the Medicaid beneficiary.

State law enacted to implement section 6035(a) of the DRA must require the health insurer that contracts with a PBM, TPA, or other such entity to administer the plan to provide the contracted entity with such information as may be necessary to enable that entity to furnish the state with information about when Medicaid beneficiaries may be (or may have been) covered by the health insurer, the nature of the coverage, and other necessary information.

**Q5: Are indemnity insurance policies considered to be third party resources for purposes of Medicaid?**

**A5:** Indemnity policies may be considered third party resources if the policies meet certain criteria. Federal Medicaid regulations at 42 CFR 433.136 define a third party as “any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a state plan.” This includes private

insurance. Section 433.136 also defines private insurer to include “any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-related insurance contracts and indemnity contracts).” Private insurers are required to comply with the Deficit Reduction Act of 2005 (DRA) and related state enactments.

Indemnity plans may include a variety of insurance policies such as accident, cancer/specified disease, dental, hospital confinement indemnity, hospital confinement sickness indemnity, hospital intensive care, long-term care, short-term disability, specified health event, and vision. An individualized review of the various policy terms would be necessary to determine if they should be considered a third party resource for purposes of Medicaid. If this review determines that the policy provides for payment of health care items and services, the policy is a third party resource and payments would be assigned to the Medicaid agency.

An indemnity policy may be designed to pay a cash benefit to policyholders, unless the policyholder chooses otherwise. The policy may state that these payments may be used to cover medical expenses or living expenses such as rent, child care, or groceries. However, the insurance company may condition payment upon the occurrence of a medical event. Whenever payments are linked to specific medical events, these payments should be considered third party payments. Thus, the state could seek to recover Medicaid payments from the policy benefits.

Where indemnity policies do not qualify as a third party resource, any payments made to a Medicaid beneficiary may be countable as income for Medicaid eligibility purposes.

### **Provision of Eligibility Coverage and Claims Data**

**Q6: What are the requirements under the Social Security Act for health insurers to share eligibility information with state Medicaid agencies?**

**A6:** Section 6035(b) of the Deficit Reduction Act of 2005 (DRA) created a new subparagraph (I) in section 1902(a)(25) of the Social Security Act (the Act), that requires states to establish laws that require the production of the information necessary for each state Medicaid agency to determine third party liability for services rendered to Medicaid beneficiaries. Specifically, section 1902(a) (25) (I) (i) of the Act directs states, as a condition of receiving federal financial participation (FFP) for Medicaid, to have laws in effect that require health insurers doing business in their state to provide the state with the requisite information with respect to individuals who are eligible for, or are provided medical assistance, i.e., Medicaid beneficiaries.

States pass their own laws regarding the submission of health insurance information to implement the provisions of the DRA. As with most federal laws that require some

action on the part of the state to implement, states have some latitude in determining how best to comply. Since the information would be provided to the state Medicaid agency as required by that state's laws, it follows that the submission should conform to what is required under that state law. Such requirements would ensure the state Medicaid agency's access to the information is necessary and sufficient to determine third party liability for care provided to Medicaid beneficiaries.

**Q7: What information are health insurers required to share with state Medicaid agencies?**

**A7** States enact laws to comply with section 1902(a) (25) (I)(i) of the Social Security Act and must require health insurers to provide, upon the request of the state, information to determine during what period Medicaid beneficiaries may be (or may have been) covered by the health insurer and the nature of the coverage that is or was provided.

This information includes, at a minimum, four (4) data elements: the insured's name, address, group or member ID number, and periods of coverage. State laws determine exactly what information is required to be submitted by the health plans. Health plans are to provide these files to state Medicaid programs so that these programs can determine whether any third party payers are liable for the medical items and services that were, or will be, delivered to a Medicaid beneficiary. In essence, the point of the information gathering is to ensure that Medicaid benefits are paid correctly.

In the case of health insurers who contract with a pharmacy benefit manager (PBM) or other third party administrator (TPA) to administer the plan, states also will need to require that such insurers provide the PBM or TPA with such information as may be necessary to enable that entity to furnish the state with the prescribed data, or deal with such inquiries directly without the aid of their PBM or TPA.

**Q8: How far back can state Medicaid agencies go in requesting eligibility and coverage information from health insurers?**

**A8:** The Deficit Reduction Act of 2005 (DRA) requires states to have laws in effect that require health insurers to honor claims submitted by the Medicaid agency within three years of the date of service.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and Sharing of Third Party Eligibility and Coverage Information with Medicaid Programs**

**Q9: How may state Medicaid agencies use the data obtained from the third party insurers?**

**A9:** State Medicaid agencies and their business associates can use the data obtained pursuant to the process established under section 1902(a)(25)(I) of the Social Security Act and applicable state laws, as permitted or required by law. This should include the

coordination of payments for services covered under the Medicaid state plan and actions to ensure that correct payment amounts are made under the Medicaid program and that mistaken payments are recovered. If the appropriate legal relationships are established (e.g., business associate agreements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)), we expect that the data could be released to entities working under contract with a state agency for use in activities such as claims adjudication activities, or for the purpose of recovering improper Medicaid payments. State Medicaid agencies must have procedures in place to ensure that the privacy of individuals is appropriately protected, and that information concerning applicants and beneficiaries is protected in accordance with the requirements of 42 CFR Part 431 Subpart F and the regulations at 45 CFR Parts 160 and 164, which were promulgated under HIPAA and Health Information Technology for Economic and Clinical Health (HITECH) Act.

**Q10: Does a health plan’s submission of information from its full eligibility file, for the purpose of matching that information to the Medicaid eligibility file, violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules?**

**A10:** State laws determine what information is required of the health plans. A health plan’s disclosure and use of information that is required to be submitted under state law – such as, information from insurer eligibility files sufficient to determine during what period any individual may be, or have been, covered by a health insurer and the nature of the coverage that is or was provided by the health insurer — is consistent with the HIPAA privacy provisions.

Under HIPAA, both the state Medicaid agency and most health insurers are covered entities and must comply with the HIPAA Privacy Rule in 45 CFR Part 160 and Part 164, Subparts A and E. In their capacities as covered entities under HIPAA, the state Medicaid agency and health insurers are restricted from using and disclosing protected health information (PHI), as that term is defined in 45 CFR section 160.103, other than as permitted or required by the HIPAA Privacy Rule. However, as relevant here:

- (1) A covered entity may use or disclose PHI to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law. (45 CFR 164.512(a)(1)) Under this provision, each covered entity must be limited to disclosing or using only the PHI necessary to meet the requirements of the law that compels the use or disclosure. Anything required to be disclosed by a law can be disclosed without violating HIPAA under the “required by law” provisions. Therefore, health insurers may disclose data elements in addition to the four minimum data elements, up to and including submission of an entire insurer eligibility file, to the extent such information is required to be submitted by state law. (45 CFR 164.512(a))

- (2) Separately, a covered entity may use or disclose PHI, without the consent of an individual, for payment activities, including to facilitate payment. (45 CFR 164.502(a)(1) and 164.506) Under HIPAA, the term payment includes activities undertaken by a health plan to determine or fulfill its responsibility for coverage and provision of benefits under the health plan. These activities include determinations of eligibility or coverage, adjudication or subrogation of health benefits claims, and collection activities. (45 CFR 164.501) To the extent plans are releasing this information to the Medicaid program for payment purposes; this is a separate basis for disclosure under HIPAA.
- (3) The HIPAA Privacy Rule generally requires covered entities to take reasonable steps to limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose. (45 CFR 164.502(b)(1)) However, among other limited exceptions, the minimum necessary requirements do not apply to uses or disclosures that are required by law under 45 CFR 164.512(a).

### **Data Matching with Out-of-State Carriers**

**Q11: May state Medicaid agencies request information on subscribers and dependents covered in other states?**

**A11:** Yes. There is a significant amount of third party coverage derived from health plans licensed in a different state than where the Medicaid beneficiary resides. This can commonly happen when the policyholder works in one state and lives in another state. For example, there may be policyholders who are enrolled in Medicaid coverage in Maryland, or have dependents that are enrolled, who work in Delaware, the District of Columbia, Pennsylvania, Virginia, or West Virginia and also have coverage through their employer in that state. This highlights the need for Medicaid agencies to obtain plan eligibility information from contiguous states in addition to collecting information in their respective state.

Another example is when Medicaid-eligible children are covered by the insurance plan of non-custodial parents who live in a different state than their child(ren). This example is not limited to contiguous states because non-custodial parents could reside in any state in the country. Depending on the size, it may be beneficial for the state to obtain the plan's entire eligibility file. The specific geographical areas to be included in the data exchange should be negotiated with the plans. We recommend use of a Trading Partner Agreement in the exchange of electronic data.

Finally, section 1902(a)(25)(I)(i) of the Social Security Act directs states, as a condition of receiving federal financial participation (FFP) for Medicaid, to have laws in effect that require health insurers **doing business in their state** to provide the state with the

requisite information with respect to individuals who are eligible for, or are provided medical assistance, i.e., Medicaid beneficiaries. State law cannot reach beyond the entities that are “doing business” in their states.

## States' Use of Contractors for Data Matching and Claims Submission

**Q12: May state Medicaid agencies use contractors to complete data matches with health insurers?**

**A12:** Yes. State Medicaid programs may enter into data matching agreements directly with third parties or may obtain the services of a contractor to complete the required matches. Such arrangements should comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA)'s "Business Associate" requirements, where applicable. When the state Medicaid program chooses to use a contractor to complete data matches, including matches as required by the Deficit Reduction Act of 2005 (DRA), the program delegates its authority to obtain the desired information from third parties to the contractor.

Third parties should generally treat a request from the contractor as a request from the state Medicaid agency. Third parties may request verification from the state Medicaid agency that the contractor is working on behalf of the agency and the scope of the delegated work.

## Medicaid Managed Care Organizations (MCOs) and Third Party Liability (TPL)

**Q13: Can Medicaid Managed Care Organizations (MCOs) use a contractor to complete data matches with health insurers, as authorized by the state Medicaid agency?**

**A13:** Yes. State Medicaid programs may contract with MCOs to provide health care to Medicaid beneficiaries, and may delegate responsibility and authority to the MCOs to perform third party liability TPL discovery and recovery activities, including data matches as required by the Deficit Reduction Act of 2005 (DRA). The Medicaid program may authorize the MCO to use a contractor to complete these activities. The contract language between the state Medicaid agency and the MCO dictates the terms and conditions under which the MCO assumes TPL responsibility. Generally, any TPL administration and performance standards for the MCO will be set by the state and should be accompanied by state oversight.

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:

- (1) Providing access to third party eligibility and claims data to identify individuals with third party coverage;
- (2) Adhering to the assignment of rights from the state to the MCO of a Medicaid beneficiary's right to payment by such insurers for health care items or services; and,

- (3) Refraining from denying payment of claims submitted by the MCO for procedural reasons.

Third parties may request verification from the state Medicaid agency that the MCO or its contractor is working on behalf of the agency and the scope of the delegated work.

### **Requiring Third Parties to Honor the State's Assignment of Rights and to Reimburse Medicaid Appropriately for Claims Paid by Medicaid**

#### **Q14: What is the responsibility of liable third parties regarding health insurers' denials of Medicaid claims based on insurers' procedural requirements?**

**A14:** Under section 1902(a)(25)(H) of the Social Security Act (the Act) before passage of the Deficit Reduction Act of 2005 (DRA), states were required to have laws in effect that to the extent Medicaid payment was made, the state was considered to have acquired the rights of the Medicaid beneficiary to reimbursement by any other party that was liable for payment. However, payers sometimes deny Medicaid claims based on procedural requirements. Section 1902(a)(25)(I) of the Act, added by the DRA, strengthens the statute by requiring states to enact laws that require health insurers:

- (1) To accept the state's right of recovery and the assignment to the state of the right of a Medicaid beneficiary or other entity to payment from such party for an item or service for which Medicaid has made payment; and,
- (2) To process and, if appropriate, pay the claim for reimbursement from Medicaid to the same extent that the plan would have been liable had the plan's card been used for billing at the "point of sale" (POS).

Specifically, the state should pass laws which require an insurer to agree not to deny claims submitted by the state 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 of coverage at the POS that is the basis of the claim.

Whether a plan provision affecting payment for an item or service is solely procedural in nature or whether it defines or limits the covered benefits must be determined on a case-by-case basis.

Note that nothing in the DRA negates the state's responsibility to provide proper documentation when submitting claims to the health insurer so that the insurer can determine that a covered service for which the insurer is liable was provided.

**Q15: Are health plans permitted to require a National Provider Identifier (NPI) for transactions with Medicaid programs?**

**A15:** No. States typically do not meet the definition of a covered health care provider under 45 CFR 160.103, and therefore, are not eligible to receive an NPI. If states encounter situations where plans are requiring them to submit an NPI, they can submit a formal complaint to the Office of E-Health Standards and Services (OESS) in CMS by using the online Administrative Simplification Enforcement Tool (ASET). ASET allows individuals or organizations to electronically file a complaint against an entity whose actions they believe violate an Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

States may submit a formal complaint electronically at: <https://htct.hhs.gov/aset/>. ASET users are required to register with OESS and create a user identification name and password. States also may submit a paper complaint. The form is available at: [www.cms.hhs.gov/Enforcement/Downloads/HIPAANon-PrivacyComplaintForm.pdf](http://www.cms.hhs.gov/Enforcement/Downloads/HIPAANon-PrivacyComplaintForm.pdf).

#### **State Medicaid Programs' Claiming Period**

**Q16: How long do states have to submit a claim for reimbursement to health insurers?**

**A16:** Section 1902(a)(25)(I) of the Social Security Act requires states to have laws in effect that require health insurers to make payment as long as the claim is submitted by the state within three years from the date on which the item or service was furnished.

Some health insurers currently deny claims submitted by Medicaid if they are not filed within a prescribed time limit, which is applied to plan beneficiaries and providers (e.g., a plan might require beneficiaries and providers to submit claims within 30 days from date of service). If the state Medicaid agency is unable to ascertain the existence of the third party coverage and submit a claim within the time limit, the insurer may attempt to avoid liability.

Any action by the state to enforce its rights with respect to such claim must be commenced within six years of the state's submission of such claim. Health insurers also must respond to any inquiry by a state regarding claims submitted within three years from the date on which the item or service was furnished.

**Q17: Are states precluded from having laws that require third parties to accept claims beyond the 3-year filing period prescribed in the Deficit Reduction Act of 2005 (DRA)?**

**A17:** No. Section 1902(a)(25)(I)(iv) of the Social Security Act requires states to pass laws that would require health insurers to accept claims submitted by the state within the 3-year period beginning with the date on which the item or service was furnished. States are not precluded from having laws or regulations that would require insurers to accept claims for a period of time longer than three years.

### **Medicare Billing**

**Q18: May Medicaid programs bill Medicare directly?**

**A18:** No. States typically do not meet the definition of a covered health care provider, and therefore, are not eligible to receive a National Provider Identifier (NPI) number to enable them to bill Medicare. The NPI is the standard unique identifier for health care providers that CMS adopted in 2007. At that time, Medicare revoked existing billing numbers previously issued to Medicaid agencies and notified Medicare carriers to stop enrolling Medicaid programs as Medicare providers. Only recognized providers and suppliers of services that have an NPI can enroll in Medicare. Medicare will not enroll state Medicaid programs, as they are not direct providers or suppliers of services.

Medicaid may submit claims to health plans on behalf of Medicaid beneficiaries who have assigned their rights to payment from third parties (other than Medicare) to the Medicaid program, under the authority of sections 1912, 1902(a)(25)(H), and 1992(a)(25)(I)(ii) of the Social Security Act. However, Medicaid doesn't have the same authority to submit claims to Medicare on behalf of a "dually" eligible beneficiary. The rights to Medicare benefits are not assignable; only the Medicare provider and the beneficiary may submit claims to Medicare.

### **Medicare Filing Timeframes**

**Q19: Is Medicare subject to the minimum 3-year timely filing period established in section 6035 of the Deficit Reduction Act of 2005 (DRA) for state laws that regulate health insurers?**

**A19:** No. The DRA limit applies to health insurers, defined in section 1902(a)(25)(A) of the Social Security Act, that are regulated by the states. Medicare Parts A and B are not subject to state regulation, as they do not need to be licensed to do business in the states. State law requiring health insurers to honor claims submitted within the timely filing period established by the state (minimum of three years) would apply to Medicare Part C and D plans.

**Q20: What is Medicare’s general timely filing period?**

**A20:** Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Social Security Act, as well as the Medicare regulations at 42 CFR section 424.44, specify the time limits for filing Medicare Fee-For-Service (FFS)--Part A and Part B--claims.

The Affordable Care Act reduced the maximum period for submission of all Medicare FFS claims to no more than 12 months (one calendar year) after the date services were furnished. This time limit policy for claims submission became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, had to be submitted no later than December 31, 2010. Section 6404 of the Affordable Care Act also mandated that CMS may specify exceptions to the one calendar year time limit for filing Medicare claims.

**Q21: What are the exceptions to Medicare’s general timely filing period?**

**A21:** Medicare regulations at 42 CFR section 424.44(b) allow for the following exceptions to the 1 calendar year time limit for filing fee for service claims:

- (1) Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.
- (2) Retroactive Medicare entitlement, where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary subsequently receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service.
- (3) Retroactive Medicare entitlement involving state Medicaid agencies, where a state Medicaid agency recoups payment from a provider or supplier 6 months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished, the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service. The state Medicaid agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired.

- (4) Retroactive disenrollment from a Medicare Advantage (MA) plan or Program of All-inclusive Care of the Elderly (PACE) provider organization, where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider or supplier 6 months or more after the date the service was furnished.

### **TRICARE Filing Limits**

**Q22:** Is TRICARE subject to the minimum 3-year timely filing period, established in section 6035 of the Deficit Reduction Act of 2005 (DRA), for states that regulate health insurers?

**A22:** No. Based upon federal authority set forth at 10 U.S.C. section 1103, Congress explicitly provided for preemption of state and local laws pertaining to health care financing methods for a contract entered into for medical and/or dental care, under Chapter 55 of the Armed Forces Title of the U.S. Code, by the Secretary of Defense or administering Department of Defense secretaries. The preemption applies to contracts entered into for the purpose of administering TRICARE. Thus, it is the position of the Department of Defense that TRICARE's 1-year timely filing limit is not superseded by the 3-year limit established in the DRA for health insurers who are regulated by the states, and that TRICARE is exempt, not only from the DRA timely filing requirements, but from the DRA requirements altogether.