Business Scenarios

Federal law generally requires health insurers and other third parties legally liable to pay for health care services to pay for such services primary to Medicaid. However, Medicaid agencies often pay claims for which a third party may be liable because they lack information about the existence of other coverage. The DRA made several changes to the third party liability provisions of the Medicaid statute which are designed to enhance States' ability to identify insurance coverage, coordinate benefits, and obtain payment from third party resources that are legally responsible to pay claims primary to Medicaid. The DRA Companion Guide for the Plan Initiated Eligibility/Benefit (PIE) Transaction provides a national standard for payers to share information with Medicaid agencies. This, in turn, makes it easier for Medicaid agencies to coordinate benefits in accordance with Federal requirements. The following table describes challenges in coordinating benefits that the DRA Companion Guide is designed to meet.

Coordination of Benefits Challenge	DRA Companion Guide Solution
The Medicaid agency is not aware that a third party payer exists and so cannot advise providers to bill that primary payer first. Medicaid agencies pay providers, then must expend administrative resources to attempt to locate and bill primary payers.	The PIE Transaction will be sent by payers, e.g. Third Party Administrators, to the Medicaid agency on a periodic basis and will include all insured lives. The Medicaid agency will match subscribers to the Medicaid agency database and identify primary payers for Medicaid recipients.
The Medicaid agency cannot confirm eligibility or submit an eligibility inquiry by traditional means because the agency does not have the required Member ID. The agency is not in a position to require that the recipient present his/her insurance card at the point of sale, since in most cases other providers (and not the agency) control the point of sale.	The PIE Transaction will be sent to the Medicaid agency on a periodic basis and will include all insured lives. The Medicaid agency will use traditional identifiers (such as name and date of birth), social security numbers, and on occasion, addresses, to match subscribers to the Medicaid agency database and collect the Member ID.
Extensive time may pass between the time the provider submits a claim to the Medicaid agency, the Medicaid agency pays it and then the Medicaid agencies seeks reimbursement. The DRA requires that claims be honored by primary payers if submitted by Medicaid within three years. For some payers it is costly to process older claims.	The Medicaid agency will use the information from the PIE Transaction to direct the provider to bill the primary payer. If the provider subsequently bills the Medicaid agency for amounts not paid by the primary payer, the Medicaid agency would process the claim for proper payment. Accurate and early identification of the primary payer benefits both the Medicaid agency and the payer by ensuring that claims are processed in a timely manner.
Excessive time is spent by Medicaid agency staff on negotiating with individual payers to outline file standards for roster files. The issue is compounded when considering expanding current match programs to a greater number of payers. Payers spend large quantities of man hours managing multitudes of file formats for relaying enrollment data to each requesting State or Federal agency.	The Medicaid agency may require all payers to conform to the DRA specifications. This allows the Medicaid agency to develop one application to read all payers' roster files. Payers benefit by developing one application to output a roster file which may be consumed by any State Medicaid agency.

Payers and Medicaid agencies can work together to ensure that coordination of benefits is efficient, effective and accurate. The following table describes some of the limitations of the DRA Companion Guide and actions that Medicaid agencies and payers can take to support coordination of benefits and claims processing.

Limitation	Payer and Medicaid Agency Collaboration
Medicaid agencies do not have complete information about primary coverage and so they submit claims which payers must process and deny, reducing efficiencies and increasing processing costs to payers.	Medicaid agencies can map Service Type qualifiers received on the PIE Transaction to corresponding services supported by the Medicaid agency. When in doubt about coverage, Medicaid agencies can clarify or update coverage by submitting a 270 eligibility inquiry with specific relevant Service Type codes and accurately process the results. Payers can send all relevant Service Type qualifiers on the PIE Transaction, and can respond to each Service Type qualifier sent on 270s.
Medicaid agencies matching on Name, Date of Birth, and Gender with no SSN store a Member ID for a Medicaid recipient that is not the ID for that person. Claims are submitted and honored erroneously because the Member ID, Name and Date of Birth and Gender match.	When no SSN is present, Medicaid agencies can include algorithms for matching on addresses before storing Member IDs and/or promote manual review of records. Payers can send all available identifiers and include full address information in the PIE Transaction to support accurate identification.
Medicaid agencies identified the primary payer based on a PIE Transaction, but since the last transmission the recipient's coverage has changed and the recipient is no longer covered.	Medicaid agencies can submit a 270 to obtain updated coverage information when notified by the provider that the claim was denied. The information received on the 271 will be used to refresh the Medicaid agency records for future transactions. Payers can support full and accurate reporting of coverage in the 270/271 transactions to ensure proper coordination of benefits and accurate claims submittal.