

**Coordination of Benefits  
and Third Party Liability  
(COB/TPL)**

**In Medicaid**

**2020**

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## Acknowledgment

The [COB/TPL](#) Handbook was completed by the [COB/TPL](#) Team in the Division of Health Homes, [PACE](#), and [COB/TPL](#) (DHPC), Disabled and Elderly Health Programs Group (DEHPG), Center for Medicaid and CHIP Services, with technical support and assistance provided by Manatt, Phelps, & Phillips, LLP, under contract with Mathematica Policy Research, Inc. Members of the [COB/TPL](#) Team were Nancy Dieter, Technical Director; Barry Levin (2014), Cathy Sturgill, and Ginger Boscas (2015 - ), Health Insurance Specialists. The [COB/TPL](#) Handbook was developed at the direction of Nancy Klimon, Former Director, and Carrie Smith, Director, [DHPC](#) (2015 - 2019).

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# ABOUT THIS HANDBOOK

- 1. Purpose:** The purpose of the Handbook is to provide an overview of [COB/TPL](#) policy on a variety of individual subjects.
- 2. Intended Audience:** The Handbook is intended for [CMS](#) Central Office (CO) and Regional Office (RO) staff working on [COB/TPL](#) issues, state Medicaid agency staff, and all other parties interested in Medicaid COB/TPL policies.
- 3. Content:** The Handbook contains policy guidance on a variety of [COB/TPL](#) topics that is current at the time of publication.

An Acronyms and Abbreviations list is included immediately after this summary.

**TIP:** Acronyms will appear in the Handbook as [blue, underlined](#) text. Position the cursor over the acronym and the full term will be displayed.

- 4. Updates:** Changes to the Handbook may only be made by [CMS CO COB/TPL](#) Team staff. Requests for changes to current information, or addition of information to address new topics should be forwarded to the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mail Stop S2-16-25, Baltimore, MD 21244, Attn: Technical Director (TD) for [COB/TPL/DHPC/DEHPG/CMCS](#).

## **5. Organization of the Handbook:**

- Chapters are major subject groupings and are designated with Roman numerals.
- Sections discuss major topics within chapters and are designated with capital letters.
- Subsections discuss single topics within sections and are designated with numbers.
- Divisions discuss single topics within subsections and are designated with lower-case letters.
- The Table of Contents lists chapters, sections, subsections, and divisions, with page numbers.
- The Index lists all topics in alphabetical order, with location identified by chapter, section, subsection, and division references.
- A Reference section located at the back of the Handbook includes lists of statutes and regulations.

h. An Appendix located at the back of the Handbook includes COB/TPL training presentations.

**TIP:** Topics in the Handbook can be accessed quickly from the Table of Contents. Position the cursor over the topic and press Ctrl + Click to move directly to the topic.

**6. Questions about format or content of the Handbook should be directed to the TD for COB/TPL.**

# ACRONYMS AND ABBREVIATIONS

Acronym (the) Act	Abbreviation
AI/AN	American Indian/Alaska Native
AOR	Assignment of Rights
BBA	Bipartisan Budget Act
CAHPG	Children and Adults Health Programs Group, CMCS/CMS
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid & CHIP Services
CMS	Centers for Medicare & Medicaid Services
CO	(CMS) Central Office
COB	Coordination of Benefits
COB/TPL	Coordination of Benefits/Third Party Liability
DEE	Division of Eligibility and Enrollment (formerly DEEO, Division of Eligibility, Enrollment, and Outreach) (CAHPG)
DEERS	Defense Eligibility Enrollment Reporting System
DEHPG	Defense Eligibility Enrollment Reporting System
DHPC	Division of Health Homes, PACE, and COB/TPL (DEHPG)
DMEP	Division of Medicaid Eligibility Programs (formerly DEE, CAHPG)
DHHS	Department of Health and Human Services
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOD	Department of Defense
DRA of 2005	Deficit Reduction Act of 2005
DSG	Division of State Systems Group
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FBDE	(Medicare) Full Benefit Dual Eligible
FEMA	Federal Emergency Management Agency
FMAP	Federal Medical Assistance Percentage
FFP	Federal Financial Participation
FPL	Federal Poverty Level
ICF/IID	Intermediate Care Facility/Individuals with Intellectual Disabilities
HIS	Indian Health Service
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MSP	Medicare Savings Program
OAA	Older Americans Act
OBRA 93	Omnibus Budget Reconciliation Act of 1993
OCSE	Office of Child Support Enforcement
PACE	Program of All Inclusive Care for the Elderly
PBM	Pharmacy Benefit Manager
QDWI	(Medicare) Qualified Disabled and Working Individual

Acronym	Abbreviation
QI	(Medicare) Qualifying Individual
QMB	Qualified Medicare Beneficiary
QMB Only	(See QMB)
RA	Remittance Advice
RO	(CMS) Regional Office
SLMB	Specified Low-Income Medicare Beneficiary
SLMB Only	(See SLMB)
SMA	State Medicaid Agency
SMM	State Medicaid Manual
SSA	Social Security Administration
SSI	Supplemental Security Income
(the) State Plan	Medicaid state plan
TAG	Technical Advisory Group
TD	Technical Director
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TPL	Third Party Liability
U.S.C.	United States Code
VA	Department of Veterans Affairs

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# COB/TPL Overview

## Coordination of Benefits:

Medicaid and Other Coverage: A Medicaid beneficiary may have a third party resource (health insurance, or another person or entity) that is liable to pay for the beneficiary's health care.

## Who are "third parties"?

- Health Insurers (includes private or employer-based coverage, Medicare and TRICARE)
- Other government programs
- Other liable people or entities

## Why identify third parties?

- To ensure that Medicaid does not pay more than required, and to help recover Medicaid payments, when a third party is responsible to pay for all or some of the health care received by the Medicaid beneficiary.
- Third parties should pay to the limit of their legal liability. Third party payment reduces or eliminates Medicaid payment.

## Coordination of Benefits (COB): Primary and Last Payers

When a person has Medicaid and there is another liable third party:

- Health insurance, including Medicare and TRICARE, generally pays first, to the limit of coverage liability.
- Other third parties generally pay after settlement of claims

Medicaid is last payer for services covered under Medicaid, except in those limited circumstances where there is a federal statute making Medicaid primary to a specific federal program. The statute must expressly state that the other federal program:

- Pays only for claims not covered by Medicaid; or,
- Is authorized, but not required, to pay for health care items or services.

## Types of Third Party Payments

Third party payments include health insurance benefits, settlements or court awards for casualty/tort (accident) claims, product liability claims (global settlements), medical malpractice, worker's compensation claims, etc.

Special types of third party payments include liens (TEFRA and other), and a claim against the estate of a deceased beneficiary.

### **COB: Medicaid and Medicare Coverage**

Beneficiaries who have both Medicare and Medicaid are “dually eligible.”

There are several types of dual eligibility: Full Benefit Dual Eligible beneficiaries (FBDE), Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI), Qualified Disabled Working Individuals (QDWI), and [QMB Plus](#) & [SLMB Plus](#) (dually eligible beneficiaries who are also eligible in another Medicaid coverage group).

Medicaid coverage of Medicare cost sharing (premiums, deductibles, coinsurance, and copayments) varies by type of dual eligibility.

### **When Do COB and Third Party Liability (TPL) Activities Take Place?**

- Identification of third parties: when Medicaid eligibility is granted or shortly thereafter.
- “Cost avoidance” (requires providers to bill health insurance before billing Medicaid): before Medicaid pays a claim.
- COB (requiring cost avoidance before billing Medicaid for any remaining balance after health insurance payment): when Medicaid pays a claim.
- “Pay and Chase” (the third party resource is not known when the claim is submitted to Medicaid, or the claim is for preventive pediatric care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or for a child with IV-D enforcement in place): when Medicaid pays a claim or becomes aware of the resource.
- Creation of Casualty/Torts, Liens, and Estate Recovery claims on behalf of the Medicaid program: after Medicaid pays a claim and determines, or is advised, that the beneficiary may have a casualty/tort claim that includes the medical items and services that Medicaid paid or the beneficiary has died.

### **References**

Statute: Social Security Act (the Act)

- General [COB/TPL](#): Section 1902(a)(25)
- Assignment of Rights: Section 1912

- Estates and Liens: Section 1917

Regulations: Code of Federal Regulations (CFR)

- 42 [CFR](#) 433.36 Liens and Recoveries
- 42 [CFR](#) 433 Subpart D Third Party Liability

Medicaid State Plan (State Plan):

- Section 4.17 and Attachment 4.17-A, Estates and Liens (for additional information please refer to pages 53 and 53a – h of the state plan)
- Section 4.22, [TPL](#) (for additional information please refer to pages 69 and 70 of the state plan)
- Supplement 1 to Attachment 4.19-B, Medicare Cost-Sharing Payment Methodologies (for additional information on a state’s Medicaid buy-in, please refer to page 29 and 29a – d of the state plan)

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# Chapter I: COB/TPL Core Concepts

## A. Federal and State Partnership in COB/TPL Activities

Medicaid’s [COB/TPL](#) activities—like the rest of the Medicaid program—are administered through a federal–state partnership. Both the federal and state governments have the responsibility to ensure that Medicaid is appropriately identifying potentially liable third parties and coordinating benefits to reduce Medicaid program costs.

The federal government takes the lead with respect to the following [COB/TPL](#) activities:

- Interpreting federal statutes governing Medicaid
- Developing federal regulations and other guidance regarding requirements governing [COB/TPL](#)
- Ensuring that [state plans](#) include the required program descriptions and assurances
- Providing technical assistance to states in administering [COB/TPL](#) programs
- Auditing state records to ensure compliance with [COB/TPL](#) rules

The states generally perform the following functions:

- Enacting state laws and regulations, and developing other guidance needed to carry out [COB/TPL](#) activities
- Drafting policies and procedures that comply with federal requirements and state laws
- Carrying out [COB/TPL](#) activities for Medicaid beneficiaries, including identifying third party resources, coordinating benefits during claims payment, filing claims and recovering payment for Medicaid benefits from settlements or awards made by liable third parties, and making claims against the estates of deceased Medicaid beneficiaries when appropriate
- Advising [CMS](#) on current [COB/TPL](#) issues through the [COB/TPL](#) Technical Advisory Group (TAG)
- Reporting on recoveries, indicating the portion of recovered funds due to the federal government

### **COB/TPL Technical Advisory Group (TAG)**

The COB/TPL TAG is a forum for state Medicaid senior COB/TPL managers to discuss technical and operational issues and share best practices with CMS, relating to Medicaid policy issues. The purpose of the TAG is to inform and advise CMS as it prepares guidance, identifies and resolves issues, reviews operational policies, and carries out its responsibilities with respect to Medicaid COB/TPL requirements. The TAG also enables CMS to apprise members of current and planned initiatives in areas of interest. State members of the TAG include a Chairperson and 10 State Representatives, one for each of the 10 CMS regions. Each State Representative is responsible to solicit subjects for discussion from the states in his region and share TAG meeting summaries and other communications with the states. The COB/TPL team and Regional Office staff attend monthly conference calls, and other program and state staff attend the TAG meetings, as appropriate.

## B. Federal Funding of COB/TPL Activities

The federal government pays a portion of the cost of health care items and services provided to Medicaid beneficiaries, as well as a portion of the costs of administering the [COB/TPL](#) activities in each state.

The rate of federal matching funds (the “Federal Medical Assistance Percentage,” or “FMAP”) for health care items and services varies by state, with 50 percent at the minimum. For administrative costs, including carrying out [COB/TPL](#) activities, the federal government covers 50 percent of state Medicaid agencies’ (SMA) costs.<sup>1</sup>

Federal matching funds are not available for Medicaid payments if:<sup>2</sup>

- The [SMA](#) fails to comply with [COB/TPL](#) rules by failing to establish the liability of a third party and seek reimbursement from that third party
- The [SMA](#) did not incur any costs since it received reimbursement from a liable third party
- The SMA should prohibit private insurers from discriminating against Medicaid beneficiaries. For example, a private health insurer is prohibited from limiting or excluding payments on the basis of the individual is Medicaid eligible.
- If the [SMA](#) receives federal matching funds for a payment and is later reimbursed by a liable third party, the [SMA](#) should refund the federal government for its share of the payment, less any amount needed for incentive payments.<sup>3</sup>

### References

#### Statutes & Regulations

- FFP and Payment of Federal Share. 42 CFR § 433.140

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<sup>1</sup> 42 CFR § 433.140(b).

<sup>2</sup> 42 CFR § 433.140(a).

<sup>3</sup> 42 CFR § 433.140(c).

## C. Assignment of Rights (AOR)

### 1. Relationship to Medicaid COB/TPL Activities

Medicaid's [AOR](#) requirements are part of the eligibility determination process, but they also support Medicaid [COB/TPL](#) activities. Specifically, [AOR](#) supports Medicaid's payer of last resort status by providing the basic authority for COB with beneficiaries' health insurance coverage and for recovery from settlements in casualty/tort cases of all types. Questions about [AOR](#) as it applies to [COB/TPL](#) should be directed to the [DHPC](#), [DEHPG](#).

General information about [AOR](#) as it applies to Medicaid eligibility is provided below. Detailed questions about [AOR](#) policy should be directed to the Division of Eligibility and Enrollment (DEE), Children and Adults Health Programs Group (CAHPG).

### 2. AOR: General Requirements Related to Medicaid Eligibility

Individuals must assign to the Medicaid program their rights to medical support and payment of medical care from a third party.<sup>4</sup>

- The individual must assign his or her rights (as well as the rights of any other eligible individuals for whom the applicant has the legal authority to assign rights), and cooperate in identifying and providing information to assist the state Medicaid agency in pursuing liable third parties, unless the individual has good cause not to do so.
- States must provide Medicaid to any otherwise eligible individual who<sup>5</sup>:
  - Cannot legally assign his or her own rights
  - Would otherwise be eligible for Medicaid but for the refusal of a person legally able to assign the individual's rights or to cooperate on the individual's behalf
- Except for poverty level pregnant women, an individual must cooperate with the state Medicaid agency in establishing paternity and obtaining medical support or payments, unless the individual has good cause not to do so.

Individuals who are able and required to assign their rights to medical support and payment of medical care, but fail to do so, are not eligible for Medicaid, and a state Medicaid agency **may not** pay for **any** services for those individuals.

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<sup>4</sup> Social Security Act § 1902(a)(45); Social Security Act § 1912.

<sup>5</sup> 42 CFR § 433.148.

Medicare beneficiaries are not legally allowed to assign their rights to Medicare (except to allow payment directly to providers). As a result, individuals who are eligible for both Medicare and Medicaid will only assign their rights to Medicaid.

In some states, individuals will need to affirmatively assign their rights as part of the Medicaid application. In other states, assignment of rights to the [SMA](#) is automatic under state law. If assignment is automatic, the state must inform the individual of the terms of the state law and that accepting Medicaid coverage leads to assignment.<sup>6</sup>

For Supplemental Security Income beneficiaries in some states (these states are referred to as “1634” states), the Social Security Administration (SSA) determines whether an individual is eligible for Medicaid. In these cases, the [SSA](#) will explain orally the requirement to assign rights to Medicaid. The [SSA](#) will also explain that the applicant must cooperate with the [SMA](#) in establishing paternity and providing information to assist the state in pursuing any liable third party. The [SSA](#) will have the applicant sign a form to assign rights.

## References

### Statutes & Regulations

- Social Security Act § 1902(a)(45).
- Social Security Act § 1912.
- Rights Assigned; Assignment Method. 42 CFR § 433.146.

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<sup>6</sup> 42 CFR § 433.146.

## D. Payer of Last Resort

### 1. General Requirements

Medicaid is generally the “payer of last resort,” meaning that Medicaid only pays claims for covered items and services if there are no other liable third party payers for the same items and services. This concept is implied in statute and regulation, and has been cited by the U.S. Congress and the U.S. Supreme Court.

The Social Security Act (the Act) requires that states take “all reasonable measures to ascertain the legal liability of third parties.”<sup>7</sup> [The Act](#) further defines third party payers to include, among others, health insurers, managed care organizations (MCOs), and group health plans (health plans offered by an employer or employee organization to provide health coverage to employees and their families),<sup>8</sup> as well as any other parties that are legally responsible by statute, contract, or agreement to pay for care and services. The regulations mirror this definition of third parties<sup>9</sup>.

This broad definition of “third parties” includes a range of federal programs, including the following:

- Medicare
- TRICARE/CHAMPUS
- The Vaccine Injury Compensation Fund
- Public health programs administered by the Health Resources and Services Administration, Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration (*e.g.*, the Hansen’s Program [leprosy]; Black Lung program [coal worker’s pneumoconiosis])

The requirements for when Medicaid will and will not pay for a particular service if a third party is liable are described in more detail in the Coordination of Benefits chapter.

### 2. Exceptions

There are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federal-administered health programs. For a federal-administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services.

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<sup>7</sup> Social Security Act § 1902(a)(25).

<sup>8</sup> Social Security Act § 1902(a)(25)(a).

<sup>9</sup> 42 CFR § 433.136.

The federal statutes creating the following programs expressly state that they pay for a service after Medicaid (and thus are exceptions to the payer of last resort rule):

- Crime Victims Compensation Fund,<sup>10</sup>
- Parts B and C of the Individuals with Disabilities Education Act (IDEA),<sup>11</sup>
- Ryan White Program,<sup>12</sup>
- Indian Health Services,<sup>13</sup>
- Women, Infants, and Children Program,<sup>14</sup>
- Veteran’s benefits, for emergency treatment provided to certain veterans in a non-[VA](#) facility,<sup>15</sup>
- Veteran’s benefits for state nursing home per diem payments,<sup>16</sup>
- State health agencies,<sup>17</sup>
- State vocational rehabilitation agencies,
- Grantees under Title V of the Social Security Act (Maternal and Child Health Service Block Grant), e.g. Children with Special Health Care Needs if provided for by arrangement or agreement with the state Medicaid agency).
- World Trade Center Health Program; P.L. 111-347
- Title IV-E prevention and family services (Section 8082(b)(1) of H.R. 6 was amended by section 471(e)(10) of the Act effective October 3, 2018).

Additionally, Medicaid will pay for a service if there is another party that may—but is not legally obligated to—pay for the service. Two examples of this are the Older Americans Act (OAA) and the Federal Emergency Management Agency (FEMA).

- Under the [OAA](#), there is a source of funding to cover some services that are also covered by Medicaid. Individuals, however, are not legally entitled to receive services through the [OAA](#), and thus the [OAA](#) program has no legal obligation to cover those services. Since the [OAA](#) program is not legally liable for the service, the [OAA](#) does not fall within the definition of “third party.” Accordingly, Medicaid will pay for a service even if the [OAA](#) program would also pay for the service.
- [FEMA](#) will sometimes pay for items, such as wheelchairs, that would otherwise be covered by Medicaid. [FEMA](#) is not legally obligated to pay for those items, however, and therefore Medicaid could pay for the service.

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<sup>10</sup> 42 U.S.C. § 10602.

<sup>11</sup> Social Security Act § 1903(c)

<sup>12</sup> 42 U.S.C. §§300ff et seq.

<sup>13</sup> See Social Security Act §1905(b)

<sup>14</sup> 42 U.S.C. § 1786.

<sup>15</sup> 38 U.S.C. § 1715.

<sup>16</sup> 38 U.S.C. § 1741.

<sup>17</sup> Social Security Act § 1902(a)(11).

## References

### **Statutes & Regulations**

- Social Security Act § 1902(a)(11).
- Social Security Act § 1902(a)(25).
- Social Security Act § 1903(c).
- Social Security Act § 1905(b).
- Definitions. 42 CFR § 433.136.
- Purpose. 42 U.S.C. §§300ff et seq.
- Special Supplemental Nutrition Program for Women, Infants, and Children. 42 U.S.C. § 1786.
- Crime Victim Compensation. 42 U.S.C. § 10602.

# Chapter II: Coordination of Benefits (COB)

## A. State Plan Requirements

### 1. Required Elements in State Plan

[State plans](#) must include specific information and assurances related to [COB/TPL](#).<sup>18</sup> The following sections of the Medicaid state plan address [TPL](#), liens and estate recovery, and Medicare cost-sharing payment methodologies for dually eligible beneficiaries:

- **TPL:** In Section 4.22 (a and b), states must affirm compliance with statutory and regulatory requirements in Section 1902(a)(25) of [the Act](#) and 42 [CFR](#) 433 Subpart D. The section also requires narrative descriptions of state processes and limitations for most of the regulatory requirements. For additional information, please also refer to pages 69 and 70 of the Medicaid state plan.
- **Liens and Recoveries:** In Section 4.17 and Attachment 4.17-A, states affirm compliance with statutory and regulatory requirements and/or election of statutory and regulatory options in sections 1902(a)(18) and 1917(a) and (b) of [the Act](#) and 42 [CFR](#) 433.36. (NOTE: The reference to age 65 in the regulation is superseded by the change to age 55, which was made in the Omnibus Budget Reconciliation Act (OBRA) 1993 amendment to section 1917(b)(1)(B) of [the Act](#).) Section 4.17 and Attachment 4.17-A also require narrative definitions and descriptions of state processes and limitations for most of the statutory and regulatory requirements. For additional information please also refer to pages 53 and 53 a-h of the Medicaid state plan.
- **Medicaid’s methodology for paying Medicare cost sharing for dually eligible beneficiaries:** In Supplement 1 to Attachment 4.19-B, states list elections with regard to paying Medicare coinsurance, deductible, and copayment costs for various dual eligibility coverage groups, as required by sections 1905(p) and 1902(n) of [the Act](#). States may also include narrative descriptions of state limitations on payment of Medicare cost sharing for specific services or coverage groups.

For additional information on a state's Medicaid Buy-in information, please refer to pages 29 and 29a-d of the Medicaid state plan.

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<sup>18</sup> 42 CFR § 433.137.

## 2. State Laws Related to COB/TPL

### a. COB

To ensure that states can effectively coordinate benefits, the Deficit Reduction Act of 2005 (DRA of 2005) requires states to provide assurance satisfactory to the Secretary, U.S. Department of Health and Human Services (DHHS), that they have laws in effect imposing certain requirements on health insurers and other potentially liable third parties. Section 6035 of the DRA amended section 1902(a)(25) of the Act.<sup>19</sup> States must enact these laws in order to receive federal matching dollars for their Medicaid programs. Specifically, states must enact laws requiring that health insurers, broadly defined to include most potentially liable third parties, do the following:

- Accept the state's right to recover amounts it has paid through its Medicaid program.
- Accept that Medicaid beneficiaries have assigned their rights to the state for any amounts paid by the state on the beneficiaries' behalf.
- Process, and if appropriate, pay claims for reimbursement from Medicaid to the same extent that the plan would have been liable had it been properly billed at the point-of-service.
- Not deny claims submitted by the state on the basis of a procedural formality, such as 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 point of service, if the claim is submitted by the state within three years from the date the item or service was provided and the state began its action to enforce its rights within six years of the state submitting its claim.

Each state's law is intended to clarify the responsibilities of potentially liable third parties, facilitating a smooth coordination of benefits process. To be considered satisfactory, the state law must include, at a minimum, the requirements set out in section 6035 of the [DRA of 2005](#). A state may elect to impose a more stringent standard; for example, a state may choose to lengthen the minimum claims filing time period beyond the 3-year period specified in the [DRA of 2005](#). The format and content of state laws will vary from state to state.

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<sup>19</sup> Social Security Act § 1902(a)(25)(I) (added by Section 6035 of the Deficit Reduction Act of 2005).

## **b. Estate Recovery**

Medicaid estate recovery claims must be filed against the estate of a deceased Medicaid beneficiary in accordance with the state’s probate code specifications. The probate code may also establish the Medicaid agency’s standing in the priority order of payment to creditors of the estate.

## **References**

### **Statutes & Regulations**

- Social Security Act § 1902(a)(25)(I)
- Section 6035 of the Deficit Reduction Act of 2005.
- State Plan Requirements. 42 CFR § 433.137.

## **B. Identifying Liable Third Parties**

### **1. Defining Third Party Payers**

The first step in the coordination of benefits process is identifying potentially liable third parties. Under the Medicaid rules, a “third party” is broadly defined to include<sup>20</sup>:

- Health insurance
- Self-insured plans (employer provides health benefits and is at risk to pay claims)
- Group health plans (employer- or employee organization-offered plans)
- Service benefit plans
- Managed care organizations
- Pharmacy benefit managers (PBMs)
- Workers’ compensation
- Liability insurance (including automobile, homeowners and medical malpractice)
- Indemnity plans (if review of the plan determines that the policy provides for payment of health care items or services, including policies that pay a cash benefit to the policyholder if the payment is conditional upon the occurrence of a medical event).
- Any other parties that are, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service.

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<sup>20</sup> See section 1902(a)(25) of the Social Security Act; 42 CFR § 433.136.

## 2. Obtaining Health Insurance Information during Eligibility Determinations

The [SMAs](#) collect information about potential third party payers at eligibility determination and redetermination or in follow-up activities after completion of the eligibility process. The exact process for collecting the information will depend on whether the [SMA](#) or some other agency determines whether an individual is eligible. If another agency determines eligibility, the [SMA](#) must have in place an agreement with the other agency outlining the data that the other agency will collect and how it will transmit that data to the [SMA](#).

In some cases, an individual may not know that they have or are eligible for third party health insurance. State Medicaid agencies may want to ask additional questions if an individual reports income from any one of the following sources:

- *Railroad retirement benefits or Social Security retirement/disability benefit.* These benefits may indicate eligibility for Medicare coverage.
- *Longshore and Harbor Workers' Compensation and Worker's Compensation.* These benefits include compensation for medical care related to injuries on the job.
- *Black Lung Benefits.* Benefits include compensation for coal worker's pneumoconiosis ("Black Lung Disease").
- *Title IV-D Payment.* Financial support payments from an absent parent may indicate potential medical support.
- *Certain Work History.* Individuals who have belonged to a union or have served in the military may have access to health insurance coverage.

Medicaid's eligibility determination activities support Medicaid [COB/TPL](#) efforts, by identifying third party resources such as health insurance and pending tort/casualty claims. States also provide information about assignment of rights to third party payments and estate recovery policies at, or shortly after, the eligibility determination. In 1634 states, SSA has the responsibility for obtaining assignment of rights and third party information from applicants.

Questions about eligibility determination and follow-up activities, as they apply to [COB/TPL](#), should be directed to the [DHPC](#), [DEHPG](#).

General questions about eligibility determination and follow-up activities should be directed to the [DMEP](#), [CAHPG](#).

### 3. Exchanging Data with Other State and Federal Databases

The [SMA](#) must also attempt to match beneficiary-identifying information with data with other state databases that may provide valuable information on potentially liable third parties. Specifically, the [SMA](#) is required to try to obtain data exchange agreements with the following information systems<sup>21</sup>:

- *State Wage Information Collection Agency (SWICA) and the Social Security Administration wage and earnings files.* Data from these sources may identify an employer of the beneficiary or the beneficiary's parent. Once the [SMA](#) has identified the employer, the agency must follow up to determine whether the employer offers health insurance to the beneficiary (or the beneficiary's parent).
- *State Workers' Compensation or Industrial Accident Commission Files.* These databases may indicate that a beneficiary had a work-related injury covered by workers' compensation.
- *State Motor Vehicle Accident Report Files.* Similarly, the motor vehicle accident report files will help a state Medicaid agency in identifying a beneficiary injured in a motor vehicle accident, regardless of whether the individual was a driver, passenger, bicyclist, or pedestrian. Motor vehicle insurance may be liable for these claims.

If the [SMA](#) is unable to secure agreements with these other data exchanges, it must submit documentation to the [CMS RO](#) demonstrating that the agency made a reasonable attempt to enter into these agreements.

The [SMA](#) should reflect how frequently it conducts each of these data exchanges.

The SMA should also leverage or establish data query of federal systems to check for Medicare eligibility. For information on relevant CMS systems, please see [here](#). For information on relevant SSA systems, please see [here](#).

### 4. Diagnosis and Trauma Code Edits

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<sup>21</sup> 42 CFR § 433.138.

[SMAs](#) must also review claims to flag diagnoses that are indicative of traumatic injury, if the SMAs have determined that these diagnoses are likely to indicate the existence of a potentially liable third party. A third party (or his/her insurer) may be liable for claims arising out of that injury.<sup>22</sup>

Once a claim has been flagged for a particular diagnosis, the [SMA](#) should follow up to determine whether there is a liable third party. The state should identify the trauma codes that yield the highest third party collections and give priority to following up on those codes. [SMAs](#) may follow up by contacting the beneficiary by phone or questionnaire to determine the nature of the trauma and then follow up with the relevant insurance companies, attorneys, witnesses, and others to establish liability. After follow up, all information that identifies legally liable third parties should be included in the eligibility file, the third party database, and third party recovery unit (for more information, see *"Incorporating TPL into Information Systems"*, below).

[SMAs](#) may elect not to identify or follow up on specific codes, based on experience that the codes are not productive of recovery from third parties. SMAs do not need to submit a state plan amendment or TPL Action Plan to change the codes subject to trauma code editing. NOTE: CMS still requires that the [state plan](#) reflects how frequently the [SMA](#) completes diagnosis and trauma edits and also outlines a procedure for identifying the trauma codes that yield the highest third party collections and giving priority to following up on those codes.

[SMAs](#) should not follow up on specific codes if it is not cost-effective to do so. SMAs may set a cost-effectiveness threshold for initiating recovery efforts, choosing a specific dollar amount, a period of time to accumulate claims, or a combination of those methods. If the SMAs elect to set a time period threshold, [SMAs](#) must accumulate claims using a specific code tied to the beneficiary, and must pursue those claims once the accumulated claims collectively reach the threshold level.

## 5. Incorporating TPL into Information Systems

Once an [SMA](#) has identified a liable third party, it must incorporate that information into its information system to streamline the [COB](#) process. Regulations specify that the [SMAs](#) must incorporate information related to liable third parties in the following systems:

- Eligibility case file
- Third party database

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<sup>22</sup> 42 CFR 433.138(e).

- Third party recovery unit

This regulatory requirement was promulgated before automated eligibility determination systems and/or [TPL](#) subsystems of the [MMIS](#) existed in many [SMAs](#). At that time, the hard-copy file was often the sole eligibility case file. Currently, [SMAs](#) can rely on the electronic files in the Medicaid eligibility determination system for the beneficiary as the “eligibility case file,” perhaps supplemented by a hard-copy file containing verifications or historic information. The [MMISs](#) now have the [TPL](#) subsystem, which can be considered the “third party database.” “Third party recovery units” still exist, but [COB](#) developmental work (determining the nature and scope of a beneficiary’s health insurance coverage, primarily for [MMIS](#) claims adjudication purposes) is generally done via direct automated data matches between [MMIS](#) and the carriers (or data matching through use of a contractor). The actual recovery work of the third party recovery units, primarily with third party resources other than health insurance, in casualty/tort claims, estate claims, or medical malpractice, may still be recorded in hard-copy files or have automated systems support.

Given the current level of automation, [CMS](#) allows the [SMAs](#) flexibility in deciding where to maintain required information, in hard-copy or electronic form, to facilitate effective use. The key point is that the [SMA](#) gathers and maintains the information specified in the regulations, to support Medicaid’s status as payer of last resort (except for the limited instances of statutory exception).

[SMAs](#) decide how to maintain information in the manner they deem most effective and efficient, so long as all information specified in the regulations and any State Medicaid Manual (SMM) guidance is maintained. The [SMA](#) should indicate in the [state plan](#) or the [TPL](#) Action Plan where specific information is maintained. The [SMM](#) guidance suggests that the [TPL](#) Action Plan is the better place to record location.

## 6. TPL Action Plans

The [SMA](#) may develop and submit a [TPL](#) Action Plan to the [CMS RO](#). The action plan should specify how the [SMA](#) will do the following<sup>23</sup>:

- Identify third parties
- Determine the liability of third parties
- Avoid payment of third party claims
- Recover reimbursement from third parties, as appropriate
- Record information and actions related to the action plan

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<sup>23</sup>42 CFR § 433.138(k).

The [TPL](#) Action Plan is the MMIS operational side of COB/TPL activities. The CMS/SMA's MMIS contract is the official document identifying system requirements related to COB/TPL activities. If the SMA chooses, they can update their TPL action plan to reflect current federal policy requirements. If a [SMA](#) establishes new or revised [TPL](#) MMIS policies, procedures, and technologies that require [CMS](#) approval, the [SMA](#) may also update its [TPL](#) Action Plan when it receives approval, and provide an updated copy to the [CMS RO](#).

## 7. Waiver of Requirements

[SMAs](#) may request a waiver of certain requirements to determine [TPL](#), if the [SMA](#) determines that the activity would not be cost-effective. An activity is not cost-effective if the cost of the required activity exceeds the [TPL](#) recoupment and the required activity accomplishes, at the same or higher cost, the same objectives as another activity that is being performed by the [SMA](#).<sup>24</sup>

To obtain a waiver, the [SMA](#) must submit a request for waiver of the requirement in writing to the [CMS CO](#), through the [CMS RO](#). The request must document that meeting a requirement is not cost-effective. [CMS](#) has 30 days to grant or deny the waiver.

If [CMS](#) grants the waiver without specifying an end date, the [SMA](#) must notify [CMS](#) if there is a change in the conditions that supported the request and approval of the waiver.

[CMS](#) may rescind a waiver at any time, if it determines that the [SMA](#) no longer meets the criteria for approving the waiver. If the waiver is rescinded, the [SMA](#) has 6 months from the date of the rescission notice to meet the requirement that had been waived.

## References

### Statutes & Regulations

- Social Security Act §1902(a)(25)
- Definitions 42 CFR § 433.136.
- Identifying Liable Third Parties. 42 CFR § 433.138.

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<sup>24</sup> 42 CFR § 433.138(l).

## C. Payment of Claims

### 1. Paying Claims with Established TPL

#### a. Standard COB: Cost Avoidance

If the [SMA](#) has determined that a third party is likely liable for a claim, it **must reject (but not deny)** the claim in most circumstances.<sup>25</sup> This is referred to as “cost avoidance” and generally occurs when the third party resource is health insurance coverage.

When an [SMA](#) rejects a claim because of known or suspected [TPL](#), it sends the claim back to the provider noting the third party that Medicaid believes to be legally responsible for paying the claim. The provider should then bill the legally liable third party. If a balance remains after the third party has paid the provider or denied payment for a substantive (i.e., non-procedural) reason, the provider can submit a claim to the [SMA](#) for payment of the balance, up to the maximum Medicaid payment amount established for the service in the [state plan](#). We note that generally Medicare fee-for-service claims will automatically cross over to the SMA to adjudicate for coverage of the Medicare cost-sharing amount (see Section E for detailed discussion).

A **rejected claim** is a claim that does not meet the state’s basic format or data requirements for submission. It contains one or more errors (for example, an invalid beneficiary ID number or a failure to identify a suspected liable third party) that are discovered via initial system edits, and before the claim is adjudicated. The SMA alerts the provider or clearing house that the claim cannot be processed as-is. Since rejected claims are not entered into the Medicaid program’s claims processing system, typically no internal control number (ICN) is assigned.

A **denied claim** passes initial system edits, is processed and assigned an ICN, but payment is denied. A Remittance Advice letter is sent back to the provider containing a denial code and explanation (for example: “This Procedure Requires Prior Authorization”). Denied claims appear in the Medicaid program’s claims adjudication reports. Typically, denied claims can be appealed and sent back to the [SMA](#) for processing.

States often employ clearinghouses for claims submission to lower the incident of rejected claims. A clearinghouse has software that allows it to “scrub” a claim prior to submission to the State. Online claim submission portals used by States will often reject a claim in real-time (i.e., shortly after the provider submits the claim). The provider should then bill the legally liable third party. Often, real-time rejection by the portal

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<sup>25</sup> 42 CFR § 433.139(b)(1).

does not allow the State to track rejection rates. Rejections for claims submitted electronically often come back as an “Electronic Data Interchange,” (EDI) rejection and will not show up on a Remittance Advice from the state. An EDI rejection might show a brief message such as “Please Resubmit – Invalid Member Number” or something similar.

Because rejected claims are not considered to have been “received” by the SMA, and do not make it into the claims processing system, Medicaid beneficiaries cannot be held liable because the services were never actually billed. Provider follow-up action is to correct and resubmit the claim. Denied claims have been accepted and processed by the Medicaid program’s adjudication system, and should not be resubmitted because the State has already finalized the payment determination. Provider follow-up action would be to appeal the denial.

Detailed questions regarding MMIS system processing of denied vs rejected claims should be directed to the Division of State Systems Group (DSG).

The Bipartisan Budget Act (BBA) of 2018 (Public Law 115.123) was signed into law on February 9, 2018. The BBA of 2018 makes changes to the BBA of 2013, specifically to Section 202(a) to SSA Section 1902(a)(25)(E) and (F). These changes narrow the TPL cost avoidance exceptions. These exceptions were delayed by two years, and were effective October 1, 2019. The repeal and amendment of the BBA of 2013 Section 202 provisions take effective retroactively, as if enacted on September 30, 2017, and applies with respect to any open claims, including claims pending, generated or filed after that date. This means that a state is no longer required to cost avoid for prenatal (including labor and delivery and post-partum care) services retroactively to September 30, 2017.

The rules establishing whether the [SMA](#) must pay all or a portion of the balance are discussed below.

#### **b. Exception to Standard COB: Pay and Chase**

There are some circumstances, however, under which an [SMA](#) may pay a claim even if a third party is likely liable and then seek to recoup that payment from the liable third party. This is referred to as “pay and chase.” Pay and chase is required or permitted in certain circumstances where there is a risk that if the [SMA](#) were to cost-avoid claims, providers might choose not to participate in the Medicaid program, in order to avoid dealing with the administrative burden associated with Medicaid cost avoidance claims processing requirements. Specifically, pay and chase is required or permitted in the following circumstances:

- **Medical Support Enforcement.** [SMAs](#) must pay and chase if the claim is for a service provided to an individual on whose behalf child support enforcement is

being carried out if (1) the third party coverage is through an absent parent and (2) the provider certifies that, if the provider has billed a third party, the provider has waited 100 days from the date of service without receiving payment before billing Medicaid.<sup>26</sup> This requirement is intended to protect the custodial parent and the dependent children from having to pursue the non-custodial parent, his/her employer, or insurer for third party liability.

- **Preventive Pediatric Services.** [SMAs](#) must pay and chase for claims for preventive pediatric services (including [EPSDT](#)).<sup>27</sup>

Depending on how a provider bills, the [SMA](#) may need to pay and chase claims that it otherwise would attempt to cost avoid. For example, some providers submit a bundled claim. If a bundled claim includes any cost-avoided services (in addition to pay and chase services) and the cost-avoided services cannot be identified and adjudicated separately, the [SMA](#) must pay and chase the entire bundled claim to ensure it complies with the requirements.

After an [SMA](#) pays a claim using the pay and chase method, it must then seek to recover from the liable third party, unless the recovery of reimbursement would not be cost-effective.

## 2. Paying Claims with No Established TPL

If there is no established liable third party, the [SMA](#) may pay claims to the maximum Medicaid payment amount established for the service in the [state plan](#). If the [SMA](#) later establishes that a third party was liable for the claim, it must seek to recover the payment. This may occur when the Medicaid beneficiary requires medical services in casualty/tort, medical malpractice, Worker's Compensation, or other cases where the third party's liability is not determined before medical care is provided. It may also occur when the [SMA](#) learns of the existence of health insurance coverage after medical care is provided.

The [SMA](#) should first seek recovery from the liable third party. If that is not feasible (for example, Medicare will not accept a claim directly from an [SMA](#)), it may be necessary to recoup the payment from the provider and ask the provider to rebill correctly. [SMAs](#) must seek reimbursement within sixty days from the end of the month in which it learns of the existence of the liable third party.

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<sup>26</sup> 42 CFR § 433.139(b)(3)(ii).

<sup>27</sup> 42 CFR § 433.139(b)(3).

### 3. Suspension or Termination of Recovery Efforts

[SMAs](#) may suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery would not be cost-effective.<sup>28</sup> [SMAs](#) may set threshold amounts for recoveries and may accumulate billings until it would be cost-effective to seek reimbursement. If an [SMA](#) sets threshold amounts or accumulates billings, it must:<sup>29</sup>

- Either specify in its [state plan](#) the threshold amount or other guideline to use in determining whether to seek reimbursement from a liable third party **or** describe the process it uses to determine whether recovery would be cost-effective. If an [SMA](#) sets its thresholds above \$100 for health insurance or \$250 for casualty claims, it must submit documentation to [CMS](#) supporting that recovery would not be cost-effective below those thresholds.
- Specify in its [state plan](#) a dollar amount or period of time for which the [SMA](#) will accumulate billing with respect to either an individual Medicaid beneficiary or a particular third party. For example, an [SMA](#) may accumulate pharmacy claims for a sixty-day period or until a set threshold is reached before it will bill the third party.

### 4. Waiver of Requirements

[SMAs](#) are permitted to request a waiver of the general requirements to cost-avoid claims if cost avoidance would not be cost-effective.<sup>30</sup> These requests seek authority to pay and chase an entire category of claims (for a specific covered service, for example) instead of applying normal cost-effectiveness authority to suspend or terminate recovery efforts for a specific claim, as discussed in Subsection 3, above. Generally, the [SMA](#) must prove that the pay and chase method of processing these claims is at least as cost-effective as the cost avoidance method. An activity would not be cost-effective if the cost of the activity exceeds the expected recovery and the activity accomplishes, at the same or at a higher cost, the same objective as another activity of the [SMA](#).

The [SMA](#) must submit a request for a cost avoidance waiver in writing to the [CMS CO](#), through the [CMS RO](#).<sup>31</sup> The request must document that meeting a requirement is not cost-effective. [SMAs](#) may submit, for example, documentation related to the

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<sup>28</sup> 42 CFR § 433.139(f).

<sup>29</sup> 42 CFR § 433.139(f).

<sup>30</sup> 42 CFR § 433.139(e).

<sup>31</sup> 42 CFR § 433.139(e).

administrative costs, the denial rate for claims, equipment costs, and computer costs. [CMS](#) has 30 days to grant or deny the waiver after receiving sufficient information to determine that it is not cost-effective to cost avoid claims. If [CMS](#) grants the waiver, the [SMA](#) must notify [CMS](#) if there is a change in waiver conditions. [CMS](#) may rescind a waiver at any time, if it determines that the [SMA](#) no longer meets the criteria for approving the waiver. If the waiver is rescinded, the [SMA](#) has 6 months from the date of the rescission notice to meet the requirement that had been waived.

Since current billing and claims systems are more sophisticated than when the cost avoidance waivers were first permitted in the 1980s, it is rare that an [SMA](#) can sufficiently demonstrate that it is not cost-effective to cost avoid claims. As a result, [CMS](#) rarely, if ever, grants a cost avoidance waiver. As of 2014, there were **no** currently approved cost avoidance waivers.

## 5. Never-covered services

States may exempt certain items or services from third party liability (TPL) requirements when submission of claims for those items or services would always result in denial because the general insurance industry does not cover them. CMS requires the state to have clear and convincing documentation of non-coverage by insurers. If a state has documentation, there is no need to further verify by submitting claims because there would be no liable third party and Medicaid TPL rules would not come into play. The controlling regulation is found at 42 CFR 433.139(b)(1), which states that "the establishment of third party liability takes place when the agency receives confirmation from a provider or a third party resource indicating the extent of third party liability."

However, the state needs to follow certain procedures to document thoroughly the absence of third party coverage. States are permitted to take the following steps to satisfy the documentation requirements:

- The state may bill third parties and receive claims rejection notices. However, the state must assure that national billing codes for the items or services are included on claims, or, if local billing codes are used, that national codes and local codes are matched, so that rejection notices accurately reflect non-coverage of the item or service.
- The state may conduct a survey of insurers' benefit packages. The state can demonstrate non-coverage if the state confirms with the top ten insurance carriers that their scope of benefits did not cover an item or service. However, since many insurers change their benefit packages on an annual basis, the state would have to confirm continued non-coverage on a yearly basis.

- For insurers not included in a survey, or as an alternative to a survey, the state may establish a precedent file by initially billing the insurer to obtain documentation of non-coverage, so that future claims would not need to be submitted to that insurer. The state would have to confirm continued non-coverage on a yearly basis.
- The state may request verification from the state agency or commission that oversees compliance with state law and regulations governing insurance plans that a certain item or service is never-covered in insurance policies available in the state, either for the general population or for a specific population segment (for example, children under age 21). The state would have to confirm continued prohibition of coverage on a yearly basis.

When non-coverage has been documented, the state may permit providers to use a specific code on the claim denoting non-coverage by the third party. This code could allow the MMIS to override the cost avoidance edit and pay the claim. The state would have to require providers to maintain documentation to substantiate non-coverage when using override codes, and could conduct provider audits to assure that the provider has appropriate documentation of non-coverage.

## References

### **Statutes & Regulations**

- BBA of 2018 Payment of Claims.
- 42 CFR § 433.139.

## D. Medical Child Support Payments

### 1. Relationship to Medicaid COB/TPL Activities

Medicaid's Assignment of Rights (AOR) requirements include pursuit of medical support from absent parents of Medicaid child beneficiaries. Generally, [SMAs](#) will refer custodial parents to the Office of Child Support Enforcement (OCSE), the state IV-D agency, to obtain a support order. Cooperation with this process is required as part of the determination of Medicaid eligibility for the custodial parent (in the absence of good cause not to cooperate). These activities also support Medicaid [COB/TPL](#) efforts by establishing court orders for the absent parent to enroll the child in available health insurance, or to pay a sum of cash medical support in lieu of such enrollment. The availability of health insurance, or of cash support, reduces Medicaid's costs for the child's health care.

Questions about medical child support as it applies to [COB/TPL](#) should be directed to the [DHPC](#), [DEHPG](#).

General information about the process of obtaining medical child support is provided below. Detailed questions should be directed to the [DMEP](#), [CAHPG](#).

### 2. General Information

Recovering from liable third parties may require assistance from other state agencies or from other states.

To ensure that [SMAs](#) are able to recover from third parties to the maximum extent feasible, states enter into cooperative agreements with other states and agencies. Specifically, as a condition of receiving federal matching dollars, the [state plan](#) provides for entering into written cooperative agreements for the enforcement of rights with at least one of the following entities:

- The state's title IV-D agency ([OCSE](#));
- Any appropriate agency of any state;
- Appropriate courts and law enforcement officials.<sup>32</sup>

[SMAs](#) generally have flexibility with regard to the substance of cooperative agreements. They must, however, include in their agreements with title IV-D agencies that the [SMA](#) will provide reimbursement to the title IV-D agency only for those child support services

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<sup>32</sup> 42 CFR § 433.151.

performed that are not reimbursable by the [OCSE](#) under title IV-D of [the Act](#) and that are necessary for the collection of amounts for the Medicaid program.

The [state plan](#) must also provide for making incentive payments to a political subdivision, a legal entity of the subdivision, or *another* state that enforces **and** collects medical support and payments for the [SMA](#).<sup>33</sup> The incentive payment **must** be 15 percent of the amount collected and be made from the federal share of the total amount collected.<sup>34</sup> Incentive payments using federal funds are only permitted if the political subdivision or other state is involved in the enforcement and collection of medical support and payments:

- **“Enforcement”** means the pursuit of medical support against someone other than the beneficiary or the pursuit of medical support against some source, if the other source is obligated to pay for medical services because of its relationship with an absent responsible relative of the beneficiary. For example, enforcement includes the pursuit of medical support against an insurance company covering a noncustodial parent and that parent’s dependents. Enforcement does **not** include pursuit of a third party based on a health insurance policy held by the Medicaid beneficiaries, themselves.
- **“Collection”** means amounts collected from sources that are responsible to pay for medical services provided to Medicaid beneficiaries.

### 3. Court-Ordered Health Insurance Coverage for Medical Child Support

[SMAs](#) will pay and chase claims for a child on whose behalf child support enforcement is being carried out when health insurance coverage is provided through the absent parent. This is an exception to the standard cost avoidance processing of claims for insured Medicaid beneficiaries.

### 4. Court-Ordered Cash Payments for Medical Child Support

Child support orders may include a requirement that the noncustodial parent make a cash payment for medical support; for example, when the noncustodial parent does not have access to, or cannot afford to pay for, health coverage for the child. State [OCSEs](#) may request this type of support payment when requesting general child support orders

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<sup>33</sup> 42 CFR § 433.153(a)

<sup>34</sup> 42 CFR § 433.153(b).

for Medicaid-enrolled children. When the support is collected, the [OCSE](#) will send the medical support payments to the [SMA](#).

## 5. Distribution of Collections

Once a state has made collections, the [SMA](#) must distribute collections among the state, the federal government, and the beneficiary in accordance with the following rules:<sup>35</sup>

- **State.** The [SMA](#) should receive an amount equal to the non-federal share of the Medicaid expenditures that were recovered.
- **Federal Government.** The [SMA](#) must distribute to the federal government the federal share of the Medicaid expenditures that were recovered, minus any incentive payments.
- **Beneficiary.** If any amount remains, the [SMA](#) must distribute the remaining funds to the beneficiary. Any amount given to the beneficiary must be treated as income or resources, as appropriate.

Before the [SMA](#) makes distributions to the beneficiary, it should use funds recovered to offset amounts spent on **any** Medicaid service provided to the beneficiary, even if that service is not covered by the third party plan. This includes payment for premiums by Medicaid to an insurer under a premium assistance program.

## References

### Statutes & Regulations

- Cooperative Agreements and Incentive Payments. 42 CFR § 433.151.
- Requirements for Cooperative Agreements for Third Party Collections. 42 CFR § 433.152.
- Incentive Payments to States and Political Subdivisions. 42

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<sup>35</sup> 42 CFR § 433.154.

## E. Dually Eligible Beneficiaries

### 1. Introduction: Medicare and Medicaid Coverage for Dually Eligible Beneficiaries

Medicare beneficiaries who have limited income and resources may get help paying for their Medicare premiums and out-of-pocket medical expenses from Medicaid.

Medicaid may also cover additional services beyond those provided under Medicare.

Individuals entitled to Medicare and eligible for some form of Medicaid benefit are often referred to as “dually eligible beneficiaries.” Dually eligible beneficiaries fall into several different categories. These beneficiaries may be enrolled first in Medicare and then qualify for Medicaid or vice versa.

### 2. Medicare Coverage

The Medicare program includes four components or “Parts”:

- **Medicare Part A.** Medicare Part A is hospital insurance. Medicare Part A is automatic for individuals aged 65 years or older (and certain individuals with disabilities) who qualify for Social Security or railroad retirement benefits. Most individuals do not pay a monthly premium for Medicare Part A coverage if they or their spouse paid Medicare taxes while working. Individuals who are not eligible for premium-free Medicare Part A may purchase coverage by paying monthly premiums. Medicare Part A includes cost sharing on some services.
- **Medicare Part B.** Medicare Part B is supplementary medical insurance that covers, among other things, outpatient care and physician services. Medicare Part B is voluntary, and individuals must enroll during specified enrollment periods. All individuals will pay a monthly premium for Medicare Part B coverage. Additionally, individuals must pay cost sharing for some services covered under Part B.
- **Medicare Part C.** Some individuals receive their Part A and Part B coverage through private health plans, referred to as Medicare Advantage plans. Medicare Advantage plans may also include prescription drug coverage offered under Part D. In addition to the standard Part A and Part B benefits or Part D coverage, Medicare Advantage plans may cover supplemental benefits, such as coverage for dental care, vision care, acupuncture, or health club memberships. If the supplemental benefits are covered for all enrollees in the Medicare Advantage plan, the benefits are referred to as **mandatory supplemental benefits**. If the

enrollee may elect whether to receive the benefits, they are referred to as **optional supplemental benefits**. [CMS](#) sets rules for and approves Medicare Advantage plans, plan benefits, and cost sharing for enrollees.

- **Mandatory Supplemental Benefits:** Non-drug benefits that are not covered by Medicare, but are covered by the plan for every enrollee of the plan. Mandatory supplemental benefits are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums, cost sharing or through application of rebate dollars.
- **Optional Supplemental Benefits:** Non-drug benefits that are not covered by Medicare. However, plan enrollees may choose whether to elect and pay for optional supplemental benefits. These services may be grouped or offered individually.
- **Medicare Part D.** Medicare also provides prescription drug coverage through private plans, referred to as Medicare Part D. Medicare sets rules for and approves Part D plans, plan benefits, and cost sharing for enrollees. Some beneficiaries may be eligible for Low Income Subsidy (LIS), also known as Extra Help, which lowers the costs of Medicare prescription drug coverage. <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/index.html>

### 3. Types of Dual Eligibility

“Dually eligible beneficiaries” generally describes individuals enrolled in Medicare and Medicaid. These beneficiaries are enrolled in Medicare Part A and/or Part B and qualify for help from Medicaid to pay some Medicare costs. Some dually eligible beneficiaries may also qualify for additional Medicaid benefits, depending on income and resources.

The eligibility categories for dually eligible beneficiaries include:

- **Full Benefit Dual Eligible (FBDE) beneficiaries.** An individual who is eligible for Medicaid either categorically or through optional coverage groups such as the medically needy. Medically needy refers to individuals whose incomes are otherwise too high to qualify for Medicaid but who have uncovered medical expenses that exceed their available income, or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for a [QMB](#) or [SLMB](#). (See below).

Dually eligible beneficiaries in the following categories are known as Medicare Savings Program (MSP) beneficiaries:

- **Qualified Medicare Beneficiary Only (QMB; sometimes referred to as QMB Only).** A [QMB](#) is an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the Federal Poverty Level (FPL), and whose resources do not exceed three times the Supplemental Security Income (SSI) limit.
- **Qualified Medicare Beneficiary Plus (QMB Plus).** Like a [QMB](#), a [QMB Plus](#) is an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the [FPL](#), and whose resources do not exceed three times the [SSI](#) limit. A [QMB Plus](#) also qualifies for full-benefit Medicaid coverage, often by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy Level.
- **Specified Low-Income Medicare Beneficiary (SLMB; sometimes referred to as SLMB Only).** A [SLMB](#) is an individual who is entitled to Medicare Part A, has income between 100 and 120 percent of the [FPL](#), and whose resources do not exceed three times the [SSI](#) limit.
- **Specified Low-Income Medicare Beneficiary Plus (SLMB Plus).** Like a [SLMB Only](#), a [SLMB Plus](#) is an individual who is entitled to Medicare Part A, has income between 100 and 120 percent of the [FPL](#), and whose resources do not exceed three times the [SSI](#) limit. A [SLMB Plus](#) also qualifies for full Medicaid benefits, often by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy Level.
- **Qualifying Individual (QI).** A [QI](#) is an individual who is entitled to Medicare Part A, has income between 120 and 135 percent of the [FPL](#), and whose resources do not exceed three times the [SSI](#) limit.
- **Qualified Disabled and Working Individuals (QDWI).** A [QDWI](#) is an individual under age 65 with a disability who lost Social Security disability benefits and Premium-free Medicare Part A because they returned to work, but who is eligible for Medicare Part A. The individual's income may not exceed 200 percent of the [FPL](#) and resources may not exceed two times the [SSI](#) limit.

Questions about Medicaid coverage groups for dually eligible beneficiaries should be directed to [DMEP](#), [CAHPG](#).

## 4. Medicaid Coverage for Medicare Costs

Medicare cost-sharing includes Medicare Parts A and B premiums, coinsurance, deductibles, and copayment amounts.

Medicaid will cover a different set of these benefits for each category of dually eligible beneficiaries, as described in the chart below:

Category	Medicare Part A Premiums	Medicare Part B Premiums	Medicare Cost-Sharing (Except Part D)		Other Medicaid State Plan Services/ Benefits
			Part A	Part B	
QMB Only	✓	✓	✓	✓	
QMB Plus	✓	✓	✓	✓	✓
SLMB Only		✓			
SLMB Plus		✓		✓*	✓
QI		✓			
QDWI	✓				
FBDE	✓	✓	✓	✓*	✓

✓\* SMAs may choose to cover Medicare cost-sharing for all Medicare-covered services (Part A and/or Part B, as indicated above) or only pay for services covered in the state plan.

### Medicare Cost-Sharing Payment Methodologies

State Medicaid programs have some flexibility in setting their Medicare cost-sharing payment methods. States can pay:

- The Medicare cost-sharing amount (generally called the Medicare rate).
- The Medicaid state plan rate for the same service when it's provided to a non-Medicare-eligible Medicaid beneficiary; or
- A negotiated rate that is approved by CMS.

The flexibility to set payment methods is established in the Social Security Act in §1902(n).

Section 1902(n)(1)-(3) is specific to a Qualified Medicare Beneficiary (QMB), but has historically been applied to other categories of Medicare Savings Program (MSP) beneficiaries (QMB Plus, SLMB Plus, etc.) along with non-MSP beneficiary identified as Full Benefit Dual Eligible (FBDE) beneficiaries.

States can choose to pay Medicare cost-sharing at the following rates:

**Medicare Rate (MR):** The state pays the amount that Medicare establishes as the cost-sharing amount.

**State Plan Rate (SP):** If the state chooses to pay at the state plan rate, to determine the state payment for services, the state compares the amount that Medicare has already paid for the claim with the state plan rate. Usually, the state plan rate is lower than or equal to the Medicare paid amount, resulting in a Medicaid payment of zero. However, if the state plan rate is higher than the Medicare paid amount, the state would then pay the difference between the Medicare paid amount and the state plan rate.

**Negotiated Rate (NR):** The state can also establish a negotiated rate for a type of service, a specific service, or a specific group of dually eligible beneficiaries.

The state can choose to pay cost-sharing at the Medicaid state plan rate, or the Medicare rate, whichever is less. Since the state isn't paying consistently at either the Medicare rate or the Medicaid state plan rate, CMS views this as a negotiated rate.

For Medicare services that are also covered in the Medicaid state plan, for non-Medicare-eligible Medicaid beneficiaries, the state may pay at a negotiated rate that is more than the Medicaid state plan rate but less than the Medicare rate.

For Medicare services that are not covered in the Medicaid state plan, for non-Medicare-eligible Medicaid beneficiaries, the state has greater flexibility in setting the negotiated rate, but the rate must be sufficient for the state to assure CMS that it will not adversely affect access to care for the beneficiary.

The state has the option to establish a different payment method for each group of dually eligible beneficiaries (QMB, QMB Plus, SLMB Plus, and other Full Benefit Dual Eligible beneficiaries) and can establish different payment methods for Part A deductible, Part A coinsurance, Part B deductible, or Part B coinsurance within each group. The state may mix all of the optional payment methods as it chooses, as long as the state can assure CMS that the selected payment methods will not adversely affect access to care for the beneficiary.

## 5. Medicaid Coverage for Medicare Advantage Plans (Medicare Part C) Enrollees

Medicaid may also provide coverage of premiums and cost-sharing for certain categories of dually eligible beneficiaries who elect to enroll in a Part C plan to receive their Part A and Part B coverage through a Medicare managed care plan. The extent of

Medicaid coverage for Part C costs depends on the enrollee’s coverage category, the type of cost-sharing, and what the [SMA](#) opts to cover in its [state plan](#).

See the chart below for an overview of when Medicaid may pay for costs associated with Medicare Part C.

<b>Medicaid Payment for Costs Associated with Medicare Part C</b>			
<b>Category</b>	<b>Part C Premium for Part A and Part B benefits plus Mandatory Supplemental Benefits</b>	<b>Part C Premium for Optional Supplemental Benefits</b>	<b>Medicare Deductible, Coinsurance, and Copayment (except Part D)</b>
<b>QMB Only</b>	Optional	Not allowed	Required
<b>QMB Plus</b>	Optional	Optional	Required
<b>SLMB Only</b>	Not allowed	Not allowed	Not allowed
<b>SLMB Plus</b>	Not allowed	Optional	Conditional*
<b>QI</b>	Not allowed	Not allowed	Not allowed
<b>QDWI</b>	Not allowed	Not allowed	Not allowed
<b>FBDE</b>	Not allowed	Optional	Conditional

\* SMAs do not generally opt to cover Medicare cost-sharing for Medicare-only services for individuals in the SLMB Plus category. They are, however, liable for a portion of the cost-sharing if the following conditions are met: (1) the Medicare service is also covered under the state plan, (2) the Medicare provider is also enrolled as a Medicaid provider, and (3) the state plan rate exceeds the Medicare payment amount. In these circumstances, the SMA must pay the provider up to the amount for the service specified in the state plan.

**Required:** Coverage of Medicare deductibles and coinsurance are required for [QMBs](#) under Section 1902(a)(10)(E)(i) and Section 1905(p)(3) of [the Act](#).

**Optional:** The [SMA](#) may limit Medicaid payment as specified in Supplement 1 to Attachment 4.19-B of the [state plan](#), including nominal cost-sharing amounts as permitted under Section 1916 of [the Act](#) and specified in attachment 4.18 of the [state plan](#). These payment limitations may result in a Medicaid payment of zero. Additionally, Section 1905(a) of [the Act](#) permits payment of health insurance premiums, other than Medicare Part B, for coverage of medical or remedial services, except for individuals who could be enrolled in Part B but are not. [SMAs](#) may elect this option in their [state plan](#).

**Conditional:** For a non-[QMB](#) eligible, there is no Medicaid liability for cost-sharing in a Medicare Advantage plan, however, [SMAs](#) are liable for payment for Medicaid-covered services rendered by Medicaid providers to Medicaid eligible individuals in excess of any third party liability (including Medicare Part C). When the following conditions are met, there may be a liability for a specific service received through a Medicare Advantage plan:

- The Medicare service is also a covered service under the [state plan](#);
- The Medicare provider is also a Medicaid provider; and
- The amount specified in the [state plan](#) is greater than the Medicare payment amount.

## 6. Medicaid Payment Methodologies for Medicare Cost-Sharing

### a. Medicaid is Payer of Last Resort

Generally, [SMAs](#) may not pay claims if it is likely that a third party (such as Medicare) is liable for the claim.

For dually eligible beneficiaries, Medicare is generally liable for claims, and thus [SMAs](#) are required to cost-avoid claims for dually eligible beneficiaries. Some Medicaid benefits, however, are not covered by Medicare, meaning that Medicare has no legal obligation to pay for the service. Accordingly, [SMAs](#) are not required to cost-avoid claims for services provided to dually eligible beneficiaries that are only covered by Medicaid.

### b. Coverage of Medicare Cost-Sharing Through “Crossover Claims”

For [QMBs](#), QMB Plus, (and [FBDEs](#) and [SLMB Plus](#) for services as specified in the [state plan](#)), [SMAs](#) will cover cost-sharing under Part A and Part B (or similar cost-sharing applied under Part C). [SMAs](#) **may not** cover any cost-sharing for Part D.<sup>36</sup>

Claims for cost-sharing submitted by providers to Medicare usually crossover from Medicare to the [SMAs](#), after Medicare has made the primary payment. These claims are referred to as “crossover claims.”

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<sup>36</sup> Social Security Act § 1935(d).

Under [the Act](#), [SMAs](#) must reimburse providers for [QMB](#) (including QMB Plus) cost-sharing amounts, even if the cost-sharing is for benefits not otherwise covered under the [state plan](#).<sup>37</sup> For those [FBDEs](#), and SLMB Plus, [SMAs](#) have the option to cover cost-sharing for all Medicare-covered services or only for Medicaid-covered services.

[SMAs](#) may pay Medicare cost-sharing at the Medicare rate, the [state plan](#) rate, or a negotiated rate proposed by the [SMA](#) and approved by [CMS](#). The provider’s total payment for a service includes the Medicare payment, the Medicaid cost-sharing payment, plus any beneficiary responsibility for Medicaid-level cost-sharing. If a [QMB](#) or QMB Plus beneficiary receives a Medicare-covered service that is **not** covered under the [state plan](#), the [SMA](#) must still pay for cost-sharing, but the [SMA](#) may establish reasonable payment limits (i.e., a negotiated rate), approved by [CMS](#), for the service.

<b>Cost-Sharing Coverage and Payment Amounts for Medicare/Medicaid-Covered and Medicare-Only Covered Services</b>		
	<b>Service Covered by Medicare and Medicaid</b>	<b>Service Only Covered by Medicare</b>
<b>Cost-Sharing Covered</b>	Required for QMBs, QMB Plus, SLMB Plus and FBDEs	Required for QMBs and QMB Plus; optional for FBDEs and SLMB Plus
<b>Payment Amount</b>	Total payment may be capped at the SMA’s choice of: <ul style="list-style-type: none"> <li>▪ State plan rate</li> <li>▪ Medicare rate</li> <li>▪ Some amount in between Medicaid and Medicare rates (i.e., a negotiated rate), as approved by CMS</li> </ul>	Total payment capped at the SMA’s choice of <ul style="list-style-type: none"> <li>▪ “Reasonable limit” (i.e., negotiated rate) approved by CMS</li> <li>▪ Medicare rate</li> </ul>

Often, when [SMAs](#) elect to cap total payments at the [state plan](#) rate, that rate is lower than the Medicare rate. [SMAs](#) that elect this option would pay a Medicare claim at the [state plan](#) rate. In some cases the [SMA](#) will make no payment, if the amount paid by Medicare exceeds the [state plan](#) rate. Regardless of whether the SMA makes a cost-sharing payment to the provider, the SMA must issue a Remittance Advice to the provider noting the amount of the Medicare cost-sharing paid (or not paid) by the SMA. This is especially important for Medicare Part A providers, who need that

<sup>37</sup> Social Security Act § 1902(a)(10)(E); see Social Security Act § 1905(p)(1) for the definition of qualified Medicare beneficiary.

documentation to request coverage of bad debt from Medicare for services for which the SMA pays less than the full Medicare cost-sharing amount.

### **c. Coverage of Medicare Cost-Sharing in Part C**

For beneficiaries enrolled in Part C plans entitled to Medicaid payment of cost-sharing, [SMAs](#) may make capitated payments to Medicare Advantage plans to cover the enrollee's cost-sharing. [SMAs](#) must outline in their [state plans](#) a methodology for calculating the capitation payments, and that methodology must be consistent with the cost-sharing levels for dually eligible beneficiaries outlined in the [state plan](#).

Medicare Advantage plans, however, are not required to accept these capitation payments.

In this case, [SMAs](#) will still cover Part C cost-sharing for [QMBs](#) and [FBDEs](#), but the providers must submit claims directly to the [SMA](#). Unlike in Part A and Part B, Medicare Advantage claims do not automatically crossover to Medicaid, once Medicare has made the initial payment. Providers, therefore, must submit a claim for the balance directly to the [SMA](#), including information on the amount paid by the Medicare Advantage plan. Some providers may be unwilling or unable to bill Medicaid directly. Since providers are prohibited under their contracts with Medicare Advantage plans from billing [QMBs](#) for cost-sharing (see below), providers who are unable to bill Medicaid will be deprived of the amounts due to them for cost-sharing. Because of these challenges, many Medicare Advantage plans will elect to accept capitated payments from the [SMA](#) to cover Medicare cost-sharing.

### **d. Prohibition on Provider Balance Billing of QMB Beneficiaries**

The actual payment made to a provider by the [SMA](#) plus the beneficiary's Medicaid level co-payments (if any) is considered payment in full for the Medicare deductibles and coinsurance. Providers are strictly prohibited from seeking to collect any additional amount from a [QMB](#) for Medicare deductibles or coinsurance (other than Medicaid nominal level cost-sharing), even if the [SMA](#)'s payment is less than the total amount of the Medicare deductibles and coinsurance.<sup>38</sup> Because of this prohibition on billing a QMB, the provider may receive less total payment for services rendered to [QMBs](#) than to other Medicare beneficiaries.

To ensure that [QMBs](#) are not billed for Medicare Part A and/or Medicare Part B cost-sharing, [SMAs](#) must ensure that their systems can pay all crossover claims. Additionally, [SMAs](#) must be able to transmit a [RA](#) to the provider explaining the extent of the [SMA](#)'s

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<sup>38</sup> Social Security Act § 1902(n)(3).

liability or why the [SMA](#) is not liable. Occasionally, [SMAs](#) report crossover claims payment challenges related to the following:

- The Medicare-certified provider submitting the claim does not participate in the state's Medicaid program;
- The [SMA](#)'s system does not recognize the provider identifier;
- The service is covered by Medicare, but not Medicaid;
- The provider type is recognized by Medicare, but not Medicaid; or
- The service is provided by an out-of-state provider.

Although each of these situations presents systems challenges, [SMAs](#) must create processes to enable payment of the crossover claims in a timely manner. This may include setting up a process to enable Medicare-certified providers to enroll in Medicaid for the limited purpose of billing for Medicare cost-sharing amounts. Although [SMAs](#) may set up a streamlined enrollment process for providers seeking to enroll for the limited purpose of billing for Medicare cost-sharing amounts, the [SMA](#) must still follow the Medicaid/[CHIP](#) provider screening and enrollment rules.<sup>39</sup>

#### **e. Medicare Timely Claims Filing Rules and Exceptions**

Finally, [SMAs](#) only need to pay crossover claims that were submitted to Medicare within Medicare's timely filing period. Under Medicare rules, fee-for-service claims must be submitted no more than twelve months (one calendar year) after the date services were furnished.<sup>40</sup> Medicare regulations allow for the following exceptions to the one-year time period for filing claims<sup>41</sup>:

- *Administrative Error.* If the failure to meet the filing deadline was caused by error or misrepresentation of a [DHHS](#) employee, Medicare contractor, or agent.
- *Retroactive Medicare Entitlement.* If the beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished.
- *Retroactive Medicare Entitlement Involving SMAs.* If the beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished and the [SMA](#) recoups payment from a provider six months or more after the date the service was furnished. The provider may submit a claim to Medicare within six months after the [SMA](#) recoups its payment.

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<sup>39</sup> Social Security Act § 1902(a)(77) and (kk).

<sup>40</sup> Social Security Act §§ 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B); 42 C.F.R. § 424.44

<sup>41</sup> 42 CFR § 424.44(b).

- *Retroactive Disenrollment from a Medicare Advantage Plan or Program of All-inclusive Care for the Elderly (PACE).* If a beneficiary was enrolled in a Medicare Advantage plan or [PACE](#) organization but was later disenrolled from that plan or organization retroactive to or before the date the service was furnished. The Medicare Advantage plan or [PACE](#) organization must also recoup its payment from the provider six months or more after the date the service was furnished.

Note that Medicare Advantage plans may establish their own timely filing limit, which may be less than the 12 months timely filing limit in Medicare fee for service.

**f. Special Considerations: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for Certain Dually Eligible Beneficiaries**

Medicaid coverage for [DMEPOS](#) for dually eligible beneficiaries is described in the table below:

<b>Medicaid Coverage for DMEPOS for Dually Eligible Beneficiaries</b>	
<b>Category</b>	<b>Medicaid Coverage for DMEPOS</b>
<b>QMB Only</b>	Medicaid pays Medicare cost-sharing amounts only. If Medicare denies payment for the service, Medicaid will <b>not</b> pay.
<b>QMB Plus</b>	<ol style="list-style-type: none"> <li>1. Medicaid pays Medicare cost-sharing amounts for Medicare-covered DMEPOS.</li> <li>2. If Medicare does not cover the service, but the state plan covers the service, the SMA will pay for the DMEPOS (subject to limitations in the state plan) when the beneficiary obtains the item or service from a Medicaid-participating provider.</li> </ol>
<b>SLMB Only</b>	Medicaid does not pay Medicare cost-sharing amounts, except Part B premiums.
<b>SLMB Plus</b>	<ol style="list-style-type: none"> <li>1. Medicaid pays Medicare cost-sharing amounts for services as specified in the state plan.</li> <li>2. If Medicare does not cover the service, but the state plan covers the service, the SMA will pay for the DMEPOS (subject to limitations in the state plan) when the beneficiary obtains the item or service from a Medicaid-participating provider.</li> </ol>
<b>FBDE</b>	<ol style="list-style-type: none"> <li>1. Medicaid pays Medicare cost-sharing amounts for services as specified in the state plan.</li> <li>2. If Medicare does not cover the service, but the state plan covers the service, the SMA will pay for the DMEPOS (subject to limitations in the state plan) when the beneficiary obtains the item or service from a Medicaid-participating provider.</li> </ol>

### **g. Special Considerations: Skilled Nursing Facility Services**

Although Medicaid provides more robust coverage for skilled nursing facility services than Medicare, Medicare does provide some coverage of these services. [SMAs](#), therefore, should cost-avoid claims for skilled nursing facility services when the beneficiary's cost of care is fully covered by Medicare. When the beneficiary's full-pay Medicare coverage is exhausted, Medicare may cover additional days at the Medicare coinsurance rate. The [SMA](#) will pay Medicare cost-sharing for the coinsurance; however, if the dually eligible beneficiary is subject to post-eligibility treatment of income rules, he/she may be responsible for payment of a portion of the cost.

If the claim is for a skilled nursing facility that is participating in Medicaid but not Medicare, Medicare has no legal obligation to cover the claim. Since Medicare has no legal obligation to cover the claim, the [SMA](#) is not required to cost-avoid that claim. If the beneficiary could have received services at a Medicare-certified skilled nursing facility without additional cost to the beneficiary, then the [SMA](#) may deny or reduce payment for the service to take into account the resource, (i.e., Medicare), that was available at no cost to the beneficiary, since the [SMA](#) would pay for cost-sharing associated with the service.

### **h. Special Considerations: Pharmacy Retroactive Part D Claims**

[SMAs](#) may not pay cost-sharing for Medicare Part D claims. However, a beneficiary may have received Medicaid payment for pharmacy services before he/she was determined eligible for Medicare Part D. If the eligibility date for Medicare Part D coverage is retroactive to or before the date of pharmacy service for which the [SMA](#) paid, then the [SMA](#) can recover the money through the Medicaid Pharmacy Subrogation process. The process requires the [SMA](#) to file a claim with [CMS](#)'s contractor who operates the Low Income Newly Eligible Transition (LINET) demonstration program for limited income Medicare beneficiaries. The [SMA](#) bills the contractor electronically, using a National Council for Prescription Drug Programs (NCPDP) form. With subrogation, there are no billing time limitations or preauthorization issues.<sup>42</sup>

## **7. Medicare Bad Debt Provider Enrollment**

The state may require Medicare-certified providers to execute a Medicaid provider agreement and enroll in the state's Medicaid program in order to submit claims for reimbursement of QMB cost-sharing. This is true for all provider types, even those that

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<sup>42</sup> 45 CFR § 162.1901 and § 162.1902.

do not provide services under the Medicaid state plan (e.g. Long Term Acute Care Hospitals). CMS encourages states to have a mechanism to ensure that providers who enroll only for the sole purpose of Medicare cost-sharing are not included on lists of other providers identified as available to serve Medicaid only beneficiaries.

Alternatively, states may utilize a simplified, limited enrollment process for Medicare providers seeking to enroll in Medicaid for the sole purpose of claiming Medicare cost-sharing reimbursement while in compliance with provider screening and enrollment requirements. As noted above, regardless of the specific enrollment mechanism chosen, states must enable all Medicare enrolled providers, including those who are out of state, some mechanism by which they can get the state to process their Medicare cost-sharing claims, including claims for QMB cost-sharing.

## References

### Statutes & Regulations

- Social Security Act § 1814(a)(1).
- Social Security Act § 1835(a)(1).
- Social Security Act § 1842(b)(3)(B).
- Social Security Act § 1902(a)(10)(E).
- Social Security Act § 1902(a)(77) and (kk).
- Social Security Act § 1902(n)(3).
- Social Security Act § 1905(p)(1).
- Social Security Act § 1935(d).
- Time Limits for Filing Medicare Claims. 42 CFR § 424.44
- Payments for Services Furnished Out of State. 42 CFR § 431.52.
- Pharmacy Subrogation. 45 CFR § 162.1901 and § 162.1902
- Center for Program Integrity – <https://www.medicaid.gov/>

## F. Managed Care

### 1. General Requirements

[COB/TPL](#) requirements apply in Medicaid [MCOs](#), as well as Medicaid fee-for-service programs. [SMAs](#) have four options for ensuring that they meet the [COB/TPL](#) requirements in Medicaid [MCOs](#). Specifically, states may:

- Exclude individuals with known sources of [TPL](#) from enrollment in [MCOs](#);
- Enroll individuals with known sources of [TPL](#) in [MCOs](#), with the [SMA](#) retaining responsibility for [COB/TPL](#);
- Enroll individuals with known sources of [TPL](#) in [MCOs](#) and contractually require that the [MCO](#) assume responsibility for [COB/TPL](#); or,
- Exclude individuals with commercial managed care coverage from enrollment in [MCOs](#), but enroll individuals with other types of third party coverage in the [MCOs](#).

[SMAs](#) can also divide responsibility for [COB/TPL](#) functions between the [SMA](#) and the [MCO](#). For example, the [MCO](#) could be responsible for [COB/TPL](#) for other forms of health insurance coverage, while the [SMA](#) retains responsibility for casualty/tort, liens, and estate recovery. Regardless of how [SMAs](#) choose to allocate responsibility for [COB/TPL](#) activities, the contract between the [SMA](#) and the [MCO](#) must list any [COB/TPL](#) responsibilities of the plan.<sup>43</sup>

If an [SMA](#) delegates responsibility for [COB/TPL](#) to an [MCO](#), the capitation rates should be reduced by an amount actuarially equivalent to the expected amount the plan will recover in [COB/TPL](#). To ensure that future adjustments for [COB/TPL](#) recoveries are accurate, [SMAs](#) must require that [MCOs](#) report any [COB/TPL](#) savings or recoveries.

If an [SMA](#) delegates responsibility for coverage of Medicare cost-sharing for an MCO's dually eligible enrollees, please see additional requirements in 42 CFR 438.3(t).

See subsection 3, below, for additional guidance about [SMAs](#)' delegation of responsibility to [MCOs](#).

### 2. COB/TPL Activities by MCOs

The same general rules that apply for [COB/TPL](#) activities in Medicaid fee-for-service apply in Medicaid managed care. *For example*, [MCOs](#) are required to pay certain types

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<sup>43</sup> 42 CFR § 438.6.

of claims and then seek recovery—“pay and chase”—in the same circumstances as the [SMA](#) is required to do so.

When a [MCO](#) seeks to recover from a third party, it has several options for how to determine what to recover from the liable third party. Specifically, the [MCO](#) can seek to recover:

- The Medicaid fee schedule amount for the service furnished;
- The full amount the insurer is legally liable to pay for the service;
- The amount the [MCO](#) allows for the service;
- The amount the provider bills for the service; or,
- The monthly capitation payment for the service.

The exact amount sought will be determined based on the [MCO](#)'s contract with the [SMA](#) and state law. Any amount recovered in excess of the [MCO](#)'s cost of providing the care should be provided to the beneficiary.

If the [MCO](#) has entered into an arrangement with a provider under which the [MCO](#) pays the provider a fixed amount for each patient, regardless of the services used (referred to as a “sub-capitation payment”), the [MCO](#) should not limit third party recovery to the amount of the sub-capitation payment to that provider. Instead, either the provider or the [MCO](#) must seek recovery for the actual cost of the services rendered.

### 3. Other Managed Care Issues

If a Medicaid managed Care beneficiary's third party coverage is provided by a commercial payer, the SMA must stipulate in their contracts with managed care plans that, unless required by statute or regulation to cover services from providers outside of their network, managed care plans cannot pay claims for services that the Medicaid managed care beneficiary received from a provider who was not in the commercial plan's network and the commercial payer denied the claim solely for that reason.

Under [the Act](#), Medicaid beneficiaries are required to use third party sources of coverage that are available to them at no cost. By seeing an out-of-network provider, the Medicaid beneficiary was not using his or her available health care resources. Consistent with the general principle that Medicaid is the payer of last resort, Medicaid will not reimburse the provider or the beneficiary for any balance not paid by the commercial plan.

Additionally, [SMAs](#) may delegate responsibility and authority to the [MCOs](#) to perform third party discovery and recovery activities, including data matches as required by the [DRA of 2005](#). The [SMA](#) may authorize the [MCO](#) to use a contractor to complete these activities.

When [TPL](#) responsibilities are delegated to an [MCO](#), third parties are required to treat the [MCO](#) as if it were the [SMA](#), including:

- Providing access to third party eligibility and claims data to identify individuals with third party coverage;
- Adhering to the assignment from the [SMA](#) to the [MCO](#) of a Medicaid beneficiary's right to payment by such insurers for health care items or services; and
- Refraining from denying payment of claims submitted by the [MCO](#) for procedural reasons.

Third parties may request verification from the [SMA](#) that the [MCO](#) or its contractor is working on its behalf, and the scope of the delegated work.

Detailed questions related to Medicaid Managed Care requirements should be directed to the Division of Managed Care Programs (DMCP), Disabled Elderly Health Programs Group (DEHPG).

## References

### **Statutes & Regulations**

- Contracts Requirements. 42 CFR § 438.6.

## G. Data and Systems

This chapter discusses data and systems that support the [COB/TPL](#) activities undertaken by [SMAs](#). It is not intended to address the many non-[COB/TPL](#)-related functions performed by a state's Medicaid eligibility determination system or its [MMIS](#).

### 1. State Systems

To maximize [TPL](#) savings through cost-avoiding claims payments for insured Medicaid beneficiaries (to the limit of their health insurer's liability) and recovering for Medicaid paid claims from liable third parties, [SMAs](#) have automated pursuing [TPL](#) to the greatest extent possible. All state systems, including the state's Medicaid eligibility system and [MMIS](#), should include features that enable the [SMA](#) to comply with federal regulations governing [COB/TPL](#).

### 2. State Medicaid Eligibility Determination Systems

An [SMA](#)'s Medicaid eligibility determination system should be able to:

- Identify Medicaid beneficiaries with third party resources.
- Provide basic information on the nature of the third party resource (health insurance or other).
- Report information on eligible beneficiaries and third party resources to [MMIS](#), to support creating a beneficiary file for claims processing.

### 3. State MMIS

An [SMA](#)'s [MMIS](#) must be able to perform, among other things, the following functions:

- Receive beneficiary information from the state's Medicaid eligibility determination system and create a record on the beneficiary file, including some third party resource information.
- Store and retrieve [TPL](#) information on services covered, policy period, and insurance company for each beneficiary.
- Edit claims to flag probable [TPL](#) and cost-avoid claims, where appropriate.
- Override cost avoidance edits for claims that were billed to and denied by the third party resource.
- Associate resubmitted claims with the original denied claim.
- Process Medicare crossover claims, including QMB cost-sharing, for adjudication of Medicaid cost-sharing amounts, including deductibles and coinsurance for

Medicare services, and to furnish the provider with an RA that explains the state's liability or lack thereof.

- Account for [TPL](#) payments to the provider in determining the amount of Medicaid payment still due the provider (if any).
- Identify claims with trauma diagnosis codes and report them to the [TPL](#) subsystem of [MMIS](#), to support development of casualty/tort recovery cases.
- Screen any verified [TPL](#) resource against a paid claims history going back at least one year to identify recoverable funds.
- Accumulate claims up to a specified threshold amount.
- Track and report cost avoidance dollars.
- Associate recoveries back to individual claims.
- Automate recovery activities by maintaining a [TPL](#) subsystem of [MMIS](#), containing identification and status information on beneficiaries with active or closed third party recovery cases, including casualty/tort, liens, and estate recovery claims.
- Automate data matches with health insurers, Motor Vehicle Administration, and Worker's Compensation Commission, to identify third party resources.
- Support health insurer data matching through use of the Payer Initiated Eligibility/Benefit (PIE) Transaction or similar information-exchange tools.

# Chapter III: Liens and Recovery TPL

## A. Liens

### 1. Description of Liens

Liens are rights to property that are given to secure a debt. Liens are filed with or referenced on the title to the property to notify the property owner and any potential buyers that there is an encumbrance on the property. When property subject to a lien is sold, the lien must be satisfied (paid) before title can transfer to the new owner.

In Medicaid, liens are used to enable [SMAs](#) to recover assets from beneficiaries under certain circumstances. [SMAs](#) may only file liens during the lifetime of the Medicaid beneficiary and when certain other conditions are met (see “When Liens are Permitted,” below).

Placing a lien **does not** transfer assets from the beneficiary to the state Medicaid program; instead, it gives an [SMA](#) the right to recover up to the amount of Medicaid expenditures from particular assets at some later date, which may be during the Medicaid beneficiary’s lifetime, or from his estate after the Medicaid beneficiary has died.

Note that, for Medicaid’s purposes, liens differ from estate claims, which are sometimes referred to as liens. Medicaid estate recovery claims are discussed in Section B, below.

### 2. When Liens Are Permitted

[SMAs](#) generally **may not** place liens on the property of Medicaid beneficiaries.<sup>44</sup> Despite this general rule, [SMAs](#) may place liens prior to the beneficiary’s death in the following circumstances:

- ***Judgment that Benefits Were Incorrectly Paid.*** If a court determines that benefits were incorrectly paid, the [SMA](#) may place a lien on the individual’s property. For example, if a court finds that an individual fraudulently obtained Medicaid coverage, a lien may be placed on that person’s property prior to the beneficiary’s death.<sup>45</sup>

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<sup>44</sup> Social Security Act § 1917(a).

<sup>45</sup> Social Security Act § 1917(a)(1)(A)(i)

- ***Liens on Real Property of Permanent Residents of Institutions.*** [SMAs](#) may place a lien on an individual’s land or home (referred to as “real property”) if the individual is (1) a permanent resident of an institution; (2) required, as a condition of receiving services in a medical institution under the [state plan](#), to spend all, but a minimal amount of his income (reserved for personal needs) for costs of medical care; and (3) determined by the [SMA](#) that he cannot reasonably be expected to be discharged and returned home.<sup>46</sup> For the purposes of these liens, an institution includes a nursing facility, Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID), or another type of medical institution.

This type of lien was authorized under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), and is often referred to as a [TEFRA](#) lien. [TEFRA](#) liens are restricted in certain circumstances, as discussed in more detail in subsection 3, below. Note that [SMAs](#) are not required to use [TEFRA](#) liens.

If a pre-death lien is permitted, a lien may be placed on any property that counts as an available resource when determining whether an individual is eligible for Medicaid. Liens may therefore, be placed on assets that are held in revocable trusts.

### 3. Restrictions on Placing Liens

[SMAs](#) may not place [TEFRA](#) liens on an individual’s home if one of the following individuals resides in the home:

- The beneficiary’s spouse,
- The beneficiary’s child, if that child is (1) under age 21, (2) blind, or (3) disabled, or
- The beneficiary’s sibling, if the sibling has an equity interest in the home and was residing in the home for at least one year before the beneficiary was admitted to the institution.<sup>47</sup>

Individuals whose eligibility is determined using Modified Adjusted Gross Income (MAGI) **may not** be subject to [TEFRA](#) liens.

### 4. Termination of Liens

[TEFRA](#) liens on real property must be dissolved (i.e., terminated without collection and removed from the official state property records) if the beneficiary is discharged from

<sup>46</sup> Social Security Act § 1917(a)(1)-(2).

<sup>47</sup> Social Security Act § 1917(a)(1)-(2).

an institution and returns to the home, since the lien is only permitted because the beneficiary was a permanent resident of the institution.<sup>4849</sup>

## References

### **Statutes & Regulations**

- Social Security Act § 1917(a)

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<sup>48</sup> Effective February 9, 2018, Congress enacted the Bipartisan Budget Act of 2018 (BBA), P.L. 115-123, repealing the SMA's ability to place liens against property for the collection of excess or improper Medicaid assistance payments made on behalf of an individual who should not have received them in the case of a court judgment and the state's right to third party payment recoupment

<sup>49</sup> Social Security Act § 1917(a)(3).

## B. Estates

[SMAs](#) are required to attempt to recover Medicaid payments from the estate of a deceased Medicaid beneficiary, for certain services received on or after, the beneficiary attained age 55. This process is referred to as “estate recovery,” and it is explained in further detail below.

### 1. General Overview of Estate Recovery

Estate recovery is permitted or required in the following circumstances:

- If the deceased beneficiary was subject to a lien on real property, the [SMA](#) **must** recover.<sup>50</sup>
- If the [SMA](#) paid claims for the beneficiary at age 55 or over, it **must** recover from the individual’s estate the costs of nursing facility services, home and community-based services, and related hospital and prescription drug services.
- [SMAs](#) **may** opt to collect costs associated with any other [state plan](#) services, except Medicare cost-sharing amounts paid for Medicare Savings Program (MSP) beneficiaries for services on, or after January 1, 2010.<sup>51</sup>
- If the beneficiary received benefits under long-term care insurance, and assets or resources were disregarded in determining the eligibility of the beneficiary, the [SMA](#) **must**

#### Estate Recovery for the New Adult Group Established by the Affordable Care Act

Most individuals age 55 or over receiving Medicaid will be eligible for coverage based on their age or a disability, but some of these individuals will be eligible for Medicaid under the new eligibility group created by the Affordable Care Act (referred to as the “new adult group” or MAGI individuals). The estate recovery rules related to claims paid after the individual reaches age 55 apply to individuals in the new adult group. CMS has advised SMAs that they may use existing statutory authorities to limit the scope of estate recovery. For example, SMAs can limit recovery based on eligibility group, such as limiting estate recovery for the new adult group to recovery for nursing facility services, home and community based services, and related hospital and prescription drug services. See State Medicaid Directors’ Letter 14-001 for additional details.

<sup>50</sup> Social Security Act § 1917(b)(1)(A). Note: the statute says the state must recover from the estate, but the regulation say the state may recover. See 42 CFR § 433.36. Statutory language governs.

<sup>51</sup> Social Security Act § 1917(b)(1)(B). Note: Statute says 55, regulations say 65. See 42 CFR § 433.36. Statutory language governs.

recover from the individual's estate costs associated with skilled nursing facility and other long-term care services, except that [SMAs](#) participating in the Long-Term Care Partnership Program are permitted to exclude from estate recovery assets equal to the amount of benefits paid out by the insurance policy.<sup>52</sup> This is the same amount that was disregarded in the eligibility determination.

Disregard of assets from estate recovery because of the Long-Term Care Partnership Program provisions above is linked with the disregard of assets for eligibility purposes. This disregard is not applicable to [MAGI](#) individuals, because assets are not counted for purposes of determining their eligibility for Medicaid. Benefits paid by a Long-Term Care Partnership Program policy are treated as third party resources.

## 2. What Services Must or May be Included in an Estate Recovery Claim

[SMAs](#) are required to recover the cost of certain services provided to individuals age 55 or over, and they may recover the cost of other services:

- The [SMA](#) **must** recover from the individual's estate the costs of nursing facility services, home and community-based services, and related hospital and prescription drug services provided to individuals age 55 or over.
- The [SMA](#) **may** opt to collect costs associated with any other [state plan](#) services, except Medicare cost-sharing paid for MSP beneficiaries for services on or after January 1, 2010.<sup>53</sup>
- The [SMA](#) **must** also recover at least a portion of any managed care capitation payments, if the [MCO](#) covers services subject to estate recovery. If the [SMA](#) elects to recover the costs of all [state plan](#) services, then it must recover from the beneficiary's estate the total capitation payment even if the MCO provides no services to the Medicaid beneficiary. If, instead, the [SMA](#) elects to recover the costs of some, but not all, [state plan](#) services, it must recover from the beneficiary's estate the portion of the capitation payment that is attributable to the recoverable state plan services even if the MCO provides no services to the Medicaid beneficiary. [SMAs](#) will need to work with an actuary to determine how much of the capitation payment is attributable to services subject to recovery.

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<sup>52</sup> Social Security Act § 1917(b)(1)(C).

<sup>53</sup> Social Security Act § 1917(b)(1)(B). Note: Statute says 55, regulations say 65. See 42 CFR § 433.36. Statutory language governs.

### 3. When Recovery is Permitted

After a [SMA](#) determines that a deceased beneficiary may be subject to estate recovery, it may only make recoveries from the beneficiary's estate under the following circumstances:

- After the death of the surviving spouse (regardless of where the spouse lives).<sup>54</sup>
- When the deceased beneficiary does not have a child who is under age 21 or blind or disabled, regardless of where the child lives.<sup>55</sup>
- If recovering based on a lien on the home of a deceased beneficiary who resided in an institution, in addition to the prohibitions above, the [SMA](#) may not recover if:<sup>56</sup>
  - A sibling resides in the house, if the sibling lived there at least one year prior to the beneficiary's admission to the institution; or
  - A son or daughter resides in the house, if the son or daughter (1) has resided in the house for at least two years immediately prior to the beneficiary's admission to the medical institution, and can establish that he or she provided care that delayed admission to an institution; and, (2) is lawfully residing there and has lawfully resided there continuously since the deceased beneficiary's date of admission to the medical institution.
- When recovery would not create an **undue hardship** for survivors<sup>57</sup>
- SMA's undue hardship policy must be set out in its state plan;
- The state plan need only specify the criteria for waiver of estate recovery claims due to undue hardship;
- SMAs have discretion in defining what constitutes an undue hardship. At the state's discretion, this may include establishing reasonable protections applicable to the same-sex spouse or domestic partner of a deceased Medicaid recipient.

Some common situations that may cause undue hardship if the [SMAs](#) enforced the Medicaid estate recovery claim include:

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<sup>54</sup> Social Security Act § 1917(b)(2)(A).

<sup>55</sup> Social Security Act § 1917(b)(2)(A).

<sup>56</sup> Social Security Act § 1917(b)(2)(B).

<sup>57</sup> Social Security Act § 1917(b)(3).

- The estate claim would remove the sole income-producing asset of survivors, and the asset produces only limited income;
- The home is of modest value, which is roughly half the average home value in the county; or
- Other compelling circumstances, such as that, without the receipt of the estate proceeds, the survivor would become eligible for public or medical assistance or recovering the assets would deprive the survivor of necessities such as food and shelter.

## 4. What Assets May Be Recovered

The [SMAs](#) recover from the beneficiary's estate. [SMAs](#) **must** define the estate to include, at the least, the beneficiary's probate estate (the estate that passes through a beneficiary's last will and testament). The probate estate will be defined under the state's probate code and will vary somewhat across states.

[SMAs](#) **may** define the estate to include the broader, non-probate estate. Assets in the non-probate estate include assets that pass automatically to another person, for example, a joint checking account or jointly held property. Assets that pass automatically by contract, such as life insurance policies or annuities, also would be part of the non-probate estate.

Certain types of financial arrangements present unique challenges for [SMAs](#) seeking to recover from estates.

- **Annuities.** Annuities are generally not part of the probate estate (though state laws may vary). [SMAs](#) that define estate as the beneficiary's probate estate, therefore, will not recover from amounts paid to the decedents' beneficiaries under annuities. The expanded definition of estate under [the Act](#), however, includes "other arrangements."<sup>58</sup> The term "other arrangements" would include annuities, and thus, in [SMAs](#) using the expanded definition of estate, the [SMA](#) would recover from amounts paid under an annuity.
- **Life Estates.** Under a life estate, an individual who owns property transfers ownership of that property to another individual while retaining for the rest of his or her life (or the life of another person) certain rights to the property. In general, a life estate, entitles the owner of the life estate to possess, use, and to obtain profits from the life estate as long as he or she lives. Actual ownership of the property transfers to another person, the owner. After the individual dies, the property passes to the owner. For example, an individual could deed a house to someone, but retain a life estate interest that would allow him/her to live

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<sup>58</sup> Social Security Act § 1917(b)(4)(B).

there until death. Under common law, that individual has no interest at the time of death, since the life estate ceases to exist when the individual dies and the full rights to the property transfers to the owner.

Although common law holds that an individual does not have an interest in a life estate after he or she dies, the expanded definition of estate under federal Medicaid law does include life estates. As a result, if a [SMA](#) has elected to use the expanded definition of estate, the life estate in which a Medicaid enrollee has an interest at the time of death is subject to estate recovery.

## 5. What Assets May NOT Be Recovered

The [SMA](#) may not recover from the estate of a deceased beneficiary the following assets, including:

- Certain Income, resources, and property of American Indians/Alaska Natives, such as:
  - Property, including land and buildings, located on a reservation or near a reservation or within the most recent boundaries of a prior federal reservation, as designated by the Bureau of Indian Affairs and the U.S. Department of the Interior, so long as the property is passing from an Indian to one or more relatives (including non-Indian relatives), to a tribe, or to one or more Indians;
  - Income received from an estate where the income derived from property that could not be recovered, so long as the individual can clearly trace the income back to the protected property;<sup>59</sup>
  - Ownership interests in rents, leases, royalties, or usage rights related to natural resources, including the right to fish, hunt, or harvest timber, as well as income derived from these sources that is collected by an Indian or a tribe and distributed to Indians; or
  - Ownership interests in or usage rights that have unique religious, spiritual; traditional; or cultural significance or rights that support a subsistence or traditional lifestyle.
- Government Reparation Payments made to survivors of Nazi persecution. The reparation payment itself is exempt, as are items purchased with the payment that are not considered to be assets, such as food and clothing. However, once

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<sup>59</sup> Social Security Act § 1917(b)(3)(B).

the payment is used to acquire an asset that would otherwise be subject to estate recovery, then the reparation payment no longer exists and there is no exemption of the asset based on the source of the purchasing funds as a reparation payment.<sup>60</sup>

## References

### **Statutes & Regulations**

- 42 CFR § 433.36
- Social Security Act § 1917(b).
- H.R. 1873, § I.a., January 25, 1994.

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<sup>60</sup> See H.R. 1873, § I.a., January 25, 1994.

## C. Casualty/Tort Recovery

### 1. General Overview of Casualty/Tort Recovery

A Medicaid beneficiary may need medical items or services because of injury caused by the action, inaction, or negligence of a third party. Such situations include vehicular and other accidents, injury caused by a defective product (product liability), job-related injury, and medical malpractice. All these situations are referred to as casualty/tort cases. In this situation, the injury creates a cause of action for the injured party, who may make a claim for compensation for medical and other losses incurred because of the injury. Claims in these cases may be settled with or without court action.

[SMAs](#) must recover from out-of-court settlements or court judgments (awards) that include compensation for medical expenses, since a third party is liable for the cost of medical care provided to beneficiaries that is necessitated by the cause of action. [SMAs](#) are required to recover, if possible, the full amount spent on a beneficiary's casualty/tort-related medical care.

### 2. Ahlborn Limitations on Settlement Funds Subject to Recovery

Settlements and awards often contain more than just payment for the cost of medical care, such as payment for pain and suffering or lost wages. A state is limited to recovering its Medicaid expenditures from the portion of the settlement, judgment or award designated for medical expenses. *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006).

In *Ahlborn*, the Supreme Court of the United States held that the federal Medicaid statute only allows recovery for medical assistance from the portion of a liability settlement attributed to medical items and services. To the extent that the Arkansas state statute provided for filing a lien for full recovery of medical assistance payments, the Court found it conflicted with the Medicaid anti-lien laws found at section 1917(a)(1) of [the Act](#). This section prohibits the state from imposing liens against any individual prior to his/her death on account of medical assistance paid on his/her behalf, with limited exceptions specified in the statute.<sup>61</sup>

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<sup>61</sup> In 2018, Congress enacted the Bipartisan Budget Act of 2018 (BBA), as P.L. 115-123, which repealed the existing amendment (Bipartisan Budget Act of 2013) giving states the authority to recover from the full settlement amount. Settlements and awards often contain more than just payment for the cost of medical care, such as payment for pain and suffering or lost wages. Nevertheless, the current law is SMAs are required to recover funds only from the portion of a beneficiary's settlement or judgment intended to cover medical items or services.

### 3. SMAs' Ability to Reduce Total Recovery

[SMAs](#) are not permitted to compromise or negotiate with the beneficiary or other third parties to reduce the amount recovered by Medicaid, unless the federal government has been reimbursed for its share of the SMA's recovery amount. Some [SMAs](#) contend that beneficiaries will not cooperate in recovery actions if they will not receive a portion of the settlement or award. [SMAs](#) have three options related to tort recovery that could result in the beneficiary receiving a portion of the settlement or award. Specifically, [SMAs](#) may elect one of the following options:

- **Apply Cost-Effectiveness Criteria.** Although [SMAs](#) are not permitted to compromise or negotiate to limit recovery, they may not pursue recovery if it is not cost-effective. For example, a [SMA](#) may determine that it is only cost-effective to pursue less than the full amount of Medicaid expenditures in order to avoid the [SMA](#)'s needing to enter litigation to recover. In this case, the [SMA](#) would be permitted to pursue the lesser amount. After recovery, the [SMA](#) would reimburse the federal government for its share of the total amount recovered—not the total amount of Medicaid expenditures. The federal share of the recovered amount is determined by multiplying the total amount recovered by the Federal Medical Assistance Percentage (FMAP).

[SMAs](#) may forgo recovery efforts if recovery would not be cost-effective, but **may not** create rules that allow beneficiaries *in every case* to retain a portion of the award. In other words, cost-effectiveness must be determined on a case-by-case basis. The [state plan](#) must describe how a [SMA](#) determines whether recovery is cost-effective (use of a dollar threshold amount of claims, time period to accumulate claims, or other guideline).

- **Allowance for Attorney Fees and Costs.** [SMAs](#) may choose to require that the full value of attorney fees and litigation costs be deducted from the settlement or award first, and then the [SMA](#) will seek to recover the full amount of Medicaid expenses. When [SMAs](#) take this approach, the full value of the attorney fees and litigation costs comes out of what the beneficiary would otherwise receive.

Alternatively, the [SMA](#) could choose to pay a proportionate share of attorney fees and costs. The [SMA](#)'s share of attorney fees and costs would be the same as its share of the total award. If the [SMA](#) shares in paying attorney fees and costs, federal financial participation is available at the standard rate for program administrative expenditures.

If an [SMA](#) elects to pay a share of the attorney fees and costs and its claim exceeds the total award, then the [SMA](#) would pay the full attorney fees and

costs. If the SMA elects to cover its share of attorney fees and costs, it would reimburse the federal government for its share based on the total amount recovered (determined by multiplying the total amount recovered by the FMAP)—not the total amount of Medicaid expenditures.

Note that [SMAs](#) **may not** have a standard reduction in recovery to account for attorney fees. Instead, they must determine the proportion of attorney fees and costs they will pay on a case-by-case basis.

- **Compromising with the SMA’s Share.** [SMAs](#) can elect to give a portion of their share of the recovery to the beneficiary once the federal government is reimbursed for its share of the SMA’s recovery amount.

## 4. Tort Recovery in Global Settlements

Mass tort global settlements present another challenge for Medicaid recovery. Often, these mass tort global settlements arise out of product liability cases related to defective drugs or devices. These settlements may include hundreds, or even thousands, of plaintiffs in multiple states, each of whom may be entitled to different recovery amounts.

[SMAs](#) may not know whether and how many of its Medicaid beneficiaries are entitled to a portion of a global settlement. Even when a [SMA](#) can identify which Medicaid beneficiaries are receiving a portion of the settlement, they may struggle to determine which Medicaid claims for each individual are related to the defective drug or device. Given these challenges, [SMAs](#) may find that it is not cost-effective to pursue recovery.

In these circumstances, [SMAs](#) should work within the established litigation process and could agree to be bound by a settlement that compensates the [SMA](#) for the medical expenses incurred by the [SMA](#) on behalf of the Medicaid beneficiaries involved in the settlement.

Although [SMAs](#) are not permitted to compromise the federal share of a claim for recovery, [CMS](#) has determined that [SMAs](#) that participate in global settlements are not violating the “no compromise” policy, since they cannot reasonably identify the medical claims paid on behalf of a specific Medicaid recipient for which a third party is clearly liable.

## 5. Settlement of Claims for Medicare/Medicaid Dually Eligible Beneficiaries

Medicare has the right to recover the cost of benefits provided from employers and workers' compensation carriers, liability insurers, automobile or no fault insurer and employer group health plans before any other entity, including an [SMA](#). Medicare also has the right to recover its benefits from any entity, including an [SMA](#) that has been paid by a third party. In other words, Medicare's recovery rights are higher than and take precedence over the rights of any other entity, including [SMAs](#), when any of these third parties is the primary payer.

Medicaid's right to recover lacks the priority of Medicare's right to recover because Medicaid gains its right to recover through the assignment of rights process. Medicaid can recover from third parties only because the beneficiary has allowed Medicaid to stand in the beneficiary's shoes and receive payments that otherwise would have been paid to the beneficiary. Beneficiaries can only assign their own rights. Under Section 1862(b)(2)(B) of the Act, Medicare has the right to recover its expenditures from a settlement, judgment, award, or other payment received by the beneficiary even before the beneficiary's share of that recovery is determined. Since Medicaid can only take the place of the beneficiary, and Medicare's recovery rights in a settlement, judgment, award, or other payment exist independent of any determination regarding the beneficiary's share of that recovery, Medicaid's right of recovery is secondary to Medicare's right of recovery.

As a result, where Medicare and Medicaid have both paid for services, and the amount available from the third party is not sufficient to satisfy the claims of both programs for reimbursement, the third party must reimburse Medicare the full amount of its claim before the state Medicaid agency may be paid.

If the third party has reimbursed an [SMA](#), or if a beneficiary/recipient, after receiving a payment from the third party, has reimbursed an [SMA](#), the [SMA](#) must reimburse Medicare up to the full amount it received if Medicare is unable to recover its payment from the remainder of the third party payment. If the [SMA](#) refuses to reimburse Medicare in full, Medicare carriers and intermediaries are instructed to refer the case to the [RO](#) for resolution. If payment is not made by the [SMA](#), the federal government will offset Medicare's claim against any federal financial participation funds that would be paid to the [SMA](#).

# Chapter IV: Other Topics

## A. Adoption & Surrogacy

### 1. Adoption

A pregnant woman who is eligible for Medicaid is entitled to Medicaid payment for prenatal, labor and delivery, and postpartum care. If she chooses to put her baby up for adoption, the adoptive family may be contractually obligated to cover the costs of the mother's care, as adoption agreements often include a provision stating that the adoptive family will cover the costs of medical care for the mother.

Section 1902(a)(25)(A) of [the Act](#) requires the [SMA](#) to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services under the [state plan](#), and to seek reimbursement to the extent of the third party's liability. The statutory definition of third party includes "parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or Service." Additionally, per section 1912 of [the Act](#), the pregnant woman, as a condition of receiving Medicaid benefits, has assigned to the state her right to payment for medical care by the third party.

The [SMA](#) should review the adoption agreement to determine the nature and extent of any contractual liability to pay for the pregnant woman's health care. If the [SMA](#) determines that such liability exists, it should utilize the third party resource, either through cost avoidance or pay and chase claims processing, depending on the claims processing requirements for the type of service as specified in 42 [CFR](#) 433.139.

### 2. Surrogacy

Similar to the adoption context, if a Medicaid-eligible woman acts as a gestational surrogate, Medicaid will pay for the prenatal, labor and delivery, and postpartum care. The surrogacy contract between the biological parents and the surrogate may specify that the biological parents are responsible for the surrogate's medical care. If the biological family is contractually obligated to cover medical costs, the surrogacy contract creates [TPL](#), and the [SMA](#) must pursue reimbursement from the biological parents to the extent of their liability under the contract.

## References

### Statutes & Regulations

- Social Security Act § 1902(a)(25)
- Social Security Act § 1912
- 42 CFR § 433.139

## B. Indemnity Plans

Some Medicaid beneficiaries may have a type of insurance referred to as an “indemnity plan.” Unlike traditional health insurance plans that cover claims submitted by providers, indemnity plans pay in a variety of ways, including paying a set amount if a certain situation occurs. For example, a policy may pay a fixed amount per day for each day that an individual is a patient in a hospital.

Like traditional health insurance plans, indemnity plans can be a source of [TPL](#) under the Medicaid rules. A third party includes “any individual, entity, or program that is or may be liable to pay all or part of expenditures for medical assistance furnished under a [state plan](#),” including insurance offered by a private insurer.<sup>62</sup> Private insurers include “any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-related insurance contracts *and indemnity contracts* [emphasis added].”<sup>63</sup>

To determine whether a particular indemnity plan counts as a source of [TPL](#), [SMAs](#) should examine the terms of the particular policy. If the policy provides payment for healthcare items or services, the policy is a third party resource. Whether the policy will be a third party resource for any specific Medicaid-covered service will depend on whether the policy explicitly includes or excludes the service from coverage. A general statement of coverage for medical expenditures would be inclusive of all Medicaid covered services.

Some policies specify that the cash payments can be used for living expenses, such as rent, child care, or groceries. These expenses are not medical assistance under the [state plan](#), but the policy constitutes [TPL](#) if the cash payments are triggered by the occurrence of a particular medical event. For example, a policy offering a cash payment for each day an individual is an inpatient in a hospital would be a source of [TPL](#), even if the individual may use the cash payment to cover nonmedical expenses such as rent.

If the indemnity policy does not qualify as a third party resource, any payments made to a Medicaid beneficiary may be countable as income for Medicaid eligibility purposes.

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<sup>62</sup> 42 CFR § 433.136.

<sup>63</sup> 42 CFR § 433.136.

## C. American Indians/Alaskan Natives

American Indians/Alaska Natives (AI/AN) and Indian Health Service (IHS) providers receive special protections under federal Medicaid law.

### 1. IHS is a Secondary Payer to Medicaid

Medicaid is generally the payer of last resort, meaning that Medicaid only pays for a service if there are no other sources of payment available. There are a few exceptions to this general rule, including, among others, [IHS](#) programs.<sup>64</sup> [SMAs](#) will pay for medical expenses that otherwise would be covered by an [IHS](#) program. The [IHS](#) will stand behind Medicaid to pay for services that are available under the [IHS](#) program but that Medicaid does not cover.

### 2. Estate Recovery

Section 1917(b)(3)(B) of [the Act](#) incorporates into statute certain specific exemptions from estate recovery for certain [AI/AN](#) income and resources, ownership interests, and usage rights. Section 3810.A.7 of the [SMM](#) provides detailed guidance about these exemptions.

While extensive, the exemptions from estate recovery are not all-inclusive. The [SMA](#) may recover income, resources, and property of a deceased [AI/AN](#) that is included in the [SMA](#)'s definition of estate and that is not exempted in the [SMM](#).

### 3. Federal Share for Reimbursement of COB/TPL Collections

[SMAs](#) receive 100 percent federal matching funds for payments for services received through an [IHS](#) program, including those operated by the [IHS](#) or an Indian tribe or tribal organization.<sup>65</sup> When a [SMA](#) recovers from a liable third party for a payment for a service received through an [IHS](#) program, the [SMA](#) should reimburse the federal government for 100 percent of the amount paid by Medicaid, less any required incentive payments.

## References

### Statutes & Regulations

- Social Security Act § 1905(b).

<sup>64</sup> Social Security Act § 1905(b).

<sup>65</sup> Social Security Act § 1905(b).

## D. Department of Veterans Affairs (VA)

### 1. COB: General Rule

Medicaid is generally the payer of last resort, meaning that Medicaid will only pay for a service if there are no other sources of payment available. In other words, Medicaid will not pay claims for services that third parties are obligated to cover.

The [VA](#) offers healthcare benefits to eligible veterans. Generally, these benefits are a source of [TPL](#), meaning that the [VA](#) must pay for a service before Medicaid. There are two specific exceptions to this general rule related to payment for nursing home care and emergency treatment in non-VA facilities.

### 2. Exception to COB: Payment for Nursing Home Care

The [VA](#) makes per diem payments for nursing home care provided to eligible veterans in facilities recognized as state veterans' nursing homes. This type of payment is generally regarded as a source of [TPL](#), thereby offsetting the amount Medicaid owes. A 2004 federal law, however, prohibits these per diem payments from treated as a third party resource for the purposes of Medicaid [TPL](#).<sup>66</sup> Because of this law, the per diem payments from the [VA](#) is not used to reduce Medicaid's share of the cost of providing nursing home services for Medicaid beneficiaries in these specific nursing homes.

### 3. Exception to COB: Payment for Emergency Treatment at Non-VA Facilities

The [VA](#) will also pay for emergency care provided to eligible veterans at facilities not operated by the [VA](#) (referred to as non-VA facilities). Veterans, however, are **not** eligible for VA coverage of emergency treatment at non-VA facilities if they are eligible for Medicaid.<sup>67</sup> As a result, the [VA](#) will not cover emergency treatment at non-VA facilities for Medicaid eligible veterans. Since the [VA](#) is not obligated to cover this emergency treatment for Medicaid-eligible veterans, Medicaid must cover it, and Medicaid cannot seek repayment from the [VA](#).

## References

### Statutes & Regulations

- Reimbursement for Emergency Treatment. 38 U.S.C. § 1725(b)(3)(B).
- Pub. L. No. 108-422, § 202

<sup>66</sup> Pub. L. No. 108-422, § 202.

<sup>67</sup> 38 U.S.C. § 1725(b)(3)(B).

## E. Department of Defense (DOD)/TRICARE

The [DOD](#) provides healthcare benefits to current and retired military and their families through the TRICARE program. Most of the general [COB/TPL](#) principles described elsewhere in this manual apply to TRICARE, but there are a few special considerations related to the TRICARE program.

### 1. TRICARE for Life

TRICARE for Life is a program for military retirees with Medicare Parts A & B, as well as their dependents who are also covered by Medicare. TRICARE for Life acts as a Medicare supplemental policy.

When TRICARE and Medicare both cover a service, Medicare acts as the primary payer and TRICARE for Life covers the beneficiary's Medicare cost-sharing. If Medicare covers a benefit, but TRICARE does not (*e.g.*, chiropractic), TRICARE for Life pays nothing. By contrast, if TRICARE covers a benefit but Medicare does not (*e.g.*, prescription drugs or overseas care), Medicare pays nothing and TRICARE for Life cost-sharing applies.

Some individuals receiving TRICARE for Life are also eligible for Medicaid. Medicaid is the payer of last resort for these individuals. Medicaid will only cover the handful of benefits or cost-sharing not otherwise covered by either Medicare or TRICARE for Life.

### 2. Timely Filing

Under the [DRA of 2005](#), states are required to pass laws requiring that health insurers make payments for claims submitted by the [SMA](#) within three years of the date of service. Congress, however, explicitly exempts TRICARE from state and local laws related to health insurance (or other health care financing mechanisms).<sup>68</sup>

As a result, the three-year claims filing period established under state law does not apply to TRICARE. Instead, claims must be submitted to TRICARE within one year of the date of service<sup>69</sup> or within one year after the state received the results of the annual data match from the Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) Division.

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<sup>68</sup> 10 U.S.C. § 1103.

<sup>69</sup> 10 U.S.C. § 1101.

## **F. CMS 64 Reporting**

Estate recovery as approved in the SMA's plan outlined under 42 CFR 433.36(h) requires the SMA to enter such recoveries on lines 9A or 9B of the CMS 64 as they apply.

### **1. 9A – Third Party Liability (TPL) Collections**

The MBES will automatically report only collections made during the quarter for the TPL on line 9A of the Summary Report. Report their source on form CMS 64.9a Schedule of third party liability collections.

The MBES will automatically enter in column (a) the amount from Section-A Third Party Liability Collections Line 2, Column (a) of the CMS 64.9a.

The MBES will automatically enter in column (b) the amount from Section-A Third Party Liability Collections Line 2, Column (b) of the CMS 64.9a.

### **2. 9B – Probate Collections**

Enter the amounts collected from the estates of deceased Title XIX recipients. Many Medicaid recipients, particularly the aged in long term care facilities, die without survivors. SMAs take part in benefit recovery through a probate collection.

If the SMA performs estate recovery, they would then be required to report on the CMS 64. In doing so, the SMA would be required to breakdown the recouped funds to include repayment of the federal share.

## **G. Health Savings Accounts (HSA)**

Under IRS regulations, an individual who is enrolled in Medicaid is not eligible to make or receive contributions into an HSA.

## **H. Contingency Fee Contracts**

As described in Section 2975 of the State Medicaid Manual (SMM), SMAs should consult with the CMS Regional Office (RO) before entering into a TPL contingency fee contract. The RO will review the contract according to guidance under Section 2975 of the SMM to offer guidance on the appropriateness of such an agreement reducing the possibility of a subsequent denial or deferral of FFP.

## 1. SMM 2975.4A

States cannot pay for certain types of collections even if they are made by contingency fee contractors:

- Third party payments shown on the claim as collected by the provider,
- Overpayment refunded voluntarily by the provider,
- Cost avoidance from third party resources already identified in state files,
- Cost-avoided claims avoided after the contractors' initial identification of third party resource (and after the timely reporting date for the contractor to inform the state of coverage).

The state sets the contingency fee percentage (keeping in mind the “effective and efficient” standard).

## 2. SMM 2975.5

CMS doesn't set a minimum or maximum percentage for contingency fee contracts.

CMS participates in payment of the contract's cost.

## 3. 45 CFR 92.36(a)

The contractor's fee is paid based on cost avoidance savings or actual recoveries.

## 4. SMM 2975.1, section 1903(a)(7) of the Social Security Act, 42 CFR 433.15(b)(7)

CMS participates in the cost of the contract at the standard (50 percent) administrative rate, not at the FMAP rate.

CMS receives a share of the recovered funds

## 5. 45 CFR 92.36(a)

- States must report collections and cost avoidance savings to CMS,
- CMS is entitled to the FMAP share of the recover amount.

## References

### Statutes & Regulations

- Resource Allocation Methods: Capitation or Diagnosis-Related Groups. 10 U.S.C. § 1101.
- Contracts for Medical and Dental Care: State and Local Preemption. 10 U.S.C. § 1103.

# REFERENCE

## List of Statutory Provisions

### U. S. Code and Public Law References:

<b>Section</b>	<b>Reference</b>
10 U.S.C. § 1101	TRICARE-Timely Filing
10 U.S.C. § 1103	TRICARE Timely Filing
38 U.S.C. § 1725(b)(3)(B)	Veterans Affairs – Nursing Home Care
42 U.S.C. § 10602	COB/TPL - Crime Victims Compensation Fund
42 U.S.C. § 300ff et seq.	Ryan White Program (Payer of Last Resort Exception)
42 U.S.C. § 1786	Women, Infants, and Children Program (Payer of Last Resort Exception)
Pub. L. No. 108-422, § 202	Department of Veterans Affairs

### Social Security Act – Title XVIII- Medicare

<b>Section</b>	<b>Reference</b>
§1814(a)(1)	Medicare Timely Filing Rules and Exceptions
§1835(a)(1)	Medicare Timely Filing Rules and Exceptions
§1848(g)(3)	Medicare Provider Sanctions

### Social Security Act -- Title XIX – Medicaid

<b>Section</b>	<b>Reference</b>
§1902(a)(10)(E)	QMB Cost-sharing
§1902(a)(10)(E)(i)(iv)	Coverage of Medicare deductibles and coinsurance for QMBs
§1902(a)(11)	Assignment of Rights (AOR)
§1902(a)(18)	Requires that a state plan for medical assistance comply with the provision of Section 1917 with respect to an estate recovery plan
§1902(a)(25)(A)-(I)	Legal Liability of Third Parties
§1902(a)(25)(a)	Defining Third Party Payers
§1902(a)(25)(l)	COB state assurance (added by Section 6035 of the Deficit Reduction Act of 2005)
§1902(a)(45)	Individuals Assignment of Medical Support
§1902(a)(60)	Provides assurances satisfactory to the Secretary that the state has in effect laws relating to medical child support required under Section 1908 of the Act
§1902(a)(77) and (kk)	Medicaid and CHIP provider enrollment rules

<b>Section</b>	<b>Reference</b>
§1902(n)(1)-(3)	Cost-sharing payment of options for states (QMB) and Prohibition of Balance Billing of QMBs
§1903(c )	Parts B & C of the Individuals with Disabilities of Education Act (IDEA)
§1903(d)(2)	Allows for reducing payments to states by the amount of TPL reimbursement
§1903(o)	Provides that Federal Financial Participation (FFP) is not available to a state if an insurer would have paid except for a Medicaid exclusionary clause
§1903(p)	Allows incentive payments for collecting and enforcing rights of support or payment assigned under Section 1912
§1905(a)	The definition of “medical assistance” expressly includes “insurance premiums for medical or any other type of remedial care or the cost thereof”
§1905(b)	Indian Health Services
§1905(p)(1)	Definition of qualified Medicare beneficiaries
§1905(p)(3)	Coverage of Medicare deductibles and coinsurance for QMBs
§1906	Allows for enrollment of Medicaid eligible beneficiaries in cost-effective group health plans. States may choose to make enrollment a condition of eligibility
§1908	Requires states to have specific laws in effect relating to medical child support that govern employers, insurers, title IV-D and Medicaid agencies
§1912	Assignment of Rights
§1912(a)(1)	Requires that a state plan for medical assistance require individuals to assign their rights to third party payment and to cooperate in establishing paternity and in identifying third parties to the Medicaid agency
§1912(a)(2)	Requires state plans to provide for entering into cooperative agreements for the enforcement of rights and collection of third party benefits. These agreements may be with the State title IV-D agency, any appropriate agency of any state, and appropriate court and laws enforcement officials
§1917(a)	Liens
§1917(a)(1)-(2)	Liens on Real Property of Permanent Residents of Institutions
§1917(a)(1)(A)(i)	Judgment that benefits were paid incorrectly
§1917(a)(3)	Terminations of Liens
§1917(b)	Requires states to have an estate recovery program in place to recover from deceased recipients’ estates payments for certain Medicaid services
§1917(b)(1)(A)	Estate Recovery

<b>Section</b>	<b>Reference</b>
§1917(b)(1)(B)	Estate Recovery
§1917(b)(1)(B)(ii)	Eliminates from estate recovery, medical assistance for Medicare cost-sharing for Medicare Savings Program benefits
§1917(b)(1)(C)	What services must or may be included in an Estate Recovery Claim
§1917(b)(2)(A)	Estate Recovery
§1917(b)(2)(B)	Estate Recovery
§1917(b)(4)(B)	Life Estates
§1917(b)(3)	Liens & Recovery-Hardship policy
§1917(b)(3)(B)	Liens & Recovery-American Indians and Alaska Natives
§1935(d)(1)(d)	

## List of Regulations

42 CFR 424.44	Medicare Timely Claims Filing Rules and Exceptions
42 CFR 424.44(b)	Medicare Timely Claims Filing Rules and Exceptions
42 CFR 431.52	Medicare DMEPOS-Payment – Out of State
42 CFR 433.36	Medicaid Estate Recovery
42 CFR 433.136	Payer of Last Resort - Definitions
42 CFR 433.137	COB State Plan Requirements
42 CFR 433.138	Identifying Third Parties - Exchanging Data with State Databases – Diagnosis & Trauma Code Edits
42 CFR 433.138(k)	TPL Action Plans
42 CFR 433.138(l)	TPL Waiver of requirements
42 CFR 433.139	Payment of Claims
42 CFR 433.139(b)(1)	Cost Avoidance
42 CFR 433.139(b)(3)	Exception to Standard COB: Pay and Chase – Preventive Pediatric Services
42 CFR 433.139(b)(3)(ii)	Exception to Standard COB: Pay and Chase-Medical Support Enforcement
42 CFR 433.139(e)	Payment of claims – Waiver of Requirements
42 CFR 433.139(f)	Payment of claims – Waiver of Requirements
42 CFR 140	FFP and Payment of Federal Share
42 CFR 433.140(a)	FFP and Payment of Federal Share
42 CFR 433.140(b)	FFP and Payment of Federal Share
42 CFR 433.140(c)	FFP and Payment of Federal Share

42 CFR 433.146	Assignment of Rights – Assignment Method
42 CFR 433.148	General Requirements – Medicaid Eligibility
42 CFR 433.151	Medical Child Support
42 CFR 433.152	Requirements for Cooperative Agreements for Third Party Collections
42 CFR 433.153(a)	Medical Child Support
42 CFR 433.153(b)	Medical Child Support
42 CFR 433.154	Medical Child Support – Distribution of Collections
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